Biennial Report of the Texas Department of Insurance to the 80th Texas Legislature

December 2006

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Commissioner of Insurance

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December 22, 2006

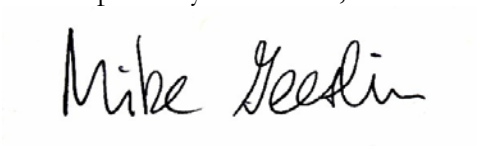
The Honorable Rick Perry, Governor
The Honorable David Dewhurst, Lieutenant Governor
The Honorable Tom Craddick, Speaker

Dear Governors and Speaker:

In accordance with Section 32.022, Texas Insurance Code, we are pleased to submit the biennial report of the Texas Department of Insurance. The report summarizes needed changes in the laws relating to regulation of the insurance industry. Further, the report contains the legislative recommendations for workers' compensation which were also provided earlier this month.

The Department is available to discuss any of the issues contained in the report and to provide technical assistance. Please contact us or Carol Cates, Associate Commissioner of Government Relations, at 463-6123 with any questions or if you need additional information. Thank you for your consideration.

Respectfully Submitted,



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PREFACE

This biennial report to the 80th Legislature is different from previous reports in format, content, and development.

As background, recommendations are preceded by brief summaries of general market conditions. The total Texas insurance market is currently $80 billion per year in premiums written. With no two markets being identical, and therefore being difficult to describe with a common general statement, the summaries are limited to the major markets that, combined, represent over $65 billion in annual revenue. If the Legislature would like additional information about a specific line of insurance, the Texas Department of Insurance (Department or TDI) is ready to provide whatever information is available.

The content of the report includes a variety of recommendations and issues; some significantly substantive, others more technical in nature. Out of deference to the Legislature, some issues contemplate reporting and delayed implementation in order to give the Legislature additional time to develop a policy approach that best fits the needs of the state. Further, the report's recommendations fall into two categories: those that seek to clarify, reconcile existing law or modernize and those that address emerging issues and are more substantial changes or amendments. The report also discusses issues that have arisen in the course of our regulatory function. These issues are described in the report and options are presented for the Legislature's consideration.

Lastly, while this report comes from the Department, its development was the result of input and contributions from many other sectors, including legislative offices, trade groups, and the Office of Public Insurance Counsel. The Department also reviewed complaint information from consumers and health care providers to identify issues for the report. While none of the recommendations made in this report have unanimous consent and all have outstanding issues, the purpose was to commence a high level of dialogue on issues prior to the legislative session. In taking this approach, the public dialogue began early on many issues, a process that will hopefully contribute to a full and detailed analysis of the issues and benefit the Legislature's consideration of and decisions on these recommendations.

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Life and Health Market Overview

The health and life insurance markets in Texas are active and thriving. Important changes enacted by the Texas Legislature over the past few sessions have been implemented and the markets are seeing the results from those changes. However, significant challenges are forthcoming, especially in the health insurance market.

In 2005, life insurers wrote approximately $7.92 billion in premium in Texas, compared with $7.77 billion in 2004. Insurers wrote approximately $12.66 billion in annuity considerations in 2005 compared with $12.53 billion in 2004.[1] Accident and health insurance premiums written in Texas in 2005 amounted to approximately $21.93 billion, compared with $20.42 billion in 2004.[2]

In spite of the almost $22 billion in premium written in the health insurance market, nearly 5.6 million Texans (25 percent of the Texas population) do not have health insurance. The 25 percent does not, however, apply to all segments of the population uniformly. When analyzed by different segments of the population, such as age or employment status, the data reflects that some populations are affected more than others. For example, the table below shows that nearly 1.4 million children (21.4 percent of all children in the state) and approximately 4.2 million adults (26.4 percent of all adults) have no insurance.[3]

Age Group	With Insurance	Without Insurance	Total	Percent Without Insurance
Under Age 18	4,958,362	1,353,083	6,311,445	21.4%
Ages 18 – 64	9,629,592	4,194,567	13,824,159	30.3%
Ages 65+	2,152,576	35,179	2,187,755	1.6%

Source: Research and Evaluation Department, Texas Health and Human Services Commission. Evaluation of U.S. Census Bureau, Current Population Survey, Texas Sample, March 2005.

A few additional facts regarding the uninsured:

- **Most uninsured adults work.** The table below shows that within the adult population in Texas who have not yet retired, 66 percent (approximately 2.7 million people) of uninsured adults under age 65 work, 10 percent (266,052) are unemployed, and 24 percent are not in the work force (retired, disabled, homemakers). From a different perspective, 26.7 percent of all working adults are uninsured.

1 (NAIC Annual Reports)

2 Texas Health Risk Pool data calls

3 (Note: only state-wide estimates of the uninsured are available at this time.)

Labor Force Status of Unretired Adults	With Insurance	Without Insurance	Total	Percent Without Insurance
Employed	7,554,040	2,746,949	10,300,989	26.7%
Unemployed	312,223	266,052	578,275	46.0%
Not in Labor Force	1,918,238	1,127,788	3,046,026	37.0%
Total	9,784,501	4,140,790	13,925,290	29.7%

Source: Research and Evaluation Department, Texas Health and Human Services Commission.
Evaluation of U.S. Census Bureau, Current Population Survey, Texas Sample, March 2005.

- The majority of uninsured Texans are U.S. citizens. Just under 73 percent (nearly 4.2 million Texans) of the uninsured are U.S. citizens and the remaining 27 percent (slightly more than 1.4 million people) are non-U.S. citizens, as shown in the table below. Of the total state population, legal, uninsured residents represent 18.6 percent of all Texans; non-legal uninsured residents represent 6.4 percent of the total state population. As a group, non-citizens have a much higher uninsured rate than citizens.

U.S. Citizen Status	With Insurance	Without Insurance	Total	Percent Without Insurance
Native U.S. Citizen	15,094,969	3,849,726	18,944,695	20.3%
Naturalized U.S. Citizen	605,379	301,527	906,906	33.2%
Not a U.S. Citizen	1,040,182	1,431,576	2,471,758	57.9%
Total	16,740,530	5,582,829	22,323,359	25.0%

Source: Research and Evaluation Department, Texas Health and Human Services Commission.
Evaluation of U.S. Census Bureau, Current Population Survey, Texas Sample, March 2005.

- 71 percent (891,768) of uninsured children live in families with incomes below 200 percent of the federal poverty level. This represents 14.2 percent of all Texas children. Many of these children appear to be eligible for Medicaid or the Children's Health Insurance Program (CHIP), but, for unknown reasons, are not enrolled.
- Employees working for small businesses are more likely to be uninsured than workers in large firms. One-third of uninsured workers are employed in firms with fewer than 10 employees. Another 12 percent work in businesses with 10 to 24 employees. However, 25 percent of uninsured workers are employed in firms with 500 or more workers.

Factors contributing to Texas' high uninsured rate include:

- Texas has a large proportion of workers employed by small businesses. Almost 400,000 small businesses employ nearly 3 million Texans, but only about one in four of these companies offer health insurance to their employees.
- Many Texans work in industries that have traditionally not offered health benefits, such as construction, agriculture, retail sales and service positions.
- There is also relatively little union activity in Texas in comparison to those states where unions have driven the issue of health insurance.

- Texas in general has a lower rate of participation in public programs such as Medicaid and CHIP.

Affordability is also a central barrier to the purchase of health insurance. Health care costs have regularly outpaced the inflation rate and growth in the Gross Domestic Product (GDP) over the past 15 years. Health care spending represented 16 percent of the GDP in 2004 compared with 11.1 percent in 1990. Future projections issued by CMS estimate total health expenditures will reach $2.16 trillion in 2006 and will rise to over $4 trillion by 2015. Per-person spending is estimated at $7,110 in 2006 and is expected to reach $12,320 by 2015.[4]

Significant cost drivers that account for increased health care and health insurance costs include:

- An aging population – due in part to medical advances that allow people to live longer
- New and improved medical technology that allows treatment of diseases and injuries that previously were untreatable
- New prescription drugs
- Improved diagnosis and treatment for diseases that once were often overlooked (such as diabetes)[5]

Average group health insurance premiums for Texas employers have nearly doubled from $2,193 for single coverage in 1997 to $4,138 in 2004. Average family premiums have increased from $5,693 to $11,196.[6] These increasing costs are juxtaposed with the concerns of small employers who state they cannot currently afford to offer health insurance for their employees.

In a survey of small employers (employers with 2 to 50 employees) conducted by the Department in 2004, 69 percent of the employers indicated that the maximum monthly contribution they could afford was $100 per-employee-per-month, i.e., $1,200 annually. Notably, 14 percent said they could not afford any amount of contribution.

To address these concerns, the Texas Legislature has enacted, and the Department has implemented several market-based initiatives that are increasing the affordability and availability of health insurance in Texas.

Consumer Choice Plans

One important legislative enactment was Senate Bill 541, enacted by the 78th Texas Legislature. SB 541 permits insurers and HMOs to offer health plans that do not include all the state-mandated benefits. These health plans, known as Consumer Choice Plans, were authorized to provide a less expensive health insurance alternative for individuals and businesses. The plans may also have higher deductibles and coinsurance requirements, which can significantly reduce premium costs, and make the plans more affordable.

4 (Source: CMS)

5 (CMS, Health Affairs)

6 TDI data

In calendar year 2004, insurance carriers sold a total of 5,341 Consumer Choice Plans to individuals and businesses. These plans covered 14,304 Texans, including 4,283 people who previously were uninsured. In 2005, insurance carriers sold 25,897 Consumer Choice Plans covering 51,628 Texans, including 7,325 people who were previously uninsured.

Consumer Choice Plans are now being offered by all insurers that offer health plans to small employers. These Plans provide greater flexibility for insurers to help meet consumers' demands and help achieve one of the Department goals to have a wide variety of plans on the market to fit a wide variety of needs and budgets.

Most of the Consumer Choice Plans filed with the Department have the same coverage found in standard plans and provide various levels of savings. The sometimes significant price reductions realized by some of these plans come from reducing or eliminating some of the mandated benefits and requiring increased deductibles and or copayments.

Cooperatives and Coalitions

Since 1993, the Texas Legislature has passed legislation to authorize and facilitate the ability of small and large employers to join together in health insurance purchasing cooperatives and coalitions. The 79th Texas Legislature enacted Senate Bill 805, which amended and clarified provisions governing health coverage purchasing cooperatives.

The cumulative effect of these enactments has been that small employer health coalitions have enjoyed steady growth but are still limited to urban areas where agents are familiar with them and willing to organize them. The first health group cooperative was established this summer between the Lubbock Chamber of Commerce and Firstcare. A statewide cooperative directed at employees of credit unions and a limited benefit cooperative marketed to employers not currently providing coverage are two additional cooperatives currently under development.

Carriers have been reluctant to embrace health group cooperatives, asserting that the requirement that they take any small employer that seeks to join creates the possibility that the risk could change dramatically from the risk initially undertaken. The Department has been actively working with carriers to resolve concerns about the creation of cooperatives. The Department, through speaking engagements, presentations and workshops, is educating agents, carriers and employers about the benefits of cooperatives and how to organize cooperatives.

State Planning Grant - Insure Houston Pilot Project

The *Insure Houston* pilot project concept is the culmination of four years of State Planning Grant research and planning activities that have included collaboration with a large group of stakeholders and interested parties, and builds on data collected specifically for this purpose. The primary purpose of the Insure Houston Pilot Project is to develop a carefully designed small employer benefit plan that will provide an acceptable, affordable option for small businesses that cannot afford coverage in the current insurance market.

The Department, through the State Planning Grant, has been working with the Greater Houston Partnership, an organization of Houston and Harris County business and community leaders, to create a program that will increase the number of small-business owners who provide health insurance. The primary goal is to decrease the number of uninsured residents by providing an affordable, sustainable benefit plan that covers the majority of health care expenses incurred by a typical person.

Initial requirements for the benefit plan were:

- an average cost of no more than $150 per month per employee;
- inclusion of preventative/primary benefits as well as some protection from catastrophic injuries/illnesses;
- a simplified enrollment and rating process that would reduce the amount of time and effort required of employers when shopping; and
- that the plan be appealing to both employers *and employees* to encourage higher employee participation.

The project working group has developed two benefit plans. One plan focuses on primary and preventative care with limited out-of-pocket costs and a low annual deductible, but includes length-of-stay limits for hospital care and limits on the number of services for other types of care. The second plan includes a higher deductible and limited coverage for primary and preventative care, but provides more extensive coverage for catastrophic care.

The Greater Houston Partnership is developing a Request for Proposal to select a carrier for the pilot project. The targeted opening enrollment date is Spring 2007. Once implemented, the plan will provide a new alternative for nearly one million Houston workers and their families. The benefit plan will be monitored and possibly expanded to other areas of the state.

Clarifications, Modernization and Reconciliations

Claims Cost Reporting

BACKGROUND The 76th Legislature enacted Insurance Code Section 1501.614, requiring a carrier issuing small or large employer coverage to report claims cost information to an insured employer upon request. The placement of this statute in the large employer subchapter led to an argument by one carrier that the statute did not apply to the small employer market. The Legislature addressed the argument by enacting Insurance Code Chapter 1209, which imposes similar requirements on issuers of all state-regulated group health benefit plans.

PROBLEM The primary issue arising from the existence of both statutes is that the two statutes have some different requirements and features, which may lead to confusion by both those who must comply as well as those whom the laws benefit. For example, one statute requires the carrier to report on the period extending back to 12 months preceding the date of the report, while the other requires reporting on the previous calendar year.

RECOMMENDATION Unify the requirements for reporting claims cost information to employers to simplify compliance and enhance information available in the marketplace.

Clarification of Investment Statutes

BACKGROUND Insurance Code Article 3.33 allows life, health and accident insurance companies to invest in certain specified assets to ensure that funds are available to pay obligations owed to policyholders and other consumers. The current statutes allow these insurers to invest prudently and earn market returns to ensure that monies are actually available when needed as insured obligations come due. Conversely, these statutes limit the ability of these insurers to make risky investments or loans that may jeopardize their reserves and financial solvency. Under Insurance Code Article 3.41, the Department applies Article 3.33 to non-Texas insurers. This policy prevents foreign insurers covering Texas consumers from investing in or making loans to hazardous, speculative business ventures that could jeopardize financial solvency.

PROBLEM The Department's application of Articles 3.33 and 3.41 to foreign (non-domestic) insurers has been challenged. Without this application, foreign insurers operating in Texas would have an unfair advantage over Texas insurance companies limited to more conservative investment standards. Moreover, the insolvency risk these speculative investments present could also result in unpaid claims owed to Texas consumers, and since the unpaid claims of insolvent insurers ultimately result in tax credits that reduce premium tax collections, this type of investment activity threatens the State's General Revenue fund.

RECOMMENDATION Clarify the applicability of Insurance Code Article 3.41 investment limitations to non-domestic insurers. This amendment will provide greater protection to Texas consumers against the threat of a foreign insurance company's insolvency as well as safeguard domestic insurers and the state's General Revenue fund. The change will also promote fair competition by ensuring that foreign insurers comply with the same investment requirements as Texas companies. A possible transitional measure could allow an insurer time to liquidate investments or allow loans to be repaid

if the insurer currently has such investments and can obtain appropriate certification on the value of those investments, which is consistent with current Department practice.

Creditable Coverage

BACKGROUND Many health benefit plans exclude coverage for pre-existing conditions. Certain health benefit plan coverage provides "creditable coverage" to a person against a pre-existing condition exclusion if the person moves to a new health benefit plan. This credit provides "portability" so that the pre-existing provisions can be covered under the new policy and encourages persons to purchase and maintain qualified health benefit plan coverage. Both group and individual health carriers must credit a person's qualified coverage, but an individual carrier must do so only if the person's most recent creditable coverage was under a group health plan, a governmental plan, or a church plan.

PROBLEM The disparity in coverage credit between group and individual plans produces some inequitable results. For example, if a person loses individual coverage because his carrier withdraws from the market, then a new individual carrier covering that person would not have to credit the person's most recent individual coverage.

RECOMMENDATION Amend Insurance Code Section 1201.154 to remove the subsection (b)(2) restriction. This change would conform the standard for crediting coverage in the individual market to the standard in the group market and resolve potential inequities for persons losing individual health benefit plan coverage.

Eligible Children

BACKGROUND Insurance Code Section 1131.802 authorizes but does not require a carrier issuing group life coverage to extend coverage to dependent children. The section defines "dependent" to include natural or adopted children younger than age 21, or older than 21 years of age if enrolled as a full-time student at an educational institution or physically or mentally disabled and under a parent's supervision.

Various Insurance Code sections define dependent children for purposes of accident and health coverage, including children under 25, newborns, court-ordered dependents, adopted children, and children of a spouse. In the case of small employer coverage, dependent coverage is a requirement.

PROBLEM Insurance Code Section 1131.802 does not include dependent children who are 21 years of age, creating a coverage gap for that one year time period.

Groups often provide life insurance in addition to accident and health coverage. Current definitions of dependent result in some persons being eligible for accident and health coverage but not life coverage. These different definitions of dependent may cause confusion and create challenges for groups attempting to make coverage consistent across all lines.

RECOMMENDATION Amend Section 1131.802 to eliminate the age 21 gap in life policies and allow dependent coverage consistent with that provided by accident and health policies, at the insured policyholder's request.

Health Insurance Risk Pool COBRA Coverage

BACKGROUND Insurance Code Section 1506.153 deems an individual ineligible for Texas Health Insurance Risk Pool (Pool) coverage under a number of circumstances, one of which is eligibility for COBRA[7] coverage. This restriction lasts for the entire COBRA eligibility period, a minimum of 18 months, even though the individual has only 60 days to elect COBRA coverage.

PROBLEM This restriction produces an inflexible situation for individuals who fail to elect COBRA as a result of temporary economic distress or other legitimate reasons. For example, an individual losing his job may have the right to elect COBRA, but may not do so because of the cost of continuing their coverage. If the individual gets a job after 90 days and can then afford coverage, it is too late for him to elect COBRA coverage, and if he tries to enroll in the Pool, he will be legally barred until his COBRA eligibility expires.

RECOMMENDATION One possible solution would be to amend the law to remove this restriction and allow individuals to enroll in Pool coverage prior to the end of their COBRA eligibility. To prevent abuse by those who did have the means to pay for COBRA coverage during their election periods, the law could authorize the Pool to impose an automatic six-month exclusion of coverage of any pre-existing conditions the individual might have, regardless of the amount of the individual's creditable coverage.[8] Other state high risk pools have employed this approach with success.

Health Insurance Risk Pool Employer Sponsored Coverage

BACKGROUND Insurance Code Section 1506.153 deems an individual ineligible for Risk Pool coverage if the individual is eligible for health benefit plan coverage provided in connection with a policy, plan or program paid for or sponsored by an employer, even if the individual declines the employer coverage.

PROBLEM While this restriction preserves the integrity of employer market coverage and is consistent with the Pool's position as the insurer of last resort in Texas, it also poses a policy question, particularly when the employer's plan provides coverage that is more limited than Pool coverage. Recently, there are increasing reports of employer plans offering limited coverage. The Department has seen employer-sponsored plans with annual maximum benefit restrictions as low as $1500; by contrast, the Pool has no annual maximum benefit.[9] The Pool reports a recent example of an enrollee with a disability who obtained employment with an employer that had very limited benefit coverage, so the person was forced to choose between maintaining employment and losing Pool coverage, or resigning employment to maintain Pool eligibility.

RECOMMENDATION When an employer makes minimal health benefit plan coverage to part-time employees as part of an overall compensation and benefit package, TDI recommends that the

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7 Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.)

8 Because COBRA has not been exhausted, federal law would not classify such an individual as "HIPAA eligible."

9 The pool has a $1,500,000 lifetime maximum benefit.

employee should be able to choose between the employer-sponsored plan and Pool coverage. As a further restriction, the Pool eligibility could be limited to those lesser plans for which the employee has to pay the entire cost of the premium (no employer contribution), which is a fairly common practice among employer plans for part-time employees.

Emerging Issues – Life and Health

Arbitration

BACKGROUND Insurance Code Chapter 541 authorizes a person to bring a deceptive trade practice action against a carrier in a court of law. The Department acknowledges this right by declining to approve forms[10] that limit an insured's right to a judicial remedy in contract disputes with the carrier, including forms requiring *pre-dispute*, mandatory binding arbitration (i.e., arbitration is required as a condition of issuing the policy).

The Department does not, however, prohibit *post-dispute* arbitration between an insured and a carrier, realizing that an insured has a right to agree to post-dispute, binding arbitration. As the dispute and agreement will occur after the contract is issued, such an agreement is generally not part of the insurance policy form, but rather a mutual agreement between the insured and the carrier to select arbitration as a dispute resolution procedure.

PROBLEM Carriers often file life, annuity, accident and health forms proposing to limit policyholders to pre-dispute, mandatory binding arbitration as the sole means of dispute resolution. The carriers assert that arbitration is a favored public policy and results in a cost savings to the carriers and, possibly, to the insureds as well.

Arbitration is a matter of contract. The courts have recognized that some arbitration agreements can be substantively unconscionable if they overly favor one party. This is especially a concern in contracts of adhesion, such as insurance policies, which provide no opportunity for the insured to negotiate any of the terms or conditions of the contract.

Some of the arbitration provisions carriers have filed with the Department are objectionable because they:

- fail to comply with Texas case law;
- limit the proceeding to one arbitrator who is, or was, employed by a carrier;
- require all cases to be heard within 90 days;
- deny enhanced damages even when authorized by statute;
- require cases to be resolved where the carrier has its office; and
- require the non-successful party to pay all costs of arbitration and the successful party's attorney fees.

10 Insurance Code Chapters 843 and 1701 require carriers to submit forms for Departmental approval prior to use.

Many of these proposed arbitration agreements also do not comply with the American Arbitration Association's arbitration rules for consumer cases. Arbitration agreements may also limit an individual's statutory rights to independent review by an Insurance Code Article 21.58C independent review organization.

OPTIONS Clarify that HMO, life, annuity, and accident and health contracts may not include pre-dispute mandatory binding arbitration agreements; or alternatively,

Establish that a pre-dispute, mandatory binding arbitration agreement contained within a life, annuity, accident and health contract must comply with:

(1) Texas law;
(2) American Arbitration Association consumer rules; and
(3) Statutory independent review requirements.

Authorize the Department to adopt rules implementing those requirements, as well as establishing venue for arbitration proceeding within the city or county where the insured resides.

Balance Billing – Health Maintenance Organizations

BACKGROUND Balance billing remains a concern for all participants in the health care system– insureds, providers and carriers. Complicating the issues are the different methods carriers use to reimburse out-of-network services, which may vary according to the type of carrier issuing the plan, the type of service rendered and the circumstances of the service. The legal standards governing reimbursement by the two types of managed care systems, Health Maintenance Organizations (HMOs) and Preferred Provider Benefit Plans (PPBPs), are detailed below.

In HMOs, balance billing should not occur. An HMO provides or arranges to provide covered services for enrollees on a prepaid basis through a network of physicians and providers (providers). The enrollee pays only a scheduled charge for these services, usually a copayment. As long as the enrollee stays within the HMO network, no payment issues should arise.

If an enrollee obtains services outside the network, the HMO is generally not obligated to pay for services. Two exceptions to this rule exist; where the HMO must refer an enrollee out-of-network because its network does not include the appropriate provider, and emergency services.

Out-of-network referral:
While Texas law contains a number of requirements promoting adequate HMO networks, networks may be inadequate for a number of reasons, including the inability of HMOs and providers to agree to contractual terms, usually involving payment rates. In such instances, Texas law guarantees adequate coverage, requiring HMOs without a sufficient network to provide medically necessary services through an out-of-network referral. The HMO must then fully reimburse the non-network provider at the usual and customary rate or at an agreed rate. This provision anticipates the parties will agree to payment terms before services are provided. The advance nature of the agreement should prevent balance billing.

Increasingly, referral to non-network providers is occurring after services have been rendered - a circumstance that may result in balance billing. This type of situation most often occurs with hospital-based providers, such as radiologists, anesthesiologists, pathologists, emergency room

physicians and neonatologists. It occurs because an enrollee may choose a network hospital and surgeon, but may receive ancillary services from non-network providers while hospitalized. After the service has been performed, the HMO and the provider may disagree on the amount of payment, and the provider may seek to recover payment from the enrollee to make up the difference. In this case, the enrollee did everything reasonably necessary to receive care through the network and should not have to pay an amount other than a copayment or deductible. The HMO is required to fully reimburse the provider at the usual and customary or an agreed rate and the enrollee is not responsible for payment of a balance bill.

Emergency Services:

The HMO Act requires an HMO to reimburse emergency services providers at the usual and customary rate or an agreed rate. The emergency services provision does not include the term "fully," as does the out-of-network referral statute. Nonetheless, the Department interprets the statute to require that an HMO enrollee not be responsible for payment of a balance bill. While different, the critical statutory similarity is that the prepaid nature of HMO coverage and the concept of pooling of risk requires that an HMO must hold harmless (except for scheduled expenses) its enrollees obtaining emergency care services. Any other interpretation could discourage HMO enrollee access to emergency care out-of-network, as enrollees fearful of financial harm might postpone necessary emergency care until they can return to their service area and network.

PROBLEM

HMO Reimbursement for Out-of-Network Referrals:

Despite the legal protections, the current situation sometimes results in HMO enrollees paying more than anticipated or required because they are billed beyond their deductibles and copays for out-of-network referrals. An enrollee who receives a balance bill should simply forward the bill to the HMO; however, most enrollees do not know to do so. Further, because of the statutory directive to HMOs to "fully" reimburse the providers needed to fill network gaps at an agreed upon or usual and customary rate, the providers, almost exclusively hospital-based, can require payment of full-billed charges, an amount that often exceeds typical contract rates.

The requirement to "fully" reimburse providers also may discourage hospital providers from contracting with the HMO. Since the providers often have an exclusive contracting arrangement with the hospital, any steerage benefit they might gain by contracting with the HMO is irrelevant. Hospital based providers treat the HMO enrollees that enter the in-network hospital by virtue of their position within the hospital and do not need to contract with the HMO. In fact, contracting with the HMO would only serve to limit their potential reimbursement.

HMO Reimbursement for Emergency Services:

Similar problems exist in the event of an enrollee's need for emergency services that exist in the out-of-network referral situation. Again, the key difference for emergency services reimbursement is that the statute does not require the HMO to "fully" reimburse the provider. The absence of the word "fully" creates additional ambiguity beyond what exists in the statute governing HMO reimbursement for out-of-network referrals.

OPTIONS Potential legislative solutions to this problem fall into two basic categories: (1) improving HMO network adequacy and (2) revising the compensation methodology of non-network providers in hospitals.

Improving Network Adequacy:
A hospital in an HMO network receives an economic benefit from that status, and some argue that it should have to maintain the HMO network's adequacy. To encourage network adequacy in this area, the state could require hospitals to develop strategies to increase utilization of network providers and protect enrollees in several ways.

1) The law could require a network hospital to develop a system to assign available HMO-contracted providers to care for the HMO's admitted patients. This solution only works if contracted providers are practicing at the hospital, which may not always be the case. The measure's effectiveness would also be limited by the number of these providers available to treat admitted HMO enrollees.

2) Another alternative would be to require hospitals to grant practice privileges to HMO network providers provisionally for the sole purpose of treating HMO patients. This measure would allow the HMO to solidify its network within the network hospital. The success of this measure depends, of course, on the HMO having providers of certain types under contract in the service area. Hospitals may argue that they should have the opportunity to set minimum quality standards for personnel, but the HMO has to credential its network members and the hospital may be able to rely on the HMO's credentialing. Moreover, the hospital's waiver of its credentialing right is arguably a trade-off for its status as a network provider, and the hospital would not have to extend to the providers the right to treat any other patients at the hospital. This measure could also be optional to allow the hospital to preserve its oversight of doctor quality if it takes other steps to ensure the presence of adequate contracted providers.

Revising the Method of Figuring Compensation of Non-Network Providers:
Another possible change involving hospitals would be to require a network hospital to condition practice privileges on a provider agreement to hold HMO enrollees harmless, just as the hospital has to agree to do when it contracts to join an HMO network. This solution has the broadest range of the three hospital-based solutions.

The state could also set a standard for compensation at the usual and customary rate. The Texas Insurance Code does not define the term "usual and customary," therefore the Legislature could either set this rate by statute, leave it to the parties to determine or create an alternative dispute resolution system, such as arbitration, to resolve disputes regarding the usual and customary rate. One way to set the rate would be to tie the usual and customary rate to an existing rate standard, such as a percentage of Medicare reimbursement, or to the carrier's highest contracted rate in the service area. While determining this standard would be contentious once set it would greatly simplify subsequent claims processing.

Emergency Care:
Adding the term "fully" to the statute would provide an unambiguously consistent standard for HMO reimbursement, foreclosing potential disagreement about the interpretation. The amendment would place providers in the same strong negotiating position regarding reimbursement that they

currently enjoy with an out-of-network referral. Accordingly, the Legislature might wish to consider concurrently establishing a base rate for these services.

Balance Billing – Preferred Provider Benefit Plans

Out-of-network reimbursement by Preferred Provider Benefit Plans (PPBPs) is more complicated than HMO reimbursement since PPBPs do not provide prepaid care. Further complicating reimbursement matters is the lack of transparency in the cost of health care. As a result, consumers cannot know the true cost of health care and at times receive unexpected medical bills. The textbox, *The Issue of Transparency*, describes this issue more fully. Two factors enter into figuring the reimbursement: the percentage level of reimbursement and amount of reimbursement.

The Issue of Transparency

When considering issues of transparency, and the future of health care markets, arriving at the true cost of health care has an impact on what individuals pay for care, either directly or through insurance premiums. Further, issue of cost-shifting is becoming more complex. Ultimately, under-standing the true market price for healthcare - not just health insurance - would enable consumers to make more informed decisions about their health care or the purchase of insurance.

Percentage Level of Reimbursement:
Insurers reimburse PPBP benefits at two levels: preferred provider (network) and basic (non-network). An insurer may pay a different (greater) level of benefits to an insured based on the insured's selection of a network provider. Generally this is done on a coinsurance percentage basis; a plan might, for example, reimburse at 90 percent for in-network care and at 60 percent for out-of-network care.

Amount of Reimbursement:
The second and more varied factor is the reimbursement amount – the figure to which the percentage is applied. Texas law contains no specific standard, such as "usual and customary," to regulate the amount of this figure. The only legal restriction is that an insurer offering a PPBP shall ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area.

This situation is best illustrated by the following example that illustrates reimbursement under a PPBP. For care within the network, assume an insured sees a primary care doctor who advises the insured to see a specialist. The following table shows the possible benefit scenarios the insured may encounter when seeing the specialist. To see an in-network specialist, the enrollee would pay only $30, however to see an out-of-network specialist, the enrollee's responsibility could range from $75 to $185.

In-Network Preferred Provider Benefits 80% Reimbursement	**Out-of-Network** Basic Level Benefits 50% Reimbursement
Contracted Rate: $150.00 80% Reimbursement: 120.00 Enrollee Coinsurance **30.00**	Possible Billing #1 *Provider bills at in-network rate* Billed at Contracted Rate $150.00 50% Reimbursement 75.00 Enrollee Responsibility $**75.00**
	Possible Billing #2 *Insurer reimburses on billed charge* Billed Charges $250.00 50% Reimbursement 125.00 Enrollee Responsibility $**125.00**
	Possible Billing #3 *Insurer/Provider Disagreement* Billed Charges $250.00 Insurer 50% Reimbursement (insurer determines reimbursement for the service to be $170.00) 85.00 Enrollee Responsibility $**165.00**
	Possible Billing #4 *Insurer/Provider Disagreement* Billed Charges $250.00 Insurer 50% Reimbursement (insurer determines reimbursement for the service to be $130.00) 65.00 Enrollee Responsibility $**185.00**

The statutory language governing emergency care in a PPBP, as is the case with HMOs, is slightly different than that governing out-of-network care. Insurance Code Section 1301.155 provides that if an insured cannot reasonably reach a preferred provider, the insurer shall provide reimbursement for specified emergency care services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider. Generally the Department interprets this language to mean the same percentage level of reimbursement.

PROBLEM Since no specific statutory guidance exists, PPBPs reimburse under several different standards. "Usual and customary," "reasonable and customary," and "allowable amount" are but three of the common terms insurers use to denote the amount they will use to calculate reimbursement for a particular service. Thus, 50 percent reimbursement for a particular out-of-network service may result in different payment amounts from one insurer to another. Although some balance billing is inherent to PPBPs, the disparity between reimbursement and billed charge may lead to unexpected and excessive financial responsibility for the insured who receives care out-of-network.

This disparity becomes even more acute when the insured is forced to seek care outside the network because the insurer does not have the appropriate provider in its network. The law offers some protection by requiring the insurer to reimburse at the same percentage level of reimbursement as a

preferred provider would have been reimbursed had the insured been treated by a preferred provider. The law does not address, however, the disparity between billed charges and the insurer's reimbursement level. This disparity results in unanticipated expenses for the insured, as the insured may be subject to a larger coinsurance bill than if the insured had been able to receive services from a network provider.

Moreover, just as HMOs argue that the "fully reimburse" language discourages providers from contracting with them, providers may argue that the ability of a PPBP issuer to set its own reimbursement amount discourages the issuer from contracting with providers, as it arguably has considerable freedom to set rates.

Reimbursement for emergency services is the same as with necessary out-of-network care; the insurer may have to pay the same percentage level, but if the amount to which the percentage applies is lower than the billed charge, the insured will suffer financial harm through balance billing.

OPTIONS Similar to the solution to HMO reimbursement issues, a standard reimbursement level could be set. The standard could be simple, such as directing payment at the usual and customary amount, or more complex, such as tying reimbursement to an existing reimbursement schedule, such as Medicare's, or developing some other system for resolving disputes over reasonableness of reimbursement.

To protect insureds, the Legislature could require PPBPs to reimburse at a percentage of billed charges for emergency services, or some other established rate such as "usual and customary." Since the care may occur out of the service area, the contracted rate may not be as appropriate an alternative as it is in the service area, but it would be an improvement over the current situation.

Contribution Level for Small Employers

BACKGROUND Insurance Code Section 1501.153 provides that while the state does not require a small employer to make an employer contribution to premium, a small employer health benefit plan issuer may require an employer contribution in accordance with the issuer's usual and customary practices for its employer group health benefit plans in this state.[11]

HB 1570 (79th Legislature) sought to allow a carrier issuing both small and large employer health benefit plans to differentiate the contribution level it requires in the two markets while retaining the requirement that it impose a uniform contribution level within the two market segments.

PROBLEM Some argue that the current law requiring a carrier setting an employer contribution level to make it uniform for both large and small employers ignores differences between the two markets and that it is inefficient to apply a uniform contribution standard to both.

OPTIONS Permitting carriers to differentiate required contribution levels in small and large employer markets would allow plan issuers to develop contribution requirements better suited to each market segment. However, some employees may experience higher rates in instances in which carriers are concerned with lowering, not raising, the employer's contribution. In any event, if carriers are

11 Insurance Code Section 1501.605(a) imposes a similar requirement for large employer health benefit plan issuers.

permitted to differentiate between the markets, a transition plan or other phase-in method should also be considered.

Credit Insurance Unearned Premium

BACKGROUND Borrowers may purchase credit insurance policies to ensure that their loan balances are paid in the event of death or disability. In many markets, such as automobile sales, consumers may not be aware that they have purchased the insurance as it may be included with a number of other transactions collateral to the principal sale. The consumer then pays a premium which may be included in the loan payment amount. Insurance Code Section 1153.202 requires credit insurance policies and certificates to provide for a premium refund if the underlying debt or the insurance terminates before the scheduled maturity date of the debt, including the termination of a debt by renewing or refinancing. The law places the requirement on the company, without requiring the insured who will have first knowledge of loan pay off to take any specific action to inform the company. However, often the insured is not aware that he is covered by credit insurance.

PROBLEM The Texas Attorney General's office has brought actions for noncompliance with the refund requirements against several companies, pursuing restitution for consumers harmed by not receiving refunds when the underlying debts for which they purchased credit insurance coverage terminated. In response, carriers contend that they often are unaware of the early termination of the underlying debt or the insurance.

OPTIONS The Department understands that various stakeholders are seeking revision of current law to obligate an insurer to refund unearned premium only when it receives notice that the underlying debt or the insurance terminates. One question this possible change raises, however, is how many insureds, due to the circumstances of sale, are even aware that they are covered by credit insurance, much less that they might have a right to refund of unearned premium.

Another proposal would charge the current holder of the underlying debt with making the refund. The current creditor could then seek reimbursement from the insurer for the refunded premium. This change would address insurer concerns that they are unaware of the terminating event and thus not in a position to make a refund, while not burdening the consumer -- who is of all the parties in the worst position to act -- to provide notice triggering the refund.

Group Policy Amendment

BACKGROUND Insurance Code Section 1501.108 requires carriers to renew policies and certificates issued in the small and large employer market at the employer's option, so long as the employer complies with the law and the terms of the plan. This duty is generally described as "guaranteed renewability" and requires continuation of the employer's election of benefits and level of coverage.

Under current law a carrier has two options for changing the terms of a guaranteed renewable policy. It can elect to discontinue the policy, in which case it must offer existing policyholders the option to purchase other small or large employer coverage it offers at the time of discontinuation. It must also provide 90 days notice of the discontinuation to the covered employers and to the

Commissioner. As guaranteed renewability does not affect a carrier's right to change the premium rates it charges, another option is simply to induce an employer to accept change by adjusting premium rates in accordance.

PROBLEM Texas's renewability protections for employers exceed those in the federal Health Insurance Portability and Accountability Act (HIPAA). HIPAA permits carriers to amend small and large employer policies without signed acceptance by the policyholder and without discontinuing the plan, so long as the changes are uniform and occur only at renewal.

OPTIONS Two basic options are to preserve the present state of guaranteed renewability in Texas or amend the law to conform to the more flexible federal standard. Adopting the federal standard would simplify carrier operations, as they would not be faced with either reaching employer agreement or initiating discontinuation option to modify policies.

The change to the federal law standard would likely affect employers, however, with the greatest impact on small employers. The current statute favors employers by giving them the ability to maintain consistent coverage for their employees. A carrier's duty to renew a plan as-is at the employer's option discourages unilateral changes to the terms of employer coverage. Current law allows unilateral change through discontinuation; any additional change facilitating a carrier's ability to alter policy terms at each renewal would considerably weaken the concept of guaranteed renewability.

Life-Only License

BACKGROUND Current Texas law requires a person who intends to only sell life insurance to obtain an insurance license to sell not only life insurance, but also accident and health insurance.[12] The majority of states offer a "life-only" license. The "life-only" license is one of the recommended major lines of insurance in the National Association of Insurance Commissioners (NAIC) Producer Licensing Model Law.

PROBLEM Several recent studies point to the persistent decline in the number of career life insurance agents available to serve the public. The life insurance industry reports that since 1975 there has been a 46 percent decline in the number of new recruits. The average age of a life insurance agent today reportedly exceeds 55 years. Members of the life insurance industry have expressed concern about these trends and believe that the introduction of a "life-only" license would help to reverse what they deem to be an unfavorable trend. It is their belief that the "life-only" license will help increase the number of new recruits into the life insurance marketing profession. In addition, they contend that the specialized license type could help to increase the number of candidates who successfully pass the examination requirement for licensure since the candidate would be tested only on the line of insurance the licensee would be authorized to sell.

12 General Life, Accident and Health License – Insurance Code Chapter 4054.

OPTIONS Add a new "life-only" license type that would allow the person obtaining the license to act as an agent of a life insurance company with restricted authority to sell life insurance and annuities and associated lines.

Adding the new license type is not contemplated to be a difficult or costly endeavor for the Department since the examination and licensing process is computerized. The Department utilizes an outside vendor for development and administration of the examination process. The test questions for a "life-only" examination are already available as a subset of the existing General Life, Accident and Health examination.

The proposed legislation would facilitate greater uniformity in producer licensing among the states as sought by the federal Gramm-Leach-Bliley Act of 1999.

Multiple Employer Welfare Arrangements

BACKGROUND A Multiple Employer Welfare Arrangement (MEWA) is an employee welfare benefit plan or any other arrangement established or maintained for the purpose of offering or providing any benefit described in the Insurance Code, Article 3.95-4, and restated in Section 7.1908 of the Texas Administrative Code, to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, provided that the arrangement describes an entity that meets either or both of the following criteria:

- one or more of the employer members in the multiple-employer welfare arrangement is either domiciled in this state or has its principal headquarters or principal administrative office in this state; or
- the multiple employer welfare arrangement solicits an employer that is domiciled in this state or has its principal headquarters or principal administrative office in this state.[13]

MEWAs originally were exempt from state regulation, but solvency problems prompted the federal government to enable states to regulate some aspects of MEWA operations.

PROBLEM More recently, entities abusing MEWAs, certain staff leasing companies and complicit third-party administrators all have come to the attention of the Department in its efforts to prevent unauthorized health insurance. Specific abuses include entities offering health coverage to small business owners through a method of changing the small business's employees to employees of the health coverage entity. Certain staff leasing companies and third-party administrators have also attempted to involve or assist MEWAs in arrangements that result in unauthorized health insurance. Such unauthorized schemes have caused millions of dollars in unpaid claims to both policyholders and providers.

OPTIONS The Legislature could consider enactment of the model regulation adopted by the National Association of Insurance Commissioners or adopting the most pertinent provisions of the model

13 Section 3(40), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(40).

regulation to prevent unauthorized health insurance through illegal MEWAs and other arrangements. The most pertinent provisions include:

- specifying that in order to be exempt from state regulation as a MEWA as a single employer plan, the entity must involve an employer who directs and controls the work of all the participating employees;
- recognizing that a staff leasing company offering self-funded health insurance is a MEWA;
- prohibiting a third party administrator from assisting or sponsoring illegal MEWAs;
- clarifying that an issuer of a stop-loss insurance policy covering employers located in this state is doing the business of insurance in this state regardless of where the employer trust is located;
- specifying that the coverage is stop-loss insurance and not reinsurance and a MEWA will not be fully insured (and thus exempt from licensure) unless the stop loss policy provides for direct liability to the participants and is not contingent; and
- requiring a preferred provider organization to exercise due diligence before contracting with health insurance plans and providing penalties for failure to exercise due diligence.

Noninsurance Benefits in Insurance Products

BACKGROUND Insurers have sought to include as a part of a life insurance or annuity contract filing a benefit or feature of ostensible value to the prospective policyholder. These situations are occurring ever more frequently. To the extent such features represent benefits; those benefits are collateral to, not arising out of, the contract itself. Anecdotal examples of such benefits or features include (1) airline mileage bonuses, (2) identity theft protection services, (3) monetary deposits to particular account types on behalf of the prospective insured, (4) will and testament preparation services, and (5) funeral advisory services. These non-insurance benefits are not part of the plan or policy of life insurance or annuity itself. Some insurers urge that even if such benefits or features are generally prohibited, they should be permitted in instances in which the item offered bears a reasonable relationship to the filed product.

PROBLEM Presently, no specific authority in Texas law authorizes noninsurance benefits for life insurance and annuity contracts. To the extent that items included in life insurance and annuity contract filings provide a noninsurance value to the prospective insured, they are subject to disapproval. If offered within the policy, they are unapprovable because they do not involve an insurance function or activity related to the policy or plan of insurance. If offered outside the policy, they are unapprovable because they represent a prohibited rebate.

OPTIONS The Department does not believe it has authority to adopt rules to permit noninsurance benefits in life insurance and annuity contracts. Absent specific statutory authority the Department will continue to disapprove filings that seek to incorporate these benefits.

If the Legislature chooses to permit this practice or provide the Department with the authority to adopt rules governing non-insurance benefits in life insurance and annuity contracts, we believe any standards developed should require that those benefits be reasonably related to the risk, beneficial to

prospective insureds and fair and equitable to all insurers offering life, annuity, individual accident and health and nonemployer group accident and health products.

Noninsurance Benefits in Health Care Coverage

BACKGROUND Health benefit coverage plans have changed markedly over recent years due to significant changes in the marketplace and within the legal framework addressing such plans and the benefits offered through them. As a result, many contemporary plans include a greater emphasis on health care services and health care information to be utilized in both preventive and therapeutic ways. Insurers have voiced concerns about what they perceive as a conflict between regulatory oversight of anti-rebating statutes and the ability of health plans to provide prospective policyholders, certificate holders, or enrollees disclosure about health care related services and information available in addition to the terms of an insurance contract or evidence of coverage.

PROBLEM Insurance Code Section 541.056 states that an insurer is prohibited from offering, directly or indirectly, an inducement to purchase or maintain insurance that is not included within the insurance contract or evidence of coverage terms. Insurers assert that the statute is in direct conflict with the sound public policy practice of permitting insurers to disclose information to prospective covered persons about health care related services and access to health care related information in order to enable/encourage them to make more informed health care decisions.

OPTIONS The Department believes it has limited rulemaking authority to address this issue. The Legislature could amend Insurance Code Section 541.058 to specifically provide that disclosure about health care related services and access to health care information provided to prospective covered persons is not a rebate or discrimination prohibited by Section 541.056. Absent specific legislative authority, the Department will likely develop rules to govern the extent to which insurers can include non-insurance benefits in health benefit plan contracts. Such rules will ensure that the noninsurance products and services are related to loss control or improving the health risk, and that the provisions are clear and beneficial to covered persons.

Preferred Provider Organizations

BACKGROUND A preferred provider is a health care provider, or an organization of health care providers, that contract with an insurer to provide medical care or health care to insureds covered by a health insurance policy.[14] The organization of providers is often referred to as a Preferred Provider Organization (PPO). The Insurance Code, however, does not define PPO and the Department has little authority over a PPO that is not also a preferred provider benefit plan (PPBP), which the Department regulates. The statute defines PPBPs as benefit plans in which an insurer provides, through its health insurance policy, for the payment of a level of coverage different from the basic policy level of coverage if the insured person uses a preferred provider.[15] The problem and proposed

14 Insurance Code Section 1301.001(8)

15 Insurance Code Section 1301.001(7)

solution identified below is a result of the work by the statutorily mandated Technical Advisory Committee on Claims Processing and is included in their 2006 report to the Legislature.

PROBLEM In recent years, the health care delivery system has developed a complex network of contracts between physicians, providers, PPOs, and insurers. Many PPOs have evolved to perform a number of different services for insurers in addition to assembling networks, such as processing and repricing claims. Without even minimal regulation, such as registration, the Department does not know the extent to which PPOs are operating in Texas and cannot always resolve consumer complaints. The Department knows of no single entity, private or governmental, that tracks PPOs in Texas and no one is certain how many are operating in the State.

Another problem is that in order to expand its network, a PPO may contract with other networks, known as silent PPOs, and may access discounts that the providers did not anticipate or grant through direct contract with the insurer. Many carriers make PPOs responsible for a significant portion of the business of health care, such as developing networks and negotiating discounts with the providers on behalf of insurers. Then, when problems with network adequacy or inappropriate discounts arise, carriers often point to the PPO.

In an attempt to address this issue the Department drafted an informal rule for comment and released it in November 2006 to the Technical Advisory Committee on Claims Processing, a formal working group primarily of providers and carriers. The rule would require a carrier to furnish a provider, at the time the carrier takes the discount, with proof of underlying contracts that permit the discount. Comments the Department received to date reflect the opposing perspectives of providers and carriers. Providers generally say that, in cases involving silent PPOs, carriers benefit from discounts not specifically included in the provider's contract with the carrier. Carriers generally respond that most contracts with providers include a provision that authorize the underlying contracts and discounts.

OPTIONS The Legislature could consider codifying the proposed rule. While diverging opinions on this matter exist, the primary goal would be to enable carriers to inform both employer and individual policyholders on the complete terms of the contract.

Suitability and Replacement of Annuities and Other Life Products

BACKGROUND Complaints received by the Department indicate that many senior citizens are sold life insurance, annuities and variable annuities unsuitable for their financial and investment needs. Many states have already adopted rules or enacted legislation that address replacement of life and annuity policies and/or require insurers and agents to inquire into the suitability of annuity products for consumers, especially senior citizens. The legislation defines acceptable practices and provides a mechanism by which regulators can hold insurers and agents accountable for recommending and/or selling unsuitable products to senior citizens and others.

PROBLEM Agents and carriers often sell life and annuity products to consumers without fully explaining the fees, penalties, risks and tax consequences associated with these products.

Consumers, especially senior citizens, are sometimes unwilling to complain and will not testify against an agent or financial advisor.

High commission levels can be a major factor in which products an agent recommends to customers, which may eclipse the short- and long-term needs of the individual in the course of a transaction. Further, when such sales replace existing insurance, annuities, or other investments, the purchase may involve high surrender charges, higher costs and adverse tax implications. Ultimately, the consumer is placed at a financial disadvantage, and in some cases, unable to recover lost wealth, leading to financial insecurity.

RECOMMENDATION Enact the National Association of Insurance Commissioners (NAIC) Suitability in Annuity Transactions and the Life Insurance and Annuities Replacement Model Regulation or authorize the Commissioner to adopt the NAIC Model Regulation. Texas is one of only five states that has no replacement law.

Consider additional statutory protections for senior citizens with regard to policy provisions based on age of issue, maximum surrender periods, longer "free look" periods, and mandatory reinstatement of a replaced policy under certain circumstances.

Consider prohibiting agent acts such as soliciting or accepting "gifts" of real estate or things of value over $5,000; soliciting or accepting investment funds in an agent's business enterprises; and being appointed a guardian and/or trustee of a client's person and/or estate or being named beneficiary on any life insurance, annuity or will when there is no legal or familial relationship to the client.

Property & Casualty Market Overview

Overall, the Texas Property and Casualty insurance market is as healthy as it has been in recent years; however, recent hurricane experience is affecting the homeowners market along the coast. Insurers have seen improved results in the major lines of insurance largely due to stabilizing loss trends and reforms enacted by the Texas Legislature that helped mitigate losses and create competition.

Homeowners Market Conditions

It is clear that recent reforms have had a positive impact on the Texas homeowners insurance market, which has rebounded with increased market competition, better product availability, and a downward trend in rates. However, current pressures face the industry due to rising concerns following the 2004 and 2005 hurricane seasons and tightening of the reinsurance markets.

Direct written premium in the admitted market for 2005 was $4.6 billion, compared with $4.4 billion in 2004. Premiums are a function of rate and the amounts of insurance purchased to maintain replacement value of the property.

On September 24, 2005, Hurricane Rita struck the upper Texas coast causing major damage in several counties, with the most severe damage occurring in Jefferson, Chambers and Galveston counties. As of October 2006, insurers had reported approximately 140,000 claims for residential lines of property insurance, totaling $1.45 billion in claims payments. Hurricane Rita losses also prompted the Texas Windstorm Insurance Association (TWIA), the insurer of last resort for property owners unable to obtain windstorm and hail coverage along the coast, to assess its member insurers $100 million. Hurricane Rita losses, as well as other hurricane loss experience in the Gulf Coast states, are having an effect on the affordability and availability of insurance for residential property located along the Texas Coast. Increased cost of catastrophe reinsurance, readjustment of catastrophe models to account for more frequent and severe hurricanes, and reevaluation of business models relating to management of catastrophe exposure have resulted in restricted wind coverage and writings, as well as price increases for properties along the Texas coast.

As a result of these developments, TWIA has seen significant growth. The number of policies written in TWIA has almost doubled since 2001. As of September 30, 2006 the policy count for TWIA was 131,581, with total premium in-force of $159.1 million. TWIA's rates for residential property have been increased by more than 17 percent since 2004. The average rate increase has been 9.6 percent, 0 percent, 3.1 percent, and 4.2 percent, respectively, for years 2004 through 2007. The most recent rate change of 4.2 percent was adopted to become effective January 1, 2007.

Market disruptions may occur in the event of a natural catastrophe that results in financially impaired carriers and/or carriers withdrawing from certain markets. Carriers might decide to limit their exposure to future storms by withdrawing from coastal regions or ceding their wind/hail exposure to TWIA where that option is available. Should the voluntary writers decide to cede even half of their wind/hail exposure to TWIA as a result of a major storm or multiple storms, this could result in TWIA more than doubling its size.

In November 2004, the policy count for the Texas FAIR Plan Association (insurer of last resort for residential property) peaked at more than 134,000 policies. As of October 30, 2006, the policy count was approximately 79,800. However, as a result of insurers restricting coastal writings and in part due to the Texas Select Lloyds receivership, the policy count in Harris and other coastal counties has actually increased since June 2006. The overall decline in policy count is an indicator of a generally healthy market.

Despite the pressures facing the industry following the recent hurricanes, average rate levels (based on the top 10 homeowners writers) to date have declined by about 4.5 percent since the mandated reductions following the 2003 reforms, which mandated reductions totaling 12.5 percent. During the time frame between October 1, 2005, and September 15, 2006, 36 insurers have filed rate decreases compared to 18 insurers who have filed rate increases. Activity by the largest homeowners writers has varied with two insurers that filed small-to-moderate rate decreases (-2 percent and -3 percent) and three insurers that filed moderate rate increases (4 percent to 9 percent range). In many instances, the filings proposing rate increases have mentioned the increased cost of reinsurance as a reason for the rising homeowners insurance costs. Of particular note is the rate activity along the Texas Gulf Coast. While an insurer may have an overall rate decrease or revenue neutral rate change, oftentimes there will be increases in areas along the coast. Again, this is often driven by concerns over catastrophe and exposure mitigation.

Any comparisons of the current market cycle and those in the 2001-2002 timeframe should be taken in the proper context. In 2001-2002, the loss environment in Texas was defined by the mold-related claims activity. That has since subsided. Now, the loss environment is defined by the speculation that the United States is in an era of increased hurricane activity. While the science does not always lead to accurate long-term forecasts, the reaction by global reinsurance and financial markets – that which assumes a large portion of risk from the primary insurance market in the United States – is nonetheless a major factor in what is driving the rate activity along the coast. The regulatory response, therefore, is to take a balanced approach, ensuring that rate changes are justified, not an overreaction to expected future catastrophes, and result in sound positioning for the state's economic future so that the shock of any future changes in rates and underwriting is mitigated.

Despite expected catastrophic losses, Texas continues to attract new entrants to the homeowners market. Since January 2005, three newly licensed companies have begun writing homeowners coverage and one company amended its license and began writing. Twenty-six companies licensed to write homeowners prior to 2005 actually began writing in 2005 and 2006. This is in addition to approximately 21 companies that entered the market in the 2003-2004 timeframe.

Since January 2005, insurers have filed 19 new homeowners products providing more choices and increased competition for Texas insurance consumers. While these new products generally include variations of the traditional coverages, there appears to be a migration toward more "all risks" type of coverage.

The sixth largest homeowner writer, Texas Select Lloyds, was placed into receivership in July 2006. The company reported $187 million in Texas premium for 2005 and had 140,000 policyholders at the time of receivership. This receivership was not due to the weakness of Texas Select per se, but

rather the holding company that was domiciled in Illinois with headquarters located in Alabama. Texas successfully redomesticated the holding company in March 2006, allowing for a greater level of scrutiny. Due to the nature of the company's condition, efforts to salvage or sell the holding company and its subsidiaries operating in the United States were on a very tight timeframe. Still, the voluntary market was sufficiently healthy to absorb most of these policyholders.

Personal Auto Market Conditions

As with the homeowners market, legislative reforms have had a positive impact on the personal auto market, which has all appearances of being competitive with new entrants, new products, much rate activity and a low volume of drivers in the assigned risk plan.

Direct written premium in the admitted market for 2005, was $11.6 billion, slightly lower than for 2004.

The Texas Automobile Insurance Plan Association (TAIPA), the market of last resort for commercial and private passenger auto, has experienced substantial decreases in total assignment counts since 2003. In 2003 the assignment counts were 74,506, in 2004 assignments decreased to 47,545, and in 2005 assignments decreased again to 31,517. Assignment counts for 2006 (through October) are currently at 20,826. One possible explanation for the decrease in the number of assignments in TAIPA may be attributed to the approval of new policy forms that deviate from the previously prescribed auto form allowing voluntary writers options to provide different coverages for different segments of the market.

Between October 1, 2005, and September 15, 2006, 119 companies made a total of 466 rate filings. About a quarter of these filings represented rate decreases ranging up to 20 percent. Less than one fifth of the filings represented rate increases ranging up to 15 percent. The remaining filings represented no overall rate change or were for rates for new products or endorsements. Rate activity among the top 10 personal auto groups varied with the top two writers taking moderate rate decreases in their individual companies and the third-largest writer taking moderate rate increases in its individual companies.

Since January 2005, three newly licensed companies have begun writing personal auto coverage and two companies amended their license and began writing. Thirty-one companies licensed to write personal auto prior to 2005 actually began writing in 2005 and 2006.

Since January 2005, companies have filed 45 new personal auto products. Along with several new entrants, these new products mean more choices and increased competition for Texas insurance consumers.

Medical Professional Liability Market Conditions

In 2003, the Legislature enacted legislation that reformed the tort system, significantly impacting medical liability insurance losses. These reforms appear to be having a positive impact on the physicians' medical malpractice market, which is more competitive compared to the previous years.

Direct written premium in the admitted market for 2005 was $430 million, compared with $448 million in 2004.

The policy count in the Texas Medical Liability Insurance Underwriting Association (JUA), which is the market of last resort for medical providers, continues to decline. The number of policyholders started to decline in December 2004, from approximately 2,600 to approximately 765 as of October 2006.

Physicians' medical malpractice rates have dropped since January 2005 with all of the top six writers announcing significant rate reductions in 2005 and/or 2006. The cumulative physician rate change since September 2003 for the top six medical liability writers ranged from -13.4 percent to -29.5 percent, with an average industry change of -19 percent.

Claim activity for physicians' medical liability also has declined. For 2003, the number of reported claims for the top four physician writers averaged 497 per month, peaking at 1,342 in September 2003. This peak coincided with the effective date of certain reforms. Beginning in 2004, the number of monthly reported claims began to decline and the number of reported claims averaged 188 per month in 2005 and 171 per month for the first half of 2006.

Since January 2005 there have been three new entrants into the admitted market for physicians. In addition, there have been several other new entrants in the medical malpractice market for other types of healthcare providers.

Workers' Compensation Market Conditions

In 2005, the Legislature enacted House Bill (HB) 7, which represents the most comprehensive organizational and policy reforms to the Texas workers' compensation system since 1989. A significant part of HB 7 is the establishment of certified workers' compensation health care networks. It is anticipated that certified workers' compensation health care networks will help reduce the cost of workers' compensation claims in Texas and that the cost savings, both anticipated and actual, will be passed on to policyholders participating in the networks in the form of a premium credit. While the market today is stable and financially healthy, the implementation of networks and the rest of the reforms from HB 7 should further improve the market by providing additional cost savings for employers through the use of network credits. The Department will monitor the impact of these reforms and report accordingly.

Direct written premium in the admitted market for 2005 was $2.7 billion, compared with $2.6 billion for 2004.

Since 2003, the workers' compensation market has experienced underwriting profits after numerous years of substantial underwriting losses. This has allowed carriers to file more rate reductions and make more use of competitive pricing tools to further reduce employers' premiums.

In the last two-year period (2005 and 2006), average rate levels have been reduced by more than 20 percent. This does not include the network credits that have been filed by carriers. There have

been far fewer rate increases filed in 2006 than in 2005 -- 20 as opposed to 37. Furthermore, there were 67 rate decreases filed in 2006 compared with 44 rate decreases filed in 2005. Most filings were revenue neutral in each year. This was mostly due to carriers adopting the Department's promulgated classification relativities. These relativities are used by carriers in determining the rates to be charged for each classification and filings of notice for the implementation of network credits.

In addition, the use of competitive pricing tools, , along with rate reductions, has brought the 2005 average premium per $100 of payroll by policy year down to $2.36, an approximately 17 percent decrease from the 2003 level of $2.85 per $100 of payroll. An example of a competitive pricing tool is schedule rating, which reflects characteristics of the policyholder (i.e., the employer) that may not be fully reflected in the employer's actual past experience. (Data is not yet available to determine changes in average premium per $100 of payroll for 2006.)

During 2005, four newly licensed companies began writing workers' compensation coverage and one company amended its license and began writing. In addition, at least three companies licensed to write workers' compensation prior to 2005 actually began writing in 2005 or 2006. Four self-insured groups were authorized in 2005 and, to date; one self-insured group has been authorized in 2006.

Since January 2005, companies have filed 320 endorsement/form filings. These filings include foreign coverage, negotiated deductible and dividend endorsements, providing policyholders with options specific to their needs.

Clarifications, Modernization and Reconciliations

Clarification of Refund Statute

BACKGROUND During the 79th Legislature, two different versions of subsections (b-1) and (b-2) of the Insurance Code Article 5.144 concerning refunds of excessive or discriminatory residential property insurance premiums were enacted (Chapters 291 and 899 as added by Acts 2005, 79th Legislature).

PROBLEM The differences between the two versions of subsection (b-1) are as follows:

- the Chapter 291 text sets the interest rate at the lesser of 18 percent or the prime rate plus 6 percent, while the Chapter 899 text sets the interest rate at the prime plus 6 percent. As a practical matter, the result is the same as long as the prime rate remains below 12 percent;
- the Chapter 291 text uses the date the Department first gives formal written notice to the insurer to mark the beginning of the period for refunds and interest, while the Chapter 899 text applies this date only to interest and not refunds; and
- the Chapter 291 text refers to the Department's formal written notice that the insurer's rates are excessive or unfairly discriminatory, while the Chapter 899 text adds the phrase "as determined by the commissioner."

With respect to subsection (b-2), providing that an insurer may not claim a premium tax credit unless it is otherwise in compliance, the difference is that the Chapter 291 text refers to the insurer's compliance with subsection (b), while the Chapter 899 text refers to the insurer's compliance with the entire article. The referenced subsection (b) authorizes the Commissioner to order an insurer to issue refunds or credits to policyholders charged illegal rates.

RECOMMENDATION Because these versions were passed by the Legislature at the same time, the rules of statutory construction require that they be read together. In order to clarify this statute, the Department recommends retaining the Chapter 291 text and deleting the Chapter 899 text.

The Department has interpreted the two versions to be legally and functionally equivalent. However, one insurer has argued that the phrase "as determined by the commissioner" in the Chapter 899 text requires the Commissioner to first issue an Order finding the rates excessive or unfairly discriminatory before "formal written notice" is given and the period for refunds and interest can begin. Under this interpretation, policyholders would not be entitled to refunds until this Order was issued. Under the Department's interpretation, formal written notice can be accomplished through an Order, Notice of Hearing, letter or other document issued by the Department which informs the insurer its rates are excessive or unfairly discriminatory.

Commercial Property Rate and Form Regulation

BACKGROUND A major goal of SB 14, enacted by the 78th Legislature, Regular Session, was to subject all licensed insurers to the same regulatory rating standards. Additionally, the majority of commercial lines policy forms are subject to prior approval, and most licensed insurers are subject to filing commercial policy forms for prior approval. Two significant exceptions still exist. Commercial property rates for coverage written by Lloyd's plan and reciprocal insurers are exempt from rate filing requirements and certain rate regulation. Secondly, rates and policy forms for inland marine, rain and hail insurance on growing crops written by Lloyd's or reciprocals are exempt from rate and form filing as well as certain rate regulation.

PROBLEM These exceptions do not provide for regulatory consistency among certain insurers and lines of insurance. Additionally, with recent changes in the commercial property insurance market, particularly related to the cost and availability of reinsurance, there have been extremely large premium increases for many categories of commercial properties, particularly apartment complexes and condominium associations. With no filing requirements, TDI has no immediate way to monitor the state of such markets or to determine and assure the reasonability of the premium charges.

RECOMMENDATION Delete the filing exemptions for Lloyd's plan and reciprocal insurers in Article 5.13-2, Section 3(a)(3). Deletion of these exemptions would subject all licensed insurers to the same rate filing requirements and rating standards for commercial property, inland marine, rain and hail. It would also provide for consistent form filing requirements for commercial lines of coverage for all licensed insurers.

Holding Company Act

BACKGROUND The Holding Company Act (Act) governs acquisitions of insurance companies and transactions between insurers and their parents or affiliates. The purpose of the Act is to ensure that the parties in control of insurance companies do not abuse their position in a manner that jeopardizes the interests of the policyholders. The current law was based on a model act adopted by virtually every state. However, there are a number of differences and inconsistencies between current Texas law and the model as enacted in other states. Currently, insurers are required to file a large volume of filings that are no longer needed by the Department in the performance of our regulatory duties. These filings are part of a comprehensive holding company registration statement filed with the Department every five years. In addition, each year the Department also obtains interim updates that include any changes that have occurred since the last five year registration statement. Other states require the registration statement on an annual basis. A substantial number of groups with multi-state operations find it less burdensome to submit these registration statements in a consistent manner on an annual basis in all states in which they do business, and already file their annual restatements with the Department.

PROBLEM Inconsistencies between the current Texas law and the laws of other states result in confusion and administrative burdens on the industry and the Department alike. These burdens include additional regulatory filings such as bylaws and articles of incorporation for noninsurance

entities, which are part of the comprehensive registration statement that is filed every five years. Because Texas is the only state with this five year restatement requirement, additional administrative burdens are created for the industry, particularly for groups with operations in several states.

RECOMMENDATION Amend Insurance Code Chapter 823 to streamline the process for holding company transactions and make Texas processes consistent with the other states. This will help ensure that Texas law only requires those regulatory filings that the Department needs to protect the public and will make Texas registration requirements uniform with other states.

Independently Procured Insurance

BACKGROUND Insurance Code Section 101.053(b)(4) provides an exception to what constitutes the business of insurance in this state if a transaction involves an insurance contract independently procured by the insured through negotiations occurring entirely outside this state that is reported and on which premium tax is paid. This exception maintains the state policy and purpose of the unauthorized insurance statutes which include maintaining fair and honest insurance markets and protecting the premium tax revenues of this state.

PROBLEM The Department has found that in practice, unauthorized entities are manipulating transactions to claim that negotiations have occurred outside the state and are therefore independently procured and subject to the exception contained in Section 101.053(b)(4). A significant number of Texas-domiciled businesses appear to be utilizing the independently procured exemption in order to obtain insurance from unauthorized and virtually unregulated offshore insurers.

RECOMMENDATION The Department believes that the goal of the independently procured exception can be preserved by requiring that the carrier be licensed in some state, as in the surplus lines context, or by amending the unauthorized insurance statutes to prevent the circumvention of the independently procured exception.

Motor Vehicle Theft and Motor Vehicle Insurance Fraud Reporting

PROBLEM Insurance Code Chapters 701 and 702 relate to the reporting of insurance fraud. Chapter 702 was enacted in 1985 (Article 21.78), six years prior to the enactment of Article 1.10D (the predecessor to Chapter 701). Chapter 702 is much narrower in scope than Chapter 701, pertaining only to fraud committed against auto insurers, specifically motor vehicle theft or motor vehicle insurance fraud. Once Article 1.10D was enacted, it established the Fraud Unit and the guidelines for reporting and investigating all lines of insurance fraud, thus eliminating the need for a statute that only pertains to motor vehicle fraud.

There are some provisions in Insurance Code Chapter 702 that are in conflict with Chapter 701 and differing definitions of the same terms exist within the two statutes. These differences do not provide a clear body of law governing the investigation and prosecution of insurance fraud. The

most egregious difference being that under Section 702.001, the TDI Fraud Unit is not included in the definition of "authorized governmental agency." As a result, an insurer does not have to report suspected motor vehicle fraud or provide information to the Fraud Unit upon request.

During the 79th Legislative Session, changes were made to the reporting provisions of Chapter 701, so that all insurers must now report suspected insurance fraud to the Fraud Unit, and may also report it to another authorized governmental agency if they choose. This change allows the Fraud Unit to provide more accurate information to the legislature regarding the types and amounts of suspected fraud occurring in Texas. An unintended consequence of not repealing Article 21.78, now Chapter 702, is that insurers may decide not to report motor vehicle insurance fraud to the Fraud Unit, thus excluding this information from the Fraud Unit's calculations.

Furthermore, if motor vehicle fraud is reported to an "authorized governmental agency" as defined in Section 702.001, the reporting entity will not be afforded the enhanced immunity protections provided by Section 701.052 that were also enacted by the 79th Legislature.

RECOMMENDATION Repeal Insurance Code Chapter 702. The repeal of Insurance Code Chapter 702 is in the best interest of the state in furtherance of its antifraud efforts. Repealing Chapter 702 would eliminate any confusion or question as to which statute should be used by motor vehicle insurers attempting to report fraud. It will ensure that all fraud is reported and investigated uniformly, thus providing the most accurate data and results to the legislature and the public.

Emerging Issues – Property and Casualty

Automobile Rating Plans – Violation Surcharges

BACKGROUND Insurance Code Article 5.01-1 prohibits an insurer from assigning any rate consequence to a charge or conviction for a violation of the Uniform Act Regulating Traffic on Highways. County mutual companies are not subject to this statute, so they are allowed to use minor violations to determine premiums. This means that insurers are not subject to the same requirements with regard to their ability to surcharge for traffic violations. This difference in treatment appears to be contrary to one of the major goals of Senate Bill 14, 78th Legislature, (i.e., to put all insurers on the same regulatory standard).

PROBLEM In the Texas market, there are 23 county mutuals that write private passenger auto insurance. The top five insurer groups, which write about 64 percent of the private passenger market in Texas, all use a county mutual, either as one that is used in conjunction with its other affiliated companies or as the sole writer of private passenger auto insurance. There are other nonaffiliated county mutuals that at one time wrote mostly nonstandard drivers, though some of them have branched into the standard and lower-risk driver markets. The result of this is that a large sector of the whole market, not just the nonstandard market, establishes rate levels, at least in part, on driving record.

This restriction has also hampered new entries into the market by companies that want to write standard and nonstandard risks. The current law restricts competition in the nonstandard market because stock companies (and other types of companies) will not enter the nonstandard, high-risk

market if they do not have the ability to rate a risk based on driving record. Use of an insured's driving record in rating has an actuarial basis in establishing rates that are reflective of risk; it encourages less risky driving behavior that is safer for other drivers and pedestrians, and, unlike other rating variables, the insured has the ability to directly influence this factor by driving safely.

RECOMMENDATION Delete Insurance Code Article 5.01-1. Deletion of this provision would put all insurers on the same footing and allow all companies to impose a surcharge for traffic violations. It would also foster competition in the high-risk, nonstandard driver market and promote less risky, safer driving behavior for all drivers. With the future implementation of Senate Bill 1670, 79th Regular Session, Texas will commence a more active effort to enforce the financial responsibility (liability insurance) requirements for drivers. The repeal of Article 5.01-1 will help ensure that drivers across the entire spectrum of risk, including high-risk drivers, have the benefit of some degree of market competition.

In the event Article 5.01-1 is repealed, insurers who have not been able to use driving record in their classification plans will likely include it. The result will be that drivers with driving violations will now be charged more: through a surcharge, by being placed in a higher-rated tier, or by being placed in an affiliated insurer or county mutual with a higher rate level. In order for the insurer's income stream from premium payments to stay the same, the insurer will need to reduce rates for the lower-risk drivers, i.e., those without any driving record violations. Overall, the insurer is taking in the same amount of money from premiums being paid. Without the use of driving record, insurers charge more to all, including the low-risk drivers, to be sure they have enough money in premiums to pay for the expected losses, setting up a subsidization of those drivers with minor violations.

Any surcharge or higher rate level imposed by an insurer would have to be actuarially sound, subject to review by the Department as part of the insurer's rate filing. Furthermore, drivers with good driving records would pay a rate that is commensurate with their risk, or receive appropriate discounts, also subject to review by the Department as part of the insurer's rate filing.

Data Mining and Pattern Recognition

BACKGROUND An increasing trend in insurance rating and underwriting is the combined use of data mining and pattern recognition technologies. The deployment of this new technology platform could far exceed anything in practice today. This recommendation is therefore made in anticipation of something that *could* develop over several years.

In the insurance context, data mining and pattern recognition is difficult to define. For discussion purposes, the combined use of the two technologies can be characterized as a means of identifying relationships among variables that are used to predict differences in the expected losses of insureds. These differences allow insurers to create new and more refined risk classifications. Insurers currently deploy similar technology to detect fraudulent claims, identify subrogation opportunities and to improve marketing effectiveness. What lies ahead, however, poses some significant policy issues.

For example, consider the use of financial information beyond what is captured in a credit report, such as rent payments, or the amount of purchasing activity at a hardware store. If a correlation is drawn indicating a pattern between either one of these variables and the potential for claims, this gives the market another tool for pricing or risk classification.

PROBLEM The use of this tool can have one of two outcomes. It has been argued by groups associated with its development that insurers will show greater willingness to enter previously underserved markets, particularly in urban areas, since this technology will increase their confidence to accurately price and underwrite insureds that previously would have been rejected. Further, these groups argue that more individuals will have access to insurance from more companies at reasonable rates.

Others argue that the use of this technology will have the opposite effect. If adopted by the majority of the market, exponentially more risk tiers are likely to emerge resulting in sharp or severe rate differentials among insureds. This may effectively make insurance unavailable to many, perhaps requiring the creation of state-sponsored pools to provide basic required coverage. They argue further that a higher segmentation of the market will have the potential for disproportionate impact on various socioeconomic groups.

Moreover, as the number of rate tiers proliferates (hyper-tiering), the risk transfer mechanism begins to break down. Policyholders could be grouped with such accuracy at a very individualized scale that there would be little risk transfer because losses are virtually predicted to a person, rather than a percentage of people within a given risk class. In theory, over several years, insurers will have the means to determine who will file a claim with a very high degree of accuracy.

If the larger market share insurers begin to use hyper-tiering at the same time, other companies will rush to a defensive market position in order to avoid being adversely selected against (i.e., protecting against insuring only the higher, more volatile risks).

Whether and to what extent either one of these outcomes will be realized is unknown. However, as technology advances, there may be little time to react as the industry responds to a sudden change in the market.

OPTIONS The Legislature should consider:

- amending rate and underwriting provisions in the Insurance Code to allow the Commissioner the authority to define and require disclosure to the Department of all elements of data mining and pattern recognition processes used in rating, tiering or underwriting;
- granting the Commissioner the authority to require moderation over two or more renewal cycles;
- permitting new and smaller niche insurers specializing in emerging urban markets to utilize certain technology; and
- requiring reports to the Legislature concerning the availability and affordability of insurance.

This approach will allow time to better outline these issues for the Legislature, develop a more thoughtful policy response, and mitigate any impact on consumers. Further, it will allow the development of new markets for urban areas under a controlled environment so that outcomes of

disproportionate impact can be avoided. Rating standards currently in law would also continue to apply.

Risk Based Capital

BACKGROUND Insurance Code Section 32.022(b) requires the Commissioner of Insurance to make recommendations relating to an insurer's amount of required capital and surplus and provide evidence on which those recommendations are based. In 1991, the Legislature increased capital requirements for most insurers in response to the failure of a large number of insurance companies. These insolvencies resulted in unpaid claims. However, the 1991 reform allowed a limited exemption for county mutual insurers and Lloyd's plans.

Most insurance companies are subject to risk based capital (RBC) requirements. RBC recognizes that insurers range widely in size, exposure, and risks and indexes the amount of capital a particular insurer needs based on its unique risk profile. The Commissioner of Insurance has authority to adopt regulations that may require capital based upon any of the following risks:

- the nature and type of risks the insurer underwrites;
- the premium volume for the insurer;
- the composition, quality and liquidity of an insurer's investments;
- fluctuations in the market value of securities held by an insurer; and
- the adequacy of an insurer's reserves.

PROBLEM Current law does not authorize the Commissioner of Insurance to apply RBC requirements to county mutual insurance companies and Lloyd's plans, even though county mutuals hold nearly 45 percent of the Texas market for private passenger automobile insurance and Lloyd's plans hold 76 percent of the Texas market for homeowners' insurance. Although these exempt insurers are exposed to the exact same risks that resulted in the application of RBC to their competitors, they enjoy an unfair advantage by being subject to substantially lower capital requirements. Moreover, since the unpaid claims of insolvent insurers ultimately result in tax credits that reduce premium tax collections, exempting these companies from RBC exposes the State's General Revenue should these exempt insurers become insolvent.

RECOMMENDATION Delete Insurance Code Section 822.205 but allow impacted insurers a phase-in period to comply with RBC requirements. Additional time may be required for certain niche writers for which there are limited alternatives for consumers.

Texas Windstorm Insurance Association

BACKGROUND Approximately 30 percent of Texas' population resides in counties along the Texas Coast and the counties adjacent to them. The insurance industry estimates that in 2004, about $750 billion in insured properties, both residential and commercial, in the state were vulnerable to hurricane losses.[16]

In 2005, hurricanes cost the insurance industry about $46 billion in losses countrywide, the worst season for losses on record.[17] The only one to hit Texas, Hurricane Rita, caused an estimated $2.6 billion in insurance losses in the state. The 2005 Atlantic hurricane season was a record year in terms of named storms, 28 in all. Some hurricane experts are predicting that the current cycle of very active Atlantic hurricanes will continue for several years.

The Texas Windstorm Insurance Association (TWIA) was created in 1971 in response to Hurricane Celia. TWIA provides windstorm and hail coverage for property owners in areas of the state where it is not readily available. TWIA consists of all property insurers authorized to write property insurance in Texas and administers day-to-day operations, including policy issuance and claims processing. TWIA is authorized to provide wind and hail insurance in the 14 counties along the Texas coast and in other areas designated as "catastrophe areas" by the Commissioner. The term "catastrophe area" is defined in the Insurance Code to include, among other things, areas where "windstorm and hail insurance is not reasonably available to a substantial number of owners of insurable property." To date, outside of the 14 coastal counties, only small portions of Harris County have been designated as "catastrophe areas."

In the event TWIA is unable to cover losses from current revenues (premiums and investment income, which amounts to approximately $45 million per year), the following funding mechanism currently applies (in order):

- $100 million assessed to member insurers;
- Catastrophe Reserve Trust Fund (CRTF) (currently about $322 million) and reinsurance (currently about $417 million);
- $200 million assessed to member insurers; and
- unlimited assessment to member insurers reimbursable from premium tax credits over five or more successive years (after the approximately $1.039 billion provided from sources 1-3).

TWIA's exposure has been growing rapidly in recent years. In 2001, TWIA had 68,758 policies. As of September 30, 2006, TWIA insured 131,581 policies with liability in excess of $37 billion with more than $20 billion of liability concentrated in Galveston and Brazoria Counties. It is estimated that TWIA's exposure, including miscellaneous coverages such as business interruption, will exceed $40 billion by the end of this year.

16 AIR Worldwide. AIR did not provide specific information on which areas of state are included in this estimate.

17 Insurance Services Office (ISO).

This growth increases the possible losses arising out of a given storm, placing state revenues at an ever-increasing risk. The current catastrophe funding capacity available to cover losses before the reimbursable tax credits are triggered (approximately $1.039 billion) is estimated to cover the probable TWIA losses from a storm that would be expected to occur every 20-25 years (a 4 percent to 5 percent chance of striking in any given year). An example might be a Hurricane Rita-type storm striking Galveston. Texas' general revenue stream would be at significant risk should a more severe storm strike the coast. For example, TWIA losses from a so-called 100- year storm (one having a 1 percent chance of striking in any given year) are estimated at about $3.3 billion, placing about $2.3 billion of state revenues at risk; a 250-year storm (one with a 0.4 percent chance of striking in any given year) would produce about $5.2 billion in losses for TWIA, jeopardizing about $4.2 billion in state revenues.

Issues and Options

Funding

The current funding mechanism for TWIA was developed in 1993 at a time when TWIA's exposure to loss was considerably less. In that year, the combined residential and commercial exposure was $6.5 billion, about one-fifth of today's levels. What may have been adequate then to promote the property market and protect state revenues may be completely inadequate today.

Future changes to TWIA's funding structure should contemplate the combination of reinsurance, financial instruments, and bonding, as well as restructuring the public-private system of coastal insurance. The changes should focus on a system that does not excessively expose the state's general revenue to hurricane losses while at the same time allowing for strong, sustainable economic growth along the coast by making necessary insurance coverage available.

The Legislature may want to consider the following options:

- Expand the funding sources available to TWIA to include pre-event and/or post-event bonding authority to be funded by some combination of policyholder surcharges rather than General Revenue premium tax credits;
- Provide for enhanced temporary liquidity in the event of a catastrophe through a stand-by bank line of credit.

Designated Catastrophe Areas

In the spring of 2006, the Department began receiving numerous inquiries and feedback from various members of the public, including representatives of the Texas Apartment Association, the Independent Insurance Agents of Texas and the Texas Association of School Boards, regarding the unavailability and unaffordability of wind and hail coverage in counties along the coast (first-tier counties) and those bordering them (second-tier counties, particularly Harris County). The majority of affected properties were condominiums, townhomes, apartments and schools located in the second-tier counties. The market restrictions and price increases generated requests to expand the areas in which TWIA can provide wind and hail coverage so that property owners may obtain coverage through TWIA.

The standard for "catastrophe area" as currently defined in the code requires that insurance not be reasonably available to a substantial number of owners of insurable property. Even though it is clear that some types of structures are having difficulty obtaining wind and hail insurance, it may not be sufficient to meet the "substantial number" standard. In addition, once an area is designated as a "catastrophe area," all insurable property located in the area is eligible for coverage through TWIA. As a result, the State's general revenue may be put at much greater risk in order to assist a segment of the market in obtaining wind and hail insurance. For example, Harris County alone currently has more than $180 billion in insurable property.

The Legislature may want to consider the following option:

- Amend the provisions that allow the Commissioner to designate additional catastrophe areas to provide flexibility for the Commissioner to expand TWIA eligibility by classification or type of risk, e.g., if certain types of entities such as public buildings or habitational risks are having difficulty obtaining coverage through the voluntary market, the Commissioner could expand eligibility on a limited basis to include only those types of risks.

Rates

The procedures used in calculating TWIA rates are set out in great detail in the statute (Insurance Code Article 21.49, Sec. 8). For example, rates must be uniform throughout the first-tier counties, certain combinations of TWIA and non-TWIA data must be used to determine the catastrophe and noncatastrophe elements of the rates and certain numbers of years of experience must be used. This differs from other insurance pools in the state where there is much greater flexibility in the actuarial procedures that can be utilized and where there is greater freedom to adapt the rate structure for changing conditions.

The Legislature should consider amending the rate-setting requirements in Article 21.49 to allow greater rating flexibility. Options to consider include:

- allowing a file-and-use implementation of rate changes not exceeding 5 percent in any 12-month period and applying the current regulatory standards (approve, disapprove, modify) to greater rate changes;
- eliminating portions of the existing law that specify the precise experience that must be used to develop rates, permitting actuaries to use whatever data would be most appropriate in the specific circumstances;
- permitting the *limited* consideration of the results of hurricane models, perhaps in conjunction with actual historic experience in the development of TWIA's rates (e.g., allow 5 percent rate increase based on the average of the hurricane models every 24 months);
- permitting geographic variations in TWIA rates where such variations can be actuarially supported;
- allowing a premium charge that would go directly (100 percent) to the CRTF (the charge would not be subject to agent commissions, administrative charges, etc.); and
- providing for the tempering of rate changes arising from changes in ratemaking procedures so as to avoid rate shock by maintaining the current statutory 10 percent cap.

Windstorm Mitigation

The Windstorm Inspection Program was started in 1988 and is administered by the Department. The program is responsible for determining building code compliance for the purpose of obtaining and maintaining windstorm and hail insurance coverage through TWIA. Until recently, a homeowner would have to obtain a Certificate of Compliance (WPI-8) in order to obtain or maintain windstorm and hail insurance through TWIA. Now, in lieu of a WPI-8, and for a specified period of time, a homeowner can obtain insurance by paying a premium surcharge.

Currently, all Texas municipalities are required to adopt the International Residential Code (IRC) and International Building Code (IBC) for the purposes of obtaining insurance from TWIA; however, the Department has adopted stronger wind-resistant construction criteria beyond what is required under the IRC and IBC.

Loss mitigation is an important element of preparing for future windstorms. Even though municipalities are required to adopt the IRC and IBC, there are currently no provisions in place to ensure that municipalities have adopted or are inspecting or enforcing these codes.

Adopting stronger building codes and enforcing them to ensure compliance with the wind resistant provisions of the code may encourage insurers to write more wind and hail coverage in the coastal counties, thus lessening the exposure for TWIA. It would also ensure that if some of these properties are eventually insured by TWIA, they will be in compliance with the windstorm building code standards and would not require expensive inspections after the structures have been completed nor would there be a need to pay premium surcharges.

The Legislature may want to consider the following options:

- requiring local jurisdictions, including counties, to adopt and enforce windstorm building code standards in coastal counties that have a significant hurricane exposure;
- requiring municipalities to develop windstorm inspection programs, including structural plan review by design professionals, windstorm inspections and certification as part of their current inspection programs to ensure compliance with the wind resistant provisions of the code; and
- providing for the long-term phase-in of any changes to allow for public education and compliance.

Reinsurance Facility

The frequency and severity of recent hurricane losses and future predictions of a continuing pattern has had a dramatic impact on reinsurance capacity and pricing which in turn has impacted the affordability and availability of primary insurance along the Texas coast. Many insurers, including TWIA have indicated they are unable to purchase the amount of reinsurance desired and that the available reinsurance costs substantially more than last year. Reinsurance prices have increased between 100 percent and 200 percent over last year. These increased costs of reinsurance are passed on to policyholders. If an insurer is unable to purchase the desired reinsurance, the insurer itself will have to bear (or insure) the losses that have historically been reinsured or will have to restrict its writings.

The 2006 cost for TWIA to purchase the same amount of reinsurance that was purchased in 2005 was almost double, or approximately $38 million dollars higher. TWIA ultimately purchased a lower level of reinsurance in 2006 at a cost that was approximately $7 million higher than the 2005 reinsurance program. Additionally, there was not sufficient reinsurer participation on the 2006 reinsurance program to obtain the full amount of reinsurance TWIA was seeking.

Reinsurance availability and price are influenced by:

- changes in hurricane models that have increased probable loss figures used by primary insurers and reinsurers;
- rating agencies becoming more conservative in evaluation of insurers' catastrophe management plans;
- forecasts of increased hurricane activity and strength;
- reinsurer needs to rebuild capital; and
- a dysfunctional market largely due to the absence of normal competitive pressure to contain costs.

The Legislature may want to consider the following option:

- establishing a windstorm reinsurance facility (Facility) similar to the Florida Hurricane Catastrophe Fund to provide a stable and ongoing source of reinsurance to insurers, TWIA, and the Texas FAIR Plan Association (TFPA) for a portion of the hurricane losses incurred by those entities.

The purpose of a Facility would be to protect and advance the state's interest in maintaining insurance capacity in Texas and to improve the availability and affordability of residential property insurance in Texas by providing reimbursements to insurers, TWIA and TFPA for a portion of their catastrophic hurricane losses at a reasonable cost. Providing a stable and ongoing source of reinsurance for TWIA and the TFPA will enable these associations to obtain a greater level of protection against catastrophic hurricane losses which, in turn, may help minimize policyholder surcharges or premium tax credits.

Options to consider in creating the Facility to help achieve the intended purpose of the Facility are:

- requiring all licensed insurers in Texas, including TWIA and TFPA, that write certain policies to purchase reinsurance from the Facility;
- providing the Facility pre-event and post-event bonding authority; and
- providing the Facility assessment authority to service the bonds or to pay for losses to the Facility.

Voluntary Market

The most immediate after-effect of Hurricane Rita has been the impact on affordability and availability of property insurance in the coastal counties. Several major insurers have filed for rate increases. In addition, several insurers have informed TDI that they will be restricting wind coverage along the coast by excluding it from their policies and in some limited instances, not writing coastal business altogether.

Moreover, some assert that the inadequate funding structure and rates of TWIA have increased the likelihood of insurer assessments and thereby stifled the full development of a competitive statewide homeowners market as insurers weigh expanding their market share against the potential for future assessments.

It is expected that addressing the issues discussed in this section would encourage the development of the voluntary market; however, the Legislature should also consider promoting voluntary entry into the property market by:

- providing for the phase-in of potential TWIA assessments over several years for new property insurance writers; and
- creating a rate filing "safe harbor" that provides that a coastal rate change not exceeding five percent in a 12-month period following a storm is presumed reasonable. After the third consecutive increase, any future rate change would be governed by current law, i.e., subject to disapproval by the Department. This should be conditioned on an insurer continuing to directly insure for wind loss.

It should be noted that these changes may only result in incremental increases in capacity, or work merely to slow the withdrawal from the coast after a major storm or storms.

Board of Directors

TWIA is governed by a nine-member Board of Directors. Five members of the board are representatives of different insurers, elected by the insurance company members of TWIA. Two members are representatives of the general public who reside in the catastrophe area and are TWIA policyholders. The public representatives must be nominated by the Office of Public Insurance Counsel and are appointed by the Commissioner. The remaining two members are general lines property and casualty insurance agents who must have their principal offices in the catastrophe area. These members are also appointed by the Commissioner.

- The Legislature should consider amending the governing structure of TWIA to mirror the Texas FAIR Plan Association. The Texas FAIR Plan Association is governed by an 11-member governing committee. The FAIR Plan governing committee has two additional representatives of the public; each committee member is appointed by the Commissioner, and the Commissioner or the Commissioner's designee serves as an ex-officio member of the governing committee.

This structure fosters a broader range of perspectives among the governing committee. Also the board would be appointed by an individual with statewide governmental authority, which strengthens the argument that TWIA's activities are not subject to federal taxation.

Funding of the Texas FAIR Plan Association

BACKGROUND In response to an insurance availability problem sparked in part by mold claims and water damage claims, the Texas FAIR Plan Association (TFPA) was established in 2002 to provide residential property insurance statewide. The TFPA consists of all property insurers authorized to write business in Texas, and those members participate in any assessments due to shortfalls in revenue. In addition to relying on member insurer assessments and reinsurance to fund excess losses, the TFPA is also statutorily authorized to issue public securities as a method to raise funds for losses. The amount of public securities that may currently be issued to fund TFPA losses cannot exceed $75 million. TFPA member insurers are expressly authorized to make a premium surcharge on each policy they issue to recoup assessments, including service fees to pay the debt service on public securities.

In November 2004, the TFPA policy count peaked at more than 134,000 policies representing $24 billion in liability. As of September 30, 2006, the policy count was approximately 79,000 with $12.9 billion in liability.

PROBLEM While the TFPA policy count and liability has declined significantly in the last two years, the problem now is its concentration of risks in areas that are vulnerable to hurricane losses, primarily in Harris and Fort Bend Counties. These and the other coastal counties account for more than half of TFPA's policies and liability. As a result of increased reinsurance costs and predictions of increased hurricane activity, voluntary insurers have restricted underwriting along the Texas coast. There is a high possibility that more and more of these coastal risks will have to obtain insurance through TFPA. There are strong similarities between TWIA and TFPA in terms of their vulnerability to a catastrophic loss from a hurricane and how shortfalls in their funding impact the policyholders of the state. Therefore, to the extent that policy decisions are being debated as to how TWIA's funding should be changed and how funding shortfalls are to be funded and who should pay for it, a similar discussion needs to take place for TFPA, which should also take into account the related purposes of TFPA and TWIA.

RECOMMENDATION

- Provide for adequate and consistent funding mechanisms to both TWIA and the TFPA to allow for growth, especially with regard to growth in areas highly subject to catastrophic loss.

Title Insurance Rates – Pilot Study

BACKGROUND Texas is one of only three states in which the Commissioner of Insurance promulgates title insurance rates, policy forms and endorsements, and the associated rules. All title underwriters and agents must use these rates and forms. This regulatory system contrasts with other lines, where greater rate freedom is permitted. For instance, at present, rates for virtually all property and casualty coverages in Texas, other than title, are subject to a file-and-use regulatory system.

PROBLEM There are dynamics to remember in title insurance rates. Under a promulgated rate system, insurers must report their expenditures for purposes of setting rates. It is in the market's best interest that expenditures are reported fairly, so that the actual price reflects actual costs. There is no disincentive, however, for insurers to have and report as high a cost as possible, because under a promulgated rate system they will not be harmed by price competition if their expenditures are too high.

Under the current system, rates are set at biennial rate and rule hearings. These are long and costly processes that produce results that may not be indicative of the current market once the final rate and rule is adopted. Given that the use of the resulting rates is mandatory, consumers do not have the ability to shop for coverage on the basis of cost as they do in other states or lines of insurance. There is no price competition in the title insurance marketplace.

There is very little direct competition with the consumer, except on service. This lack of competition results in inefficiencies in the marketplace. For instance, instead of competing directly for consumers' dollars, many, though not all, agents compete by expending their marketing efforts on real estate agents, lenders, builders and other "producers" who can direct the ultimate consumers, property buyers, to a particular title agency. Moreover, the current system allows builders, producers, lenders and others to own agencies dedicated to particular real estate developments. While such integration may be efficient on its face, additional costs may find their way into the rate structure with no effective level of competition to keep those costs in check.

Some small, rural and/or independent agents contend that large, metropolitan, and/or underwriter-owned agents put them at a competitive disadvantage by their arrangements with large property developers which control the title transaction and pay the smaller agents only a fraction of the overall premiums. If a rural agent, who may be the only agent in a particular county, is put out of business, the local population loses the local title expertise needed to evaluate and minimize local title issues.

It should be noted that the shift in regulatory platform discussed in this recommendation is a major change in public policy. There are numerous considerations, such as predatory pricing and the impact on title agencies in rural and midsized counties, for which the ultimate consequences are unknown. Any change, therefore, should be incremental and conducted under the close scrutiny of the Legislature.

RECOMMENDATION Allow the Commissioner of Insurance the explicit flexibility to develop alternative rating structures that introduce some measure of price competition into the market. Any alternative rating structures should have a delayed effective date to allow for any legislative changes.

Alternative rating structures could take on several forms, such as initially permitting the filing of independent rates on a prior-approval basis, followed by a file-and-use system over a longer period of time.

There are several considerations to implementing an alternative rating structure on an incremental basis. For example, should a rating structure permit rating distinctions based on geographic region or the size of the underwriter or agency? Rating distinctions could include variations in the monetary split between underwriters and agents to account for the cost-shifting cited by many rural agents. Measures should be taken to prevent predatory pricing that may adversely impact title

agencies and therefore the quality of title transactions in certain counties. Further, consideration should be given to whether title insurance premium rates should be all-inclusive, the scope of any changes and the amount of time over which any changes are implemented.

These changes may result in some downward pressure on rates. Further, it could curb marketing and other expense practices that presently place some upward pressure in costs that would otherwise be kept at a minimum in a more competitive environment.

The initial development of a competitive market structure should be commenced no sooner than 2009. Further, any reforms, however incremental, should be implemented gradually while data on outcomes is gathered and analyzed. The time and quality of information gathered will allow the market to evolve at a much more gradual pace, giving the Legislature, industry and consumers time to adjust and make recommendations to ensure an orderly transition.

Overview of the Status of the Texas Workers' Compensation System

The past two years have seen significant changes in the Texas workers' compensation system. Policymaker and system participant concerns about high medical costs, problems with access to medical care and poor return-to-work outcomes, coupled with increased frustration with the administration of the system by the former Texas Workers' Compensation Commission (TWCC) spurred interest in a legislative overhaul of the system. Interest in making legislative changes also coincided with the scheduled Sunset review of TWCC in 2005 by the Sunset Advisory Commission, which resulted in a series of significant management and legislative recommendations.[18] These recommendations covered issues such as: changes in system administration, including the creation of an agency geared towards assisting injured workers; the promotion of managed care networks that would resemble group health regulation as closely as possible; enhancement of certain types of income benefits; streamlining medical and income benefit dispute resolution; and the promotion of key legislative goals, including the importance of ensuring the safe and timely return of injured workers to productive employment.

In response to these Sunset recommendations and with significant input from system participants, the 79th Legislature adopted House Bill (HB) 7 in 2005, which represents the most significant set of reforms to the Texas workers' compensation system since 1989.

Key aspects of these reforms included:

- the abolishment of the former TWCC and the transfer of its administrative duties to the Division of Workers' Compensation (Division) at the Texas Department of Insurance (TDI or Department) headed by a governor-appointed Commissioner of Workers' Compensation (Commissioner Albert Betts – appointed in September 2005);
- the creation of a newly formed Office of Injured Employee Counsel (OIEC) to serve as a voice for injured workers during rulemaking and assist them during dispute resolution headed by a governor-appointed Public Counsel (Public Counsel Norman Darwin – appointed in December 2005);
- the establishment of a mission statement for the Division and legislative goals to provide strategic statutory guidance to the Division's administration of the system;
- the formation of workers' compensation health care delivery networks geared towards improving the quality of medical care received by injured workers at a reasonable cost to Texas employers;
- the creation of a performance-based oversight program administered by the Division to promote incentives for insurance carrier and health care provider compliance and to assist the Division's prioritization of compliance activities;

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18 For more information regarding the Sunset Advisory Commission's recommendations regarding the Texas Workers' Compensation Commission (TWCC) and the rest of the workers' compensation system, see Sunset Advisory Commission, *Sunset Staff Report on the Texas Workers' Compensation Commission*, April 2004, and the Sunset Advisory Commission, *Sunset Decisions for the Texas Workers' Compensation Commission*, September 2004, which can be found at http://www.sunset.state.tx.us/79.htm.

- the abolishment of the Division's Approved Doctors' List (ADL) starting on September 1, 2007 or earlier if determined by the Commissioner of Workers' Compensation;
- the streamlining of medical and income benefit dispute resolution processes to improve the timeliness of dispute resolution; and
- increased focus on improving return-to-work rates in Texas.

A little more than a year after the effective date of HB 7, most of the key provisions of this legislation are currently being implemented by TDI. However, while it is too early to effectively gauge the full impact of this legislation, it is important to continuously assess the operational effectiveness of the Texas workers' compensation system to establish a baseline by which policymakers and system participants may measure the relative impact of the HB 7 reforms in the future.

The following assessment provides a high-level picture of several important system trends that TDI continues to track, including:

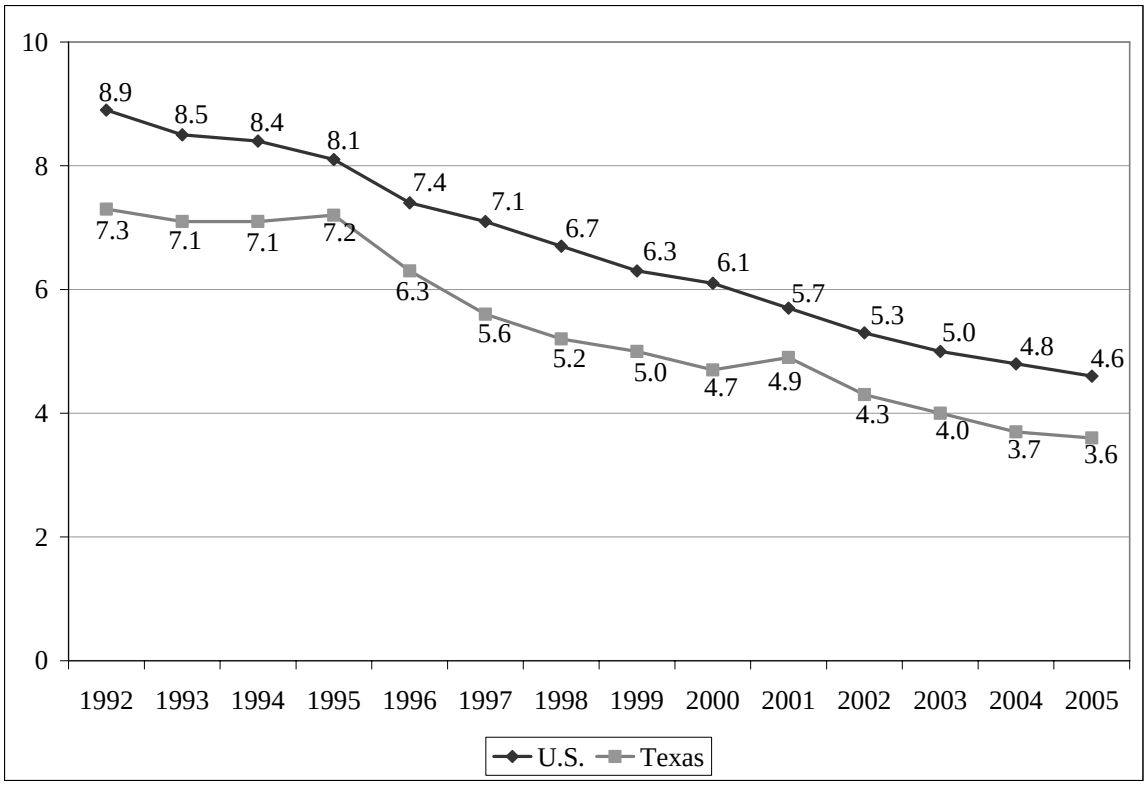
- injury rates;
- employer participation in the Texas workers' compensation system;
- medical costs, as well claim and medical billing denial rates;
- access to medical care;
- income and medical benefit dispute resolution;
- the implementation of workers' compensation health care delivery networks; and
- injured worker perceptions regarding the workers' compensation system.

It should be noted that in addition to these particular trends highlighted, the agency is also tracking other important issues such as complaint resolution, adequacy of income benefits, and improvement of customer service operations. However, the system trends presented in this report allow TDI, other policymakers and system participants to determine the relative "health" of the current system and consider whether minor adjustments in the Texas Workers' Compensation Act are necessary to facilitate the full implementation of the HB 7 reforms.

Injury Rates Continue to Decrease

A key legislative goal identified by HB 7 is the promotion of "safe and healthy workplaces through appropriate incentives, education or other actions." One important statistic in measuring the system's ability to maintain safe workplaces is the nonfatal occupational injury and illness rate. This rate calculation is currently based on an annual survey of Texas employers conducted by the U.S. Department of Labor, Bureau of Labor Statistics (BLS) and the Division. Between 1992 and 2005, the nonfatal occupational injury illness rate in Texas decreased 51 percent from 7.3 to 3.6 injuries per 100 full-time workers. The most significant injury rate declines occurred between 1995 and 2000. The injury rate in Texas has been consistently below the national average (see Figure 1).

Figure 1: Texas and U.S. Nonfatal Occupational Injury and Illness Rates Per 100 Full-time Workers (1992-2005)

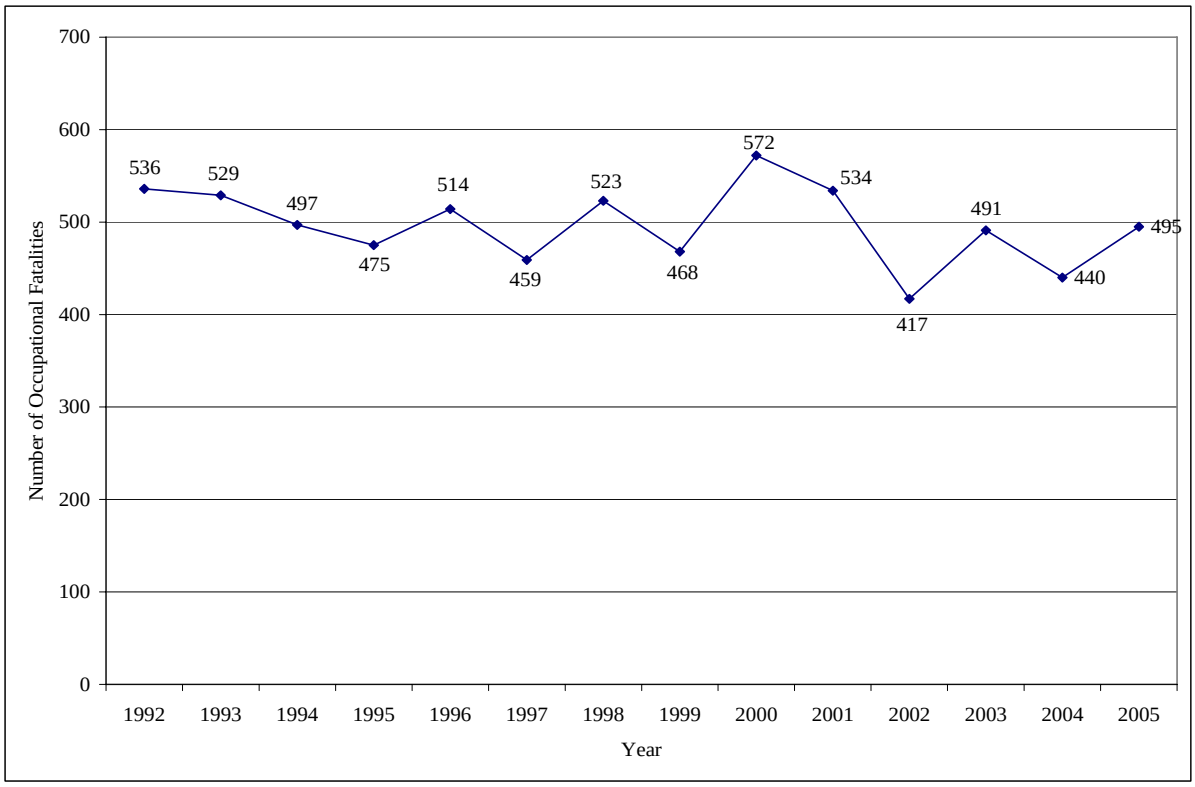


Source: Texas Department of Insurance, Division of Workers' Compensation and U.S. Department of Labor, Bureau of Labor Statistics, *Annual Survey of Occupational Injuries and Illnesses,* 2005.

Although the non-fatal occupational injury and illness rate in Texas and nationwide has seen a continuous decrease since 1992, the number of fatal occupational injuries in Texas has continued to fluctuate over time (see Figure 2). The industries that continue to see the highest number of fatalities in 2005 include construction and extraction (137 fatalities) and transportation and material moving jobs (135 fatalities), altogether accounting for 55 percent of all fatal work-related injuries in Texas.[19]

19 See also U.S. Department of Labor, Bureau of Labor Statistics, *Texas Workplace Fatalities in 2005*, http://www.bls.gov/ro6/cfoi_tx.htm.

Figure 2: Number of Fatal Injuries in Texas by Year, 1992-2005



Source: Texas Department of Insurance, Division of Workers' Compensation and U.S. Department of Labor, Bureau of Labor Statistics, *Census of Fatal Occupational Injuries*, 2005.

Employer Participation Rates and Employee Coverage Rates Have Begun to Stabilize

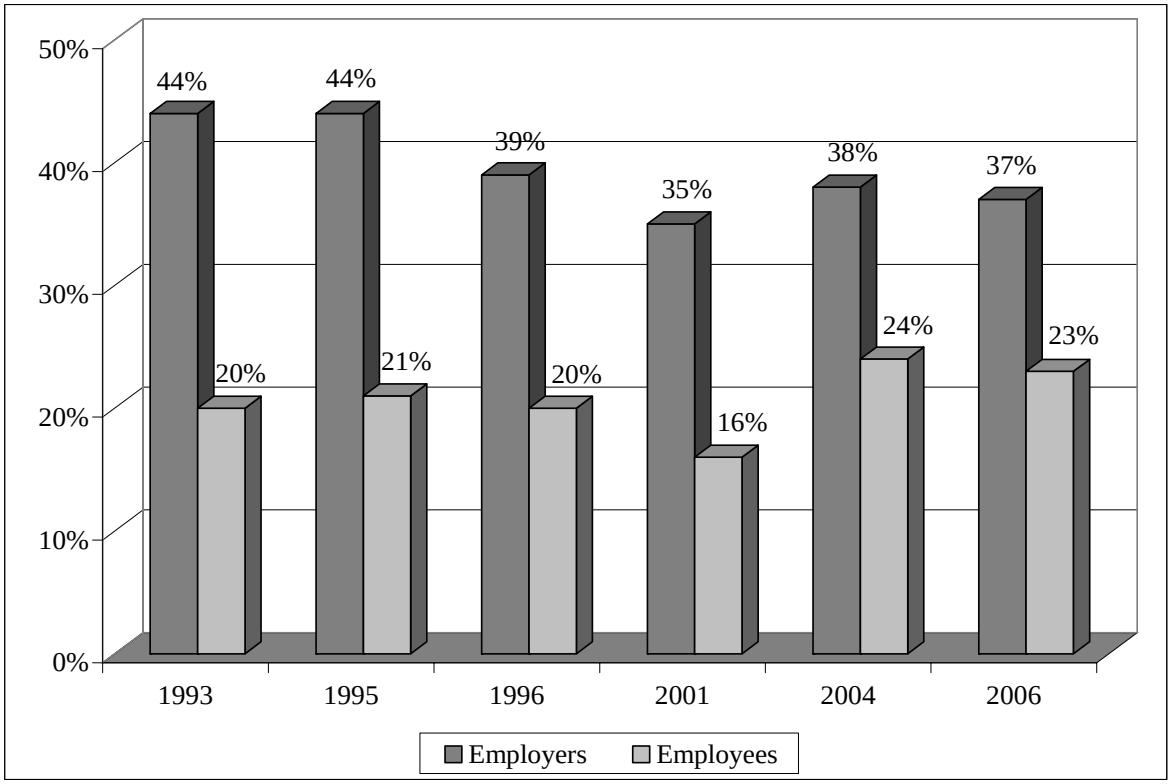
Texas is currently the only state where private-sector employers (regardless of employer size or industry) are allowed the option of obtaining workers' compensation coverage or becoming "nonsubscribers" to the workers' compensation system.[20] Employers who choose to not obtain workers' compensation coverage (either through purchasing a commercial policy or becoming a certified self-insured employer or a member of a certified self-insurance group of employers) lose the protection of statutory limits on liability and may be sued for negligence by their injured workers.

Nonsubscription rates remain an important performance measure in the workers' compensation system since it roughly measures employers' perspectives regarding whether the benefits of participating in the workers' compensation system are greater than the costs of obtaining the coverage. The percentage of Texas employers that are nonsubscribers to the workers' compensation system fell by one percentage point from 38 percent in 2004 (an estimated 110,200 employers) to 37 percent in 2006 (an estimated 107,300 employers). Approximately 23 percent of Texas employees (representing approximately 1,772,000 employees) work for nonsubscribing

20 In New Jersey all employers are required to have coverage or be self-insured. Non-compliant employers are fined and their injured employees receive income and medical benefits through the Uninsured Employers' Fund (UEF).

employers in 2006 (see Figure 3). This represents a one percentage point drop since 2004, but is the second highest percentage of Texas employees working for nonsubscribing employers since 1993. The 2006 drop, while minimal, is statistically significant and may be due to changing factors in the Texas workers' compensation system such as stabilizing premium costs and lowered concerns about high medical costs.

Figure 3: Percentage of Texas Employers That Are Nonsubscribers and the Percentage of Texas Employees That Are Employed by Nonsubscribers, 1993-2006



Source: *Survey of Employer Participation in the Texas Workers' Compensation System,* 1993 and 1995 estimates from the Texas Workers' Compensation Research Center and the Public Policy Research Institute (PPRI) at Texas A&M University; 1996 and 2001 estimates from the Research and Oversight Council on Workers' Compensation and PPRI; and 2004 and 2006 estimates from the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group and PPRI.

Results from a recent 2006 analysis highlight the continuing trend of larger employers making the decision to opt out of the Texas workers' compensation system for reasons that centered primarily on high workers' compensation premium costs and an ability to adequately control medical costs for their work-related injuries outside of the workers' compensation system.[21]

21 For more information about nonsubscription rates and employers' reasons for participating or not participating in the Texas workers' compensation system, see Texas Department of Insurance, *An Analysis of the Effect of the 2005 Legislative Reforms on the Affordability and Availability of Workers' Compensation Insurance for Texas Employers: A Report to the 80th Legislature*, 2006; and Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, *Employer Participation in the Texas Workers' Compensation System: 2006 Estimates*, October 2006.

Medical Costs Are On the Decline, While Denials of Both Claims and Medical Services Have Increased Over Time

Since the 76th Legislature passed House Bill (HB) 3697 in 1999 mandating a series of studies comparing the cost, quality and utilization of medical care provided to injured workers in Texas with injured workers in other states and other health care delivery systems, medical costs have been a concern in the Texas workers' compensation system. The results from these and other studies showed that Texas had some of the highest average medical costs per claim and that these costs were primarily driven by the amount of medical care provided to injured workers (also known as the utilization of care).[22] Additionally, compared with similarly injured workers in other states, these studies highlighted that Texas injured workers had poorer return-to-work outcomes and satisfaction with care. Growing concerns from policymakers and system participants about high medical costs and poor outcomes led to the passage of House Bill (HB) 2600 by the 77th Legislature in 2001, which included key components, such as:

- abolishing the former TWCC's consensus-based treatment guidelines;
- eliminating the spinal surgery second opinion process and requiring preauthorization for spinal surgeries;
- requiring medical necessity and preauthorization disputes to be reviewed by Independent Review Organizations (IROs) (i.e., panels of independent doctors certified by TDI);
- instituting a registration and training requirement for doctors treating injured workers (i.e., the Approved Doctor's List or ADL);
- increasing training requirements for doctors performing impairment rating examinations; and
- requiring the use of Medicare's reimbursement structure, payment policies, and coding requirements for medical billing.

Since the passage of HB 2600, a significant amount of attention has been placed on the issue of lowering medical costs through a reduction in the overutilization of medical services provided to injured workers. The issue of reducing medical costs and improving the quality of medical care provided to injured workers was also a key component driving the passage of a new health care delivery model in HB 7 – workers' compensation health care delivery networks.

For injuries occurring in 2001-2003, the median medical costs per claim continued to increase, however, the growth of these medical costs began to slow down compared to the double digit increases seen in prior years. Since 2003, the median medical costs per claim have actually declined for the first time since 1999 (see Figure 4). Continued monitoring is necessary to determine whether this medical cost decline will continue in the future.

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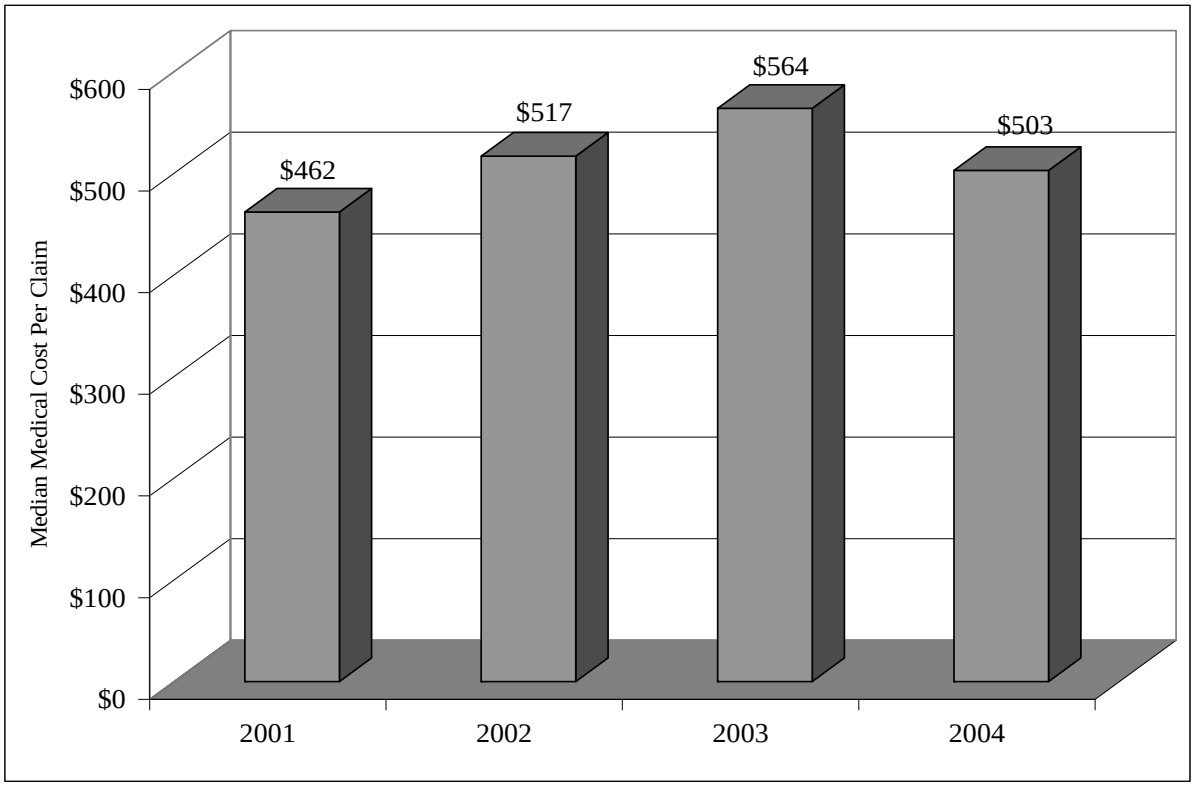
22 See Research and Oversight Council on Workers' Compensation, *Striking the Balance: An Analysis of the Cost and Quality of Medical in the Texas Workers' Compensation System: A Report to the 77th Legislature*, 2001; Research and Oversight Council on Workers' Compensation, *Returning to Work: An Examination of Existing Disability Duration Guidelines and Their Application to the Texas Workers' Compensation System: A Report to the 77th Legislature*, 2001; Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, Medical Cost and Quality of Care Trends in the Texas Workers' Compensation System, 2004; and Workers' Compensation Research Institute, *CompScope Benchmarks for Texas, 6th Edition*, 2006.

Figure 4: Median Medical Cost (Professional Services and Hospital Costs) Per Claim, One Year Post Injury, Injury Years 2001-2004

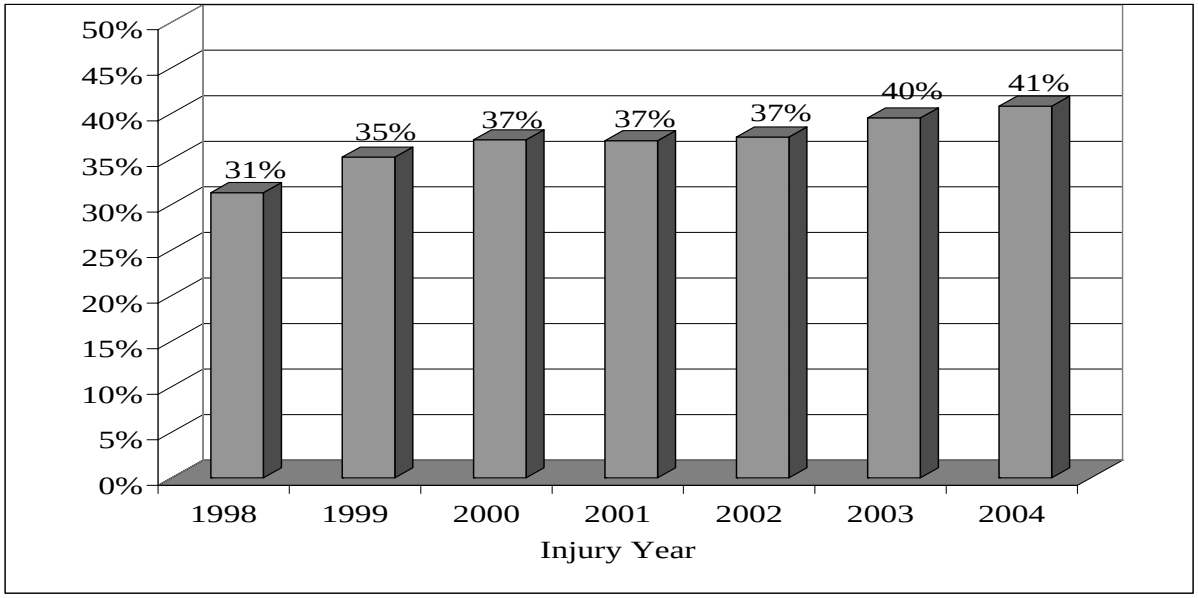


Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2006.
Note 1: There has also been a decline in the mean (average) medical cost per claim for this time period. However, since injury year data for 2004 is not yet complete, the mean medical cost per claim data has not been presented here.
Note 2: The medical costs presented here do not include pharmacy costs and some durable medical equipment. The Division has just recently begun collecting pharmacy data through the 837 medical billing format.

One possible reason why medical costs have begun to stabilize in Texas can be found by examining insurance carrier denials of both workers' compensation claims and medical services over time. Since 2001, both the percentage of reportable claims and the percentage of professional medical services initially denied/disputed have increased (see Figures 5 and 6). In particular, denials of professional medical services have almost doubled since the passage of HB 2600.[23]

23 It should be noted that these professional medical denials represent denials for medical treatments and services that have already been rendered. Preauthorization denials are not included in these numbers.

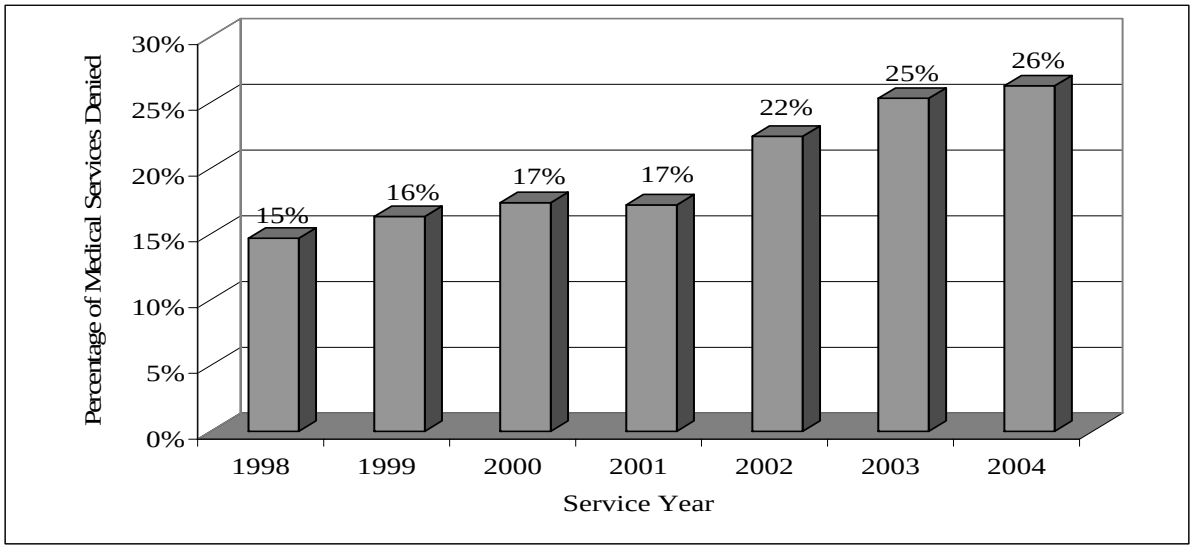
Figure 5: Percentage of Reportable Claims That Are Initially Denied/Disputed for the Top 25 Workers' Compensation Insurance Carriers, Injury Years 1998-2004[24]



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2006.
Note 1: The 2004 figures should be interpreted with caution since the data are incomplete.
Note 2: HB 2600, a reform bill aimed at reducing medical costs was passed in 2001.

24 The top 25 insurance carriers represent over 90 percent of the workers' compensation premiums in 2003 and 2004 and account for 60-70 percent of the total amount of medical payments made during 1998-2004. For the purpose of this analysis, the same 25 insurance carriers were used in each year to calculate both the claim and medical billing denial rates.

Figure 6: Percentage of Professional Medical Services Denied for the Top 25 Workers' Compensation Insurance Carriers, Service Years 1998-2004



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2006.
Note: The 2004 figures should be interpreted with caution since the data are incomplete.

The reasons insurance carriers gave for these medical billing denials have also changed significantly over time. Prior to 2001, the majority of professional medical billing denials were denied because of inappropriate or insufficient medical documentation provided in conjunction with the medical bill and because medical services were required to be preauthorized, but a preauthorization request was not made. Since 2001, the majority of these denials were the result of insurance carriers' determinations that the treatment being billed was not medically necessary (see Table 1). In particular, an increasing percentage of these denials are associated with the results of a peer review doctor's opinion requested by the insurance carrier.

Table 1: Percentage of Denied Professional Medical Services by the Top 10 Denial Reasons, Service Years 1998-2004

	1998	1999	2000	2001[3]	2002	2003	2004[1]
Unnecessary Treatment (without peer review)	10%	12%	12%	13%	25%	26%	22%
Unnecessary Treatment (with peer review)	<1%	<1%	1%	4%	13%	16%	15%
Inappropriate Documentation	36%	42%	39%	26%	21%	14%	10%
Preauthorization Required But Not Requested	19%	17%	16%	16%	3%	2%	2%
Not by Treatment Guidelines	13%	7%	8%	10%	4%	–	–
Entitlement to Benefits	6%	8%	9%	10%	9%	7%	7%
Extent of Injury	7%	6%	6%	7%	8%	8%	8%
Final Adjudication	<1%	<1%	<1%	<1%	<1%	<1%	2%
Unbundling	5%	4%	4%	5%	4%	7%	13%
Payment Policy	<1%	–	<1%	<1%	<1%	4%	11%
Other reasons[2]	4%	4%	5%	9%	13%	16%	11%

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2006.
Note 1: The 2004 figures should be interpreted with caution since these numbers are tentative and are current as of February 2005.
Note 2: "Other reasons" include "not timely filed," "not treating doctor," "inappropriate health care provider," "final adjudication," preauthorization requested, but denied."
Note 3: The most recent professional medical fee guideline, which incorporated Medicare's payment policies, went into effect in August 2003.

Access to Care Remains a Concern in the System, but Results Are Mixed

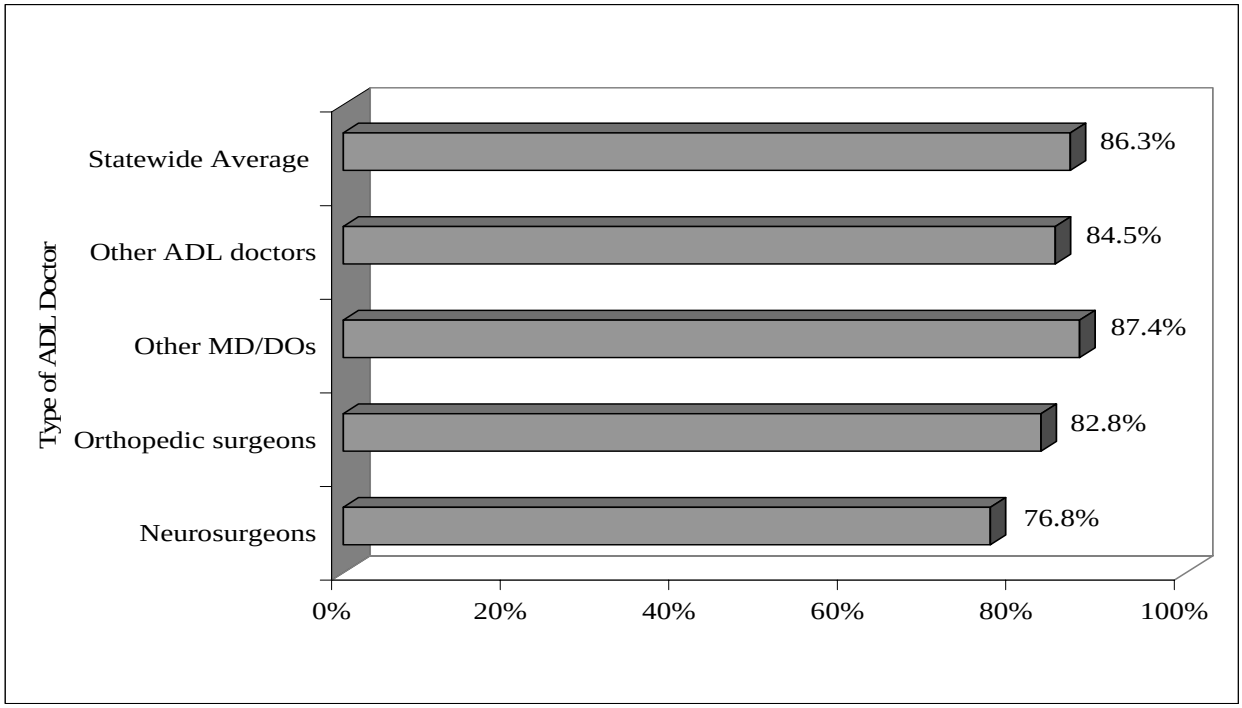
Policymakers and system participants continue to express widespread concern that fewer health care providers are treating injured workers in Texas than in earlier years. Anecdotal evidence suggests that health care providers face a barrier of administrative "hassle factors" in the workers' compensation system that they do not generally experience in group health arrangements. Further, 31 percent of injured workers surveyed in 2005 say that getting medical care for their on-the-job injuries is a "big problem" while 12 percent said that their experience in scheduling medical appointments for their work-related injuries was worse than scheduling appoints for their regular health care.[25] However, recent analyses of medical billing data as well as recent surveys of doctors of the Division's Approved Doctor List (ADL) demonstrate the complex nature of this issue.[26]

25 See Texas Department of Insurance, Workers' Compensation Research and Evaluation Group and the Public Policy Research Institute (PPRI) at Texas A&M University, *2005 Injured Worker Survey Results*, 2006.

26 With the passage of HB 2600 in 2001, all doctors who want to treat injured workers (including medical doctors, doctors of osteopathy, chiropractors, dentists and podiatrists) must register to be on the Division's Approved Doctors' List (ADL). Doctors who register must receive some basic training on workers' compensation billing and reimbursement rules, as well as other workers' compensation issues such as return-to-work. Only doctors who are registered on the ADL or have received a temporary exception from the Division to treat injured workers may be reimbursed for their services in the Texas workers' compensation system.

Currently there are over 18,000 health care providers registered on the ADL which includes 1,200 providers with temporary exceptions granted so they may treat injured workers. Approximately 86.3 percent of ADL provider offices surveyed by the Division in August 2006 indicated that they were currently accepting workers' compensation patients; however, this does not necessarily mean that they have not placed restrictions on the types of patients they are currently accepting. These surveys revealed that the percentage of ADL providers who say they are accepting workers' compensation patients does vary geographically and by medical specialty. Only about two-thirds of the surveyed ADL providers in West Texas said they were accepting workers' compensation patients, compared to nearly all of the ADL providers surveyed in Central Texas. Generally a lower percentage of ADL "specialist" providers, such as neurosurgeons and orthopedic surgeons indicated that they were accepting workers' compensation patients, compared with "primary care" providers (see Figure 7).

Figure 7: Percentage of Doctors on the Approved Doctors' List (ADL) Who Indicated That They Were Currently Accepting Workers' Compensation Patients by Type of ADL Doctor



Source: Texas Department of Insurance, Division of Workers' Compensation, Survey of the Approved Doctors' List (ADL), August, 2006.

In the vast majority of geographic locations where ADL providers said they were accepting workers' compensation patients (80 percent), ADL providers indicated that they were accepting both new and existing workers' compensation injuries. For those ADL providers who said they are not currently accepting workers' compensation patients, the most frequent reasons cited for not accepting workers' compensation patients included problems identifying who the insurance carrier is and contacting adjustors; problems with reimbursement delays or denials; fee issues; the amount of paperwork required for workers' compensation claims; and problems with the preauthorization process.

In addition to the results of the Division's ADL provider survey, a recent analysis of the Division's historic medical billing data suggest that from 1999-2004, the number of injuries treated per health care provider changed little over time (see Table 2).[27] It is important to note that this analysis has been restricted to the medical billing records during the first six months of 1999-2004 in an effort to provide an "apples to apples" comparison since medical billing data in late 2004 and all of 2005 are currently incomplete. TDI is currently in the process of collecting this data and plans to update this analysis once data collection has been completed.

Although there are fewer health care providers (both ADL and non-ADL providers) who treated injured workers in 2004 than in previous years (approximately 41,228 providers treated workers during the first six months of 2004 compared to 43,538 providers in 2002), the average patient caseload for most health care provider types did not increase significantly (see Table 2). This is primarily due to the fact that there were fewer injuries reported in the workers' compensation system in 2004 than in previous years, as a result of both decreasing injury rates (see Figure 1 – injury rates) and fewer injured workers covered by workers' compensation coverage (see Figure 3 – nonsub rates).

Table 2 shows that medical doctors treated an average of 15.6 injuries during the first six months of 2004, after slight increases in the previous three years; however, this average caseload was still lower than what the system saw during the first six months of 1999. Similarly, average caseloads for both chiropractors and physical therapists increased from 1999/2000-2001, but then began to decrease starting in 2003. Only osteopaths had a higher ratio of injuries to doctors in 2004 than in any of the previous years in the study.

27 For more information on access to care, see Texas Department of Insurance Workers' Compensation Research and Evaluation Group, *Access to Medical Care in the Texas Workers' Compensation System*, 2006.

Table 2: (Number of Injuries Treated per Doctor) and Total Number of Injuries by Type of Health Care Provider, Jan – June 1999-2004

Provider Types	Jan - June 1999	Jan - June 2000	Jan - June 2001	Jan - June 2002	Jan - June 2003	Jan - June 2004
Medical Doctors (MD)	(16) 328,720	(15.3) 317,453	(14.4) 304,378	(14.7) 320,977	(15) 314,471	(15.6) 280,419
Chiropractors (DC)	(4.8) 28,199	(5.5) 34,452	(7.2) 42,364	(7.7) 45,197	(7.3) 43,476	(5.6) 26,044
Physical/Occupational Therapists (PT/OT)	(5.8) 48,059	(5.3) 48,561	(6) 58,064	(6.2) 62,780	(6.3) 66,270	(4.1) 63,566
Doctor of Osteopathy (DO)	(20.5) 29,910	(20.4) 30,839	(19.6) 30,141	(20.2) 32,133	(21.3) 32,133	(23.7) 32,209

Source: Texas Department of Insurance Workers' Compensation Research and Evaluation Group, 2006.
Note 1: There may be double counting if the injured worker was treated by multiple providers.
Note 2: The 2004 totals may reflect changes after the implementation of the Approved Doctor List in September 2003.

An important issue driving many of the concerns about access to care is the timeliness of medical care received by injured workers. If there are problems with access to care, injured workers may have to wait longer periods of time in order to receive medical treatment. A review of the Division's medical billing data from 1999-2004 reveals that 80 percent of workers injured in 2004 received medical treatment in the first week after their injuries, compared to 68 percent in 2001. Additionally, 44 percent of workers injured in 2004 who were treated by medical doctors (MDs) for non-emergency injuries were treated on the same day of the injury - up from 36 percent in 1999. Of workers injured in 2004 who were treated by osteopaths (DOs) for non-emergency injuries, 43 percent were treated on the same day of the injury, compared to 38 percent in 1999.

Market concentration analyses also showed that roughly the same percentage of health care providers is actively treating a majority of Texas injured workers. Approximately 16 percent of health care providers (about 7,000 providers, including both ADL and non-ADL providers) treated 80 percent of workers in 2004. This percentage has remained relatively unchanged for the last three consecutive years of the study.

These statistics combined with the Division's ADL survey results suggest that there is not a significant gap in access to basic primary care for most work-related injuries. However, there do appear to be issues with access to care in areas of the state that are traditionally medically underserved (i.e., West Texas) and in specialty care services statewide, particularly services such as neurosurgery and orthopedic surgery. Additionally, roughly 45 percent of workers injured in 2004 received medical treatment from doctors not on the ADL, which may indicate that the ADL alone may not be sufficient to treat the injured worker population.

The Division will continue to monitor the issue of access to care and is evaluating ways to reduce administrative burdens for health care providers who actively participate in the system. Some of these initiatives include the implementation of electronic medical billing rules; the adoption of treatment guidelines and treatment planning rules to bring more certainty to what is considered "medically necessary" for work-related injuries; and the streamlining of medical dispute resolution processes. Additionally, the elimination of the ADL registration requirement by HB 7 starting in

September 1, 2007 (or earlier if determined by the Commissioner of Workers' Compensation) will remove another perceived barrier by allowing participation by any health care provider who wishes to treat injured workers and complies with the Division's financial reporting requirements.

It should also be noted that the simultaneous implementation of workers' compensation health care delivery networks will also have an impact on the number of health care providers treating injured workers in the future. Further analyses with more current data will be needed to track the impact of these changes and to identify emerging access to care trends in the Texas workers' compensation system in future years.

Return-to-Work Rates Are Improving Slightly

One of the most basic objectives of the Texas workers' compensation system is to return injured workers to safe and productive employment. Previous studies by both the Research and Oversight Council on Workers' Compensation (ROC) and the Workers' Compensation Research Institute (WCRI) indicated that compared to similarly injured workers in other states, Texas injured workers were generally off work for longer periods of time and were more likely to report that their take-home pay was less than their pre-injury pay.[28] Armed with these study findings, policymakers and system participants have placed considerable attention on improving return-to-work outcomes in recent years.

Additionally, several components of HB 7 place additional focus on the importance of return to work, including a requirement for the Division to adopt return-to-work guidelines; the institution of a return-to-work pilot program geared toward small employers (i.e., less than 50 employees); greater coordination of vocational rehabilitation referrals between the Division and the Department of Assistive and Rehabilitation Services (DARS); changes in the work-search requirements for injured workers who qualify for Supplemental Income Benefits (SIBs); and the ability for the Division to adopt disability management rules that include the coordination of treatment plans and return-to-work planning.

Since 2001, there has been a slight increase in the percentage of injured workers receiving Temporary Income Benefits (TIBs) (i.e., injured workers with more than seven days of lost time) who have initially returned to work post-injury. Of those workers injured in 2001 receiving TIBs, 70 percent initially returned to work within six months post-injury, compared to 74 percent of workers injured in 2004 (see Table 3).[29]

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28 See Research and Oversight Council on Workers' Compensation, *Returning to Work: An Examination of Existing Disability Duration Guidelines and Their Application to the Texas Workers' Compensation System: A Report to the 77th Legislature*, 2001; and Workers' Compensation Research Institute, *CompScope Benchmarks for Texas, 6th Edition*, 2006.

29 For more information on these and other return-to-work statistics, see Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, *Return-to-Work Outcomes for Texas Injured Workers*, 2006.

Table 3: Percentage of Injured Workers Receiving TIBs Who Have Initially Returned to Work (6 months to 3 years post-injury)

Injury Year	Within 6 Months Post-Injury	Within 1 Year Post-Injury	Within 1.5 Years Post-Injury	Within 2 Years Post-Injury	Within 3 years Post-Injury
2001	70%	79%	83%	85%	88%
2002	71%	80%	84%	86%	
2003	72%	81%	85%		
2004	74%				

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2006.
Note 1: The study population includes 217,498 workers injured in 2001-2003 who also received Temporary Income Benefits (TIBs).
Note 2: Although the increases of initial return-to-work rates were small, they were statistically significant at the 0.01 significance level.

While the percentage of injured workers who initially return to work is an important benchmark of system performance, whether these injured workers remain employed once they go back to work is a more accurate measure of the system's ability to promote "successful" return to work. As Table 4 indicates, the percentage of injured workers receiving TIBs who have initially returned to work and remained employed for at least three successive quarters (or nine months) has also increased slightly since 2001.

Table 4: Percentage of Injured Workers Receiving TIBs Who Have Initially Returned to Work and Remained Employed for Three Successive Quarters (6 months to 3 years post-injury)

Injury Year	Within 6 Months Post-Injury	Within 1 Year Post-Injury	Within 1.5 Years Post-Injury	Within 2 Years Post-Injury	Within 3 years Post-Injury
2001	61%	68%	73%	76%	80%
2002	62%	70%	74%	77%	
2003	64%	71%			

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2006.
Note 1: The study population includes 217,498 workers injured in 2001-2003 who also received Temporary Income Benefits (TIBs).
Note 2: Workers injured in 2004 were excluded from this portion of the analysis due to insufficient data.

Not only have the percentage of injured workers who returned to work and remained employed improved slightly since 2001, but the amount of time the average injured worker who received TIBs is off work after an injury has decreased somewhat since 2001 (see Table 5).

It will be important to continue to monitor these return-to-work measures on a continuous basis to track the impact of recent legislative reforms, including the implementation of workers' compensation health care delivery networks, on return-to-work outcomes in Texas.

Table 5: Mean and Median Days Off Work for Injured Workers Who Returned to Work At Some Point Post-Injury, Injury Years 2001-2003

Injury Year	Mean Days	Median Days
2001	150	32
2002	140	31
2003	115*	30*

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2006.
Note 1: The mean and median days off work in 2003 may be under-estimated due to data maturity and should be viewed with caution.
Note 2: "Days Off Work" was defined as days from the injury date to the initial RTW date. Please note that these numbers do not take into account any additional time off work that may have occurred after the initial return-to-work date.
Note 3: The analysis was based on the claimants who returned to work, and did not include those who did not return to work by the end of 2005. Injury year 2004 was excluded because of insufficient data.

Injured Workers' Perceptions of the System Have Not Significantly Changed Over Time

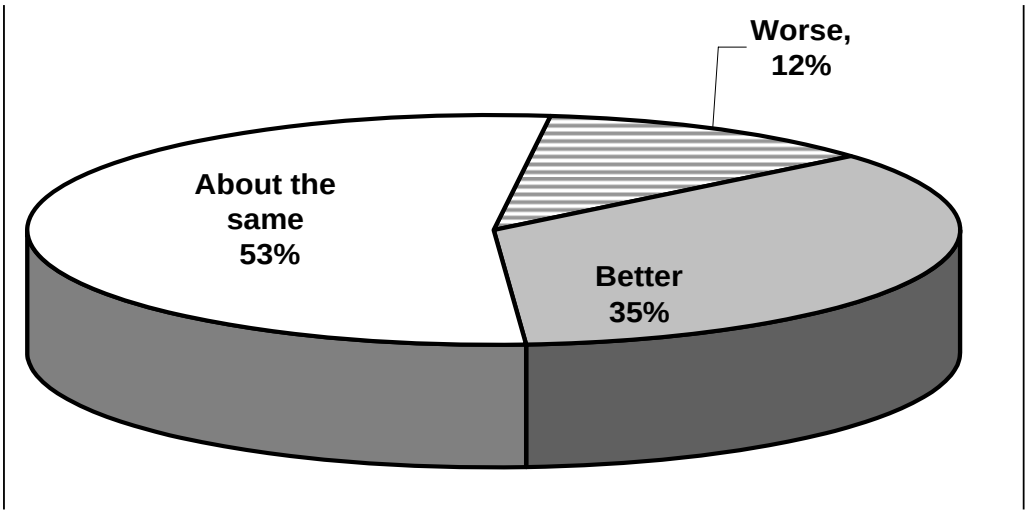
A key determinant of the health of any workers' compensation system is the perception of the people who are most directly affected by the system itself - injured workers. In an effort to continuously gauge workers' observations about system trends, TDI's Workers' Compensation Research and Evaluation Group (REG) and its predecessor, the ROC conducted a series of surveys with injured workers on issues such as access to care, satisfaction with care, return to work, and workers' physical and mental functioning abilities post-injury (i.e., workers' abilities to physically recover to a state close to where they were pre-injury).[30] Workers were surveyed in 2000, 2002 and most recently in 2005, just prior to the implementation of HB 7.

The results of these surveys are remarkably consistent and show little change in injured workers' perceptions over time. Injured workers' physical and mental functioning remains significantly worse than the general U.S. population and injured workers who had returned to work consistently reported better functioning than workers who had not returned to work.

Additionally, injured workers' evaluations regarding their ability to schedule a doctor's appointment compared to their normal health care have not changed significantly since 2002. Figure 8 shows that 35 percent of injured workers surveyed reported that their ability to schedule a doctor's appointment for their work-related injury was better than their normal health care experiences, while 53 percent reported that it was "about the same" and only 12 percent reported that their ability to schedule a doctor's appointment was "worse" than their normal health care.

30 See Research and Oversight Council on Workers' Compensation, *Striking the Balance: An Analysis of the Cost and Quality of Medical in the Texas Workers' Compensation System: A Report to the 77th Legislature*, 2001; Research and Oversight Council on Workers' Compensation, *Survey of Injured Workers Regarding Work-Related Health Problems: Comparison of State and Private Sector Worker Experiences*, 2003; and the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, *2005 Injured Worker Survey Results*, 2006.

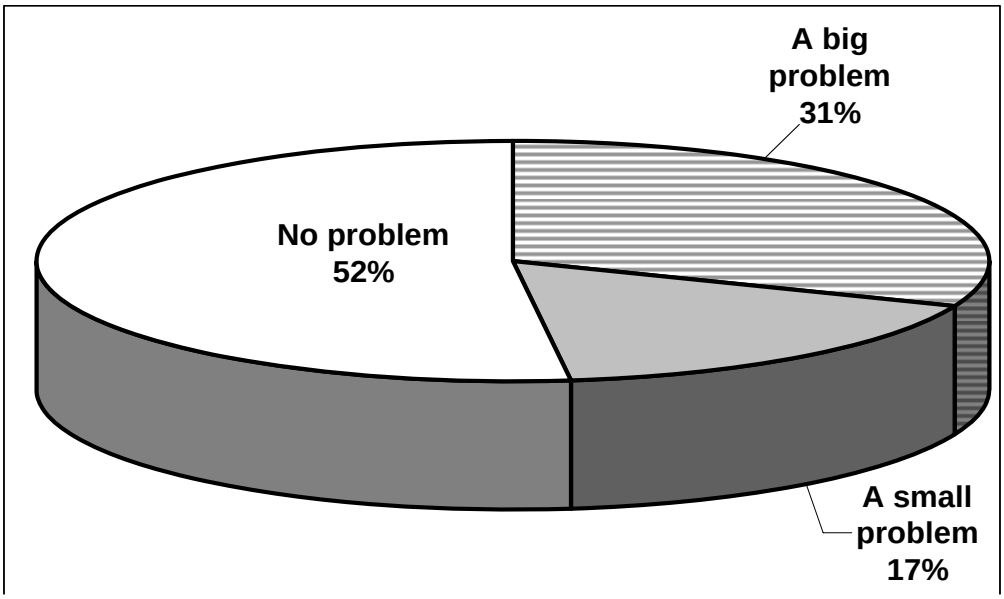
Figure 8: Compared to the medical care you usually receive when you are injured or sick, your ability to schedule a doctor's appointment for your work-related injury or illness was:



Source: *2005 Injured Worker Survey* from the Texas Department of Insurance Workers' Compensation Research and Evaluation Group and the Public Policy Research Institute (PPRI) at Texas A&M University.

Although few injured workers reported problems with the scheduling of doctor appointments, a significant percentage (48 percent) reported having "some" or "big" problems getting the medical care they or their treating doctor felt was necessary (see Figure 9). When questioned further, injured workers attributed these problems to their perception that the insurance carrier did not want the care to be provided (64 percent), that there was difficulty properly diagnosing their injury (35 percent), that they couldn't get an appointment to see a specialist soon enough (33 percent) or that travel to get medical care was too difficult to arrange (20 percent).

Figure 9: Percentage of Injured Workers Surveyed Who Reported Having Problems Getting the Medical Care They Needed for Their Injury

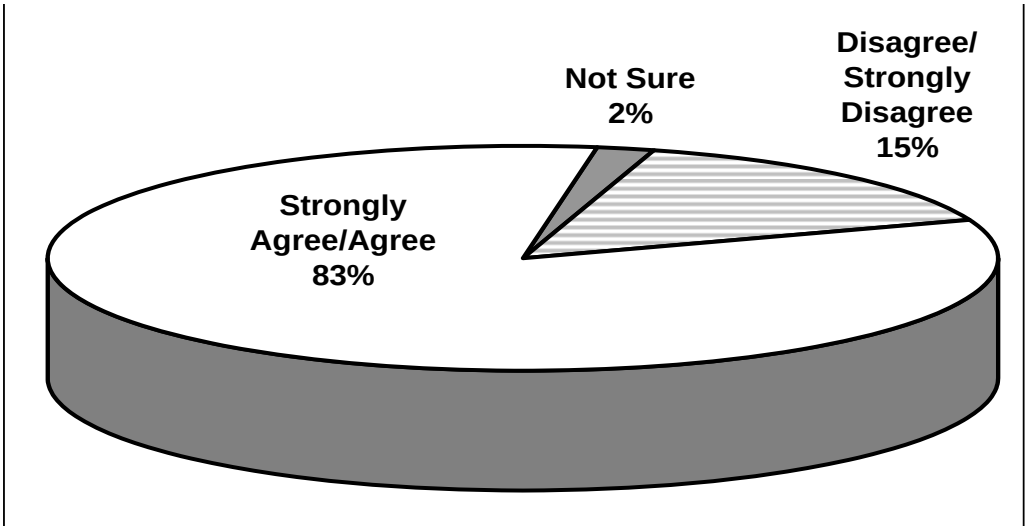


Source: *2005 Injured Worker Survey* from the Texas Department of Insurance Workers' Compensation Research and Evaluation Group and the Public Policy Research Institute (PPRI) at Texas A&M University.

Consistent with survey findings in 2000 and 2002, approximately 83 percent of injured workers surveyed in 2006 reported that they received good medical care that met their needs (see Figure 10). It should be noted that while these percentages appear high, the 2001 ROC *Striking the Balance* study and recent injured worker surveys conducted by WCRI illustrate that Texas injured workers reported less satisfaction with the medical care they received compared to similarly injured workers in other states.[31] Given the constancy of workers' perceptions about the Texas workers' compensation system since 2000, it will be important to see how the implementation of workers' compensation health care delivery networks affects workers' perceptions regarding access to care and satisfaction with care over time.

31 The *Striking the Balance* study published by the ROC in 2001 found that 81 percent of injured workers from other states reported that they received good medical care that met their needs compared to only 73 percent of injured workers in Texas. See Research and Oversight Council on Workers' Compensation, *Striking the Balance: An Analysis of the Cost and Quality of Medical in the Texas Workers' Compensation System: A Report to the 77th Legislature*, 2001.

Figure 10: Percentage of Injured Workers Surveyed Who Indicated That the Doctor They Saw Most Often for Their Work-Related Injury Provided Them with Good Medical Care That Met Their Needs



Source: *2005 Injured Worker Survey* from the Texas Department of Insurance Workers' Compensation Research and Evaluation Group and the Public Policy Research Institute (PPRI) at Texas A&M University.

Indemnity and Medical Dispute Trends

One aspect of income and benefit delivery that has been scrutinized in recent years is the process by which indemnity and medical disputes are resolved by the agency. HB 7 made several changes in an effort to help streamline these dispute processes, including the elimination of appeals of medical disputes to the State Office of Administrative Hearings (SOAH) and the limitation of two Benefit Review Conferences (BRCs) per indemnity dispute. Since the implementation of these legislative changes cannot yet be effectively measured, this section examines the status of indemnity and medical dispute resolution just prior to the implementation of HB 7.

As Table 6 illustrates, the top ten most frequently disputed indemnity issues have not changed significantly from 2002-2005.[32] The most frequently disputed issues continue to be disputes over whether the injured worker's disability is related to an on-the-job injury (approximately 20 percent

32 Workers' compensation indemnity disputes are handled through a multi-tiered administrative dispute resolution process administered by the Division. Staff at the Division's local field offices initially attempt to resolve disputes informally. Approximately 40 percent of disputes are resolved this way. If a dispute cannot be resolved informally, the parties move on to the first step of the administrative dispute process – the Benefit Review Conference (BRC) – which is an informal mediation between the injured worker and the insurance carrier presided by one of the Division's Benefit Review Officers. Disputes that cannot be resolved through BRC mediation move on to the Contested Case Hearing (CCH) level, which consists of a formal hearing presided by one of the Division's Contested Case Hearing Officers. Decisions are rendered at this level. Parties unhappy with the CCH decision may appeal it to the Division's Appeals Panel (AP), which consists of a paper review of the CCH decision by three administrative law judges. Parties still unhappy with the results of the AP review may appeal their dispute to district court. Less than 1 percent of indemnity disputes are appealed to district court each year. Injured workers participating in the Division's indemnity dispute process may be represented by attorneys, assisted by ombudsmen through the OIEC or represent themselves during dispute proceedings.

of indemnity disputes); disputes over the extent of the worker's injury (approximately 14 percent of indemnity disputes); disputes over whether the injury is work-related (i.e., compensability) (approximately 12 percent of indemnity disputes); and disputes over the worker's average weekly wage (approximately 9 percent of indemnity disputes).

Table 6: Distribution of Top 10 Most Frequently Disputed Indemnity Issues by Formal Request Year at the Division's Benefit Review Conference (BRC) Level

Issues	BRC Formal Request Year			
	2002	2003	2004	2005
Other issues	22%	22%	22%	22%
Existence/duration/extent of disability raised by other evidence	21%	20%	19%	20%
Extent of injury	12%	13%	14%	14%
Compensability/injury existence	12%	12%	11%	12%
Amount of average weekly wage	10%	10%	9%	9%
Designated doctors impairment rating	7%	8%	8%	7%
Designated doctors MMI date	5%	6%	7%	5%
Reporting injury to employer	3%	3%	3%	3%
SIBs entitlement/subsequent quarters	2%	2%	3%	3%
Compensability/occupational disease	3%	3%	2%	2%
Timely contest by carrier	2%	3%	2%	3%
Total	49,372	49,724	47,325	36,351

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2006.

One of the issues driving the need to streamline dispute resolution in the workers' compensation system was the amount of time it takes to resolve disputes that proceed all the way through the various levels of the indemnity dispute process. It should be noted that between 70-80 percent of disputes get resolved either prior to a request for a BRC or at the BRC mediation level; however, for the remaining 20-30 percent of disputes that proceed beyond the BRC level, resolution of these disputes may take 5-7 months through the Division's administrative process, depending on whether disputes are appealed to the CCH and then to the AP level of the process.[33] As Table 7 shows, the average number of days to resolve indemnity disputes has increased during 2002-2005.

33 Although the vast majority of disputed indemnity issues brought to a BRC are still resolved at the BRC level without being appealed further, recent changes to the way BRCs are handled (i.e., more like mediation) have resulted in an increase in the percentage of these disputes not being resolved at the BRC level.

Starting in 2005, the Division has made efforts to reduce these timeframes while implementing the various provisions of HB 7. Continued monitoring will be necessary to determine the extent to which the HB 7 provisions geared towards reducing dispute resolution timeframes are successful.

Table 7: Average Number of Days from Formal BRC Request to Completion of BRC or Issuance of Indemnity Dispute Decision by Year Dispute Was Resolved and Final Resolution Level

Resolution Year	From Formal BRC Request to Completion of BRC (Disputes Stopped at BRC)	From Formal BRC Request to Issuance of Final Decision at CCH (Disputes Stopped at CCH)	From Formal BRC Request to Issuance of Final Decision at AP (All Disputes Appealed to AP)
2002	118	148	217
2003	122	153	227
2004	124	157	238
2005	123	149	235

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2006.

The distribution of indemnity dispute decisions made by Division CCH Officers has not changed significantly from 2002-2005 (see Table 8). Approximately 44 percent of indemnity disputes brought before a CCH are decided against the injured worker and 43 percent are decided in favor of the injured worker. An additional 12 percent of these disputes are resolved by mutual agreement between the disputing parties.

Table 8: Outcomes of Indemnity Disputes at the Division's Contested Case Hearing (CCH) Level by Year Dispute Was Resolved

Resolution Year	Against Injured Worker	For Injured Worker	Resolved By Agreement
2002	44%	45%	11%
2003	44%	45%	10%
2004	43%	45%	12%
2005	44%	43%	12%

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2006.

In addition to indemnity disputes, the Division also administers a process for resolving medical disputes, including fee disputes, preauthorization disputes (i.e., disputes regarding the medical necessity of certain medical services that require pre-approval from the insurance carrier), and retrospective medical necessity disputes (i.e., disputes regarding the medical necessity of medical services that have already been rendered to the injured worker).[34] Table 9 provides information on the number and distribution of medical disputes received by the Division from 2002-2005.

Table 9: Number and Distribution of Medical Disputes Submitted to the Division by Type of Medical Dispute, 2002-2005 (as of March, 2006)

Received Year	Pre-authorization Disputes	Fee Disputes	Retrospective Medical Necessity Disputes	Total
2002	15%	58%	27%	(8,910) 100%
2003	11%	70%	19%	(17,501) 100%
2004	13%	61%	26%	(14,315) 100%
2005	12%	71%	17%	(13,468) 100%

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2006.
Note: The number of fee disputes submitted to the Division (formerly TWCC) increased significantly from 2002 to 2003 due to the adoption of a new professional medical fee guideline, which incorporated Medicare's payment policies in August 2003. Additionally, a significant number of pharmacy disputes were submitted in 2003 (approximately 4,000) by a handful of health care providers. Most of these disputes were later withdrawn.

Policymakers and system participants continue to scrutinize the amount of time it takes for medical disputes to be resolved in the workers' compensation system. In particular, policymakers are concerned with the timeframe to resolve preauthorization disputes since these are disputes regarding the medical necessity of care (such as surgery) that has not yet been provided to the injured worker. As Table 10 indicates, the number of days it takes to resolve preauthorization disputes and retrospective medical necessity disputes has significantly improved since 2002, although the agency continues to seek ways to further reduce these dispute durations. The amount of time it takes to resolve fee disputes, on the other hand, has increased since 2002 as the frequency of these disputes increased. Because of the number of fee and retrospective medical necessity disputes that are still unresolved, dispute durations for 2005 are excluded in Table 10.

It will be important to track these dispute frequencies and durations once the implementation of workers' compensation health care delivery networks is in full swing. Since fee disputes for network medical care are handled internally by these networks rather than the Division and since

34 In accordance with HB 2600 in 2001 and HB 7 in 2005, medical fee disputes for services not provided by workers' compensation networks are resolved by Division staff, while preauthorization and retrospective medical necessity disputes (for both network and non-network services) are reviewed by Independent Review Organizations (IROs) (i.e., panels of independent doctors certified by the TDI). Parties dissatisfied with the results of the Division's fee dispute review or the IRO review may appeal the decision directly to district court, rather than to the State Office of Administrative Hearings (SOAH). The constitutionality of eliminating SOAH appeals has been challenged recently in Travis County District Court.

the Division is in the process of adopting new fee guidelines for outpatient and inpatient hospital services, it is expected that fee dispute frequencies will decline in the future.

Table 10: Mean and Median Number of Days to Resolve Medical Disputes (Aggregate Duration, as of March, 2006)

Year Dispute Received	Pre-authorization		Fee		Retrospective Medical Necessity	
	Mean	Median	Mean	Median	Mean	Median
2002	107	85	259	218	230	189
2003	58	48	509	559	185	150
2004	53	43	353	347	144	115
2005	57	53	N/A	N/A	N/A	N/A

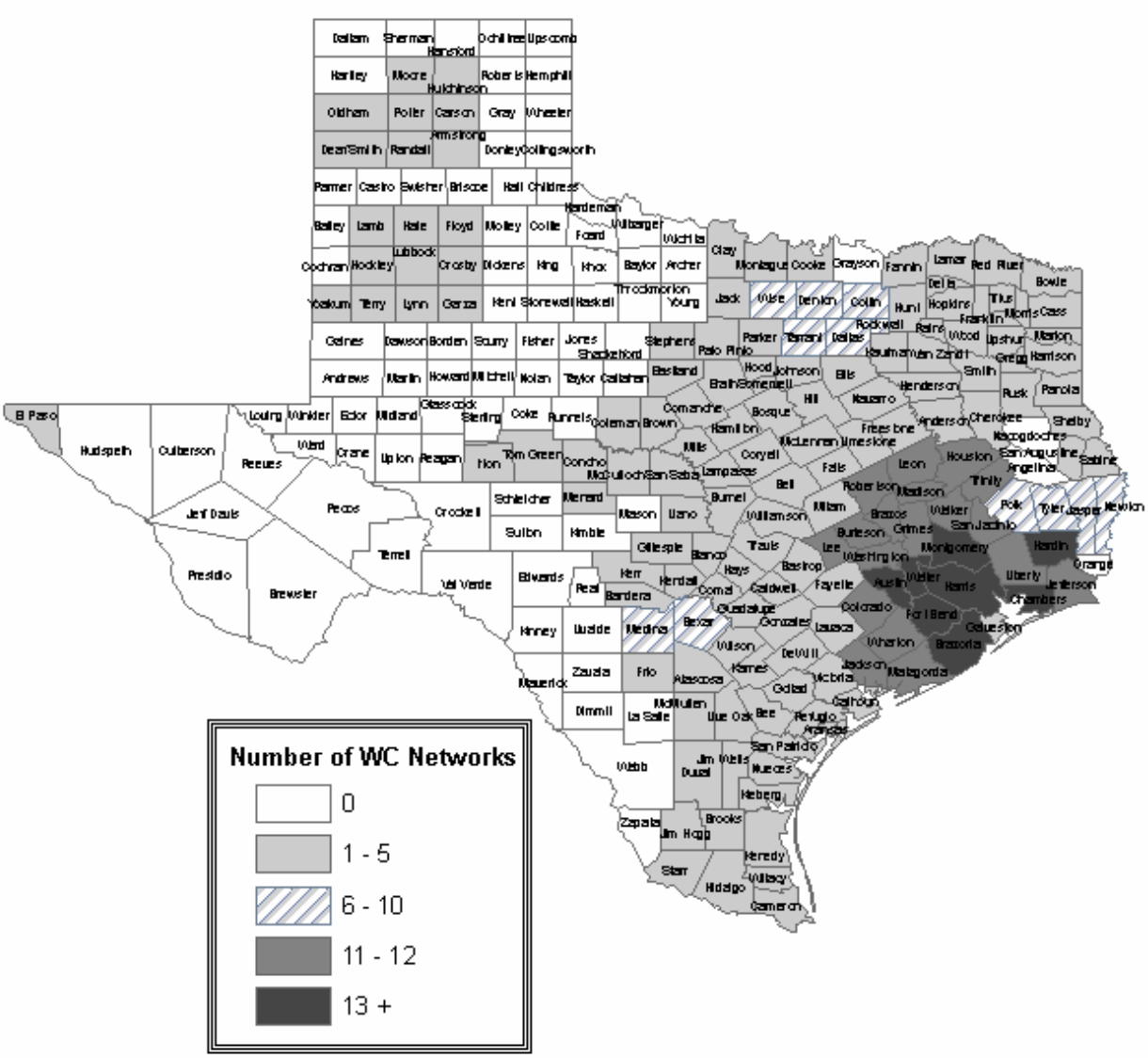
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2006.
Note 1: These dispute resolution durations were only calculated for disputes that had been concluded as of March 2006 – disputes that were withdrawn or dismissed were excluded from the analysis. Hospital disputes, disputes submitted without DWC-60 and disputes with incorrect jurisdiction were also excluded. The duration includes the period from IRO decision date to case closure date.
Note 2: Dispute durations for 2005 are incomplete and should be viewed with caution since as of March 2006, there were still 89 preauthorization disputes, 6,473 fee disputes and 218 retrospective medical necessity disputes that were received in 2005 and had not yet been resolved, and therefore the mean and the median durations in 2005 would be significantly understated.

The Implementation of Workers' Compensation Networks Has Begun in Texas

TDI began accepting applications for the certification of workers' compensation health care networks on January 2, 2006. As of November 1, 2006, TDI has certified 17 networks extending over 164 counties. The shaded counties shown in Figure 11 are Texas counties included in the service area of at least one certified network as of November 1, 2006.

Currently, these certified networks are concentrated in counties primarily located in central, northeast, and southeast Texas. In addition, several Texas panhandle counties and one west Texas county have also been incorporated into the service areas of a certified workers' compensation network. As can be inferred from Figure 11, the networks that have been certified as of the writing of this report will primarily cater to injured workers in the larger metropolitan areas.

Figure 11 The Number of Certified Workers' Compensation Networks per Texas County (as of November 1, 2006)



Source: Texas Department of Insurance, Health and Workers' Compensation Network Certification and Quality Assurance Division, 2006.

Although more than one-third of Texas counties do not currently have coverage from a certified network, the concentration of networks in selected Texas metropolitan areas is not surprising given the distribution of reportable claims by the injured worker's residence county. Table 11 shows the distribution of 2004 workers' compensation reportable claims by the county of residence and metropolitan area of residence for the injured worker.[35] In 2004, 86 percent of

35 2004 claim data was used for this report since it represents the most current and complete year in which claim data can be analyzed as of November 1, 2006.

workers' compensation reportable claims were filed by injured workers living in a major Texas metropolitan area.

Table 11: Distribution of Workers' Compensation Reportable Claims by the Major Metropolitan Statistical Areas (MSA) of Residence for Workers Injured in 2004[1]

Texas Metropolitan Statistical Areas (MSA)	Percentage of Reportable Claims	Number of Reportable Claims	Number of Networks in MSA
Dallas/Fort Worth/Arlington	26.6%	41,558	8
Houston/Sugar Land/Baytown	21.1%	33,084	14
San Antonio	8.7%	13,640	6
Austin/Round Rock	5.6%	8,762	5
El Paso	3.7%	5,746	3
McAllen/Edinburg/Mission	2.9%	4,467	4
Corpus Christi	1.8%	2,778	4
Beaumont/Port Arthur	1.7%	2,623	13
Brownsville/Harlingen	1.7%	2,637	3
Killeen/Temple/Fort Hood	1.4%	2,168	3
Lubbock	1.4%	2,163	4
Waco	1.1%	1,670	3
Amarillo	1.0%	1,508	3
Laredo	0.9%	1,472	0
Tyler	0.9%	1,445	4
College Station/Bryan	0.8%	1,176	11
Longview	0.8%	1,324	4
Odessa	0.7%	1,048	0
Abilene	0.6%	990	0
Wichita Falls	0.6%	936	1
Midland	0.5%	758	0
Sherman/Denison	0.5%	768	0
Victoria	0.5%	838	3
San Angelo	0.4%	639	3
Texarkana	0.3%	474	1
Total	86.2%	134,672	17

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2006.
[1]Note: Approximately 2,336 (2%) claims were missing information regarding the injured worker's county of residence.

The metropolitan area with the highest number of reportable claims is the Dallas/Fort Worth/Arlington area (26.6 percent). Eight of the seventeen certified WC networks include the Dallas/Fort Worth/Arlington metropolitan area in their service area. The Houston/Sugar Land/Baytown metropolitan area contains the second highest number of reportable claims (21.1 percent). All but three of all the currently certified workers' compensation networks include the Houston/Sugar Land/Baytown metropolitan area in their service area. The San Antonio metropolitan area contains the third highest number of WC reportable claims (8.7 percent). Six of the eighteen certified workers' compensation networks cover the San Antonio metropolitan area in their service area. Together these three metropolitan areas made up approximately 56 percent of

workers' compensation reportable claims in 2004. Overall, the current distribution of certified workers' compensation networks is primarily concentrated in the metropolitan areas and surrounding counties with the highest concentration of reportable workers' compensation claims.

To gather some basic information regarding the current usage of certified workers' compensation networks by insurance carriers in Texas and the availability of these network plans to Texas employers, TDI initiated a data call in September 2006 with thirteen of the largest workers' compensation insurance carrier groups. Overall, these 13 insurance carrier groups represent about 84 percent of the direct workers' compensation premium written as of the second quarter of 2006. The purpose of this data call was to collect initial estimates regarding the percentage of insurance carriers that have contracted with or established a certified network, as well as initial estimates regarding the number and percentage of Texas policyholders (employers) and workers' compensation claims (injured workers) that are currently participating or will likely participate in a certified network during 2007 and 2008.

Given the infancy of the implementation of workers' compensation networks, these estimates should be viewed as preliminary and subject to change. Key findings from this data call revealed:

- Nine out of the thirteen insurance carrier groups surveyed reported that they had contracted with or established a certified workers' compensation network as of September 1, 2006.
- Of those insurance carriers that had not contracted with or established a certified network as of September 1, 2006:
  1) Two companies reported being in the final stages of the certification process or waiting for approval;
  2) One company reported that it was very likely that their group as a whole or some of their companies would contract with or establish a certified network within the next six months; and
  3) Only one company reported that they were not sure if their group or any of their member companies would contract with or establish a certified workers' compensation network.
- Six out of the nine insurance carriers with a certified network had already begun offering their networks to policyholders.
- Eight out of the nine insurance carriers with an established certified network were offering or planned to offer a network credit to policyholders who agreed to participate in their network.
- Only three insurance carriers reported that they had policyholders who have agreed to participate in their certified networks as of September 1, 2006.
- Seven of the nine insurance carriers who reported that they had already contracted with or established a network projected that the participation of both policyholders and injured workers in their certified network would increase significantly by the end of 2007.
- By the end of 2007, nine of the insurance carriers surveyed reported that approximately 29,634 claims (injured workers) would be treated by certified WC networks; and

- By the end of 2008, nine of the insurance carriers surveyed reported that approximately 50,840 claims (injured workers) would be treated by certified WC networks;
- Two of the insurance carriers surveyed reported that approximately 2,527 injured workers were already being treated in a certified network as of September 1, 2006.[36]

TDI will initiate future data calls on a periodic basis to update this information.

Relatively Few System Participants are Aware of the Recent HB 7 Reforms

Although many of the provisions of HB 7 went into effect on September 1, 2005, several of HB 7's key provisions require agency rulemaking, and in the case of workers' compensation health care networks, network certification before they can be implemented. In an effort to provide system participants with information about the numerous changes to the system brought about by HB 7 during its implementation, various program areas at TDI (including the Division, Consumer Protection, the Research and Evaluation Group, Fraud and Life and Health) have conducted seminars, speeches, "brown-bag" lunches and distributed printed information to injured workers and employer, insurance carrier, attorney and health care provider groups across the state. Additionally, TDI sponsored several meetings of the Workers' Compensation Working Group, which consisted of system participants representing injured workers, employers, insurance carriers, and health care providers. Topics included issues such as return-to-work, performance-based oversight, network certification and report card, overviews of Division rules, and ways to reduce administrative hassles for health care providers in the Texas workers' compensation system.

When asked about their degree of knowledge regarding the abolishment of the TWCC and the transfer of its functions to TDI, only 11 percent of employers surveyed by the REG in 2006 consider themselves "extremely knowledgeable," while 63 percent said that they had "no knowledge at all" about those reforms. Sixty-eight percent of Texas employers reported that they weren't aware that HB 7 created a new state agency (OIEC) to advocate for injured workers. Additionally, 64 percent weren't aware of the most significant aspect of the HB 7 reforms – the creation and use of workers' compensation networks (see Table 12).

Since a significant percentage of Texas employers are not knowledgeable about the HB 7 reforms, it is possible that with increased employer education and greater network availability over time, the HB 7 reforms may improve employers' perceptions about the business climate and economic development opportunities in Texas.

36 Approximately 12 percent of these injured workers had a "legacy" claim, meaning that they were injured prior to the implementation of HB 7 in September 2005. HB 7 allows insurance carriers to directly enroll injured workers with "legacy" claims into WC networks. These injured workers must still live in the network's service area and receive a copy of the network's notice from the insurance carrier.

Table 12: Employer Knowledge about the 2005 HB 7 WC Reforms

Main aspects of the 2005 reforms	Employer knowledge about the 2005 Reforms		
	Not at all Knowledgeable	Somewhat Knowledgeable	Extremely Knowledgeable
HB 7 abolished TWCC and transferred its functions to TDI	63%	26%	11%
HB 7 created a new state agency, the OIEC, to assist injured employees with complaints and disputes and advocate for them during rulemaking	68%	25%	7%
Under HB 7, employers who purchase workers' compensation insurance now have the option to participate in a health care network through their insurance carrier	64%	26%	10%
Under HB 7, an injured employee who lives in their carrier's network service area and receives a copy of the network requirements must choose a treating doctor from the network	62%	26%	12%
Under HB 7, small employers who purchase WC insurance and pay for worksite modifications in order to bring their employees back to work may be eligible for a reimbursement from TDI, up to $2,500 annually	75%	19%	6%

Source: *Survey of Employer Participation in the Texas Workers' Compensation System,* Public Policy Research Institute at Texas A&M University and the Texas Department of Insurance Workers' Compensation Research and Evaluation Group, 2006.

Concluding Remarks

A little over a year from the effective date of HB 7, implementation of these reforms are underway and showing early signs of progress. Going into the 80th Legislative Session, it is clear that significant changes to HB 7 are not necessary at this juncture and may actually impede the overall implementation of this reform. In considering legislative recommendations for this biennial report, TDI and the Division attempted to be very selective for two main reasons. One is that the implementation of HB 7 reforms is still in its early stages and these reforms have not had time yet to be fully evaluated. Second, TDI and the Division are scheduled for Sunset Review in 2009, which will entail a thorough examination of all areas of the agency's operations as well as the underlying statutory structure that it oversees. The legislative recommendations presented as part of this biennial report, with the exception of the recommendation regarding the licensure of workers' compensation third-party administrators, are generally technical in nature and will assist the agency in its ability to both effectively implement the HB 7 reforms and administer the Texas workers' compensation system.

Workers' Compensation Legislative Recommendations

Workers' Compensation Fraud Penalties

BACKGROUND Chapter 701, Texas Insurance Code establishes the Insurance Fraud Unit (Fraud Unit) within the TDI. The Fraud Unit investigates and refers for prosecution persons engaged in, or suspected of being engaged in, fraudulent insurance activities. In response to the passage of HB 7 (79th Legislature, Regular Session, 2005) and to utilize the Fraud Unit's law enforcement authority and experience, the Commissioner of Workers' Compensation, Commissioner Albert Betts, delegated to the Fraud Unit the task of investigating and referring suspected workers' compensation fraud for prosecution. The types of workers' compensation cases the Fraud Unit investigates include claim fraud, health care provider fraud, premium fraud and also agent/adjuster/company fraud. Chapter 418, Labor Code, addresses criminal penalties to be assigned to workers' compensation fraud.

PROBLEM The maximum penalty for committing workers' compensation fraud under Chapter 418, Labor Code, is a state jail felony. This does not parallel the penalty provisions in the Penal Code which follow the standard value ladder for committing insurance fraud or other similar financial crimes and in which punishment is dependent upon the value of the claim.

Prosecutors should have the flexibility to use the penalty provisions in the Penal Code so that workers' compensation fraud can be punished in the same manner as fraud committed against other lines of insurance. Because the Labor Code statute is specific to workers' compensation fraud, it could be argued that a defendant can only be charged under a Labor Code statute, thus potentially impeding a prosecutor's election of the appropriate penalty provision.

Adding an "Election of Prosecution" provision to the Labor Code would eliminate this arguable double standard and will improve prosecutors' and TDI's ability to obtain a proper judgment against persons who commit criminal insurance fraud in the workers' compensation system. The Insurance Code affords this type of language in §85.052, which offers the election of prosecution for all criminal acts enumerated in the code.

SOLUTION Amend the Labor Code to provide an "Election of Prosecution" provision similar to that found in TIC §85.052, to clarify that a person who commits an offense under the Labor Code may be prosecuted under the Labor Code or any other law of this state under which the person may be prosecuted.

Third Party Administrators

BACKGROUND Under Chapter 4151 of the TIC a certified administrator (Third Party Administrator or TPA) collects premiums from or adjusts or settles claims for annuities, life, health, and accident policies for Texas residents. Workers' compensation insurance is a property and casualty product and individuals adjusting such claims are required to hold a Texas adjuster license; however, the wording of the adjuster licensing in the TIC §4101.001(a) limits the license to an individual. Entities that provide TPA services for workers' compensation are not required to be certified administrators. The result is that TPA entities that handle workers' compensation policies are not subject to any specific licensing requirements.

PROBLEM Although TPA entities that collect premiums from or adjust or settle claims for annuities, life, health, and accident policies are subject to the Department regulatory authority, TPA entities that handle workers' compensation policies and claims are not subject to Department regulatory authority. Under current law, the Department is limited to taking action against the workers' compensation insurance carrier for actions of the contracted TPA.

SOLUTION Amend the definition of "administrator" in TIC §4151.001(1) to include workers' compensation benefits, and amend TIC §4101.001(b) to clarify that persons adjusting workers compensation claims on behalf of a TPA must maintain an adjuster's license. Such revisions would make the current statutes and regulations applicable to TPAs that handle workers' compensation claims.

Submission of Claims by Health Care Providers

BACKGROUND HB 7 (79th Legislature, Regular Session, 2005) amended §408.027, Labor Code, to align the timeframes regarding the payment of medical services provided in and outside of workers' compensation health care delivery networks, as well as to reflect some of "prompt pay" provisions in the Insurance Code. Subsection (a) of §408.027 requires a health care provider to submit a claim for payment to an insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee and subsection (b) requires insurance carriers to pay, reduce, deny, or determine to audit not later than the 45th day after the date of the receipt by the carrier.

PROBLEM When a provider treating a covered injured employee bills a group health carrier in error and later obtains accurate billing information and submits the bill to the appropriate workers' compensation carrier, the carrier denies payment when the bill is submitted later than 95 days from the date the service was provided.

SOLUTION

- Amend §408.027, Labor Code to add language similar to the provisions of TIC §843.337, (a) (b) (e) and (f), which govern the timely submission of a claim to a Health Maintenance Organization (HMO).