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An Analysis of Managed Care Network Standards in Other State Workers' Compensation Systems

by Dana Baroni and Amy Lee

House Bill 2600 (77th Texas Legislature, 2001), an omnibus workers' compensation bill addressing several concerns related to the cost and quality of medical care, introduced an alternative model for workers' compensation health care delivery in Texas.[1] In Article 2 of the bill, the legislature commissioned a study to determine the feasibility of establishing regional workers' compensation health care delivery networks in Texas, which would encompass both effective cost-control and quality medical outcomes. It also created a Governor-appointed Health Care Network Advisory Committee (HNAC) to set the standards for health care provided through these regional networks, and make other important decisions involving the feasibility and operation of these networks.

Article 2 also stipulated that a "managed care" model would be utilized, by providing that the current state standards for Preferred Provider Organizations (PPOs) would serve as minimum standards for any workers' compensation regional networks that are created.[2] In addition, the HNAC may consider adopting other network standards, including but not limited to:

- standards that ensure broad access to and timeliness of medical care;
- use of treatment guidelines;
- accreditation of regional networks;
- development and adherence to provider eligibility and screening criteria;
- submission of timely and accurate cost and quality of care data by individual networks;
- training of care providers consistent with the Texas Workers' Compensation Commission's (TWCC) rules;
- availability of board-certified occupational medicine specialists; and
- implementation of medical dispute resolution and change of doctor processes.

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Background

Definitions of "managed care" vary significantly for each type of health care delivery system; however, managed care as it is most broadly defined constitutes a comprehensive set of medical services provided by a network of health care providers and controlled by some type of medical organization.[3] The medical organization is typically either a managed care organization (MCO), also referred to as a health maintenance organization (HMO), or a preferred provider organization (PPO). The managed care model for Texas outlined in Article 2 is something of a hybrid between the HMO and the PPO models,

since the enabling statute allows an injured worker to bring his or her family doctor into the network under certain circumstances (unlike an HMO, where the employee must choose a primary care physician from the network list) and allows referrals outside of the network under certain circumstances. Another distinction is that participation in any Article 2 networks will be entirely voluntary for employees (although employees will be bound by this decision after certain durations).

In an ideal environment, managed care seeks to provide quality medical care while controlling excessive and unnecessary medical costs. This is achieved by setting specific health care objectives (i.e., network standards of care) and monitoring the network's adherence to those objectives. Generally, there are five categories of state workers' compensation managed care arrangements:[4]

1. A state mandated managed care program for all employers;
2. A state regulated managed care program, in which the employee must treat within employer's plan if the employer participates in program;
3. A state regulated managed care program, in which the employee may opt out of the employer plan in certain circumstances;
4. A state allowed managed care program, in which the *employer* directs care within the plan; and
5. A state allowed managed care program, in which the *employee* directs care within plan.

According to the Workers Compensation Research Institute (WCRI), 16 states use the allowed model with employee-directed care, making it the most prevalent arrangement (see Table 1). The least prevalent model is the mandated managed care arrangement, practiced in 4 states. The Texas model, as outlined in Article 2 of HB 2600, represents a regulated managed care arrangement, although participation in the regional networks, if deemed feasible, will be optional for the insurance carrier and the injured worker. While HB 2600 places Texas in the regulated managed care category as well as the allowed/employee-directed care model, it is unique in that it is the state that directly manages the regional health care delivery networks (under the direction of the HNAC) rather than the managed care network seeking state certification (as required in other regulated managed care state systems).

The purpose of the research summarized in this article is to assist the feasibility study consultant and the HNAC in their efforts to establish regional network standards by collecting information about other states' workers' compensation managed care network standards, certification requirements and regulations. In this regard, ROC staff conducted telephone interviews with personnel in the states identified by WCRI as having a regulated workers' compensation managed care arrangement. The MCO certifying agencies for each state were asked to explain their certification processes and describe any positive or negative experiences their state has had with MCO certification. After information was gathered via telephone, states were e-mailed or faxed a copy of their responses for verification.

A total of fifteen states participated in the survey. Although New York's MCO pilot was not renewed, the state does have a PPO program that requires a similar certification process to the MCO, and was therefore included in the survey. North

Table 1
Managed Care Arrangement Breakdown by States

Type of MCO Arrangement	Total Number of States
Mandated	4
Regulated, employee must treat within the plan	10
Regulated, employee may opt out of the plan in certain circumstances	11
Allowed, employer directs care	10
Allowed, employee directs care	16

Source: Workers Compensation Research Institute (WCRI), *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002.*

Carolina and Rhode Island were excluded from the survey because they have yet to receive any MCO applications and therefore have had no actual experience with their certification requirements.

Certification Requirements in Other States

Early resistance to managed care for state workers' compensation systems was driven by stakeholder concerns that injured workers would receive lower quality medical care from the MCO. It was feared that cost-cutting efforts (using a capitated or case-rate basis) to minimize the number of services provided would adversely impact the quality of care. To address these quality of care concerns, some states have developed MCO certification requirements that focus on customer service, financial stability and quality assurance capabilities. These states then use these certification requirements as a monitoring tool. However, little research exists on the effectiveness of state MCO certification in promoting quality medical care while controlling costs.

Specific certification requirements vary by state. See Tables 2, 3, and 4 for a breakdown of the basic certification requirements found in each of the surveyed states.

State Certification Processes

The processes by which MCOs are certified vary significantly in each state depending on the perceived need for managed care, the number of available

Table 2
State Certification Requirements

State	Require Minimum Provider Type & Number in Network	Require Network to Conduct Utilization Review	Require Network to Conduct Medical Case Mgmt.	Require Network to Have Treatment Guidelines	Require Network to Have Internal Dispute Resolution	Require Network to Have Peer Review Function
AR	•	•	•	--	•	•
CA	•	•	•	•	•	•
CT	•	•	--	•	•	--
FL	•	•	•	•	•	•
GA	•	•	•	•	•	--
KY	•	•	•	•	•	•
MA	•	•	--	--	•	•
MN	•	•	•	--	•	•
MO	•	--	--	--	•	--
MT	--	--	--	--	•	•
NE	•	--	•	•	•	•
NY	•	•	•	•	•	•
OH	•	•	•	•	•	•
OK	•	•	•	•	•	•
OR	•	•	•	•	•	•
Total	**14**	**12**	**11**	**10**	**15**	**12**

Source: Research and Oversight Council on Workers' Compensation, *Survey of State MCO Certification Requirements*, 2002.

Table 3
State Certification Requirements, *Continued*

State	Require Physician Training	Require Occupational Medical Specialists	Require Return to Work Programs	Require Safety Services	Require Quality Assurance (QA)	Require Financial Disclosure
AR	•	--	•	--	•	•
CA	•	•	•	•	•	•
CT	--	•	--	--	--	--
FL	•	--	•	--	•	--
GA	--	--	•	--	•	--
KY	--	--	•	--	•	•
MA	--	--	--	--	--	--
MN	•	--	•	--	•	--
MO	--	•	--	--	--	•
MT	--	--	•	--	•	•
NE	--	--	•	--	--	•
NY	--	--	•	--	•	--
OH	•	--	•	•	•	•
OK	--	--	•	•	•	•
OR	--	--	•	•	•	•
Total	**5**	**3**	**12**	**4**	**11**	**9**

Source: Research and Oversight Council on Workers' Compensation, *Survey of State MCO Certification Requirements*, 2002.

Table 4
State Certification Requirements, *Continued*

State	Require Geographic Access to Care	Require Timely Access to Care	Specify Traveling Distance for Care	Require 24 hour Info	Allow Accreditation in Lieu of Certification	Set Advertising Standards
AR	--	--	--	--	--	--
CA	•	•	•	•	--	•
CT	•	•	•	--	--	--
FL	•	•	•	--	--	--
GA	•	•	•	•	--	--
KY	•	--	--	•	--	--
MA	•	•	--	•	•	--
MN	•	•	•	•	--	--
MO	•	--	--	•	--	--
MT	•	•	--	•	--	--
NE	•	•	•	•	--	--
NY	•	•	•	•	•	--
OH	•	•	--	•	--	•
OK	--	--	•	--	--	•
OR	•	•	•	•	--	--
Total	**13**	**11**	**9**	**11**	**2**	**3**

Source: Research and Oversight Council on Workers' Compensation, *Survey of State MCO Certification Requirements*, 2002.

MCOs, and the regulatory authority of the state's certifying agency. Tables 5 and 6 highlight the specific MCO certification processes in each of the states surveyed.

All but one of the states that require a certification fee set the cost at some amount between $500 and $1,500; California charges a significantly higher fee ($20,000), which has been seen by some MCOs as cost prohibitive. California's re-certification fee is likewise significantly higher ($10,000, compared to fees ranging up to $1,500 in other states).

Implementation Issues

The states surveyed for this report were asked to relate their experience with implementing a workers' compensation MCO program in their state, and consistently mentioned two issues as obstacles to effective implementation. First, the steep learning curve involved with the number of new rules and regulations resulted in a slow start in receiving and processing MCO applications. Second, there were a number of issues related to MCO compliance with data reporting requirements. It was felt that increased education, training, and stakeholder participation in the development of reporting requirements would have helped ensure a greater degree of compliance with data reporting.

Conclusion

It is important to remember that the statutory structure for Texas' regional health care delivery networks is different than the MCO structures used in other states. The proposed Texas networks are "fee-for-service" and allow both the insurance carrier and the injured worker to voluntarily "opt in" and, under certain circumstances, allow the injured worker to subsequently "opt out" of the network. No other state MCO program offers this much flexibility to both insurance carriers and injured workers; it has yet to be determined whether this flexibility could result in less certainty in network participation and therefore make it more difficult to negotiate and establish regional network contracts.

An even more significant difference between the network structure in Texas and other states is that under the Texas model, the state certifying agency, namely TWCC (under the direction of the HNAC), contracts directly with network administrators rather than simply certifying the MCOs and their contracts with insurance carriers and/or employers. This places more responsibility and administrative burdens on TWCC and the HNAC, which must evaluate network proposals and monitor network contracts. However, it also gives them more authority to enforce network standards and reporting requirements through the use of contract penalties or contract termination.

Table 5
Overview of State MCO Certification Processes

State	Initial Cost for MCO Certification	# of Years Until Re-certification	Cost for Re-cert.	Number of MCOs Currently Certified	Negotiated Discounts Allowed	Non-Ownership by Carrier
AR	$500	2	--	4	Yes	Yes
CA	$20,000	3	$10,000	14	Yes	Yes
CT	--	2	--	40	Yes	--
FL	$1,000	2	$1,000	430*	Yes	--
GA	$1,000	1	$500	22	Yes	--
KY	no charge	2	no charge	42	Yes	--
MA	$500	1	$500	53	Yes	Yes
MN	$1,500	--	$400 annual fee	4	--	Yes
MO	no charge	--	--	25	Yes	--
MT	$1,500	2	--	12	Yes	--
NE	$1,500	--	--	8	Yes	Yes
NY	$500	--	--	17 (PPOs)	Yes	Yes
OH	$1,000	2	$1,000	35	Yes	Yes
OK	$1,500	5	$1,500	16	Yes	--
OR	$1,500	--	--	8	Yes	Yes
Total	**13**	**10**	**--**	**--**	**14**	**8**

Source: Research and Oversight Council on Workers' Compensation, *Survey of State MCO Certification Requirements*, 2002.

Note: * Florida certifies arrangements between insurance carriers, self-insureds, managed care administrators and provider networks rather than individual organizations.

Table 6
Overview of State MCO Certification Processes, *Continued*

State	State Requires MCO Provider Screening	State Has Authority to Review MCO Contracts	State and MCOs Conduct Liaison Meetings	State Specifies Required Data Elements	State Has MCO Reporting Requirements	State Conducts On-Site Audits
AR	--	•	--	--	--	--
CA	•	•	•	•	•	•
CT	--	--	--	--	--	•
FL	•	•	--	--	•	•
GA	•	•	•	•	•	•
KY	•	•	--	•	•	--
MA	--	--	--	--	--	•
MN	•	•	--	--	•	•
MO	--	--	--	--	•	--
MT	•	•	--	--	•	--
NE	•	•	•	•	•	--
NY	•	•	--	•	•	•
OH	•	•	•	•	--	•
OK	•	•	--	•	•	•
OR	•	•	•	•	•	•
Total	**11**	**12**	**5**	**8**	**11**	**10**

Source: Research and Oversight Council on Workers' Compensation, *Survey of State MCO Certification Requirements*, 2002.

These differences in network structure also make it more difficult for Texas to simply adopt the certification requirements used in other states, since state-run voluntary health care delivery systems like the Texas model provide a less predictable patient volume than do mandated or regulated MCO arrangements. Flexibility in adopting certification requirements may compensate for any perceived barriers to profitability. General MCO certification requirements in other states relating to overall patient access to care and MCO financial stability, however, are readily transferable to the Texas model.

In short, if there is a broad lesson to be learned from other states that have implemented these types of MCO arrangements, it is that establishing network arrangements takes time, and that stakeholder "buy in" on network standards, report card standards, certification processes, data collection, and reporting requirements is essential to ensure reasonable compliance from all parties and eventual success in meeting the goals of network implementation – namely, high quality, cost-efficient medical care.

Notes to pages 1-5

[1] See *Texas Labor Code*, Section 408.0221.

[2] See Article 3.70-3C, *Texas Insurance Code*, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997.

[3] See Workers Compensation Research Institute (WCRI), *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002.*

[4] *ibid.*

Health Care Network Report Cards:

Requirements in Other State Workers' Compensation Systems and Other Health Care Delivery Systems

by Amy Lee and Dana Baroni

Among the requirements for the regional workers' compensation health care delivery networks outlined in Article 2 of House Bill 2600 (76th Texas Legislature), is a requirement that evaluation standards and specifications necessary to implement a regional network "report card" be developed.

By statute, these standards and specifications are to be developed jointly by the Governor-appointed Health Care Network Advisory Committee (HNAC) and the Research and Oversight Council on Workers' Compensation (ROC). At a minimum, the report card must include an evaluation, adjusted for similar types of injuries, of:

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 re-injury prevention;
8) appropriate clinical care;
9) health care costs;
10) utilization of health care; and
11) statistical outcomes of medical dispute resolution provided by independent review organizations.

The statute also requires that a report card be provided to injured workers during their enrollment process for the regional networks, so they could make an informed decision as to whether they should participate in the network.[1] The format, frequency, data collection and distribution methods of this report card have not yet been determined by the HNAC and will be considered during the network feasibility study, which began in June 2002. To facilitate these efforts, this article presents a brief summary of health care report card standards in other state workers' compensation systems and other health care delivery systems.

Use of Report Cards in Other Health Care Delivery Systems

Systematic measures of access and quality of health care are a relatively new phenomenon and most often linked to the emergence of managed care. Many of these monitoring efforts began at the federal level to measure the quality of care being provided to Medicare and Medicaid patients during the early to mid 1990s, primarily by agencies such as the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (formerly the federal Health Care Financing Administration, or HCFA). As managed care became more prevalent in the group health arena – either in the form of Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs) – many states began to develop informational materials (i.e., "report cards") to help consumers make valid comparisons between the available health plans.

Table 7 provides a summary list of states with managed care report cards designed to provide general group health care consumers with objective and easily-understood information about the performance of participating HMO or PPO health care plans. Most of these state report cards are based on the HEDIS® standardized data measures and CAHPS® survey results.[2] Even with the widespread use of standardized quality of care measures, HMO and PPO rating systems vary considerably among states.

In response to growing health care quality concerns from consumers and policymakers, several national non-profit organizations such as the National Committee for Quality Assurance (NCQA), the American Accreditation Health Care Com-

Table 7
States with HMO or PPO Consumer Report Cards

STATE	WEBSITE URL	SOURCE OF REPORT CARD INFORMATION
CA	http://www.opa.ca.gov/report_card/	HEDIS® (Health Plan Employer Data Information) Administrative Data Measures and CAHPS® (Consumer Assessment of Health Plans Survey) results
CO	http://www.coloradohealthonline.com/report.htm	HEDIS® data and HMO Member Satisfaction Survey
CT	http://www.state.ct.us/cid/	Administrative Data Provided by Managed Care Organizations & HMO Member
FL	http://www.floridahealthstat.com/rg_insurance.	Administrative Data Provided by Managed Care Organizations & HMO Member Satisfaction Survey
IN	http://www.state.in.us/idoi/companyinfo.html	HEDIS® data
IA	http://www.iid.state.ia.us/division/consumer/	HEDIS® data
KS	http://www.ksinsurance.org	NA ("coming soon" as of 12/2001)
MD	http://www.mhcc.state.md.us/hmo/_hmo.htmhttp://www.mhcc.state.md.us/hmo/_hmo.htm	HEDIS® data and CAHPS® survey results
MA	http://www.state.ma.us/dhcfp/pages/dhcfp107.htm	HEDIS® data
MI	http://www.cis.state.mi.us/ofis/pubs/guides/health/hmocongd/intro.asp	Administrative Data Provided by Managed Care Organizations
MN	http://www.mhdi.org/quality/health-plan-projects/95survey/index.html	HMO Member Satisfaction Survey
MO	http://www.mchcp.org/brokers/01pe_publica.htm	HEDIS® data & HMO Member Satisfaction Survey
NC	www.ncdoi.com/consumer/publications	HEDIS® data and CAHPS survey results
NJ	http://www.state.nj.us/health/hmo2001/	HEDIS® data
NM	http://hpc.state.nm.us/reports/WEBG97.PDF	HEDIS® data
NY	http://www.ins.state.ny.us/hgintro.htm	HEDIS® data and CAHPS survey results
OR	www.cbs.state.or.us/external/ins/docs/sb21/sb21_reports.htm	Administrative data reported by MCOs, HEDIS® and CAHPS® survey results for select insurers
TX	http://www.thcic.state.tx.us/ Texas Health Care Information Council http://www.opic.state.tx.us/counties.html Office of Public Insurance Council	HEDIS® data and CAHPS® survey results
UT	http://www.healthdata.state.ut.us/	CAHPS® survey results
VT	http://www.bishca.state.vt.us/	HEDIS® data and CAHPS® survey results

Source: Research and Oversight Council on Workers' Compensation, *Survey of State HMO and PPO Report Cards*, 2002.

mission (also known as the Utilization Review Advisory Committee or URAC), and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) have created health care report cards or benchmarking initiatives to systematically measure access to care, patient satisfaction, and best practices.[3] Many of these organizations require or strongly suggest that participating health care plans adhere to their benchmarking initiatives as part of the accreditation process. All of these benchmarking initiatives have been developed for use in the Medicare, Medicaid, and commercial health care markets; however, URAC, with a grant from the Robert Wood Johnson Foundation,[4] has recently developed performance measures for workers' compensation (see Table 8).

Table 8
Description of URAC Workers' Compensation Performance Measures

Performance Measures Types	Explanation of Measures	Number of Measures	Source of Data for Performance Measures
Access to care	Timely access to care	2	Patient Survey
Appropriateness of care	Appropriate assessment, diagnosis and counseling	12	Administrative Data and Patient Survey
Work-related outcomes	Return to work	7	Administrative Data and Patient Survey
Utilization	Volume of services	7	Administrative Data
Medical outcomes	Physical functioning post injury	1	Patient Survey
Patient Satisfaction		6	Patient Survey
Coordination of services	Case-management	6	Administrative Data and Patient Survey
Medical costs		5	Administrative Data
Communication between employers, providers and injured workers	Therapeutic relationships	2	Patient Survey
Prevention of re-injuries and future injures	Safety services	1	Patient Survey

Source: URAC, 2001, and the Research and Oversight Council on Workers' Compensation, 2002.

The report card or benchmarking initiatives utilized in Medicare, Medicaid and the commercial group health markets base comparisons on the percentage of patients who receive various types of preventative tests, the timing of certain diagnostic tests, and the extent of pre- and post-natal care allowed by each health plan. By contrast, URAC's performance measures include return-to-work outcomes, communication among system participants, case management, and prevention of re-injury measures – all of which are issues that directly impact the success of any workers' compensation system. Although URAC's performance measures have undergone some validation, they have not been widely tested and have not yet been implemented by any other state workers' compensation system.

Use of Report Cards and/or Performance Benchmarking in Other State Workers' Compensation Systems

Although health care report cards and standardized benchmarking initiatives are prevalent in other health care delivery systems, few state workers' compensation systems currently publish similar health care plan information for injured workers. One notable exception is the MCO report card put out by Ohio's Bureau of Workers' Compensation (BWC), which includes aspects such as timeliness of first report of injury reporting; degree of disability management per health plan; and overall employer and employee satisfaction with each health plan.[5] Ohio's BWC establishes minimum benchmarks for each of these general report card measures and monitors individual health plans for compliance with these minimum benchmarks.

Many state workers' compensation systems, however, collect a variety of data relating to the performance of their managed care organizations, or MCOs. Data collection mechanisms vary among states, but many states require reporting of aggregate level information either monthly, quarterly or annually by each MCO, which may be subsequently validated by the state

Table 9
Types of MCO Performance Information Collected by State Workers' Compensation Systems with Regulated Managed Care Arrangements

State	Medical Costs	Patient Satisfaction	Utilization of Services	Return to Work	Access to Care
Arkansas	--	--	--	--	--
California	•	•	•	•	--
Connecticut	--	--	--	--	•
Florida	•	•	•	•	•
Georgia	•	•	•	•	•
Kentucky	--	--	--	--	--
Massachusetts	--	•	•	--	--
Minnesota	--	--	--	--	•
Missouri	•	--	--	--	•
Montana	•	•	•	•	--
Nebraska	•	•	•	--	--
New York	•	•	•	--	--
Ohio	•	•	•	•	•
Oklahoma	--	•	•	--	--
Oregon	•	•	•	--	•
Total	**9**	**10**	**10**	**5**	**7**

Source: Research and Oversight Council on Workers' Compensation, *Survey of State MCO Certification Requirements*, 2002.

agency in charge of certifying workers' compensation MCOs through periodic audits.

To get a better understanding of the types of information collected by state MCO programs, ROC staff surveyed fifteen states identified as having a regulated workers' compensation managed care arrangement by the Workers Compensation Research Institute (WCRI) (see the preceding *Texas Monitor* article on network standards for more information). Table 9 presents a brief summary of the types of MCO performance information currently collected by state MCO programs.

It is important to note, however, that states vary widely on how they define data elements (such as what constitutes "return to work" for an injured worker), and collect and analyze reported data from their MCOs. Virtually no state uses similar measures or methods for comparing their workers' compensation MCOs with HMO or PPO plans in their own states.

Conclusion and Recommendations

Concerns about the quality of health care by consumers and policymakers have spurred an increase in the systematic monitoring, benchmarking and reporting of health care quality and patient satisfaction information. Unfortunately these consumer-focused "report cards" do not yet exist in most workers' compensation systems (primarily because there are no widely accepted report card standards for workers' compensation MCOs). However, since HB 2600 requires the creation of report card standards for Texas MCOs (and lays out the statutory minimum requirements for these report cards), the HNAC may want to examine the performance measures developed by URAC (which are based on the general structure of HEDIS® and the CAHPS® survey) as a starting point. The HNAC and its feasibility consultant should also confer with members of the Texas Healthcare Information Council and the Office of Public Insurance Counsel in order to examine whether it may be possible to use some of the same measures, data collection requirements, report card formats and/or dissemination methods as the Texas HMO report card, since comparisons between the quality of health care for injured workers in network plans and the quality of care in Texas HMOs may be of interest to both consumers and policymakers. The HNAC and its feasibility consultant will also want to discuss with TWCC how a workers' compensation report card would be published and ultimately distributed to injured workers.

Although the statute specifically lays out the minimum standards for a network report card, it is likely that it will take years

for the data collection requirements for all of these measures to be completely implemented by regional MCOs. It is a complicated process to develop the data collection systems and to build the analysis capabilities necessary to translate the data into meaningful and easy to understand reports. Therefore, the HNAC and its feasibility consultant may want to consider prioritizing these measures or aspects of these measures and phasing in the data reporting requirements over several years.

As the *Texas Monitor* article on network standards indicated, several states are currently experiencing difficulties with MCO data reporting requirements. These states have suggested that obtaining "buy in" from the MCOs on what will be captured, how it will be captured, and how often it will be captured is key to ensuring adequate data reporting compliance. These states also recommend periodic data quality checks and adequate penalties or other incentives to encourage continued compliance.

With the adoption and ultimate implementation of the report card elements outlined in HB 2600, Texas has a unique opportunity to help establish quality of care outcome measures that will help injured workers make informed choices about participation in the Article 2 regional networks and choice of health care providers. These outcome measures also allow policymakers and system administrators to compare the quality and efficiency of health care received by workers in and outside of regional networks.

Notes to pages 6-10

[1] Section 408.0221 (h), Texas Labor Code requires the Texas Workers' Compensation Commission (TWCC) to distribute these report cards to the public.

[2] HEDIS® (Health Plan Employer Data and Information Set) is a standardized set of quality of care measures developed and maintained by the National Committee for Quality Assurance (NCQA). NCQA is a national, non-profit entity that captures, validates and reports data on the quality of care provided by HMOs. Much of the data is self-reported by the HMOs themselves; however, NCQA uses independent analysts to validate this data using patient charts and other administrative records. CAHPS® (Consumer Assessment Health Plan Survey) is a standardized set of patient satisfaction and access to care measures developed by the Agency for Healthcare Research and Quality (AHRQ) which is the health services research arm of the U.S. Department of Health and Human Services.

[3] For more information about these organizations or their accreditation process, see *An Analysis of Managed Care Network Standards in Other State Workers' Compensation Systems* (Research and Oversight Council on Workers' Compensation, 2002) or visit these organizations on the internet at www.ncqa.org; www.urac.org; and www.jcaho.org.

[4] The Robert Wood Johnson Foundation is a non-profit philanthropic organization devoted to improving the health and health care of Americans through various research grants and sponsored research studies. For more information, see http://www.rwjf.org.

[5] For more information, see http://www.ohiobwc.com/downloads/blankpdf/2Kreport.pdf.

Impact of Insurance Rate Increases on Employers' Propensity to Drop Workers' Compensation Coverage

by Joseph Shields and Xiaohua Lu

Texas is the only jurisdiction in the United States that does not mandate that its private sector employers carry workers' compensation (WC) coverage; however, the majority of employers (65 percent) and an even greater percentage of the Texas workforce (84 percent) are covered under the Texas Workers' Compensation Act.[1] These percentages represent the highest recorded rates of participation in the system since the Texas WC Act was overhauled in 1989. However, based on the responses to the 2001 Research and Oversight Council on Workers' Compensation (ROC) survey regarding employer participation in the WC system, this trend of increased participation may reverse if employers continue to experience further increases in their

WC insurance premiums.

The 2001 ROC survey found that a substantial proportion of employers (42 percent) experienced an increase in the cost of their most recent premium, which indicates that the WC market in Texas showed signs of hardening even before the September 11, 2001 terrorist event. Further, large employers were more likely to have experienced a recent increase in premiums than small employers. The survey also found that almost half of current subscribers said that they would seriously consider becoming nonsubscribers (i.e., dropping coverage) if their WC insurance premiums increased by some increment up to 20 percent (hereinafter referred to as a moderate premium increase).[2] Based on recent loss experience of insurance carriers in Texas and various media reports indicating that reinsurance costs following the terrorist attacks are likely to rise, an increase of this magnitude is certainly possible in the near term.[3] However, it is impossible to know the percentage of employers that would actually drop their coverage.

The purpose of this article is to identify the types of employers (in terms of size, industry, and a variety of other factors) that would be most likely to consider opting out of the WC system in Texas if faced with rising costs.

Data and Analysis

This article is based on the responses of 1,692 employers to the ROC's 2001 nonsubscription survey. The data were collected from Texas employers through telephone interviews conducted between August 9, 2001 and October 31, 2001.[4] Employers included in this analysis include only current subscribers to the Texas WC system, who provided some indication of how they would respond if confronted with an increase in the cost of their WC coverage.

A logistic regression model was employed to determine which factors have a significant impact on an employer's WC coverage decision when faced with a moderate increase in WC costs.[5] This research approach allowed for each factor to be analyzed separately, while all other factors differentiating employers were held constant. For purposes of brevity, only variables found to be statistically significant are discussed in detail in this article.

Key Findings

Several factors were found to be significantly associated with an employer's WC coverage decision when faced with a hypothetical increase in the cost of coverage. Findings are separated into six main categories: Industry, Firm Size, Subscription History, Reasons for Carrying WC Coverage, Satisfaction with Subscriber Experience, and Employer Return-to-Work Programs. Please refer to Table 10 for a complete list of variables having a significant statistical relationship with the decision to drop WC coverage in the event of a moderate premium increase.

Industry

Three different industries (mining, agriculture, and retail trade) were found to have a statistically significant association with an employer's decision to retain or drop coverage when confronted with a moderate premium increase.[6] Businesses in the agriculture sector (which also includes forestry and fishing) and the retail trade sector were more likely to be sensitive to insurance premium increases, and were significantly more likely to seriously consider dropping their WC coverage if they experience a moderate rise in cost. By contrast, businesses in the mining sector, which has a generally low nonsubscription rate, were significantly less likely to seriously consider such a move.[7]

Firm Size

For the purposes of this analysis, firm size is measured by the average number of workers a business employed during the four quarters of 2000. Businesses with fewer than 10 workers were significantly more inclined than their larger counterparts to seriously consider dropping WC coverage if they experience a moderate premium hike.[8] While over half of the smallest employers in the state (those with fewer than 10 workers) said they would seriously consider dropping their WC coverage if confronted with a moderate premium increase, it is significant to note that a sizable proportion (over a third) of the largest firms (those with 500 or more workers) also said they would consider opting out of the

system. Figure 1 illustrates that the percentage of firms willing to seriously consider dropping their WC coverage decreased with the size of the company.

Subscription History

Historically, when Texas employers decide whether or not to purchase WC insurance, they tend to stick to their decision. The vast majority of Texas employers either always have been subscribers to the WC system (60 percent) or have never carried WC insurance (26 percent). It is only the remaining 14 percent of firms that have both purchased WC coverage and been nonsubscribers at different times in their companies' history. Thus, the fact that such a high percentage of businesses indicated they would seriously consider dropping coverage if confronted with a moderate premium increase may be a signal that this high degree of stability in WC coverage decisions may change with rising insurance rates.

After controlling for other factors (e.g., industry, firm size), businesses that always have had WC coverage were significantly less price sensitive than those that opted out of the WC system at least once in the past. While a substantial proportion of these firms that always have had coverage indicated that they would consider becoming a nonsubscriber (44 percent) if insurance rates rose moderately, they were less likely to seriously consider the nonsubscription option than firms that have opted out of the system in the past.

Reason for Carrying WC Coverage

During the course of the telephone survey, employers were asked to rate the importance of a variety of factors on their company's decision to purchase or repurchase WC coverage. If an employer indicated a 4 or 5 on a 1-to-5 scale, where 1

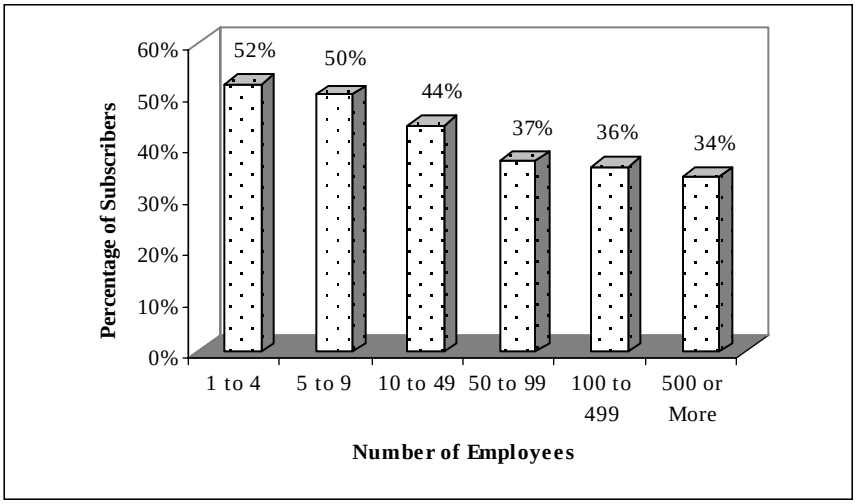
Table 10
Factors Associated with Decision to Become a Nonsubscriber as a Result of Moderate (Up to 20%) WC Rate Hike

More Likely to Drop WC Coverage	Less Likely to Drop WC Coverage
Employer in Retail Trade Sector***	Employer in Mining Sector*
Employer in Agriculture Sector**	Employer Has Always Been a Subscriber***
Employer Cited "Lower Insurance Rates" as an Important Reason for Purchasing WC Coverage***	Employer cited "Company Philosophy to Provide Occupational Benefits to Injured Workers" as an Important Reason for Purchasing WC Insurance***
Smaller firm: employer has fewer than 10 workers***	Employer is Satisfied that WC is a "Good Value" for Their Company***
	Employer Has a Written Policy to Assist Injured Employees to Return to Work*

Source: Survey of Employer Participation in the Texas Workers' Compensation System, Research and Oversight Council on Workers' Compensation and the Public Policy Research Institute at Texas A&M University, 2001.

Notes: *** denotes statistical significance at the .01 level; ** denotes statistical significance at the .05 level; and * denotes statistical significance at the .10 level.

Figure 1
Businesses Willing to Seriously Consider Dropping WC Coverage If Faced with a Premium Hike of 20 Percent of Less



Source: Survey of Employer Participation in the Texas Workers' Compensation System, Research and Oversight Council on Workers' Compensation and the Public Policy Research Institute at Texas A&M University, 2001.

means "Not at All Important" and 5 means "Extremely Important," the factor was categorized as *Important*.

While several possible reasons for carrying WC coverage were explored in the statistical model, just two reasons proved to be significantly associated with price sensitivity. These two reasons illustrate that subscribers tend to fit into two primary profiles: 1) those that purchase WC insurance primarily due to a company philosophy to provide adequate benefits to injured workers; and 2) those that purchase WC insurance because they believe it is cost effective. Companies indicating that "lower insurance rates" was an important reason for carrying WC coverage were significantly more likely to seriously consider dropping their insurance if premiums rose by some increment up to 20 percent. Conversely, employers who said they purchase WC primarily due to their company philosophy were less likely to say they would consider dropping out of the Texas WC system due to a moderate price increase.

By contrast, current subscribers who indicated that "company philosophy to provide adequate occupational benefits to injured workers" was an important reason for purchasing or repurchasing WC coverage were significantly less likely to seriously consider becoming nonsubscribers if insurance costs rose moderately. Company philosophy was cited as the primary reason for carrying WC coverage by 36 percent of current subscribers – more than any other reason.

Satisfaction with Subscriber Experience

Businesses were asked to rate their level of satisfaction with various aspects of their subscriber experience (e.g. adequacy of benefits, service by insurance carrier, value of coverage, and ability to manage claim costs).[9] It was assumed that companies with higher levels of satisfaction with their respective subscriber experiences would be less likely to opt out of the WC system if faced with higher costs than would employers with lower satisfaction levels; however, this was not universally found to be the case. There was no statistical association found between the propensity to seriously consider dropping WC coverage based on a moderate rate increase and any of the following variables:

- Employer satisfaction with the adequacy and equity of benefits;
- Employer satisfaction with insurance carrier service; or
- Employer satisfaction with the ability to control claim costs.

However, employers who were satisfied with the degree to which WC coverage was a "good value" for their company were significantly less likely to consider becoming nonsubscribers when faced with rising costs compared to firms less satisfied that WC was a good value. Employers who thought it was a good value would be more inclined to absorb a price hike than those that felt it was a "borderline" value or were less satisfied with the price of their coverage. This finding is intuitively what one might expect to observe and it reinforces the information reported above regarding the decision driver, "lower insurance rates," being associated with a higher likelihood of dropping coverage when premiums increase.

Return-to-Work Programs

Holding other factors constant, companies with written policies to assist injured workers to return to work were less likely to consider dropping their WC coverage when confronted with a moderate premium hike.[10] Such companies may feel that they have more control of claim costs and their WC program in general, and are more willing to weather fluctuation in WC insurance rates (possibly offsetting the rate increases with better loss experience). These employers are also typically larger companies.

Conclusion

One of the key issues to emerge in the ROC's nonsubscription study was the price sensitivity of current subscribers to potential increases in WC insurance rates. The findings presented here clearly illustrate that employers willing to drop out of the WC system when faced with premium increases differ in many ways from those unwilling to consider the nonsubscription option. For example, it appears that those in higher risk/high nonsubscription

rate industries (e.g., retail trade) are more likely to leave the system than employers in lower risk/low nonsubscription rate industries (e.g., mining). Also significant is the effect that the reason for initially purchasing WC coverage has on the propensity to drop when faced with rising insurance costs. Firms that purchased WC insurance because of a company philosophy to provide adequate occupational benefits were significantly less likely to drop coverage when WC insurance rates rose. Conversely, employers that initially purchased coverage because of lower insurance rates were significantly more likely to drop coverage if WC insurance costs escalated.[11]

While the actual number of employers that would drop their coverage when faced with a jump in premiums is unknown, the fact that nearly half of current subscribers are cost-sensitive enough to consider such a move may be of interest to both insurance regulators and policymakers.

Notes to pages 10-14

[1] Joseph Shields and D.C Campbell, *A Study of Nonsubscription to the Texas Workers' Compensation System: 2001 Estimates* (Research and Oversight Council on Workers' Compensation, 2002).

[2] If WC premiums rose by less than 10 percent, 12 percent of current subscribers indicated that they would seriously consider the nonsubscription option. If premiums increased by between 10 and 15 percent, an additional 17 percent of current subscribers said they would consider dropping their coverage. A premium increase of between 16 and 20 percent would result in yet another 20 percent of current subscribers seriously re-evaluating their decision to carry WC coverage.

[3] See Stephanie K. Jones, "Workers' Comp Texas: A League of Its Own," *Insurance Journal-Texas/South Central*, March 25, 2002.

[4] The telephone survey was administered by the Public Policy Research Institute (PPRI) at Texas A&M University through an interagency contract with the ROC.

[5] The dependent variable in the regression model was the willingness of an employer to consider dropping WC coverage if premiums increased by some increment (e.g., 1 to 9 percent, 10 to 15 percent, or 16 to 20 percent) up to 20 percent. Twenty-seven independent variables were tested for significance, including various reasons for carrying WC coverage, satisfaction with subscriber experience, whether employer experienced a recent WC premium increase, industry, firm size, return-to-work programs, location of company headquarters, subscription history, and tenure of business. Copies of the compete regression results are available upon request.

[6] Manufacturing, which had a moderate overall nonsubscription rate when compared to other industries, served as the reference category for the model.

[7] In 2000, the federal Bureau of Labor Statistics reported that total case incidence rates (per 100 employees) in Texas were as follows: Agriculture (3.7); Mining (3.2); Construction (4.6); Manufacturing (7.4); Transportation and Public Utilities (6.0); Wholesale Trade (4.7); Retail Trade (5.0); Finance, Insurance & Real Estate (2.0); and Services (3.5). However, data reported in the Texas Detailed Claim Information (DCI) Data Call reveal that closed claims in the mining sector tend to be among the most costly in Texas.

[8] In the model, a dummy variable for small companies with fewer than 10 employees was created. Companies with 10 or more employees served as the reference category for the variable.

[9] If an employer indicated a 4 or 5 on a 1-to-5 scale, where 1 means "Not at All Satisfied" and 5 means "Extremely Satisfied," the factor was categorized as *Satisfied*.

[10] The vast majority of firms with written return-to-work policies indicated that the policy includes light, modified, or transitional duty for injured employees.

[11] To further reinforce the dichotomy of employers being "philosophically driven" versus "cost sensitive," companies that indicated they were satisfied that WC was a good value were also less likely to drop their WC coverage, when confronted with a moderate rise in insurance costs.

Multiple Employment Provision Effective

July 1 marked the effective date for a significant provision of HB 2600, passed by the 77th Legislature in 2001. This provision allows injured employees injured on or after July 1, 2002 to claim wages from more than one job toward their average weekly wage, which is used to calculate the amount of benefits for which the employee is eligible. Previous to this change, only wages from the job where the injury occurred could be counted toward the average weekly wage.

The employee is responsible for pursuing the benefit and documenting other wages, and only wages that are reportable to the IRS for tax purposes are eligible. Insurance carriers that pay additional income benefits based on this provision are eligible to request reimbursement for these payments from TWCC's Subsequent Injury Fund.

– Jon Schnautz

Abstracts of all ROC research reports and back issues of the *Texas Monitor* are available at www.roc.state.tx.us.

Texas Workers' Compensation: Resources for Assistance

The ***Texas Workers' Compensation Commission*** (TWCC) is the state agency responsible for administering the Texas Workers' Compensation Act. Most questions of a claim-specific nature should probably be referred to TWCC.

The ***Research and Oversight Council on Workers' Compensation*** (ROC) is the Texas state agency that oversees the agencies and entities involved in administering the entire workers' compensation system, including TWCC, the State Office of Risk Management (SORM), the Texas Mutual Insurance Company (formerly the Texas Workers' Compensation Insurance Fund), the Texas Property and Casualty Insurance Guaranty Association, and the workers' compensation division of the Texas Department of Insurance (TDI). Workers' compensation questions of a system-wide nature, or issues that have not been able to be resolved at the agency level, should be referred to ROC.

Texas Workers' Compensation Commission (TWCC)

TWCC's primary responsibilities are to:

- provide customers with information about their rights and responsibilities under the Act;
- administer a benefit delivery system to ensure that employees with job-related injuries and illnesses receive fair and appropriate benefits in a timely and cost effective manner;
- ensure appropriate and efficient health care for all injured employees and fair and reasonable reimbursement for health care providers;
- resolve disputes through the administrative dispute resolution process as soon as possible;
- ensure compliance with the Texas Workers' Compensation Act and Rules;
- promote safe and healthy workplaces;
- assist in timely returning injured workers to productive roles in the Texas workforce.

If you need assistance but have **not** contacted the local field office of the Texas Workers' Compensation Commission (TWCC), please call:

TWCC Injured Worker Hotline
(for injured employees & employers.
The call will be directed to the field office closest to the caller):
1-800-252-7031

If you have already contacted the local TWCC field office but still need further assistance, please call:
TWCC Customer Service toll free
(general information or procedural issues):
1-800-372-7713

Other inquiries may be directed to:
TWCC Austin Administrative Offices
512-804-4000

TWCC website: www.twcc.state.tx.us
E-mail: customer.services@twcc.state.tx.us

Research and Oversight Council on Workers' Compensation (ROC)

The ROC is mandated by law to report on the effectiveness of the workers' compensation system and to identify problems in the system with recommendations for regulatory and legislative action. The ROC analyzes issues raised by those requesting assistance to determine whether the application of the Texas Workers' Compensation Act and/or Rules generates fair results and whether the Commission is responsive to the participants' needs. The ROC may be directly involved with individual claim assistance when prior attempts to resolve an issue with the appropriate agency have failed. In its contact with system participants, ROC's responsibilities are to, as appropriate:

- identify the complaint, analyze the issues, and contact the appropriate agency staff for resolution;
- provide oral and/or written responses to requests for assistance;
- document service-related problems and procedural issues; and/or
- identify problems in the workers' compensation system and make recommendations for changes in policy or in legislation/rules to ensure that the application of the Texas Workers' Compensation Act and/or Rules generates fair results.

Contact information for the Research and Oversight Council on Workers' Compensation (ROC):
phone: (512) 469-7811
fax: (512)469-7481
ROC website: www.roc.state.tx.us
e-mail: info@roc.state.tx.us

Research and Oversight Council on Workers' Compensation
9800 N. Lamar Blvd., Suite 260
Austin, TX 78753

RETURN SERVICE REQUESTED

9800 N. Lamar Blvd., Suite 260
Austin, Texas 78753
Telephone: (512) 469-7811
Fax: (512) 469-7481
E-mail: info@roc.state.tx.us
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