HOUSE COMMITTEE ON BUSINESS & INDUSTRY
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2004

A REPORT TO THE
HOUSE OF REPRESENTATIVES
79TH TEXAS LEGISLATURE

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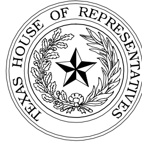

Committee On
Business & Industry

December 9, 2004

Helen Giddings
Chairman

P.O. Box 2910
Austin, Texas 78768-2910

The Honorable Tom Craddick
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

The Committee on Business & Industry of the Seventy-Eighth Legislature hereby submits its interim report including recommendations for consideration by the Seventy-ninth Legislature.

Respectfully submitted,

Representative Helen Giddings, Chair

Rep. Dwayne Bohac

Rep. Gary Elkins

Rep. Lois W. Kolkhorst, CBO

Rep. Trey Martinez Fischer

Rep. Joe Moreno

Rep. Rene Oliveira

Rep. Burt Solomons

Rep. Bill Zedler

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INTRODUCTION

At the beginning of the 78th Legislature, the Honorable Tom Craddick, Speaker of the Texas House of Representatives, appointed nine members to the House Committee on Business & Industry. The committee membership included: Representatives Helen Giddings, Chair; Gary Elkins, Vice-Chair; Dwayne Bohac; Lois Kolkhorst; Trey Martinez Fischer; Joe Moreno; Rene Oliveira; Burt Solomons; and Bill Zedler.

During the interim, Speaker Craddick assigned the Committee on Business & Industry the following five charges:

1. Study ways to reduce specific cost drivers under the workers' compensation system related to provider, surgical and physical therapy services or care and the reduction of return-to-work time periods.

2. Study the cost effectiveness of the state workers' compensation system including:
a) Economic benefits, if any, of inclusion of the UT System, A & M University System, Texas Department of Transportation and Employees Retirement System under the State Office of Risk Management programs;
b) Costs or savings to the state by allowing state agencies to self-insure; and
c) The creation of workers' compensation provider networks for state employees.

3. Actively monitor the activities of the Texas Workers' Compensation Commission in the continued implementation of HB 2600, 77th Legislature and workers' compensation legislation passed during the 78th Legislature.

4. Monitor the implementation of HB 1366, 78th Legislature. Consider concerns from interested parties regarding the use of the remediation funds and recommend legislative changes to the 79th Legislature.

5. Study the potential impact on the cost and quality of medical care through employer and/or insurance carrier selection of initial treating doctor and change of doctor in the workers' compensation system.

In addition, the committee was charged with conducting active oversight of the agencies under the committee's jurisdiction: the State Office of Risk Management, the Risk Management Board, the Texas Workers' Compensation Commission, the Texas Mutual Insurance Company Board, and the former Research and Oversight Council on Workers' Compensation (now the Workers' Compensation Research Group at the Texas Department of Insurance).

This report represents the final conclusions and recommendations for each charge and supporting documentation. The members of the Committee on Business & Industry as a whole have approved all sections of this report.

The Chair and committee staff wish to thank Amy Lee of the Workers' Compensation Research Group at the Texas Department of Insurance; she and her staff have gone above and beyond the call of duty. The Chair and committee staff would also like to thank the staff of the Texas Workers' Compensation Commission, especially Rhonda Myron, Bob Shipe and Chairman Hachtman; the staff of the Texas Department of Insurance, especially Carol Cates, David Durden, and Commissioner Montemayor; the staff of the Office of Risk Management, especially Jonathan Bow, Stephen Vollbrecht, Brad Cargile, and Paul Harris; and Terry Frakes and Jaelene Fayhee of Texas Mutual. Committee staff would also like to thank Ambrose Gonzales of the Texas Legislative Council Computer Center; Mary Colletti and staff of the Committee Coordinator's Office; and David Weber of the Speaker's Office.

Lastly, the committee wishes to extend thanks to the citizens of Texas who attended and testified at the public hearings. Your time and efforts are greatly appreciated.

HOUSE COMMITTEE ON BUSINESS & INDUSTRY

INTERIM STUDY CHARGES

The Speaker of the House of Representatives gave the Committee on Business & Industry the following Interim Study Charges:

1. Study ways to reduce specific cost drivers under the workers' compensation system related to provider, surgical and physical therapy services or care and the reduction of return-to-work time periods.
2. Study the cost effectiveness of the state workers' compensation system including:
a) Economic benefits, if any, of inclusion of the UT System, A & M University System, Texas Department of Transportation and Employees Retirement System under the State Office of Risk Management programs;
b) Costs or savings to the state by allowing state agencies to self-insure; and
c) The creation of workers' compensation provider networks for state employees.
3. Actively monitor the activities of the Texas Workers' Compensation Commission in the continued implementation of HB 2600, 77th Legislature and workers' compensation legislation passed during the 78th Legislature.
4. Monitor the implementation of HB 1366, 78th Legislature. Consider concerns from interested parties regarding the use of the remediation funds and recommend legislative changes to the 79th Legislature.
5. Study the potential impact on the cost and quality of medical care through employer and/or insurance carrier selection of initial treating doctor and change of doctor in the workers' compensation system.
6. Monitor the agencies under the committee's jurisdiction.

Committee Charge # 1

Cost Drivers in the Workers' Compensation System and Return to Work Issues

REPORT ON INTERIM CHARGE # 1

Charge and Public Hearings

Due to the rising costs of workers' compensation costs, the Speaker of the House charged the Committee to "Study ways to reduce specific cost drivers under the workers' compensation system related to provider, surgical and physical therapy services or care and the reduction of return to work time periods." The committee heard testimony on several occasions regarding this charge. Testimony and research identified several cost drivers that needed to be studied in more depth and suggested why current return to work efforts were not having the desired intent. Hearings on this topic were held on April 27, 2004, on May 11, 2004, on August 25, 2004, and on August 26, 2004. Other relevant testimony was heard at previous committee hearings.

Background

Of the comparable states, Texas' medical costs are higher. According to the Workers' Compensation Research Institute *Area Variations in Texas Benefit Payments and Claim Expenses* report, costs associated with workers' compensation in Texas varied greatly: Benefit cost per paid claim in the El Paso geographic area was almost 50 percent higher than in the lowest-cost area, Austin/San Antonio with Dallas/Ft. Worth and Houston being somewhere in the middle.

The Committee did note the rise in medical costs associated with workers' compensation was not unique and did not happen in isolation. Health care costs in general increased significantly in Texas and across the comparable states. As a matter of fact, Reuters and the Knight Ridder news organization reported on September 9, 2004, that there has been a 25.1% rise in health care costs between 2002 and 2004 nationally, a pace of growth that was five times that of inflation.

While medical costs per claim have risen in other states, the rise in Texas from 1999 until 2003 has continued even though the state has seen a reduction in its rates of worker accident occurrence. The Texas Department of Insurance indicates that while Texas had 7.3 injuries per hundred full-time employees in 1992, it had 4.9 injuries per hundred in 2001. Yet in the Workers' Compensation Research Institute's (WCRI's) 2004 study, *CompScope Benchmarks: Multi-state Comparisons*, the average medical payment per claim was $644 for claims arising October 1998 to September 2000, but went up to $688 per claim for claims arising October 2001 to September 2002.

The current medical fee for physicians of 125% was set in September 2003. Other fees included in the cost of claims such as hospital fees, ambulatory surgical center fees, and prescription fees for the most part were set only recently. Even so, there are serious concerns regarding workers' compensation costs, particularly in view of workers' dissatisfaction and the poor return to work outcomes.

Previous studies from both the Research and Oversight Council on Workers' Compensation (ROC) and the Workers' Compensation Research Institute (WCRI) demonstrate that Texas has high average medical costs per claim when compared with other state workers' compensation systems. Yet, in spite of these rising medical costs, injured workers are neither getting back to work more quickly nor are they more satisfied with their overall care. Testimony at most of the Committee's hearings, the Texas Sunset Advisory Commission hearings, and from the Texas Workers' Compensation Commission(TWCC) public meetings indicated that while Texas had higher medical costs, many of the stakeholders in the workers' compensation system felt the system was close to crisis. This was not a new phenomenon; in 1989 - 1990, the system was truly in crisis.

In order to address rising medical and indemnity costs and other issues in the workers compensation system, HB 2600 was passed during the 77th Legislative session in 2001. While research reveals some indication that this legislation is beginning to show some results, a number of parties expressed concern that the implementation of HB 2600 has been slow and the recent downturn could be temporary. Therefore, additional examinations of the issue and the identification of corrective measures were viewed as appropriate.

In order to determine whether more could be done to reduce the medical and indemnity costs, the Committee looked at several issues: What types of services were driving medical costs; why were indemnity costs so high in Texas; and why were return to work rates so low?

Significant Cost Drivers

While there are many cost drivers that can be shown as contributing to the costs of the workers' compensation system, several significant cost drivers were identified during testimony. These include provider services, hospital and surgical services, physical therapy and chiropractic care, referrals and medical management services.

Provider Services
When discussing cost-drivers in the workers' compensation system, one of the first topics to come to mind are provider services. Please see Appendix for a slide on the Distribution of Total Workers' Compensation Medical Costs by Provider Type - Service Years 1999-2001, generated by the Workers' Compensation Research Group at TDI and a slide on the Distribution of Health Care Providers that Account for 50 Percent of Non-Hospital Medical Costs, Injury Year 2000.

Over-utilization
One of the cost drivers identified and most often cited was over-utilization of health services in the workers' compensation system. Many research organizations, including the Workers' Compensation Research Institute (WCRI) and the Workers' Compensation Research Group at the Texas Department of Insurance (TDI), note that over-utilization continues to be a problem in the Workers' Compensation arena in Texas. By this, they mean the amount of care provided to any injured worker as opposed to the cost of this care. Texas' medical costs include fees for services provided by medical doctors and doctors of osteopathy, chiropractors, surgeons, hospitals, surgical centers, and other providers. Medical costs also include the costs of handling a claim, such as investigating and adjusting a claim, peer reviews, etc.

While it is true that over-utilizers are only a fraction of the medical doctors and health providers who accept Workers' Compensation patients, these few are sometimes guilty of egregious over-utilization. Testimony presented by the Texas Department of Insurance' Workers' Compensation Research Group showed that care provided by 1681 providers accounted for 50% of the medical costs in Texas. Of these, 29% or 487 were chiropractors. HB 2600 was passed, in part, in order to address these "bad actors"; the effects of those efforts are only now beginning to be seen with the institution of TWCC's Approved Doctor's List (ADL), the Medical Quality Review Panel and other mechanisms meant to rid the ADL of over-utilizers. Further culling may be realized if TWCC decides to adopt provider treatment guidelines or Disability Management Guidelines as addressed elsewhere in this report.

Under-utilization
Of equal importance, as far as the treatment of the injured worker is concerned, is the issue of under-utilization. It is believed that some injured workers may not be getting the care they should be getting because their doctors are hesitant to be labeled as over-utilizers. As in the case of cancer doctors who may hesitate to prescribe Schedule III pain drugs because they may be accused of over-prescribing, many physicians are feeling the pressure not to recommend certain treatments even if treatment is, in their opinion, medically necessary.

The other reason given for increased under-utilization is due to denial of claims by insurance carriers as not medically necessary. Many physicians feel that this may in turn contribute to lost time and poor return to work outcomes. Additionally, many physicians report being worn down by the denials. For example, denials are up for medical necessity: In 2001, the ten insurance carriers that accounted for the majority of medical payments in the system denied payments at a rate of 21.4%, and in 2002, these medical payments were denied at a rate of 26.9%. About 25% of claims were denied for compensability i.e. they were deemed not to be work-related injuries.

Hospital and Surgical

According to figures generated by TWCC, hospital charges in 2003 accounted for thirty-three percent (33%) of total medical costs and Ambulatory Surgical Centers (ASCs) accounted for 5.7 percent of medical costs. With overall workers' compensation medical costs at approximately $1.194 billion in 2003, the hospital costs accounted for about $396 million while ASCs received about $68 million.

New medical fee guidelines for Ambulatory Surgical Centers, adopted by the Commission on April 15, 2004, and that became effective September 1, 2004, should reduce overall costs attributable to ASCs. TWCC is meant to adopt new fee guidelines for hospitals sometime next year.

Physical Therapy and Chiropractic Services

Recent studies by WCRI and the Workers' Compensation Research Group at TDI have shown that Physical Medicine services have increased. While there has been a very small decline in services by physical therapists, in the same time period, there has been a tremendous increase in billings by chiropractors, including physical medicine services that they provide.

An April 2004 WCRI FlashReport shows that workers in Texas use chiropractic care much more often than in the typical state studied. Compared to chiropractors in the typical state, Texas chiropractors treated thirty percent (30%) of claims (5-10% is typical), received revenue per claim that is four times higher, treated with an average of 38 visits (18-21 is typical), and received average prices that are fifty percent (50%) higher.

Texas chiropractors received twenty percent (20%) of all medical payments made for claims that arose between October 2000 and September 2001, a significant increase from seven percent (7%) five years earlier.

The WCRI FlashReport further states that the average or mean workers' compensation case in Texas has about double the number of chiropractic visits

per case compared to the typical state studied. If a small number of chiropractors were responsible for this difference, one might expect to see the median case have a more similar number of visits per claim in Texas as in the other states. However, the median case with chiropractic care in Texas also has about twice the number of visits as in most other states in the study: 33 visits per claim, compared to 10-17 in most other states studied. If one were to take California out of the study (since it had a similar number of visits to Texas prior to its new legislation), the number of visits per claim is even more marked between Texas and the other states studied.

In order for a small number of chiropractors to be responsible for this result, these chiropractors would have to be responsible for providing care in at least half of the cases in Texas. This is not very likely in a state as large and geographically diverse as Texas. It is even more unlikely when one recognizes that 30% of all cases in Texas with more than 7 days of lost time receive chiropractic care.

Chiropractors provided testimony and a study by MGT of America, Inc. This study concluded that chiropractors treated 29.9% of workers with low back injuries, but were responsible for only 17.5% of the costs. Chiropractors believe they are often a better treatment option - and less intrusive than surgery - for certain types of injuries.

Referrals

One of the cost drivers identified deals with referrals. One of the fastest growing segments for referral appears to be for imaging services. Many of these are self-referrals to clinics or facilities owned and/or operated by the referee. In other cases, the referral may be made by someone with a financial interest in the referral. Providers are generally the party most often cited in self-referrals. While many self-referrals may be legitimate - and in some cases the only option in an underserved or rural area - such referrals can lead to abuse in either the over-utilization of services or in the provision of unnecessary services. Currently, providers are supposed to self-disclose their financial interest in facilities or partnerships. Since the reality is that oversight and/or enforcement of any financial interest is as good as non-existent, it is probable that many providers either do not disclose their financial interests or do not disclose them fully.

At the Federal level, self-referrals are forbidden by the Stark Law for federally-funded programs. In 1989, recognizing that there were rising costs associated with certain referrals, Stark I was passed prohibiting physician referrals to clinical laboratories with which the physician (or an immediate family member) had a financial relationship. The intent was not to affect the free market system, but to require disclosure of such relationships.

According to the Special Fraud Alert issued by the Office of Inspector General, the reasoning behind this law is that incentive programs can interfere with the physician's judgment of what is the most appropriate care for a patient. They can inflate costs to the Medicare program by causing physicians to overuse inappropriately the services of a particular hospital or facility. The incentives may result in the delivery of inappropriate care to Medicare and Medicaid recipients by inducing the physician to refer patients to the hospital providing financial incentives rather than to another hospital (or non-acute care facility) offering the best or most appropriate care for that patient. Accordingly, it is illegal for hospitals to provide financial incentives to physicians for their referrals.

In January, 1995, Stark II expanded Stark I by adding 10 "designated health services" to include radiology and other services, such as physical therapy, occupational therapy, and radiology. It was also expanded to include durable medical equipment and supplies as well as inpatient and outpatient hospital services. Self-Referral type laws are designed to discourage physician ownership of various ancillary treatment centers. Originally these laws were limited to clinical laboratory services but were expanded in 1995 to include radiology and certain other imaging services. Under these laws, referrals are banned if the referring physician has either an ownership interest in or a direct or indirect compensation relationship with the entity to which the physician is referring a patient.

Employers would like to see laws similar to the federal Stark laws prohibiting provider self-referrals since they see this as driving up medical costs and therefore premiums.

Referrals by anyone to a party in which they have either a financial relationship or an abiding financial interest needs to be studied more closely.

There is almost no relevant financial disclosure at this time by any of the parties involved in the workers' compensation system. As long as there is no transparency in the financial dealings of parties involved in the WC system, there will be incentives to self-refer and to gain financially from the referral.

Medical Management Services

WCRI published a document researching Area Variations in Texas Benefit Payments and Claim Expenses. An interesting paragraph in the document's abstract was as follows:

Claim expenses were the fastest growing component of all costs in Texas, increasing by more than 12 percent per year across all geographic areas for claims with 12 months maturity. Expenses for medical management services, which accounted for more than half of all claim expenses in Texas, increased in all geographic areas by at least 14 percent per year and by over 25 percent per

year in the Dallas/Fort Worth and Houston geographic areas for 1994 and 1996 claims.

Medical expenses can include the expenses of administering a claim, the expenses of investigating a claim, the expenses of reviewing a claim, etc. The confusion arises regarding the difference between medical costs and medical expenses: medical costs are the actual medical costs while medical expenses are the costs mentioned above.

The real problem occurs, in the Committee's opinion, when medical management expenses cost as much as the "actual" medical costs themselves.

Other Cost Drivers

Other medical cost drivers have been identified with the Workers' Compensation system. Some of these are leading to good doctors leaving the system. They include, but are not limited to, the high cost of overhead and other administrative costs noted by health care providers, including the "hassle" factor. Add to this the perception that providers are suspected of being over-utilizers and many doctors leave the system for other patients who do not require the extra work, especially the psychosocial issues often associated with injured workers.

Conditions of working within the workers' compensation system cited by many doctors, in addition to those concerns mentioned above, are as follows:

√ Increased paperwork and documentation: 13 TWCC medical forms for doctors (compared to 10 for employers, 14 for insurance carriers, and 16 for employees). This number of forms is in addition to any forms required by insurance companies or peer review companies.
√ The difficulty of getting approval for referrals for testing or to specialists; this also increases the overhead and administrative costs.
√ Concern over who is reviewing work: nurses or non-medical personnel, out-of-state doctors or health personnel, doctors with a different specialty than the treating doctor, or "anonymous" doctors.

Doctors also note that current fee guidelines have not been changed since 1996. Low fees coupled with the issues noted above and the fact that WC claims are difficult to file and less likely to be paid than any other type of claim, have contributed further to good doctors choosing not to take new workers' compensation patients or being unable to continue to treat existing ones. As one doctor pointed out, he could "only take so much charity work and continue to practice medicine."

As good doctors leave the system, costs go up for the workers' compensation system. This is due to injured workers having to go out-of-area for medical care with the resultant extra costs for travel expenses, hotel and meals.

Return to Work

In Texas, statistics are kept on employees who are injured on the job and eligible for workers' compensation benefits; there is a waiting period of seven days before an injured employee is eligible for benefit determination. The majority of injured employees never reach this seven day threshold, but for those who do, the results can be devastating in regards to Return to Work (RTW).

An employee's ability to RTW after the worker is injured on the job in Texas is uncertain at best, especially if the worker has been off the job more than 30 days. Generally, outcomes are poor in Texas with only about 50% of those who lose more than seven days of work after an injury returning to the same or a comparable job. Of the other 50%, about 30% either return to a lesser paying job and/or one in another field and up to 20% may never return to work at all.

The results are even worse for those workers whose first language is not English, those with little education, those who are older, and those who work in certain trades (especially manual trades like construction, landscaping, etc.). Over 47% of these workers never return to consistent employment at all.

When the current Workers' Compensation system was initiated in Texas in 1989, the initial idea was a system that would allow an employer to provide proper medical care and a percentage of lost wages to the injured worker and bring that worker back to work in a timely manner; in return for these benefits, the employer would not be liable for further remedies. In 2001, it became apparent that something was not working, so HB 2600 was passed. This rather comprehensive overhaul bill stressed that the RTW component should be a high priority for the Texas Workers' Compensation Commission (TWCC) and challenged TWCC to do more to achieve adequate RTW.

During the 2002 interim, the Committee on Business and Industry was given a charge to study TWCC's implementation of HB 2600 and to determine which areas needed improvement. The Committee concluded that little if anything was being done to promote RTW. It found that there were no clear RTW policies or guidelines for many companies. It also found that smaller companies were particularly ill-equipped to deal with RTW and certain disincentives in the current system failed to promote RTW. Following this report, during the 78th Legislative Session (2003), proposed bills and legislative guidance further clarified that RTW should be a major focus for TWCC. The recent Sunset Advisory Commission Staff Report on TWCC (May 2004) verified

that RTW was still a large and unresolved issue for TWCC.

There is consensus in the iterature which states that, Stay At Work - Return To Work is the best option for the injured employee. (Studies by the Workers' Compensation Research Institute, the National Council on Compensation Insurance, and others bear this out.) In instances where good communication exists between the parties, better rates are achieved for RTW. There are also higher rates of return for injured employees who have continual contact with their employer and co-workers. This is due to the so-called halo effect (they care about me and want me back at work since I am an integral part of the team). These studies also show that the longer it takes an injured employee to return to work the higher the likelihood that the worker will never return to work at all. Given enough time off, the employee becomes virtually unemployable with additional psychological, emotional and financial concerns compounding the problem.

The current workers' compensation system does not provide the education or incentives for effective communication and teamwork between the employer, employee, provider, and carrier to return an injured worker to work in a timely manner. In fact, some employees may not be getting the medical treatment they need in order to RTW, delaying any meaningful job placement; this is exacerbated by insurance carrier delay in payment of medical claims, medical dispute resolution, and TWCC appeals processes. In some cases, the provider is caught between the employer who wants an employee back at work even if the employee isn't healed and the employee who feels that no one cares what happens to him. At TWCC there is only one employee in the agency who is specifically tasked for RTW at the present time.

The success that an employer has in assisting an employee returning to work after an injury depends on many factors. The expectations and experience of the employer are the most critical; however, a subtle but equally strong influence is the managers’ and supervisors’ beliefs about how and when an employee should return to work.

Under the best circumstances, beliefs are based on clear corporate policies and an understanding of lost-time research. But the reality is that return-to-work decisions are more often based on misinformation, negative stereotypes, unfounded fears, and personal convenience. These beliefs directly influence employers’ workplace practices and affect lost time.

Some return-to-work beliefs based on half-truths, overgeneralizations, or inaccurate information -- otherwise called return-to-work myths -- are described below. Some myths are easily changed; others are extremely resistant and can become chronic problems in an organization.

The 100 Percent or Nothing Myth:

> *Employees must be able to do 100 percent of their job tasks before returning to work.*

Not so. Employees regain their ability to work incrementally and can therefore transition back into the workplace gradually. In most cases, work tasks can be modified for short periods of time without reducing the overall productivity of an organization.

The Light-Duty Myth

> *Light duty is an effective way to return employees to their full productivity.*

Light duty can be static and open-ended. Uncontrolled or poorly managed light duty can encourage an employee to remain in a reduced-productivity position too long, or indefinitely. Without a planned transition back to full productivity, employees will not become reconditioned or build up the tolerance they need to resume full job duties. And if appropriate expectations are not established on the front end, miscommunication between the employer and employee can occur.

The Total-Disengagement Myth

> *People who are ill or injured need total rest and removal from everyday life in order to recover.*

People heal from illnesses and injuries incrementally. Getting back to normal daily activities, including work, is part of that process. Recovery progresses quickly and successfully when there is a combination of early mobilization treatment and increased transitions back to a normal way of living. Workplace managers play a key role in the recovery process when they involve the physician and the employee in return-to-work planning and a discussion of the need for temporary modifications in the workplace.

The Skeptic's Myth

> *Most employees want to stay out of work as long as possible.*

Sure, there is a small percentage of employees with low work motivation who may use an injury or illness to avoid returning to work, but most can and do want to return to work. In addition to the economic incentive, work is a strong source of dignity and self-esteem. Sometimes this myth is misapplied to individuals who aren't unmotivated but instead are fearful about resuming work after an injury or illness.

The Physician-as-Occupational-Expert Myth

> *Physicians always offer work restrictions based on solid knowledge of job demands and know when a patient is ready to return to work.*

An employer holds essential information about specific workplace policies and job demands. Physicians are experts in the field of diagnosis and treatment of disease and disability, but need the cooperation of the employer in order to

make well-informed return-to-work assessments. A physician isolated from this kind of input may unnecessarily limit the patient's work options. Usually, this is unintentional and the result of inaccurate or incomplete information.

In some cases, a physician's training and work focus may not provide the best skills and clinical setting to assess functional capacity and make return-to-work plans.

The "We Can't Afford It" Myth

Return-to-work accommodations cost too much.

Workplace accommodations are usually not expensive and may be as simple as rearrangement of equipment. A study has shown that 70 percent of accommodations cost less than $500 and 20 percent cost nothing at all. In addition to keeping an employee at work, workplace accommodations may have an added bonus by reducing workers' compensation costs.

Contrary to popular belief, such accommodations are rarely too expensive when compared with the costs for training new staff to do the job of an experienced, though injured, employee. There is a tremendous amount of adaptive equipment available, much of it at minimal cost. In fact, many adaptive devices have been fabricated at the workplace, by a creative supervisor, for virtually no cost (e.g. ramps over stairs, lowered work stations).

Light Duty / Modified Duty

In most cases, some temporary modification of duties can be made for an employee that would allow them to return to work in a limited capacity, subject to his/her medical restrictions. Such temporary modifications are called "light duty, limited duty, or modified duty" assignments. In general, light duty assignments are typically limited in duration; an example would be 30 - 45 days.

Reasonable Accommodation is the modification or adjustment to a job, the work environment, or the way things are usually done that enables a qualified person with an injury or a new disability to enjoy equal employment opportunities.

It is expected that most requests for reasonable accommodation will involve existing employees who have become disabled, either through a work related injury or illness. The most common request will include the restructuring of jobs or tasks within a job, reassignment to a vacant position in another classification, modification of the existing work site, or acquisition of special equipment and devices.

Often the employee's medical restrictions involve limitation of movement of one or more limbs. This is the case with back injuries that limit lifting, leg injuries that limit walking or bending, and arm/hand injuries that restrict any type of

repetitive motion (e.g. carpal tunnel). Permanent job restructuring may involve reassignment of the injury aggravating tasks to another employee, perhaps in exchange for another task that the injured employee is able to perform.

For example, a cook who has a permanent back injury, may be unable to lift heavy pots or food sacks any longer. It is possible that this task may be assigned to another employee in exchange for additional cutting, peeling or washing chores that do not place additional strain on the back.

There are three primary areas of focus for the supervisor in dealing with an injured worker:

1. The supervisor must be able to accurately, and objectively, develop a duty statement or job description for each employee's assignment that accurately defines the "essential functions of the job."

2. The supervisor must be open to returning an injured employee to work if he/she (a) can continue to perform the essential functions of the assigned job with reasonable accommodation, or (b) are qualified to perform another available job with or without reasonable accommodation.

3. The supervisor should not use a person's injury as an excuse to preclude him/her from doing work that he/she is qualified and medically able to perform. This is especially true for injured workers who otherwise qualify for promotions, transfers, etc.

No matter how hard employers try to keep their injured workers employed, there are some situations when the employee's disability is so extensive, that he/she is incapable of performing most of the essential tasks of the job. If an employee is incapable of returning to work because of the severity of the medical restrictions imposed by the physician, then referral to rehabilitation specialists for work training or re-training may be necessary.

Barriers to Effective Return to Work

There are several potential barriers to effective RTW programs. Employers, especially smaller employers, point to the cost of maintaining someone in-house to coordinate RTW activities or of having to provide "light duty" positions which may not contribute to their businesses. Providers point to the fact that they may know little if anything about the employee's job description or know little of what other jobs might be available at the jobsite of a particular employer. Employees are often fearful that they will be forced to work too soon or be asked to do tasks forbidden by their physician; by going back to work too soon, they fear they may be set up for further and more damaging injuries. Underlying all these concerns are uncertainties about what the system was

created to do, recent best practices for medical care, economies of the workplace, and suspicion among the various parties.

Recommendations

1. It appears that in order for workers to get the proper care and to return to work in a timely manner and in the interests of controlling costs, a new system merits strong consideration.

2. As hospitals and ambulatory fee guidelines are being put into place by TWCC, the committee needs to monitor these fees for appropriateness.

3. Fees for medical doctors should be investigated to determine whether they need to be increased in order to recruit additional doctors into the system as well as cover the state geographically. Additional consideration may be warranted in order to ensure that all necessary medical specialties are covered.

4. Assemble and compile data already available as to self-referrals. A TDI study should be conducted to determine if there are measurable and/or significant differences between referrals that are self-referred and non-owned.

5. Identify outlier insurance carriers (i.e. denials of medical necessity and compensability) as is currently being done for outlier physicians and providers.

6. Establish back to work guidelines and education of employers.

7. Electronic billing needs to be implemented as soon as possible. The committee previously questioned TWCC about the possibility of electronic billing by physicians to workers' compensation insurance carriers.

While many discussions are being held regarding networks and managed care for workers' compensation, certain areas, because of distance, scarcity of physicians, and economic feasibility, may not be able to participate in a network system. Therefore, with or without networks or managed care, these recommendations should be beneficial.

Committee Charge # 2

Cost Effectiveness of the State's Workers' Compensation System

REPORT ON INTERIM CHARGE # 2

Charge and Public Hearing

The Speaker of the House of Representatives gave the Committee the Charge to study the cost effectiveness of the state workers' compensation system including:
a) Economic benefits, if any, of inclusion of the UT System, A&M University System, Texas Dept. of Transportation and Employees Retirement System under the State Office of Risk Management programs;
b) Costs or savings to the state by allowing state agencies to self-insure; and
c) The creation of workers' compensation provider networks for state employees.

The Committee on Business & Industry met on April 19, 2004, to discuss these issues and heard testimony from the State Office of Risk Management (SORM), the UT System (UT), the A&M University System (A&M), the Texas Department of Transportation (TxDot) and the Employees Retirement System (ERS). Follow-up testimony was heard in subsequent hearings and briefings.

Background

In the July 1991 Texas Performance Review, the Texas State Comptroller reported that among the 41 states in the National Association of State Personnel Executives, the majority of states' workers' compensation programs were administered by either a central personnel, employee benefits or administrative agency, or by a separate entity that administered that worker's compensation program exclusively. Noting that risk management activities were administered by the Texas Workers' Compensation Commission (TWCC) while the state employees' workers' compensation program was administered by the Office of the Attorney General (OAG), the Comptroller recommended the transfer of the administration of state workers' compensation to a centralized personnel office in fiscal year 1994. The Comptroller also noted that the recommendation could be the basis of transferring the Risk Management Division from the TWCC as well.

After an interim study and recommendation for the 74th Legislature by the Legislative Oversight Committee on Workers' Compensation and the House Business and Industry Committee, a bill was introduced and passed by the House, but died in Senate committee. The concept was reintroduced the following session as HB 2133. The bill analysis at the time noted that prior studies had concluded:

* Agencies had, at the time, no financial incentive for holding down workers' compensation claims costs. Salary replacement and medical costs were paid through an appropriation to the OAG Workers' Compensation Division, rather than with funds coming from the agencies' own budgets;
* Low priority was generally given to health, safety, and loss programs because only the Attorney General's office and not the agencies received the program savings; and
* A premium allocation system should be mandated to ensure accountability by each agency.

State Office of Risk Management

The State Office of Risk Management (the Office or SORM) was created by House Bill 2133, 75th Legislature, and became a state agency effective September 1, 1997. The Office was created from the merger of the Workers' Compensation Division of the Office of the Attorney General (OAG) and the Risk Management Division of the Texas Workers' Compensation Commission (TWCC).

The Office's operations are governed by the Texas Labor Code, Chapters 412 and 501. Operating costs for the risk management and workers' compensation strategies are funded by interagency contracts and direct General Revenue Fund appropriations. Costs for workers' compensation payments are funded by direct General Revenue Fund appropriations, OAG debt collections, and subrogation receipts. The Office assists state agencies in controlling risks and losses.

The Office is governed by a six-member Board appointed by the Governor. Members of the Board serve staggered terms. The Board is responsible for:

- Oversight of the agency and the appointment of an Executive Director;
- Approval of risk management guidelines for distribution to state agencies;
- Approval of rules necessary for the implementation of the risk management and workers' compensation programs; and,
- Reporting to the legislature on methods to reduce exposure to loss for state agencies; the operation, financing, and handling of risks by state agencies; the handling of claims brought against the state.

The Office provides services to state agencies for the protection of the state's resources. Currently, these resources include approximately 172,000 employees, more than $8.8 billion dollars in capital investments in buildings, and approximately $2.2 billion in fixed assets. The Executive Director of the Office serves as the "State Risk Manager".

SORM's responsibilities include:
- Providing immediate feedback to state agencies in identifying, evaluating, and reducing potential liability exposure and liability losses, including workers' compensation losses;
- Reviewing, verifying, monitoring, and approving risk management programs adopted by state agencies;
- Providing risk management training for state agencies;
- Consulting state agencies regarding their insurance needs;
- Purchasing insurance on behalf of state agencies;
- Approving the purchase of surety bonds for state agencies, as warranted, including the scope and amount of the bond; and,
- Collecting data from insurers regarding insurance purchases by state agencies.

The Office publishes risk management guidelines, trains state agency personnel, conducts safety reviews, devises protocols and responses at the request of state agencies or in response to external threats or risks, and provides risk management analyses, consultations, and insurance services to state agencies. State agencies are required to submit annual reports to the Office on claims and loss information, existing and potential exposure to loss, estimates by category of risk of losses incurred but not reported, and any additional information deemed necessary by the Executive Director.

State agencies intending to purchase property, casualty, or liability insurance coverage other than through the services provided by the Office must report the purchase to the Office within 30 days of the purchase. The Office administers the State Employees Workers' Compensation Program for state agencies. SORM also administers workers' compensation claims for employees of Community Supervision and Corrections Departments. SORM's workers' compensation claims program is responsible for:

- Operating a self-insured workers' compensation program for the State of Texas pursuant to the Texas Labor Code and TWCC regulations;
- Receiving and investigating reports of injury filed on behalf of state employees;
- Determining whether a claim is compensable;
- Paying income and medical benefits as due;
- Reviewing medical bills to determine reasonableness, necessity, and compliance with TWCC fee guidelines;
- Appearing as an adversary before TWCC and the courts and presenting the legal defenses and positions of the workers' compensation program;
- Preparing reports for the legislature on workers' compensation claims information; and,
- Providing workers' compensation training for state agencies.

The Office is located in Austin, Texas. At this time, SORM has no field office locations, although services are provided to agencies throughout the state.

Provider Networks for State Employees

In 2001, the 77th Legislature enacted HB 2600, an omnibus bill relating to workers' compensation. The bill created the Health Care Network Advisory Committee (HNAC) to advise the Commission on regional workers' compensation health care networks. HNAC members were appointed by the Governor and consisted of three voting employer representatives, three voting labor representatives, the Texas Workers' Compensation Commission Medical Advisor (who serves as chairman), three non-voting health care provider representatives, three non-voting insurance carrier representatives (including a representative from the State Office of Risk Management), and one non-voting actuary.

A mandate from HB 2600 required the State Office of Risk Management (SORM), the University of Texas System (UT), Texas A&M University System (TAMU), and the Texas Department of Transportation (TxDot) to participate in the implementation of the regional network concept. The recently completed study of the Feasibility of Regional Workers' Compensation Networks (RWCNs) in Texas was awarded to MedFx LLP.

The study concluded that RWCNs are conditionally feasible if at least fifteen percent of the state's workers' compensation medical costs were handled within the RWCN. They recommended that a pilot project be implemented in the Austin/San Antonio and Houston regions as defined. The study estimated savings to be expected as a result of implementing the RWCNs. The basis of the estimates included a factor to account for the fact that the RWCNs authorized under HB 2600 were voluntary.

The voluntary aspect of RWCNs means that employees had the opportunity to decide whether to participate in the RWCN; they could elect to participate at any time between the date of hire and the date of injury. Those electing to participate could, within fourteen days of the date that the employee first received medical treatment in the network and under certain conditions, opt-out of the RWCN.

The feasibility report included a section entitled "Costs and Benefits of the Regional Networks." The discussion of the derivation of the savings estimates made reference to three critical assumptions:

- The opt-in rate: the percentage of employees electing to use the network,
- Achievable savings: the potential reductions in medical and indemnity costs, and

- Health risk (selection) adjustment: a factor accounting for the relative health status of those electing to use the network versus those not using the network. Empirical evidence suggests that less severely injured workers will opt into the network if it is voluntary.

The savings factor was estimated as the product of the opt-in rate, the achievable savings and the health risk adjustment. The factor derived in the feasibility study was:

40%	X	30%	X	60%	= 7.2%
opt-in rate		savings in medical and indemnity costs		selection adjustment	savings factor

The savings factor was multiplied by the losses in a given region to estimate the savings due to the RWCN. The estimates MedFx derived were based on data provided by the Texas Workers' Compensation Commission (TWCC). The data for injury years 1999 and 2000 that were analyzed for the Feasibility Report included the indemnity losses that were used to estimate aggregate losses for SORM, UT, TAMU and TxDOT for the Austin/San Antonio and Houston regions.

A summary of the costs by region is shown in the table below:

Region	Biennial Indemnity Losses	Estimated Total Biennial Losses
Austin/San Antonio	$7,895,299	$15,790,598
Houston	$19,973,306	$39,946,612
All Other Regions	$36,115,160	$72,230,320
Total	$63,983,765	$127,967,530

Applying the savings factor to the losses in the Austin/San Antonio and Houston areas generated the savings estimates to the state's workers' compensation program reported below:

Region	Estimated Total Biennial Losses	Savings Factor	Estimated Biennial Savings to State Workers' Compensation Costs
Austin/San Antonio	$15,790,598	7.2%	$1,136,923
Houston	$39,946,612	7.2%	$2,876,156
Total	$55,737,210	7.2%	$4,013,079

The savings results reported in the study were $1.1 million in Austin and $2.9 million in Houston.

The feasibility report included a break-even analysis. This was an estimate of the minimum level of participation required to fund expected implementation and on-going costs. Stated another way, the break-even analysis set the floor at which the network could recover their costs. MedFx previously estimated that a minimum participation rate of fifteen percent was required to break-even.

Revised Savings Estimate

The development of estimated savings using a basis of mandatory network participation followed the same approach as that discussed above. Mandatory network participation affected the first and last terms of the savings factor equation: the opt-in rate became 100% since the network was mandatory, and the selection adjustment term became 100% since the ability to opt-in or opt-out was eliminated. Using a mandatory employee participation model, the revised savings equation was as follows:

100%	X	30%	X	100%	=	30%
opt-in rate		savings in medical and indemnity costs		selection savings adjustment factor		

Assuming that the RWCNs were made mandatory for state employees, the state could expect to save approximately thirty percent in medical and indemnity costs for the Austin/San Antonio and Houston areas. These savings by region are summarized in the table below:

Region	Estimated Total Biennial Losses	Savings Factor	Estimated Biennial Savings to State Workers' Compensation Costs
Austin/San Antonio	$15,790,598	30%	$4,737,179
Houston	$39,946,612	30%	$11,983,983
Total	$55,737,210	30%	$16,721,162

One other consequence of mandatory network participation should be noted. The feasibility report concluded that it would be advantageous to pilot the RWCN concept in two regions. This allowed for the demonstration of the concept and the validation of the results. Mandatory network participation would increase the expected savings significantly. There might be other regions in which SORM and the related state employers operate that could eventually benefit from the RWCN model.

Med Fx estimated that if the RWCN concept were expanded to include all state employees statewide, estimated aggregate savings would be about $38.4 million. They suggested that SORM and the related state employers could contract to build networks in those areas where geographic deficiencies existed and still save significant amounts in those areas. They noted that the only significant difference would be an additional four to six months to contract with providers in those areas where geographic deficiencies were identified.

The MedFx analysis concluded that the proposed network model was feasible, but that the success of the model would be dependent on the receipt of satisfactory RFP responses consistent with the financial model and assumptions discussed in their full report.

Recommendations

Despite testimony alluding to the resistance of some state agencies to embrace a state employee network system, the State Office of Risk Management says they are intrigued by the possibilities inherent in a network. They point to the fact that there is less uncertainty with negotiated rates.

At the current time, the Committee feels that UT, A&M, and TxDot are doing a good job of covering the needs of their respective employees' workers'

compensation programs. Studies by TDI indicate that these agencies' workers' compensation costs are lower than for other state agencies, and for this the committee commends them.

However, the Committee recommends that other state agencies not be allowed to opt out of SORM. There are several reasons for this:

- Recent data suggests that SORM is beginning to show results from its risk management, safety, and other programs. There is generally a lag time from establishing a program until it reaches its fruition. Given that SORM inherited some problems at its inception as well as an enormous mandate, it is not surprising that the lag time was a bit longer than expected. SORM admits that there was a period of learning, but estimates that approximately $20 million will be credited for the current fiscal year.

- In the past, SORM realized less savings from its' cost containment efforts due to a limited budget for cost containment services. UT, TAMU, and TxDot have had much higher expenditures for bill review and cost containment services than SORM, but also appear to have achieved greater savings as a result of those expenditures. (For comparison purposes, per bill expenditures by UT were 250% of the per bill cost paid by SORM for FY2003.) SORM's recent cost containment strategies should ensure that greater savings will be realized in the future.

- Allowing other additional state agencies to leave SORM would require them to set up their own risk management systems, a duplication of increasingly scarce state resources. While it is true that some state agencies would possibly be better off "going it alone" due to their younger employee base, their better utilization of training and safety programs, etc., other agencies would have to make up the slack. This in turn could bring down the experience rating of SORM as a whole. If the purpose of enterprise risk management is to increase the value of the enterprise, then allowing agencies to opt out negates savings.

- Agencies who opted out would have unfunded liability for claims already in process. Since the life of a claim can cover many years, an agency not experienced in determining their future liability could find themselves with a shortfall.

- Some state agencies are so small that economies of scale cannot be achieved unless they band together with other agencies.

- SORM has enough trouble recruiting and retaining skilled claims adjusters and other staff who have learned the processes. If other agencies were competing for the same pool of experienced employees, the state would in effect be competing against itself.

Recruiting and retention of a well-trained, dedicated, and competent workforce is an ongoing challenge for all state agencies. SORM is no exception: turnover in the Office's workforce was 32 percent in FY 2000 and 28 percent in FY 2001. Although SORM's turnover rate continues to drop, it still exceeds the statewide turnover rate for FY 2001, reported at 17.6 percent, and continues to be a significant concern for the Office, especially since the costs of training new employees affect the bottom line.

Internal reports indicate that the percentage of employees leaving the Office for higher paying jobs (as opposed to other reasons) fell from 66 percent in FY 2000 to 60 percent in FY 2001. SORM has had difficulty competing financially with the pay scales of other governmental entities or private sector companies in the insurance field. An experienced claims adjuster at SORM makes about half of what a private sector adjuster would be paid and also has a higher caseload. While SORM has tried to address this, it may be that more needs to be done to reduce caseloads and provide other incentives for staff to remain at the agency.

Administrative support is still being provided by the OAG, pursuant to SORM's enabling legislation; this separation has caused some issues. While it may be advantageous to share resources where it makes sense, it may not be desirable for such disparate agencies.

The Committee on Business & Industry should continue to monitor the State Office of Risk Management and to receive updates on their cost containment and other services once every six months.

Committee Charge # 3

HB 2600 Implementation

REPORT ON INTERIM CHARGE # 3

Background and Charge

The Committee on Business & Industry was given the charge to monitor the activities of the TWCC in the continued implementation of HB 2600, 77th Legislature, and Workers' Compensation legislation passed during the 78th Legislature by the Speaker of the Texas House of Representatives. The Committee heard relevant testimony on August 25, 2004, and August 26, 2004; other testimony was received at previous hearings and briefings.

History of Workers Compensation in Texas

Texas had no real need for an industrial workers' compensation system at the beginning of the 20th century. Its economy was still dominated by ranching and agriculture where the number and severity of injuries were few when compared to industrialized workplaces.

Things began to change in 1901 when oil was struck at Spindletop, just south of Beaumont, Texas. The result was the largest gusher the world had ever seen, spurting a steady stream of oil over 100 feet high. Other major oilfields, discovered shortly after Spindletop, produced even greater amounts, and oil provided the catalyst for spectacular economic growth throughout Texas. The work required to bring in a well was quite hazardous, but the pay was good, and men flocked to the oilfields for jobs. For the first time in its history, Texas needed a politically acceptable means of protecting a large number of workers from industrial accidents. As a result, Texas enacted its first workers' compensation law in 1913.

In 1917, the U.S. Supreme Court ruled that states could legally require employers to provide compensation to injured workers. As a result, many states revised their laws to include mandatory workers' compensation. Texas revised its workers' compensation law in 1917, but retained voluntary employer participation in the system. Today, Texas is the only state (with the exception of New Jersey) that allows employers to choose whether or not to provide workers' compensation, although public employers and employers that enter into a building or construction contract with a governmental entity must provide workers' compensation.

The 1917 Texas law provided the basic framework for the state's workers' compensation system for the next 75 years.

In 1987, amid growing public complaints about high insurance costs and low benefit rates, the Legislature appointed a Joint Select Committee on Workers' Compensation Insurance to study the state's workers' compensation system and make recommendations for change. The Joint Select Committee study was completed in 1989. The study found that:

Work-related fatality rates in Texas were among the highest in the comparable states;

Texas work-related injury rates were widely believed to be among the highest in the comparable states, although reliable statistics comparing state rates were unavailable;

Texas benefit rates and payment durations, especially those for seriously injured workers, were low compared with other states;

Almost 50 percent of all compensable lost-time claims in Texas were filed with the help of attorneys, regardless of whether or not the claim was disputed;

Workers' compensation-related medical costs were higher in Texas than in other states and had increased faster than medical costs outside the system and faster than indemnity costs;

A higher percentage of claim disputes in Texas were resolved in the courts, and, settlements were sometimes inequitable or inappropriate for the injury;

Insurance rates in Texas had more than doubled over the previous five years and were among the highest in the comparable states; and

Texas was one of the only three states that did not allow private employers to self-insure.

The Texas Legislature responded to the Joint Committee report by adopting the Texas Worker's Compensation Act (Senate Bill 1, 71st Legislature, Second Called Session) on Dec. 13, 1989. The Act attempted to ensure that injured workers were compensated fairly and appropriately for workplace injuries and applied to work-related injuries and illnesses that occurred on or after January 1, 1991.

Workers' compensation is basically a contract between the employer and the employee. If the employer provides coverage, the employee will receive medical and income replacement benefits as established by statute. Providing this coverage protects the employer from lawsuits except in cases of gross negligence. If the employer does not provide workers' compensation coverage, the injured employee can sue the employer. Texas law does not require that an employer provide workers' compensation coverage; only public employers and employers that enter into a building or construction contract with a governmental entity are required to provide coverage.

Highlights of the Act:

Voluntary participation
Texas is the only state (with the exception of New Jersey where the effect is that no employers opt out) that still allows any private employer to choose whether or not to purchase workers' compensation insurance. Employers who choose not to maintain coverage must notify the Commission and their employees that they do not intend to maintain workers' compensation insurance. The Act also created more insurance options for employers, including self-insurance for large employers who meet established criteria and are certified by the Commission; group self-insurance for employers with similar risks; deductible options for employers; and group purchasing options for employers with similar risks.

Workplace health and safety
The Act consolidated and strengthened workplace health and safety programs by creating a Health & Safety Division at the Commission and statutorily establishing several injury prevention and employer safety outreach programs.

Improved benefits and benefits delivery
The Act established a new income benefits system, raised basic income benefit levels and set tight deadlines for employers and carriers to improve benefit delivery. Workers' compensation benefits are the exclusive remedy of an employee of a covered employer, except in the case of a fatality caused by an employer's gross negligence or an intentional act or omission by the employer. Compromise settlement agreements were prohibited in exchange for a structured income benefit system and the ability to resolve income benefit disputes administratively at the Commission.

Dispute resolution
An administrative income benefit dispute resolution process was created in place of the previous "trial de novo" process in an attempt to resolve claim disputes informally whenever possible. Income benefit disputes must first go through a multi-level hearing process at the Commission before a disputing party can appeal to district court. As part of this administrative dispute process, the parties must first attempt to mediate the dispute (at a proceeding called a Benefit Review Conference or BRC) then proceed to a formal hearing (called the Contested Case Hearing or CCH) and then finally the parties may appeal the CCH decision to a panel of three administrative law judges (called the Appeals Panel). The Act also created an Ombudsman Program, which provides free assistance to injured workers and other system participants who have not hired attorneys to represent them in Commission dispute hearings.

Compliance

The Act strengthened the Commission's ability to monitor system participants and to assess administrative penalties for noncompliance with the Act or Commission rules. The Commission also investigates fraud and may work with local prosecutors and law enforcement officials to prosecute workers' compensation fraud.

Cost control

The Act requires the Commission to develop medical fee guidelines to control the price of medical services provided to injured workers. In addition, the Commission has the authority to adopt treatment guidelines and return to work guidelines, as long as these guidelines meet basic statutory standards.

Attorneys' fees

Attorneys fees are limited to time and actual expenses, up to a maximum of 25 percent of an injured worker's weekly income benefit check. The fees are taken directly from the employee's benefits.

Research & Oversight

The Legislature originally created a Workers' Compensation Research Center and in 1989 created a Legislative Oversight Committee - these were merged in 1993. The Research and Oversight Council conducted independent studies and research on workers' compensation-related issues and monitored the operational effectiveness of the system. In 2003, the research functions were transferred to the Texas Department of Insurance and became the Workers' Compensation Research Group (HB 28, 78th Legislature, 3rd Called Session).

WC in Texas, Compared to Other States

In Texas private employers may opt to either provide workers' compensation or not; in every other state (with the exception of New Jersey), workers' compensation is mandatory. New Jersey does not require employers to carry coverage, due to the restrictive nature of its statute, all employers in New Jersey have thus far chosen to carry workers' compensation coverage. It should also be noted that many states have statutory exceptions that allow small employers (typically those with less than 20 employees) the option of purchasing workers' compensation coverage. So in most states, business owners can only watch helplessly as their workers' compensation premiums continue to climb while Texas employers have another choice: They can opt out of the system altogether. Although there are certain risks to employers who opt out, many smaller employers have no other option.

To some extent, the Texas system of optional coverage allows one to view workers' compensation as a commodity, not a necessity. For employers that chose to purchase coverage (called subscribers in Texas), workers'

compensation insurance pays all reasonably required medical bills for an employee's work-related injury, replaces some lost wages, offers monetary compensation to injured employees with permanent impairment caused by a work-related injury, pays benefits to qualifying beneficiaries when an employee dies as a result of a work-related accident or illness, protects employers against lawsuits by injured workers, and pays employers' legal defense costs and indemnity (payment for losses) in gross negligence death cases. Additionally, workers' compensation carriers offer workplace safety training, loss prevention education, and other programs designed to minimize the risks and effects of work-related injuries.

In short, workers' compensation insurance costs money. Studies have shown that premium cost is the primary driver cited by businesses that opt out of the workers' compensation system; these businesses are known as non-subscribers.

Studies by the Workers' Compensation Research Group at TDI and its predecessor (the Workers' Compensation Research & Oversight Council or ROC) have shown that after several years of a downward trend, the number of non-subscribers has begun rising, indicating that in addition to the economy, high premiums may be affecting the market once again. The latest estimate by TDI shows that 38% of Texas employers do not carry workers' compensation coverage and that 24% of the Texas workforce is employed by these non-subscribers (Testimony to the Joint House Business & Industry Committee and the Senate Select Committee on Workers' Compensation, August, 26, 2004).

The state agencies involved with workers' compensation are:

The Texas Workers' Compensation Commission (TWCC) was established in April 1990 as part of a broad legislative effort to reform the state workers' compensation system (Prior to reform the agency was named the Industrial Accident Board). The Commission's primary responsibilities are to:

help Texas employers provide safer workplaces by providing accident prevention training and services;

administer a system to ensure that injured and ill workers receive fair and appropriate benefits in a timely manner;

develop and administer a program to resolve claim disputes administratively and, when possible, informally;

develop and administer programs to contain or reduce medical and legal costs and to ensure overall system efficiency while regulating benefit delivery and medical cost containment initiatives;

ensure compliance with the Texas Workers' Compensation Act and Commission rules; and

certify and regulate self-insurance for private employers.

The Commission administers and regulates the workers' compensation industry (employers, employees, carriers, attorneys and health care providers).

The Texas Department of Insurance (TDI) licenses insurance carriers that write workers' compensation insurance in Texas, licenses insurance agents and adjusters, regulates workers' compensation carriers, establishes classification codes and modifiers, and provides research on workers' compensation issues.

The State Office of Risk Management (SORM) is the insurance carrier for state agencies and public universities (except UT, A&M and TxDOT) and represents the state at dispute resolution proceedings involving state employees.

The State Office of Administrative Hearings (SOAH) holds administrative hearings on appeals of Commission decisions such as removal of doctors from the Approved Doctor List (ADL), medical fee disputes, Independent Review Organization (IRO) decisions on medical necessity and preauthorization, identification as a hazardous employer, etc.

In addition to the state agencies listed above, there are 2 quasi-state entities that have functions in the Texas Workers' Compensation system:

The Texas Mutual Insurance Company (formerly the Texas Workers' Compensation Insurance Fund) serves as the insurer of last resort for employers unable to purchase workers' compensation insurance through the voluntary market and acts as a competitive force in the marketplace.

The Texas Property and Casualty Guaranty Association takes over management of claims when an insurance carrier is designated "impaired" by the Texas Department of Insurance. If TPCIGA needs monies to cover costs of administering claims for an impaired carrier, they can assess every carrier writing compensation insurance in the state.

Disability Management Update

Since April 2004, Stakeholders, Commission staff, and Commissioners have met and discussed disability management, treatment guidelines and treatment planning. Stakeholder meetings were held on April 28th, June 2nd, June 17th and August 12th. The Commission has received a great deal of helpful input since beginning these informal Stakeholder meetings. Disability management was initially presented in very broad terms at the first stakeholder meeting. As the Commission continued these meetings and received additional stakeholder input, the original concept evolved and the Commission has narrowed the focus of the disability management paradigm.

At the April 28th stakeholder meeting, the idea of disability management was introduced as a means to control over-utilization and improve treatment and return to work outcomes through the use of treatment guidelines, treatment planning and return to work guidelines. At the June 2nd stakeholder meeting, use of Disability Management Doctors (DMD's) to resolve treatment plans was discussed. At the June 17th stakeholder meeting, the use of Independent Review Organization or IROs instead of Disability Management Doctors (DMDs) was discussed. At the August meeting, presumptive weight of treatment guidelines, treatment planning and the use of benchmarks, and return to work coordination was discussed.

At this last stakeholder meeting, there seemed to be somewhat of a consensus developing. While most stakeholders did not seem to favor the use of treatment guidelines, particularly if given presumptive weight; most did seem amenable to targeting certain claims that meet defined benchmarks, when the provider falls into an outlier category based on Commission data.

Commission staff requested that stakeholders provide input, comments and recommendations on how to proceed with disability management by mid-September. After the Commission receives additional comments from stakeholders, there will be at least one more stakeholder meeting and maybe more. Hopefully, the Commission and all stakeholders can arrive at a consensus on a concept for a rule proposal relating to disability management.

Medical Treatments Costs and Duration Data

In an attempt to better understand the types of claims that have significant impacts on system costs, the Commission initiated a review of the duration of medical treatments and associated medical costs. As a result of this review and further analysis to be completed in the future, the Commission hopes to identify benchmarks for certain claims, in order to efficiently focus on treatment planning requirements while eliminating unnecessary "hassle factors" for providers.

Analysis. The analysis includes:

- Injuries from calendar year 2002
- Medical payments through December 2003
- Duration of medical services
- Length of time to reach one of the following benchmarks:
  - Six office visits
  - Eight PT/OT sessions
  - Eight Manipulations
  - Second set of injections
- Summarized by the HB3697 studies diagnostic groupings

Number of Claims.

- There were 207,571 total injuries in calendar year 2002 for which medical care was paid.
- Approximately 50% of all claims complete care within the first 30 days after date of injury.
- Of those that go beyond 30 days, another 20% of all claims complete their care before reaching one of the benchmarks included in the last pre-proposal draft (6 office visits, 8 PT/OT visits, 8 manipulations, and/or multiple injections.)
- Therefore, approximately 70% of all claims do not have care after 30 days or do not reach any benchmark; these are unlikely to be "problem" claims.

Low Back Claims. Low back claims stand out as a significant factor in the system.

- The low back claim category is the largest single payment grouping, nearly 29% of all payment. This is even more significant for benchmarked low back claims at nearly 32% of payments for all bench marked claims. The hand and wrist (including forearm) category is a distant second at 12% and 10% respectively.

- Low back claims (40,325) are approximately 20% of all claims but benchmarked low back claims (18,587) are 29% of all benchmarked claims.

- Sixty percent of all low back claims have completed medical care within 90 days of their initial treatment. Thirty-five percent of low back claims that reach a benchmark are still receiving medical care more than one year after the initial care. These benchmarked claims that extend past one year account for almost $150 million in medical payments.

Approved Doctor List (ADL) Update

TWCC has continued to monitor the number of doctors in the workers' compensation system to identify any access issues that may require immediate attention. Although the rate of growth has slowed down from where it was when the ADL was initiated in September, 2003, they insist the number of doctors approved to provide treatment continues to grow. As the map in the Appendix indicates, there are over 17,000 providers who have been approved to provide workers' compensation treatment. Approximately 14,600 of those doctors are located in Texas, and the map shows the geographic distribution of those doctors.

In response to concerns about whether doctors who are approved to treat are actually treating patients, TWCC has also been monitoring the medical billing data (recognizing that all of the data for care provided since the ADL change on 9/1/2003 has not been reported to the Commission at this time) to identify any disconnect between the number of doctors with the ADL certification and the number that are actually billing for care. Excluding the billing associated with things that are not "direct care," such as billing coming from assessment of maximum medical improvement and impairment, or care that is provided in an emergency room, TWCC has received billing for care of patients with injuries since September 1, 2003, from 67% (11,158) of the doctors approved to provide treatment.

The TWCC recognizes that there are some locations in the state and types of injuries where it may be difficult to find a doctor. The processes they have put in place through the field offices and the Medical Director's office to assist workers in connecting with a doctor appear to be helping. As of August 23, 2004, 415 patients have been assisted by the Medical Advisor or his staff to find an appropriate doctor. The number of calls for this type of assistance has decreased by about one third over the last six months. Whether this is because injured workers are better able to find the doctors they need or whether it stems from other causes remains to be seen. It should be noted that the Committee members continue to receive letters and calls from injured workers and their families advising them that finding a doctor to treat them is difficult.

On the flip side of the doctor issue, the Medical Advisor's Medical Quality Review Panel (MQRP) has been very busy in reviewing doctors making recommendations for denial of ADL applications or removal from the ADL. As of August 20, 2004, the MQRP and the Medical Director have reviewed 93 doctors and the Commission has taken action to deny 36 doctors from providing treatment. Of the denials, 7 doctors have filed suit in court against the Commission – 3 in district court and 4 in federal court. Of the cases in district court, two temporary restraining orders and 1 temporary injunction are in place

to prevent making the denial effective. The Commission's recommendations have been upheld in the federal cases and are either pending based on requests for reconsideration of the court's decision or court dates. Over the next several months, TWCC will be preparing for the trials on the merits for these cases. They expect the preparation and defense of those cases will require the dedication of a significant amount of resources.

Medical Fee Guideline Update

The Medical Fee Guideline (MFG) provides maximum allowable reimbursement amounts for health care providers treating injured workers in the State of Texas. The MFG rule uses required Medicare methodologies, models, and values for determining reimbursement in the Texas workers' compensation system. In developing the MFG, the TWCC analyzed all of the statutory and policy mandates and utilized recommendations from the Commission's Medical Advisor.

Other concerns were to ensure that injured workers received quality health care as required for their injury and to ensure that fee guidelines were fair and reasonable while achieving effective medical cost control. At the current time, reimbursement as determined by TWCC is the Medicare reimbursement amount for a particular service, multiplied by 125%.

More information regarding MFG is available at http://www.twcc.state.tx.us/mr/mfginfo.html

Health Care Network Advisory Committee (HNAC)

In 2001, the 77th Legislature enacted HB 2600, an omnibus bill relating to workers' compensation. The bill created the Health Care Network Advisory Committee (HNAC) to advise the Commission on regional workers' compensation health care networks and provided for a pilot program involving the Office of Risk Management (SORM), the State University Systems, and the Texas Department of Transportation (TxDOT).

According to TWCC, the last meeting of the Health Care Network Advisory Committee (HNAC) was held in the latter part of calendar year 2003 and there have been numerous conference calls since the last full meeting. However, the Commission and HNAC have delayed further action based on several factors: A number of Legislative Committees are studying the workers' compensation system and the use of networks in the system.

Under current law, the networks are in voluntary nature (both for injured workers and carriers); there is significant start-up cost in establishing networks; the pilot state entities already have forms of networks in place and control their costs when compared to the workers' compensation system's

private entities; there has been significant resistance to dismantling the current state systems in favor of a costly yet uncertain network model.
Statutory "outcomes" reporting must be coordinated with the new service model developing under the Business Process Improvement (BPI) project at the Commission, which is still in the design and implementation phases.

In deference to the Legislature and its interim studies currently under way, TWCC has decided that further implementation of the "pilot" program will be delayed until an improved model of networks is evolved through the legislative process.

Concerns with Pilot Program and Regional Networks
There are a number of issues concerning the structure of the regional networks and the pilot program envisioned by HB2600. Also, the statutory structure for these networks is significantly different from managed care structures that seem to work in other states. Some of the difficulties include the following:

- It is uncertain as to the level of participation that can be expected in the networks envisioned by HB2600 since employees may opt out of the networks. There is concern that this flexibility could result in less certainty in network participation and therefore make it more difficult to negotiate and establish networks. The regional networks are "fee-for-service".
- Only "public employers", primarily "state employees" represented by the State Office of Risk Management (SORM), the State University Systems, and the Texas Department of Transportation (TxDOT) are required to participate in a pilot project for networks. The University of Texas and Texas A&M Systems as well as TxDOT already have workers' compensation programs in place that they believe to be more desirable than the network pilot programs envisioned.
- Participation in regional networks by insurers and certified self-insurers is optional;
- Insurers electing to participate have the option of limiting participation to a particular employer or region of the state; and
- Data collection and reporting requirements are not yet fully developed and this is necessary to prepare the required Request for Proposal (RFP) to solicit network proposals for the pilot program. This requires co-ordination with the evolving Business Process Improvement (BPI) project at the Commission, which is still in various implementation phases.

Committee Charge # 4

HB 1366 Dry Cleaner Remediation Implementation

REPORT ON INTERIM CHARGE # 4

Charge

The Speaker of the House has charged the Committee to "Monitor the implementation of HB 1366, 78th Legislature. Consider concerns from interested parties regarding the use of the remediation funds and recommend legislative changes."

Background

During the 78th Legislative Session, Representative Gary Elkins filed HB 1366, relating to the environmental regulation and remediation of certain dry cleaning facilities, which was referred to the Committee on Business & Industry. The bill was heard in committee twice, on March 25, 2003, and again on April 8, 2003, when it passed unanimously with a committee substitute. HB 1366 was passed by the House on May 8, 2003, and was passed by the Senate on May 22, 2003. The Governor signed it into law on June 20, 2003.

Prior to the passage of HB 1366, there was no provision for a dry cleaning pollution clean up program. The cost of cleaning up pollution, also known as remediation, can be very expensive. Should the contamination involve extensive soil or groundwater remediation, it can be almost impossible for smaller, family-owned dry cleaning businesses to afford. Even for larger dry cleaners, the cost of remediation can be professionally devastating.

HB 1366 added Chapter 374, Dry Cleaner Environmental Response, to the Health and Safety Code and attempted to provide assistance to the dry cleaning industry in cleaning up chemical spills. The purpose of the bill was to prevent future pollution and move industry toward less polluting chemicals and pollution prevention in the delivery of, storage, use and handling of certain chemicals: the dry cleaning solvent perchloroethylene, also known as tetrachloroethylene, petroleum-based solvents, hydrocarbons, silicone-based solvents, and other non-aqueous solvents used in dry cleaning. Perchloroethylene is a manufactured chemical that is widely used for dry cleaning of fabrics and for metal-degreasing. It is also used to make other chemicals and is used in some consumer products.

Perchloroethylene is a nonflammable liquid at room temperature. It evaporates easily into the air and has a sharp, sweet odor. Most people can smell perchloroethylene when it is present in the air at a level of 1 part perchloroethylene per million parts of air (1 ppm) or more, although some can smell it at even lower levels.

High concentrations of perchloroethylene (particularly in closed, poorly ventilated areas) can cause dizziness, headache, sleepiness, confusion, nausea, difficulty in speaking and walking, unconsciousness, and death. Irritation may

result from repeated or extended skin contact with it. These symptoms may occur when people have been accidentally exposed to high concentrations.

In industry, most workers are exposed to levels lower than those causing obvious nervous system effects. The health effects of breathing in air or drinking water with low levels of perchloroethylene are not known.

Based on concerns regarding the possible future effects of perchloroethylene exposure and possible hazards from water and ground water contamination by the solvent, twelve other states have adopted dry cleaner remediation programs. Kansas' statute was the basis for HB 1366, but with changes designed to meet Texas' unique needs.

The legislation's intent is to fully administer the program from proceeds received from registration fees. The dry cleaner remediation fund's floor is ten million dollars and the ceiling is twenty million dollars. To date, $4,144,250.00 has been deposited to the fund.

Meetings

The Committee on Business & Industry deferred hearings on this charge since the Texas Commission on Environmental Quality (TCEQ) has been holding meetings on the implementation of HB 1366 for the past year. The Dry Cleaners Advisory Committee has had six meetings to date, beginning on November 24, 2003, with the most recent on August 6, 2004. There was a Stakeholders' meeting on May 7, 2004; this hearing was well-attended.

Ten issues were identified at the Dry Cleaners Advisory Committee meetings and at the Stakeholders' Meeting as requiring further study. These include the following:

1) Whether mobile drop stations and vehicles owned by dry cleaners that are used for the drop-off and pick-up of garments should pay the drop station registration fee.

2) Whether to regulate dry cleaning businesses other than the retail neighborhood dry cleaner.

3) Whether former facilities are eligible for fund benefits if the owners pay their registration fee.

4) Whether the TCEQ should exempt facilities with less than $200,000 in gross receipts from performance standards.

5) What constitutes gross annual receipts; do they include only the part of the business that provide laundry or other services and products, or should they be separated from dry cleaning services?

6) Whether there should be containment for dry cleaning facilities that use other solvents since negative results from using these solvents may be discovered in the future.

7) How often the TCEQ should reprioritize sites and modify their status for investigation and clean-up.

8) How the TCEQ accesses emergency response and corrective action.

9) Whether solvent suppliers or dry cleaners should be required to keep records; who is responsible for keeping what records and how long should they be retained?

10) Whether solvent suppliers should be registered. It is believed that solvent suppliers may have the best overall knowledge of dry cleaners using certain solvents, especially since they are collecting the fees required by HB 1366.

TCEQ staff believes the Rules process (please see updated timeline in the appendices) will be completed within the next seven months with an effective date of April 14, 2005.

Committee Suggestions

Fee Schedule and Opt-Out Clause

The Fee Schedule and Opt-Out Clause should be revised. Currently there is a $2500 fee for gross annual receipts over $100,000.00 and $250 for those with gross receipts under $100,000.00 or for those not using *perchloroethylene;* there may be a need to make this tiering more equable.

Technical Issues

Comptroller's List: It appears that many dry cleaners have not registered for the Dry Cleaners Remediation Program. Initially, the TCEQ sent registration information to dry cleaners identified by the State Comptroller's office based on gross receipts. When it was determined that many dry cleaners had not been contacted using this method, the TCEQ used other means to obtain better registration.

To date, 3557 facilities are registered. A total estimate of active dry cleaners, facilities and drop stations in Texas is estimated at 4884, based on research of yellow/white pages. The number of facilities initially identified by the

Comptroller's Office, based on gross receipts, was only about 2000. It is now over a year since HB 1366 became effective, yet it was learned at a recent Advisory Meeting that only about 30% of Houston area dry cleaning facilities are currently registered even though registration is mandatory. Obviously, something needs to be done to ensure more reliable listings of facilities and therefore better compliance.

New Contracts: An issue has arisen over whether landlords should be eligible for claims arising from prior or existing contracts. It is the committee's opinion that contracts for new leases should address this, but that older or existing contracts should not be retroactively addressed.

There are additional issues that may need to be explored during the 79th Legislative Session with workgroup meetings.

Additional information on the Dry Cleaners Remediation Program and the Dry Cleaners Remediation Program Advisory Committee may be found at http://www.tnrcc.state.tx.us/permitting/remed/dry_cleaners/index.html

Committee Charge # 5

Workers' Compensation Managed Care or Network Systems

REPORT ON INTERIM CHARGE # 5

Charge and Public Hearings

The Speaker of the House charged the Committee on Business & Industry to study the potential impact on the cost and quality of medical care through employer and/or insurance carrier selection of initial treating doctor and change of doctor in the workers' compensation system. The Committee heard relevant testimony at public hearings held on April 27, 2004, August 25, 2004, and August 26, 2004.

Although more recent data indicate that medical costs may be trending down for workers' compensation, for several years, prior to the passage of HB 2600 (an omnibus workers' compensation reform bill passed during the 77th Legislative session) the medical costs rose at a dramatic rate. According to the Texas Department of Insurance's Workers' Compensation Research Group, the average medical cost per claim rose 21% from injury year 1999 through injury year 2001, one year post injury. (Testimony on April 27, 2004)

Managed care has been used for employee health insurance for many years with relative success. The Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) models are fairly familiar to most employees and employers.

In an attempt to control medical and indemnity costs while improving the quality of medical care provided to injured workers in Texas, policymakers explored the idea that well structured and managed workers' compensation health care networks could possibly hold the promise of providing consistently appropriate health care and disability management for injured workers in Texas while bringing down medical and indemnity costs. Such quality services could possibly improve functional recovery, and prevent economic losses for all participants in the Texas workers' compensation system. Injured workers too often report that they are not receiving quick and appropriate treatment in the current system.

Regular reporting on workers' compensation health care and disability management performance could improve the quality of care in several ways: it could provide guidance for health care quality improvement; it could allow injured workers to select high quality sources of care; and it could keep all parties in the system informed of workers' compensation health care effectiveness in a timely manner.

Health Care Network Advisory Committee

Article 2, Section 2.01, of House Bill 2600, passed in 2001 by the 77th Texas Legislature, established a Health Care Network Advisory Committee (HNAC) consisting of members from the labor, business, insurance carrier and health

care provider communities to advise the Texas Workers' Compensation Commission (TWCC) on the feasibility and implementation of regional fee-for-service health care networks.

As part of its statutory functions, the HNAC was required to make recommendations to the Commission about:

standards for regional networks;

the feasibility of establishing or contracting with one or more regional networks

the procurement of regional network contracts; and

the selection of administrators to build and manage the regional networks and to report on their progress.

In an effort to determine the feasibility of implementing these regional networks, TWCC contracted with MedFx LLC, of Mill Valley, California to develop network standards, report cards and reporting requirements, and a Request for Information (RFI) from interested networks and providers for HNAC approval. MedFx solicited stakeholder input on these issues at meetings in Austin, Dallas, Houston, and San Antonio in early September 2002.

MedFx issued the RFI in September 2002 and studied the responses and input on proposed network standards and reporting requirements. The firm also analyzed current practice patterns in Texas as a baseline for network care management and an indication of network feasibility. MedFx made recommendations to the HNAC about the feasibility of contracting with or developing regional networks in various parts of Texas. Issues identified by MedFx LLC, affecting network feasibility included: the availability of needed providers; interest by potential network administrators; the willingness of injured workers, insurers, and employers to voluntarily participate in these regional networks; and the availability of data to manage the networks.

The MedFx analysis concluded that the proposed network model was feasible, dependent upon the receipt of satisfactory Request for Proposals (RFP) responses consistent with the financial model and assumptions discussed in the feasibility report. In response, TWCC and the Chairman of the HNAC (Committee Hearing, January, 2004) testified that it intended to issue an RFP (Request for Proposal) to gauge the interest of existing networks to provide these services; however, to date the RFP has not been issued. At the most recent hearings, the Commission testified that it has decided that further implementation of the network model will be delayed until an improved model of networks is evolved through the legislative process.

If regional networks were to be established, HB 2600 requires periodic production of report cards to monitor and manage care and functional disability that cover important elements of workers' compensation health services, which include:

- access to care;
- communication among system participants;
- coordination of care and return to work;
- return to Work outcomes;
- health-related outcomes;
- employee, health care provider, employer, and insurance carrier satisfaction;
- disability and re-injury prevention;
- appropriateness of clinical care;
- utilization of health care resources;
- health care costs; and
- statistical outcomes of medical dispute resolution.

The report cards were intended to assist networks in managing care and absence from work, help injured workers select effective health care providers and health service delivery organizations, and inform the people of the State of Texas about the effectiveness of their workers' compensation health care and health-related services.

Under HB 2600, public employers like SORM, UT, A&M, and TxDOT, would be required to participate in these networks if implemented. Insurance carriers may offer network services to their client employers. Injured workers covered by participating insurers may receive medical care from regional networks on a voluntary basis, although once they elect to participate, they must receive care from the network for that injury, with certain exceptions.

If implemented, network administrators and the Research and Oversight Council on Workers' Compensation (now the Workers' Compensation Research Group at TDI) were required to report periodically to the commission and the HNAC on the progress of implementing the regional networks.

Issues Identified and Recommendations

One of the problems in a state the size of Texas is how to set up a feasible network model. As indicated by the HNAC feasibility study, many areas of Texas would not provide the optimum number of providers or a large enough pool of injured workers to support a network. At least initially, most networks would probably be local or regional in scope.

Just as the workers' compensation system is optional in Texas, it is believed that networks would be optional, instead of mandatory. Since each carrier has a unique mix of insured employers, a network may not be feasible or desirable in all situations, or in some areas of the state. Likewise employers should be able to decide if the network offered to them meets their and their employees' needs.

In order to achieve maximum cost-containment benefits from a network model, employees should still have choice of doctor, but should choose from a large list of providers developed by a network; a panel of doctors is not sufficient. Injured workers should be required to obtain treatment within the provider network, unless authorized to obtain treatment outside the network or in an emergency. Obviously, in areas where networks are not offered, an alternative should be provided.

So far, there is no clear blueprint of what a workers' compensation network should look like. However, certain issues have been identified that should be addressed in any network legislation and the following are presented as recommendations:

Networks should maximize choice of treating doctors and allow a change of treating doctor. Questions as to how many doctors would be available within a given network and how much control these providers would have over treatment plans are crucial. Reimbursement guidelines should be at a level to attract and retain good doctors.

Networks should provide adequate access to medical specialists. Active recruitment of good physicians and other providers should be undertaken.

Networks should guarantee that providers be paid promptly and fairly.

Some self-insured employers currently utilizing networks have recently noticed that medical costs for self-insured networks are rising, indicating that networks might not bring down costs as much as originally supposed. Further research might be done to determine whether this is an indication of better treatment (thereby allowing an injured worker to return to work faster) or symptomatic of other issues.

Managed care is not as easy to navigate as it looks and the question arises as to who would be the advocate for the injured worker in a network system. The idea of patient advocates or coordinators within the network should be explored.

Workers’ compensation networks should have adequate regulation and oversight by state regulators. Network adequacy regulations should guarantee appropriate access to physicians, hospitals and other facilities and should also specifically ensure access to all needed chronic pain and other therapies as well. Dispute resolution processes should be clearly defined and streamlined.

Networks should measure for performance to ensure that workers are getting the care they deserve and to ensure that employers are getting the best of network care for their money. Research and evaluation by the Workers' Compensation Research Group at TDI and contracts with WCRI should be utilized.

A reporting system should be established for networks so that the legislature and others are aware of their effectiveness.

Incentives to make the network concept more acceptable to employees and labor should be investigated. In order to give up the option of open choice of doctor, the employee should receive other considerations.

The Texas Commissioner of Insurance should study the effects of a managed care system on workers' compensation insurance rates. The following should be evaluated:

1) Identify and quantify the savings generated by the use of a managed care system, and
2) Review workers' compensation insurance rates to determine the extent to which the savings were reflected in rates. When reviewing the rates, consideration should be given to an insurer's premium revenue, claims costs, and surplus levels.

A determination should be made by the Commissioner as to whether the rates adequately reflect the marketplace. The Commissioner would then have authority to enter into negotiations with carriers to set rates.

While a network model may not be the silver bullet that some of its proponents have claimed, exploring the possibilities while taking into consideration the concerns mentioned above is necessary. Throughout the interim, the committee heard many complaints about the current workers' compensation system. Many of the complaints centered around access to care, uncertainty of payment, lengthy disputes, and inability to return injured workers back to work in a timely manner. It is obvious that even if the workers' compensation system in Texas isn't in crisis, it needs some serious attention. However, even though the situation is urgent, it is extremely important that any network model adopted by the Legislature not impose an additional bureaucracy or become a minefield for those who use the system.

APPENDICES

1. HB 2600 FlowChart
2. Dry Cleaner Registration Form and Instructions
3. Frequently Asked Questions on HB 1366
4. Frequently Asked Questions for Solvent Distributors
5. Frequently Asked Questions Regarding Affidavit
6. Distribution of Total Workers' Compensation Medical Costs by Provider Type - Service Years 1999-2001
7. Dry Cleaner Environmental Response Rule Project Time Line
8. Map - Doctors Approved to Treat by Area