Biennial Report of the Texas Department of Insurance to the 81st Texas Legislature

December 2008

Mike Geeslin
Commissioner of Insurance

Texas Department of Insurance
Commissioner of Insurance
333 Guadalupe • P. O. Box 149104, Austin, Texas 78714-9104
512-463-6464 telephone • 512-475-2005 fax • www.tdi.state.tx.us

December 23, 2008

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, I am 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, provides information on market conditions and includes a study related to the Texas Health Insurance Risk Pool required by House Bill 1977 (80th Legislature, Regular Session).

The Department is available to discuss any of the issues contained in the report and to provide technical assistance. Please contact me 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,

Mike Geeslin
Commissioner of Insurance

Table of Contents

Introduction

Balance and Position: Regulation and the Markets

Insurance markets, and the laws that govern the regulatory structures for those markets, are being tested like never before. The current economic conditions, weather events, changing demographics, and basic human needs present a series of challenges that the Texas Department of Insurance (Department) has embraced as we enter these uncharted times.

In an effort to proactively and wisely position the state for what lies ahead and to fulfill its statutory obligations, the Department is committed to regulating the insurance industry fairly, promoting a stable and competitive market, and providing information to consumers that makes a difference. To accomplish these goals the Department has a number of regulatory tools, and this Biennial Report to the Legislature provides agency recommendations for amending or adding to those regulatory tools. To set the stage for these recommendations, this report will begin with a look at key regulatory events since the last legislative session, provide a summary of market conditions, and conclude with recommendations.

Because the Department is undergoing Sunset Review, many issues mentioned in the Sunset reports released to date are not included in this Biennial Report, and vice versa. Further, issues such as funding for the Texas Windstorm Insurance Association and Hurricane Ike continue to develop, and therefore the Department does not have specific recommendations at this time.

Regulatory Events 2007-2008

Homeowners Insurance Rates Because of the array of weather risks that are unique to the state, certain Texans are subject to homeowners insurance rates that are higher than other areas of the state. The market has shifted from the post-mold recovery period to the post-Katrina/Ike era that began in 2005 (hence, the weather-related differences in rates and premiums among the regions of the state). Major insurance reform in 2003 gave the Department rate regulation authority over companies writing property and casualty insurance in Texas. Overall rates decreased 13.5 percent between 2003 and 2006 and are currently 2.7 percent below the 2003 level (reflective of adverse rating conditions along the Texas coast). Further, average premiums are down for several areas of the state.

In addition to reviewing rate filings and informally resolving issues related to unjustified rates, more formal enforcement tools have been used. For example, as a result of actions by the Department, the largest homeowner writers either made modified rate filings or were ordered to reduce rates, saving consumers approximately $289 million. Additional actions were taken to place two carriers under prior approval.

Even in light of the enforcement actions and review of rate filings the markets for many regions appear to be functional, with companies making rate changes to reduce rates or provide greater discounts without Department intervention. Additional carriers have begun writing new business in Texas. While the effects of Hurricane Ike on the markets outside of the coastal region have not yet materialized, there is expectation that the non-coastal markets will remain competitive.

Other Enforcement Actions The Department has a number of means by which to enforce compliance with the Texas Insurance Code by carriers, agencies and agents, ranging from cease and desist orders to revocation of licenses. Taken together, restitution to consumers and

administrative penalties, fines, and forfeitures totaled more than $25.3 million in FY 2006, more than $34.6 million in FY 2007, and more than $51 million in FY 2008. These statistics may fluctuate from year to year given the nature and magnitude of the enforcement cases. Notable recent cases include:

- In November 2007, United Healthcare Insurance Company, United Healthcare of Texas was ordered to pay a $4.4 million fine for failing to promptly pay clean claims and for failing to properly maintain complaint logs.
- In August 2008, Blue Cross and Blue Shield of Texas, A Division of Health Care Service Corporation, was ordered to pay a $250,000 fine with an additional fine of $3.9 million for failing to make nonpreferred benefits reasonably available to its insureds and failing to maintain an accurate listing of its preferred providers. The $3.9 million is subject to possible dollar-for-dollar reduction to zero based on restitution paid.

Fighting Fraud The Department's Fraud Unit protects the public from financial harm by investigating criminal insurance fraud.

- In FY 2007, the Fraud Unit secured 80 convictions and ordered more than $13.4 million in fines, penalties, and restitution to consumers;
- In FY 2008, the Fraud Unit secured 116 convictions and ordered more than $3.8 million in fines, penalties, and restitution to consumers.

Consumer Assistance In its most recent fiscal year (FY 2008), the Department's Consumer Protection (CP) division responded to more than 649,000 consumer inquiries, closed 20,375 complaints, and successfully returned more than $32 million to consumers in the form of additional claims payments and refunds. CP helped recover more than $33.5 million in FY 2007 and more than $56.2 million in FY 2006.

Other recent consumer-directed activities of note include:

- In 2008 the Department revised its existing website, ***HelpInsure.com***, in conjunction with Office of Public Insurance Counsel to implement SB 611 (80th Legislature, Regular Session), providing robust comparison information and transparency to consumers shopping for homeowner and auto insurance. The Consumers Federation of American ranked the Department's website among the top 10 in the nation, specifically citing this new consumer resource.
- The agency continued to maintain a similar consumer resource for health insurance, ***TexasHealthOptions.com***, which provides information to help Texans find health coverage, including lists of agents and companies offering various types of health plans.
- A Department task force worked cooperatively with the federal Centers for Medicare and Medicaid Services (CMS) to address abusive marketing practices in the sale of Medicare Advantage products to seniors. The Department issued an emergency order in November to prohibit the sale of Medicare Advantage products by temporary agents after a pattern of fraudulent sales activities came to light. Statewide consumer outreach efforts began during the 2008 enrollment period and are ongoing.
- The 2008 hurricane season brought hurricanes Dolly, Gustav, and Ike and tropical storm Edouard to both southern and northern portions of the Texas coast. Hurricanes Dolly and Ike caused the most extensive damage and disruption to the Texas coast in 50 years. The Department catastrophe response teams deployed to affected areas immediately following each storm and remain in place at present (December 2008).

Section A: Market Overview

Effect of the Economy on the Insurance Industry

The insurance industry is capital-intensive primarily due to regulatory requirements and competitive pressures. The amount of capital maintained by an insurer can help it weather rough economic conditions and declining asset values. However, insurers are presently being buffeted by economic conditions of a magnitude not seen in recent years, and certain sub-industries and insurers are being impacted more than others. The duration of the current economic conditions will determine how well insurers respond to the various pressures. This section describes:

- economic pressures impacting insurance companies, including why certain types of insurers have been impacted more than others;
- a summary of pertinent regulatory protections for consumers; and
- actions being taken by the Department to protect the public.

Life and Annuity Insurers In general, the current economy and declines in the investment markets have impacted life and annuity insurers more than other types of insurers.

- Life and annuity insurers generally hold a greater percentage of their assets in stocks, real estate and mortgage-related securities, including sub-prime mortgages and collateralized mortgage obligations. As a result, declines in these markets have caused relatively larger declines in the investment portfolios held by these insurers.
- Certain life and annuity insurers have entered into sophisticated financial transactions, such as securities lending programs, which have resulted in financial losses for some companies.
- The credit-crunch and capital market disruptions have made it difficult for certain life and annuity insurers to raise additional capital.
- Life and annuity insurers generally reported lower investment yields in their 3rd quarter financial statements this year. Some insurers have also reported material capital losses.
- Because their portfolios often include assets whose values have declined, life and annuity insurers have been more likely to express an interest in obtaining relief under the $700 billion federal Troubled Asset Relief Program (TARP).

Property and Casualty Insurers Property and casualty insurers have generally not been impacted to the same degree by investment market declines as life and annuity insurers because they typically hold different classes of assets. Nevertheless, the property and casualty industry has also been significantly impacted by the economy, and certain types of companies have been impacted more than others.

- Property and casualty insurers generally hold higher percentages of their investment portfolios in bonds. Because these insurers generally hold relatively smaller percentages in stocks, real estate and mortgage-related securities, declines in these markets have not impacted the property and casualty industry to the same degree as the life and annuity industry.
- The above comparison is relative, as property and casualty insurers have still been impacted by the credit-crunch and declines in the investment markets.
- The economy has also had a greater impact on title insurers, financial guaranty (bond) insurers, and mortgage guaranty insurers. Some title insurance agencies have been negatively impacted by stagnating real estate markets.

- Insurer losses from the 2008 Atlantic hurricane season were significant, with hurricanes Ike and Gustav causing the most damage. In Texas, hurricanes Dolly and Ike caused the most extensive damage and disruption to the coastal areas in 50 years.
- Nevertheless, representatives of the industry have signaled the comparative strength of property and casualty insurers and the lack of a need to seek assistance under the $700 billion federal TARP legislation.

Consumer Protections The following is a non-exhaustive summary of certain protections for the insurance-buying public:

- Authorized investment statutes limit the types of investments that can be made by insurers. These laws are designed to ensure that insurers invest conservatively, limit or prohibit risky investments, and diversify their investment portfolios.
- Risk Based Capital (RBC) requirements index the amount of capital that insurers are required to maintain to the unique risks they assume. For example, larger insurers and those that make riskier investments are required to maintain more capital than smaller insurers and those that invest conservatively. This report includes a recommendation that the Texas legislature repeal an exemption from RBC requirements that exists for county mutual insurers to enhance protections for Texas consumers.
- The Holding Company Act is designed to protect insurance companies and their policyholders from potential abuses of insider control positions.
- Insurance companies must undergo annual audits by independent certified public accountants and have their reserves reviewed by actuaries. Included in this report is a recommendation that the Texas legislature enhance the current audit requirements of large insurers to provide for even greater transparency and reliability on financial statements prepared by insurers.
- The accounting and financial statement disclosure requirements for insurers are explicitly more conservative in nature than generally apply to other industries.
- Guaranty Associations exist to pay certain insured claims for insurers that have been declared insolvent. These associations are comprised of other insurers in the insurance industry who pay the outstanding insured claims of a failed insurer in the event a company becomes insolvent.

Protecting the Public – Informal Actions The Department is undertaking a number of steps to protect the interests of the insurance-buying public. The Department stands ready, if necessary, to intervene in troubled company scenarios. The Department typically views formal regulatory intervention as a last resort when other options have been exhausted. The Department's pre-intervention actions include, but are not limited to:

- continued financial monitoring of certain insurers and specific types of assets held in investment portfolios;
- coordinating efforts with insurance regulators from other states and other types of regulatory agencies, such as the Federal Reserve, the State Banking Department, state and federal securities boards, etc.;
- working with representatives of the life insurance industry to consider changes to certain technical reserve and Risk Based Capital (RBC) requirements in light of current economic conditions;

- keeping apprised of industry activity and assisting in development of industry efforts to coordinate responses based on shared goals rather than individual optimization;
- initiating proposals to the National Association of Insurance Commissioners regarding Statutory Accounting Principles to clarify requirements relating to investment write-downs given current market conditions,
- policing insurers' compliance with solvency requirements such as authorized investment statutes and RBC requirements; and,
- assisting the public by providing consumers with additional sources of information regarding specific insurers and situations.

Protecting the Public – Regulatory Interventions The Department strives to address regulatory concerns informally when possible, such as by hosting conferences with company management to discuss regulatory concerns; however, the Department can and will formally intervene in troubled insurance company scenarios when necessary to protect consumers. The Department uses this authority judiciously; but, the state of the current economy has increased the possibility that the Department will need to exercise this authority to protect the interests of the public. The Department's intervention authority includes, but is not limited to:

- issuing emergency cease and desist orders;
- issuing hazardous financial condition orders that require insurers to take corrective action;
- issuing orders that place insurers under supervision or conservation; and
- petitioning the Travis county district court to place insurers into receivership, either for rehabilitation or liquidation.

Life and Health Overview

While the health and life insurance markets in Texas continue to enjoy strong growth, the state also faces difficult challenges in some areas, particularly with the growing number of Texans who have no health insurance. The U.S. Census Bureau's most recent Current Population Survey (CPS) reports that more than 5.9 million Texans were without health insurance during the entire 2007 calendar year, up from 5.7 million in 2006. One quarter of Texans were uninsured, the highest uninsured rate in the country.

The reasons for Texas' high uninsured rate have been discussed and analyzed at length. While no single factor can be blamed, a combination of population demographics, rising health care and health insurance costs, increased demand for health care services, and related economic and workforce dynamics play an interrelated role in the problem. Compared to states with low uninsured rates, Texas has:

- lower availability of employer sponsored insurance coverage;
- lower average wages;
- higher average insurance premiums;
- a larger immigrant population;
- a higher percentage of Hispanic citizens; and
- fewer unionized businesses.

Although the uninsured population is not limited to any one particular demographic group, certain characteristics increase the likelihood that an individual may or may not have health insurance.

- **Age:** Of the 5.9 million uninsured Texans, 4.5 million (76 percent) are adults. Young adults ages 18-24 are at greatest risk of having no health coverage; nearly half (41.7 percent) were uninsured, followed closely by adults ages 25-34 years old (39.5 percent are uninsured). Texas also has the highest uninsured rate (4.1%) of any state for adults over age 65, a population that has more than doubled since 2005. Nationally, 1.9 percent of adults age 65 and older are uninsured.

Uninsured Rates by Age – 2007

Age Range	Number Uninsured	Percent of Total Uninsured	Percent Uninsured Within Age Category
Ages 6 and Younger	570,053	9.6%	20.4%
Ages 7 – 17	864,926	14.5%	22.0%
Ages 18 – 24	960,561	16.1%	41.7%
Ages 25 – 34	1,350,623	22.7%	39.5%
Ages 35 – 44	929,402	15.6%	27.6%
Ages 45 – 64	1,186,401	19.9%	21.8%
Ages 65 +	100,039	1.7%	4.1%
Total	**5,962,004**	**100.0%**	**25.2%**

Source: U.S. Census Bureau. March 2008 Current Population Survey (Texas Sample).

- **Race/Ethnicity:** Like other border states, the uninsured in Texas are disproportionately Hispanic. Although Hispanics represent approximately 36 percent of the state's total population, they account for nearly 60 percent of the uninsured.
- **Poverty Status:** Though the uninsured as a group have a wide range of incomes, a majority (almost 60 percent) live in families with incomes below 200 percent of the federal poverty level. An estimated 27 percent have incomes below 100 percent of poverty ($21,200 for a family of four in 2008). More than 1.7 million uninsured Texans live in families with incomes above $50,000.
- **Citizenship:** A large majority of uninsured Texans are U.S. citizens. However, non-citizens are much more likely to be uninsured, with an uninsured rate of 60 percent compared to 20 percent for native citizens and 33 percent for naturalized citizens.
- **Employment Status:** Most uninsured adults (69 percent) are employed. Of the remaining uninsured, only five percent are considered unemployed (i.e., are actively looking for work). The remaining 26 percent are not in the labor force, including parents who are taking care of children, early retirees who no longer work, non-working college students, adults caring for aging parents, individuals who are disabled and unable to work, and other adults who for various reasons are not working or looking for work.

Uninsured Rates by Poverty Status – 2007

Income/Poverty Level	Number Uninsured*	Percent of Total Uninsured	Percent Uninsured Within Income Category
Under 50%	665,872	11.2%	44.7%
51% to 99%	957,046	16.1%	39.7%
100% to 149%	980,580	16.5%	38.6%
150% to 199%	841,251	14.2%	38.9%
200% to 249%	750,540	12.6%	33.7%
250% or Higher	1,749,124	29.4%	13.6%
Total	**5,944,413**	**100.0%**	**25.1%**

** Applies to the portion of the population for whom poverty status was determined.*

Source: U.S. Census Bureau. March 2008 Current Population Survey (Texas Sample)

Uninsured Rates by Citizenship – 2007

Immigration Status	Number Uninsured	Percent of Total Uninsured	Percent Uninsured Within Immigration Status Category
U.S. Citizen (Native)	4,091,625	68.6%	20.4%
U.S. Citizen (Naturalized)	355,733	6.0%	32.9%
Not a U.S. Citizen	1,514,646	25.4%	60.0%
Total	**5,962,004**	**100.0%**	**25.2%**

Source: U.S. Census Bureau. March 2008 Current Population Survey (Texas Sample).

Despite the growing uninsured population, Texas is widely recognized as having one of the healthiest commercial insurance markets in the country. In 2007, insurers reported more than $19 billion in accident and health premiums, and more than $9 billion in coverage issued by health maintenance organizations. Life and annuity premiums totaled more than $38 billion. More than 700 insurers and 50 HMOs were licensed to offer life and health insurance products and an additional 14 HMOs provided comprehensive health insurance coverage for more than one million Texans covered under fully-insured commercial benefit plans. The state also maintains a competitive insurance market for small employers looking for health insurance options. While some states have reported difficulty attracting insurers for small businesses, Texas continues to have more than 45 carriers offering small group health insurance.

As demonstrated above, while availability of health insurance coverage is not a problem in Texas, affordability continues to present challenges for many Texans. As a result of revisions in the regulation of small group insurers and creation of the Texas Health Insurance Risk Pool, almost all state residents are guaranteed access to insurance. However, health insurance premium costs have continued to escalate and many employers and working families cannot afford the insurance options available to them. Compared to other states, Texas has a lower rate of

employer-sponsored coverage, particularly among small business owners. In 2007, approximately 50% of Texans received coverage under an employer sponsored plan, compared to a national average of 60 percent.[1] While most states have experienced declining rates of employer-sponsored coverage in recent years, the decline in Texas has been more pronounced. Since 2001, the percentage of Texans with employer coverage has dropped from 58.5 percent to the current rate of 50.4 percent, a 16 percent decrease in six years.

The rising cost of coverage has been particularly challenging for small business owners. While nearly 90 percent of large firms (more than 50 employees) offered coverage to their workers, only 32 percent of small firms (2-50 employees) did so.[2] Although all employers have experienced significant premium increases in recent years, the increases are usually more difficult for small firms to absorb and discourage many employers from even attempting to obtain coverage. Since 1997, the average annual premium cost-per-person for small businesses has more than doubled from $2,172 to $4,463 in 2006.[3] While these increases are dramatic, they are even more compelling when considered in the context of how much money uninsured employers are able to spend for health insurance. In a 2004 survey of employers that did not offer health insurance, the vast majority of survey respondents indicated they could afford less than half of the average cost of coverage. While the average monthly cost-per-employee in 2004 was $362, only one percent of surveyed employers reported they could pay at least $300 per month. Only 37 percent were able to spend at least $100 a month; one third could pay $50 or less per-employee. Fourteen percent of employers reported they could not afford any amount for health insurance.

Previous Expansion Initiatives

To address the challenges associated with rising insurance costs and provide more affordable options for small businesses, the Texas Legislature has created several market-based initiatives in recent years.

Consumer Choice Plans (CCP) – Consumer Choice plans were authorized by the 78th Legislature and were first offered in 2004. The plans may exclude or reduce coverage for certain mandated benefits as determined by statute, which should result in lower premium costs and provide a more affordable option for employers and individuals. Small employer carriers/HMOs must offer at least one Consumer Choice plan; individual and large group carriers may offer the plans, but are not required to do so.

Though enrollment was slow during the initial year, the number of insureds covered under Consumer Choice plans has more than tripled since plans were first offered in 2004. However, while the plans were intended to attract uninsured groups into the market, most enrollees were previously insured and switched to a consumer choice plan from another plan. In 2007, three percent of the plan enrollees were previously uninsured. Small employer benefit plans have attracted the highest enrollment with 141,078 insureds. Although these are not previously uninsured individuals for the most part, some small employers may have otherwise chosen to drop

1 U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement
2 Agency for Healthcare Research and Quality, 2006 Medical Expenditure Panel Survey – Insurance Component.
3 Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey – Insurance Component, 1997-2006.

coverage entirely if the Consumer Choice option was not available. Most small employers, however, have continued with the full-coverage benefit plans that include all mandated benefit requirements. Approximately 15 percent of small employers with insurance offered a consumer choice plan in 2007. The enrollment (including employees and dependents) represents 12 percent of total lives covered under all small employer plans.

Health Cooperatives/Purchasing Coalitions – Texas law allows small employers, and in some cases large employers, to create health group purchasing cooperatives or coalitions for the purpose of joining together to purchase health insurance. The larger group size attained by combining a number of firms together theoretically improves the group's purchasing power, enabling them to negotiate for lower insurance rates. Insurance carriers/HMOs are required to issue coverage to small group coalitions and cooperatives with no more than 50 employees. Insurance agents have reported some employers have experienced premium reductions of 20 to 30 percent, primarily through lower administrative costs.

State Planning Grant – Harris County Pilot Project – The Harris County pilot project was the final phase of a five year federally funded study of Texas' uninsured population. The State Planning Grant program offered by the Health Resources and Services Administration (HRSA) provided the Department the opportunity to complete a comprehensive study of the state's uninsured population, and develop a pilot program using the data and information obtained as a result of the research study. The primary purpose of the Harris County pilot project was to develop a carefully designed small employer benefit plan that would provide an affordable benefit plan for uninsured small businesses in the Harris County area. The Department worked with the Greater Houston Partnership, an organization of Houston and Harris County business and community leaders to design a program with an average premium cost of approximately $150 per employee per month, and with a benefit plan that would appeal to both workers and employers. The Department and the Harris County stakeholders worked closely with a diverse stakeholder group that included providers, health plans, insurance brokers, employers and employees, and local business leaders.

In December, 2006, the Department hosted an industry conference to present the study findings and pilot proposal and to discuss implementation of the program. The Harris County Healthcare Alliance subsequently issued a Request for Proposals (RFP) in February to solicit an insurance carrier for the benefit plan designed under the program. The Alliance planned to create a healthcare cooperative that would administer the program for small businesses in the Houston area. However, after discussions with three carriers, the Alliance was unable to reach agreement on the terms of a health care program that would implement the program objectives using the benefit plan designs while meeting the affordability requirements.

Current Expansion Initiatives

In 2007, the 80th Legislature continued to address concerns regarding affordable health insurance with the enactment of two provisions under Senate Bill 10:

- **Premium Subsidy Study:** the Legislature directed the Texas Health and Human Services Commission and the Department to conduct a joint study of small employer premium assistance programs and how such a program might be designed to provide financial assistance to small employers. The agencies were required to review other states' programs and provide

recommendations for the Legislature's consideration. The report was completed and submitted to the Legislature in November 2008 and is available on the Department's website at: http://www.tdi.state.tx.us/reports/life/documents/uninsured_subsidy.doc.

- **Healthy Texas Program for Small Employers:** the Legislature also directed the Department to design and make recommendations regarding a Healthy Texas program to provide health insurance coverage to uninsured small employers and their employees. The Department, working through a stakeholder group that included representatives from the offices of the Governor, Lieutenant Governor, Speaker, and several members of the Texas Legislature, has designed a program that would lower premium costs for eligible small employers by creating a state-funded reinsurance system that would assume the risk of high-cost insurance claims. The program would provide a comprehensive, sustainable health benefit plan option that creates a unique, public/private partnership of insurers, providers, agents, employers, employees, state and local government. The Department submitted a preliminary report to the Legislature, which is available at: http://www.tdi.state.tx.us/reports/report5.html. A supplemental report will be issued early 2009.

Property and Casualty Overview

In general, the Texas Property and Casualty insurance market remains healthy; however, the recent hurricane experience is affecting the residential and commercial property market along the coast. Insurers continue to see 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

Overall, in recent years the Texas homeowners insurance industry experienced improved profitability and the market has continued to see increased competition, better product availability and a downward trend in rates. Direct written premium in the admitted market for 2007 was $5.1 billion, compared with $4.8 billion in 2006. Understanding the Texas insurance market for homeowners necessitates understanding that it can be separated into several different markets; therefore, what happens in one area of the state may not happen in another area of the state.

The Texas Gulf Coast presents a distinctly different picture of the homeowners market. The active hurricane seasons of 2004 and 2005 and predictions of continued increased hurricane activity led to affordability and availability problems for properties along the Texas Gulf Coast. The 2008 hurricane season was an active one for the Texas coast with hurricanes Gustav, Dolly and Ike, and tropical storm Edouard. Hurricane Ike hit Texas on September 13, 2008; and as of October 31, 2008, insurers had reported approximately 730,000 claims for all lines of insurance, totaling $3.2 billion in claims payments and an estimated total gross loss of $9.2 billion from this single weather event. Residential property losses are expected to be a significant portion of the total loss. As the industry continues to assess damages, the full impact of Hurricane Ike has yet to be realized. If the effects and experiences in Florida following the 2004 hurricane season are any indication, Texas can expect further rate increases and a decrease in availability of insurance along the Texas Gulf Coast.

The Texas Windstorm Insurance Association (TWIA) has continued to experience significant growth due to decreased availability of insurance along the Texas Gulf Coast. The number of

policies written in TWIA has almost tripled since 2001. As of October 31, 2008 the policy count for TWIA was 229,779, with liability in force of $62.6 billion. This does not include indirect liability such as additional living expense and business income, which is estimated at $5.9 billion. TWIA's rates for residential property have increased by more than 30 percent since 2006. The most recent rate change of 12.3 percent was adopted to become effective February 1, 2009.

TWIA member insurers were assessed in 2008 a total of $100 million for Hurricane Dolly and $430 million for Hurricane Ike, with $230 million of the assessments subject to premium tax credits. In addition, the $470 million catastrophe reserve trust fund was used to pay losses and TWIA estimates that its $1.5 billion in reinsurance will be exhausted.

As the Gulf Coast works to recover from Hurricane Ike, the workload at the Department has increased dramatically. The Department anticipates that Hurricane Ike may result in the need for 200,000 additional windstorm inspections. The Department reallocated staff resources to meet the increased needs of consumers. In addition, the Texas Windstorm Insurance Association (TWIA) has set aside $5.3 million to assist with the increased inspection related activities.

The Texas FAIR Plan Association (the insurer of last resort for residential property) has also been affected by concerns for hurricane exposed areas of the state. In November 2004, the policy count for the FAIR Plan peaked at more than 134,000 policies. As of October 31, 2008, the policy count was approximately 87,000. The overall decline in policy count is normally an indicator of a healthy market. However, as a result of insurers restricting coastal writings, the policy count in Harris and other coastal counties has actually increased since June 2006. While the FAIR Plan is prohibited from providing windstorm and hail coverage in the first tier coastal counties and those areas designated as a catastrophe area in Harris County, it does provide this coverage in the remainder of Harris County and all other counties in the state. The growth seen in the FAIR Plan in the second tier coastal counties indicates potential availability and affordability problems for residents in those areas. The FAIR Plan recently revised its rates upward by 20 percent in the second tier coastal counties and downward by 20 percent in the first tier coastal counties. The remainder of the state also received rate decreases ranging from 8 percent to 20 percent.

Based on the top ten insurers in the market, overall rates decreased 13.5 percent between June 2003 and September 2006. However, this reduction has been gradually shifted and rate levels are now about 2.7 percent below the June 2003 levels when homeowners insurance reforms were enacted. These changes were due in large part to major weather events before the 2008 hurricane season, changes in reinsurance, and other market forces. During the time frame between January 1, 2007 and December 1, 2008, insurers made 58 filings with rate decreases compared to 54 filings with rate increases. During 2008, activity by the largest homeowners writers has varied with three insurers that filed moderate rate decreases around 3 percent and seven insurers that filed small to large rate increases (2 percent to 13 percent range). Rate increases continue along the Texas Gulf Coast while rates in other areas of the state are constant or decreasing.

Despite expected catastrophic losses, Texas continues to attract new entrants and new products to the homeowners market, providing more choices and increased competition for Texas insurance consumers. Between January 1, 2007 and December 1, 2008, ten insurers began writing homeowners insurance and insurers filed 12 new homeowners products. While these new products generally include variations of the traditional coverages, the migration toward more "all risks" type of coverage continues.

Personal Auto Market

The personal auto market appears competitive with new entrants, new products, moderate rate increases and a continued decline in the volume of drivers in the assigned risk plan. Direct written premium in the admitted market for 2007 was $12.0 billion, slightly higher than the $11.8 billion for 2006.

The Texas Automobile Insurance Plan Association (TAIPA), the market of last resort for commercial and private passenger auto, continues to experience substantial decreases in total assignment counts. In 2005 the assignment counts were 31,517; assignment counts for 2008 (through October) are 11,432.

TexasSure Vehicle Insurance Verification, the financial responsibility verification program mandated by SB 1670 (79th Legislature, 2005), was implemented in late 2008 to verify insurance during traffic stops by law enforcement and at vehicle registration renewal. The Department led development of this multi-agency project in conjunction with the Texas Department of Public Safety, Texas Department of Transportation and Texas Department of Information Resources. The Department anticipates this program will impact the personal auto market as previously uninsured motorists seek minimum liability coverage in compliance with State law. Staff met with industry representatives in March 2008 to ensure their preparedness for additional customers and claim volume following the implementation of TexasSure.

Between January 1, 2008 and December 1, 2008, 153 companies made a total of 646 rate filings. About 11 percent of these filings represented rate decreases ranging up to nearly 20 percent. Approximately one third of the filings represented rate increases under 10 percent. Three percent of filings had rate increases higher than 10 percent. The remaining filings represented no overall rate change or provided rates for new products or endorsements. Rate activity in 2008 produced an average increase of +5.5% following several years of stable or declining rates.

Texas continues to attract new entrants to the personal automobile market. Between January 1, 2007 and December 1, 2008, 11 insurers began writing personal automobile insurance and companies filed 16 new personal auto products. These new products and new entrants mean more choices and increased competition for Texas insurance consumers.

Medical Professional Liability Market

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

Direct written premium in the admitted market for 2007 was $267 million, compared with $364 million in 2006. Direct written premium has been declining over the last several years, down

from a high of $539.9 million in 2003. This reduction in written premium is due in large part to rate reductions implemented by insurers.

Physicians' medical malpractice rates have dropped with all of the top five writers announcing significant rate reductions over the past several years. The cumulative physician rate change since September 2003 for the top six medical liability writers ranged from -17.4 percent to -34.5 percent, with an average industry change of -27.5 percent.

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 271 as of October 31, 2008.

Between January 1, 2007 and December 1, 2008, there has been one new entrant into the admitted market for physicians and one additional admitted insurer has a license application pending before the Department. In addition, several new risk retention groups have been registered to write medical liability insurance. Risk retention groups are formed under the provisions of the federal Liability Risk Retention Act (LRRA) for the purpose of providing insurance. The rates and policy forms of risk retention groups are not regulated, and risk retention groups are not covered by the Guaranty Fund.

Title Market

After 10 years of unprecedented growth in the Texas title insurance industry, the effects of the current economic downturn are becoming apparent. Ten agents were placed in conservatorship or receivership in calendar year 2008, as opposed to an average of one per year for 2005 through 2007. The Commissioner convened an industry work group on title agent insolvency which issued a report providing recommendations to address this issue. The Department implemented many of the work group recommendations that did not require statutory changes and is evaluating other recommendations.

Direct written premium for both 2006 and 2007 was $1.6 billion.

The 2006 Biennial Rate Hearing was concluded with no premium rate change. In addition, the hearing process adopting initial forms and rates for personal property lien protection was concluded. The 2008 Biennial Rate Hearing is currently pending at the State Office of Administrative Hearings (SOAH).

During fiscal year 2007, 628 licensed title agents held a total of 1,767 licenses. In fiscal year 2008, 637 licensed title agents held a total of 1,698 licenses.

There were 7,058 escrow officers holding 7,832 escrow officer licenses in fiscal year 2007, and 6,701 escrow officers holding 7,711 escrow officer licenses during fiscal year 2008.

There were 17 licensed direct operations in both fiscal year 2007 and fiscal year 2008.

During fiscal year 2007 there was $243 billion in title escrow accounts. This number increased to $251 billion in fiscal year 2008.

Workers' Compensation Market – Rates

Since 2002, the workers' compensation insurance industry has experienced underwriting profits after numerous years of substantial underwriting losses. This has allowed insurers to file more rate reductions and increase the use of competitive pricing tools to further reduce employers' premiums.

Direct written premium in the admitted market for 2007 was $2.7 billion, compared with $2.8 billion for 2006.

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. The Department was required to hold a hearing before December 1, 2008 to determine the impact of the HB 7 reforms on workers' compensation rates and premiums. This hearing was held November 5, 2008 and a report that will include information regarding the impact of HB 7 on the availability and affordability of workers' compensation insurance will be available in December 2008. While it is still too early to fully evaluate the impact that HB 7 will have on rates, it is clear that losses have come down significantly since the late 1990's and, while rates and premiums have generally followed suit, there appears to be room for further reductions. The Department is evaluating and finalizing an action plan for workers' compensation rates and premium in order to further implement some of the provisions of HB 7. These provisions direct the Commissioner to implement rules as necessary to mandate rate reductions or to modify the use of individual risk variations if the Commissioner determines that the rates or premiums charged by insurance companies do not meet rating standards.

Between January 1, 2007 and December 1, 2008, average rate levels were reduced by approximately 15 percent. This does not include the network credits that have been filed by insurers. There were minimal rate increases filed in 2007 and 2008; 17 and 15 respectively. Furthermore, there were 117 rate decreases filed in 2008 compared with 76 rate decreases filed in 2007. Most filings were revenue neutral in each year mostly due to insurers adopting the Department's promulgated classification relativities. These relativities are used by insurers in determining the rates charged for each classification.

In addition, the use of competitive pricing tools, along with rate reductions, brought the 2007 average premium per $100 of payroll by policy year down to $1.93; an approximately 17 percent decrease from the 2005 level of $2.32 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 for 2008.)

Between January 1, 2007 and December 1, 2008, five newly licensed companies began writing workers' compensation coverage; and companies made 815 endorsement/form filings. The majority of these filings are terrorism endorsements (due to changes and extension of the Federal law), negotiated deductible endorsement filings, and filings adding various schedules to the Information Page.

Overview of the Status of the Texas Workers' Compensation System

More than three years since the passage of House Bill (HB) 7 by the 79th Legislature, the Texas workers' compensation system has undergone significant changes. These changes are reflected in the abolishment of the former Texas Workers' Compensation Commission and transfer of duties to the newly created Division of Workers' Compensation at the Texas Department of Insurance, as well as the frequency, cost and return-to-work rates of claims filed within the system.[4]

Most of the key provisions of HB 7 have been implemented by the Texas Department of Insurance (Department), Division of Workers' Compensation (Division); however it is still too early to effectively gauge the full impact of this legislation. Nevertheless, 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 HB 7 and other legislative or regulatory reforms in the future.

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

- injury and claim frequency rates;
- employer participation in the Texas workers' compensation system;
- medical costs, including pharmacy costs and utilization;
- claim and medical billing denial rates;
- return-to-work rates;
- impairment ratings and the frequency of permanent partial disability benefits; and
- the implementation of workers' compensation health care networks.

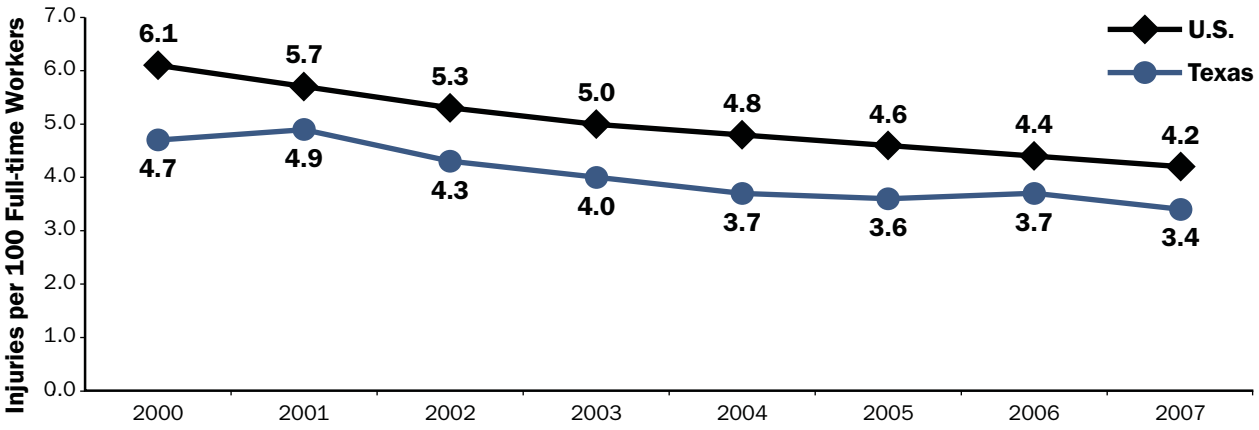
It should be noted that in addition to these highlighted trends, the agency is also tracking other important issues such as dispute and complaint resolution trends, access to care, usage of medical peer reviews by insurance carriers and improvement to customer service operations. The system trends presented in this report allow the Department, 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 and Claim Frequency Continues to Decrease

The Texas workers' compensation system continues to experience marked reductions in both the non-fatal occupational injury and illness rate and the overall number of reportable claims filed with the Division. Between 2000 and 2007, the nonfatal occupational injury and illness rate in Texas decreased 28 percent from 4.7 to 3.4 injuries per 100 full-time employees. Workplace injury and illness rates vary widely by industry; however, several industry sectors including manufacturing, wholesale trade, transportation, warehousing, utilities, financial activities, educational services, and health care and social assistance experienced their lowest nonfatal injury and illness rate in the last five years. The industry sectors with the highest rates include: transportation and warehousing (5.8 injuries/illnesses per 100 full-time employees),

4 For a complete description of HB 7, see http://www.tdi.state.tx.us/wc/transition/ hb7changes.html.

Figure 1: Texas and U.S. Nonfatal Occupational Injury and Illness Rates Per 100 Full-time Employees (2000-2007)



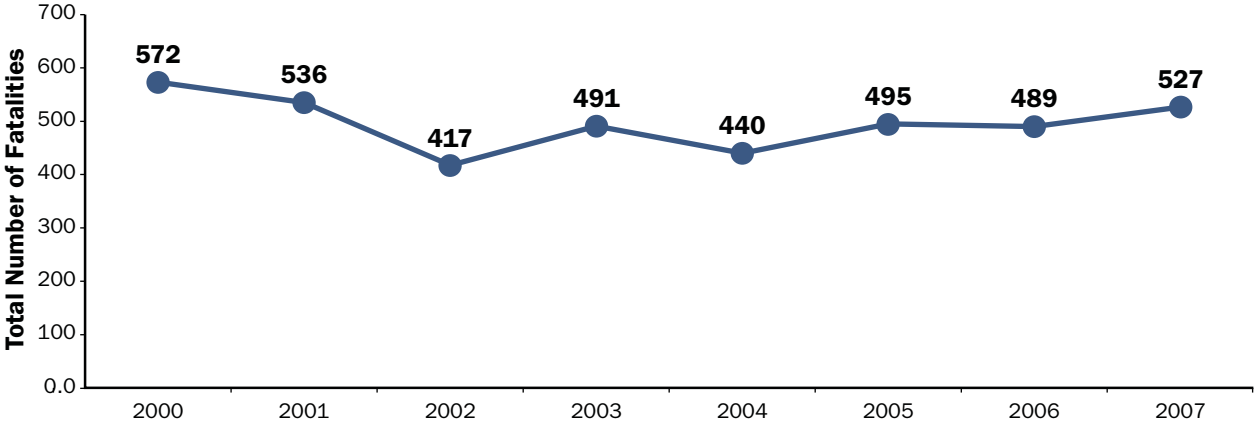
Source: Texas Department of Insurance, Division of Workers' Compensation and U.S. Department of Labor, Bureau of Labor Statistics, Census of Fatal Occupational Injuries, *2008.*

agriculture/forestry/fishing/hunting (5.3), manufacturing (4.4), retail trade (4.3), and leisure and hospitality (4.2). Compared with the rest of the nation, the injury rate in Texas has been consistently below the national average (see Figure 1).

Although the non-fatal occupational injury and illness rate in Texas and nationwide has seen a continuous decrease over time, the number of fatal occupational injuries in Texas continues to fluctuate (see Figure 2). Transportation incidents continue to be the leading cause of work-related fatalities in Texas (192 in 2007), and an increasing number of fatalities can be attributed to assaults and violent acts against employees (86 fatalities in 2007 – a 46 percent increase from 2006). Nearly one-third (29 percent) of all fatalities reported in 2007 occurred in the construction and extraction occupation group.

Similar to the non-fatal occupational injury and illness rates seen in Figure 1, the number of workers' compensation claims actually reported to the Division has declined steadily since 2000 (see Figure 3). The reasons for these reported declines, both nationally and in Texas, stem from

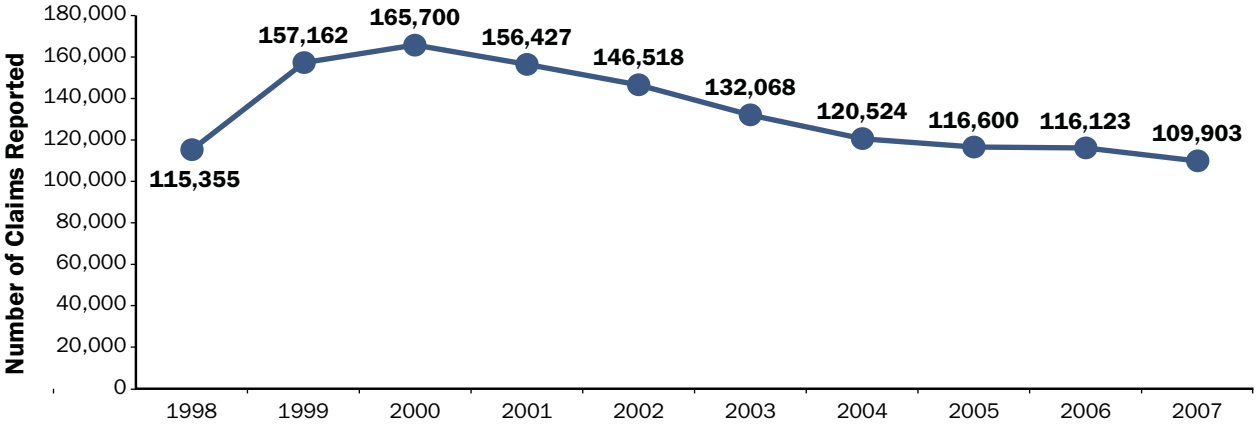
Figure 2: Number of Fatal Injuries in Texas by Year, 2000-2007



Source: Texas Department of Insurance, Division of Workers' Compensation and U.S. Department of Labor, Bureau of Labor Statistics, Census of Fatal Occupational Injuries, *2008.*

a variety of factors, including increased safety awareness among employers and employees, enhanced health and safety outreach and monitoring efforts at the federal and state level, improvements in technology, globalization, increased use of independent contractors, and the possibility of under-reporting of workplace injuries and illnesses.

Figure 3: Number of Workers' Compensation Claims Reported to the Division of Workers' Compensation, Injury Years 1998-2007



Note: These numbers include the claims that are required to be reported to the Division, including fatalities, occupational diseases, and injuries with at least one day of lost time. Medical-only claims are not required to be reported to the Division.

Source: Texas Department of Insurance, Division of Workers' Compensation, 2008.

Employer Participation Rates Have Improved, but Employee Coverage Rates Have Declined

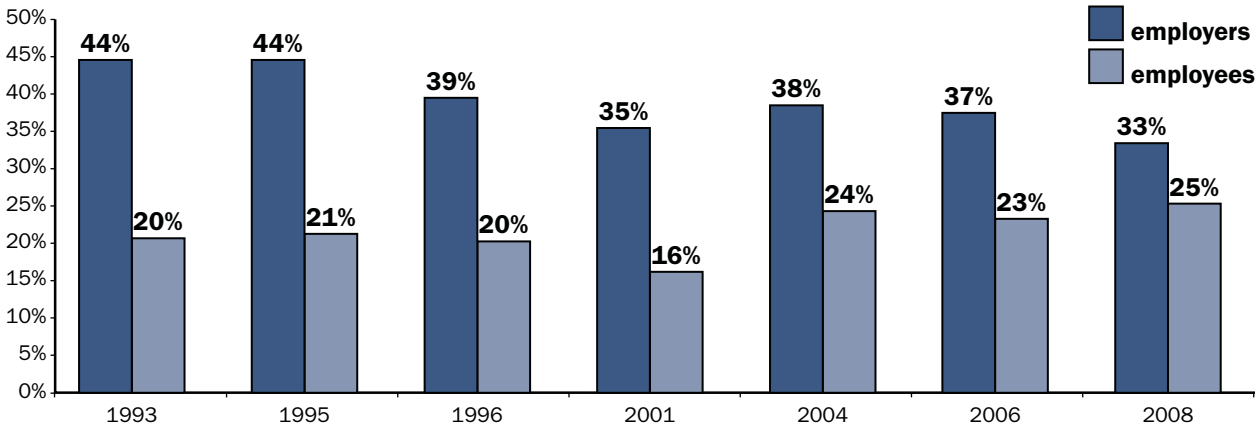
Texas is currently the only state where private-sector employers (regardless of employer size or industry) are allowed the option of obtaining workers' compensation coverage or becoming "non-subscribers" to the workers' compensation system.[5] Employers who choose to not obtain workers' compensation coverage (either through purchasing a commercial policy, becoming a certified self-insured employer or a member of a certified group of self-insured employers) lose the protection of statutory limits on liability and may be sued for negligence by their injured employees.

The non-subscription rate remains 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 non-subscribers to the workers' compensation system decreased to 33 percent in 2008 – the lowest percentage since 1993 (an estimated 106,308 employers). However, an estimated 25 percent of year-round Texas employees (representing approximately 3 million employees) worked for non-subscribing employers – the highest percentage since 1993 (see Figure 4).

While the percentage of Texas employers who have workers' compensation coverage has increased since 2006, due primarily to lower insurance premiums and the increased availability

5 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).

Figure 4: Percentage of Texas Employers that are Non-Subscribers and the Percentage of Texas Employees that are Employed by Non-Subscribers, 1993-2008



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, 2006 and 2008 estimates from the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group and PPRI.*

of workers' compensation health care networks, the results from the 2008 analysis continue to highlight the trend of larger employers (i.e., employers with 500+ employees) making the decision to opt out of the Texas workers' compensation system (an estimated 26 percent of large employers are non-subscribers in 2008 compared to 21 percent in 2006). These larger employers continue to cite the high cost of participating in the workers' compensation system and the ability to more effectively manage medical costs as their primary reasons for opting out.[6]

Compliance Efforts Regarding Reporting Requirements for Non-Subscribing Employers

While the types and amounts of benefits provided to injured employees who work for non-subscribing employers as well as the administration of those benefit programs fall outside of the jurisdiction of the Department's and the Division's regulation, non-subscribers are still subject to certain reporting requirements under the Workers' Compensation Act and Rules. Non-subscribers are required to report to the Division annually (using the DWC-5 Form) that they have elected to opt out of the workers' compensation system.[7] Additionally, non-subscribers who employ at least five employees are required to file a notice with the Division (using the DWC-7 form) for every fatality, occupational disease, and every work-related injury that results in more than one day of lost time.[8] Failure to comply with these reporting requirements may result in enforcement action and administrative penalties levied up to $25,000 per day per occurrence.

---

6 For more information about non-subscription rates and employers' reasons for participating or not participating in the Texas workers' compensation system, see Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, *Employer Participation in the Texas Workers' Compensation System: 2008 Estimates,* which can be viewed at http://www.tdi.state.tx.us/reports/wcreg/documents/2008_Employer_Partic.ppt.

7 See Section 406.004, Labor Code.

8 See Section 411.032, Labor Code.

Last session, the 80th Legislature added Appropriation Rider 19 to the Department's budget, which requires the Division to submit, as part of its biennial report to the legislature, a report regarding the compliance of non-subscribing employers with these reporting requirements as well as any administrative penalties levied against non-complying employers. Prior to the 2007 legislative session, non-subscriber reporting compliance efforts on behalf of the agency were primarily complaint driven. Since 2000, the Division and its predecessor – the Texas Workers' Compensation Commission – received 14,428 DWC-5 filings by non-subscribers; however, since 1992, the agency has only received 35 complaints regarding non-subscriber reporting compliance and initiated seven enforcement actions as a result of those complaints.

Since last session, the Division commenced efforts to not only increase employer awareness about non-subscriber reporting requirements, but also to proactively identify potential non-complying employers. In addition to providing information about these reporting requirements on the agency website, the Division has included this information in multiple agency-sponsored educational conferences; published articles in the agency's newsletter, the *Workers' Comp Update*; issued a Commissioner of Workers' Compensation memo to system stakeholders in December 2007; issued a press release and submitted an article to the Comptroller's quarterly newsletter – the *Sales Tax Update*. At the same time, using workers' compensation policy data collected by the National Council on Compensation Insurance (NCCI) on behalf of the Division, as well as information collected by the Texas Workforce Commission (TWC) regarding the identity of employers who participate in the Unemployment Insurance program, the Division identified a list of employers who were potential non-subscribers. This list of employers was then compared with the list of non-subscribers who submitted a DWC-5 form to the Division to develop a list of potential non-complying employers.

Given the large volume of potential non-complying employers, the Division prioritized its notice and compliance efforts first on the largest employers (i.e., employers with 500+ employees) and sent letters to 300 of these employers. In the letters, the Division asked these large employers to provide information regarding their current workers' compensation coverage status or to file the required reports with the Division. Of the 300 large employers who received letters, almost one-third (86) indicated they were non-subscribers who had not reported their coverage status to the Division. The remaining 214 employers either had workers' compensation coverage, were no longer in business (returned mail), or were able to show they had filed the required notice with the Division.

Additionally, the Division sent letters to 300 randomly selected employers who had filed the DWC-5 form to inquire whether these employers had any occupational injuries, illnesses or fatalities during calendar year 2008 that should be reported to the Division using the DWC-7 form. As of November 1, 130 of these employers indicated that they had no reportable injuries and illnesses for calendar year 2008, 18 reported injuries and illnesses that they had not previously reported, 16 indicated they now had workers' compensation coverage, 40 reported having fewer than five employees and are exempt from these reporting requirements, and the remaining employers (94) have not yet responded to the Division's letter or are no longer in business.

The Division is currently in the process of taking enforcement action against those employers who have not complied with the non-subscriber reporting requirements or who have not

responded to the Division's letters of inquiry regarding coverage status or notice of occupational injuries and illnesses. Warning letters have been sent to those employers who failed to respond to the Division's letters of inquiry and the Division is in the process of determining administrative penalties for the non-compliant employers. However, despite the Division's recent compliance and education efforts regarding these reporting requirements, overall non-subscriber compliance with existing reporting requirements remains low (less than 10 percent of non-subscribers are estimated to be in compliance with the DWC-5 form filing requirement).

This enforcement effort has proved to be challenging for the agency for several reasons, including the volume of potentially non-subscribing employers and the completeness, accuracy and timeliness of workers' compensation policy data and employer identifying data collected by the Division and other Texas state agencies. For example, an employer may have filed for unemployment insurance purposes with the TWC using the Federal Employment Identification Number (FEIN) of the parent organization, but may have different workers' compensation insurance policies under various FEINs and names of subsidiaries of the parent organization. As a result, it is somewhat difficult for the Division to identify individual employers that may be non-subscribers and to check for these employers' compliance with reporting requirements. Another issue is the fact that most non-subscribers, with some exceptions, are small employers who are unfamiliar with the reporting requirements under the Act and Rules. Educating these small employers will require a significant and continuing effort on the part of the Division. Over the next biennium, the Division will be exploring ways to partner with state agencies such as the TWC and employer trade organizations to distribute information about these requirements and to identify more efficient ways to consolidate employer reporting requirements across state agencies. Additionally, the Division will be taking steps to consolidate workers' compensation policy data collection under a single statistical agent, which will enhance the Division's abilities to monitor the completeness of this data and allow the Division to better examine discrepancies in employer identification across state agency databases.

Medical Costs Have Stabilized, While Denials of Both Claims and Medical Services Have Increased Over Time

Since the 76th Legislature passed HB 3697 in 1999 mandating a series of studies comparing the cost, quality and utilization of medical care provided to injured employees in Texas with injured employees 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 employees (also known as the utilization of care).[9] Compared with similarly injured employees in other states,

9 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.

these studies also highlighted that Texas injured employees 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 HB 2600 by the 77th Legislature in 2001, which included key components, such as:

- abolishing the former Texas Workers' Compensation Commission'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 the Department);
- instituting a registration and training requirement for doctors treating injured employees (i.e., the Approved Doctor's List or ADL);
- increasing training and testing 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 employees. The issue of reducing medical costs and improving the quality of medical care provided to injured employees was also a key component driving the passage of a new health care delivery model for workers' compensation in HB 7 – workers' compensation health care networks. The system has just begun to fully realize the effects of some of the various legislative and regulatory reforms enacted by HB 2600. It is still too early to effectively gauge the impact that HB 7 will have on medical costs in the future, especially the implementation of treatment guidelines and certified health care networks.

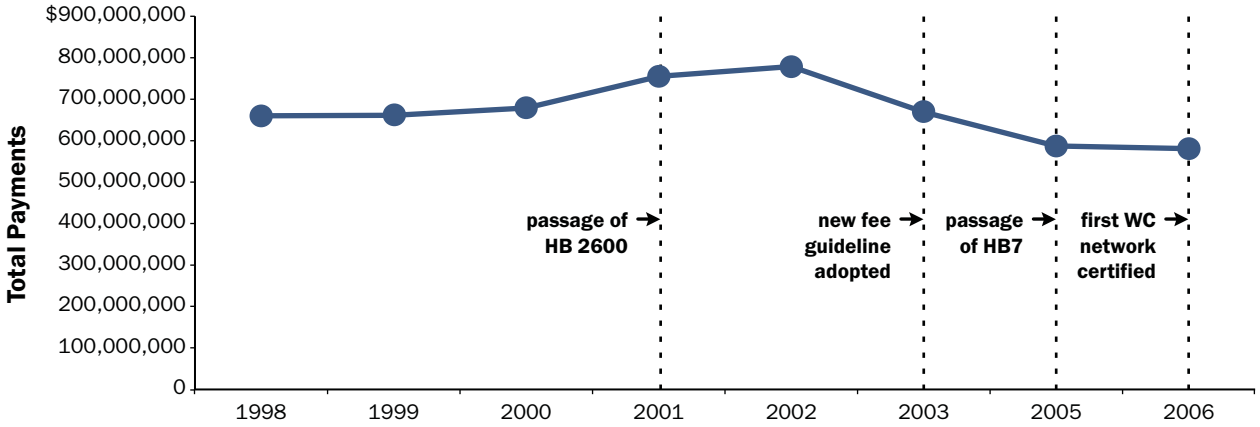
Figures 5 and 6 illustrate the medical cost trends that the system was experiencing prior to and just after the implementation of HB 2600 in 2001. Overall, total medical payments in the system have continued to decline since 2003 due to a variety of factors, including fewer claims being filed, reductions in medical reimbursement amounts, and reductions in the amount of care being rendered for new claims (see Figure 5).[10]

As injury rates continue to decline in Texas, there have been some changes in the types of injuries and the proportion of lost-time claims that receive medical treatment in the workers' compensation system. Looking at Figure 6, it appears that after controlling for differences in injuries and types of claims over time, the average medical cost per claim has begun to stabilize since the passage of HB 2600, compared to the double-digit percentage increases in medical costs that the system was experiencing in the late 1990's.

---

10 On August 1, 2003, the system's first Medicare-based professional service fee guideline took effect. While this fee guideline increased reimbursement for some categories of services, including primary care, reimbursements for specialty surgery services were significantly reduced. On the whole, the reimbursement rates for professional medical services in the Texas workers' compensation system went from approximately 140 percent of Medicare to approximately 125 percent of Medicare.

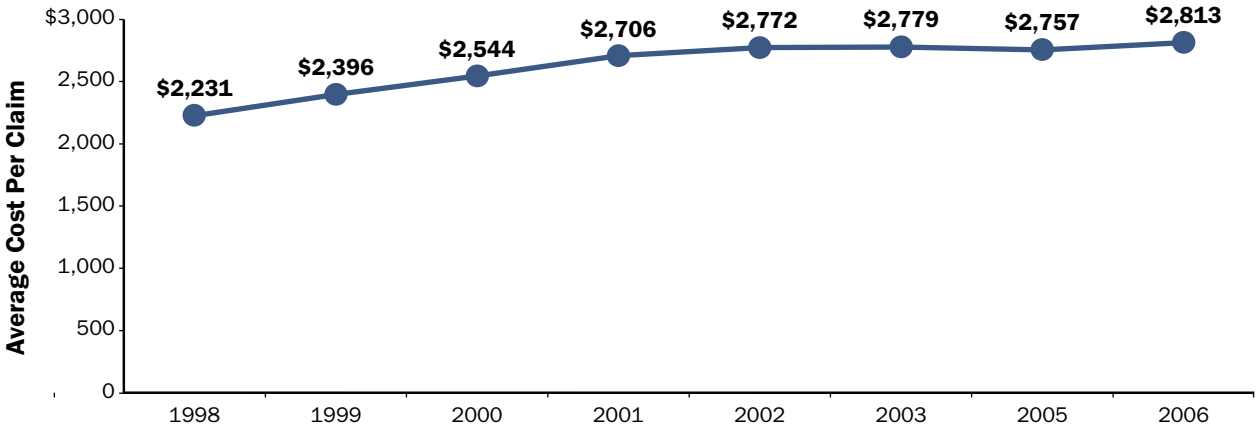
Figure 5: Total Medical Payments (Professional and Hospital), One-Year Post Injury, Unadjusted, Injury Years 1998-2006



Note: Injury year 2004 was excluded from this analysis due to missing data.

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

Figure 6: Average Medical Cost Per Claim (Professional and Hospital), One-Year Post Injury, Adjusted, Injury Years 1998-2006



Note: Injury Year 2004 was excluded from this analysis due to missing data. The figures presented above are adjusted for injury type and type of claim differences that may exist between the groups.

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

One possible explanation for 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 7 and 8). In particular, denials of professional medical services increased significantly after the adoption of a new Medicare-based medical fee guideline in August 2003, which included the adoption, by reference, of the Medicare billing rules and payment policies into the Texas workers' compensation system.[11]

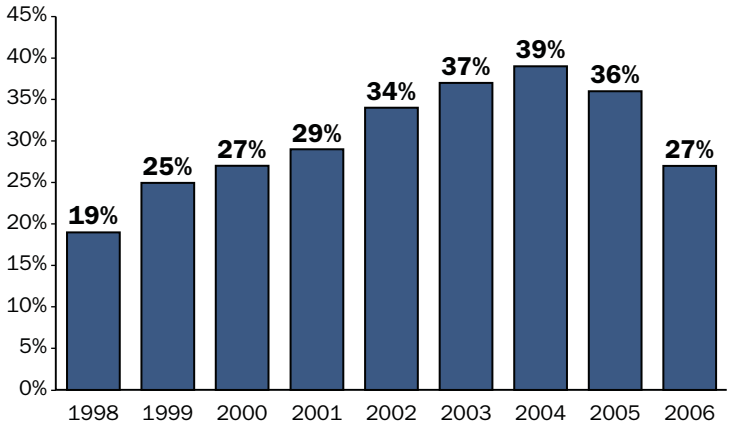
11 It should be noted that these professional medical denials represent denials for medical treatments and services that have already been rendered. Preauthorization denials are not included in these numbers.

Pharmacy Costs and Utilization Garner More Focus in the System with the Upcoming Adoption of a Closed Pharmacy Formulary and New Pharmacy Fee Guideline

Balancing concerns about rising pharmacy costs, while ensuring that injured employees have adequate access to the pharmaceutical drugs that are medically necessary continues to be a challenge in the Texas workers' compensation system. In an effort to bring greater certainty in payment for those pharmacies that dispense pharmaceutical drugs to injured employees, as well as to emphasize the use of evidence-based medicine by prescribing doctors, the legislature required the Division, as part of HB 7, to adopt a closed pharmacy formulary and a new pharmacy fee guideline.

The Division is developing a proposed closed pharmacy formulary, which will not only provide guidance in terms of which drugs are medically necessary for certain medical conditions, but also, provide guidance regarding the evidence-based usage of those drugs. Once the formulary has been adopted, the Division plans to propose a new pharmacy fee guideline that will reinforce the usage of those drugs that are part of the Division's closed formulary.

Figure 7: Percentage of Reportable Claims that are Initially Denied/Disputed for the Top 25 Workers' Compensation Insurance Carriers, Injury Years 1998-2006[12]



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

Note 1: The 2006 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.

Closed pharmacy formularies (i.e., lists of pharmaceutical drugs that are covered by health plans) are somewhat unique in state workers' compensation programs, although they have been used for years in the Federal Medicaid program. Understanding the types of drugs most frequently prescribed to injured employees as well as the types of injuries that are receiving these prescriptions was an important part of the Division's efforts to develop a pharmacy formulary that would best meet the needs of the injured employee population. Additionally, the Division has been examining the use of closed formularies in other state workers' compensation systems and other health care delivery systems to determine if there are "best practices" that can be incorporated into the Division's rulemaking efforts.

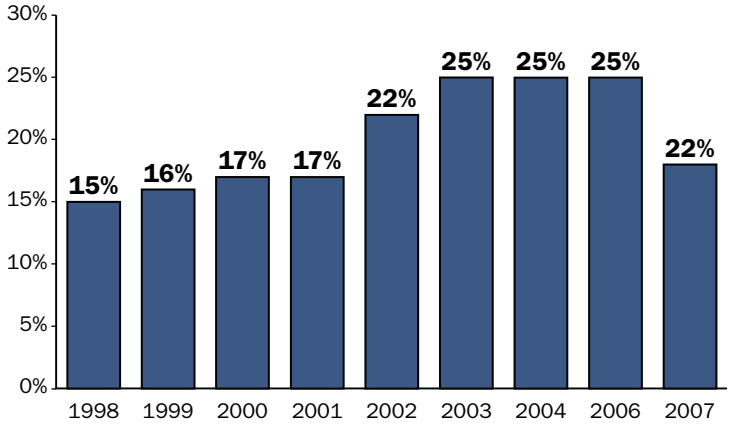
12 The top 25 insurance carriers represented over 90 percent of the workers' compensation premiums in 2006 and accounted for 60-70 percent of the total amount of medical payments made during 1998-2004. For the purpose of this analysis, the same 25 insurance carriers were used in each year to calculate both the claim and medical billing denial rates.

As Table 1 shows, pharmacy payments represented approximately 14 percent of the total medical payments made by insurance carriers during 2006 (the latest data available as of this report).

In terms of the types of claims that receive the most pharmaceutical drugs in the Texas workers' compensation system, employees with older injuries (pre-2000) represent approximately 13 percent of employees receiving drugs, but they constitute a disproportionate percentage of prescriptions (33 percent) and payments (46 percent) in the system (see Table 2).

Given that the vast majority of work-related injuries are strains and sprains (soft tissue injuries); it is not surprising that the types of drugs most frequently prescribed to injured employees are highly concentrated into seven of the eighty-nine major pharmacy classification groups. As Table 3 indicates, seven major pharmacy classification groups represent 79 percent of the prescriptions and 84 percent of the pharmacy payments made in the Texas workers' compensation system in 2006. These seven major pharmacy classification groups will be the focus of the new closed pharmacy formulary rule, which will be proposed some time next year. In addition, this rule proposal will also include an appeal process by which an injured employee can continue to receive drugs that are not part of the Division's closed formulary if these drugs are medically necessary.

Figure 8: Percentage of Professional Medical Services Denied for the Top 25 Workers' Compensation Insurance Carriers, Service Years 1998-2006



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

Note 1: Denial rates for 2007 should be interpreted with caution since these numbers are tentative.

Note 2: House Bill (HB) 2600, a workers' compensation reform bill aimed at reducing medical costs, was passed in 2001.

Note 3: In August 2003, the most recent professional medical fee guideline, which incorporated Medicare's payment policies, went into effect.

Table 1: Distribution of Medical Payments by Type of Medical Care, Service Year 2006

	Service Year 2006	
Medical Type	**Percent of Total Payments**	**Total Payments**
Professional	$535,603,000	57%
Hospital	$275,923,000	29%
Pharmacy	$131,647,000	14%
Dental	$1,049,000	<1%

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2007.

Table 2: Distribution of Pharmaceutical Utilization and Payments, by Injury Year, Prescription Year 2006

Injury Years	Number and (%) of Injured Employees	Number and (%) of Prescriptions	Number and (%) of Drug Days	Total and (%) of Payments
1991 - 2000	21,094 (13%)	545,591 (33%)	12,749,849 (40%)	$61,061,807 (46%)
2001- 2004	25,666 (15%)	457,480 (28%)	9,770,829 (31%)	$38,651,958 (29%)
2005	23,766 (14%)	252,673 (15%)	4,288,462 (14%)	$14,898,811 (11%)
2006	97,699 (58%)	392,822 (24%)	4,759,971 (15%)	$17,034,883 (13%)
Total	168,225	1,648,566	31,565,111	$131,647,459

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2007.

Note 1: Percent of Total Payments may not add up to 100 percent because of rounding.

Table 3: Distribution of Pharmaceutical Prescriptions by Therapeutic Classification Group, Prescription Year 2006

Therapeutic Classification Group	Number of Prescriptions	Cumulative Percentage of Prescriptions	Total and (%) of Payments	Cumulative Percentage of Payments
Analgesics - Opioids	522,521 (32%)	32%	$43,046,837 (33%)	33%
Analgesics – Anti-Inflammatories	257,092 (16%)	48%	$18,637,705 (14%)	47%
Musculoskeletal Therapy	225,173 (14%)	62%	$17,141,168 (13%)	60%
Antidepressants	99,189 (6%)	68%	$9,164,644 (7%)	67%
Anticonvulsants	96,298 (5%)	73%	$14,362,712 (11%)	78%
Hypnotics	64,116 (4%)	77%	$6,315,282 (5%)	82%
Anti-anxiety Agents	40.668 (2%)	79%	$2,030,153 (2%)	84%
Other Pharmacy Types	343,509 (21%)	100%	$20,948,958 (16%)	100%

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2007.

Note: Texas WC prescriptions in 2006 were for 6,001 unique Drug Names from 626 subclasses. The subclasses fall into 89 distinct Therapeutic Classification Groups as defined by the Medi-Span classification system.

Return-to-Work Rates Continue to Improve

One of the most basic objectives of the Texas workers' compensation system is to return injured employees to safe and productive employment. Effective return-to-work programs can not only help reduce the economic and psychological impact of a work-related injury on an injured employee, but it can also reduce income benefit costs and curb productivity losses for Texas employers.

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 employees in other states, Texas injured employees were generally off work for longer periods of time and were more likely to report that their post-injury take-home pay was less than their pre-injury pay.[13] Armed with these study findings, policymakers and system participants have placed considerable attention on improving return-to-work outcomes in recent years.

Several components of HB 7 placed significant focus on the importance of return to work, including a requirement for the Division to adopt return-to-work guidelines;[14] 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); improvements in return-to-work outreach efforts; and the ability for the Division to adopt rules to implement changes in the work-search requirements for injured employees who qualify for Supplemental Income Benefits (SIBs) and disability management rules that include the coordination of treatment plans and return-to-work planning.

Since 2001, there has been a steady increase in the percentage of injured employees receiving Temporary Income Benefits (TIBs) (i.e., injured employees with more than seven days of lost time) who have initially returned to work post-injury. Of those employees injured in 2001 receiving TIBs, 70 percent initially returned to work within six months post-injury, compared to 78 percent of employees injured in 2006 (see Table 4).[15]

---

13 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.

14 The Division adopted the *Medical Disability Advisor,* published by Presley Reed, as its return-to-work guideline, which became effective on May 1, 2007.

15 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 4: Percentage of Injured Employees 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%	89%
2003	72%	81%	85%	87%	90%
2004	74%	83%	86%	91%	93%
2005	75%	87%	90%	92%	
2006	78%	88%	90%		

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

Note 1: The study population includes 392,331 employees injured in 2001-2006 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 employees who initially return to work is an important benchmark of system performance, whether these injured employees 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 5 indicates, the percentage of injured employees receiving TIBs who have initially returned to work and remained employed for at least three successive quarters (or nine months) has also improved since 2001. Roughly 72 percent of employees injured in 2006 who initially returned to work within the first six months of their injuries remained employed for three consecutive quarters, compared to only 61 percent of employees injured in 2001.

Table 5: Percentage of Injured Employees 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%	81%
2003	64%	71%	76%	79%	86%
2004	66%	73%	78%	84%	88%
2005	68%	77%	84%	86%	
2006	72%	77%			

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

Note 1: The study population includes 392,331 employees injured in 2001-2006 who also received Temporary Income Benefits (TIBs).

Note 2: Employees injured in 2007 were excluded from this portion of the analysis due to insufficient data.

Not only have the percentage of injured employees who returned to work and remained employed improved slightly since 2001, but the amount of time the average injured employee who received TIBs is off work after an injury has decreased since 2001 (see Table 6).

It is important to continue to monitor these return-to-work measures to track the impact of the implementation of treatment and return-to-work guidelines and the impact of workers' compensation health care networks on return-to-work outcomes in Texas.

Table 6: Mean and Median Days Off Work for Injured Employees Who Returned to Work At Some Point Post-Injury, Injury Years 2001-2005

Injury Year	Mean days off work	Median days off work
2001	153	34
2002	145	33
2003	139	31
2004	127	29
2005	124	28

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

Note 1: "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 2: 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 2007. Injury year 2006 was excluded because of insufficient data.

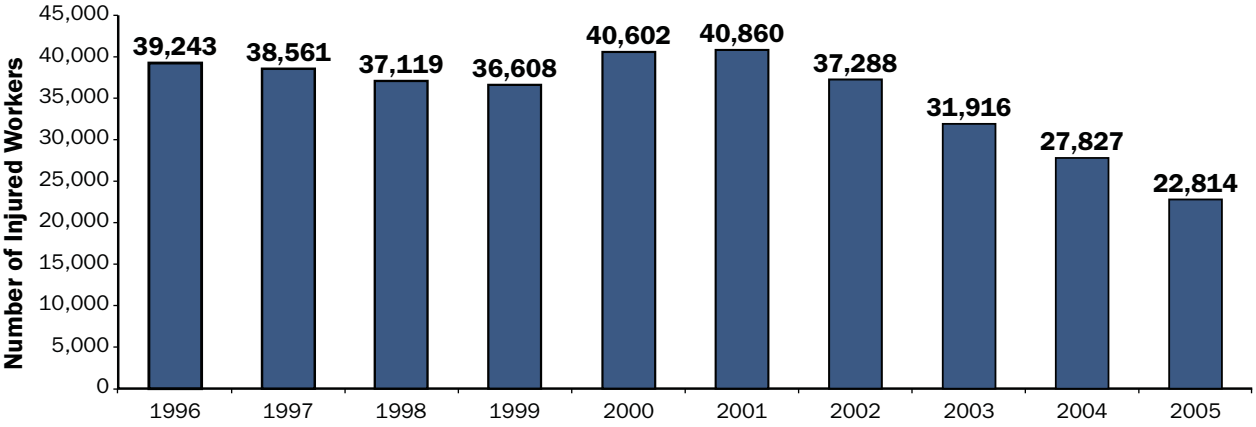
Fewer Injured Employees Are Receiving Permanent Partial Disability Benefits

Along with the trend of lower injury rates and better return-to-work outcomes in Texas, the system has also begun experiencing another important cost trend – fewer injured employees receiving the second and third tier of income benefits payable in Texas – Impairment Income Benefits (IIBs) and Supplemental Income Benefits (SIBs). IIBs and SIBs (also known as Permanent Partial Disability Benefits in other states) are payable to injured employees with permanent impairments directly resulting from their work-related injuries.

IIBs are payable after the first tier of income benefits (Temporary Income Benefits – TIBs – which are payable while the employee is off work) are exhausted. IIBs were designed to compensate employees with serious injuries and are payable regardless of whether the employee has returned to work or not. The amount of time an employee may receive IIBs is directly related to that employee's impairment rating, which measures the percentage of the employee's body that is permanently impaired. Doctors, including the employee's treating doctor, the Division's designated doctor, or the insurance carrier's required medical examiner (RME) may assign employee's impairment rating using the American Medical Association's *Guides to the Evaluation of Permanent Impairment, Fourth Edition*. Each percentage point assigned translates into three weeks of IIBs (ex: a 10 percent impairment rating would result in 30 weeks of IIBs).

As Figures 9 and 10 illustrate, fewer injured employees are receiving IIBs and the average duration of these benefits has decreased over time. These decreases resulted primarily from fewer injuries and claims in the Texas workers' compensation system over the same time period. Moreover, improvements in return-to-work rates and legislative changes in 1999[16], 2001[17] and 2003[18] affecting the way impairment ratings are issued and finalized have also impacted the number of employees receiving these benefits as well as the duration of these benefits.

Figure 9: Total Number of Injured Employees Who Received IIBs, Injury Years 1996-2005



Source: Texas Department of Insurance Workers' Compensation Research and Evaluation Group, 2008.

Note 1: Injury year 2005 data should be interpreted with caution since data may not be complete.

Note 2: Claims that did not have a valid claim, benefit and impairment rating record on file with the Division of Workers' Compensation were excluded from this analysis.

Additionally, the number of injured employees who qualify and receive the third tier of income benefits – Supplemental Income Benefits (SIBs) – after their IIBs are exhausted – have also declined (see Figure 11). SIBs are payable to injured employees who have at least a 15 percent impairment rating, have not returned to work or are underemployed, can show that their inability to work is a direct result of their work-related injury, and have made a "good faith effort" to find employment commensurate with their ability to work. SIBs eligibility is determined quarterly (the first quarter is determined by the Division and subsequent quarters are deter-

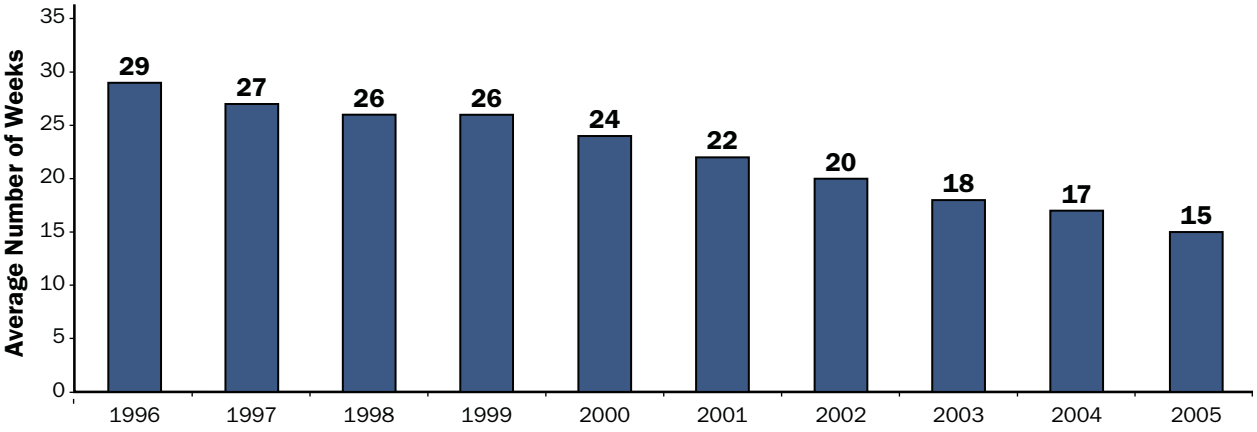
16 The 76th Legislature passed HB 2510 which allowed the Texas Workers' Compensation Commission to adopt the 4th Edition of the *AMA Guides* for the calculation of impairment ratings (effective for exams conducted after 10/15/01). Impairment rating exams conducted prior to 10/15/01 were based on the 3rd Edition, Second Printing of the *AMA Guides*.

17 The 77th Legislature passed HB 2600, which required all doctors who assign impairment ratings to be trained and tested in the use of the *AMA Guides* and required insurance carriers who wanted to dispute an impairment rating or seek an impairment rating to request a rating from a designated doctor (i.e., an independent doctor assigned by the agency). Carriers are allowed to request an exam from their own doctor to rebut the designated doctor's findings; however, by statute, designated doctor exams have presumptive weight in agency dispute proceedings.

18 The 78th Legislature passed HB 2198, HB 3168 and SB 820, which provided a maximum 90 day limit on the timeframe for a party to dispute an injured employee's maximum medical improvement (MMI) or impairment rating. This statutory change resulted from a court decision in March 2002 (Fulton vs. Associated Indemnity), in which a previous agency rule specifying a 90-day limit to disputes over the first MMI or impairment rating was struck down due to lack of statutory authority.

mined by the insurance carrier); and as a result, SIBs eligibility disputes are some of the most frequent types of disputes resolved by the Division.[19]

Figure 10: Average Impairment Income Benefit Duration Per Employee, Injury Years 1996-2005



Source: Texas Department of Insurance Workers' Compensation Research and Evaluation Group, 2008.

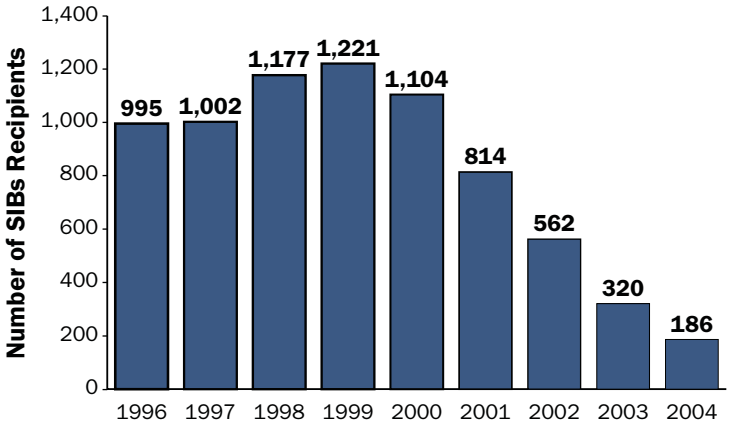
Note 1: Injury year 2005 data should be interpreted with caution since data may not be complete.

Note 2: Claims that did not have a valid claim, benefit and impairment rating record on file with the Division of Workers' Compensation were excluded from this analysis.

Workers' Compensation Networks Continue to Grow in Texas; However, It is Too Early to Gauge the Impact of These Networks on Costs and Quality of Care

The Department began accepting applications for the certification of workers' compensation health care networks on January 2, 2006. As of November 1, 2008, the Department has certified 32 networks extending over 234 counties. Of these, 18 networks were actually treating injured employees as of February 1, 2008. The shaded counties shown in Figure 12 are Texas counties included in the service area of at least one certified network as of October 23, 2008.

Figure 11: Total Number of Injured Employees Who Received SIBs Injury Years 1996-2004



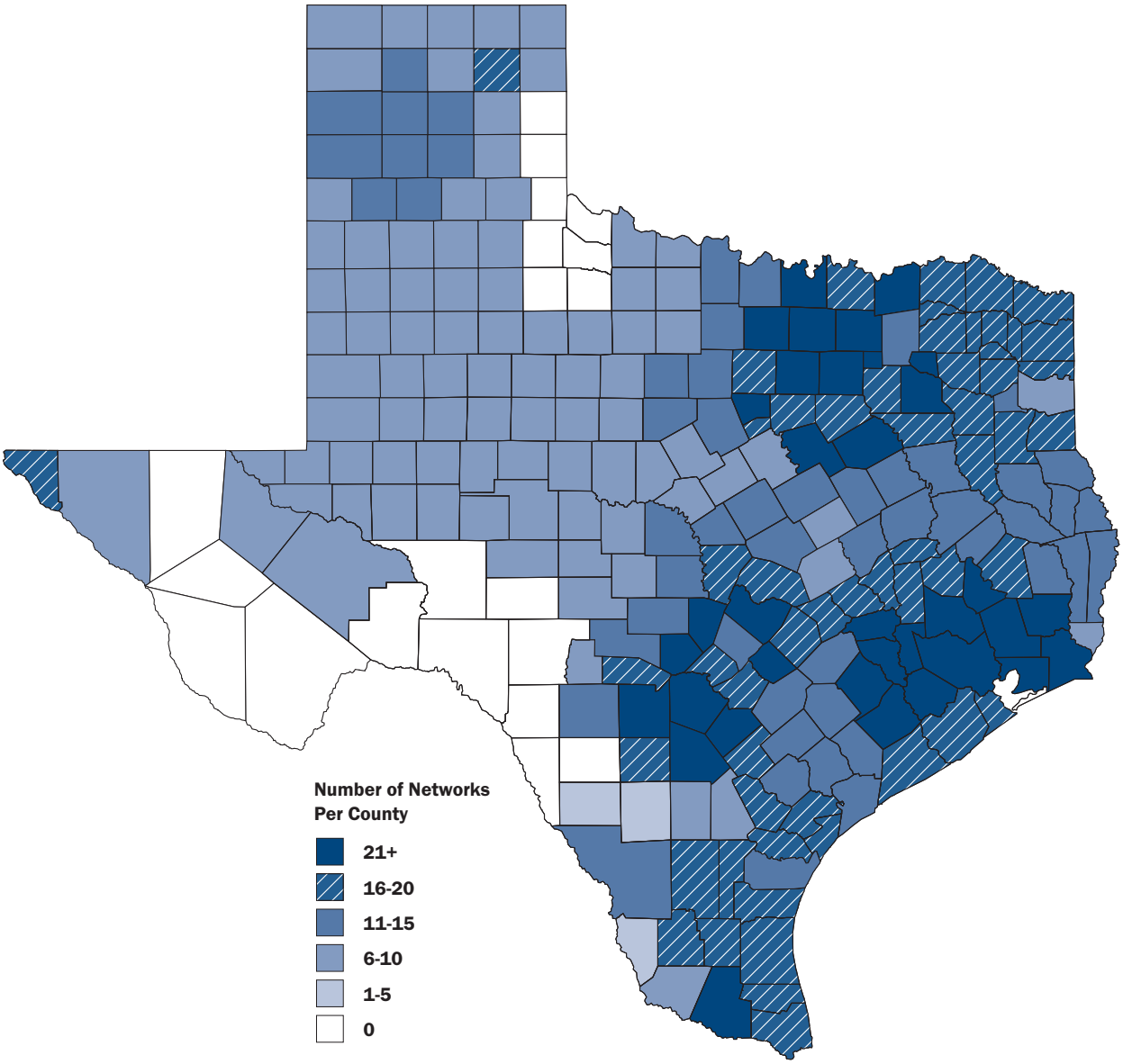
Source: Texas Department of Insurance Workers' Compensation Research and Evaluation Group, 2008.

Note: Injury year 2004 data should be interpreted with caution since data may not be complete. Injury Year 2005 was excluded from this analysis since few employees injured in 2005 have exhausted their IIBs and are eligible to receive SIBs.

19 The Workers' Compensation Act caps an injured employee's eligibility for income benefits, with the exception of Lifetime Income Benefits, Death Benefits and Burial Benefits at 401 weeks from the employee's date of injury. See Section 408.083, Labor Code.

Figure 12: Counties with Certified Workers' Compensation Networks

Total number of covered counties=234



Currently, certified networks cover the vast majority of Texas counties, with the exception of a handful of counties in the Panhandle, the Valley and West Texas. Most Texas counties with network coverage support multiple networks, allowing insurance carriers and their policyholders various options for network coverage, and larger metropolitan areas such as Houston, Dallas-Ft Worth and Austin-San Antonio support more than 21+ networks (see Figure 12).

The Department continues to track the participation of both Texas policyholders (employers) and injured employees in workers' compensation health care networks created by HB 7. According to the results of a July, 2008 data call with thirteen of the largest workers' compensation insurance carrier groups (representing 84 percent of the direct workers' compensation premium written in Texas), approximately 34,040 policyholders, most of whom are small and mid-sized employers, have agreed to participate in workers' compensation networks in exchange for premium credits that range between 5-15 percent.

While twelve of the top thirteen insurance carrier groups have contracted with or established a certified network for their policyholders, usage of networks among insurance carriers varies widely. As of July 2008, only four of the twelve insurance carrier groups offering a network option reported that more than 20 percent of their policyholders have agreed to participate in their workers' compensation network. While network participation among Texas policyholders has grown considerably since 2006 (34,040 policyholders in 2008 compared to 7,500 policyholders in 2006), it remains to be seen how differences in carrier marketing strategies, the concentration of high deductible policies within a carrier's book of business, the level of premium credits offered for network participation, employer requirements to provide employee network notices, and the impact of the economy on carrier profitability and market competition will affect the participation rates for Texas policyholders over the next biennium.

In addition to tracking the participation of Texas policyholders in workers' compensation networks, the Department also tracks the number of injured employees who have been treated by networks through separate data calls with each certified network. As of February 1, 2008, approximately 39,991 injured employees had been treated by a certified network – a roughly five hundred percent increase from a year earlier. While the number of injuries being treated by certified networks continues to grow, the overall percentage of injuries being treated by networks is still relatively low. The Department estimates that roughly 16 percent of all new injuries and nine percent of all new lost-time claims are being treated by certified networks. Additionally, the population of injuries being treated by networks (roughly 70 percent) is highly concentrated in one certified network associated with the largest workers' compensation carrier in Texas.

Given that many certified networks are still in the early stages of implementation, it is still too early to fully evaluate the impact of networks on claims costs and quality of care. However, initial information from the annual workers' compensation network report card produced by the Department in September 2008 provides some insight into the early implementation of networks.[20]

---

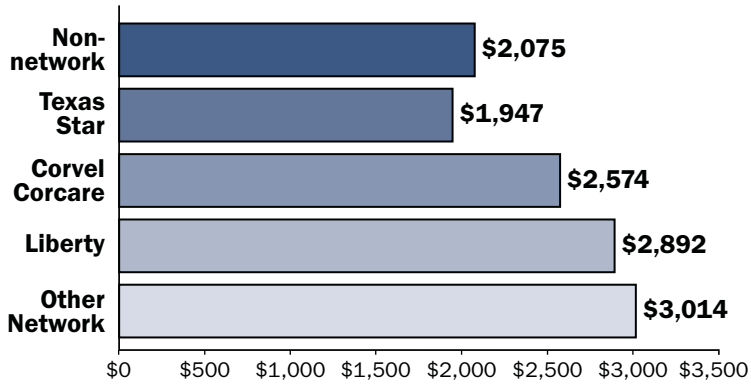
20 For more information about how individual networks compare with each other and with non-network claims on a variety of cost, utilization, access to care, satisfaction with care, return-to-work, and health outcomes measurements, see Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, *2008 Workers' Compensation Network Report Card Results,* 2008 (http://www.tdi.state.tx.us/reports/report9.html).

Only three certified networks: Texas Star, Liberty HCN and Corvel CorCare had sufficient claim volume to be compared with each other and with non-network claims. The remaining 15 certified networks that had reported treating injured employees according to the February Department data call were combined into an "other networks" category for comparison purposes.

In general, differences have begun to emerge among individual networks. As Figure 13 shows, at six-months post-injury, Texas Star's average medical cost per claim was lower than other networks and non-network claims; however, with the exception of Texas Star, the average medical cost per claim for the other certified networks was higher than non-network claims. Medical cost differences between network and non-network claims at this early stage in network implementation appear to be driven primarily by higher hospital fees, higher pharmacy utilization and higher utilization of certain physical medicine services and diagnostic tests than non-network claims with similar types of injuries.

Generally, injured employees who received medical care in certified networks had poorer perceptions regarding access to care and satisfaction with care than non-network employees (see Figure 14). However, it should be noted that the perceptions of employees being treated in certified networks are similar to those employees analyzed by the Department in 2005 (before the implementation of certified net-

Figure 13: Average Medical Cost Per Claim, Network and Non-Network Claims, 6 Months Post Injury

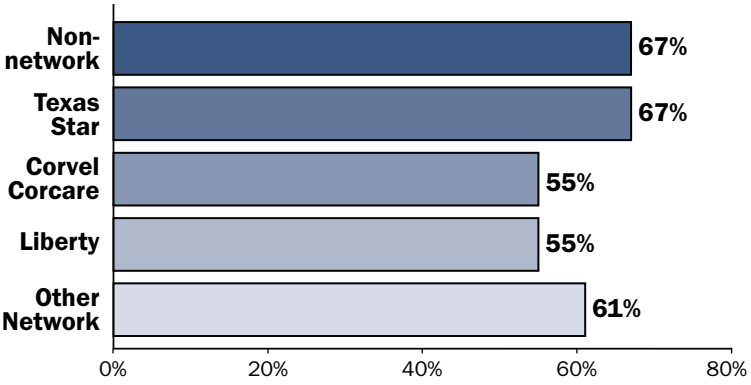


Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

Note: Medical cost differences between non-network and Corvel CorCare, Liberty HCN, and other networks are statistically significant. The figures presented above are adjusted for injury type and type of claim differences that may exist between the groups.

Figure 14: Getting Needed Care

Percent of injured workers who reported no problem getting • a personal doctor they like • to see a specialist • necessary tests or treatment • timely approvals for care:



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

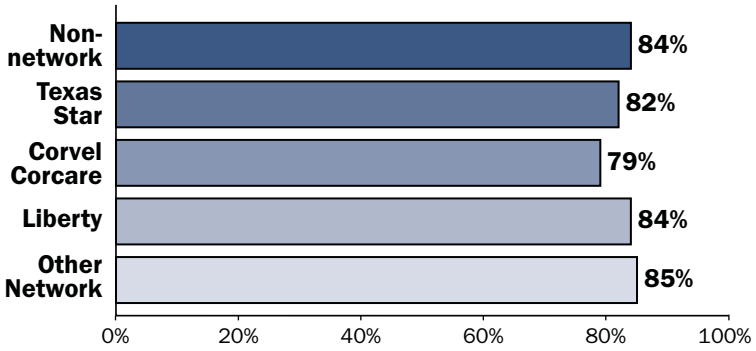
Note: Differences between non-network and Corvel CorCare, Liberty HCN, and other networks are statistically significant. The figures presented above are adjusted for injury type, and type of claim, race/ethnicity, gender, age, education, age of injury at the time of the survey, medical insurance, and self-rated health differences that may exist between the groups.

works) who reported choosing a doctor recommended to them by their employer or insurance carrier.[21]

In addition to medical costs, it is still too early to determine what impact, if any, that certified networks will have on return-to-work outcomes and resulting indemnity costs. As Figure 15 indicates, the 2008 report card shows that there is little difference between network and non-network claims in the percentage of injured employees who reported that they had returned to work at some point after their injury. These differences may become more pronounced over time.

Figure 15: Return to Work

Percent of injured employees who indicated that they had returned to work at some point after they were injured



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

Note: Differences between non-network and Texas Star are statistically significant. The figures presented above are adjusted for injury type, and type of claim, race/ethnicity, gender, age, education, age of injury at the time of the survey, medical insurance, and self-rated health differences that may exist between the groups.

Concluding Remarks

Since the passage of HB 2600 in 2001 and HB 7 in 2005, the workers' compensation system has changed significantly and continues to show signs of progress. Although it is too early to fully evaluate the impact of many of the HB 7 reforms, including health care networks, there are many indications that costs have stabilized and return-to-work rates continue to improve in the system. However, certain trends, including an increasing percentage of employees who aren't covered by workers' compensation remain troubling. Going into the 81st Legislative Session, it is clear that significant changes to the Workers' Compensation Act are not necessary given the upcoming Sunset Review of the Division of Workers' Compensation scheduled for 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. For these reasons, the legislative recommendations presented as part of this biennial report 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.

21 For a summary of the 2005 injured worker survey findings, see *Biennial Report of the Texas Department of Insurance To the 80th Legislature: Division of Workers' Compensation,* which can be viewed at http://www.tdi.state.tx.us/reports/report9.html.

Section B: Recommendations

Market Stability

Risk Based Capital for County Mutual Insurers

BACKGROUND: Insurance Code section 32.022(b) requires the Commissioner 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, but allowed a limited exemption for certain insurers, including county mutual insurers. Most other insurance companies are subject to risk based capital (RBC), which recognizes that insurers vary in size, exposure and types of risks assumed. RBC indexes the amount of capital a particular insurer needs to its own unique risk profile. The Commissioner has authority to adopt RBC regulations for most other insurers based upon any of the following factors:

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

PROBLEM: Current law does not authorize the Commissioner to apply RBC requirements to county mutual insurance companies, even though county mutuals hold over 43 percent of the Texas market for private passenger automobile insurance. These exempt insurers are exposed to the same risks as their competitors who are subject to RBC. Applying RBC standards to county mutuals will help ensure that these insurers are able to pay claims and remain solvent. Continuing to exempt county mutuals from RBC requirements exposes the State's General Revenue funds in the event that one of these exempt insurers becomes insolvent, because unpaid claims of insolvent insurers ultimately result in a reduction of the State's premium tax collections.

RECOMMENDATION:

- Make RBC requirements applicable to county mutual insurance companies.
- Provide a phase-in period to comply with new RBC requirements.

Certificate of Authority Application Process

BACKGROUND: The Insurance Code requires the Commissioner to hold a hearing before denying an application for a certificate of authority for a company that desires to enter the Texas market. In contrast, in the review of an application for the acquisition of control of an existing insurer (Form A), the Insurance Code required process allows the Commissioner to deny the Form A without first holding a hearing and, if the Commissioner denies an application, then the applicant is entitled to a hearing on the denial.

PROBLEM: The current hearing requirement prolongs the review process and diverts valuable resources from other applications and other regulatory functions. Providing an applicant with a hearing after denial maintains the applicant's due process rights, allows the Department to require strict adherence to the standards that must be met before a certificate of authority is issued, and minimizes time spent on unqualified applications.

RECOMMENDATION:

- Enact legislation that grants the Commissioner authority to deny an application for a certificate of authority without being required to first holding a hearing.
- Provide the applicant the right to request a hearing after the denial to show that the applicant met all requirements for issuance of a certificate of authority.

Corporate Governance – Best Practices

BACKGROUND: Currently, insurance companies and HMOs with more than $1 million in premium in Texas are required to obtain an audit of their financial statements performed by an independent certified public accountant. The Texas requirements are based on model audit requirements developed by the NAIC. Recently, the NAIC revised the model audit requirements to incorporate provisions regarding corporate governance, accounting, and auditing requirements that will primarily impact large, non-public insurers and HMOs. The revised model was designed to obtain the biggest public benefit at the lowest cost of compliance. As a result, small, medium and certain large insurance carriers (those with less than $500 million in premium) were exempted from many of the model's new requirements. These new revisions will be required for state insurance departments to maintain their accreditation which is necessary to ensure uniform financial regulation.

PROBLEM: Currently, large, non-public insurance companies and HMOs are not required to comply with best practices for corporate governance. Requiring such compliance would improve the oversight and internal controls for these insurers who have substantial market share in Texas. Additionally, public insurers who are already required to comply with best practices for corporate governance under federal law are not required to file mandated reports with insurance regulators.

RECOMMENDATION:

- Amend Chapter 401, Insurance Code, to improve Texas' surveillance of the financial condition of insurers and HMOs by incorporating NAIC model requirements for corporate governance and governance best practices.
- Consideration should be given regarding the costs of compliance on insurance companies and HMOs, including lessening requirements for smaller companies.

Consumer Protection

Disaster Recovery Mediation Program

BACKGROUND: Hurricane Ike struck the Texas coast on September 13, 2008 causing extensive property damage on the Texas Coast and to areas inland. As a result, several thousand policyholders have claims arising out of Hurricane Ike. The large volume of claims filed by policyholders (approximately 730,000 as of October 31, 2008) may result in a corresponding increase in complaints received by the Department and possibly in litigation from policyholders dissatisfied with the resolution of claims.

PROBLEM: The Department seeks to ensure that claims are resolved as quickly and fairly as possible. Prompt and fair resolution of claims will minimize consumer complaints and corresponding litigation. A mediation program may assist both consumers and insurance companies with the insurance claims arising out of damages to residential property as the result of a disaster. The following states have mediation programs related to the occurrence of a disaster: Florida, Mississippi, Louisiana, Alabama, California, and North Carolina.

Mediation is a non-adversarial mechanism to assist with disputes.

The benefits derived from mediation programs are as follows:
- Provides an expedited process to resolve disputes.
- Costs less in comparison to regular court proceedings.
- Allows the Department an additional mechanism to assist consumers and insurance carriers to resolve claim disputes.

RECOMMENDATION:
- Enact legislation that grants the Department rulemaking authority to establish a disaster-recovery mediation program to facilitate the resolution of property damage claims due to the occurrence of a disaster, such as a hurricane.
- Allow a consumer the right to a mediation conference with his/her insurance company in order to resolve a property claim dispute.
- Allow the Department to contract with an outside entity to administer the mediation program and specify that the insurance company must pay for the costs associated with the mediation.

Enhancement of Independent Review

BACKGROUND: Texas consumers with managed care health plans regulated by the Department, such as HMOs and preferred provider plans, are currently entitled to independent (external) review of their carriers' decisions in one circumstance, denial of pre-authorization of treatment based on the carrier's decision that the treatment is not medically necessary. No provision of the Insurance Code requires independent review of a carrier's conclusion that a service should be denied because it is experimental or investigational. Likewise, no provision of the Code provides for independent review of a carrier's conclusion *after the fact* that a service was not medically necessary.

Review of Experimental/Investigational Denials – Chapters 4201 and 4202 of the Insurance Code provide the circumstances when the independent review option is required. Independent Review is required only after a carrier has conducted "utilization review," which is defined in section 4201.002 as "a system for prospective or concurrent review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to an individual within this state." There is no clear reference in the Code to how experimental/investigational denials should be reviewed. Because of this, health plans may deny a requested service for the reason that the plan deems it to be experimental or investigational, and the provider or claimant does not have access to an administrative process to seek review of the denial. However, in the workers' compensation context, experimental/investigational decisions are entitled to independent review both prospectively and retrospectively through a process coordinated by the Department. A study by a national association of health plans found that a majority of states currently have external review programs that also appear to cover either all adverse decisions or at least all adverse decisions involving medical necessity or services deemed to be experimental.[22]

Review of Retrospective Medical Necessity Denials – Review of the denial of claims after the fact based upon the lack of medical necessity is briefly addressed in sections 4201.501 and 4201.502 of the Insurance Code, but independent review of such claims is not required. A 2002 Kaiser Family report concluded that only three states (including Texas) had any limitations on retrospective reviews of denials based on medical necessity, and that Texas appeared to be the only state with an independent review law that did not extend to retrospective reviews of at least emergency and urgent care.[23] Since the publication of that report, the two other states listed in the report have expanded their external review laws, meaning that Texas now appears to be the only state with an external review law that has more limited retrospective reviews than prospective reviews.

PROBLEM: The Department's health insurance complaint data for 2007 reflects 48 complaints on experimental/investigational issues and 165 complaints regarding medical necessity generally. Since there are no provisions in the Insurance Code for review of experimental/investigational denials and only limited standards for retrospective denials, there is often little the Department can do about such complaints. Carriers appear to have widely varying standards for what is experimental and investigational. In regard to retrospective reviews, the Department's data regarding workers' compensation claim denials arguably shows that carriers may get retrospective denials wrong more often than prospective denials. Specifically, in the workers' compensation system, the Department's data reflects that prospective medical necessity decisions by carriers are overturned approximately 30 percent of the time when independent review is conducted. However, retrospective medical necessity decisions by workers' com-

---

22 An Update on State External Review Programs, 2006, America's Health Insurance Plans, www.ahipresearch.org/PDFs/StateExternalReviewReport.pdf, pages 8-10.

23 Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation, 2002, Kaiser Family Foundation, www.kff.org/insurance/externalreviewpart2rev.pdf, page 9.

pensation carriers (which include experimental/investigational denials) are overturned 68 percent of the time after an independent review is conducted.[24]

RECOMMENDATION: Require independent review of experimental/investigational denials and independent review of denials based on retrospective reviews when requested by the insured, provider, or person acting on behalf of the insured.

Additional Protections for Seniors

BACKGROUND: Sales of insurance products to seniors have shown an increase over time, especially in the area of annuities. From 2005 to 2006, for example, the American Council of Life Insurers reports that premium receipts from individual life insurance rose by 1.8 percent, while premium from individual annuities rose by 12 percent.[25] With the increasing sales, the Department has received increased complaints regarding a variety of issues relating to sales of insurance products to seniors, including unsuitable annuity products and dramatic increases in long term care insurance rates.

Agent Incentives – Some products sold to seniors are purchased through single or annual premium payments. Carriers will often compensate agents for such sales through a large, immediate commission. An agent's sale of a variable annuity, for example, may result in a large upfront, one-time commission to the agent based upon a percentage of the face value of the annuity. Often the annuities that provide the largest commissions are those with particularly severe surrender charges, which in turn support the large commission structure. In the Medicare supplement context, this type of compensation was prohibited in 1998 by a rule adopted by the Department of Health and Human Services that prohibits first year commissions from being more than 200 percent of renewal commissions. A similar rule was also adopted by the Department.[26]

Annuity Maturity Dates – The Department has concerns relating to the surrender charges utilized by some annuity companies. Chapter 1107 of the Insurance Code specifies the minimum nonforfeiture amounts that the annuitant will receive if they surrender their contract. In calculating the maximum permissible surrender charges under Chapter 1107, annuities with optional maturity dates are required to use maximum maturity dates of the 70th birthday of the annuitant or 10 years, whichever is later. This requirement is known as the 70/10 Standard. However, fixed maturity date annuities are able to set their maturity date at any time because the 70/10 Standard is not currently applicable to annuities with fixed maturity dates. The longer the timeframe before maturity, the higher the initial surrender charges may be. At the national level, the Interstate Insurance Product

---

24 In 2007, 204 out of 290 independent reviews of workers' compensation carriers' denials of pre-authorization of treatment were upheld. On the other hand, only 83 out of 263 independent reviews after the fact upheld the carriers' decisions. Percentages for the years 2004-2006 were consistent, with no results varying by more than 7%.

25 2007 Life Insurers Fact Book, www.acli.com/NR/rdonlyres/A85A882F-F871-431D-976E-3316884C63EB/11356/FB_0407_Income1.pdf, page 35.

26 http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=3&rl=3317

Regulation Commission, of which Texas is a member pursuant to Chapter 5001 of the Insurance Code, sets the standards for national filing of insurance products and recently adopted the 70/10 Standard for fixed maturity date annuities.[27]

Charitable Gift Annuities – The Department has also become aware of fraudulent charitable gift annuity schemes being sold to seniors. Insurance Code Chapter 102 specifically exempts charitable gift annuities from being considered and regulated as insurance and establishes the requirements that must be satisfied to be considered a charitable gift annuity. However, because the Department is unable to investigate companies claiming this exemption, Chapter 102 provides a statutory safeguard for fraudulent actors working under the cover of a charitable organization. Section 102.102(c) provides that a charitable organization may not be made to submit additional information except to determine appropriate penalties for failure to notify the Department of its intent to issue charitable gift annuities.

Long-Term Care – Many long-term care insurance companies write business in multiple states, most of which regulate rates. Long-term care carriers file for rate increases in the various states as needed. Occasionally, a carrier is denied a rate increase in one state and then in order to collect the amount of premium it believes necessary the carrier will file for rate increases in other states that do not regulate rates, such as Texas, to make up for the inadequate rates it is charging in the rate regulated states. This issue was recently discussed in a Government Accountability Office report entitled "Long-Term Care Insurance, Oversight of Rate Setting and Claims Settlement Practices."[28]

PROBLEM:

Agent Incentives – High upfront commissions can potentially lead to high pressure sales tactics by agents or other inappropriate sales behavior, when the agent is more concerned about making an initial sale than about whether the consumer keeps the product for the long term.

Annuity Maturity Dates – Recently, carriers have begun to file annuity contracts that set the maturity date at ages as high as 115, allowing for surrender charges far higher than would be allowed under the 70/10 Standard. When an annuity company artificially sets the maturity date of an annuity at a high age, such as 115 years, it is then able to have higher surrender charges and pay higher upfront commissions to agents. It is clear that 115 years is not a reasonable maturity age, and it is far more likely that the consumer will pass away prior to the end of the surrender charge period, leaving their beneficiaries to have to pay a surrender charge to liquidate the asset after death. Expanding the 70/10 Standard to apply to annuities with fixed maturity dates would end this abusive practice.

Charitable Gift Annuities – While most charitable gift annuities are legitimate, some are not. The Department's inability to request information from the entities issuing gift annuities may dramatically lengthen the time before the Department uncovers any evidence that a

---

27 www.insurancecompact.org/rulemaking_records/080530_ind_def_nonvar.pdf.

28 www.gao.gov/new.items/d08712.pdf, page 21.

gift annuity arrangement is actually a scam, resulting in needless harm to Texas consumers. The current statutory requirements allow fraudulent actors to assume control of a dormant and previously legitimate charitable organization and to issue fraudulent charitable gift annuities completely unhindered by any regulation or investigation by the Department.

Long-Term Care – Some Texas consumers are being forced to pay higher premiums for long term care insurance to compensate for the lower rates consumers pay in the states in which those companies' rate increases have been denied.

RECOMMENDATION:

- **Agent Incentives** – Provide the Commissioner authority to order carriers to change their commission payment schedules when the schedules are found to incentivize inappropriate sales behavior.
- **Annuity Maturity Dates** – Amend section 1107.006 of the Insurance Code to apply the 70/10 Standard to annuities with fixed maturity dates.
- **Charitable Gift Annuities** – Amend section 102.102(c) of the Insurance Code to permit the Department to verify and investigate the actual nature of charitable organizations issuing charitable gift annuities.
- **Long-Term Care** – Provide rulemaking authority that would require insurers to use Texas experience, if credible, or another actuarial method adopted by rule, in order to prevent Texas consumers from subsidizing other states.

Supplementary Agent Qualifications for Complex Products

BACKGROUND: The Department routinely receives a large number of complaints relating to inappropriate and unsuitable sales of complex insurance products. Subsequent investigations by the Department into these complaints indicate that an agent's lack of knowledge or expertise on the features and operation of the products is often a contributing factor to an inappropriate sale.

PROBLEM: Certain insurance products are so complex that the general agent licensing and continuing education requirements are insufficient to ensure the level of agent expertise necessary to safeguard consumer interests. Texas agents should be equipped with the necessary skills and knowledge to assist insureds appropriately in their purchases. Requiring additional agent training or demonstration of knowledge before selling particularly complex products would mitigate the negative impact caused by agents selling complex products without the training and knowledge necessary to sell them in a manner fair and beneficial to insureds.

For example, in 2003, California enacted a law requiring that all life/health agents complete an eight-hour annuity training course before selling an individual annuity. The law, which is equally applicable to non-resident agents, also requires an additional four hours of annuity-specific training every two years to be able to continue selling individual annuities. The law went into effect January 1, 2005, and allows the California Department of Insurance to specify the content of the courses.[29]

---

29 California Insurance Code section 1749.8

Another example where an additional training requirement could be beneficial involves agents who intend to sell or agents selling flood insurance or Medicare Advantage or Medicare Part D Plans. Oklahoma currently requires eight hours of continuing education related to Medicare Advantage or Medicare private fee for service products every two years.[30]

RECOMMENDATION:

- Enact legislation that grants the Department rulemaking authority to place additional qualifications on agent licenses before they are authorized to sell specific products.
- The rules adopted shall identify the reasons why a product line needs additional qualifications for its sale and specify what additional qualifications are necessary for its sale.
- Apply to all new applications for licenses categorically; grandfather existing licenses except if limits are ordered by the Commissioner on a case-by-case basis.

Return of Unearned Premium

BACKGROUND: The Department's Fraud Unit and Enforcement Division have experienced an increase in the number of suspected fraud reports associated with agents who convert money belonging to insureds, insurers and premium finance companies. Insureds who are unable to pay the entire premium may seek funding from premium finance (PF) entities. It is common for the PF company to forward the loan proceeds directly to the agent who assumes responsibility for remitting the premium to the insurer.

PROBLEM: There has been a growing fraud trend among agents. Several types of fraudulent conduct are common:

- In transactions where the premium is financed through a premium finance company, agents misapply money when the premium finance company forwards the loan proceeds directly to the agent.
- Agents misapply money when the insurer routes unearned premium through the agent instead of returning the money directly to the insured or premium finance company.
- Agents fail to return unearned advanced commission when the policy cancels before the policy period expires.
- Agents submit false applications to generate advance commissions.

If the agent fails to remit the premium, the insurer will not issue the policy or if it was issued, will cancel the policy for non-payment. Insureds may discontinue making payments to the PF company for the non-existent policy. However, the PF company does not look to the agent for repayment. Instead, it will proceed with collection actions against the individual whose name appears on the finance contract; often with full knowledge that the agent misapplied the insured's funds.

When an insurance policy is canceled, section 651.162(e) of the Insurance Code allows the insurer to elect to return unearned premium to the agent instead of directly to the PF company. Although this provision ultimately holds the insurer responsible for paying the unearned premium to the PF company, that obligation does not arise until the 121st day after cancella-

---

30 Oklahoma Administrative Code section 365:25-3-18

tion. Consequently, the PF company may have already initiated collection action against the individual whose name appears on the finance contract.

Similarly, when the policy cancels before the policy expiration date, some insurers, or their managing general agents, will refund the unearned premium to the agent who assumes responsibility for remitting the unearned premium to the insured. Because agents recognize that insureds may not be aware a premium refund is due, the agent may illegally withhold the premium refund money.

Industry practice is to pay the agent a large upfront commission when the policy is issued. If the policy cancels before the policy period expires, the agent is contractually obligated to return the unearned commission to the insurer. However, the agent often fails to return the unearned commission. While some insurers are able to offset the unearned commission by retaining "new" commissions, this effort does not always allow the insurer to recoup all of the money it advanced to the agent.

Another problem related to advancing commissions is the incentive for an agent to fabricate applications in order to generate money. Often by the time the company detects the fraud, it has advanced thousands of dollars. There have been instances where an agent has perpetrated this advance commission scheme on several insurers before the matter was reported to or discovered by the Department.

RECOMMENDATION:

- Enact legislation that requires a PF company to remit funds directly to the insurance company or require the agent to have a written contract with the PF company to disburse funds to the insurer and that the agent in this capacity is acting as the designated agent of the PF company which makes the PF company responsible for what the agent does.
- Enact legislation and amend Insurance Code section 651.162 to require insurers to return unearned premium directly to the insured or PF company, as applicable.
- Enact legislation that establishes a PF company's responsibility for fraudulent acts of agents who represent them in a loan transaction.

Unauthorized Insurance Guaranty Fund

BACKGROUND: There are administrative and judicial remedies available under the Insurance Code to handle unauthorized insurers. The administrative remedies include the issuance of a cease and desist order under Chapter 83 of the Insurance Code. The judicial remedies include a receivership proceeding under Chapter 443 of the Insurance Code, which authorizes the Attorney General to file an action on behalf of the Commissioner. In a receivership, the Commissioner is appointed by the Court as the Receiver of the entity.

PROBLEM: While a cease and desist order can stop the entity's unauthorized business of insurance, it does not provide a mechanism to pay the claims of the victims of the scheme. A receivership proceeding does contain such a mechanism, but the payment of claims depends on the existence of assets available to the entity. The process for collecting such assets can be difficult and lengthy. If the assets are insufficient to pay the claims, claims must be paid on a pro-rata basis.

The existing funding mechanisms created to protect policy claimants of failed insurers do not cover the victims of unauthorized insurers. Guaranty associations, which consist of licensed insurers, only cover the claims of their member companies. While funds are available from the Abandoned Property Fund to pay for a receivership's administrative expenses, such funds cannot be used to pay claims.

RECOMMENDATION:

Amend the Insurance Code to create an unauthorized insurance guaranty fund (UIGF) to provide the Receiver with funding to pay claims of unauthorized insurers, as follows:

Source of Funding

The UIGF would receive funds derived from fines and penalties imposed on: (a) unlicensed entities that are doing the business of insurance, and (b) licensed entities that are doing an insurance business that they are not authorized to do.

Use of Funds

In the event of a receivership of an unauthorized insurer, funds could be disbursed from the UIGF to the receivership as follows:

- **Allowable Claims** – Funds could be used to pay expenses and policy type claims to the extent that the receivership has insufficient assets to pay such expenses and claims. The funds would not be used to pay other claims, e.g., claims of general creditors.
- **Claim for Disbursements** – The UIGF would have a claim in the receivership for all funds disbursed to the receivership.
- **Partial Disbursements** – In the event that the funds held by the UIGF were insufficient to pay the shortfall for expenses and policy type claims in all existing or reasonably anticipated receiverships of unauthorized insurers, partial disbursements would be authorized from the UIGF to the receiverships in an equitable manner.

Enforcement and Compliance

Registration of Contract Examiners

BACKGROUND: Some states use contract examiners to perform examinations of insurers and may not coordinate those examinations with other states; this lack of coordination may result in duplicate examinations or, in some instances, in duplicate charges for the same examination work.

PROBLEM: Because the insurer is required to pay the costs of examination, this often results in duplicate costs to the insurer. The Department seeks to minimize the potential for unnecessary and duplicative cost to insurers for multiple examinations of the same issue. Requiring contract examiners to register with the Department, and enacting rules to establish the specific requirements, could reduce the duplication of cost and effort.

RECOMMENDATION:

- Enact legislation requiring an examiner who has a contract with any other state to examine a Texas domestic company to register with the Department before participating in any examination of a Texas-domiciled insurer.
- Authorize the Commissioner to enact rules to establish the specific requirements for filing examination plans.

Use of Automatic Fines

BACKGROUND: The Insurance Code and related administrative rules impose a number of technical requirements on persons licensed by the Department. For example, title agents are required to file an escrow audit report with the Department on an annual basis. These requirements serve the important function of providing the Department with information about licensees and the marketplace necessary to fulfill the Department's regulatory responsibilities. In general, isolated violations of these types of requirements are considered relatively minor in nature and do not typically result in consumer harm. However, a pattern of such violations usually indicate more serious problems such as mismanagement, incompetence or fraud.

PROBLEM: Currently, if the program areas (e.g., Title, Financial, State Fire Marshal) want to initiate an action for a violation, the program area must refer each violation to the Enforcement Division. Attorneys in the Enforcement Division typically negotiate and draft a Consent Order which must then be reviewed and signed by the Commissioner. Consent Orders resolving these violations generally include an administrative penalty between $500 and $10,000. Violations which cannot be resolved by Consent Order must be adjudicated at the State Office of Administrative Hearings.

The Department seeks to minimize the use of attorney and litigation support resources to address issues which could be resolved at the program area level through the use of automatic fines. The attorney resources could then be reallocated to projects involving consumer harm and/or serious misconduct.

Currently, section 4005.109 of the Insurance Code authorizes the Department to resolve certain violations through a fine. A listing of these violations includes the failure of insurance

agents to complete continuing education, file address changes and report disciplinary actions by other states. The proposal set forth below would allow the Department to create rules to resolve a wider variety of violations through fines and to use staff resources efficiently.

RECOMMENDATION:

- Authorize the Department to establish by rule authority of program areas to issue and provide notice of fines for certain violations.
- The legislation should give a licensee the right to request a hearing at the State Office of Administrative Hearings if the licensee disagrees with the automatic fine.
- The legislation should not limit the Department's ability and discretion to take other disciplinary action against a license holder as otherwise provided by law.

Confidentiality of Investigative Files

BACKGROUND: The Department often receives public information requests for case or investigative files maintained in the Enforcement Division. If a public information request is received for a case file which is open and pending, the Department may seek to prevent public disclosure of the information by submitting a referral to the Office of the Attorney General. The Department may assert that the case file is protected from disclosure as pending litigation under Government Code section 552.103. Information "relating to litigation of a criminal or civil nature to which the state or political subdivision is, or may be a party" may be excepted from disclosure under the Public Information Act.

Further, there is a difference between the confidentiality protections afforded the investigative files maintained by the Enforcement Division and the Division of Workers' Compensation. For investigative files maintained by the Division of Workers' Compensation, the Labor Code contains statutory language that expressly provides that investigative files are confidential and not subject to disclosure under the Public Information Act, Chapter 552, Government Code. Currently, the Department lacks the ability to ensure that all investigative files are treated uniformly.

PROBLEM: The litigation must be pending or anticipated in order to assert Government Code section 552.103 to protect the disclosure of investigation files in the Enforcement Division. Once the litigation is concluded and the case file is closed, section 552.103 no longer applies and the case file may be subject to public disclosure. Often, there are other case files based on the same facts, and disclosure may jeopardize the enforcement of those cases.

RECOMMENDATION:

- Amend the Insurance Code to provide that investigative files maintained by the Department are confidential and not subject to disclosure under the Public Information Act, Chapter 552, Government Code.
- The legislation should state that investigative files are privileged and confidential and are not subject to discovery, subpoena, or other means of legal compulsion for release to any person except in specific circumstances.

Criminal History Information

Background: The Department is charged with examining persons to determine fitness for an insurance license. The department is authorized to deny a license to a person who has engaged in certain criminal conduct or has been convicted of a crime directly related to the business of insurance.

Problem: The Department is allowed to access criminal history information on some applicants who have convictions, but persons who engage in the same conduct but receive deferred adjudication of sentencing may obtain non-disclosure orders after completion of the probationary period. When the Non-Disclosure Order is issued, the person may legally indicate on the licensure application that he/she has not been the subject of criminal proceedings. This ability to deny the existence of the criminal history prevents the department from obtaining complete information related to an applicant for a license. The Government Code lists a number of entities and agencies that are permitted to receive criminal history information which allows the agencies and entities to obtain complete information on an applicant for determining fitness for licensure. Because of the trust insurance consumers place in insurance agents and companies it is important that any criminal history be considered when determining whether to issue a license.

Recommendation: Amend section 411.081(i) of the Government Code to add the Texas Department of Insurance as an entity entitled to receive criminal history information.

Workers' Compensation Legislative Recommendations

Continue the Availability of the Return-to-Work Reimbursement Program and Improve Communication between Insurance Carriers and Employers about Return-to-Work Coordination Services

BACKGROUND: As part of HB 7, the 79th Texas Legislature enacted Texas Labor Code §413.022 which required the Commissioner of Workers' Compensation to establish a return-to-work pilot program designed to assist small employers (i.e., private-sector employers who employ at least two but not more than 50 employees) to make necessary workplace modifications to facilitate an injured employee's return to work after a work-related injury. Employers participating in the pilot program may be reimbursed up to $2,500 annually for expenses they incurred by making workplace modifications (e.g., purchasing new equipment, furniture or technology) in order to accommodate an injured employee's physical restrictions and return the employee to full or modified duty. In 2007, the 80th Legislature amended §413.022 to allow the employer to submit a proposal that describes the required workplace modifications, and request and receive a guarantee of reimbursement of expenses incurred up to the $2,500 limit. The pilot program expires September 1, 2009.

Additionally, the 77th Legislature as part of the HB 2600 reforms (2001) enacted Texas Labor Code §413.021 which requires insurance carriers to provide their employers, upon agreement, with return-to-work coordination services (e.g., job analyses to identify physical demands of jobs, assessments of workplace modifications, or vocational and medical case management services). In 2005, HB 7 added new language to §413.021 to require insurance carriers to evaluate injuries that may result in lost time and initiate skilled case management if necessary to improve return-to-work outcomes. While §413.021 does not require employers to participate in return-to-work coordination services or require insurance carriers to provide actual workplace modifications for employers, this section does establish the legislature's expectations that insurance carriers and employers communicate about methods to improve return-to-work outcomes for injured employees.

PROBLEM: To date, few employers have submitted applications to seek reimbursements under the small employer return-to-work pilot program (a total of 7 applications have been received as of October 1, 2008) despite the agency's efforts to educate employers about the availability of this program. However, research shows that small employers are less likely to have established return-to-work programs and are less likely to have sufficient resources to make workplace modifications that may be necessary to return an injured employee to productive employment. While insurance carriers are currently required to offer return-to-work coordination services to employers and are encouraged to target these services for employers without return-to-work programs or employers with lost-time claims, it is not clear to what extent these communications between insurance carriers and employers are taking place. Additionally, since these return-to-work coordination services may entail insurance carrier assessments of workplace modifications, there may be opportunities to educate employers about the availability of the small employer return-to-work reimbursement program in "real-time," which may encourage increased participation in this program by Texas employers.

RECOMMENDATION:

- Delete §413.022 (g) and rename this section as "Return-to-Work Reimbursement Program for Employers;"
- Amend §413.022 (a) (2) to allow the Commissioner of Workers' Compensation to define the types of employers who would be eligible to participate in this program. This would provide the Division with the flexibility to open up this reimbursement program to employers who have more than 50 employees or to target these reimbursements for the specific industries that have lower return-to-work rates;
- Increase the current maximum reimbursement amount for workplace modifications from $2,500 to $5,000;
- Allow employers to receive a portion of the preauthorized reimbursement in advance;
- Clarify §413.021 to require insurance carriers to offer return-to-work coordination services to employers who have workers' compensation claims in which the injured employee qualifies for Temporary Income Benefits (TIBs) (i.e., the employee misses more than seven days of work) and require insurance carriers to maintain documentation of their communication with employers about these services. This recommendation does not contemplate that an employer would be required to return the employee to work; rather it will ensure that insurance carriers and employers engage in timely communications about the benefits of return-to-work, and if appropriate, the availability of financial assistance from the State to help make recommended workplace modifications;
- Provide the Commissioner of Workers' Compensation with the authority to establish documentation requirements and minimum standards for return-to-work coordination services by rule if necessary; and
- Require insurance carriers to provide information to eligible employers about the Division's employer return-to-work reimbursement program as part of the return-to-work coordination services they provide under §413.021.

Clarifications

The following recommendations to the Texas Labor Code clarify existing statutory requirements.

Remove References in the Labor Code to the Expired Approved Doctors' List (ADL)

BACKGROUND: The 79th Legislature, as part of the HB 7 reforms, amended Texas Labor Code §408.023 to eliminate the requirement that doctors register to participate on the Division's Approved Doctors' List (ADL) after September 1, 2007. The ADL is no longer in existence; however, existing references in this and other sections of the Texas Labor Code cause confusion for system participants, especially for those participants trying to understand the current statutory requirements for doctors who provide medical care for work-related injuries.

RECOMMENDATION:

- Revise §408.023 to delete subsections (a) through (g) and subsection (i); and
- Delete any other references to the ADL, which expired on September 1, 2007, in other sections of the Texas Labor Code.

Correct Statutory Reference for Immunity for Doctors Performing Medical Reviews at the Request of the Division

BACKGROUND: The purpose of Texas Labor Code §413.054 is to provide doctors performing medical reviews at the request of the Division, including designated doctors, independent medical examiners, doctors performing a medical case review, and members of a peer review panel the same immunity from liability as the Commissioner of Workers' Compensation. These reviews may be requested by the Division in an effort to resolve a medical dispute or in a review of an individual health care provider's or insurance carrier's activities on a particular claim. Prior to HB 7, §413.054 referenced the immunity provision for a member of the Texas Workers' Compensation Commission, the Division's predecessor agency, located in §402.010, "Civil Liability of Member." When HB 7 eliminated the Texas Workers' Compensation Commission and created the Division, the statute amended §413.054, changing the immunity reference for doctors performing reviews at the request of the Division from §402.010 to §402.0024, which does not exist in the Texas Labor Code. However, §402.00123, "Civil Liability of Commissioner," rather than §402.0024, is the correct statutory citation for the Commissioner of Workers' Compensation's statutory immunity from liability.

RECOMMENDATION:

- Modify §413.054 to reference §402.00123, and delete the reference to §402.0024.

Section C: Workforce Strengthening

BACKGROUND: This section contains issues that are outside of the normal scope of the Biennial Report but are included because of their importance to the quality of the Department's workforce. The Department is available to work with the appropriate legislative committees for their consideration of the following ideas.

The Department has a highly skilled workforce and recognizes that its effectiveness depends on recruiting and retaining employees who perform with the utmost proficiency and integrity.

In light of current economic conditions, the State of Texas, as a major employer in this economy, must consider innovative and creative ways to maintain a first-rate workforce. The Texas Department of Insurance offers the following recommendations to allow agencies to recognize the superior work product and dedication of the state's employees.

Issue 1: Merit Eligibility

The Government Code allows agencies to award merit salary increases and one-time merit payments to classified employees whose job performance is consistently above that normally expected and required. A classified employee may receive a merit salary increase or one-time merit payment if:

The employee has been employed in the position for six continuous months and the effective date of the increase is at least six months after the employee's last promotion, one-time merit payment or merit salary increase for performance in that position.

RECOMMENDATION:

- Amend statutes to allow agencies the flexibility to award one-time merit payments in recognition of special or meritorious service without affecting the employee's eligibility for a regular merit salary increase.
- The legislation should provide that such one-time merit payments are not to exceed $1,500, and there should be no more than two merit awards within a three-year period.

Issue 2: Compensation for Disaster Duty

In 2008, the citizens of Texas have been directly affected by at least four natural disasters: Hurricanes Gustav, Dolly and Ike, and Tropical Storm Edouard. After each disaster, state employees demonstrated their compassion and willingness to assist fellow Texans by offering to engage in disaster duty efforts throughout the state. Employees subject to the Fair Labor Standards Act (FLSA) may receive monetary compensation for working extra hours in response to disaster situations if an agency authorizes payment of overtime hours worked. Employees not subject to the FLSA (FLSA exempt) may only receive compensatory time.

RECOMMENDATION: Amend statutes to allow agencies to authorize payment for compensatory time earned by FLSA exempt employees for work in response to disaster situations. Payment for compensatory time for FLSA exempt employees would increase employee participation in disaster relief efforts.

Issue 3: Telecommuting

A December 2000 E-Texas Recommendation from the Texas Comptroller of Public Accounts encourages teleworking among state agencies. The report concludes that offering state employees the opportunity to telecommute or telework would give the state an additional employee recruitment and retention tool, while eliminating some of the state's need for additional office space and parking facilities, and reducing traffic congestion and auto pollution. The report includes information from several agencies detailing the cost savings related to fuel, reduced lease space and a reduction in time-off from work.

For teleworkers, the employee's personal residence is designated as the employee's regular place of business as permitted by state law. However, section 659.018 of the Texas Government Code prohibits employees from accumulating compensatory time for work performed at their personal residence.

RECOMMENDATION: Amend statutes to allow classified employees who receive prior written authorization to earn state compensatory time for work performed at the employee's personal residence. This provision would encourage increased participation in telecommuting programs at state agencies.

Issue 4: Series I Bonds

State law requires every eligible employee to become a contributing member of the Employees Retirement System (Government Code section 812.003). Contributions are based on gross salary with 6% contributed by the employee, and 6% contributed by the state.

State law should allow for a similar matched contribution by state agencies, excluding state agency heads and if funds are available, regarding the purchase of Series I Bonds. Series I Bonds are a low-risk, liquid savings product that earn interest and protect from inflation. Currently, Series I Bonds may be purchased through payroll deduction. Encouraging savings lessens upward pressure on salaries and allows for greater flexibility for spending needs prior to retirement.

RECOMMENDATION:

- Amend statutes to allow state agencies to match a state employee's payroll deduction of Series I Bonds up to $50 per month, if funds are available.
- This legislation should exclude state agency heads from this allowance.

Section D: Study Related to the Texas Health Insurance Risk Pool

I. BACKGROUND

House Bill 1977

In 2007, the Legislature enacted House Bill (HB) 1977, which directed the Texas Department of Insurance (Department) to conduct a study of a potential program under which the Texas Health Insurance Risk Pool (Pool) would offer coverage to an individual who is also covered under a group health benefit plan that is provided or offered to the individual through an employer. HB 1977 stipulated that under this program, Pool coverage would be secondary to coverage provided under the employer plan. The bill further required that the study results be included in the Department's Biennial Report and should:

- include an analysis of the advantages and disadvantages of the proposed program and recommend minimum standards applicable to group health benefit plans that may be included in the program; and
- identify program components, requirements, or restrictions necessary for successful implementation of the program.

In working on this study, the Department staff worked closely with representatives of the Pool to ensure the report is both comprehensive and accurate.

Texas Health Insurance Risk Pool Overview

In 1989, the Texas Legislature created the Pool, which was not funded at that time. In 1997, the Legislature authorized funding and designated the Pool to serve as the state's alternative mechanism for providing guaranteed access to health insurance in the individual market, as required under the federal Health Insurance Portability and Accountability Act (HIPAA). Since 1998, the Pool has provided coverage for those individuals who have been denied health insurance because of a pre-existing condition and do not have other coverage options.

Pool Eligibility

As required by HIPAA, individuals are eligible for Pool coverage if they are

- under age 65 (or over 64 and not eligible for Medicare),
- a legal resident of Texas, and
- have maintained health benefit plan coverage for at least 18 months preceding application for coverage to the Pool, with no gap in coverage greater than 63 days, and their last health benefit plan coverage was provided:
  1) by another state's high risk pool; or
  2) through employment, with a U.S. employer. (United States citizenship or 3-year legal permanent residency is not required for this HIPAA eligibility category only.)

Individuals are also eligible for Pool coverage if they are under age 65, have been for at least 30 days and remain a legal resident of Texas and a United States citizen or a legal permanent resident of the United States for at least 3 continuous years, and meet one of the following specific eligibility criteria:

- Received a notice of rejection or refusal by an insurance company to issue substantially similar individual health benefit plan coverage due to health reasons;

- Received a certification from an agent or salaried representative of an insurance company, on the Pool's application form, that the agent or representative is unable to obtain substantially similar individual health benefit plan coverage with any state-licensed insurance company, which the agent or representative represents, because the applicant will be declined for coverage, as a result of medical condition, under the underwriting guidelines of the insurance company;
- Received an offer by an Insurance Company to issue substantially similar individual health benefit plan coverage that excludes a medical condition or conditions;
- Have been diagnosed with one of the Qualifying Medical/Health Conditions as established by the Pool.

Dependents are also eligible for Pool coverage. If the eligible individual is a child, family members of the child who have been (for at least 30 days) and remain legal residents of Texas and United States citizens and who reside with the child are also eligible for Pool coverage.

Prior to 2007, individuals with access to employer sponsored health care coverage were not eligible for Pool coverage. However, in 2007, the Legislature passed two exceptions that apply to individuals with employer sponsored coverage:

- Individuals transitioning from an employer plan who have not exhausted their COBRA continuation coverage may now access Pool coverage with a minimum 6-month pre-existing condition exclusion period if they are otherwise eligible for Pool coverage.
- Individuals who meet all of the following three conditions are allowed to choose Pool coverage if: (a) they are employed part-time; (b) their employer makes no contribution to their employer sponsored coverage; and (c) the employer sponsored coverage offered is more limited than that offered by the Pool. These plans are often referred to as "Mini Meds" or "Limited Benefit Plans."

Limited Benefit Plans

As noted above and further discussed below, some Texas employers purchase health benefit plans that provide low levels of health insurance coverage. Commonly referred to as "limited benefit plans," these insurance plans typically provide very low annual benefit maximums (generally ranging from $2,000 to $25,000) and/or internal limits for specific services (such as a limit of $30 for a doctor visit). Because of the low benefit levels, these plans provide some level of coverage at a significantly lower cost to employers and employees. While these plans provide some insurance protection, the coverage is often inadequate for individuals who have a serious injury or illness or a chronic health condition that requires on-going care. Individuals who work for firms that offer these benefit plans are currently ineligible for enrollment in the Pool, even if the individual declines the employer-sponsored plan.

II. ANALYSIS

Because the Department does not normally collect health plan enrollment information specifically for limited benefit plans, the Department surveyed carriers to determine how many carriers actually sell limited benefit plans, the types of employers that purchase the plans, and the number of Texans covered by these plans. Based on the survey responses, three carriers reported they market plans with annual maximum benefit levels of $50,000 or less. More than 95 percent of the insureds were covered under plans offered by large employers (those with more

than 50 employees). Only one carrier reported selling such plans to small employer groups. Combined, the three carriers reported a total of 35,211 Texans with limited benefit plans in 2006 and 38,645 in 2007, 80 percent of which were insured by one carrier.

In the survey, carriers were also asked whether they offered benefit plans that included internal limits for specific services, but did not include a total annual maximum benefit level. An example given was a plan that provides $1,000 in annual benefits for out-patient medical care and/or $5,000 in annual benefits for in-patient medical care, but with no limit on the annual medical coverage for all services combined. All three companies reported that they offer such plans.

Insurers also were asked to indicate the number of covered insureds who reached the annual maximum benefit level under a policy. Carriers were instructed not to report individuals who reached one of the internal limits. Only two of the three carriers were able to provide the requested information. One company reported that 7,722 people reached the annual maximum benefit level. The second company reported that two people reached the annual maximum benefit level. Finally, insurers were asked to describe the types of employers who most commonly purchase limited benefit plans. Carriers reported that large employers generally offer these plans to part-time, hourly, and seasonal employees and to certain full-time employees. The most common industry types offering these plans include retail, restaurant, staffing (general, clerical, industrial, technical), janitorial, retirement/nursing care facilities, hospitality, convenience stores, and security firms.

III. PROPOSED PLAN DESIGN

Some of the primary concerns identified in this study were consideration of the long term impact of any proposed changes on the private market, the Pool, and the interaction between the private market and the Pool. If employees with limited benefit plans are permitted to also enroll in the Pool, care must be taken to avoid creating an incentive that would encourage employers to drop comprehensive coverage and offer limited-coverage benefit plans, with the knowledge that their unhealthy employees could also access coverage through the Pool. The Pool has traditionally been viewed as an insurer for individuals who cannot obtain individually underwritten health insurance coverage, but not as a vehicle for employers and their insurers to shift the cost of high-risk employees and their dependents. Since the Pool is partly funded by assessments on insurers, increasing the losses of the Pool will ultimately affect all insureds as the assessments are passed on to those insureds by their insurers. To avoid this, the Department and the Pool have considered carefully the design features of a program that would allow insureds in limited benefit employer plans to access Pool coverage, while preserving some employer responsibility for funding the costs of health insurance for their employees. In view of this goal, the following plan design parameters are recommended:

- For an employer plan to be eligible for secondary Pool coverage, employers would have to offer a limited benefit plan with the annual maximum benefit level set by the Department. The data provided by carriers to the Department indicates that very few employees exhaust the benefits in limited benefit plans with annual maximum benefits above $20,000. This suggests that the $20,000 level is a reasonable balance of requiring an acceptable level of coverage by the employer, which would lessen the financial impact on the Pool, while not raising the level of required employer coverage so high that few employers would make this

option available to their employees. The Department suggests that plans should also be precluded from establishing internal benefit levels that would restrict access to specific types of care under the benefit plan. The Department and Pool staff concluded that keeping the requirements for the underlying employer plan benefit design as simple as possible would avoid otherwise prohibitive administrative costs to the Pool.

- Since small group carriers are not currently subject to assessment by the Pool because they offer guaranteed issue coverage, regardless of health status, and the data indicates that there are not many small groups purchasing limited benefit plans, an initial step could be to restrict this program to the large employer market.

IV. ISSUES TO CONSIDER

Discussions about creating a program of this sort have raised numerous issues. They are identified below.

Plan Design:

- If the Pool is "secondary" to an in-force employer plan, the Pool will have to commit significant administrative resources to ensure that it only pays after the employer plan has paid.
- Some limited benefit plans do not cover some charges that the Pool covers or have different limits on certain benefits than the Pool coverage. If Pool coverage is secondary on a benefit by benefit level, paying whenever a particular benefit is exhausted, the administrative cost to the Pool would be prohibitive. A less expensive alternative would be for the Pool to become primary for all claims whenever the employer plan has paid a specific calendar year maximum amount or after the employee has met a maximum out-of-pocket amount for all covered charges.
- Many insureds with chronic illnesses routinely exhaust the calendar year maximum benefit of the employer's limited benefit plan in the early months of the calendar year. This raises the question of when the insureds should be required to enroll in the Pool – at the beginning of the year or upon exhaustion of benefits? If enrollment does not occur until exhaustion of the employer's plan benefits, there could be a gap in coverage for the time necessary to accomplish Pool enrollment.
- Once enrolled in the Pool as secondary coverage, what happens to an enrollee with a chronic illness at the end of each calendar year? Does the individual lose Pool coverage until he or she exhausts the next calendar year maximum of the employer plan?
- If enrollment in the Pool occurs at the beginning of the calendar year, when would a Pool premium be required? Should Pool premium be waived until the Pool coverage becomes primary? Similarly, should the individual be required to continue paying premium for the limited benefit employer coverage for the balance of the calendar year when no benefits are payable under that coverage? There is concern that if premium is not paid to the Pool until Pool coverage becomes primary, the premium required to cover that risk would be unaffordable or, if set lower, inadequate to cover the risk and adverse impact to the Pool.
- Once an employee has exhausted limited benefit plan coverage and begins Pool coverage, how long can the individual remain in the Pool? If the Pool disenrolls the individual at the start of every calendar year when the employer coverage renews, there should be no penalty for re-enrollment in less than 12 months, as the current Pool statute provides.

- Would the Pool have a reduced premium rate for individuals enrolled under this program? Should the employer be required to pay all or part of the Pool premium for the coverage? Should the insurer that writes the limited benefit plan be subject to a higher Pool assessment for individuals placed in the Pool under this program?
- Should small employer carriers be assessed to help support the operations of the Pool if small employers with limited benefit coverage are allowed to participate in this program? Should the assessment be tied to the number of limited benefit policies the carriers issue, the total number of insured lives, or the number of individuals from such plans enrolled for Pool secondary coverage?
- Any program developed must ensure that the Pool remain the secondary payor to any limited benefit plan that might also be issued to a Pool enrollee. Implementation proposals should be carefully considered to avoid provisions that would allow the Pool to become the primary benefit plan and first-dollar payor.

Administration:

- What reporting requirements (covered lives claims and premiums paid) should be required from carriers whose insureds enroll in the Pool secondary coverage program? The Department would need authority to promulgate regulations to ensure program success. The fewer variations permitted for employer plans to be eligible for secondary Pool coverage, the easier it will be for the Pool to administer benefits secondary to those plans. However, this will limit eligibility to those employees whose employer purchases a qualifying plan.
- This program poses a challenge to the Pool to coordinate administration and could have adverse financial impact on the Pool, depending on the extent to which employers and employees utilize this option.

Market Impact:

- It is highly possible that implementation of this program could have unintended consequences on the employer market. One question raised is whether this program will encourage employers to drop comprehensive coverage that they currently offer.
- It is reasonable to believe that minimum and maximum requirements for benefit levels of employer coverage will impact employer decisions. Although lower benefit requirements for the required primary employer coverage might cause employers, not currently offering health insurance, to offer a limited benefit plan in order to qualify for the Pool program, it may also encourage employers who currently offer more comprehensive coverage to also move to the program.
- If this program is implemented, the potential market impact should be carefully considered to ensure that unintended consequences are mitigated.