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Insurance Carrier Monitoring:
A Comparison of the Amount of Physical Medicine Services Paid by Insurance Carriers in Texas

by Amy Lee and D.C. Campbell

During the 2001 legislative session, policymakers in Texas passed a comprehensive piece of legislation that was designed to help reduce high medical costs while improving the quality of medical care provided to injured workers. House Bill (HB) 2600 (77th Legislature, 2001) contained several components that provided the Texas Workers' Compensation Commission (TWCC) with greater authority to monitor and impose sanctions on health care providers and insurance carriers (including their utilization review agents, or URAs) whose medical practice and/or review patterns are "substantially different from those [TWCC] finds to be fair and reasonable based on either a single determination or a pattern of practice."[1] It also clarified the statutory role of TWCC's Medical Advisor and set up a Medical Quality Review Panel (MQRP) of independent doctors to carry out these quality of care reviews and make recommendations to TWCC's Commissioners regarding potential sanctions or, in the case of health care providers, possible deletion from TWCC's Approved Doctor List (ADL).[2]

Over the past year, ROC staff have collaborated with TWCC's Medical Advisor and Compliance and Practices staff to produce a methodology that identifies insurance carriers whose review patterns result in substantially higher or lower amounts of medical treatment for similar types of injuries. This collaboration represents the third in a series of monitoring initiatives sponsored by TWCC (with the technical assistance of the ROC) to carry out the legislative intent of Article 1 of HB 2600. The previous two monitoring initiatives (health care provider and designated doctor monitoring programs) were described in the August 2002 special edition of the *Texas Monitor*.[3]

Consistent with the health care provider monitoring program, the initial carrier monitoring activity is a comparison of the amount of certain physical medicine services paid by 18 of the top private market insurance carrier groups (i.e., those with the largest share of the workers' compensation insurance market) and one large public insurance carrier. Collectively, these private insurance carriers accounted for approximately 67 percent of the Texas workers' compensation insurance market and approximately $1.8 billion annually in workers' compensation insurance premiums as of the first quarter of 2001.[4] Physical medicine services include modali-

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ties (e.g., hot and cold packs) and active or passive therapies (e.g., therapeutic exercises, manipulations). Several types of providers can provide these services in the Texas workers' compensation system, including physical therapists, occupational therapists, chiropractors, osteopaths, and medical doctors. In keeping with the published results of the previous health care provider and designated doctor monitoring initiatives, this article does not publish the names of individual insurance carriers, but rather identifies them as Carrier A, Carrier B, etc.

Based on a data analysis to identify carriers with payment patterns that are higher or lower (i.e., "outlier") than the median pattern experienced by the entire population of carriers in Texas, it is anticipated that TWCC will initiate a certain number of insurance carrier or URA reviews by requesting copies of medical records from the carrier or the health care provider (or both) for a sample of individual claims. These records will be reviewed to determine whether the data analysis results match the actual patient records or were a result of misreported data. If the information from the patient records validates the need for a clinical review, TWCC's Medical Advisor will prioritize the review and assign it to selected MQRP members. The goal of this initial monitoring activity is to reduce the amount of overpayment of medical bills, which can result not just from overutilization by health care providers (discussed in the previous *Texas Monitor* Special Edition), but also from overpayment by carriers due to inadequate utilization review procedures. This focus on overpayment of medical services is the result of research that found that Texas has significantly higher medical costs than other state workers' compensation systems

Table 1
Median Number of Unattended Electrical Stimulation Services Paid per Patient with Low Back Injuries
Injury Year 2000 – One-Year Post-Injury

	Low Back Soft Tissue Injuries	Low Back Nerve Compression Injuries
All Carriers	**5**	**9**
All Providers	**4**	**5**
Carrier A	3	5
Carrier B	4	4
Carrier C	3	5*
Carrier D	4	6
Carrier E	4	7
Carrier F	4	3*
Carrier G	N/A**	N/A**
Carrier H	3	6
Carrier I	4	7
Carrier J	3	6
Carrier K	3	5
Carrier L	3	3
Carrier M	3	4
Carrier N	4	7
Carrier O	4	4
Carrier P	4	5
Carrier Q	3	3*
Carrier R	4*	11*
Carrier S	3	5*

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

Notes: The data contained in this table are reflective of 18 of the top insurance carriers in Texas and one large public insurer.
According to the TWCC 1996 Medical Fee Guideline, the Maximum Allowable Reimbursement (MAR) for Unattended Electrical Stimulation (per unit of service) is $15.
* Indicates that insurance carrier's median number of services is based on less than 10 claims and should be viewed with caution.
** No claims and therefore no paid medical services could be attributed to this insurance carrier in the analysis dataset.

and other health care delivery systems. Furthermore, it was found that these high medical costs stem primarily from overutilization of medical services.[5] For more information on the types of sanctions that may result from an MQRP review and the appeal process, see Section 408.0231 of the *Texas Labor Code* and TWCC Rules 180.26-27.

Tables 1-5 provide some examples of the amount of specific physical medicine services paid for by these top insurance carriers in Texas, compared to the population of insurance carriers as a whole, for two types of injuries – low back soft tissue and low back nerve compression injuries. These two diagnostic groups are the most common and most costly (in terms of total medical costs) types of injuries in the Texas system. Results for the entire population of insurance carriers (including all private market insurance carriers, certified self-insured employers, the state and all political subdivisions and governmental entities) are expressed in terms of the *median* (i.e., the 50th percentile, or midpoint in the group of values) rather than the *mean* (i.e., the average of all the values). The median is more representative of an insurance carrier's typical payment and review patterns, while the mean may be skewed by one or two extremely high or extremely low utilization cases, particularly among carriers with a relatively small number of cases included in the analysis.

To make it easier to compare the amount of medical care paid for by carriers to the amount of medical care rendered by health care providers, Tables 1-5 also include the median number of services rendered by the population of health care providers as a whole (these health care provider medians were published in

Table 2
Median Number of Therapeutic Exercises Paid per Patient with Low Back Injuries
Injury Year 2000 – One-Year Post-Injury

	Low Back Soft Tissue Injuries	Low Back Nerve Compression Injuries
All Carriers	**8**	**18**
All Providers	**6**	**9**
Carrier A	6	9
Carrier B	5	11
Carrier C	4	11
Carrier D	6	9
Carrier E	5	12
Carrier F	5	42*†
Carrier G	N/A**	N/A**
Carrier H	5	8
Carrier I	6	10
Carrier J	4	12
Carrier K	7	11
Carrier L	4	7
Carrier M	5	8
Carrier N	7	10
Carrier O	5	11
Carrier P	8	7
Carrier Q	N/A**	N/A**
Carrier R	7 *	10*
Carrier S	5	2*

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

Notes: The data contained in this table are reflective of 18 of the top insurance carriers in Texas and one large public insurer. According to the TWCC 1996 Medical Fee Guideline, the Maximum Allowable Reimbursement (MAR) for therapeutic exercises (per unit of service) is $35. Each unit = 15 minutes.
* Indicates that insurance carrier's median number of services is based on less than 10 claims and should be viewed with caution.
** No claims and therefore no paid medical services could be attributed to this insurance carrier in the analysis dataset.
† Based on this value, further scrutiny is warranted to eliminate the possibility of a data reporting error.

Table 3
Median Number of Manipulations Paid per Patient with Low Back Injuries
Injury Year 2000 – One-Year Post-Injury

	Low Back Soft Tissue Injuries	Low Back Nerve Compression Injuries
All Carriers	**9**	**13**
All Providers	**6**	**7**
Carrier A	6	7
Carrier B	2	6
Carrier C	11*	1*
Carrier D	4	7
Carrier E	7	9
Carrier F	9*	N/A
Carrier G	N/A**	N/A**
Carrier H	8	8
Carrier I	6	11
Carrier J	3	5
Carrier K	8	10
Carrier L	4	6
Carrier M	5	9
Carrier N	6	4
Carrier O	7	8
Carrier P	8	12
Carrier Q	N/A	26*†
Carrier R	2*	5*
Carrier S	5	4

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

Notes: The data contained in this table are reflective of 18 of the top insurance carriers in Texas and one large public insurer.
According to the TWCC 1996 Medical Fee Guideline, the Maximum Allowable Reimbursement (MAR) for manipulations (per unit of service) ranges from $35 – $103.
* Indicates that insurance carrier's median number of services is based on less than 10 claims and should be viewed with caution.
** No claims and therefore no paid medical services could be attributed to this insurance carrier in the analysis dataset.
† Based on this value, further scrutiny is warranted to eliminate the possibility of a data reporting error.

a previous special edition *Texas Monitor* highlighting the health care provider monitoring program).[6] Interestingly, for all but one of the physical medicine services highlighted in this article (hot and cold packs, see Table 5), the median amount of services paid for by all insurance carriers in Texas is higher than the median amount provided by all health care providers.[7]

Generally speaking, these differences mean that the typical insurance carrier is paying for a greater number of services per claim than the average health care provider renders for the same type of injury. This is most likely the result of some carriers paying for a greater number of services from certain health care providers who over-utilize relative to their peers. Since health care providers' actual practice patterns — rather than insurance carrier payment patterns — form the basis of most nationally recognized treatment guidelines, it is reasonable to suggest that both health care providers and insurance carriers should compare their own practice and review patterns with the median for all health care providers.

While these tables illustrate that there is some variation in the amount of physical medicine services paid by the largest insurance carriers in Texas, in general these larger insurance carriers are paying for most physical medicine services *at or below* the median for all health care providers and insurance carriers (except for unlisted physical medicine services). The exception is in the

area of low back nerve compression injuries, where the median for certain larger carriers does exceed the median for all carriers and health care providers.

On the surface, it appears that this general finding (largest carriers paying at or below the median for all providers) contradicts the phenomenon noted above (total population of carriers paying for more services than are being provided by the total population of providers). ROC staff therefore examined the experiences of selected smaller carriers (those with more than one or two workers' compensation claims) and found that indeed, many smaller and mid-sized insurance carriers (including private market carriers, certified self-insured employers, political subdivisions and governmental entities) are generally paying for medical services at or significantly above the median for all health care providers and insurance carriers.

Figures 1-3 illustrate how smaller insurance carriers compare with the insurance carrier population as a whole for three physical medicine services. Each of the following graphs contains the median number of services (e.g., therapeutic exercises, unattended electrical stimulation procedures and hot and cold packs) for all providers and insurance carriers compared to the median number of these same services for selected smaller insurance carriers in the Texas workers' compensation system. Although the number of claims for each of the individual carriers in these graphs is small (between 3 and 20 claims each), these examples show that smaller insurance carriers generally pay for more medical care for the same type of injury than the rest of the insurance carrier population.

Table 4
Median Number of Unlisted Physical Medicine Services Paid per Patient with Low Back Injuries
Injury Year 2000 – One-Year Post-Injury

	Low Back Soft Tissue Injuries	Low Back Nerve Compression Injuries
All Carriers	**8**	**8**
All Providers	**5**	**6**
Carrier A	6	1*
Carrier B	21*	N/A**
Carrier C	2	N/A**
Carrier D	8	4
Carrier E	17	480*†
Carrier F	N/A**	N/A**
Carrier G	N/A**	N/A**
Carrier H	30	9*
Carrier I	7	26
Carrier J	6*	2*
Carrier K	9	51
Carrier L	3*	13*
Carrier M	147*†	524*†
Carrier N	92*†	N/A**
Carrier O	N/A**	N/A**
Carrier P	2*	13*
Carrier Q	N/A**	N/A**
Carrier R	3*	9*
Carrier S	N/A**	1*

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

Notes: The data contained in this table are reflective of 18 of the top insurance carriers in Texas and one large public insurer.
Unlisted physical medicine services are reimbursed at their fair and reasonable rate; the TWCC 1996 Medical Fee Guideline does not specify a Maximum Allowable Reimbursement (MAR).
* Indicates that insurance carrier's median number of services is based on less than 10 claims and should be viewed with caution.
** No claims and therefore no paid medical services could be attributed to this insurance carrier in the analysis dataset.
† Based on this value, further scrutiny is warranted to eliminate the possibility of a data reporting error.

Table 5
Median Number of Hot and Cold Packs Paid per Patient with Low Back Injuries
Injury Year 2000 – One-Year Post-Injury

	Low Back Soft Tissue Injuries	Low Back Nerve Compression Injuries
All Carriers	4	8
All Providers	4	4
Carrier A	3	4
Carrier B	3	4
Carrier C	3	2
Carrier D	3	5
Carrier E	3	4
Carrier F	3	3*
Carrier G	N/A**	N/A**
Carrier H	3	4
Carrier I	3	6
Carrier J	2	6
Carrier K	3	4
Carrier L	2	3
Carrier M	3	3
Carrier N	4	2
Carrier O	3	4
Carrier P	3	7
Carrier Q	3	3*
Carrier R	3*	8*
Carrier S	3	6*

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

Notes: The data contained in this table are reflective of 18 of the top insurance carriers in Texas and one large public insurer.
According to the TWCC 1996 Medical Fee Guideline, the Maximum Allowable Reimbursement (MAR) for hot and cold packes (per unit of service) is $11.
* Indicates that insurance carrier's median number of services is based on less than 10 claims and should be viewed with caution.
** No claims and therefore no paid medical services could be attributed to this insurance carrier in the analysis dataset.

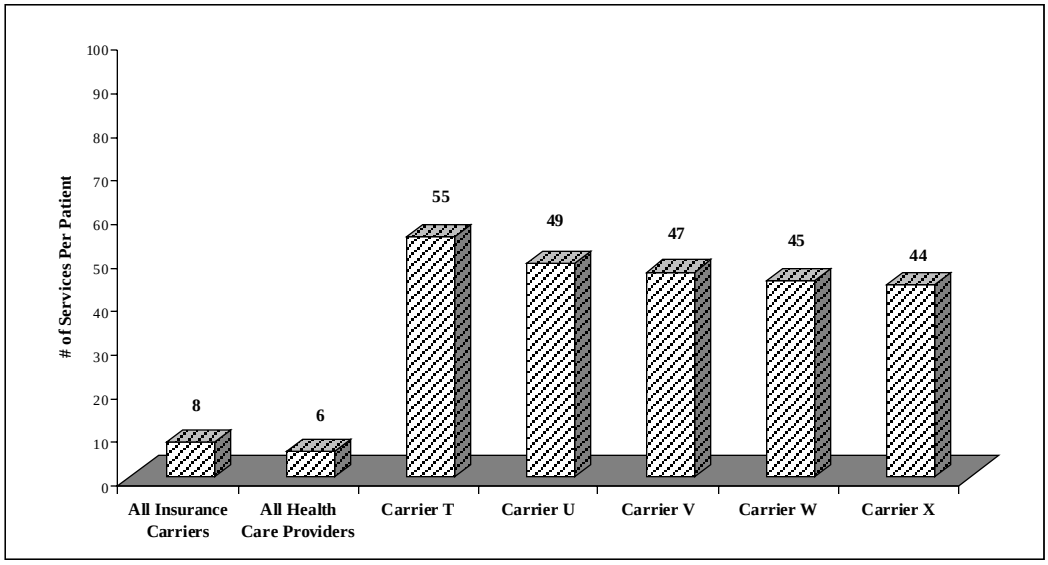
Conclusion

Article 1 of HB 2600 gave TWCC greater authority to monitor and take action against health care providers, insurance carriers, and utilization review agents whose practice and/or review patterns differ significantly from the norm. In order to facilitate this new monitoring program at TWCC, ROC staff has developed a methodology to compare the amount of medical care actually paid for by individual insurance carriers with the population of insurance carriers as a whole.

After using this methodology to compare the physical medicine payment patterns of 18 of the top insurance carrier groups in Texas, it is clear that while some variation does exist in the amount of physical medicine services paid for among these large carriers, many are paying for services at or below the population median for all insurance carriers. However, some of these larger carriers are paying for more services than their competitors, particularly for low back nerve compression injuries. Preliminary analyses of payment patterns for small and mid-sized insurance carriers reveal that many of these smaller carriers are paying for a significantly greater amount of medical care for the same types of injuries than their larger industry counterparts.

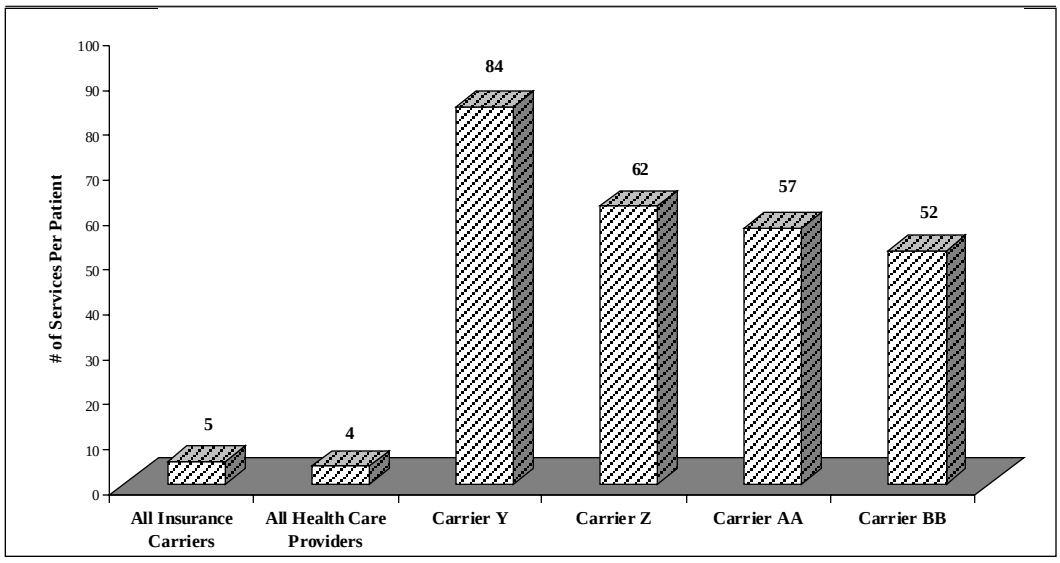
However, this article also points out that due to the mix of health care providers whom the carriers pay (i.e., certain insurance carriers are paying for more medical services from health care providers that tend to overutilize

Figure 1
Median Number of Therapeutic Exercises Paid Per Patient for Selected Smaller Insurance Carriers Compared to All Carriers and All Providers Low Back Soft Tissue Injuries Injury Year 2000 – One-Year Post-Injury



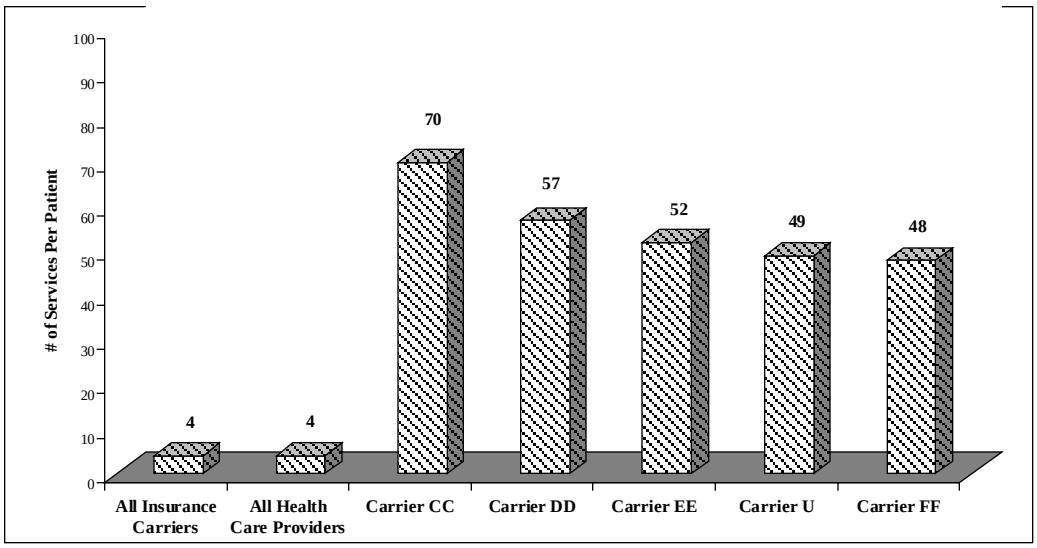
Source: Research and Oversight Council on Workers' Compensation, 2002.
Note: The medians for carriers T, U, V, W and X are based on less than 10 claims.

Figure 2
Median Number of Unattended Electrical Stimulation Services Paid Per Patient for Selected Smaller Insurance Carriers Compared to All Carriers and All Providers Low Back Soft Tissue Injuries Injury Year 2000 – One-Year Post-Injury



Source: Research and Oversight Council on Workers' Compensation, 2002.
Note: The medians for carriers Y, Z, AA and BB are based on less than 10 claims.

Figure 3
Median Number of Hot and Cold Packs Paid Per Patient
for Selected Smaller Insurance Carriers Compared to All Carriers and All Providers
Low Back Soft Tissue Injuries
Injury Year 2000 – One-Year Post-Injury



Source: Research and Oversight Council on Workers' Compensation, 2002.
Note: With the exception of carrier CC, the medians for carriers DD, EE, U, and FF are based on less than 10 claims.

than others) the population median for insurance carriers is higher for many of these physical medicine services than the population median for health care providers. Based on this information, many insurance carriers have the opportunity to review their own payment patterns for these physical medicine services to see if additional scrutiny in these areas is warranted.

Future *Texas Monitor* articles will examine other key medical services areas such as injections, diagnostic testing and surgery.

Notes to pages 1-5

[1] See *Texas Labor Code*, Section 408.0231.

[2] See *Texas Labor Code*, Sections 413.0511 and 413.0512.

[3] For a more detailed description of the data and methods used to calculate the amount and duration of medical care paid by insurance carriers, see Research and Oversight Council on Workers' Compensation, "Monitoring Programs for Health Care Providers and Designated Doctors in the Texas Workers' Compensation System," *Texas Monitor*, vol. 7, no. 2, Special Edition, 2002.

[4] See Texas Department of Insurance, *Quarterly Legislative Report on Market Conditions: 1st Quarter of 2001*, 2002 which can be downloaded from TDI's website at www.tdi.state.tx.us.

[5] See Research and Oversight Council on Workers' Compensation (ROC), *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System*, 2001. Summaries and ordering information are available at: http://www.roc.state.tx.us/pubform.htm.

[6] See Research and Oversight Council on Workers' Compensation, "Health Care Provider Monitoring Results for Physical Medicine Services," *Texas Monitor*, vol. 7, no. 2, Special Edition, 2002.

[7] The median for all health care providers is derived by calculating the median number of services rendered by individual health care providers, determining the distribution of these health care provider medians and then calculating the median of this distribution. This results in the identification of the median health care provider (i.e., the provider whose own practice represents the 50th percentile of all providers' practices). Similarly, the median for all insurance carriers is derived by calculating the median number of services paid for by individual insurance carriers, calculating the distribution of these insurance carrier medians and then determining the median of this distribution. Using this method, insurance carriers are able to compare the practice patterns of the average health care provider with the payment patterns of the average insurance carrier.

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

The Multiple Employment Provision of HB 2600 and Projected Impact on Subsequent Injury Fund

SIF Funding May Be Adequate Through FY 2007-2008

by Jon Schnautz and Xiaohua Lu

One of the primary goals of the Texas workers' compensation system is to compensate injured employees for lost wages through the payment of income benefits. The weekly amount of income benefits an injured employee receives is based largely on that employee's pre-injury Average Weekly Wage (AWW). Since the major Texas workers' compensation system reform in 1989, income benefits for injured employees have been calculated based only on the wages earned at the job where they are injured.[1]

Over the ensuing years, some policymakers have shown an interest in how this method of calculating the AWW and resulting benefit levels might impact injured employees who rely on income from more than one job, but are compensated only for lost wages from the job where the injury occurs (i.e., their "at-injury" employment).

During the 77th Legislative session in 2001, a proposal allowing injured employees to claim wages from any employment, rather than just their at-injury employment, won approval. This proposal – Article 10 of House Bill (HB) 2600 – allows an injured employee to claim any IRS-reportable wages toward the calculation of his or her AWW. The statutory change was effective July 1, 2002 and incorporated what is often called a "multiple employment" provision into the Texas workers' compensation system.

Since allowing injured employees to claim wages from more than one job toward the calculation of their income benefits will likely lead to an increase in the amount of total benefits paid in the workers' compensation system, cost and funding of the multiple employment provision was a concern for Texas workers' compensation system stakeholders. This article presents findings from an August 2002 Research and Oversight Council (ROC) report on the projected cost of the multiple employment provision and its potential impact on the Subsequent Injury Fund (SIF), a special, dedicated state fund managed by the Texas Workers' Compensation Commission (TWCC). The SIF is tied to the multiple employment provision because insurance carriers are allowed to claim reimbursement from the SIF for additional income benefits paid based on this new multiple employment provision. This information is intended to inform policymakers and system stakeholders about not only the cost of additional income benefits available based on the multiple employment provision, but also the impact of the provision on the SIF.[2]

While the full report provides much more detailed information on the many aspects of the cost of the multiple employment provision and the income and expenditures of the SIF, this article focuses on two central points:

1. What are the projected additional workers' compensation system liabilities and costs based on the multiple employment provision over the next six fiscal years (i.e., fiscal year (FY) 2002 to FY 2007)[3]?; and
2. What is the projected impact of the multiple employment provision on the economic viability of the SIF over the same time period?

Liability and Cost Projections

To project the additional benefits available to injured employees under the multiple employment provision, ROC used data from the United States De-

partment of Labor, Bureau of Labor Statistics (BLS) on the percentage of Texas employees who have more than one job. For 2002, this percentage was about 4.85 percent; ROC projected the percentage over the remaining five fiscal years considered in this analysis based on historical BLS data.

The multiple employment provision of HB 2600 allows injured employees to claim additional benefits based on non-injury employment for five different types of benefits: Temporary Income Benefits (TIBs); Impairment Income Benefits (IIBs); Supplemental Income Benefits (SIBs); Lifetime Income Benefits (LIBs); and Death Benefits (DBs). The ROC projected the number of injured employees who would receive each of these types of benefits in each fiscal year from 2002 to 2007, based on historical data taken from the TWCC *System Data Report*.[4] The projected percentage of employees eligible to receive additional benefits because they work more than one job (based on the BLS data) was then applied to the projected total number of employees who would receive each benefit type, to produce an estimated additional benefit cost for each fiscal year. The amount of additional benefits available and the duration of the additional benefits were also considered in these projections, based on the average benefit amounts and durations for each of the different benefit types as reported in historical *System Data Report* data. Benefit durations ranged from relatively short (18.3 weeks on average per worker) for TIBs (the primary lost-time benefit for injured employees), to very long (more than 36 years) for relatively rare LIBs claims. Statutory caps on the amount of benefits an injured employee may receive were also considered, since these caps may limit the amount of additional benefits an injured employee with more than one job can actually receive under the new provision.

Two ways to project additional system costs due to the multiple employment provision were considered in the report. One focuses on the total additional system liabilities *incurred* for injuries in a given fiscal year, over the life of the injury; the other on the additional benefits actually *paid* in a given year. The difference can be significant, particularly for benefits that pay out over a very long period of time. For example, the eventual liability for additional benefits available to a multiply-employed LIBs claimant injured in FY 2003 would be very significant, while the actual additional benefits paid to this claimant *in* FY 2003 would be relatively small.

Another consideration was also incorporated into both the liability and annual cost projections. It is extremely unlikely that all employees eligible to claim additional benefits based on the multiple employment provision will do so. Some may not be informed about the benefit or choose not to pursue it; others may not be able to "prove up" their additional wages; still others may be forced to dispute denial of their entitlement and not prevail. Other factors, such as the relatively low percentage of unionization and attorney involvement among Texas workers, are also expected to work against rapid dispersal of the multiple employment provision. Therefore, in order to more accurately estimate the utilization of the multiple employment provision, ROC used two "learning curve" models. Both models assume that no more than approximately 80 percent of eligible injured employees will ever successfully claim additional benefits under the provision. One model is described as a "three-year learning curve" because it projects this maximum level of utilization to be reached in the third year of the provision (FY 2004). The other model is described as a "four-year learning curve" because it projects maximum utilization to occur in the fourth year (FY 2005).

Tables 6, 7 and 8 show the projected additional liabilities and projected additional annual costs of the multiple employment provision. Table 6 shows projected additional costs and liabilities *without* consideration of the learning curve models (i.e., assuming all eligible injured employees utilize the multiple employment provision), while Tables 7 and 8 show the projected additional costs and liabilities based on the four- and three-year learning curve models, respectively.[5]

Projections for SIF Impact

As noted previously, insurance carriers who pay additional benefits based on the multiple employment provision are eligible to receive reimbursement for these benefits from the SIF. In addition to the projected additional liabilities and costs of the multiple employment provision, the implications for the SIF of this new category of expenditure are a significant issue for the workers' compensation system.

The SIF's original and primary obligation is the payment of Lifetime Income Benefits (LIBs) in subsequent-injury claims.[6] The SIF's primary source of income are death claims in which the deceased employee has no beneficiary; in these cases, the insurance carrier for the claim is required to pay an amount equal to 364 weeks of benefits into the SIF. The SIF also earns interest income at a rate set by the State Comptroller's Office.

With its revenue comfortably exceeding its liabilities throughout much of the 1990s, the SIF's FY 2001 year-end available assets had grown to about $18.9 million.[7] However, the addition of multiple employment reimbursements, as well as other new obligations added in HB 2600, will have a significant effect on the future economic viability of the SIF. In forecasting the SIF's balance over the next six fiscal years, ROC projected the following:[8]

1. The SIF's projected revenues from death claims, based on a forecasted number of "SIF deaths" (those in which no beneficiary survives the deceased employee);
2. The SIF's projected liabilities for LIBs claims, assuming the addition of one new SIF LIBs claim per year (a reasonable estimate based on historical claims data), mortality projections for the current SIF LIBs recipients, and historical data on the annual amount of benefits paid to these claimants;
3. The SIF's projected annual payments for reimbursements of benefits paid by insurance carriers as a result of interlocutory orders or decisions of TWCC that are later overturned (based on a number of factors detailed in the full report, this SIF expenditure is projected at about $1 million annually);
4. Payment from the SIF of $1.5 million for funding regional workers' compensation health care network feasibility studies, based on another provision on HB 2600 (in the forecast, $1 million was removed from the SIF's beginning balance in FY 2003 and $500,000 from the beginning balance in FY 2004); and
5. The projected cost of reimbursements to insurance carriers based on the multiple employment provision.

In projecting the SIF impact of reimbursements for additional benefits based on multiple employment, the annual *cost* projections discussed in the previous section are much more relevant to the SIF's year-end balance than the *liability* projections. This is because the SIF will only make reimbursements for multiple employment-based benefits as insurance carriers pay the ben-

Table 6
Projected Additional Income Benefit System Liabilities and Annual System Costs of the Multiple Employment Provision of HB 2600, FY 2002-2007

	FISCAL YEAR					
	2002	2003	2004	2005	2006	2007
Additional benefit liabilities for claims occurring in fiscal year	$4.1 mill.	$24.2 mill.	$23.8 mill.	$23.9 mill.	$23.8 mill.	$23.4 mill.
Additional benefit costs per fiscal year	$1.1 mill.	$17.3 mill.	$20.3 mill.	$21.8 mill.	$22.7 mill.	$23.5 mill.

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

Table 7
Projected Additional Income Benefit System Liabilities and Annual System Costs of the Multiple Employment Provision of HB 2600, FY 2002-2007
(Four-year "learning curve" model applied)

	FISCAL YEAR					
	2002	2003	2004	2005	2006	2007
Additional benefit liabilities for claims occurring in fiscal year	$372,123	$5.1 mill.	$12.2 mill.	$18.0 mill.	$19.2 mill.	$19.0 mill.
Additional benefit costs per fiscal year	$102,640	$3.4 mill.	$8.8 mill.	$14.3 mill.	$16.9 mill.	$17.9 mill.

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

Table 8
Projected Additional Income Benefit System Liabilities and Annual System Costs of the Multiple Employment Provision of HB 2600, FY 2002-2007
(Three-year "learning curve" model applied)

	FISCAL YEAR					
	2002	2003	2004	2005	2006	2007
Additional benefit liabilities for claims occurring in fiscal year	$372,123	$8.9 mill.	$18.4 mill.	$19.4 mill.	$19.3 mill.	$19.0 mill.
Additional benefit costs per fiscal year	$102,640	$5.8 mill.	$13.4 mill.	$16.6 mill.	$17.8 mill.	$18.3 mill.

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

efits and apply for reimbursement.

Tables 9 and 10 show the projected revenues, expenditures, and year-end assets of the SIF with consideration of the four- and three-year learning curves, respectively. In projecting the actual payout from the SIF for reimbursement of multiple employment-based benefits, ROC also considered the reimbursement schedule that TWCC intends to employ. Under this schedule, no reimbursements will be made until October 2003 (early in FY 2004). TWCC plans to continue this reimbursement schedule, paying in October of each year. Based on this plan, ROC assumed that additional benefits based on the multiple employment provision that are paid in FY 2002 and FY 2003 will be reimbursed in FY 2004; that benefits paid in FY 2004 would be reimbursed in FY 2005; and so on. Therefore, no SIF payouts related to multiple employment are shown in FY 2002 or FY 2003, since TWCC does not plan to make the first multiple employment-related SIF reimbursements until early FY 2004.

Conclusion

The projected liabilities for the new multiple employment provision are somewhat higher in the new ROC estimates than in the original fiscal note produced for HB 2600. However, consideration of other factors not included in the original fiscal note estimates (such as the July 1, 2002 effective date for the provision, and the fact that not all eligible employees are likely to claim the benefit) make the projected liabilities through FY 2007 very similar to those in the original fiscal note.

In addition to eventual liabilities, the more recent estimates include projections of the annual costs to the workers' compensation system and to the SIF based on the multiple employment provision. These cost-based projections more closely reflect the actual impact on the SIF based on the multiple employment provision, since carrier reimbursements will only be made after additional benefits are paid and submitted to TWCC, not in advance. Also delaying the impact on the SIF of the additional costs due to multiple employment is the reimbursement schedule TWCC plans to employ, which will not make any multiple employment-based benefit reimbursements until October 2003 (early in FY 2004).

Assuming full multiple employment utilization – a very unlikely scenario – these projections indicate that the SIF would run out of available assets to make reimbursements sometime in FY 2005. Under the more realistic four- or three-year "learning curve" scenarios, this would occur in FY 2007. Under the four-year model, the SIF might not reach this point until FY 2008.

It should also be noted that Article 10 of HB 2600, in anticipation of a possible shortfall, provided two additional mechanisms to augment the SIF's funding. One of these allows the SIF to make partial payments to carriers for multiple employment-based reimbursements if an actuarial analysis indicates an inadequacy in funding; the other allows TWCC to increase the workers' compensation maintenance tax based on a similar finding.[9] None of the scenarios shown for the SIF in this article assume any partial payments or increases in the maintenance tax, but rather focus on how long the SIF might remain a viable source of multiple employment reim-

Table 9
Projected SIF Revenues, Expenditures, and Year-end Assets –
Four-year "Learning Curve" applied to Multiple Employment Utilization

	FISCAL YEAR					
	2002	**2003**	**2004**	**2005**	**2006**	**2007**
Revenue: SIF death benefits	$4.5 mill.	$4.8 mill.	$4.8 mill.	$5.0 mill.	$5.1 mill.	$5.3 mill.
Revenue: Interest	$1.0 mill.	$1.2 mill.	$1.2 mill.	$741,211	$327,287	($189,423)
SIF LIBs liabilities (reserved)	$9.5 mill.	$10.2 mill.	$10.8 mill.	$11.3 mill.	$11.8 mill.	$12.4 mill.
Expenditures: Carrier reimbursement, non multiple employment	$942,642	$1.0 mill.	$1.0 mill.	$1.0 mill.	$1.0 mill.	$1.1 mill.
Expenditures: Multiple employment reimbursements	$0	$0	$3.5 mill.	$8.8 mill.	$14.3 mill.	$16.9 mill.
Estimated year-end available assets (cash value)	**$22.6 mill.**	**$25.9 mill.**	**$26.2 mill.**	**$21.7 mill.**	**$11.2 mill.**	**($2.1 mill)**
Estimated year-end available assets (present value)	**$23.1 mill.**	**$26.9 mill.**	**$27.6 mill.**	**$23.7 mill.**	**$13.7 mill.**	**$741,603**

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

Table 10
Projected SIF Revenues, Expenditures, and Year-end Assets –
Three-year "Learning Curve" applied to Multiple Employment Utilization

	FISCAL YEAR					
	2002	**2003**	**2004**	**2005**	**2006**	**2007**
Revenue: SIF death benefits	$4.5 mill.	$4.8 mill.	$4.8 mill.	$5.0 mill.	$5.1 mill.	$5.3 mill.
Revenue: Interest	$1.0 mill.	$1.2 mill.	$1.0 mill.	$603,591	($22,435)	($732,144)
SIF LIBs liabilities (reserved)	$9.5 mill.	$10.2 mill.	$10.8 mill.	$11.3 mill.	$11.8 mill.	$12.4 mill.
Expenditures: Carrier reimbursement, non multiple employment	$942,642	$1.0 mill.	$1.0 mill.	$1.0 mill.	$1.0 mill.	$1.1 mill.
Expenditures: Multiple employment reimbursements	$0	$0	$5.9 mill.	$13.4 mill.	$16.6 mill.	$17.8 mill.
Estimated year-end available assets (cash value)	**$22.6 mill.**	**$25.9 mill.**	**$23.8 mill.**	**$14.4 mill.**	**$1.3 mill.**	**($13.5 mill.)**
Estimated year-end available assets (present value)	**$23.1 mill.**	**$26.9 mill.**	**$25.1 mill.**	**$16.1 mill.**	**$3.4 mill.**	**($11.0 mill.)**

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

bursements based *only* on the SIF's current funding and assuming that all requests for reimbursement are paid in full.

The implications for the SIF based on the revised estimates differ only slightly from those suggested at the time HB 2600 was passed. It still appears that the SIF is a viable short- and perhaps medium-term funding mechanism, and that the fund might sustain reimbursements even slightly longer than was suspected during the 2001 Legislative session – but likely not one that can sustain full reimbursements on an ongoing, long-term basis.

Notes to pages 10-14

[1] Prior to 1989, statutory language related to "same or similar employment" by an injured employee led to court interpretations that allowed some consideration of multiple employment in income benefit levels. This led to a limited consideration of multiple employment. See Research and Oversight Council on Workers' Compensation (ROC's) online publication *Multiple Employment in the Texas Workers' Compensation System: Features and Benefits*, August 2001, available online at http://www.roc.tx.us/Multemp.htm for more details on pre-1989 interpretations of multiple employment-related system features.

[2] The projections included in this article and the ROC's August 2002 report revise earlier projections made at the time HB 2600 was being considered. The original projections were produced in response to a legislative request to assess the potential cost of the multiple employment provision and were based on the best information available at the time they were created (spring 2001). For much more detail on the original projections, see the full report.

[3] The state's fiscal year begins on September 1 and ends on August 31. FY 2002, for example, began on September 1, 2001 and ended on August 31, 2002.

[4] The TWCC System Data Report is a twice-yearly publication showing aggregate calculations of various categories of data relevant to the Texas workers' compensation system, including number of injuries, income and medical benefits paid, and other items. It is available online at www.twcc.state.tx.us.

[5] In all tables, the projections for FY 2002 are considerably lower than in latter years because during only two months of the fiscal year (July and August 2002) are injured employees eligible to claim the benefit. All numbers shown are cash value projections. On a present value basis, the long-term liabilities are somewhat lower. For example,

for the liabilities shown in Table 1, the present value projections for FY 2002 to 2007 would be $3.8 million, $22.1 million, $21.8 million, $21.9 million, $21.9 million, and $21.6 million, respectively.

[6] The SIF is responsible for payments of LIBs to claimants who qualify for these benefits as the result of a subsequent injury. For example, a claimant who is blind in one eye and then loses sight in the other eye as a result of an on-the-job injury (thereby qualifying for LIBs) would receive these payments from the SIF. In FY 2002, 36 claimants are receiving LIBs from the SIF, and $9.5 million is reserved to pay these claims on a *cash value* basis. Cash value assumes adequate reserves to pay all projected benefits due on a claim without consideration of the interest income that may be earned during the period the benefits are paid out. A present value calculation of reserves would allow this interest to be considered and would result in smaller reserves required to ensure payment of the claims. For example, in FY 2002, only $5.6 million would need be reserved on a *present value* basis. The SIF is currently operated and reserved for LIBs on a cash value basis.

[7] The SIF's actual balance was about $27.2 million, but a significant portion of this amount is reserved to pay LIBs benefits and therefore not an available asset.

[8] HB 2600 also requires the SIF to reimburse insurance carriers for pharmaceutical benefits used by injured employees in the first seven days following an injury, in claims that are eventually determined to be non-compensable. Based on an expectation that this would not be a significant additional expense to the SIF and a lack of available data on which to base a projection, ROC did not include additional SIF costs based on this liability.

[9] The maintenance tax is a tax on gross workers' compensation insurance premiums in Texas and is paid by all insurance carriers and certified self-insurers operating in the state, except for governmental entities.

Errata/Clarification

ROC's Spring 2002 article entitled *Mid-Biennium Status of ROC's 2000 Biennial Report Policy Options and Recommendations* (*Texas Monitor*, Vol. 7, No. 1, Spring 2002) contained two items that require further clarification or correction.

1. The article inadvertently excluded information related to the issue of late claims by injured workers filed against insolvent insurance companies (page 11, item 17).

This portion of the article involved the application of filing deadlines for claims against insolvent insurers. When an insurance company becomes insolvent and enters bankruptcy proceedings, filing deadlines are imposed to bring claims against the company. These deadlines could bar an injured employee from pursuing a claim against the company, particularly in the case of a latent condition that does not appear until after the deadline. ROC recommended in the 2000 Biennial Report that the Texas Department of Insurance (TDI), the Texas Property and Casualty Insurance Guaranty Association (TPCIGA, which handles Texas claims of insolvent insurance carriers), and the Texas Workers' Compensation Commission (TWCC) develop a formal resolution to this issue to ensure that injured employees are not barred by these filing deadlines.

In the *Mid-Biennium Status* article, ROC indicated that no legislative or regulatory action had occurred on this item. However, in February 2001 TDI Commissioner Jose Montemayor issued an official order approving an amendment to TPCIGA's Plan of Operation proposed by the TPCIGA Board of Directors. The amendment stipulates that covered claims are considered filed with TPCIGA if the claim is either received prior to the claims filing deadline imposed in the bankruptcy proceeding *or* if the claim is for workers' compensation benefits. The ROC regrets the error in omitting it from the article.

2. The article also stated in an item related to the issuance of Medical Interlocutory Orders (page 10, item 10), that TWCC "has yet to develop a procedure to evaluate potential medical interlocutory orders, and has indicated that it intends to evaluate requests for these orders on a case-by-case basis. *To date, TWCC has not issued any medical interlocutory orders* (emphasis added)." Although the first part of the statement is correct, and although ROC staff still considers the issue of appropriate use of TWCC's medical interlocutory order authority afforded by a statutory change to the Labor Code in the 76th Legislative session (1999) one that may be in need of further attention, the italicized sentence is incorrect, in that TWCC staff in resolving indemnity disputes does sometimes issue interlocutory orders applicable to the payment of medical benefits. However, these do not relate directly to the authority granted in the 76th session. ROC regrets this error and any confusion it may have caused.

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