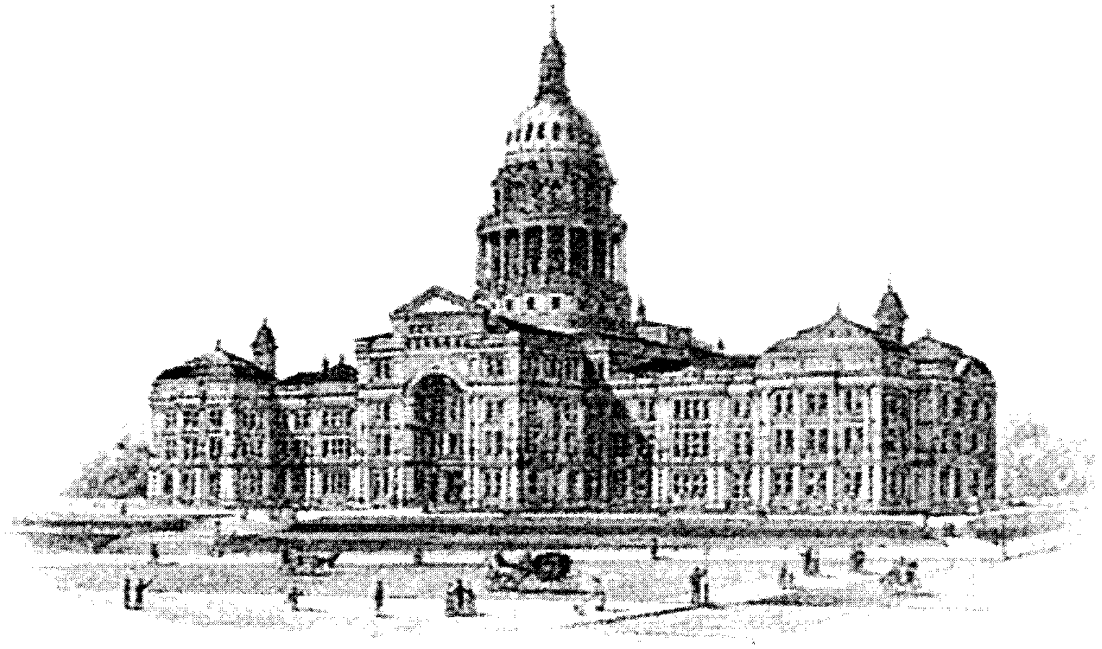
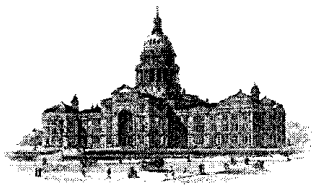
Senate Select Interim Committee on Workers' Compensation



Report to the 79th Legislature

December 2004

Senate Select Interim Committee on Workers' Compensation



December 1, 2004

The Honorable David Dewhurst
Lieutenant Governor of the State of Texas
P.O. Box 12068
Austin, TX 78711

Dear Governor Dewhurst:

The Senate Select Interim Committee on Workers' Compensation is pleased to submit its final report. The report encompasses the committee's seven charges:

- Examine the status of the regional workers' compensation health care delivery networks outlined in Article 2, House Bill 2600 (77th Legislature, 2001);
- Study the potential impact of networks on the workers' compensation health care delivery system;
- Study the impact of the Texas Workers' Compensation Commission's (TWCC) 2002 Medical Fee Guideline on access to quality care and medical costs;
- Survey the costs and benefits of other health system cost-containment strategies;
- Conduct a cost-benefit analysis comparing the Texas workers' compensation system to systems operating in other states;
- Study the efficiency and effectiveness of the state's workers' compensation system, including a comparison of the costs associated with the Texas A&M University System, the University of Texas System, the Texas Department of Transportation, and the State Office of Risk Management; and
- Study and make recommendations relating to the pricing of workers' compensation insurance premiums in Texas.

This report is submitted with the understanding that recommendations requiring funding should be pursued only in the event funding is available. In accordance with your request, copies of the report have been sent to the appropriate parties.

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SAM HOUSTON BUILDING, ROOM 445 • (512) 463-0067

The committee members appreciate the challenge you gave us in evaluating this complex system and offering recommendations for improvements. We look forward to working with you to make these improvements in the 79th Legislative Session.

Respectfully submitted,

Senator Todd Staples,
Chairman

Senator John Carona

Senator Robert Duncan

Senator Craig Estes

Senator Juan Hinojosa

Senator Kyle Janek

Senator Frank Madla

Senator Jane Nelson

Senator Royce West

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Charges of the Senate Select Interim Committee on Workers' Compensation

Charge 1: Examine the status of the Health Care Network Advisory Committee's (HNAC) and the Texas Workers' Compensation Commission's implementation of the regional workers' compensation health care delivery networks outlined in Article 2 of HB 2600 (77th Legislature, 2001).

Charge 2: Study the potential impact of networks on the workers' compensation health care delivery system. Include in the study:

- Quality of care;
- Network adequacy and access to care;
- Disclosure of information to patients, complaint procedures, appeal rights and overall patient satisfaction;
- Costs of care;
- Provider credentialing, selection, and dispute resolution;
- Financial risks to providers, employers and carriers;
- Effects of networks on the Texas Workers' Compensation Commission; and
- Quality monitoring systems such as independent report cards.

Charge 3: Study the impact of the Texas Workers' Compensation Commission's 2002 Medical Fee Guideline on access to quality medical care for injured workers and medical costs, including recommendations on whether the legislature should statutorily prescribe a methodology for calculating the workers' compensation conversion factor.

Charge 4: Survey the costs and benefits of other health system cost-containment strategies as they relate to medical, therapeutic, and pharmaceutical care, including but not limited to, doctor selection, deductibles, co-payments, preauthorization of services, and return-to-work programs.

Charge 5: Conduct a cost-benefit analysis, to the extent possible, comparing the Texas workers' compensation system to systems operating in other states. Make

recommendations to improve the quality of care for injured workers, reduce fraud and inefficiencies, reduce overall claim costs, and streamline the administration of the system. Recommendations should address data exchange, advisory groups and review panels, dispute resolution, enforcement issues, paperwork reduction, and billing and administrative efficiencies.

Charge 6: Study the efficiency and effectiveness of the state's workers' compensation system including a comparison of the medical and indemnity costs associated with the Texas A&M University system, the University of Texas system, the Texas Department of Transportation and the State Office of Risk Management. Evaluate the potential costs and benefits associated with state agency participation in workers' compensation networks.

Charge 7: Study and make recommendations relating to the pricing of workers' compensation insurance premiums in Texas, including, but not limited to, the impact of rating tools such as schedule rating, negotiated experience modifiers, negotiated deductibles, and underwriting.

Introduction and Acknowledgements

This report represents the findings and recommendations of the Senate Select Interim Committee on Workers' Compensation.

The report contains three sections, following this introduction: Section I, which includes a general overview of workers' compensation in Texas and historical and recent developments; Section II, comprised of specific analyses of the seven committee charges; and Section III, which highlights the committee's findings and recommendations on each charge.

The committee's work included five hearings between February and October 2004, a comprehensive review of research, analyses, recent legislation and rules, public and expert comment, numerous meetings and discussions with workers' compensation system participants and stakeholders, and reviews of the features and performance of other state workers' compensation systems and other health care delivery systems.

The committee is grateful to the Texas Department of Insurance (TDI), in particular the Workers' Compensation Research Group, and the Texas Workers' Compensation Commission (TWCC), for providing numerous analyses and lending expert assistance. The committee also expresses its gratitude to all the witnesses who testified on these charges and shared their experiences with the workers' compensation system. A complete list of witnesses is located at Appendix D.

Section I: Overview of Workers' Compensation in Texas

What is workers' compensation, and how does the Texas system function?

Workers' compensation is a form of insurance provided by employers to pay for medical and income losses incurred by employees who are injured on the job. In Texas, workers' compensation coverage generally is optional for private sector employers, while public sector employers must provide coverage. Private employers may obtain coverage by purchasing it from an insurance carrier; employers that meet certain requirements can also choose to self-insure through the Texas Workers' Compensation Commission (TWCC)-administered Certified Self-Insurance Program. Private employers can also purchase insurance as a group, or, after a statutory change in 2003, may self-insure as a group.[1]

Public entities (such as cities, counties, and school districts) may self-insure individually, participate with other public entities in a risk pool, or purchase commercial coverage. The State of Texas self-insures its employees and administers most claims through the State Office of Risk Management (SORM), although certain state agencies and entities (the University of Texas System, Texas A&M University System, and the Texas Department of Transportation) administer their own self-insured workers' compensation programs.[2]

Several other state agencies and state-created entities currently play key roles in the Texas workers' compensation system:

[1] See House Bill (HB) 2095, 78th Legislature, 2003. As of late September 2004 TDI had issued one license to self-insure as a group, to the Texas Cotton Ginners Trust. Two other applications were pending.

[2] The state workers' compensation programs are discussed in more detail in Section II of this report, in the evaluation of Charge 6.

Texas Workers' Compensation Commission (TWCC)[3]

TWCC was created during the workers' compensation system reforms of 1989 and replaced the Industrial Accident Board (IAB) in 1991. TWCC is charged with administering the workers' compensation system in Texas. It does so through its central facility in Austin and 24 field offices around the state. Other specialized services of TWCC include workers' health and safety, medical review, compliance and practices, dispute resolution, ombudsman assistance, and self-insurance regulation programs.

Much of the attention of this report focuses on TWCC's efforts in administering the medical aspect of the workers' compensation system, which includes statutory requirements for the agency to promulgate medical fee guidelines, regulate the Approved Doctors List (ADL), resolve medical disputes, and perform other related functions.

Texas Department of Insurance (TDI)

TDI regulates most lines of insurance in Texas, including workers' compensation. TDI's responsibilities in terms of workers' compensation include ensuring that insurance companies are solvent; ensuring that rates are reasonable and calculated correctly; ensuring that policies and forms comply with the law and are easy to understand; protecting policyholders and the public from fraudulent and unethical behavior by insurance companies, agents, adjusters, and medical utilization review agents; and developing insurance data, such as detailed claims information and unit statistical data, for use by the Legislature, the public, insurance companies, and other interested parties.

In September 2003 TDI also took on the research functions of the former Research and Oversight Council on Workers' Compensation (ROC), after funding for ROC as a stand-

[3] As discussed in this report, as part of its regular review of the performance and functions of the Texas Workers' Compensation Commission, the Sunset Advisory Commission in September 2004 recommended abolishing TWCC as a stand-alone agency and dividing its functions between the Texas Department of Insurance and Texas Workforce Commission. When the term "TWCC" is used in this report in reference to recommended future actions, it should be understood to mean "TWCC or an appropriate successor agency (or agencies)."

alone agency was discontinued.[4] Through this function, TDI conducts professional studies related to workers' compensation system issues.[5]

State Office of Risk Management (SORM) and other state programs

SORM administers workers' compensation benefits for most state employees, and also approves and inspects state agency risk management programs. SORM was created in 1997 by the 75th Legislature by merging the Workers' Compensation Division of the Office of the Attorney General and the Risk Management Division of the TWCC. The University of Texas System, Texas A&M University System, and Texas Department of Transportation administer their own workers' compensation programs.

Texas Mutual Insurance Company

(formerly the Texas Workers' Compensation Insurance Fund)

Texas Mutual is an insurance company created by the state to write workers' compensation insurance in Texas as part of the 1989 workers' compensation reform package. Although created by state action, Texas Mutual is not a state agency and does not receive legislative appropriations. Legislation passed in 2001 designated Texas Mutual a domestic mutual insurance company, effective September 1, 2001.[6] Texas Mutual is the largest writer of workers' compensation insurance in Texas, with an estimated 26 percent of the insurance market as of 2003.[7]

Texas Mutual began operations on January 1, 1992 with three basic objectives:

- to lower workers' compensation insurance rates by acting as a competitive force in the marketplace;
- to guarantee that workers' compensation insurance is always available to Texas employers; and

[4] Funding for the ROC was provided in the Appropriations bill but line-item vetoed by the Governor. See HB 1, 78th Legislature, 2003.
[5] See House Bill (HB) 28, 78th Legislature, 3rd called session, 2003, which transferred the general research functions of the ROC to TDI.
[6] See House Bill (HB) 3458, 77th Legislature, 2001.
[7] Estimates by the Texas Department of Insurance, 2004.

- to serve as the "insurer of last resort" for employers who want to purchase workers' compensation insurance but cannot find coverage elsewhere.

The change from the Workers' Compensation Insurance Fund to Texas Mutual Insurance Company did not alter Texas Mutual's status as the insurer of last resort.

Texas Property and Casualty Insurance Guaranty Association (TPCIGA)

TPCIGA is a non-profit, unincorporated association of property and casualty insurance companies admitted to do business in Texas. TPCIGA handles claims against all covered insolvent property and casualty insurance companies, including those that write workers' compensation insurance.[8]

These are only a few of the state agencies and prominent entities involved in Texas workers' compensation. Many others are also mentioned throughout the course of this report.

A translation of commonly used acronyms, along with a table describing the Texas workers' compensation system in a broad sense, can be found at Appendices E and F, respectively.

History of Texas workers' compensation law and reform

The Texas workers' compensation system is 91 years old. While the system created in 1913 serves a vastly different Texas in 2004, its essential purpose remains the same: to provide a quick and certain system of benefits to workers injured on the job, without regard for fault; to limit the liability of employers; and to transfer the cost of occupational injuries from the injured worker and society at large, to employers and consumers of their products.

[8] Certified self-insured employers in Texas are also subject to a guaranty association to pay claims in the event of insolvencies; see *Texas Labor Code* Section 407.121, establishing the Texas Certified Self-Insurer Guaranty Association.

The system begins with the employer and his or her employees. However, many other groups play essential roles, including doctors and other health care providers and facilities, insurance carriers, attorneys, and the state, through agencies that administer the system and rule on disputes.

The workers' compensation statute has been amended countless times in the nine decades since its creation. The most recent systemic reform came in 1989, after two years of intensive review and research, extensive debate, and several special sessions of the Legislature. The most significant features of that reform included:

- eliminating settlement agreements that ended an injured worker's ability to receive reasonable and necessary medical care;
- establishing a more objective structure for paying indemnity benefits to injured workers;
- providing a more structured administrative dispute resolution system, with access to the courts only as a last resort;
- creating the Texas Workers' Compensation Commission (TWCC), a much larger and more broadly-focused agency than the predecessor Industrial Accident Board (IAB);
- allowing employers who meet certain standards to self-insure;
- creating the Texas Workers' Compensation Insurance Fund (later Texas Mutual Insurance Company) to foster competition and serve as the insurer of last resort; and
- creating an ongoing research function to examine workers' compensation system issues and conduct professional studies.

In the ensuing 15 years, the system has continued without significant structural change. In large part, this testifies to the success to the 1989 reforms in addressing the issues of greatest need at that time. A system that in the late 1980s was one of the costliest in the country - with high rates of litigation and very limited, if any, affordable insurance options for employers - improved significantly. Costs went down and employer

participation in the system increased.[9] At the same time, good economic times throughout much of the 1990s removed many of the external pressures on the workers' compensation system, and allowed it to function with relatively little controversy or call for major reform for almost a decade.

The late 1990s and concerns about Medical Care

By the late 1990s, however, warning signs became apparent and began to receive attention from policymakers. Most of these concerns involved medical care, particularly cost issues, at a time when cost concerns were becoming paramount for many other health care delivery systems, as well.

In 1999 the Legislature passed House Bill 3697, which called for a thorough, data-based cost comparison of the Texas system with other states' workers' compensation programs and other health care delivery systems. The HB 3697 analysis was conducted by the Research and Oversight Council on Workers' Compensation (ROC), an agency created in response to a broad policy goal of the 1989 reform that objective research and data be available to policymakers and the public about the Texas workers' compensation system.[10]

The results of the HB 3697 studies were published in February 2001, and they revealed that concerns about medical costs and outcomes in the system were well-founded. Of nine states evaluated, for workers injured in 1997, Texas had the highest average workers' compensation medical cost per claim, almost $400 per claim higher than the second-highest state.[11]

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[9] When first measured through a survey of Texas employers in 1993, the Texas Workers' Compensation Research Center estimated that 56 percent of Texas employers carried workers' compensation insurance. By 2001, that figure had increased to 65 percent. Only in the most recent survey, in 2004, did employer participation decrease (to 62 percent). These findings are discussed in more detail in Section II.

[10] The first workers' compensation research agency to emerge from the 1989 reforms was the Texas Workers' Compensation Research Center; a Legislative Oversight Committee on Workers' Compensation was also created. The two entities were consolidated in 1995 as the ROC.

[11] See *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System;* Research and Oversight Council on Workers' Compensation and Med-FX, LLC., January 2001, p. 23. Other states included in the study were New Jersey, California, Colorado, Florida, Georgia, Oregon, Minnesota, and Kentucky.

Comparing Texas workers' compensation costs with group health insurance costs, the difference was even more striking. The HB 3697 reports found that for the ten most common medical diagnoses in workers' compensation, average medical costs per claim in the workers' compensation system - *not* including indemnity (i.e., income replacement) benefits - were about six times higher than medical costs in the group health system.[12]

In the area of lost time from work, Texas particularly lagged behind comparison states. Fewer injured workers surveyed, more than two years after their injury, indicated they were currently working than did workers in other states (64 percent in Texas, compared to 75 percent in the other states).[13] The HB 3697 studies also showed that when Texas workers missed time because of an on-the-job injury, they were absent longer than their counterparts in other states. For the ten most common types of on-the-job injuries, Texas workers were absent an average of 21 weeks from work, second only to California (29 weeks) among the states studied.[14]

These findings were supported by other analyses. In 2000, Texas was one of a group of states that participated in a national study by the Workers' Compensation Research Institute (WCRI) known as the CompScope project. WCRI is a private national entity that conducts a variety of workers' compensation data analyses and state-to-state comparisons. WCRI's studies on medical costs and outcomes in recent years consistently have shown Texas to be the most expensive state analyzed in terms of medical costs per claim, to be among the states with the longest lost time from work durations for injured employees, and to have relatively mediocre to poor results in other system outcomes for injured workers.

Updated findings from independent Texas research conducted by the ROC, the Texas Department of Insurance (TDI), WCRI and other entities are discussed in more detail in Section II, particularly the discussion of Charge 5.

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[12] See *Striking the Balance*, p. 27.
[13] See *Striking the Balance*, p. 57.
[14] See *Striking the Balance*, p. 44.

In short, by the end of the 1990s the Texas workers' compensation system appeared to be costing employers too much and doing too little to return injured employees to health and function.

House Bill 2600 and Attempts at Improvement

The findings of the HB 3697 studies, arriving in the early stages of the 77th Legislative session in 2001, set the stage for policy changes in an attempt to address the problems the studies showed. After lengthy negotiation and compromise, the result was House Bill 2600, authored by then-State Representative Kim Brimer and sponsored in the Senate by Senator Robert Duncan. The bill became an omnibus workers' compensation reform package that represented the most significant changes in the system since 1989.

The general focus of HB 2600 was to improve the medical quality and cost control features in the workers' compensation system. Major efforts in this area included:

- Providing additional authority and resources for TWCC to monitor and impose sanctions on doctors on the state's Approved Doctor List (ADL), requiring new registration and training requirements for doctors to be on the ADL, and requiring doctors to disclose financial interests in other health care providers;[15]
- Creating the Health Care Network Advisory Committee (HNAC), and charging that committee to conduct a feasibility study, evaluate and make recommendations on a network care delivery model in Texas workers' compensation;[16]
- Abolishing statutory provisions requiring a "second opinion" process for spinal surgery, modifying statutory provisions related to preauthorization of medical services, abolishing the existing TWCC treatment guidelines, and setting new standards for any future treatment guidelines;[17]

[15] See *Texas Labor Code* Sections 408.023 and 408.0231.
[16] See *Texas Labor Code* Sections 408.0221 and 408.0222.
[17] See *Texas Labor Code* Sections 413.014 and 413.011.

- Creating a voluntary precertification process for medical care that did not require preauthorization;[18]
- Requiring TWCC to implement fee guidelines based on those used in the Medicare system;[19]
- Requiring TWCC to adopt a pharmaceutical formulary giving preference to generic drugs;[20]
- Enhancing the role of TWCC designated doctors in evaluating permanent disability;[21] and
- Requiring disputes over the necessity of medical services (both before and after service delivery) to be decided by Independent Review Organizations (IROs).[22]

Many other provisions not directly related to medical care were also included in HB 2600. Most significant were:

- Prohibiting the use of pre-injury waivers by employers who do not subscribe to the workers' compensation system;[23]
- Expanding the list of injuries eligible for Lifetime Income Benefits (LIBs) to include certain severe burns;[24]
- Allowing employees with more than one job to collect workers' compensation income benefits based on their compensation at all jobs, rather than just the job where they are injured;[25]
- Requiring insurance carriers to pay injured workers' attorneys' fees in some District Court claims;[26]
- Implementing new provisions to encourage communication about return-to-work issues, and requiring insurance carriers to provide certain return-to-work coordination services;[27]

[18] See *Texas Labor Code* Section 413.014(e).
[19] See *Texas Labor Code* Section 413.011.
[20] See *Texas Labor Code* Section 408.028.
[21] See *Texas Labor Code* Section 408.0041.
[22] See *Texas Labor Code* Section 413.031.
[23] See *Texas Labor Code* Section 406.033(e).
[24] See *Texas Labor Code* Section 408.161(a)(7).
[25] See *Texas Labor Code* Section 408.042.
[26] See *Texas Labor Code* Section 408.221(c).

- Changing the state's system for allocating workers' compensation costs to state agencies from one primarily general revenue-funded to one primarily agency-funded;[28]
- Requiring TWCC to establish a schedule of specific monetary penalties for specific violations of the workers' compensation statute or rules;[29] and
- Moving the TWCC sunset review date from 2007 to 2005.

While HB 2600 included numerous changes to the *process* of how medical care is delivered to injured employees in Texas, it did not change the fundamental *structure* of the delivery system. Employees remain free in Texas to select any doctor who is willing and able to be on the TWCC ADL; insurance carriers and their agents review the care of these providers, either prospectively or retrospectively, and approve or deny care or reimbursement for care; and TWCC and other outside entities (IROs, the State Office of Administrative Hearings (SOAH), and District Courts) resolve disputes over care or payment for care that is denied.

78th Legislative session, 2003

With the passage of HB 2600 in 2001 and the prospect of major changes in 2005, the 2003 session produced no systemic changes to workers' compensation in Texas. Most of the bills that did win approval involved clarifications or modifications to HB 2600 provisions.[30]

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[27] See *Texas Labor Code* Section 409.005.
[28] See *Texas Labor Code* Section 412.0123.
[29] See *Texas Labor Code* Section 415.021(a).
[30] Significant workers' compensation legislation from the 78th session included: HB 3168, authorizing TWCC to implement a low-cost medical dispute resolution process; SB 1804, revising statutory provisions related to a voluntary precertification process for medical care and requiring Independent Review Organizations (IROs) to consider the payment policies of the Medicare system; SB 1572, revising statutory requirements for any TWCC-adopted treatment guideline; HB 833, allowing injured employees to "upgrade" to brand-name medications at their own expense; HB 2198, setting a time limit on disputes of Maximum Medical Improvement (MMI) and Impairment Rating (IR); HB 2199, revising the timeframe for a carrier to dispute the compensability of an injury and the penalties for untimely payment of benefits; HB 2095, allowing employers to self-insure as a group; and SB 1574, allowing TWCC to share information more freely with medical licensing boards and setting the State Average Weekly Wage for fiscal years 2004 and 2005. For a more thorough description of bills approved and proposed during the 78th session, see "Review of Workers' Compensation Bills from the 78th Texas Legislature," *Texas Monitor*, Vol. 8, Number 2, Research and Oversight Council on Workers' Compensation, Summer 2003.

However, legislation was filed in both chambers to create a new network care delivery model.[31] Under this model, insurance carriers or employers would have been allowed to enter into agreements with provider networks, and if such an agreement was in place, injured employees would have been required to seek treatment within these networks. The model of care delivery was more similar to that found in group health plans and some other states' workers' compensation systems. After weeks of discussion between groups representing carriers, employers, and physicians, negotiations over this legislation broke down, and neither the House nor Senate bill was ever heard in committee.

Creation of the Senate Select Committee

In December 2003, Lieutenant Governor David Dewhurst appointed the Senate Select Interim Committee on Workers' Compensation, and charged it to address the seven issues listed in the Introduction to this report and again at the beginning of Section II.

The committee held hearings in February, March, April, August and October 2004.

At the same time as the Senate Select Committee's work, the Sunset Advisory Commission was considering the function and performance of TWCC. The Sunset Commission's staff report, issued in April 2004, was highly critical of TWCC's performance, particularly in failing to set an appropriate strategic direction for the agency's role in administering the system, but recommended the agency be continued for 12 years with significant modification.[32] The Sunset Commission, however, in September 2004, recommended abolishing TWCC as a stand-alone agency, dividing its functions between TDI and the Texas Workforce Commission. The Sunset Commission also approved recommendations in favor of a network model of workers' compensation

[31] See House Bill 1896 and Senate Bill 1134, 78th Texas Legislature, Regular Session, 2003.
[32] See Sunset Advisory Commission Staff Report on the Texas Workers' Compensation Commission, April 2004.

medical care (see Charge 2), and income benefit and dispute resolution process changes, among others. [33]

In the House, the Committee on Business and Industry considered a list of charges including similar topics to the Senate Select Committee's, the House Economic Development Committee considered a charge related to the impact of workers' compensation costs on the business climate in Texas, and a House Select Committee considered a charge related to workers' compensation issues in the construction industry.

This level of legislative scrutiny from various points of view is likely unprecedented in the history of workers' compensation in Texas.

[33] A full description of the Sunset Commission's actions is available online at http://www.sunset.state.tx.us/79threports/twcc/dec_04.pdf.

Section II: Analysis of Committee Charges

This section of the report provides the detailed response to the Select Committee's seven interim charges. The conclusion for each charge contains specific findings and/or recommendations related to that charge. Section III of the report highlights these findings and recommendations.

For ease of discussion, the charges are addressed not in order by number but instead from the most general to the most specific. Order is as follows:

Charge 5: Conduct a cost-benefit analysis, to the extent possible, comparing the Texas workers' compensation system to systems operating in other states. Make recommendations to improve the quality of care for injured workers, reduce fraud and inefficiencies, reduce overall claim costs, and streamline the administration of the system. Recommendations should address data exchange, advisory groups and review panels, dispute resolution, enforcement issues, paperwork reduction, and billing and administrative efficiencies.

Charge 4: Survey the costs and benefits of other health system cost-containment strategies as they relate to medical, therapeutic, and pharmaceutical care, including but not limited to, doctor selection, deductibles, co-payments, preauthorization of services, and return-to-work programs.

Charge 7: Study and make recommendations relating to the pricing of workers' compensation insurance premiums in Texas, including, but not limited to, the impact of rating tools such as schedule rating, negotiated experience modifiers, negotiated deductibles, and underwriting.

Charge 2: Study the potential impact of networks on the workers' compensation health care delivery system. Include in the study:

- Quality of care;

- Network adequacy and access to care;
- Disclosure of information to patients, complaint procedures, appeal rights and overall patient satisfaction;
- Costs of care;
- Provider credentialing, selection, and dispute resolution;
- Financial risks to providers, employers and carriers;
- Effects of networks on the Texas Workers' Compensation Commission; and
- Quality monitoring systems such as independent report cards.

Charge 1: Examine the status of the Health Care Network Advisory Committee's (HNAC) and the Texas Workers' Compensation Commission's implementation of the regional workers' compensation health care delivery networks outlined in Article 2 of HB 2600 (77th Legislature, 2001).

Charge 3: Study the impact of the Texas Workers' Compensation Commission's 2002 Medical Fee Guideline on access to quality medical care for injured workers and medical costs, including recommendations on whether the legislature should statutorily prescribe a methodology for calculating the workers' compensation conversion factor.

Charge 6: Study the efficiency and effectiveness of the state's workers' compensation system including a comparison of the medical and indemnity costs associated with the Texas A&M University system, the University of Texas system, the Texas Department of Transportation and the State Office of Risk Management. Evaluate the potential costs and benefits associated with state agency participation in workers' compensation networks.

Charge 5: Conduct a cost-benefit analysis, to the extent possible, comparing the Texas workers' compensation system to systems operating in other states. Make recommendations to improve the quality of care for injured workers, reduce fraud and inefficiencies, reduce overall claim costs, and streamline the administration of the system. Recommendations should address data exchange, advisory groups and review panels, dispute resolution, enforcement issues, paperwork reduction, and billing and administrative efficiencies.

Background

Charge 5 is the most comprehensive of the Select Committee's charges, calling for an overall examination of the effectiveness of the Texas workers' compensation system. As such, this section of the report encompasses a number of issues, from safety and employer participation in the system, to claims costs and outcomes. These and many other components of the system are essential elements in assessing its overall value.

The work of the Joint Select Committee on Workers' Compensation Insurance, created by the 70th Legislature in 1987, is useful in delineating areas of the system that should be examined. The Joint Select Committee identified more than a dozen aspects of the workers' compensation system that were important to consider in measuring system performance.[34]

For purposes of evaluating the current status of the system, this section will focus on five key areas: Safety; Coverage; Medical Care/Return to Work; Benefit Adequacy; and System Administration.[35]

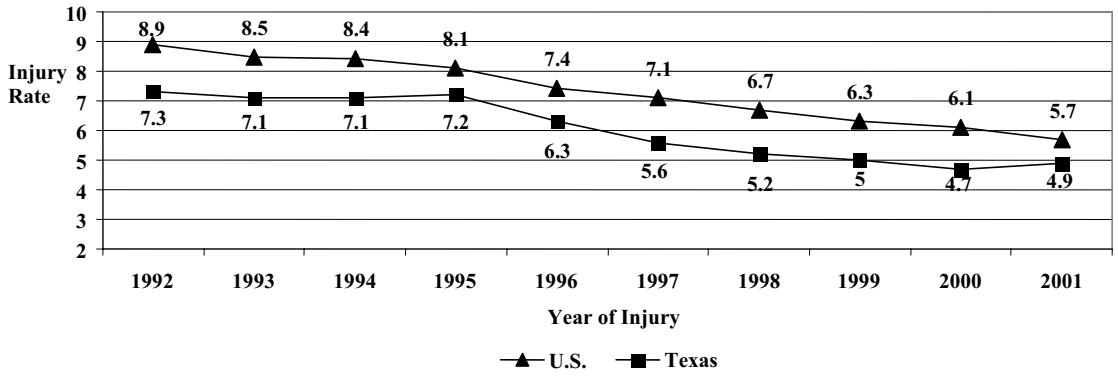
[34] The areas identified by the Joint Select Committee included: Safety; Coverage; Medical Care and Rehabilitation; Benefit Adequacy; Benefit Equity; Effective Delivery of Benefits; Agency Control; Policy Control; System Monitoring; Return to Work; Insurance; Economic Viability; Cost Internalization; and Protection Against Cost Transfer. For more discussion on these points, see the *Biennial Report of the Research and Oversight Council on Workers' Compensation*, ROC, December 2002.

[35] Insurance and Economic Viability is another area of the system identified by the 1987 report that remains vital in assessing its value; however, it is discussed separately in Charge 7. System Administration was not one of the points laid out in the 1988 charges *per se*, but combines elements of several other points that were, such as Policy Control, Agency Control, and System Monitoring.

Safety

As many witnesses testified to the Select Committee and others, avoidance of injuries is the best outcome for both employers and employees. In the important area of safety, both national trends and recent trends in Texas are positive. In fact, in contrast to the aspects of the workers' compensation system where Texas performs much more poorly than many other states, Texas' record in minimizing occupational injuries is consistently better than the national average (see Figure 1).[36]

Figure 1
Occupational Injury and Illness Rate Per 100 Full-Time Workers, Texas and U.S., 1992-2001



Source: Texas Workers' Compensation Commission, System Data Report, and Bureau of Labor Statistics.

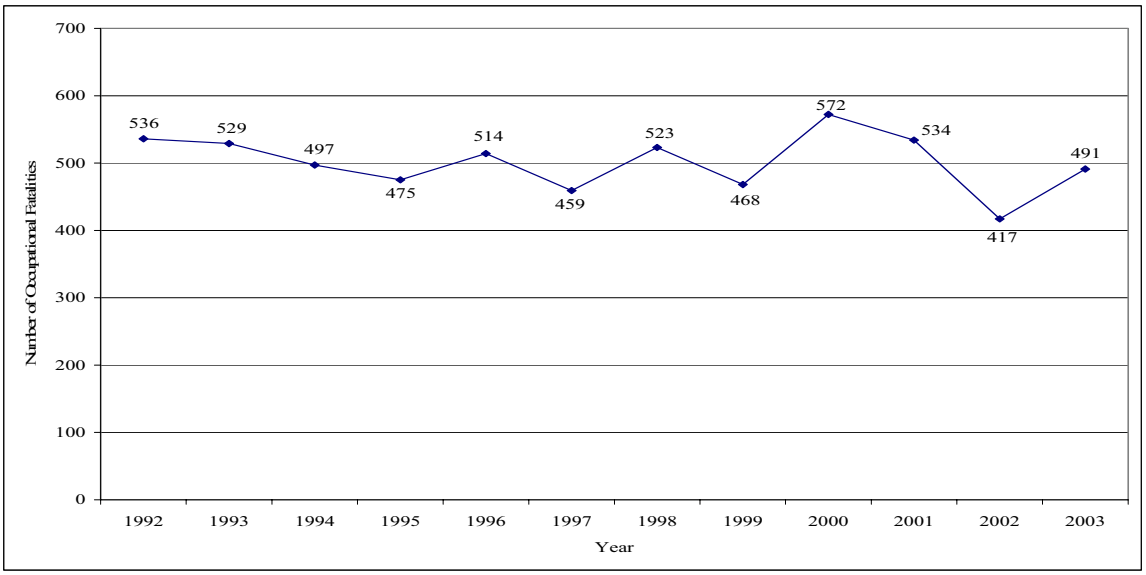
The data shown in Figure 1 is based on an employer survey conducted by the Bureau of Labor Statistics (BLS). Data for 2002 indicates an injury rate for Texas of 4.3 per 100 full-time workers, and a national rate of 5.3; however, due to methodological changes, BLS advises that the 2002 rates should not be compared to previous year's rates, and therefore they are not shown in Figure 1.

The number of the most serious occupational injuries - fatalities - has shown some fluctuation in the last decade. A significant increase from 468 on-the-job deaths in Texas

[36] See Texas Workers' Compensation Commission *System Data Report*, data through June 30, 2004, p. 2. It is important to remember that injury data reported here is based on an annual survey of Texas employers (both subscribers and nonsubscribers) conducted by the United States Department of Labor's Bureau of Labor Statistics, and is not comparable to the data collected by TWCC on the numbers of injuries or claims in the workers' compensation system.

in 1999 to 572 in 2000 seemed to have reversed somewhat, as the figure dropped to a eleven-year low of 417 in 2002 (see Figure 2). However, in 2003 Texas suffered 491 on-the-job fatalities. Obviously, as the workforce has grown in real numbers since 1992, the fatality rate has gone down over that time.

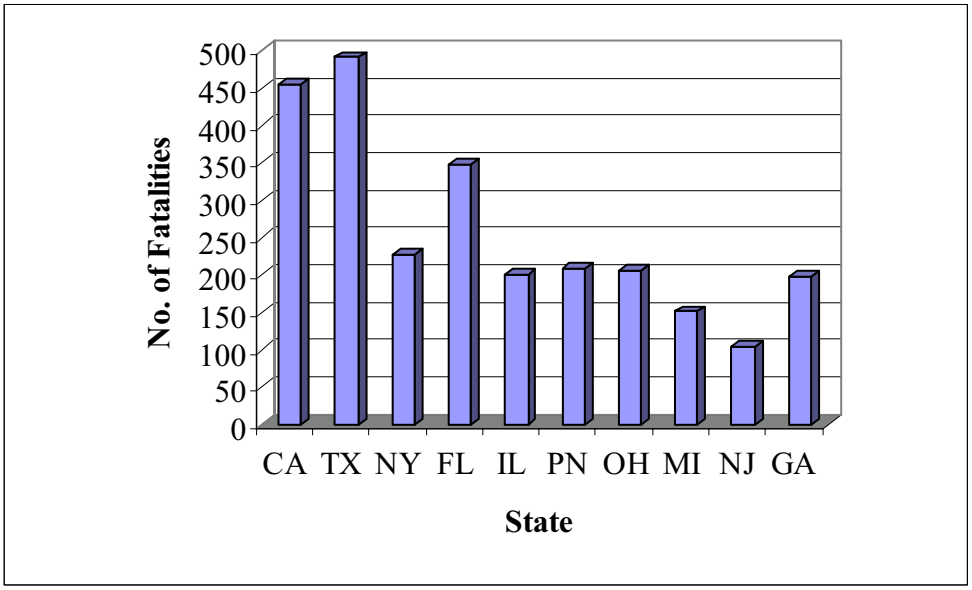
Figure 2
Texas Occupational Fatalities,
1992-2003



Source: Bureau of Labor Statistics, United States Department of Labor, 2004.

With the increase in occupational fatalities in 2003, Texas ranked first in the nation in total fatalities. Figure 3 shows the total occupational fatalities for 2003 in the ten most populous states, in order by population (based on the 2000 U.S. Census).

Figure 3
Number of Fatal Occupational Injuries
Ten Most Populous States, 2003



Source: Bureau of Labor Statistics, United States Department of Labor, 2004.

The relatively low injury rate in Texas remains one of the few factors working in the system's favor. In a recent "report card" comparison of state workers' compensation systems based on performance in the overall rate of injuries, rate of injuries with lost time and duration of lost time, recovery rates, and performance in treating two key injury types (low back strains and carpal tunnel syndrome), Texas received a "D-" grade for its performance through 2002. This is actually higher than the "F" Texas received in a similar report card based on data through 2000, and the improvement, the authors noted, was primarily due to "excellent performance in prevention and safety."[37]

Coverage

It is often said that Texas is the only state in which workers' compensation coverage is not mandatory for employers. It is more accurate to say that Texas is the only state in which coverage is *truly* optional for all private employers, since some other states do

[37] See *2004 State Report Cards for Workers' Comp*, Work Loss Data Institute, July 2004.

allow specific industry types or smaller employers not to carry coverage, and public employers in Texas are required to provide coverage.[38]

Those Texas employers who carry coverage (either through insurance policies or self-insurance) are required to follow the provisions of state law pertaining to workers' compensation, and are often referred to as "subscribers" to the system. Those opting not to provide workers' compensation coverage are often referred to as "nonsubscribers." Legally, the chief difference between subscribers and nonsubscribers relates to their ability to be sued in the event of an on-the-job injury. In general, nonsubscribers can be sued for simple negligence in an on-the-job injury or death, while subscribers can only be sued for an on-the-job fatality, and only under certain circumstances.[39]

In any discussion of subscription and nonsubscription it is also important to remember that an employer's nonsubscription status does not necessarily mean that employer's employees have no coverage for occupational injuries. As current and previous research shows, many nonsubscribers, particularly larger nonsubscribers, do offer some type of occupational injury coverage. These plans are generally not governed by state workers' compensation law, but rather by the federal Employee Retirement Income Security Act (ERISA). More detail on nonsubscriber plans is provided later in this section.

2004 Update of Nonsubscription Estimates

Since the Texas system is generally optional for employers, the level of subscription can serve as an important barometer of the health of the system, or at least of employers'

[38] New Jersey allows employers two options in purchasing on-the-job injury coverage: purchase of a standard workers' compensation insurance policy, or (if approved to self-insure by the state), purchase of a form of employers' liability insurance based on traditional common law remedies. Due to the restrictive nature of this statute, almost all employers opt to purchase workers' compensation coverage. Some other states allow exemptions for coverage for particular types of employers (including Georgia, Kansas, Missouri, Nebraska, and Wyoming, for agricultural employers), and 14 other states exempt some small employers (five or fewer employees) from coverage. None of these provisions are comparable to Texas' generally optional coverage provision. See *Comparison of State Workers' Compensation Systems*, Texas Department of Insurance Workers' Compensation Research Group, testimony to the Senate Select Committee on March 25, 2004.

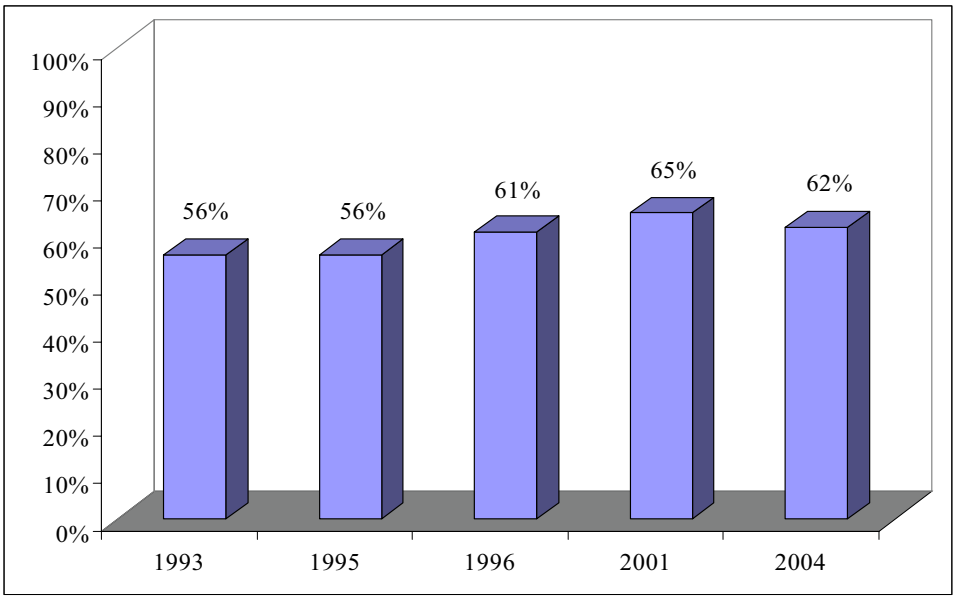
[39] *Texas Labor Code* Section 408.001 allows the recovery of exemplary damages by the surviving spouse or heirs to the body of a deceased employee whose death was caused by an intentional act or omission of the employer, or by the employer's gross negligence.

willingness to participate in it. The levels of subscription and nonsubscription in the system have been measured through projects conducted by the Workers' Compensation Research Center, Research and Oversight Council on Workers' Compensation, and, most recently, by the Texas Department of Insurance's Workers' Compensation Research Group. The project bases its estimates of subscription on a survey of several thousand Texas employers about their participation in the system and other issues, stratified by employer size and industry classification.

The nonsubscription study was first conducted in 1993, with follow-up studies in 1995, 1996, 2001, and 2004. The 2004 findings, reported to the Select Committee in August, indicate that at present 62 percent of Texas employers choose to carry workers' compensation insurance coverage; 38 percent, then, are nonsubscribers.[40] These findings represent a reversal of a trend found in each previous study, which found employer participation in the system increased over time, measured at an all-time high of 65 percent in 2001, as shown in Figure 4.

[40] See Employer Participation in the Texas Workers' Compensation System - 2004 Results, Texas Department of Insurance Workers' Compensation Research Group presentation to the Select Committee, August 26, 2004.

Figure 4
Percentage of Employers who are Subscribers, 1993-2004

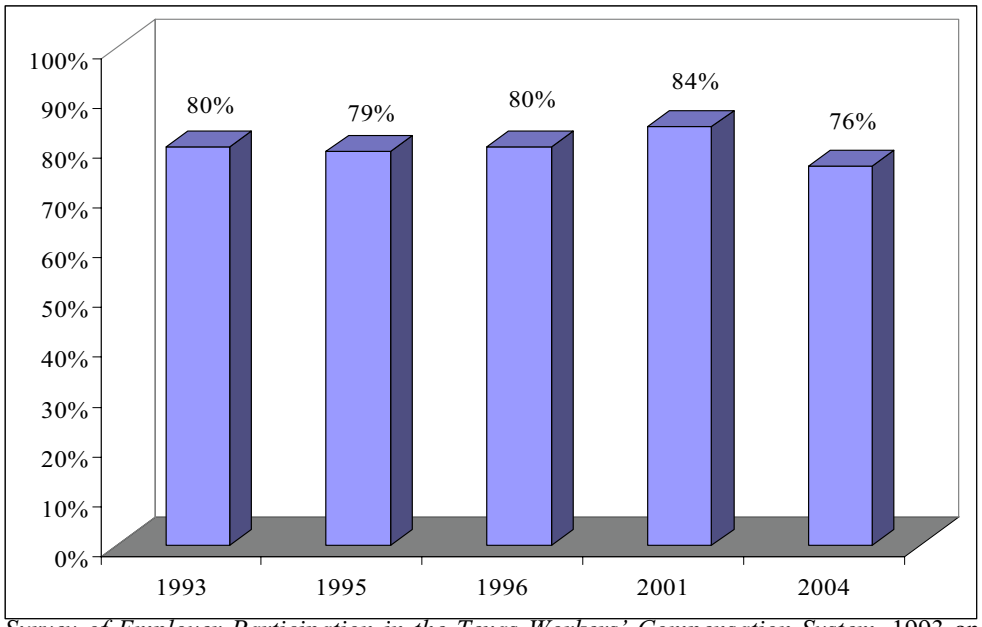


Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, 1993 and 1995 estimates from the Texas Workers' Compensation Research Center and the Public Policy Research Institute (PPRI) at Texas A&M University; 1996 and 2001 estimates from the Research and Oversight Council on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

Of even more concern for the health for the system than the 3 percent reduction in employer participation is the reduction in the percentage of Texas employees covered by subscribing employers. Previous research had found that employer size is the single greatest determinant of nonsubscriber status; smaller employers are more likely to nonsubscribe than larger.[41] As a result, the percentage of the Texas workforce covered by subscribers is significantly higher than the percentage of employers in the system. Figure 5 shows the percentage of the Texas workforce covered by workers' compensation in each study.

[41] In the 2001 estimates, for example, 47 percent of employers with one to four employees were nonsubscribers, as were 29 percent of those with five to nine employees; on the other extreme, only 13 percent of employers with 100 to 499 employees nonsubscribed, as did 14 percent of employers with 500 or more employees. See *A Study of Nonsubscription to the Texas Workers' Compensation System: 2001 Estimates*, Research and Oversight Council on Workers' Compensation, February 2002.

Figure 5
Percentage of Employees Working for Subscribers, 1993-2004



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 estimates from the Texas Department of Insurance Workers' Compensation Research Group and PPRI.

The 2004 estimate that 76 percent of Texas employees are covered by workers' compensation represents a disconcerting change from 2001, when an all-time measured high of 84 percent of employees were covered. This shift suggests that many of the employers who have left the system since 2001 are larger employers, a finding consistent with anecdotal claims that employers were more closely examining nonsubscription as an option as workers' compensation coverage became more expensive and otherwise less desirable.

When the 2004 survey results are examined closely, it is even more clear that a higher percentage of large employers are choosing nonsubscription than in previous years. Table 1 shows the differences in subscription rates by employer size from each of the nonsubscription studies.

Table 1
Percentage of Subscription by Employer Size, 1993-2004

Employer Size	1993*	1995	1996	2001	2004
1-4 Employees	N/A	45%	56%	53%	54%
5-9 Employees	N/A	63%	61%	71%	63%
10-49 Employees	N/A	72%	72%	81%	75%
50-99 Employees	N/A	76%	77%	84%	80%
100-499 Employees	N/A	80%	83%	87%	84%
500 + Employees	N/A	82%	86%	86%	80%

Note: * Nonsubscription estimates for 1993 were based on different employer size categories than were used in later years so they are not directly comparable.
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 estimates from the Texas Department of Insurance Workers' Compensation Research Group and PPRI.

Reasons for Subscription and Nonsubscription

The 2004 study and previous studies also examined the reasons why employers choose to purchase or not purchase workers' compensation insurance. For employers who did purchase workers' compensation in 2004, fear of lawsuits was the primary reason cited by the most employers (30.1 percent).[42] Other common primary reasons were the employer's participation in a high-risk industry (11.4 percent), the necessity of workers' compensation to bid on government contracts (11 percent),[43] the employer's confidence in the administration of the workers' compensation system (9.2 percent), and the employer's ability to self-insure or take advantage of deductibles and other premium discounts to reduce costs (8.9 percent).

[42] See Employer Participation in the Texas Workers' Compensation System - 2004 Results, Texas Department of Insurance Workers' Compensation Research Group presentation to the Select Committee, August 26, 2004.
[43] See *Texas Labor Code* Section 406.096, which requires governmental entities entering into building or construction contracts to certify that the contractor provides workers' compensation insurance coverage.

For nonsubscribers, the primary motivation for not purchasing coverage was most often that premium costs in workers' compensation were too high (37.9 percent). Other common factors cited were that the employer had too few employees (21.1 percent), that workers' compensation was not required by law (9.8 percent), that medical costs in the system were too high (4.9 percent), and that the employer had too few on-the-job injuries (4.7 percent).

Since premium costs were such a major consideration for nonsubscribers, the study also examined how much workers' compensation premiums would have to decrease to induce nonsubscribing employers to participate in the system. Interestingly, 37 percent of nonsubscribers said that they would never purchase coverage regardless of cost; another 21 percent would require more than a 50 percent reduction in premiums to participate. However, 18 percent of nonsubscribers indicated they could be induced to purchase workers' compensation coverage by less than a 20 percent reduction in premiums.

Benefits provided by Nonsubscribers

As noted, nonsubscription status by an employer does not necessarily mean no on-the-job injury coverage for employees. According to the 2004 estimates, 58 percent of Texas nonsubscribers pay medical and/or wage replacement benefits to their injured employees, up slightly from 56 percent in 2001.[44] Larger nonsubscribers are more likely to offer such benefit plans than smaller, so a higher percentage of the nonsubscriber workforce is employed by employers who pay some benefits. Some nonsubscribers pay benefits informally, without any written plan to do so; others, particularly larger nonsubscribers, have carefully crafted plans that encompass many of the areas the workers' compensation system regulates.

In addition to overall percentages of employers and employees estimated to be participating in the workers' compensation system, the 2004 TDI survey also provides an estimate of the overall percentage of the Texas workforce employed by employers who

[44] Since larger nonsubscribers are more likely to offer on-the-job injury benefits than smaller, this finding again suggests that more large employers are choosing nonsubscription.

offer no apparent on-the-job injury benefits (i.e., not a subscriber, and do not claim to pay medical or income benefits as a nonsubscriber). An estimated 3 percent of the Texas workforce work for such companies, based on the 2004 survey.[45]

Use of Waivers and Arbitration by Nonsubscribers

As mentioned previously in the discussion of the provisions of HB 2600, some nonsubscribing employers seek to minimize their lawsuit exposure through the use of various tools. One specific tool that drew keen legislative interest in 2001 was the use of pre-injury waivers of liability. Under such agreements, an employee of a nonsubscriber waived the right to sue the employer in the event of an on-the-job injury. Litigation was brought challenging the validity of such agreements; during the 2001 Legislative session, the Texas Supreme Court ruled that such waivers were enforceable. The legislature responded by specifically outlawing pre-injury waivers as a key component of HB 2600.[46] Proponents of outlawing such waivers argued these agreements were contrary to the public policy underlying the general difference between subscribers and nonsubscribers - that nonsubscribers were to assume greater risk for litigation than were subscribers.

In the ROC's 2001 study of nonsubscription, only 7 percent of nonsubscribing employers overall indicated they used some sort of liability waiver; however, a significant percentage of larger employers (27 percent of those with 50 or more employees) indicated they did so. It is also interesting that the 2001 ROC survey on which this percentage is based took place after pre-injury waivers had been barred.

However, the 2004 survey indicates much lower usage of waivers, with approximately 6 percent of nonsubscribers using some form of waiver, but the variation in use between smaller and larger nonsubscribers no longer significant (6.2 percent and 6.8 percent, respectively). This suggests that nonsubscribers, particularly large nonsubscribers, have

[45] See Employer Participation in the Texas Workers' Compensation System - 2004 Results, Texas Department of Insurance Workers' Compensation Research Group presentation to the Select Committee, August 26, 2004.
[46] See *Texas Labor Code* Section 406.033(e).

become more aware of and/or more compliant with the prohibition on pre-injury waivers.[47]

Some nonsubscribers, particularly larger companies, use arbitration agreements for disputes involving on-the-job injury claims. The use of arbitration was not tracked in the previous ROC surveys, so it is impossible to say conclusively that such agreements have become more prevalent, although this is suggested by the elimination of other lawsuit-avoidance options (i.e., pre-injury waivers). In 2004, only 12 percent of all nonsubscribers surveyed indicated they asked their employees to agree to arbitrate any disputes involving on-the-job injury claims, but a much larger percentage (40 percent) of companies with 50 or more employees did so.[48] Overall, the TDI Workers' Compensation Research Group estimated that in 2004, 29 percent of the nonsubscriber workforce is employed by companies that use either waivers or arbitration agreements.

Medical Care

No area of the workers' compensation system has received as much legislative and public attention in recent years as the delivery of medical care. Concerns have been raised on all sides: from employers, that insurance premiums are too high and that injured workers do not return to work in a timely fashion; from insurance carriers (and employers), that medical costs and utilization are out of control; from providers, that reimbursement is too low, administrative burdens too high, and denials and hassles from carriers too frequent; and from injured workers, that quality care is hard to find and that medical treatment is too often denied or delayed.

In specific cases, all of the above complaints have merit. This section of the report - and indeed, this entire report - attempts to look at *systemwide* trends, and the results of

[47] It is important to note that the HB 2600 ban on pre-injury waivers did not affect the legality of post-injury waivers of liability.

[48] Supplemental communication between TDI Workers' Compensation Research Group staff and committee staff.

analysis of data, in order to offer policy recommendations that address broad problems in the system.

The importance of the issue of medical care is highlighted by the fact that four of the Select Committee's seven charges relate directly to this issue. This portion of the discussion of Charge 5 focuses on the general state of the system related to medical care, and leaves discussion of some specific medical issues to the other charges as appropriate.

Recent analyses of medical cost and quality in Texas

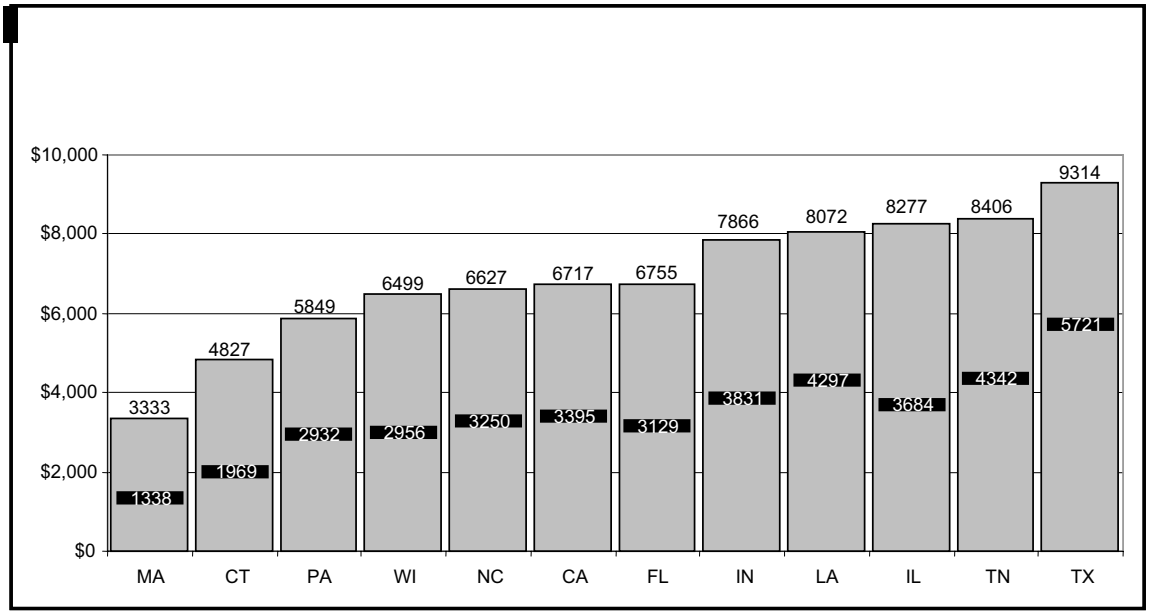
Medical Cost and Utilization

As noted in Section I, research based on data from the late 1990s - conducted by both the state and outside entities - found that Texas had among the highest workers' compensation medical costs per claim in the nation. Unfortunately, the most recent research available indicates that this remains the case.

In a 2004 analysis of medical costs and utilization in 12 states, examining claims occurring between October 2000 and September 2001, WCRI found that Texas had the highest average medical payment per claim, at about $9,300. WCRI's analysis included only claims with more than seven days lost time from work.[49] See Figure 6.

[49] See *The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 4th Edition*; Workers' Compensation Research Institute, Cambridge, Massachusetts, 2004. The figures cited are adjusted for injury and industry mix among the states and are measured at 12 months maturity. At 36 months maturity, Texas' cost remained highest among the states analyzed, at $12,686, more than $2,000 higher than the second-highest state, Louisiana.

Figure 6
WCRI 12-State Comparison
Average Medical Payment Per Claim
with More Than Seven Days Lost Time

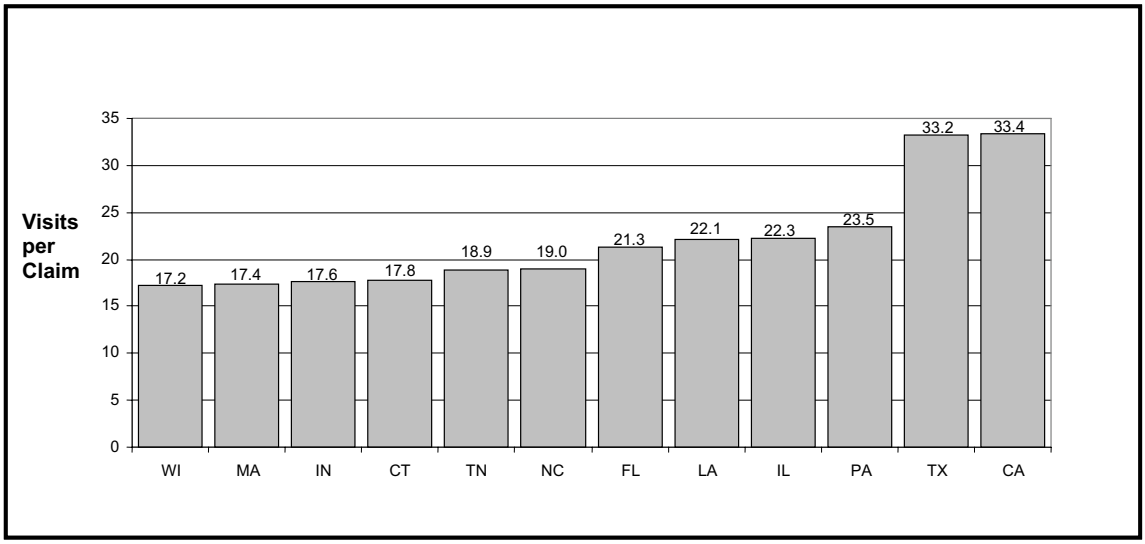


Source: *The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 4th Edition*; Workers' Compensation Research Institute, 2004; Figure A, Executive Summary, pp. xxv-xxvi.
Note: Numbers inside the black bars represent median values. Average measured at 12-months post-injury, adjusted for injury and industry mix.

Overall medical cost has two components: price per service and utilization of services (essentially, unit cost and volume, respectively). Also reflecting the findings of previous studies, WCRI's analysis revealed that in Texas, *in general*, higher utilization of medical services, rather than higher prices per service, drives high medical costs.

In the area of medical visits per claim, for example, for those claims with more than seven days lost time, Texas and California were in a virtual tie for the highest utilization among the 12 state-group, and were each 10 visits higher than the third-highest state. See Figure 7.

Figure 7
WCRI 12-State Comparison
Average Number of Visits Per Claim
with More than Seven Days Lost Time



Source: *The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 4th Edition*; Workers' Compensation Research Institute, 2004; Figure E, Executive Summary, p. xxix.

Table 2 shows how higher costs in Texas compare to the 12-state median in the areas of average payment per claim (i.e., overall cost), average visits per claim and average medical services per visit (both measures of utilization), and average price per service.[50]

[50] Information from WCRI presentation to the Senate Select Committee, April 29, 2004.

Table 2
WCRI Comparison of Texas Medical Cost to Median of 12 States, Selected Measures

	Texas	12-State Median	% Difference
Ave. Payment/Claim	$9,314	$6,736	+38%
# of Services/Visit	3.9	3.4	+15%
# of Visits/Claim	33.2	20.2	+64%
Ave. Price per Service	$75	$109	-31%

Source: Workers' Compensation Research Institute, Presentation to Select Committee, April 29, 2004.
Note: Average price per service is based on the 1996 TWCC fee guideline. Claims included missed more than seven days lost time and numbers are adjusted for injury and industry mix between states.

While overall average utilization and medical costs are high in Texas compared to other states, it is possible that particular medical service areas are the primary drivers of higher costs. This was one of the possibilities examined by the ROC in the HB 3697 reports. The ROC report examined utilization in five medical treatment areas - surgery and related hospitalization, physical medicine, office visits, diagnostic tests, and pharmaceuticals - to determine in which areas Texas showed comparatively high utilization compared to other states' workers' compensation systems, other delivery systems, and national treatment guideline recommendations.[51] At the time of the HB 3697 reports, these five areas of treatment together accounted for 91 percent of the total medical costs in the system.[52]

The ROC report also focused on the six most frequent types of injuries in the Texas workers' compensation system - neck soft tissue injuries, low back soft tissue injuries, low back nerve compression injuries, shoulder soft tissue injuries, hand and wrist nerve compression injuries, and hand and wrist soft tissue injuries. The report then examined the comparative utilization of various types of medical treatment for these conditions in

[51] See *Striking the Balance*, p. 29
[52] See *Striking the Balance*, p. 19. The specific breakdown was as follows: hospitalization/surgery, 48 percent; physical medicine, 21 percent; office visits, 11 percent; diagnostic testing, 8 percent; and pharmaceutical drugs, 3.5 percent. Percentages may have changed somewhat since the 2001 report but there is no evidence to suggest drastic changes.

Texas and eight other states - Florida, Kentucky, New Jersey, Oregon, Minnesota, California, Colorado, and Georgia.

The ROC report found particularly high medical utilization for Texas in the following areas:

Surgery

Texas ranked highest in utilization of surgery (among workers who had surgery) for four of the six conditions. Texas was second or third for the other two conditions.[53] See Table 3.

[53] It is particularly interesting that high surgical utilization was found for injuries diagnosed as soft tissue conditions. As the *Striking the Balance* report noted: "Interestingly, there were fairly high surgery rates in every state for soft-tissue injuries. Most nationally-accepted treatment guidelines do not typically recommend surgery for 'soft tissue' injuries, since the vast majority of these workers recover with conservative treatment rather than surgery. Further, the failure rates for surgery for these conditions are quire high. Without an individual claim audit, however, it is not conclusively clear whether these 'soft tissue' surgeries are clinically indicated or the result of misdiagnosis, mis-reporting of subsequent diagnostic codes that would indicate surgery, or inappropriate care." See *Striking the Balance*, p. 29. Examples of treatment guidelines referenced include the American College of Occupational and Environmental Medicine's practice guidelines, the Agency for Health Care Policy and Research Guideline on acute low back problems, and others.

Table 3
Average Number of Surgeries Per Injured Worker Who Received Surgery, Texas and Other States, Averages for the Top Six Diagnostic Groups (highest rates are shaded below)

State	Neck Soft Tissue Injuries	Low Back Soft Tissue Injuries	Low Back Nerve Compression Injuries	Shoulder Soft Tissue Injuries	Hand & Wrist Nerve Compression Injuries	Hand & Wrist Soft Tissue Injuries
FL	2.5	2.7	2.5	2.1	2.1	1.9
KY	1.9	2.5	1.8	1.9	1.7	1.8
NJ	2.7	2.3	**4.8**	1.8	2.3	1.7
OR	1.9	2.0	1.8	2.1	1.6	1.5
MN	2.1	1.7	2.0	1.8	1.7	1.6
CA	2.6	2.4	2.6	2.1	2.3	**2.1**
CO	2.4	2.0	1.8	1.9	1.6	1.8
GA	2.2	2.5	3.6	**2.3**	2.1	1.5
TX	**3.4**	**3.4**	2.7	**2.3**	**2.7**	1.9

Source: Med-FX, LLC. and the Research and Oversight Council on Workers' Compensation, 2000; published in *Striking the Balance*, 2001.
Note: Based on an analysis of multi-state insurance carrier data. Each surgery included in this table may include multiple individual surgical procedures.

Injections

Injections, including epidural steroid injections and trigger point injections, were also an area of high utilization in Texas. Texas ranked highest among the states for five of the six conditions. See Table 4.

Table 4
Average Number of Injections Per Injured Worker Who Received Injections, Texas and Other States, Averages for the Top Six Diagnostic Groups (highest rates are shaded below)

State	Overall Utilization Rate for Top 10 Diagnostic Groups	Neck Soft Tissue Injuries	Low Back Soft Tissue Injuries	Low Back Nerve Compression Injuries	Shoulder Soft Tissue Injuries	Hand & Wrist Nerve Compression Injuries	Hand & Wrist Soft Tissue Injuries
FL	4.5	7.3	6.9	6.9	2.9	3.4	2.6
KY	3.0	3.3	5.7	3.8	2.0	1.6	2.5
NJ	3.6	5.4	4.5	**8.0**	2.9	2.5	2.3
OR	2.5	3.7	4.0	3.7	2.2	1.6	2.1
MN	2.2	4.2	2.5	3.7	1.8	1.8	2.3
CA	3.9	6.1	5.7	4.5	2.6	3.7	2.5
CO	3.2	7.0	4.1	3.8	2.6	1.8	2.2
GA	3.5	3.2	5.2	**8.0**	3.2	2.5	2.6
TX	**6.2**	**10.2**	**10.0**	5.1	**3.6**	**4.9**	**3.0**

Source: Med-FX, LLC. and the Research and Oversight Council on Workers' Compensation, 2000, published in *Striking the Balance*, 2001.
Note: Based on an analysis of multi-state insurance carrier data. Includes therapeutic injections such as trigger point, facet, and epidural steroid injections. Lytic and radiologic injections are not included.

Physical Medicine

Physical medicine, a term that in this context includes a broad range of treatments and modalities, was also an area of high utilization. One common treatment is manipulation; Texas ranked first in the average number of manipulations for five of the six conditions, and was a close second for the other condition. See Table 5.

Table 5
Average Number of Manipulations Per Injured Worker Who Received These Services, Texas and Other States, Averages for the Top Six Diagnostic Groups (highest rates are shaded below)

State	Overall Util. Rate for Top 10 Diag. Groups	Neck Soft Tissue Injuries	Low Back Soft Tissue Injuries	Low Back Nerve Compression Injuries	Shoulder Soft Tissue Injuries	Hand & Wrist Nerve Comp. Injuries	Hand & Wrist Soft Tissue Injuries
FL	8.7	10.9	7.4	9.5	9.9	10.2	7.9
KY	14.4	21.1	15.3	18.9	13.2	12.7	5.3
NJ	11.9	10.9	10.0	24.8	15.3	12.8	8.5
OR	8.5	9.8	7.6	12.4	10.4	11.3	7.0
MN	11.7	14.3	10.7	18.5	11.8	16.3	7.0
CA	23.7	**29.5**	26.1	36.5	19.4	25.0	14.3
CO	12.4	16.0	13.1	13.8	10.8	10.6	8.2
GA	7.5	9.4	5.6	7.0	9.7	10.8	7.0
TX	**26.4**	28.5	**27.2**	**38.2**	**21.5**	**27.5**	**24.3**

Source: Med-FX, LLC. and the Research and Oversight Council on Workers' Compensation, 2000, published in *Striking the Balance*, 2001.

Note: Based on an analysis of multi-state insurance carrier data. Includes manipulations conducted by all health care provider types (including M.D.s, P.T.s, and Osteopaths). For comparability purposes, office visits to chiropractors were included in manipulation rates rather than office visit rates since it more accurately reflects the common usage of those medical procedure codes.

In other physical medicine service areas, including therapeutic exercises and physical medicine modalities (including, for example, hot and cold packs, and massage), Texas' comparative utilization was somewhat lower, although Texas ranked at least third for all conditions. See Tables 6 and 7.

Table 6

Average Number of Therapeutic Exercise Treatments Per Injured Worker Who Received These Services, Texas and Other States, Averages for the Top Six Diagnostic Groups (highest rates are shaded below)

State	Overall Utilization Rate for Top 10 Diagnostic Groups	Neck Soft Tissue Injuries	Low Back Soft Tissue Injuries	Low Back Nerve Compression Injuries	Shoulder Soft Tissue Injuries	Hand & Wrist Nerve Compression Injuries	Hand & Wrist Soft Tissue Injuries
FL	16.2	17.6	13.8	25.3	20.6	18.9	14
KY	13.0	13.0	9.6	49.0	17.6	15.9	17.6
NJ	**30.0**	**30.3**	**24.3**	**56.8**	**40.1**	**37.3**	**20.1**
OR	11.1	10.8	10.2	19.6	13.1	11.3	10.1
MN	13.7	13.6	14.3	24.3	16.3	15.1	10.8
CA	18.3	19.7	16.2	22.2	22.9	27.7	16.9
CO	16.0	15.0	17.3	30.5	16.4	8.7	13.5
GA	18.0	13.4	17.1	12.4	25.8	17.3	12.8
TX	19.2	21.3	18.4	34.4	23.5	24.0	17.7

Source: Med-FX, LLC. and the Research and Oversight Council on Workers' Compensation, 2000, published in *Striking the Balance*, 2001.

Note: Based on an analysis of multi-state insurance carrier data. Therapeutic exercise treatments include items such as active therapy and assisted exercise.

Table 7

Average Number of Physical Medicine Modalities Per Injured Worker Who Received These Services, Texas and Other States, Averages for the Top Six Diagnostic Groups (highest rates are shaded below)

State	Overall Utilization Rate for All 10 Diagnostic Groups	Neck Soft Tissue Injuries	Low Back Soft Tissue Injuries	Low Back Nerve Compression Injuries	Shoulder Soft Tissue Injuries	Hand & Wrist Nerve Compression Injuries	Hand & Wrist Soft Tissue Injuries
FL	16.2	19.8	13.9	29.6	20.8	16.1	13.6
KY	16.7	26.8	17.3	46.7	17.8	16.1	12.8
NJ	30.4	38.8	25.4	35.1	38.3	**51.1**	25.8
OR	16.3	18.5	14.8	23.1	19.6	18.7	13.8
MN	13.4	16.5	11.4	15.1	14.0	21.8	15.9
CA	**36.6**	**49.4**	**38.8**	49.2	**40.1**	46.7	28.0
CO	6.6	9.9	6.1	12.4	6.4	10.7	5.9
GA	15.3	18.2	13.6	27.8	18.0	28.9	15.5
TX	33.9	44.7	35.6	**54.4**	33.8	41.5	**28.2**

Source: Med-FX, LLC. and the Research and Oversight Council on Workers' Compensation, 2000, published in *Striking the Balance*, 2001.

Note: Based on an analysis of multi-state insurance carrier data.

Other service areas

The findings of the ROC reports were similar in other service areas. In both provider office visits and diagnostic testing, Texas ranked first or second in utilization for almost

every type of condition.[54] In the area of pharmaceuticals, Texas was also second only to California in average number of prescriptions per worker, with seven.[55]

Frequency of types of treatment

Most the ROC analyses described above examined the utilization of services only for workers who *received* those services. However, the report also examined the general frequency of types of care for injured workers in Texas and the other states. For example, for low back soft tissue injuries, the ROC examined the percentage of all workers who received surgery and the percentage who received physical medicine. As Table 8 shows, Texas ranked first in both lumbar fusions and laminectomies (two types of spinal surgery), first in manipulations, and second in therapeutic exercises among workers with low back soft tissue injuries.

[54] Among utilization comparisons in 28 different areas related to office visits or diagnostic tests, the only areas in which Texas did rank either first or second highest in utilization were: Magnetic Resonance Imaging (MRI) scans for low back nerve compression and hand and wrist soft tissue injuries; and CT scans for shoulder soft tissue injuries and hand and wrist nerve compression injuries. See *Striking the Balance*, pp. 37-41.

[55] See *Striking the Balance*, p. 42.

Table 8
Percentage of Injured Workers With Low Back Soft Tissue Injuries Who Received Surgery and Physical Medicine, Texas and Other States
(highest rates are shaded below)

State	Surgery		Physical Medicine	
	Lumbar Fusions	**Laminectomies**	**Manipulations**	**Therapeutic Exercises**
FL	1.1%	3.6%	19.0%	48.0%
KY	0.6%	2.4%	19.6%	29.3%
NJ	1.1%	3.0%	17.1%	48.4%
OR	0.8%	3.8%	45.0%	44.4%
MN	0.5%	2.5%	42.6%	43.3%
CA	0.7%	2.1%	39.0%	**71.9%**
CO	0.7%	3.0%	28.9%	24.4%
GA	0.7%	3.0%	17.8%	50.7%
TX	**2.5%**	**4.9%**	**45.5%**	59.5%

Source: Med-FX, LLC. and the Research and Oversight Council on Workers' Compensation, 2000, published in *Striking the Balance*, 2001.

These findings suggest that injured workers in Texas receive these types of medical treatment more often than their counterparts in other states, and that when they do, they receive more treatments.

Comparisons to group health systems

In addition to comparing medical costs in Texas to those in other states' workers' compensation systems, the ROC report further examined how costs compared to the state's group health care system. As noted previously, the overall costs differences for the ten most common diagnostic groups was on the order of six times higher in workers'

compensation, measured at 18 months post-injury. Utilization rates for surgery were found to be higher in Texas workers' compensation than in group health; even more significant differences in utilization were seen in the areas of injections, physical medicine (specifically for manipulations and therapeutic exercises), and some diagnostic tests.[56]

Updates of medical cost and utilization findings

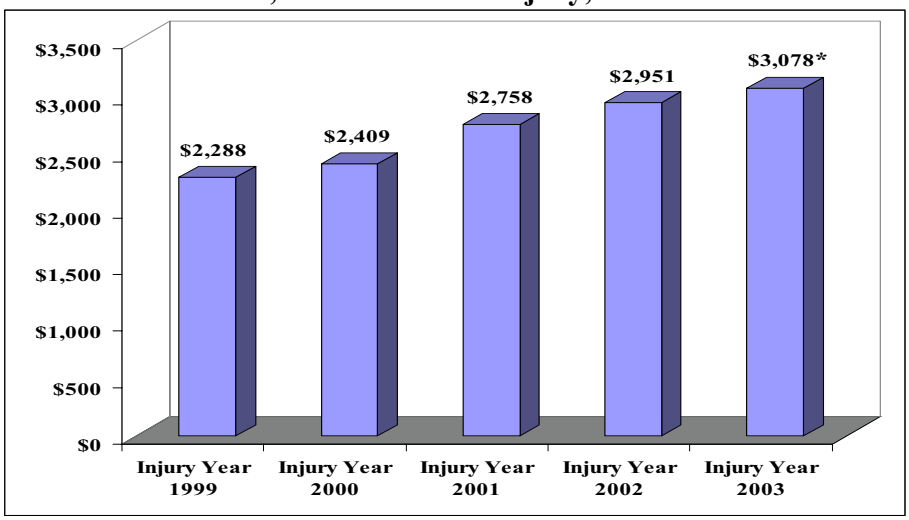
The specific findings reported by the ROC were for injuries occurring during 1997. Although findings from WCRI and other studies suggest that the trends did not change significantly in subsequent years, Texas Department of Insurance (TDI) research staff was asked in early 2004 to update medical cost and utilization findings for Texas based on the most recent data available.

Overall, the TDI findings showed that average medical cost per claim, assessed at 12 months post-injury, in Texas rose from injury year 1999 ($2,288) to 2000 ($2,409) to 2001 ($2,758), to 2002 ($2,951).[57] (See Figure 8). Costs per claim for injury year 2003 ($3,078) are also shown but should be considered preliminary, since they are based on medical data for only a few months of injuries from that year.

[56] See *Striking the Balance*, p. 44-46.

[57] See Update on Medical Cost Trends in the Texas Workers' Compensation System, presentation of TDI Workers' Compensation Research Group to Senate Select Committee, August 2004.

Figure 8
Average Workers' Compensation Medical Cost Per Claim in Texas, All Claims, One Year Post-Injury, 1999-2003



Source: Texas Workers' Compensation Commission, Medforms database, as of April 2004 and the Texas Department of Insurance, Workers' Compensation Research Group, August 2004.
Note: Average medical costs per claim do not include pharmacy costs. * Average medical cost estimates for injury year 2003 should be considered preliminary until insurance carriers have submitted all remaining medical data pertaining to 2003 and 2004 medical services to the Texas Workers' Compensation Commission.

TDI's analysis shows almost a 35 percent increase in the average medical cost of a Texas workers' compensation claim in just five years, during a period in which the pricing for most medical services was unchanged (i.e., subject to the 1996 TWCC fee guideline). The difference in these figures and the WCRI average ($9,314, in the most recent analysis) is due to WCRI's consideration of only claims with more than seven days lost time from work.

In terms of overall costs and utilization, WCRI's most recent analyses found that Texas ranked first among the 12 states in average number of services per claim among claims with more than seven days lost time, at 131 medical services per claim.[58] The median state in this analysis, Florida, had 72 services per claim.

[58] See *The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 4th Edition*; Workers' Compensation Research Institute, Cambridge, Massachusetts, 2004.

TDI's 2004 update also examined how utilization patterns may have changed in the specific service areas previously shown to be unusually high in Texas (surgery, injections, physical medicine, and diagnostic testing, in particular).

For all surgical episodes and for specific back surgeries (laminectomies and spinal fusions) that had been examined in the HB 3697 reports, TDI found relatively little change in utilization between 1999 and 2001, save for one area of analysis. For fusion surgeries related to both low back soft tissue injuries and low back nerve compression injuries, the number or procedures billed per surgical episode increased, suggesting perhaps that more intensive procedures were being performed. See Table 9.

Table 9
Average Number of Spinal Fusion Surgical Procedures per Surgical Episode, Low Back Soft Tissue and Low Back Nerve Compression Injuries, Injury Years 1999-2001, Eighteen Months Post-Injury

	Avg. # of Surgical Procedures Per Episode, Low Back Soft Tissue	Avg. # of Surgical Procedures Per Episode, Low Back Nerve Compression
1999	3.1	3.1
2000	3.1	3.4
2001	3.3	3.4

Source: Texas Workers' Compensation Commission, Medforms Data as of April 2004; and the Texas Department of Insurance Workers' Compensation Research Group, 2004.

Generally, injection utilization remained fairly constant, with some increase seen in facet injections.[59]

In physical medicine, TDI examined ten treatments and modalities and found all ten showed increased utilization - in terms of average number of treatments per worker who received that treatment - between 1999 and 2001. Percentages of increase ranged from 5.6 percent to 54.5 percent.[60]

[59] TDI's analysis showed that the average number of facet injections per patient for all injuries (assessed at one-year post injury) increased from 4.4 injections for injury year 1999 to 4.5 in 2000 and 5.4 in 2001.
[60] Physical medicine services analyzed included therapeutic exercises (33.3% increase from 1999 to 2001); manipulation (18.2%); aquatic therapy (54.5%); chronic pain management (14.1%); work hardening (5.6%); work conditioning (9.1%); neuromuscular reeducation (25%); therapeutic exercise, group (45%);

Diagnostic testing in general did not show the same pattern of increase, as TDI found in the follow-up analysis that there had been no significant increase in these services between injury years 1999 and 2001. The one exception was for nerve conduction studies.[61] Interestingly, while overall utilization in this area did not increase significantly, the average payment per worker for nerve conduction studies increased in some areas, suggesting perhaps that more expensive studies were being utilized.

WCRI also evaluated comparative rates of physical medicine and surgery in its 2004 *Anatomy of Workers' Compensation Medical Costs and Utilization* report. Among the 12 states compared, Texas had the highest percentage of claims with more than seven days lost time that involved payment for physical medicine (67 percent of these claims, accounting for 30 percent of non-hospital system costs). See Figure 9.

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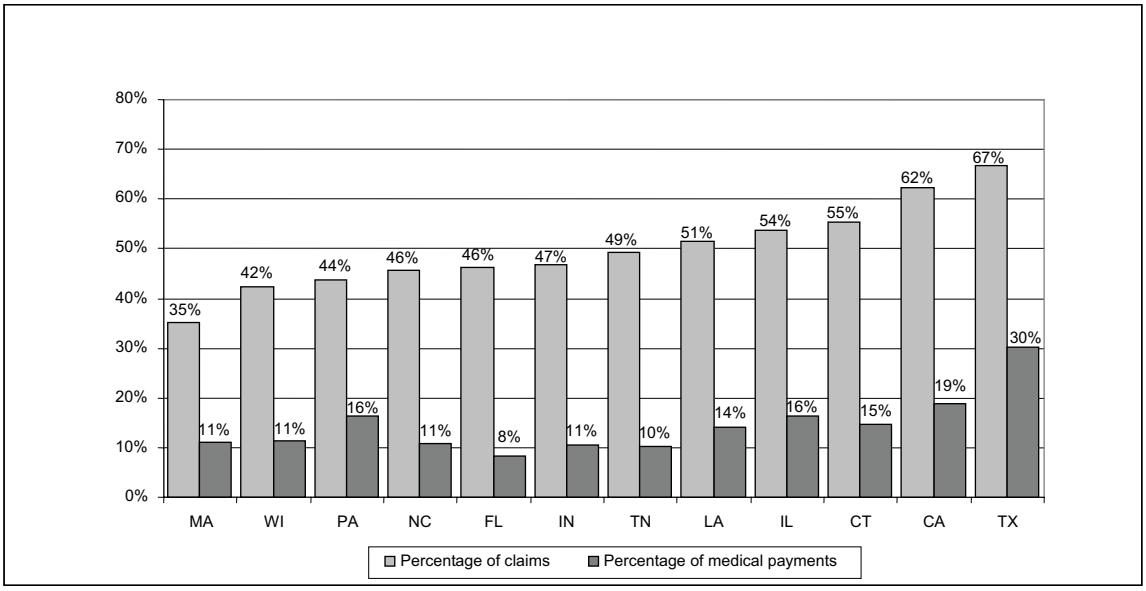
therapeutic exercise, one on one (18.2%); and unlisted procedures (25%). Percentage changes reflect changes in the median number of services provided per injured worker who received those services. See Medical Cost and Quality of Care Trends in the Texas Workers' Compensation System, Texas Department Insurance Workers' Compensation Research Workgroup, presentation to the Senate Select Committee, March 25, 2004.

[61] Nerve conduction studies increased from 11.8 per worker who received such services in 1999 to 15 in 2001.

Figure 9
WCRI 12-State Comparison:
Distribution of Claims and Payment for Physical Medicine Services
by Nonhospital Providers for Claims with More Than Seven Days Lost Time



Source: *The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 4th Edition*; Workers' Compensation Research Institute, 2004; Figure 3.26, p. 61.

In the area of surgical utilization, Texas ranked higher than the median state for both minor and major surgery (22 and seven percent higher, respectively) for claims with more than seven days lost time. Texas also ranked higher than the median in minor and major surgery in average medical payment per claim, despite ranking somewhat lower than the median in price per service in both areas, pointing again to higher utilization.[62]

Utilization and cost comparisons by provider type

Just as Texas' medical cost trends vary for different types of treatment, there is also variation in how cost and utilization in Texas compare to other states by type of provider. As Table 10 shows, in the most recent WCRI analysis, Texas ranked below the 12-state median in only very few areas of the analysis - those applicable to prices per service for

[62] See *The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 4th Edition*; Workers' Compensation Research Institute, Cambridge, Massachusetts, 2004.

physicians and three measures related to hospitals. In all other areas, Texas was above the median.

Table 10
Comparison of Texas to WCRI 12-State Median:
Average Medical Payment per claim and Utilization by Provider Type
for Claims with more than 7 days lost time
(Number shown represents % variance (+/-) from 12-state median)

	Physician[63]	Chiropractor	PT/OT[64]	Hospital
Average Medical Payment Per Claim	+19	+329	+40	-12
Average Number of Visits Per Claim	+35	+93	+5	-36
Average Number of Services Per Visit	+30	+36	+16	+18
Average Price per Service[65]	-23	+53	+20	+12
Average Payment per Visit	0	+106	+28	+33
Provider type involved (% of claims)	+5	+357	+10	-15

Source: *The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 4th Edition*; Workers' Compensation Research Institute, 2004; Compiled from Table 4.42a, p. 343.
Note: Includes claims occurring between October 2000 and September 2001, measured at March 31, 2002. Median is considered the average of the states ranked sixth and seventh.

While average utilization and cost in Texas is higher than the median in almost all areas and for almost all provider types, the extreme differences in cost and utilization in some measures by chiropractors (on the order of three times or more than the median state for average medical payment per claim and percentage of provider type involved in a claim) have drawn particular interest, analysis, and speculation. Texas, like many other states, generally allows chiropractors to serve as treating doctors in the workers' compensation system.[66] Some states, however, including four of the other 11 studied for the WCRI

[63] Medical doctor or doctor of osteopathy.
[64] Physical or occupational therapist.
[65] Comparison based on the 1996 TWCC fee guideline.
[66] Thirty-six states allow chiropractors to serve as treating doctors; 12 do not specify; and two (Oregon and Virginia) specifically restrict in some fashion. See *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2002-2002*; Workers' Compensation Research Institute, Cambridge, Massachusetts. However, since many of the states that allow chiropractors to serve as

CompScope and *Anatomy* comparisons (North Carolina, Tennessee, Florida, and California), do set hard limits on the number of chiropractic visits reimbursable for a workers' compensation claim, although the extent to which these limits are reflected in the historical data varies.[67]

While chiropractic utilization in Texas appears higher than in other states, some witnesses supporting the efficacy of chiropractic treatment in testimony before the Select Committee argued that chiropractic care cannot be a major driver of higher costs in Texas, citing a 2003 study by MGT of America commissioned by the Texas Chiropractic Association.[68] The MGT study examined TWCC medical payment data for the years 1996 to 2001 and found chiropractic care accounted for only 12.5 percent of medical costs in the Texas workers' compensation system (not including pharmaceutical costs, which TWCC does not currently collect), and concluded that this relatively small percentage of costs could not constitute a major driver of overall medical costs. By way of response to the MGT study, WCRI noted the percentage of system medical costs attributable to chiropractors increased from 7 percent (for 1996 injuries) to 18 percent (for 2001 injuries) of system costs.[69]

WCRI also emphasized the contrasts between the frequency of chiropractic involvement in claims in Texas compared to the other states studied. In addition to the variations from the 12-state median shown in Table 10 above, WCRI's comparisons show that chiropractors treated in 30 percent of all claims in Texas with more than seven days lost time and received 20 percent of medical payments for these claims. In no other state

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treating doctors also use employer choice of doctor or managed care systems, this does not mean that all states that theoretically allow chiropractors to be treating doctors see participation from chiropractors in this role on a large scale.

[67] Tennessee employs a 12-visit limit; North Carolina, 20; Kansas, 21; Florida, 24 (increased from 18 in 2003); California, 24; Hawaii, 30 visits in 180 days; and Alaska, 46 visits in one year). Communication from Dr. Richard Victor, Workers' Compensation Research Institute, to Senate Select Committee staff, February 2004.

[68] See *Chiropractic Treatment of Workers' Compensation Claimants in the State of Texas, Final Report*, MGT of America, February 2003.

[69] See WCRI Flashreport, April 2004, FR-04-05, *Is Chiropractic Care a Cost Driver in Texas? Reconciling Studies by WCRI and MGT/Texas Chiropractic Association*.

analyzed did these percentages exceed 15 and 7 percent, respectively; the median state was only at about 7 percent and 2 percent.[70]

Two valid points seem to emerge from the data-intensive debate about chiropractic treatment in Texas. One is that chiropractic utilization and the share of system cost devoted to chiropractic is much higher in Texas than in most other states. The other, however, is that chiropractic utilization and cost is clearly not the only area in which Texas is out of line with its peers.

Medical Quality

No discussion of the cost and utilization of medical care is complete without also considering the quality of care. After all, policymakers in a state with higher than average workers' compensation medical costs may find these costs justified if workers and employers in the state enjoy significantly better outcomes.

Unfortunately for Texas, high medical costs clearly have not led to improved outcomes, either in objective measures (such as return work, where Texas is significantly below average) or more subjective measures like satisfaction with care (where Texas appears to be average, at best).

In fact, while the comparison is complicated by other factors that may be unique to the states involved, there appears to be no correlation whatsoever between states with high average medical costs in workers' compensation and improved outcomes. The assumption should not be made, however, that simply lowering medical costs necessarily *improves* outcomes, either - particularly in a system like Texas', where medical cost controls are largely implemented on the "back end" of care through retrospective denials and disputes.

[70] See *The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 4th Edition*; Workers' Compensation Research Institute, Cambridge, Massachusetts, 2004, p. 53.

Return to Work

Healthy, sustained return to employment is the most basic goal of any workers' compensation system. Research indicates that the longer an injured worker remains off work, the less likely that worker is to ever return; specific findings have suggested that three-quarters of disability costs are accounted for by those claims that miss more than six months of work, and that these claims experience an increasingly slim chance of ever returning to work.[71] While quality medical care is clearly not the only important factor in achieving return to work, it is one of the most basic and essential, and is therefore discussed here in the context of medical quality.

Since comprehensive, reliable data on return-to-work outcomes is not collected in Texas or in most other states, analyses of return to work are usually conducted either through examining data "proxies" such as the duration of temporary disability payments (as in the WCRI and ROC studies cited), or through follow-up surveys of injured workers.

WCRI analysis showed that Texas had the longest average duration of temporary disability - initial lost time from work due to an injury - among the 12 states studied. Texas showed an 18 week average duration of temporary disability benefits among those claims with more than seven days lost time; the median for all states was 14 weeks.[72] Even more discouraging was that Texas ranked first in duration of temporary disability despite the fact that Texas also had the second-highest percentage of all claims that missed at least seven days of work (26 percent, compared to the 12-state median of 21 percent).[73] In other words, more Texas injured workers missed at least a week of work, and once they did, they stayed off work longer than did workers in the comparison states.

Both WCRI and the ROC recently conducted surveys of injured workers to examine return to work and other health-related outcomes and perceptions. The WCRI survey

[71] See *Recommendations for Improvements in Texas Workers' Compensation Safety and Return-to-Work Programs: A Report to the 77th Legislature*; Research and Oversight Council on Workers' Compensation and Research and Planning Consultants, LP, January 2001, p. 2.
[72] See *Compscope Benchmarks: Multistate Comparisons, 4th Edition*; Workers' Compensation Research Institute, February 2004, p. 63.
[73] See *Compscope, 4th Edition*, p. 63.

involved workers in four states - Texas, California, Massachusetts, and Pennsylvania.[74] Overall results were as follows:

- Texas workers reported the worst physical recoveries among workers in the four states;[75]
- More Texas workers had either not returned to work or not "substantially" returned to work than workers in other three states;[76]
- Severity of injury (based on the workers' own perception of severity) was not a significant factor in whether or not a worker substantially returned to work;[77]
- Two types of factors stood out as correlated to return to work - extent of physical recovery, and the presence of factors regarded as potential disadvantages in the labor market (such as low education level, low wage, short tenure on the job, and Spanish as a primary language);[78]
- Workers in Texas reported similar or less access to care;[79] and
- Workers in Texas were less likely to report they were satisfied with their primary provider than were workers in Massachusetts and Pennsylvania.[80]

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[74] See *Outcomes for Injured Workers in California, Massachusetts, Pennsylvania, and Texas*, Workers' Compensation Research Institute, December 2003.

[75] See presentation of Workers' Compensation Research Institute to Senate Select Committee, April 29, 2004, citing *Outcomes for Injured Workers in California, Massachusetts, Pennsylvania, and Texas*, Workers' Compensation Research Institute, December 2003.

[76] See presentation of Workers' Compensation Research Institute to Senate Select Committee, April 29, 2004, citing *Outcomes for Injured Workers in California, Massachusetts, Pennsylvania, and Texas*, Workers' Compensation Research Institute, December 2003. Substantial return to work for the purpose of this analysis was defined as lasting at least one month. Specifically, 15 percent of injured workers in Texas had not returned to work at all, and 25 percent had no substantial return to work; these percentages compared to 10 percent 16 percent in California, 8 percent and 14 percent in Massachusetts, and 6 and 10 percent in Pennsylvania. See *Outcomes*, p. 55.

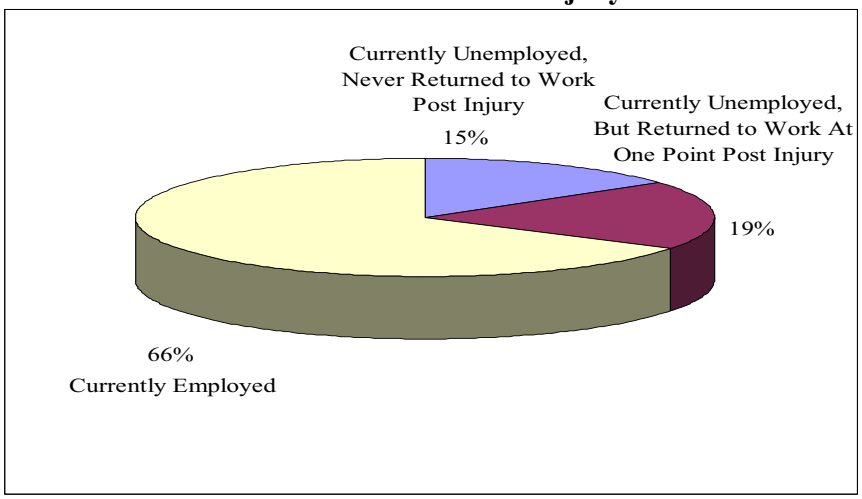
[77] See presentation of Workers' Compensation Research Institute to Senate Select Committee, April 29, 2004, citing *Outcomes for Injured Workers in California, Massachusetts, Pennsylvania, and Texas*, Workers' Compensation Research Institute, December 2003, p. 57.

[78] See presentation of Workers' Compensation Research Institute to Senate Select Committee, April 29, 2004, citing *Outcomes for Injured Workers in California, Massachusetts, Pennsylvania, and Texas*, Workers' Compensation Research Institute, December 2003, pp. 57-67.

[79] See presentation of Workers' Compensation Research Institute to Senate Select Committee, April 29, 2004, citing *Outcomes for Injured Workers in California, Massachusetts, Pennsylvania, and Texas*, Workers' Compensation Research Institute, December 2003. Specifically, 15 percent of Texas workers reported "big problems" with access to desired medical services, compared to 14 percent in California, 9 percent in Massachusetts, and 10 percent in Pennsylvania. See *Outcomes*, p. 103. It should also be noted that this analysis took place prior to the implementation of the 2002 TWCC Medical Fee Guideline, which had a generally negative impact on access to care in Texas. At the time of the WCRI analysis, in fact, Texas' fee schedule was generally more generous to providers than fees in California and much more generous than fees in Massachusetts. See *Outcomes*, p. 148.

ROC's survey, conducted in 2002, involved injured workers in Texas with low back, neck, and shoulder soft tissue injuries occurring in 2000. As Figure 10 shows, more than a third of workers surveyed were not working at the time of the survey, even though the survey involved workers who had been injured 21 to 33 months earlier. Further survey questions evaluated what percentage of workers reported being off work due to their injury; 26 percent indicated this was the case.[81]

Figure 10
Return-to-Work Outcomes for Injured Workers in Texas, 21 to 33 Months Post-Injury



Source: *Survey of Injured Workers Regarding Work-Related Health Problems: Comparison of State and Private Sector Worker Experiences*; Research and Oversight Council on Workers' Compensation, August 2003.

This percentage is consistent with results found in the 2001 ROC reports pursuant to HB 3697, which found that 64 percent of injured workers in Texas were working, more than two years after their injury, compared to 75 percent of workers in other states.[82] In

[80] See presentation of Workers' Compensation Research Institute to Senate Select Committee, April 29, 2004, citing *Outcomes for Injured Workers in California, Massachusetts, Pennsylvania, and Texas*, Workers' Compensation Research Institute, December 2003. Specifically, 62 percent of Texas workers were "very satisfied" with their care, compared to 59 percent in California, 72 percent in Massachusetts, and 65 percent in Pennsylvania. See *Outcomes*, p. 127.
[81] See *Survey of Injured Workers Regarding Work-Related Health Problems: Comparison of State and Private Sector Worker Experiences*; Research and Oversight Council on Workers' Compensation, August 2003.
[82] See *Striking the Balance*, p. 57.

addition, for those workers in Texas who did return to work, fewer were working for the same employer (62 percent vs. 79 percent in the other states), or doing the same kind of work as before the injury (61 percent vs. 76 percent), and more Texas workers said their take-home pay was lower than before the injury (28 percent vs. 13 percent in the other states).[83]

In an interesting accompanying finding, a higher percentage of Texas workers felt they had gone back to work *too soon* (32 percent), than did workers in other states (26 percent).[84] This was despite the fact that injured workers in Texas missed more time than workers in all but one of the comparison states (California).[85]

Other outcomes

Both the 2001 HB 3697 studies and the 2002 ROC survey also examined workers' post-injury mental and physical functioning. In both areas, based on scores derived from self-reported worker perceptions of function, Texas injured workers ranked four to five points lower than injured workers in other states.[86] The 2002 ROC survey did not compare functional abilities of Texas injured workers to those in other states, but did find that Texas injured workers with low back, neck and shoulder soft tissue injuries had significantly lower mean physical and mental health scores than the general population.[87]

Satisfaction with care can be another important measurement of quality. ROC's 2001 reports found that while overall satisfaction levels were fairly high both in Texas and in the comparison states at that time, Texas lagged slightly behind in most key measures. Interestingly, between six and eight percent fewer Texas workers surveyed indicated that

[83] See *Striking the Balance*, p. 57.
[84] See *Striking the Balance*, p. 57.
[85] See *Returning to Work: An Examination of Existing Disability Duration Guidelines and their Application to the Texas Workers' Compensation System, Report to the 77th Legislature*, Research and Oversight Council on Workers' Compensation and Med-FX, LLC, p. 44. For the ten most common diagnostic groups found in workers' compensation, Texas workers missed an average of 21 weeks due to work-related injuries. Other state averages were California, 29 weeks; Georgia, 19; Florida, 16; Colorado, 14; Oregon, 13; New Jersey, 11; Minnesota, 10; and Kentucky, 10.
[86] See *Striking the Balance*, p. 60.
[87] See *Survey of Injured Workers Regarding Work-Related Health Problems: Comparison of State and Private Sector Worker Experiences*. Texas workers rated at 39.1 in physical health and 45.9 in mental health; the U.S. population mean is 50.

their doctor "took their medical condition seriously," "had their complete trust," or "treated them with respect."[88] This is particularly interesting in light of the fact that Texas employees are allowed to choose their own medical provider more freely than in many other states.

In rating their overall satisfaction with care, 73 percent of Texas employees agreed that their doctor "overall, provided (them) with very good medical care that met (their) needs," while 10 percent were not sure and 17 percent disagreed. Among workers in the other HB 3697 comparison states, 81 percent agreed with the statement, 10 percent were not sure, and 10 percent disagreed. It should be noted that while there may be some differences, these were not considered statistically significant in the ROC analysis.[89] The same question was also asked of Texas workers in the 2002 ROC survey, and 84 percent of workers agreed, 2 percent were undecided, and 14 percent disagreed.[90] Since the 2002 survey was not accompanied by a survey of workers in other states, it should not be assumed that workers in other states would be more or less satisfied.

Recent Medical Quality and Cost initiatives and developments, post-HB 2600

As noted in Section I of this report, HB 2600 was passed in large part to address the medical cost and quality issues substantiated by the research findings from both the state and outside entities. The bill in turn directed TWCC to take on a number of initiatives designed to address system cost and quality issues. These initiatives and their current status are discussed below.

TWCC Approved Doctors List (ADL) Registration and Enforcement

Prior to the passage of HB 2600, any doctor licensed to practice medicine in the state could serve as a treating (i.e., primary care) doctor in the workers' compensation system. As part of an effort to step up TWCC's regulation and enforcement related to the ADL,

[88] See *Striking the Balance*, p. 52.
[89] See *Striking the Balance*, p. 54.
[90] See *Survey of Injured Workers Regarding Work-Related Health Problems: Comparison of State and Private Sector Worker Experiences*.

doctors are now required to apply for the list and complete a training program, which varies in intensity depending on the roles the doctor intends to play in the system.[91]

HB 2600 also granted TWCC broader, clearer authority to review the practices of doctors and insurance carriers and to impose sanctions or restrictions as appropriate, and created a Medical Quality Review Panel (MQRP) to assist the TWCC Medical Advisor in meeting this charge.[92]

The doctor and insurance carrier monitoring efforts mandated by HB 2600 represented a significant challenge for TWCC. Essentially, TWCC was asked to do a much better job of policing a medical care delivery system involving thousands of health care providers, dozens of insurance carriers and associated entities, millions of medical bills, and hundreds of millions of dollars in medical payments. While TWCC could evaluate the general utilization and billing patterns of health care providers, and the payment patterns of insurance carriers, based on available data, this analysis alone was not sufficient. In order to take action against a provider or carrier, a much more in-depth review of the specific clinical circumstances involved in claims is required. Even then, system participants who are identified for removal or imposition of sanctions by TWCC can be expected, in many cases, to fight this removal through any available channels, including the courts.[93]

The monitoring process mandated by HB 2600 progressed at a very slow pace. Through the end of 2002 - about 18 months after HB 2600's passage - TWCC had begun reviews of six doctors on the Designated Doctor List (DDL), and gathered records to review other

[91] Two levels of ADL certification are possible. ADL Level 1 certification allows a doctor to provide health care to 18 or fewer workers' compensation claimants per year, and to perform utilization review and peer review functions. ADL Level 2 allows a doctor to provide health care to more than 18 claimants a year, and doctors must have ADL Level 2 certification in order to be considered for the TWCC Designated Doctor List (DDL). See testimony of the Texas Workers' Compensation Commission to the Senate Select Committee, March 25, 2004, p. 1.

[92] See *Texas Labor Code* Sections 408.023 and 408.0231.

[93] As of November 2004, TWCC was involved in active litigation with at least seven doctors over their exclusion from the ADL.

doctors, but had not formally imposed sanctions on any provider or insurance carrier using the authority granted by HB 2600.[94]

Some relative progress has been made in the last year and a half. TWCC reported to the Select Committee in August 2004 that 32 doctors had been denied admission to the ADL for issues related either to poor quality of care or overutilization of care. Twenty-one of these doctors were MDs, three were osteopaths, and eight were chiropractors.

In all, as of August 2004 TWCC had reviewed 86 doctors and had 22 reviews ongoing. These included 12 reviews of doctors on the TWCC Designated Doctor list, the pool of doctors selected on a rotating basis to certify whether employees have reached Maximum Medical Improvement (MMI) and, if so, to assign the employee an Impairment Rating (IR) - and who therefore play a critical role in ensuring the appropriate assessment of permanent impairment and the injured employee's ongoing eligibility for income benefits.[95] One designated doctor had been removed from the list based on TWCC review. TWCC had also reviewed the practices of four insurance carriers and had ongoing reviews of nine, but had taken no action pursuant to these reviews. TWCC's Medical Advisor also testified to the Select Committee that the MQRP review process for an individual case took about six months to complete and involved significant coordination with and preparation by TWCC's legal resources.[96]

Even though the process is more than three years old, TWCC has only relatively recently began to take significant action regarding more than a handful of providers. It remains unclear to what extent providers removed from the ADL, denied admission, or significantly restricted in their ability to practice might successfully challenge TWCC's actions through the courts in the future.

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[94] See *Biennial Report of the Research and Oversight Council*, ROC, December 2002.

[95] See Texas *Labor Code* Section 408.0041 and 408.122. Designated doctors' opinions on MMI and Impairment Rating issues are given "presumptive weight" (i.e., presumed correct unless the great weight of the evidence is to the contrary) in disputes.

[96] See testimony of Dr. William Nemeth, TWCC Medical Advisor, to the Senate Select Committee, March 25, 2004.

Implementation of new Medical Fee Guidelines

In workers' compensation in Texas, prices for medical services are set in one of two ways: by TWCC, in its adoption of fee guidelines; or by system participants themselves through agreement or through the medical dispute process, for those services for which TWCC's fee guidelines do not determine a price. Issues related to the 2002 TWCC Medical Fee Guideline are discussed in more detail in the discussion of Charge 3.

HB 2600 made a significant change in the methodology used by TWCC to adopt fee guidelines and set the accompanying fees. The bill required TWCC to adopt the billing, coding, and payment rules of the Medicare system, allowing TWCC to make only minimal modifications to the Medicare reimbursement structure as necessary for treating occupational injuries.[97] While HB 2600 did not specify the appropriate level for medical fees, it did tie the methodology for computing fees to the Resource-Based Relative Value System (RBRVS) used by Medicare, a structure that takes into account the relative difficulty and other factors of various medical treatments.[98]

TWCC in April 2002 adopted the new fee guideline and a reimbursement rate of 125 percent of Medicare - representing an aggregate cut from existing Texas workers' compensation medical fees, which were estimated at the time by TWCC to be at 140 percent of Medicare. In response, the Texas Medical Association (TMA) and Texas AFL-CIO sued TWCC to block implementation of the new guideline, arguing that the conversion factor was not determined in a method consistent with the statute and would adversely impact injured workers' access to quality health care.[99] The Texas Association of Business (TAB) in turn intervened in the suit on behalf of TWCC. Implementation of the guideline was enjoined on August 21, 2002, just ten days before it was scheduled to take effect.

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[97] See *Texas Labor Code* Section 413.011.

[98] Three factors are considered in the RBRVS used in Medicare and in Texas workers' compensation: work expense (the professional resources required to perform the service), practice expense (the overhead expenses associated with the procedure), and malpractice expense (the related cost of malpractice insurance).

[99] See Texas Medical Association and Texas AFL-CIO v. Texas Workers' Compensation Commission, Cause No. GN2-02203, 250th District Court, 126th Judicial District, Travis County.

After months of debate and discussion and a hearing on the issues with the new guideline in Travis County District Court, TWCC prevailed - meaning that the fee guideline was found to be compliant with the statutory requirements - and the new guideline went into effect August 1, 2003.

HB 2600 also required TWCC to apply the Medicare methodology to its facility fee schedules - namely, the Ambulatory Surgery Center (ASC), hospital inpatient, and hospital outpatient fee schedules.[100] As of this writing TWCC has adopted a new facility fee schedule only for ASCs, calling for 213.3 percent of the Medicare rate to be paid for facility fees to these centers. The ASC fee guideline also represented a general reduction in fees, and provoked a strong response from the ASC community.[101]

The implications of the 2002 TWCC Medical Fee Guideline are discussed further in Charge 3 and other sections of this report.

Treatment Guidelines

Since January 1, 2002, there have been no systemwide treatment guidelines in place in workers' compensation in Texas. This was the effective date for an HB 2600 provision that repealed the TWCC treatment guidelines.[102] In conjunction with this repeal, adoption of treatment guidelines by TWCC was made optional rather than mandatory, and if adopted, treatment guidelines were required to be "nationally recognized, scientifically valid, and outcome-based."[103]

These HB 2600 provisions followed findings from ROC's HB 3697 analyses that showed TWCC's Texas-specific treatment guidelines were generally less specific than national

[100] TWCC does not at present have in place a fee schedule for hospital outpatient facility fees; hospital inpatient fees are determined on a per diem basis. Only the professional services and ASC facility fee guidelines have been aligned with the Medicare mandate as of late 2004.
[101] In addition to the level of reimbursement, ASC groups also took issue with Medicare rules regarding which surgical procedures may be performed in an ASC setting and with reimbursement for implantable devices. TWCC convened a group of interested parties to discuss the latter two issues shortly after the September 1, 2004 effective date of the ASC guideline. In November 2004, TWCC proposed amendments to the rule in attempt to address these concerns.
[102] See HB 2600, 77th Legislature, 2001.
[103] See *Texas Labor Code* Section 413.011.

guidelines, did not specify the amounts of treatment that would be appropriate, and did not provide guidance for surgical appropriateness.[104] Given the relative level of utilization in Texas during the time when these treatment guidelines were in effect, it was clear they did not lead to reasonable, effective utilization of care.

Witnesses before the Select Committee and other committees have testified that the lack of treatment guidelines is one of the major causes of frequent medical disputes and a general lack of agreement over what constitutes reasonable medical care for a work-related injury. There was hope from some system stakeholders, particularly carriers and employers, that the Medicare payment policies, adopted as part of the 2002 Medical Fee Guideline, would serve as a guideline for appropriate treatment. However, TWCC has taken the position in its interpretation of the fee guideline and a commission advisory that the Medicare payment policies do not constitute a treatment guideline, or in and of themselves an appropriate rationale for denial of payment.[105]

Largely in response to concerns about the lack of treatment parameters, TWCC has recently discussed proposal of treatment guidelines as part of a larger effort toward encouraging "disability management" as a philosophy of treating occupational injuries. The TWCC effort might have stipulated that care delivered within the parameters of the TWCC-adopted guideline would be presumed medically necessary, in an effort to forestall denials of care for doctors treating within the guideline. Cases progressing beyond certain time durations (a set number of weeks was not determined during the preliminary discussions) would have triggered a requirement for the treating doctor to establish a treatment plan that the carrier would then review. If the carrier denied the plan, a doctor reviewer selected by the TWCC would settle the dispute, or could lay out his or her own plan. TWCC's preliminary proposal would also have attempted to put more focus on return to work and "stay at work" efforts by requiring intervention by a "stay at work" coordinator for claims past a certain duration of lost time.[106]

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[104] See *Striking the Balance*, p. 71.
[105] See Texas Workers' Compensation Commission Advisory 2002-11, August 7, 2002.
[106] See Pre-proposal Draft Rules on the Disability Management Rule, Texas Workers' Compensation Commission, May 2004.

Stakeholder reaction to the TWCC preliminary disability management proposal, including a new treatment guideline, treatment planning process, and "stay at work" initiative was largely negative. Many respondents to the preliminary proposal were positive about the concepts of disability management embodied in it, but negative about attempts to manage a complex disability management process at the TWCC level, particularly with a major legislative review of the agency and workers' compensation policy ongoing. Others were negative about the concept in general, arguing it would only add bureaucracy and layers of review to the system; others suggested TWCC did not have the statutory authority to implement the new processes as proposed; and some were generally positive on the proposal but suggested changes.

As of this writing, TWCC has yet to formally propose a disability management process, treatment guideline, or treatment planning process. The agency has held several open stakeholder meetings to discuss the general concepts, and has most recently emphasized a process that would focus on treatment planning or more intensive disability management for "outlier" claims rather than broad changes focused on all claims.

As the discussions sponsored by TWCC on disability management have demonstrated, the details of how to improve quality of care in the system through treatment guidelines, treatment planning, and disability prevention and management can be overwhelming. The concept in general, however, is critical in changing the focus of the system. For any treatment parameters, it is important that evidence-based treatment - treatment planning based on scientific proof of efficacy and outcomes, where available - gain a greater foothold in the system. At present, quality improvement and cost control in workers' compensation medical care tends to focus reactively, if it all, attempting to use denials and reviews by TWCC as a method of improving practice.

Evidence-based practice guidelines, such as the guidelines of the American College of Occupational and Environmental Medicine (ACOEM) and others, emphasize that for low back pain, for example, the most common complaint in workers' compensation systems,

the most appropriate care plan calls for an evaluation of any "red flags" for a serious condition and, in the absence of these, a focus on maintaining normal activity and work as quickly as possible.[107] This approach also favors focusing on restoration of activity and function rather than "curing the pain" at the expense of activity and at the risk of long-term debilitation from inactivity. Other states - including, for example, Colorado - use strong treatment guidelines as part of a overall strategy to hold down medical costs and improve outcomes.[108] Colorado was included in the ROC's *Striking the Balance* analysis and showed significantly lower average medical costs and better outcomes in areas such as return to work than Texas.

As a policy issue, the key is finding ways to reward doctors who focus on early, appropriate return to work and achieve good outcomes. There is no easy answer to address this; in part, it can be encouraged by supporting the practices of doctors who provide such care through the review and dispute resolution process.

It is important to note that the current system, in general, provides exactly the opposite incentive. A doctor who does focus on quick restoration of function and return to work risks losing his patients to other doctors who will provide lengthy absences from work and lengthy courses of treatment. The statute itself enables a vague standard of medical care through the current statutory definition of "medical necessity" - a broad, vague standard that does nothing to guide providers - nor those who review care or decide medical disputes - toward evidence-based, effective care.

Practice and/or treatment guidelines that focus on restoration of function should go hand-in-hand with a renewed emphasis in the system on return-to-work. Much of the testimony heard by the Select Committee and others, and a significant criticism levied against TWCC by the Sunset Commission, was that the system and the agency did not

[107] See *Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers*, 2nd edition, American College of Occupational and Environmental Medicine, p. 288.

[108] Communication between committee staff and Dr. Katherine Mueller, MD, Medical Director of the Colorado Division of Workers' Compensation, June 2004. See also Executive Summary of the Medical Treatment Guideline Case Review and Cost Studies, Colorado Division of Workers' Compensation Quality Improvement Program, July 2000.

make return-to-work a main focus.[109] Through an agency reorganization effective in August 2004, TWCC has attempted to place more emphasis on return-to-work outreach and education for employers. Educational efforts for employers are vital, and key opportunities also exist to educate all stakeholders about common musculoskeletal complaints such as low back pain. An Australian study found that education emphasizing clear messages about remaining active and remaining at or returning to work reduced disability and workers' compensation costs related to low back pain.[110]

Review, denials, and disputes over medical care and claims

Medical care in the Texas workers' compensation system is subject to review by the insurance carrier for medical necessity, as well as compliance with relevant TWCC rules. Three types of medical necessity review are possible: preauthorization (prospective review); concurrent review (review of an ongoing service, such as hospitalization); and retrospective review (review after care is delivered).

Prior to HB 2600, required preauthorization was generally an unpopular form of utilization control for health care providers. It delays care, requires significant coordination between provider and carrier, and is regulated by more specific statutory mandates.[111] While insurance carriers often favored requiring preauthorization for medical treatments that were potential sources of overutilization, prospective review is also a relatively costly process for carriers. Given the utilization rates found in Texas by the HB 3697 studies, it also appears that the various utilization controls - preauthorization, retrospective review, and others - were generally not effective means of eliminating excessive care.

[109] See Sunset Advisory Commission's staff report on the Texas Workers' Compensation Commission, April 2004.
[110] See study by Rachelle Buchbinder, Damien Jolly, and Mary Wyatt, published in *BMJ (British Medical Journal)*, Vol. 322, June 23, 2001, p. 1516.
[111] For statutory provisions relevant to utilization review, see *Texas Insurance Code* Section 21.58A.

HB 2600 mandated that some medical services be preauthorized, and listed those services in statute.[112] Beyond these minimum services, TWCC is allowed to add other services to the preauthorization list by rule. After the passage of HB 2600, TWCC initially proposed adding many other services to the preauthorization list, including chiropractic manipulations beyond a certain number, acupuncture, and other services. Following consideration of public comments both from health care providers who felt they were being unfairly targeted for review and from some insurance carriers concerned about the cost of mandated preauthorization, however, TWCC added only those services mandated by statute.[113]

In an atmosphere in which overutilization and medical costs were becoming a greater concern, it is possible that carriers would turn their attention to greater scrutiny on retrospective bill review in an attempt to control utilization and costs. Indeed, this appears to have been the case. An analysis of the denial rates of the ten largest workers' compensation insurance carriers in Texas (in terms of percentage of medical payments associated with that carrier) showed an increase in denials between 2001 and 2002, and sustained through 2003 (see Table 11).

Table 11
Percentage of Medical Treatments Denied for the Ten Insurance Carriers That Account for the Highest Percentage of Medical Payments, Service Years 2000-2003

Average for all top 10 carriers	Service Year 2000	Service Year 2001	Service Year 2002	Service Year 2003
	21.9%	21.4%	26.2%	26.9%

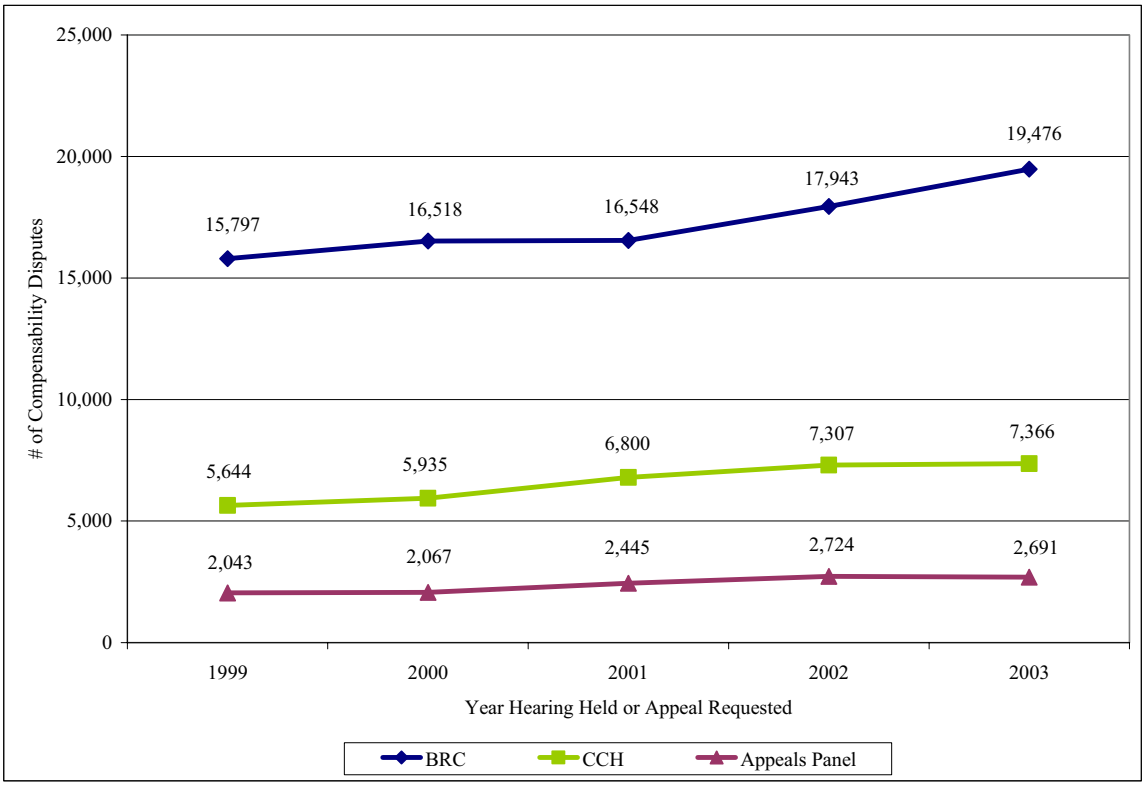
Note: "Service Year" is the year that the medical treatment or service was rendered. These ten insurance carriers accounted for approximately 42.2 percent of all medical payments made in 2003.
Source: Texas Workers' Compensation Commission, MedForms Database as of March 2004, and the Texas Department of Insurance Workers' Compensation Research Group, 2004.

[112] See *Texas Labor Code* Section 413.014. Services statutorily required to be preauthorized are: spinal surgery; work-hardening or work-conditioning services provided by a health care facility that is not credentialed by an organization recognized by commission rules; inpatient hospitalization, including any procedure and length of stay; outpatient or ambulatory surgical services, as defined by commission rule; and any investigational or experimental services or devices.
[113] See TWCC Rule 134.650.

Distinct from denials of medical necessity but also significant are denials based on compensability of a claim, extent of injury, and other issues that fall under the scope of indemnity-related disputes in the workers' compensation system. While medical necessity denials and disputes relate to specific treatments and specific medical bills, indemnity disputes are more broad, relating to whether an injury occurred in the course and scope of employment or whether the extent of the employee's injury relates to a particular body part or condition. According to data analyzed by the TDI Research Group, the number of claims involving key indemnity dispute issues has increased in recent years, despite a general downward trend in the number of workers' compensation claims (see Figure 11).[114]

[114] Figures reflect the number of dispute proceedings per year regardless of the year in which the injury occurred. Dispute counts shown include disputes involving the existence of a compensable injury or occupational disease, extent of a compensable injury, timely reporting of an injury to the employer, and timely contest of compensability by an insurance carrier. Not included are claims for which compensability or extent of injury is challenged by the carrier (and benefits denied) but for the injured employee does not seek or is not granted a request for a Benefit Review Conference (BRC).

Figure 11
Frequency of Compensability Issues Disputed at the BRC, CCH and Appeals Panel Levels of the TWCC Administrative Dispute Resolution Process
1999-2003



Source: Texas Workers' Compensation Commission, DRIS Database as of June 2004; and the Texas Department of Insurance, Workers' Compensation Research Group, 2004.
Note: BRC=Benefit Review Conference; CCH=Contested Case Hearing; AP=Appeals Panel.

In order for the indemnity dispute process to function well, it must both handle disputes efficiently and produce fair decisions. The quality of a particular decision can only be addressed by appeal - to the TWCC Appeals Panel, and then to District Court. However, an analysis of the outcomes of compensability disputes among the TWCC field offices (see Table 12) shows significant variation in dispute outcomes. While this analysis alone does not mean inappropriate decisions are being made, it does suggest closer agency scrutiny of the overall patterns of decisions of TWCC hearing officers may be warranted.[115]

[115] Previous analyses have also shown variation in practices among TWCC field offices. See *Change of Treating Doctor Issues in the Texas Workers' Compensation System*, ROC, August 2000, which found significant differences in the results of Change of Treating Doctor requests for different field offices.

Table 12
Compensability Dispute Outcomes at the Contested Case Hearing (CCH) Level of the Texas Workers' Compensation Commission (TWCC) Administrative Dispute Resolution Process by TWCC Field Office, Hearing Years 1999-2003 Combined (TWCC Field Offices Ranked in Descending Order by Percentage of Decisions Against the Injured Worker)

TWCC Field Office	Number of Disputed Issues Heard, 1999-2003	Percentage of Decisions Against the Injured Worker	Percentage of Decisions in Favor of the Injured Worker	Percentage of Decisions Resolved by Mutual Agreement
Waco	481	64.0%	25.0%	11.0%
Bryan/College Station	419	63.5%	19.6%	17.0%
Austin	765	54.9%	35.2%	9.9%
Harlingen*	161	54.0%	43.5%	2.5%
Weslaco	435	51.7%	41.8%	6.4%
Laredo	305	50.2%	41.6%	8.2%
Victoria	255	50.2%	40.0%	9.8%
McAllen*	258	48.1%	47.7%	4.3%
Amarillo	483	48.0%	51.8%	0.2%
Corpus Christi	858	47.8%	47.0%	5.2%
Lubbock	490	47.6%	49.8%	2.7%
Beaumont	793	47.5%	40.4%	12.1%
El Paso	2,275	47.3%	44.0%	8.7%
Denton	1,378	46.3%	50.4%	3.3%
Lufkin	437	45.3%	43.5%	11.2%
Tyler	1,693	45.0%	48.4%	6.7%
Dallas	5,568	44.6%	48.0%	7.4%
Wichita Falls	335	44.5%	54.3%	1.2%
Fort Worth	4,538	44.4%	48.2%	7.4%
San Antonio	2,977	43.7%	44.7%	11.6%
Houston West	2,014	40.4%	48.2%	11.5%
Galveston*	102	40.2%	50.0%	9.8%
Houston East	2,100	40.2%	52.0%	7.8%
Angleton*	66	4.09%	43.9%	15.2%
San Angelo	271	38.8%	58.3%	3.0%
Midland/Odessa	681	32.6%	56.0%	11.5%
Abilene	694	30.4%	69.6%	0.0%
Sugarland*	282	29.8%	64.5%	5.7%
Missouri City	585	29.1%	57.8%	13.2%

Note: * Indicates that these field offices are not currently in operation, but were handling disputes at some point during 1999-2003.
Source: Texas Workers' Compensation Commission, Dispute Resolution Information System as of June 2004; and the Texas Department of Insurance Workers' Compensation Research Group, 2004.

As noted previously, a similarly important dispute resolution role is played by TWCC Designated Doctors. Given the often definitive role these independently-selected doctors play in the system, it is critical their decisions be reviewed frequently to ensure accountability.

Medical Dispute Resolution

Prior to HB 2600, there were two major concerns with the medical dispute resolution process in the Texas workers' compensation system: one, that disputes were decided by TWCC staffers with little or no medical training; and two, that disputes took too long to work their way through the TWCC process. As a solution, HB 2600 looked to the Independent Review Organization (IRO) process used in the group health system to review denials by Health Maintenance Organizations (HMOs) since 1997.[116] This process was appealing because it involved review by a doctor - addressing concerns about the quality of the review process - and because in the group health process it produced more rapid results.[117]

The IRO process has now been used in Texas workers' compensation for almost three years. In terms of the quality of medical dispute decision-making, while specific issues have been raised with the consistency and basis for some IRO decisions, the IRO process on the whole clearly is better positioned to provide sound medical decisions than the prior TWCC staff process.

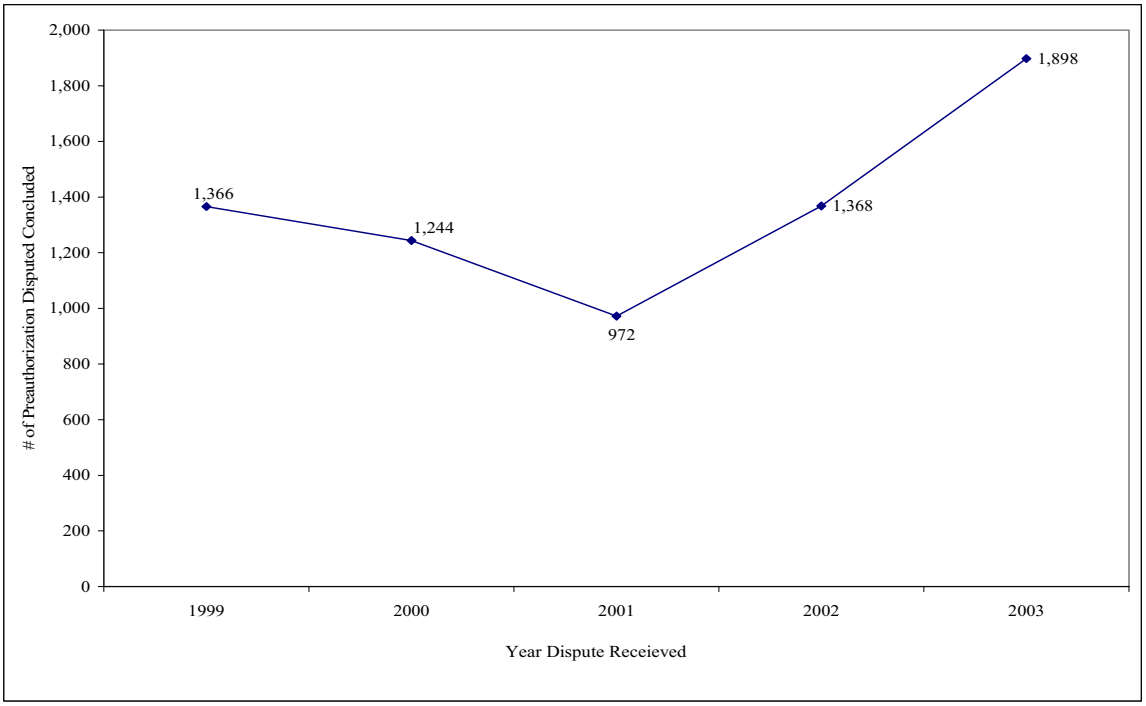
While a comprehensive evaluation of the quality of the IRO process is beyond the scope of this report, data are available to compare trends in dispute volume, timeliness, and other important issues. Dispute volume - both of preauthorization and retrospective disputes - has varied greatly both pre- and post-IRO implementation. Dispute volume is a function of several factors, including the volume of medical services provided, frequency of insurance carrier denials, and the perceived or real accessibility of the dispute resolution process. In the case of preauthorization disputes, the number of

[116] See Senate Bills 384 and 386, 75th Legislative session, 1997.

[117] IRO reviews of HMO denials are limited to prospective (prior to service delivery) denials of medical care. The HMO is required to pay the cost of the IRO dispute regardless of outcome.

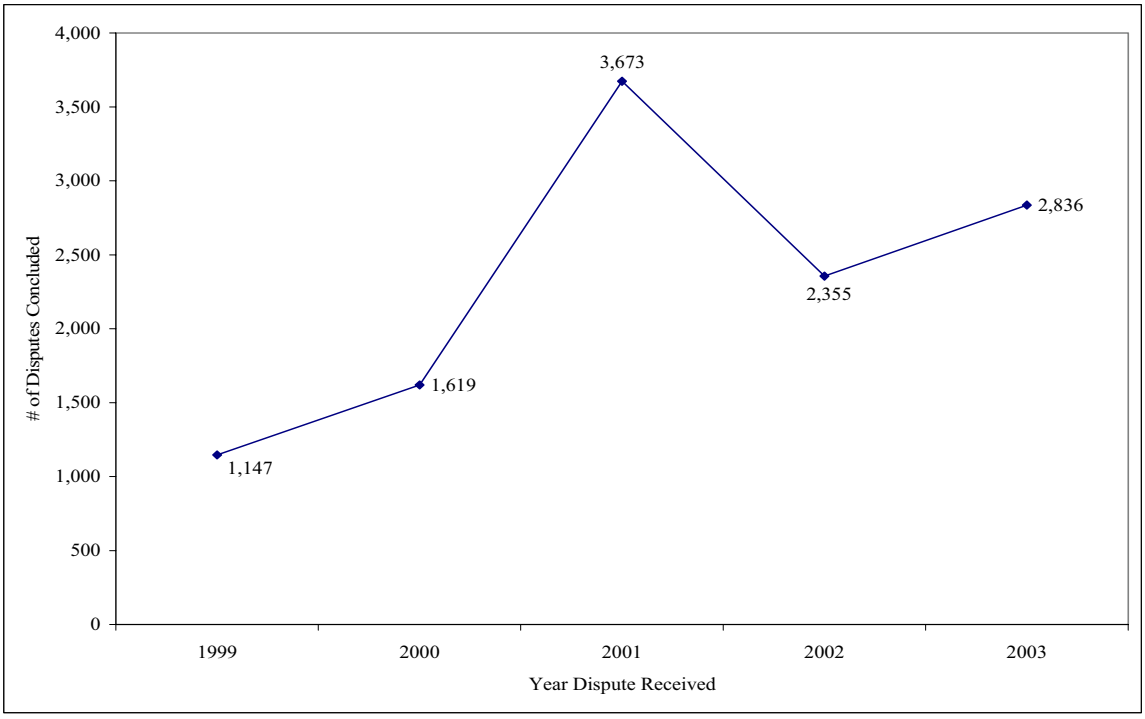
services for which preauthorization is required also has a direct effect on dispute volume. As Figures 12 and 13 show, dispute volume in the post-IRO years (2002 and 2003) has trended upward.

Figure 12
Frequency of Preauthorization Disputes Concluded, 1999-2003



Source: Texas Workers' Compensation Commission, Medical Dispute Resolution Information System as of March 2004, and the Texas Department of Insurance Workers' Compensation Research Group, 2004.

Figure 13
Frequency of Retrospective Medical Necessity Disputes Concluded, 1999-2003



Source: Texas Workers' Compensation Commission, Medical Dispute Resolution Information System as of March 2004, and the Texas Department of Insurance Workers' Compensation Research Group, 2004.

Both Figures 12 and 13 refer to the number of disputes *concluded.* This description implies, correctly, that disputes are sometimes withdrawn prior to an IRO decision. In fact, this is a major consideration for retrospective medical necessity disputes, particularly in the post-IRO period, when about a third of filed disputes were withdrawn prior to conclusion of the process (see Table 13).

Table 13
Percentage of Preauthorization and Retrospective Medical Necessity Disputes Withdrawn Prior to Conclusion of Medical Dispute Resolution, 1999-2003

Preauthorization		Medical Necessity	
Year Dispute Received	Percentage of Disputes Received by TWCC that were Withdrawn	Year Dispute Received	Percentage of Disputes Received by TWCC that were Withdrawn
1999	6.1%	1999	23.4%
2000	17.2%	2000	21.2%
2001	15.4%	2001	34.0%
2002	9.1%	2002	35.7%
2003	4.3%	2003	31.8%

Source: Texas Workers' Compensation Commission, Medical Dispute Resolution Information System as of March 2004, and the Texas Department of Insurance Workers' Compensation Research Group, 2004.

In addition to better medical dispute expertise, the IRO process was envisioned to provide more rapid dispute resolution outcomes. This is particularly important for preauthorization disputes, where potentially necessary care is delayed pending review. Improvements in dispute timeframes, unfortunately, have yet to be demonstrated in a lasting manner. Tables 14 and 15 show the dispute resolution timeframes for the past five full years.

Table 14
Mean and Median Number of Days to Resolve Preauthorization Disputes, 1999-2003

Year Dispute Received	Mean	Median
1999	39.9	41.0
2000	35.8	35.0
2001	45.2	40.5
2002	94.7	75.0
2003*	51.1	44.0

Note: These durations are only calculated for disputes that have been concluded as of March 2004 – disputes that were withdrawn or dismissed have been excluded from the analysis. *Dispute durations for 2003 should be viewed with caution since as of March 2004, there were still a significant number of these disputes that had not yet been resolved, and therefore these dispute durations may be understated.
Source: Texas Workers' Compensation Commission, Medical Dispute Resolution Information System as of March 2004, and the Texas Department of Insurance Workers' Compensation Research Group, 2004.

Table 15
Mean and Median Number of Days to Resolve
Retrospective Medical Necessity Disputes,
1999-2003

Year Dispute Received	Mean	Median
1999	442.8	473.0
2000	196.0	77.0
2001	163.9	148.0
2002	210.9	185.0
2003*	136.3	104.0

Note: These durations are only calculated for disputes that have been concluded as of March 2004 – disputes that were withdrawn or dismissed have been excluded from the analysis. *Dispute durations for 2003 should be viewed with caution since as of March 2004, there were still a significant number of these disputes that had not yet been resolved, and therefore these dispute durations may be understated.
Source: Texas Workers' Compensation Commission, Medical Dispute Resolution Information System as of March 2004, and the Texas Department of Insurance Workers' Compensation Research Group, 2004.

The overall timeframes shown in Tables 14 and 15 include both the time an IRO takes to review the dispute and render a decision (a timeframe that is subject to regulatory standards) and the time TWCC takes to assign an IRO and otherwise triage the dispute (a timeframe *not* subject to regulatory standards).[118] Figures 14a and 14b and Figures 15a and 15b show the median and mean durations for processing disputes by TWCC and by IROs for both preauthorization and retrospective medical necessity disputes, respectively.

[118] TWCC Rule 133.308(o) sets a regulatory goal of 20 days for IRO review of a preauthorization dispute and 30 days for a retrospective dispute.

Figure 14a
Mean and Median Number of Days for TWCC to Process a Preauthorization Dispute, 2002-2003

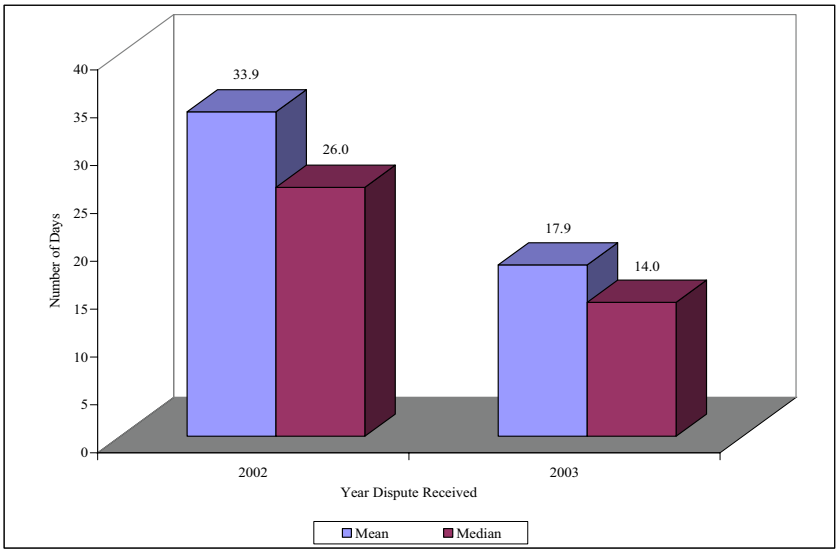
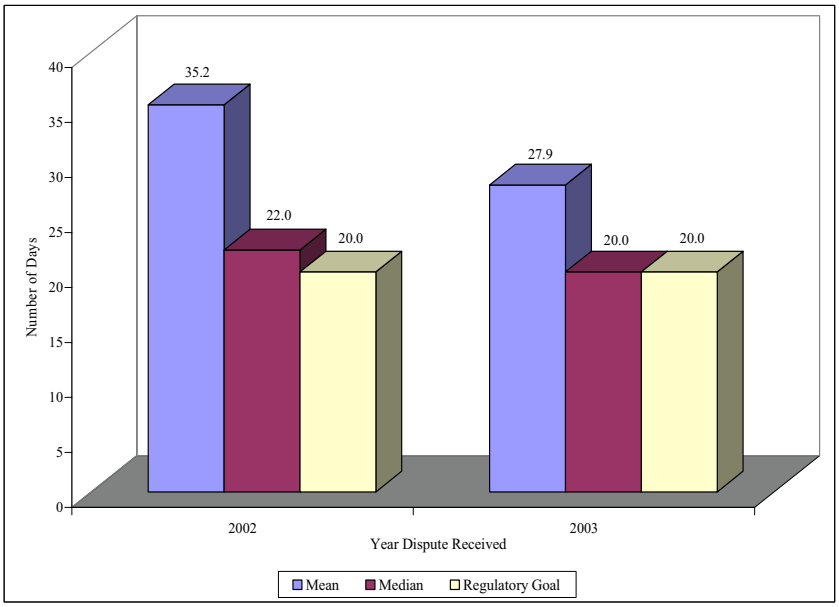


Figure 14b
Mean and Median Number of Days for an IRO to Render a Decision for Preauthorization Disputes, 2002-2003



Note: These durations are only calculated for disputes that have been concluded as of March 2004. The "Regulatory Goal" represents the number of days that the TWCC rules have established for IRO reviews.
Source: Texas Workers' Compensation Commission, Medical Dispute Resolution Information System as of March 2004, and the Texas Department of Insurance Workers' Compensation Research Group, 2004.

Figure 15a
Mean and Median Number of Days for TWCC to Process a Retrospective Medical Necessity Dispute, 2002-2003

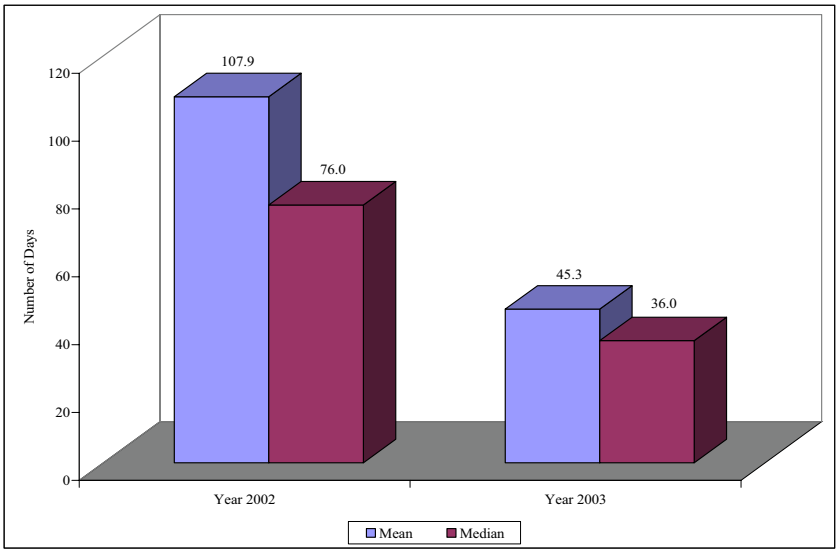
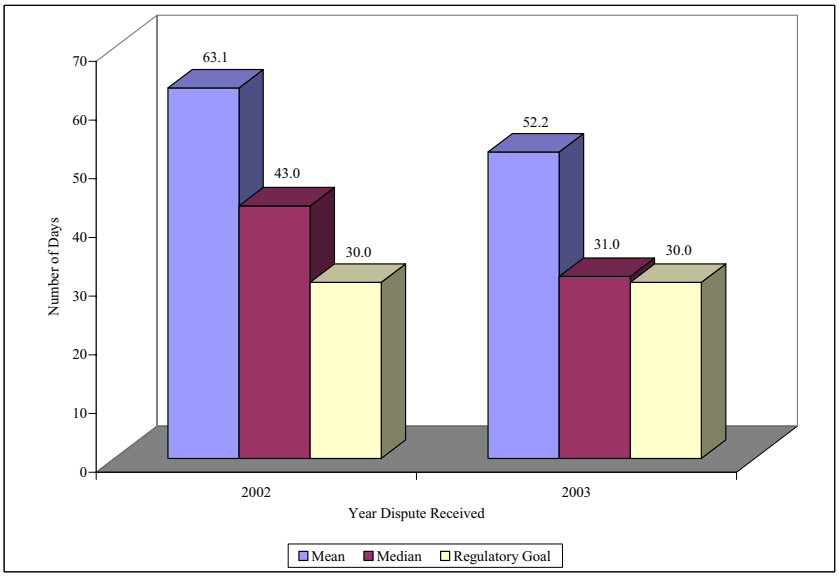


Figure 15b
Mean and Median Number of Days for an IRO to Render a Decision for Retrospective Medical Necessity Disputes, 2002-2003



Note: These durations are only calculated for disputes that have been concluded as of March 2004. The "Regulatory Goal" represents the number of days that the TWCC rules have established for IRO reviews.
Source: Texas Workers' Compensation Commission, Medical Dispute Resolution Information System as of March 2004, and the Texas Department of Insurance Workers' Compensation Research Group, 2004.

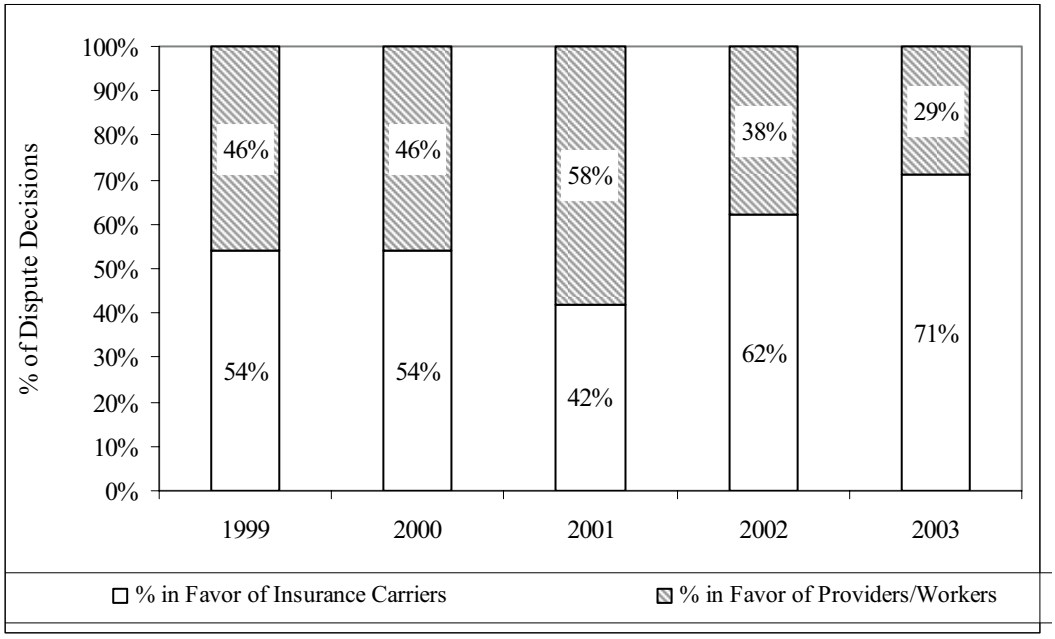
While TWCC's part of the IRO review process appears from the above figures to be adding significant duration, there are some important caveats to keep in mind. First, use of the IRO process was new for TWCC and all system stakeholders, and clearly required some "learning curve." Second, it appears from the 2003 durations that TWCC has made some improvements in processing disputes. Those factors aside, there remains significant improvement to be made to TWCC's medical dispute process.

In terms of outcome, IRO decisions can generally be divided between those in favor of a health care provider or injured worker and those in favor of an insurance carrier.[119] Based on TDI analysis of medical dispute resolution both pre- and post-IRO implementation (January 1, 2002), it is clear that outcomes differ significantly for disputes involving preauthorization denials and those involving retrospective denials. Generally, insurance carriers prevail more often on preauthorization disputes, while health care providers and injured workers prevail more often on retrospective denials.[120] In addition, these prevailing ratios increased in 2003 compared to 2002 for each type of party for each type of dispute. See Figures 16 and 17.

[119] Under current law, a party to a preauthorization or retrospective medical necessity dispute also retains the right to appeal the IRO decision - first to the State Office of Administrative Hearings (SOAH), and then to District Court.

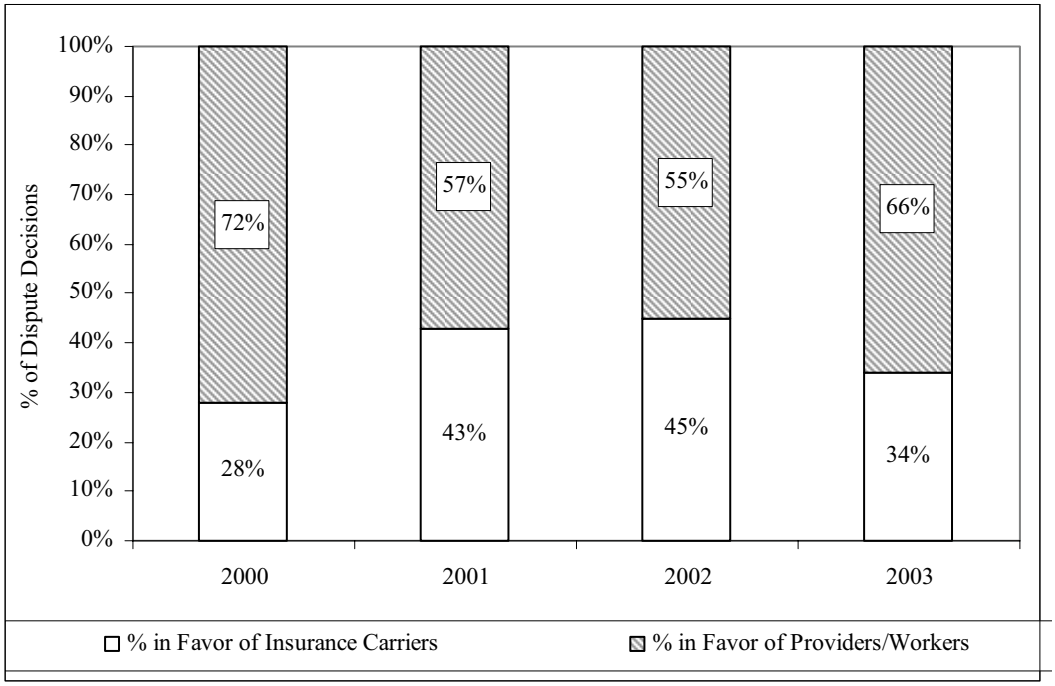
[120] It is important to note that the types of services subject to preauthorization also changed in early 2002, almost concurrently with the change to the IRO process. Spinal surgery, for example, which was subject to a statutory "second opinion" process, was made subject to preauthorization. There are a variety of other factors that may be driving the differences in IRO outcomes for preauthorization versus retrospective review.

Figure 16
Percentage of IRO Decisions in Favor of Health Care Providers/Injured Workers and Insurance Carriers, Preauthorization Disputes, 1999-2003



Note: These prevailing ratios are only calculated for disputes that were concluded as of March 2004.
Source: Texas Workers' Compensation Commission, Medical Dispute Resolution Information System as of March 2004, and the Texas Department of Insurance Workers' Compensation Research Group, 2004.

Figure 17
Percentage of IRO Decisions in Favor of Health Care Providers/Injured Workers and Insurance Carriers, Retrospective Medical Necessity Disputes, 2000-2003



Note: These prevailing ratios are only calculated for disputes that were concluded as of March 2004. The prevailing ratios for 1999 have not been included due to data problems.
Source: Texas Workers' Compensation Commission, Medical Dispute Resolution Information System as of March 2004, and the Texas Department of Insurance Workers' Compensation Research Group, 2004.

The main advantage of the IRO process - a better qualified medical decision - comes at a significant cost. IRO decisions cost either $650 or $460, depending on the specialty of the doctor reviewing the case. In addition, for retrospective denials of payment based on a determination that a service was medically unnecessary, the health care provider whose bill is denied must pay the cost of the dispute upfront, although the provider can recover this cost if he or she prevails.[121] Insurance carriers, on the other hand, must pay all IRO costs in cases involving prospective denials of care, regardless of outcome. Both providers and carriers have raised concerns about the fairness of this process, with providers complaining most loudly that the high cost creates a threshold for review, and

[121] This likely accounts in part for the much higher percentage of retrospective disputes withdrawn prior to the conclusion of the IRO process, as shown in Table 13.

allows carriers to deny relatively small bills and know that the provider may not, because of the dispute process, contest the denial.

The legislature attempted to address this issue at least in part in 2003 with the passage of HB 3168, which gave TWCC to authority to create a lower-cost alternative for less expensive services in dispute. In August 2004 TWCC adopted such a process, to be effective for disputes filed on or after October 1, 2004; however, litigation challenging the lack of an appeal process in TWCC's low-cost alternative has enjoined its implementation until at least December 2004.[122] As of this writing, it is impossible to assess what impact the new process might have on overall denial and dispute patterns.

Concerns have also expressed about the length, cost, and "hassle" of the dispute appeal process, in which IRO decisions are subject to State Office of Administrative Hearings (SOAH) and District Court review, in that order. Witnesses before this and other committees have pointed out that in the HMO arena (the only other health care setting in Texas to use the IRO process), IRO decisions are not subject to these appeal avenues. It is important to recall that when the IRO process was first implemented in workers' compensation, system stakeholders were generally unfamiliar with it and somewhat unwilling to make IRO decisions "final" by limiting appeal. Important considerations for streamlining the medical dispute process are discussed in the findings and recommendations for this charge.

Benefit Adequacy

Texas, like all states, reimburses in income benefits only a portion of an injured employee's lost wages.[123] How closely the employee's income benefits approach his or

[122] See Insurance Council of Texas v. Texas Workers' Compensation Commission, Cause No. GN 403210, in the District Court of Travis County, 345th Judicial District.

[123] Temporary Income Benefits (TIBs), the most common lost-time benefit, are paid at a rate of 70 percent of the employee's gross pre-injury Average Weekly Wage for most employees; employees earning less than $8.50 an hour receive 75 percent of their Average Weekly Wage for up to the first 26 weeks of lost time. TIBs are offset for any post-injury earnings by the employee during the period of TIBs eligibility. See *Texas Labor Code* Section 408.103. Texas' percentage of reimbursement for TIBs is reasonably generous compared to other states; 35 states pay 66.67 percent of the employee's pre-injury wage. See Comparison of State Workers' Compensation Systems, Texas Department of Insurance Workers' Compensation Research Workgroup presentation to the Select Committee, March 25, 2004, p. 12-13.

her pre-injury take-home pay will vary significantly depending on the employee's specific circumstances. Whatever the case, all workers' compensation income benefits in Texas are subject to a statutory "cap" on weekly compensation.[124]

Other caveats also apply to how and when injured employees accrue benefits. Texas, like all states, imposes a "waiting period" on the accrual of income benefits; benefits do not accrue until the eighth day of lost-time, after a seven-day waiting period.[125] As Table 16 shows, Texas is among 22 states that impose a seven-day waiting period.

Table 16
State-by-State Comparisons of Statutory Waiting Periods (as of January 2003)

3 Days	4 Days	5 Days	7 Days
Alabama	North Dakota	Idaho	Arizona
Alaska		Massachusetts	Arkansas
California		Mississippi	Florida
Colorado		Nevada	Georgia
Connecticut		Montana	Indiana
Delaware			Kansas
Hawaii			Kentucky
Illinois			Louisiana
Iowa			Maine
Maryland			Michigan
Minnesota			Nebraska
Missouri			New Jersey
New Hampshire			New Mexico
Oklahoma			New York
Oregon			North Carolina
Rhode Island			Ohio
Utah			Pennsylvania
Vermont			South Carolina
Washington			South Dakota
West Virginia			Tennessee
Wisconsin			**Texas**
Wyoming			Virginia

Source: U.S. Department of Labor, Office of Workers' Compensation Programs, January 2003; the U.S. Chamber of Commerce, 2003 Analysis of Workers' Compensation Laws, 2003; and various state workers' compensation agency websites, 2004.

[124] The cap on income benefits is tied to the State Average Weekly Wage, currently set at $539 by *Texas Labor Code* Section 408.047. TIBs, Lifetime Income Benefits, and Death Benefits are capped at 100 percent of this amount; Impairment Income Benefits and Supplemental Income Benefits are capped at 70 percent of this amount. Due to a change in the historical methodology used to the compute the State Average Weekly Wage, the 78th Legislature, through SB 1574, set the specific amount in statute for 2004 ($537) and 2005 ($539). A long-term methodology must be revisited in the 79th session.
[125] See *Texas Labor Code* Section 408.082.

Many states, including Texas, also allow an injured employee to recoup his or her income benefits from the waiting period (in Texas, the first seven days) if the employee misses a specified period of time from work set by statute. This period is often called the "retroactive period." As Table 17 shows, at 28 days, Texas has among the longest retroactive periods in the country.[126]

Table 17
State-by-State Comparisons of Statutory Retroactive Periods
(as of January 2003)

5-10 Days (# of days in parentheses)	14 Days	21 Days	28 Days	42 Days
North Dakota (5)	California	Alabama	Alaska	Louisiana
Nevada (5)	Colorado	Massachusetts	New Mexico	Nebraska
Connecticut (7)	Illinois	Florida	**Texas**	
Delaware (7)	Iowa	Georgia		
Vermont (7)	Maryland	Indiana		
West Virginia (7)	New Hampshire	Kansas		
Wisconsin (7)	Oregon	North Carolina		
South Dakota (7)	Utah	Virginia		
New Jersey (7)	Washington			
Wyoming (8)	Indiana			
Minnesota (10)	Mississippi			
	Arizona			
	Arkansas			
	Kentucky			
	Maine			
	Michigan			
	South Carolina			
	Pennsylvania			
	Ohio			
	New York			
	Tennessee			
	Missouri			

Source: U.S. Department of Labor, Office of Workers' Compensation Programs, January 2003; the U.S. Chamber of Commerce, 2003 Analysis of Workers' Compensation Laws, 2003; and various state workers' compensation agency websites, 2004.
Note: Hawaii, Oklahoma, Rhode Island and Montana have no statutory retroactive period.

Texas' statutory cap on income benefits is also relatively low compared to caps set in other states. The 2004 cap of $537 a week for Temporary Income Benefits (TIBs) was

[126] See *Texas Labor Code* Section 408.082.

tied for 34th highest in the nation with North Dakota.[127] State caps ranged from $1,103 a week (in Iowa) to $331.06 a week (in Mississippi).

System Administration

Under the broad area of system administration this charge considers several issues - the structure of the agency or agencies charged with administering the workers' compensation system; administrative and enforcement issues related to various system participants; and issues related to data collection and ongoing research.

Agency Administration

As is clear from the description of the various tasks given to TWCC by House Bill 2600 and other legislative directions, the agency played a key role in the success or failure of attempts to improve the system. Unfortunately for both the system and the agency, significant successes have not been realized in many key areas. This has called into question, through the various committee reviews ongoing of the Texas system, what changes are needed to make real improvements in the system: changes in the workers' compensation statute; changes in the way the system is administered; or a combination of both approaches.

As the Select Committee found, other states use varying administrative structures to oversee their workers' compensation systems.[128] Generally, states can be divided between those that administer their system through separate, dedicated agencies (19 states) and those that do so through divisions of more broadly-focused agencies (the remaining states; typically, through the agency assigned to workforce and labor issues, sometimes through the agency charged with insurance regulation). Throughout recent history, during the tenure of TWCC and the predecessor Industrial Accident Board (IAB), Texas has used the former structure.

[127] See Comparison of State Workers' Compensation Systems, Texas Department of Insurance Workers' Compensation Research Workgroup presentation to the Select Committee, March 25, 2004, p. 21-22.
[128] See Comparison of State Workers' Compensation Systems, Texas Department of Insurance Workers' Compensation Research Workgroup presentation to the Select Committee, March 25, 2004, p. 29-30.

The governance of the agency dedicated to workers' compensation issues also varies. The majority of states (27) now use a "single administrator" structure.[129] Texas' structure at present utilizes a committee approach to governance, with the six-member commission split evenly between commissioners representing employers and commissioners representing wage earners. These commissioners hire an executive director to run the agency's day-to-day operations.

Given the importance of the state workers' compensation agency's performance to that of the system as a whole, and particularly the agency's critical role in carrying out legislative directives, there is significant interest in creating more direct accountability through a "single commissioner" structure.

Billing and Administrative Issues

Some of the most common complaints from providers in the workers' compensation system relate to billing, payment, and administrative issues. This was one of the key claims brought by providers in contesting the 2002 TWCC Medical Fee Guideline - that the guideline's Medicare plus 25 percent model did not adequately consider the additional burdens placed on providers in workers' compensation.

Certainly, there are different burdens placed on providers in workers' compensation than in other systems. Chief among these - and very difficult to address - is the presence of causality and work-relatedness issues that are not present to the same extent in other health delivery systems. Doctors have cited other differences, as well, in testimony before the Select Committee - return to work coordination with the employee and employer, for example, and "patient attitudes and motivations that may interfere with good communications."[130]

In addition to these almost intrinsic complications to workers' compensation medical care, other non-intrinsic factors are also present. For example, workers' compensation

[129] See Comparison of State Workers' Compensation Systems, Texas Department of Insurance Workers' Compensation Research Workgroup presentation to the Select Committee, March 25, 2004, p. 29-30.
[130] See testimony of the Texas Medical Association before the Senate Select Committee, April 29, 2004.

does not at present incorporate electronic medical billing. In addition, as noted earlier in this charge, the current Texas workers' compensation system involves an increasing percentage of retrospective denials of payment for services deemed not medically necessary.

While almost all stakeholders would agree that these factors make it more difficult for providers to operate in Texas, quantifying their impact and translating that to a specific number - for example, a percentage of Medicare's reimbursement rate - is very speculative. TWCC officials testified in August before the House Committee on Business and Industry that they were interested in quantifying these burdens for consideration in TWCC's statutorily-mandated biennial review of the fee guideline, but that the agency had yet to see what it regarded as a reliable quantification.[131]

Attempts have been made to compare the specific costs to physicians of operating in different systems - most notably, a study published in 2002 in the *Journal of Bone and Joint Surgery* based on an analysis of costs for 518 patients associated with the practice of an orthopedic surgeon who specialized in sports-related disorders of the knee in a large orthopedic group practice.[132] The study concluded that payer type was an important factor in this practice affecting practice expenses, "particularly with respect to nonvalue-added activity expenses," and that workers' compensation was the highest-cost system for this provider.[133] These sorts of "nonvalue-added" expenses included obtaining insurance authorization, resolving collection and billing disputes, and providing information to third parties.

Assuming that it is at least somewhat more difficult - and more expensive - for providers to practice in workers' compensation than in other health delivery systems, there are two basic ways to offset this difference: one, to pay more per service for workers' compensation medical care than those other systems; and two, to remove to the greatest

[131] See testimony of Acting Executive Director Robert Shipe before the House Committee on Business and Industry, August 25, 2004.
[132] See Brinker, O'Connor, Woods, Pierce, and Peck, The Effect of Payer Type on Orthopaedic Practice Expenses, *Journal of Bone and Joint Surgery*, Volume 84-A, Number 10, October 2002.
[133] Other payment systems analyzed were self-pay, HMO plans, PPO plans, indemnity plans, and Medicare.

extent possible those "hassles", burdens, and uncertainties. One way to do the latter would be in a network setting, in which agreements could be reached up-front that might abrogate the need for exhaustive retrospective review, documentation, arguments over fees, and many of the other conflicts that occur in the current system, as well as make options like electronic billing more likely. Specific suggestions are offered in the discussion of Charge 2.

While networks, if implemented, could make some administrative burdens unnecessary non-network care in workers' compensation might remain subject to greater "hassles." To some extent, network arrangements to minimize administrative burdens could serve as a roadmap that the non-network system might follow: methods that prove successful in a network setting could be imported. If there is concern that this method will not streamline the non-network system in a timely fashion, the legislature could simply require that carriers move to accept electronic billing from providers by a date certain, or require TWCC to adopt a rule to that effect, with allowances for smaller carriers or those with unusual circumstances to request more time to comply or a waiver. A similar process was used when the state began requiring insurance carriers to report data to TWCC electronically.

Data Exchange, Collection, and Research

In its work prior to the 1989 Legislative sessions that eventually created the most recent major reform in workers' compensation in Texas, the Joint Select Interim Committee on Workers' Compensation Insurance noted that, at that time, inadequate information was being collected about the system to ensure good policymaking.[134] The reforms of 1989 attempted to correct this deficiency by creating an ongoing research function to provide objective information about the system. This function, significantly modified over the ensuing years and now housed at the Texas Department of Insurance (TDI), has proven very valuable in compiling and analyzing data about the system. In fact, if one were to point to a particular area in which the Texas workers' compensation system seems

[134] See *Summary of the Research Papers of the Joint Select Committee on Workers' Compensation Insurance*, October 1988, Chapter 9, pp. 23-24.

comparatively well-off among other states, access to comprehensive system data and the ongoing capability to meaningfully analyze it may be such an area.

That said, there are aspects of the current system data collection that can be improved. If the recommendations of the Select Committee become law, TWCC and TDI will need better information on the performance of networks, return to work outcomes, and other issues. As the state looks to collect more or different information, it is appropriate that the agencies also examine what existing information is either not being used or not being reported in a manner that is usable. Comprehensive data about the system is only as good as what is reported, and there is legitimate concern that data quality can be improved. Such concerns are highlighted, for example, by the failure of the State Office of Risk Management (SORM), the agency that administers the workers' compensation program for the majority of state employees, to report medical payment data to TWCC for more than a year, a fact that complicated the Select Committee's analysis of Charge 6 (although an accurate analysis was eventually possible).

Policymakers have also voiced concern about the "lag" in workers' compensation data, as often the most recent information available on important issues like medical costs are 18 months to two years old. Many of the reasons for these delays are built into the system - providers have up to a year, for example, to submit medical bills. Carriers are to submit medical data to TWCC within 30 days of paying or denying a medical bill, but as the SORM example illustrates, it is unclear if this is always a meaningful requirement.

Fraud and Enforcement

Fraud in the Texas workers' compensation system represents a huge but unknown cost. The National Health Care Anti-Fraud Association (NHCAA) estimates that at least 3 percent of the nation's annual health care spending - or about $130 billion, in 2000 - was lost to outright fraud.[135] In a health delivery system like workers' compensation, with

[135] See National Health Care Anti-Fraud Association Fact Sheet, available online at http://www.nhcaa.org/pdf/all_about_hcf.pdf.

numerous system participants and more complicated eligibility criteria, the percentage is likely higher.

There is also no one, clear label that can describe all the activities that workers' compensation system participants may regard as fraud. A 2001 ROC report described several broad categories of fraud, including:

- workers who receive improper benefits through intentional deception;
- health care providers, attorneys, and others who bill for services not rendered, misrepresent their services, receive kickbacks for referrals, and/or contribute to a worker receiving improper benefits;
- employers who avoid payment of proper insurance premiums;
- employers, carriers, and medical agents or experts who knowingly act to deny or dispute legitimate claims by workers; and
- officers and agents who market illegal insurance products, and those who raid the assets of insurance companies.[136]

Successful fraud prevention efforts in Texas workers' compensation require diligence from system participants themselves, from the agencies involved in fraud detection and prevention (TWCC and TDI) and, for serious cases, from prosecuting authorities. Unfortunately, one of the areas of TWCC's operations most criticized by the recent Sunset staff review were those directed at compliance.[137] Historically, prosecutorial interest in workers' compensation fraud has also been inconsistent, with prosecution of violent crime a higher priority.[138]

In recent months, a Texas Coalition on Insurance Fraud, with participation from TDI, TWCC, and numerous insurance industry representatives, convened to discuss and make

[136] See *Fraud Detection and Prevention in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation, August 2001, available online at http://www.tdi.state.tx.us/company/roc/fraud2001.html.
[137] See Sunset Advisory Commission Staff Report on the Texas Workers' Compensation System, Issue 7, April 2004.
[138] See *Fraud Detection and Prevention in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation, August 2001, available online at http://www.tdi.state.tx.us/company/roc/fraud2001.html.

recommendations related to improving efforts to combat fraud, including workers' compensation fraud. In July, Governor Perry issued an Executive Order calling for increased attention on fraud - particularly health care, unemployment insurance, and workers' compensation fraud - among state agencies.[139] Both these initiatives should bring increased attention to the fraud issue.

The general enforcement of the provisions of the workers' compensation act and TWCC rules also falls under the purview of TWCC's compliance function. Effective enforcement is vital to a system like workers' compensation, with myriad rules and requirements that can be rendered meaningless if not enforced. Much of the criticism levied against TWCC in testimony before the Select Committee and others related to a perceived ineffectiveness in enforcement of the statute and rules.

Findings and Recommendations

Workers' compensation is an issue on which agreement between diverse stakeholder groups can be extremely difficult. Despite this fact, the current state of medical care in workers' compensation seems to have united stakeholders like none other, in one sense: every major stakeholder group - employers, employees, insurance carriers, and various types of providers - has expressed dissatisfaction with the current system.

The dissatisfaction focuses on different aspects of the system. Employers and carriers take issue with the continued relatively high medical cost of claims, while employees and providers tend to focus on an increasing percentage of claims in which medical care or bills are denied. All sides seem to have valid points, and all sides seem to agree that outcomes of care in the current system are far from optimal.

Because Charge 5 is very broad, the findings and recommendations offered for this charge blend with those offered on charges to be discussed later.

The committee finds the following:

[139] See Governor's Executive Order RP-36, July 12, 2004.

- While no workers' compensation system can be complacent about workplace safety issues, Texas appears to do a comparatively good job of reducing on-the-job injuries. Injury rates have been consistently below the national average and have helped to hold down overall (though not average) workers' compensation costs.
- The most recent findings regarding employer participation in Texas workers' compensation should be cause for concern about the health of the system, particularly its continued viability for employers. For the first time ever measured since the state began examining participation rates in the early 1990s, employer participation has decreased, from 65 percent in 2001 to 62 percent in 2004. The percentage of employees covered by workers' compensation policies in Texas (76 percent) is the lowest ever measured and is 8 percent lower than just three years ago.
- There is no meaningful, evidence-based standard of reasonable care for a work-related injury. Care is provided on what could be described as an "anything goes, but anything may get denied" basis that emphasizes back-end argument and dispute over front-end best practices. Partly as a result, average medical costs per claim are extremely high, outcomes are poor, and denials, disputes and controversy about the medical necessity of care are increasingly common. Carrier denials of medical bills have increased in attempts to reduce high medical costs and utilization; however, even if these attempts are successful in containing costs, they can do little to proactively improve the quality of care or to restore injured employees to function and work, and they create more friction and conflict in the system.
- Texas workers' compensation medical costs per claim, based on the most recent available data, remain far out of line with other comparable states, and have increased in each recent year. High costs are driven largely by high utilization rather than high prices per service.
- Dispute processes in Texas - both for medical and indemnity issues - struggle to provide rapid, definitive answers for participants with issues in controversy.

- Texas' system on the whole remains one of particularly poor value in comparison with others nationwide, combining high costs and poor outcomes. Numerous analyses show Texas workers are more likely to miss time from work than workers in other states, that those workers who do miss time are off work longer than are workers in other states and are less likely to return to work, that workers do not recover as well, and are no more satisfied and, in some cases, less satisfied with the care they receive. The high cost and poor outcomes in the Texas system encourage employers to leave the system and hinder expansion of business and location of new business in Texas.
- Three and a half years after the passage of HB 2600, TWCC has accomplished little to broadly address medical quality and cost issues. In addition to the policy recommendations offered in this charge and others, improved performance and accountability from TWCC or whatever state agency is charged with administering the workers' compensation system will be vital to better outcomes.

Based on these findings, and in conjunction with findings and recommendations discussed for other charges, the committee recommends the following:

1. The Texas workers' compensation system should define medical necessity in a manner that encourages evidence-based treatment focused on return to work and function. Decisions about medical necessity ultimately revolve around how the statute defines necessity, and linking the definition more closely to the principles of evidence-based care and return to work and function would support medical practice that adheres to those principles.

2. To further enhance the day-to-day application of evidence-based care, TWCC should adopt treatment guidelines that meet the statutory standards and are evidence-based, to the greatest extent possible. To encourage appropriate return to work, such guidelines should be adopted in conjunction with return-to-work guidelines. Although the primary purpose of guidelines would be to improve front-end medical care in workers' compensation claims through education about

best practices, these guidelines should also be used in reviewing claims, both prospectively and retrospectively. It is important, however, to recognize that guidelines are not absolute limits on coverage, and that they be challengeable through an accessible dispute resolution process. It is appropriate that the medical dispute process consider the evidence-based guidelines adopted for the system for the care those guidelines address, although the dispute process should be allowed to overrule guideline recommendations in cases that are sufficiently persuasive.

Since a major purpose of guidelines is education, TWCC and other appropriate system stakeholders should take steps to more strongly emphasize education of employers and employees about the benefits of early return to work. Even more specifically, educational efforts could target low back injuries and produce information designed to educate employees about back complaints and how to manage back pain (both before and after any particular injury has occurred).

3. As noted in the discussion of Charge 2, the committee also recommends allowing workers' compensation networks. In keeping with the concept of allowing agreement between providers, networks, and carriers on issues that would otherwise be managed more closely by the state, within network arrangements it may be advisable to allow other treatment guidelines and treatment planning or disability management processes to be used, as long as these meet the general statutory standards. However, networks should still be monitored and held accountable for their performance in reducing disability and providing effective care, as discussed in Charge 2.

4. For care provided outside of networks, TWCC's role in medical management will remain more significant. While treatment guidelines and statutory standards provide good general guideposts and educational tools, a more intensive treatment planning process focused on specific claims that are or may become "outliers" seems to hold the most promise for settling disputes about appropriate medical care on a case-by-case, prospective basis. TWCC should continue discussion

with stakeholders on how to implement such a treatment planning process designed to prospectively review problem claims *on a pilot program basis*, thereby reducing retrospective disputes and denials.

5. Most system stakeholders appear to favor a more rapid, efficient dispute resolution process. Sunset Commission staff devoted significant attention to dispute resolution improvements and made some reasonable suggestions for streamlining dispute processes. On the medical dispute side, one common suggestion is to eliminate the ability of a party to a medical dispute to appeal an IRO decision to the State Office of Administrative Hearings (SOAH), thereby eliminating a process in which a medical decision is reviewed by an authority without any particular medical expertise (a state Administrative Law Judge). On the indemnity dispute side, options exist to insert independent medical expertise into an evaluation of frequently-disputed issues such as the extent of an employee's injury, ability to work, and others, through a review by a TWCC designated doctor. If implemented, these changes should be accompanied by greater scrutiny and enforcement from TWCC on the quality of both IRO and designated doctor decisions, as outlined in the recommendation to follow.

6. While the implementation of networks will significantly reduce or eliminate TWCC's need to "police" the Approved Doctors List (ADL), the TWCC Medical Advisor and Medical Quality Review Panel (MQRP) functions should continue with a redirected focus. Important medical quality aspects in the system, including ensuring the quality of Designated Doctor and Independent Review Organization decisions, are appropriate functions for the expertise of the MQRP and are much more manageable than ADL enforcement. Important opportunities will also remain for Medical Advisor/MQRP intervention into specific cases with medical quality concerns in the non-network and perhaps in-network systems, as well. Further, TWCC should ensure greater accountability for its own decision makers at the hearing officer level and other levels, as data suggest significant variation in rulings between different commission field offices.

7. Enhancements should be made to income benefits in the Texas workers' compensation system to approach the national medians. Texas' retroactive period for income benefits is among the longest in the nation, and the cap on weekly income benefits is in the bottom third nationally. The retroactive period should be shortened from 28 to 14 days. In addition, the cap on weekly income benefits should be raised to more closely approximate the national median state (currently Tennessee, at about $600 a week, compared to Texas' $539). In at least the case of shortening the retroactive period, to avoid increasing workers' compensation costs prior to savings from other reforms, the benefit enhancement should be tied to the expected implementation of networks and other provisions expected to lower overall system costs.

8. To encourage greater accountability, the committee recommends that the workers' compensation administrative agency operate under a single commissioner structure, with the commissioner appointed by the Governor with the advice and consent of the Senate.

9. Workers' compensation is a system with a myriad of rules and regulations designed to protect system stakeholders and ensure fairness. These rules and regulations are only as effective as their enforcement; unfortunately, ineffective enforcement is one of the main weaknesses of the current structure. As other system changes are implemented, state agency enforcement activities must be enhanced to better ensure appropriate incentives are in place for compliance.

10. The system should retain a workers' compensation research function, adequately staffed to complete a similar level of research projects to the former Research and Oversight Council (ROC). The most appropriate location for this function is likely TDI (its current location), although other options could be considered. In any case, the function, through the head of its agency, should propose and adopt an annual research agenda as did the ROC, with input from the public and

stakeholders. In the next several years, much of the function's efforts should involve evaluation of the proposed new network care model and report card requirements, along with other legislative changes expected in the 79th session.

11. TWCC should take steps to implement electronic billing for health care providers, along the lines discussed earlier in this charge. TWCC should also continue efforts to eliminate administrative hassles and uncertainties for providers, consistent with implementation of a treatment planning process focused on "outlier" claims. However, it is important that the legislature and administrative agency not take decisive action to eliminate review of medical bills until the system can reasonably expect better up-front medical care - whether through a network system, use of treatment guidelines, a treatment planning process for out of network claims, or combinations of all these elements. While the denial of medical bills by insurance carriers is a legitimate complaint by providers and injured workers, and may or may not be in keeping with effective cost and quality control, simply requiring payment for questionable medical care with little or no review is no better an outcome for the system as a whole.

Charge 4: Survey the costs and benefits of other health system cost-containment strategies as they relate to medical, therapeutic, and pharmaceutical care, including but not limited to, doctor selection, deductibles, co-payments, preauthorization of services, and return-to-work programs.

Background

The rise in health care costs is by no means limited to workers' compensation medical care. All health care delivery systems are affected to some extent. However, the structures of different delivery systems, and the tools those systems use or allow to control cost, vary significantly. Charge 4 asks for an examination of cost-containment strategies in other systems, their effectiveness, and their potential use in controlling workers' compensation costs.

In comparing the structure of group health insurance plans, other health delivery systems, and workers' compensation, it is important to remember the differences in how coverage for medical conditions and injuries is determined. Workers' compensation in Texas operates from the general theory that any medically necessary care related to a compensable injury is covered. Coverage is limited only to the extent specific care can be argued not to be medically necessary for a particular compensable injury, or not related to a compensable injury. Group health plans - and most other health care delivery systems - have greater flexibility to exclude types of care or conditions from coverage. Although they may be subject to mandates of coverage for particular conditions in law or regulation, group health plans still operate under a less comprehensive theory of coverage than workers' compensation.

Some group health plans also impose dollar limits on medical costs that will be paid under any circumstances; no such limits exist in workers' compensation.

On the other hand, workers' compensation's broad theory of coverage applies only to treatment *related to* a compensable injury. This adds a complication to treatment of

workers' compensation injuries that is not as important in group health or other comprehensive coverage where causation and relatedness are not key to coverage.

Medical cost pressures on the various systems also differ. While pharmaceutical costs are a major consideration for most public and private group health plans, they tend to make up a smaller portion of workers' compensation costs, largely because workers' compensation generally does not cover preventative care.[140]

With those caveats in mind, this section of the report analyzes each of the possible cost-containment features described in the charge.

Doctor selection

As noted in other sections of this report, injured employees in the Texas workers' compensation system generally are allowed to select their own treating doctor. This has been the case since a statutory change from an employer choice of doctor system in 1973.[141] At present, Texas is one of 30 states that allow some form of employee selection of doctor; however, only 20 other states allow a similar degree of doctor selection to Texas.[142]

Few if any private health insurance plans provide the flexibility in doctor selection that the Texas workers' compensation system does. Historically, any doctor licensed to practice medicine in Texas was eligible to treat workers' compensation patients, and patients could choose any doctor willing to treat. This situation has changed somewhat

[140] The ROC's *Striking the Balance* report pursuant to HB 3697 found that pharmaceutical costs accounted for about 3.5 percent of all workers' compensation medical costs (for injury years 1996 through 1998). While pharmaceutical costs account for a relatively small part of system medical costs, the ROC reports also found the utilization of pharmaceuticals was comparatively higher in Texas than in all but one of the other states studied. See *Striking the Balance*, p. 20 and p. 42.

[141] See *Research Papers of the (Texas) Joint Select Committee on Workers' Compensation Insurance*, Summary Report, October 1988, Chapter 1, p. 3.

[142] Five of these 30 states allow an injured worker to choose his or her own treating doctor only if the employer or insurance carrier does not have a managed care plan in place; three allow injured workers to choose their doctor from a list provided by the employer; and one allows an injured worker to choose a doctor who has a history of treating the worker or a family member. None of these provisions allow the degree of choice seen in Texas. See *Comparison of State Workers' Compensation Systems*, Texas Department of Insurance Workers' Compensation Research Group, testimony before the Senate Select Interim Committee, March 25, 2004, p. 7-8.

since the implementation of new requirements for the TWCC Approved Doctors List (ADL), and as discussed in Charge 3, the pool of willing ADL doctors clearly has contracted. However, injured employees remain free to choose any willing doctor on the ADL and cannot be required to treat with any particular doctor, group of doctors, or type of doctor for treatment.

Almost all group health insurance plans are more restrictive than this, although both "closed" (i.e., Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO) plans) and "open" (i.e., Preferred Provider Organization (PPO) plans) networks are available and regulated (to varying extents) by the Texas Department of Insurance. Closed networks operate on the general premise that all care will be provided in network, with exceptions for emergency care or care not available in network. Open networks encourage covered employees to receive care in-network by paying a higher percentage of medical costs if network providers are used, but generally allow the employee to more easily access out of network care by that employee's choice. Generally, closed systems are more tightly regulated by the state because they allow a more limited ability to receive care out of network; open plans have less stringent patient protections.[143]

Deductibles and Co-payments

Deductibles and co-payments are not used in workers' compensation in Texas, and are relatively rare in all state workers' compensation systems.[144] Deductibles and co-payments are a part of almost all group health insurance plans, Medicare coverage, and an increasing number of other public health care delivery systems.

The absence of a requirement for injured employees to pay for any portion of medically necessary care related to a compensable injury dates back many years in workers'

[143] See Texas Department of Insurance, Health Insurance Regulation Presentation to the Senate Select Committee, March 25, 2004.

[144] Florida and Montana require injured worker co-payments in some situations. A few other states specifically limit covered medical care in general in some cases, so workers seeking this treatment outside what is covered would be responsible for their own care. See *Comparison of State Workers' Compensation Systems*, Texas Department of Insurance Workers' Compensation Research Group, testimony before Select Interim Committee, March 25, 2004.

compensation and likely derives in part from the fact that in workers' compensation, employees are injured in the course of their employment, rather than for any other non-specific reason.

The degree to which co-payments and deductibles can control costs is partly measurable and partly not measurable. In measurable terms, the state Employee Retirement System (ERS) testified to the Select Committee that in fiscal year 2003, the state's group health plan saved $179.6 million in co-payments and deductibles, about six percent of the total eligible charges made to ERS.[145] What is not as easily measured is the effect co-payments and deductibles are thought to have in encouraging covered employees to seek care only when necessary, an incentive not present in fully-paid plans.

Preauthorization of services

Many types of health delivery systems use preauthorization - required approval from the insurance carrier or health plan, prior to delivery of service - as a cost containment tool. Preauthorization tends to be a relatively expensive form of cost containment, as it requires review by a doctor (if a request is to be denied) and requires decisions within a relatively short timeframe, since delivery of care is being delayed pending the decision. In both workers' compensation and in HMO group health plans in Texas, preauthorization denials are subject to review by Independent Review Organizations (IROs), which scrutinize the denial and the proposed service and render a decision as to its medical necessity.[146] In both workers' compensation and HMO preauthorization denials, the insurance carrier/HMO is required to pay the cost of the IRO review (either $460 or $650, depending on the licensure of the IRO reviewer), regardless of the outcome of the dispute.

While preauthorization in workers' compensation only applies to certain medical services laid out in statute or TWCC rule, all other medical services are subject to retrospective review by the carrier for medical necessity. While this form of retrospective review has

[145] See Cost Containment Practices of the Group Benefits Program, Employees Retirement System of Texas, testimony before the Senate Select Committee, March 25, 2004.
[146] See *Texas Insurance Code* Section 21.58C.

been allowed for some time in workers' compensation, it appears to have increased in use as a cost containment tool following the passage of HB 2600, as noted in the discussion of Charge 5.

Unlike in HMO denials, retrospective denials of medical necessity in workers' compensation are also subject to the IRO process, but the cost of the review is paid by the losing party, rather than necessarily the carrier.[147] This in turn creates a financial decision for a provider whose bill has been retrospectively denied - particularly if the service in question costs less than the IRO cost.[148]

Aside from the structure of preauthorization and utilization review programs - i.e., the services required to be preauthorized, and fees and timeframes associated with the process - the performance of the key entities involved in utilization review is also key to the success or failure of the process. These key entities include the insurance carrier or utilization review agent (URA) with which the carrier contracts, as well as doctors and other health care providers. It is important to recall on this point that Texas' high medical costs per claim reflect only those services actually paid for - in other words, those that either the utilization review process or TWCC medical dispute resolution process approved for payment as medically necessary. This fact calls into question the general historical effectiveness of utilization review programs, including preauthorization.

A ROC evaluation as part of the HB 3697 studies found that, indeed, utilization review practices regarded as ineffective - such as acceptance of unvalidated diagnoses, misapplication of screening criteria, and use of "screening lists" to search for key words that would trigger payment or denial, rather than a review of the specific circumstances at

[147] The law also allows injured employees to access the retrospective Medical Dispute Resolution process for cases in which the employee has paid for care out-of-pocket and denied reimbursement. However, in these cases, the injured employee is not required to pay the cost of the IRO review, regardless of outcome. See *Texas Labor Code* Section 413.031(j).

[148] Policy concern about this issue and the possibility that the cost of the IRO process could be cost-prohibitive in some cases led to the passage of HB 3168 in the 78th Legislative session in 2003, granting authority to TWCC to implement a lower-cost dispute resolution alternative. TWCC adopted such a rule in August 2004, to become effective October 1, 2004, although implementation of this process has been enjoined by litigation. More information on medical dispute resolution is available in the discussion of Charge 5.

hand - were "widespread."[149] The ROC report further found that "clearly, when compared with other states and guidelines, the current combination of state guideline regulation and insurance carrier monitoring is not effectively controlling the delivery of care."[150]

It is important to note that some of the utilization and cost control features regarded as ineffective - such as the prior TWCC treatment guidelines - have since been removed from the system, and carrier denial rates have increased. However, there is no real evidence to suggest that the utilization review process in general has made significant improvements since the ROC evaluation.

Return-to-work programs

While not traditionally considered a cost-containment strategy in the same sense as deductibles or preauthorization, rapid, appropriate return to work may have a greater ability to both improve outcomes and contain costs than many of these approaches. As discussed earlier, results of analyses in Texas and other states show that higher than average medical costs per claim have not led to improved return-to-work outcomes, and research also shows that high medical costs and poor return-to-work patterns often co-exist. Numerous studies have also shown that the longer an injured employee remains off work, the lower the chances of that employee returning to productive employment.[151]

As discussed in Charge 5, stay-at-work and return-to-work can be encouraged through appropriate medical care. Employers, of course, also play a key role. TWCC has attempted through preliminary discussion about its proposed disability management rule to place doctors in a role that focuses more on describing any limitations to an injured employee's ability to work, and then placing the responsibility on the employer to determine if work exists within those limitations, rather than allowing the doctor to

[149] See *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System: A Report to the 77th Legislature*, Research and Oversight Council on Workers' Compensation and Med-FX, LLC, February 2001, p. 77.
[150] See *Striking the Balance*, p. 79.
[151] See *Recommendations for Improvements in Texas Workers' Compensation Safety and Return-to-Work Programs: A Report to the 77th Legislature*; Research and Oversight Council on Workers' Compensation and Research and Planning Consultants, LP, January 2001, p. 2.

simply "take the claimant off work." At present, return-to-work communications such as these often occur when doctors complete a "Work Status Report" form known as the TWCC-73, designed to assess the employee's functional abilities. Clearly, the employer plays a key role in return-to-work, and changes to enhance that role could be beneficial.

For some employers, however, particularly smaller employers, prolonged absences from work create acute hardships that make returning their injured employees to the job all the more difficult. Part of the solution to this problem could occur through less frequent and shorter absences from work that would naturally follow from more evidence-based medical care. However, smaller employers without the ability to offer modified duty for injured employees and without the resources to focus on return to work will still face greater challenges.

Other states have attempted incentive programs to reward employers for hiring injured employees or returning them to work. Oregon, for example, maintains a Reemployment Assistance Program that provides incentives to employers who choose to hire injured workers. Two separate Reemployment Assistance Programs are actually administered: a Preferred Worker Program, targeting workers who have recovered from their injuries but still have some degree of permanent impairment; and the Employer-at-Injury Program, which focuses on workers who are still recovering.

The Preferred Worker Program identifies injured workers who have a work-related permanent disability that prevents return to regular work. An employer who hires such a worker is then exempt from paying workers' compensation premiums on him or her for three years. Costs for any claim filed during this three-year period of exemption are paid by the state, rather than by the insurer.[152] Through the same program and funding source, Oregon also funds wage subsidies for employers who hire these workers (up to 50 percent reimbursement for up to six months). Worksite modifications and other employment-related purchases (uniforms, licenses, etc.) can also be paid for. Total

[152] See *Oregon Workers' Compensation Return-to-Work Programs*, Research and Analysis Section, Oregon Department of Consumer and Business Services, December 2003. Funding for payment of claims is through the Workers' Benefit Fund, a state fund supported by payments from workers and their employers.

benefits paid out under the Preferred Worker Program were about $5.5 million in fiscal year 2003.[153] Employment rates for workers participating in the program - in comparison to workers who were qualified to participate, but did not - have been about 20 percent higher.[154]

Another program, the Employer-at-Injury Program, pays direct subsidies to employers who return their own injured employees who cannot return to regular duty to modified duty or transitional work. Assistance generally consists of a 50 percent wage subsidy for up to three months. For 2002, placements under the program totaled 6,404 at a cost of $9.1 million in benefits.[155] Because of the multiple programs available in Oregon to assist injured workers and employers with return to work, measurement of the effects of the Employer-at-Injury program in particular are difficult. Comparisons of employees who participate in the program with other permanently disabled workers who did not show workers in the program have had about five percent higher employment rates over the last four study periods (1997, 1999, 2001, and 2002).[156]

Along a similar but more limited line, California included in its 2004 workers' compensation reform package a Return-to-Work Program that would reimburse smaller private employers (those with 50 or fewer full-time workers) for expenses and accommodations incurred in returning injured workers to the workforce.[157]

Vocational Rehabilitation in Texas

Vocational rehabilitation is also an important consideration in assessing the system's return-to-work efforts. Some states specifically designate vocational rehabilitation as a type of benefit to be provided to injured workers in need of such services, although the

[153] See *Oregon Workers' Compensation Return-to-Work Programs*, Research and Analysis Section, Oregon Department of Consumer and Business Services, December 2003.
[154] See *Oregon Workers' Compensation Return-to-Work Programs*, Research and Analysis Section, Oregon Department of Consumer and Business Services, December 2003.
[155] See *Oregon Workers' Compensation Return-to-Work Programs*, Research and Analysis Section, Oregon Department of Consumer and Business Services, December 2003.
[156] See *Oregon Workers' Compensation Return-to-Work Programs*, Research and Analysis Section, Oregon Department of Consumer and Business Services, December 2003.
[157] See California Senate Bill 899, 2004, amending *California Labor Code* Section 139.48.

percentage of states that do so seems to have decreased in recent years, with concerns that entitlements to vocational rehabilitation create a significant added system cost with uncertain returns.[158]

In Texas, vocational rehabilitation is not afforded specific status as a statutory workers' compensation benefit, but is available through the federally and state-funded Vocational Rehabilitation program of the Department of Assistive and Rehabilitative Services (DARS). Within DARS, the Division of Rehabilitative Services administers the Vocational Rehabilitation program.[159] Services available through the program are varied, ranging from counseling and guidance, job placement assistance, vocational and other training, to a wide variety of other services that could help an individual gain or maintain employment.[160] As of this writing, DARS employed 519 counselors who provide direct services through the program in 123 locations across the states; some other services are contracted for through the program as needed.[161]

The DARS Vocational Rehabilitation program serves any individual who qualifies under the federal Rehabilitation Act of 1973 - including, but in no way limited to, workers' compensation claimants. In fiscal year 2003, of 67,337 total applicants to the program, 11,857, or about 18 percent, were known to be workers' compensation claimants.[162]

DARS also reported to the Select Committee on the outcomes of cases involving workers compensation claimants served through the program in fiscal years 2002 and 2003. Table 18 summarizes this information.

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[158] California, for example, as part of its recent (2004) reform package, curtailed some aspects of its vocational rehabilitation entitlement.

[159] Under the provisions of HB 2292, 78th Legislative session, 2003, DARS was created from predecessor agencies including the Texas Rehabilitation Commission, which previously administered the Vocational Rehabilitation Program. Funding for the Vocational Rehabilitation program is 78.5 percent federal and 21.5 percent state-funded. See testimony of the Department of Assistive and Rehabilitative Services before the Senate Select Committee, March 25, 2004.

[160] See testimony of the Department of Assistive and Rehabilitative Services before the Senate Select Committee, March 25, 2004.

[161] Communication between DARS and committee staff, October 2004.

[162] See testimony of the Department of Assistive and Rehabilitative Services before the Senate Select Committee, March 25, 2004.

Table 18
Workers' Compensation Claimants Served in DARS Vocational Rehabilitation Program, Fiscal Year 2002-2003

	2002	2003
Total Clients Served in VR Program	124,072	127,071
Total Injured Workers Served	23,078	23,920
Percent of Total who are Injured Workers	18.6%	18.8%
Injured Workers who Continued to Receive Services at End of Year	13,720	14,866
Injured Workers Rehabilitated and Employed	3,847	3,297
Injured Worker Cases Closed Unsuccessfully after Services Provided	2,851	3,177
Injured Worker Cases Closed After Determined Eligible, Before Services Provided	2,660	2,580

Source: Department of Assistive and Rehabilitative Services.

Over the past several years, and through the work of the Select Committee, improvements have been suggested or offered by DARS and/or TWCC to enhance the Vocational Rehabilitation program's ability to assist injured workers. Most often heard is the suggestion that early referral to and intervention by DARS is critical. This issue has been acknowledged by both agencies in communication with committee staff, and was offered even as early as the 1988 Joint Select Committee's report as a key element in program success.[163] However, the clearest statutory requirements directing TWCC to refer injured employees to DARS hinge on the employee's eligibility for Supplemental Income Benefits (SIBs), which is unlikely to be in question until at least a year (and probably much later) after injury.[164] While SIBs-eligible claimants may indeed be in need of these services, there is nothing to say that other claimants would not be.

[163] See *Summary of the Research Papers of the Joint Select Committee on Workers' Compensation Insurance*, October 1988, Chapter 8, page 5.

[164] See *Texas Labor Code* Section 408.150. The reference to SIBs in this section ties to the fact that an injured employee may be required to participate in a vocational rehabilitation program in order to qualify for SIBs.

In efforts to improve this process, TWCC and DARS have engaged in discussions about finding ways to better identify claims that could benefit from the Vocational Rehabilitation program and to better track outcomes of TWCC referrals to DARS (and workers' compensation claimants served in general).

Findings and Recommendations

In seeking ways to better control workers' compensation costs, it is appropriate to examine the successes and failures of other health care delivery systems, as well as those controls traditionally used in workers' compensation. The potential use of other health system cost-containment strategies can best be considered in conjunction with the general committee recommendations that a network medical care system be allowed (Charge 2) and that changes and improvements be made to the system in general to enhance its overall value (Charge 5).

The committee finds and recommends the following in regard to Charge 4:

- In the area of *doctor selection*, Charge 2 offers specific recommendations on how networks of providers could lower costs, improve outcomes, and improve accountability for quality medical care. Within the network panel, the injured employee should retain the right to select his or her own treating doctor. Such an arrangement would more closely mirror doctor selection practices currently allowed in group health networks.
- While *deductibles and co-payments* could have some effect in controlling workers' compensation medical costs, their use on a significant enough scale to make a difference would represent a major departure from the longstanding full coverage of workers' compensation. There is better, more comprehensive evidence from other states to suggest that network care systems, coupled with the encouragement of evidence-based medicine, can better control costs and improve outcomes. Workers' compensation medical care should continue to be fully paid but should be provided in a network setting, where networks are available and where the employer elects to participate.

- *Preauthorization and retrospective review,* when used appropriately, can be important cost-containment tools. Their historical success in containing workers' compensation costs in Texas, however, has been limited, and they have added significant cost and administrative burdens to the system with uncertain returns. Within a network setting, negotiation should be allowed as to what services should or should not be preauthorized and otherwise reviewed, much the same as medical fees and other medical care delivery aspects can be negotiated. In addition, just as evidence-based treatment guidelines should be used in the front-end treatment of injuries, it is important that carriers and utilization review agents use evidence-based criteria in their decision-making about payment.
- Effective *return-to-work programs* have great potential to both improve outcomes and better control medical costs. While improved medical care should in and of itself improve return-to-work outcomes, employers, assisted by insurance carriers, also must play a key role in encouraging and supporting return to work. It will remain a greater challenge for some employers, particularly smaller employers, to return injured employees to the job. The Legislature should consider incentive programs, perhaps funded through administrative penalties collected by TWCC or another funding source, to encourage smaller employers to employ injured workers. The most logical approach would be a pilot program evaluated by the workers' compensation research function and modified or expanded as indicated by the results.
- The Vocational Rehabilitation program administered by the Department of Assistive and Rehabilitative Services (DARS) plays a key role in returning injured workers to the workforce. With modifications to how injured workers are referred to the program, and improvement in how outcomes of referrals are measured, improved service to injured workers and improved outcomes are possible. Any statutory or rule barriers to effective communication between TWCC and DARS should be identified and eliminated, and the agencies should be required to further enhance their interaction and report on the results to the Legislature.

Charge 7: Study and make recommendations relating to the pricing of workers' compensation insurance premiums in Texas, including, but not limited to, the impact of rating tools such as schedule rating, negotiated experience modifiers, negotiated deductibles, and underwriting.

Background

A healthy workers' compensation system must include insurance coverage available to employers at a reasonable cost. Much of the focus of the Select Committee's charges is on the poor outcomes and high costs in the system, particularly high average medical costs in Texas compared to other states. Also important, however, are how these direct costs are passed on to employers in Texas who pay workers' compensation insurance premiums. As witnesses testified before the Select Committee and others, high workers' compensation costs and premiums discourage employers from providing coverage, and also discourage the expansion of existing business and new business in Texas.[165]

During the workers' compensation reforms of the late 1980s, availability of insurance coverage - particularly affordable coverage - was a primary concern. Many insurance carriers had left the workers' compensation market, some had become insolvent, and alternatives outside commercial coverage were few, as Texas employers were not allowed to self-insure.[166] The largest workers' compensation carrier in the state stopped writing policies in 1989 and was declared insolvent two years later. Payment of claims from the increasing number of insolvent insurers was assessed on those insurers that remained in the market. Workers' compensation rates and rating plans were promulgated by TDI, with very little opportunity for deviation from these state-promulgated rates by

[165] As discussed in Charge 5, the single most common factor cited by nonsubscribers for their non-participation in the Texas workers' compensation system was that premiums were too high (37.9 percent cited this as the primary reason). See Employer Participation in the Texas Workers' Compensation System - 2004 Results, Texas Department of Insurance Workers' Compensation Research Group presentation to the Senate Select Committee, August 26, 2004. Previous ROC research on subscription found that subscribing employers were also increasingly sensitive to premium increases and that more were willing to consider nonsubscription as premiums increased. See *A Study of Nonsubscription to the Texas Workers' Compensation System: 2001 Estimates*, ROC, February 2002.

[166] See *Effects of Reforms on the Texas Workers' Compensation Insurance Market*, ROC, August 1999.

insurance carriers. Competition in the workers' compensation insurance market was minimal.

Several important insurance-related changes were implemented in 1991:

- Implementation of a "file and use" system for determining workers' compensation insurance rates, replacing the promulgated system;
- Establishment of large and small deductible options for employers seeking coverage;
- Creation of the Texas Workers' Compensation Insurance Fund (later renamed Texas Mutual Insurance Company) to act as the "insurer of last resort" and to enhance competition in the market; and
- Allowing employers who met certain criteria to self-insure, through the Certified Self-Insurance Program administered by TWCC.

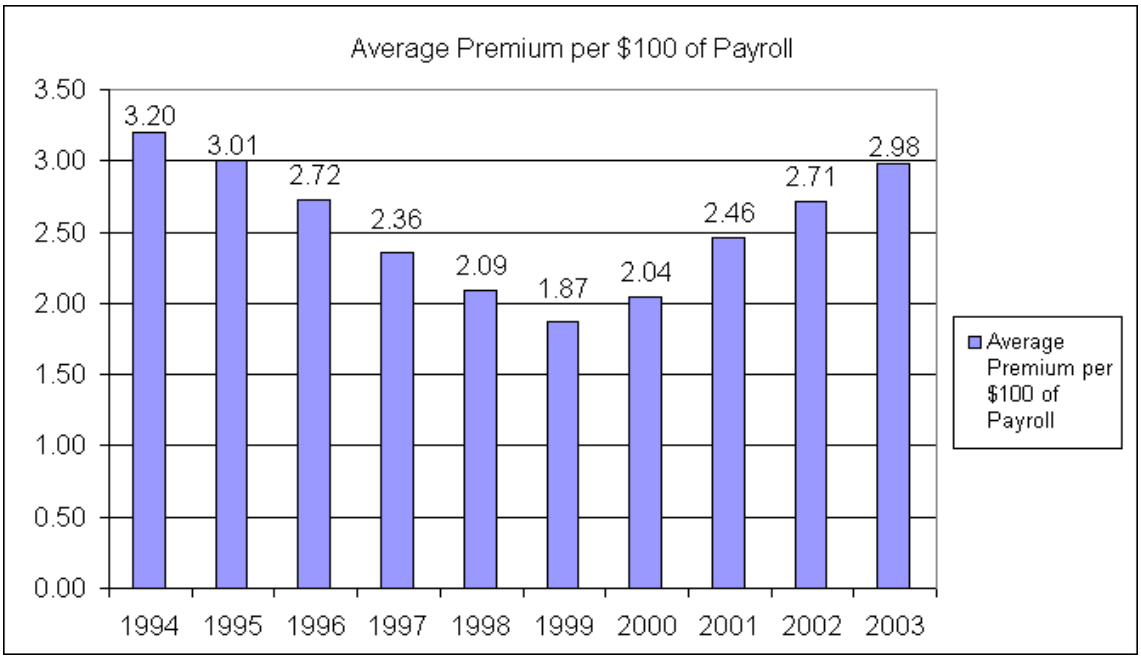
Other changes have also taken place since 1991, further enhancing employers' options in seeking coverage.[167]

In general, in terms of regulation, the workers' compensation insurance market in Texas has gone from one that prior to 1991 was very tightly regulated, with minimal options for competition, to one where rates and premiums are left to competition to determine, where carriers have many options in pricing coverage, and employers have options in acquiring coverage.

It is clear that competition in the workers' compensation market, improved controls on overall workers' compensation losses (largely through the other workers' compensation system reforms effective in the early 1990s), and an improving economy all helped reduce workers' compensation insurance premiums throughout much of the 1990s. As Figure 18 shows, the average premium paid by employers per $100 of payroll fell throughout the 1990s, reaching a low point in 1999 before beginning a steady increase through 2003.

[167] One example includes 2003 legislation (HB 2095) to allow employers to self-insure as a group.

Figure 18
Average Premium Paid Per $100 of Payroll
(Includes all Premium Adjustments Except Deductibles)

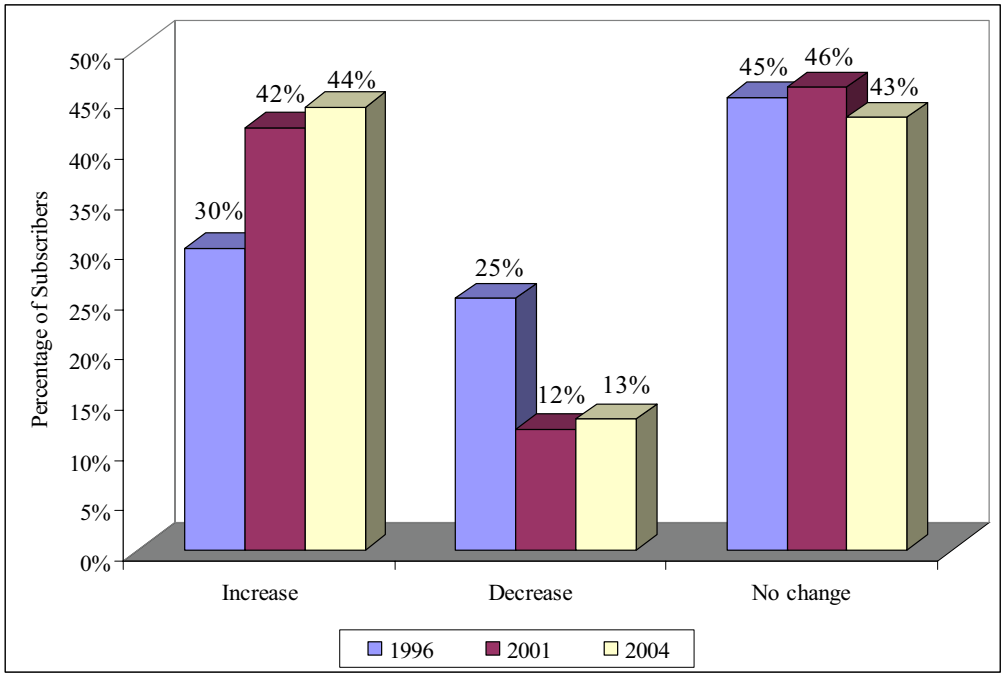


Source: Texas Department of Insurance, testimony to Senate Select Committee, October 12, 2004. Averages are based on data reported in the December 31, 2003 Financial Data Call and material taken from the 2003 Class Relativity Study.
Notes: Average premiums shown reflect insurers' rating deviations from TDI's relativities, experience rating, schedule rating, expense and loss constants, the effect of retrospective rating, and premium discounts. They do not reflect the effects of discounts due to deductible policies nor policyholder dividends.

These average premium increases in recent years tend to be corroborated by ROC and TDI Research Group findings, which showed that an increasing percentage of employers responding to a survey regarding their workers' compensation subscription status indicated their premiums had increased in the previous year.[168] See Figure 19.

[168] TDI's survey of employers did not analyze in detail the possible reasons for the reported increase in premiums, or whether changes such as increases in payroll or injuries may have played a role. However, given that the reported premium increases by employers held across multiple employer size groups, and that the injury rate in general in Texas has decreased over time, these types of changes are unlikely to be the major reasons for the reported increases.

Figure 19
Percentage of Employers Experiencing a Change in their Workers' Compensation Insurance Premiums Compared to the Previous Policy Year



Source: Texas Department of Insurance Workers' Compensation Research Workgroup, testimony to the Senate Select Committee, August 26, 2004. Study information taken from *Survey of Employer Participation in the Texas Workers' Compensation System*, 1996 and 2001 estimates from the Research and Oversight Council on Workers' Compensation and the Public Policy Research Institute (PPRI) at Texas A&M University; and 2004 estimates from the Texas Department of Insurance Workers' Compensation Research Group and PPRI.

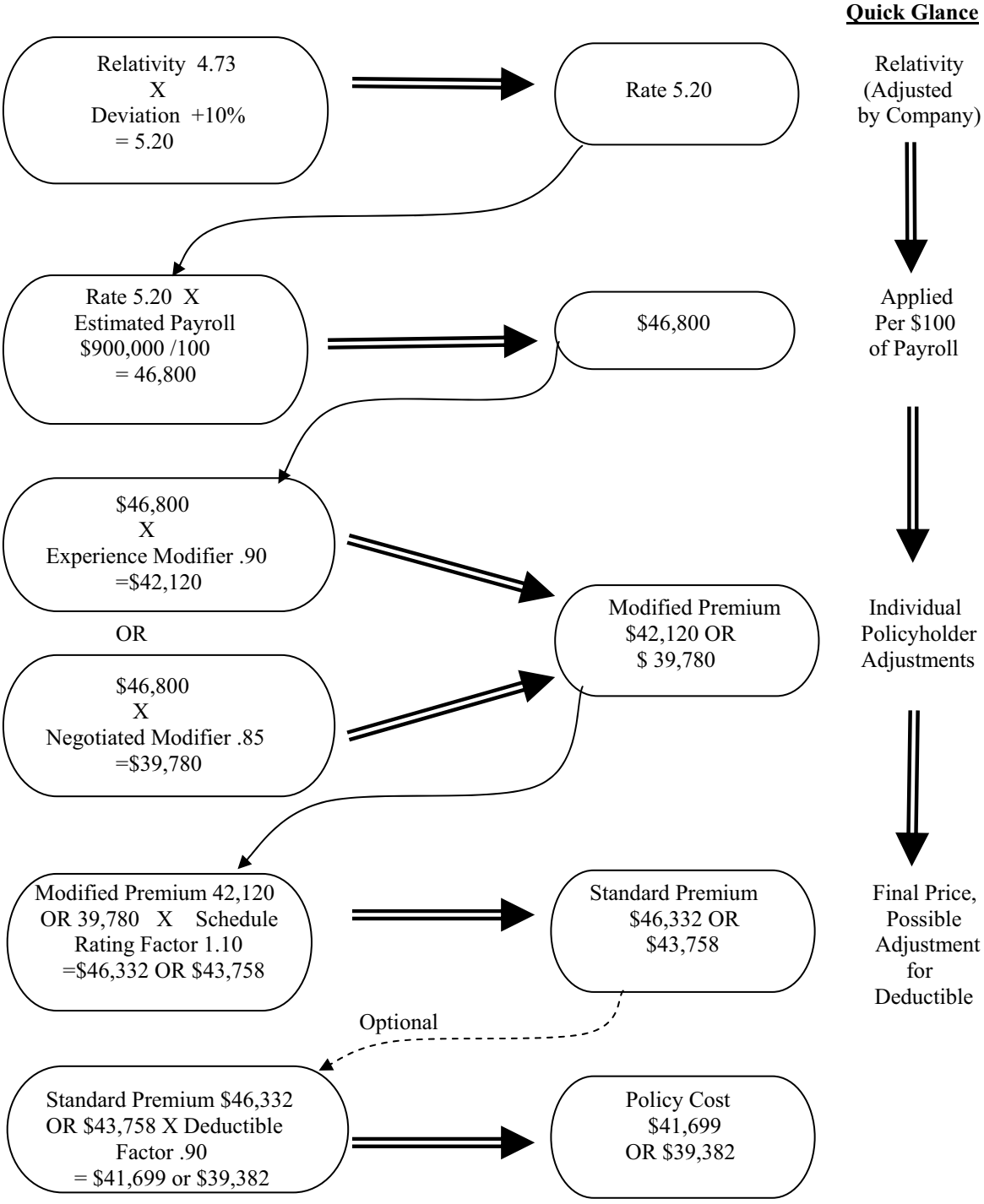
In an accompanying survey finding, 20 percent of subscribing employers indicated that a premium increase of even as little as 10 percent might cause them to seriously consider dropping workers' compensation coverage. Fifty-three percent of subscribing employers surveyed in 2004 indicated they would seriously consider dropping workers' compensation coverage with a 20 percent increase in premiums.[169] Employers indeed may be acting on these concerns to some extent - as discussed in Charge 5, a smaller percentage of employers carry workers' compensation coverage in 2004 than did in 2001. The implications of further premium increases are clear.

[169] See TDI Workers' Compensation Research Workgroup Presentation to the Senate Select Committee, August 26, 2004.

Elements of Workers' Compensation insurance pricing in Texas

Although the numbers in Figure 18 show aggregate average premiums per $100 of payroll, a specific employer's actual premium in the current Texas workers' compensation market is determined through a complex process involving the employer's individual experience, the relative risk of the employer's business, market competition, negotiation, and the employer's willingness and ability to assume risk through deductibles. The discussion to follow describes the role each of these factors play in determining a final premium. Figure 20 also describes the process by which premiums are determined.

Figure 20
Workers' Compensation Policy Premium Calculation, Hypothetical Example



Source: Texas Department of Insurance, testimony to Senate Select Committee, October 12, 2004.
Note: This hypothetical policy is insured with Company A, which has a filed deviation of +10%. Class Code used is RESTAURANT NOC with a TDI promulgated relativity of 4.73, payroll of $900,000, experience modifier of .90 OR negotiated modifier of .85, and Schedule Rating Debit of 10%; Optional Deductible Credit of 10% for a $10,000 per accident deductible.

Relativities and Rates

In contrast to the pre-1991 system, TDI's role in setting workers' compensation insurance rates is limited, and involves determining "relativities" for industry classes (i.e., types of employees). These relativities do not speak to rates *per se*, but rather the relative risk of different types of employment. Texas is the only state to use the relativity concept.

Workers' compensation insurance carriers are required by law to file their rates (expressed in terms of deviations from TDI's promulgated relativities) with TDI, but prior approval by TDI is not necessary before rates can be used (hence the description "file and use" in reference to Texas workers' compensation rates).[170] Carriers may, and typically do, deviate from TDI's relativities in setting their rates, and are not required to use TDI's relativities at all, if the carrier files and justifies its own specific relativities.[171] Deviations may be higher or lower than TDI's relativities, and currently range from minus 30 to plus 120 percent.[172] The average deviation in 2003 was plus 12.6 percent above the TDI relativities.[173]

TDI's relativities since 1999 have been set at an average overall level equal to 70 percent of the average rate that would have been generated by the last (1990) state-promulgated workers' compensation rates. In October 2004, TDI adopted new relativities based on the most recently available experience data - from policy years 1997 to 2001 - for policies effective no later than January 1, 2005. However, due to recent projections of Texas' loss experience, which produce much lower "combined ratios" (i.e., higher levels of profitability) for the industry as a whole, TDI reduced the average overall relativity to 65 percent of the last promulgated rates.

Whether this reduction in relativities actually translates to a reduction in workers' compensation premiums is unclear at present and dependent on many factors. TDI's relativities, for example, changed little between 2001 and 2004, while average premiums

[170] See *Texas Insurance Code* Article 5.55, Section 3(a).
[171] As of late 2004, TDI reports that all but one workers' compensation insurance carrier group in Texas (Zenith) used the TDI relativities.
[172] See the *Texas Workers' Compensation Rate Guide,* Texas Department of Insurance.
[173] See testimony of the Texas Department of Insurance to the Senate Select Committee, October 12, 2004.

rose significantly. Changes in relativities may or may not result in changes in rates, and changes in rates may or may not in turn translate to changes in premiums. For companies that do not file to change their rate deviations, TDI's relativity change will produce a 7.1 percent rate decrease. Other factors influencing overall pricing are discussed below.

While the state no longer promulgates rates, and the file-and-use system allows a good deal of flexibility to carriers in making rates, TDI does operate under a statutory mandate to ensure that rates "may not be excessive, inadequate, or unfairly discriminatory."[174]

Schedule Rating

Schedule rating is a pricing tool that uses debits and/or credits to modify a rate based on the special characteristics of the employer being insured.[175] Schedule rating factors and practices vary from carrier to carrier, and credits and debits range from minus 40 to plus 40 percent, respectively. The use of schedule rating will therefore result in higher premiums for some employers and lower premiums for others, depending on the carrier's use of schedule rating and the conditions present at the employer. TDI estimates the 2003 impact of the application of schedule credits and debits resulted in an average overall decrease in premiums of approximately 4 percent statewide.[176]

Each workers' compensation insurance carrier files a Schedule Rating Plan with TDI. However, TDI has no oversight on a carrier's application of schedule rating to a particular employer. Application of schedule rating is one way that the premiums charged by a carrier may increase or decrease significantly even with no change in the carrier's filed rates or in TDI's relativities.

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[174] See *Texas Insurance Code* Article 5.55, Section 2 (d).

[175] See testimony of the Texas Department of Insurance before the Senate Select Committee, October 12, 2004. These characteristics are broad and may include such factors as condition of the employer's premises, use of safety programs, the employer's cooperation with the carrier, and other factors.

[176] Communication between Texas Department of Insurance and committee staff. This is an estimate of the aggregate impact of schedule rating and does not mean all employers realized a 4 percent reduction.

Experience Rating

Experience rating is another tool used by an insurance carrier to develop a premium for a specific employer.[177] The carrier uses the employer's loss experience of the previous three years to calculate an "experience modifier" that is applied to the rate. The greater the policyholder's losses, the higher the experience modifier, and the higher the premium. The lower the policyholder's losses, the lower the experience modifier, and the lower the premium. Experience rating is mandatory in Texas for employers with (1) annual workers' compensation premiums of at least $10,000 and a one-year experience history, or (2) an average premium of $5,000 and at least two years of experience.[178]

Carriers and employers may negotiate an experience modifier downward, but not upward. An employer with a poor loss history could therefore negotiate a lower experience modifier and a lower premium, if it were felt that the past loss history was not a good indicator of likely future losses.

Negotiated experience modifiers are rarely used in today's Texas workers' compensation market, although TDI reports they were used more widely in the much softer market in the late 1990s. Negotiated experience modifiers are not filed with TDI.

Deductibles

With a deductible, an employer agrees to reimburse the insurance carrier for part or all of the costs of claims in exchange for a premium credit.[179] Deductibles on Texas workers' compensation policies may be promulgated by TDI or negotiated between the carrier and employer. Essentially, TDI's promulgated deductible program applies to small deductible plans, with "large deductible" plans left to negotiation.[180]

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[177] See testimony of the Texas Department of Insurance before the Senate Select Committee, October 12, 2004.

[178] See the *Texas Basic Manual of Rules, Classifications and Experience Rating Plan for Workers' Compensation and Employers' Liability Insurance*.

[179] See testimony of the Texas Department of Insurance before the Senate Select Committee, October 12, 2004.

[180] The highest promulgated "per accident" deductible is $25,000 and the highest "aggregate" deductible is $100,000. TDI allows insurers to negotiate terms of a deductible when (1) an employer elects a deductible in excess of $25,000 or $100,000, respectively, or (2) the employer's annual policy premium exceeds $100,000 prior to the application of any deductible credit. See *Texas Basic Manual of Rules,*

Negotiated deductibles are not filed with TDI, and the agency has limited oversight on a carrier's use of such deductibles. TDI's authority is primarily in the approval of forms, and in some instances, the collateral an employer must provide. TDI reports deductible credits have decreased premiums for participating employers by as much as 83 percent in recent years.[181]

Underwriting

Underwriting is the process by which insurers decide to accept or reject an application for coverage by an employer, or decide the level of coverage to be offered.

In Section I of this report, mention was made of the market share of insurers writing workers' compensation policies in Texas. Market share is often analyzed by "carrier group". Commonly, particularly for the larger carrier groups in the Texas workers' compensation market, coverage is actually written through one of a number of carriers within a carrier group. These different carriers may have different rates and may differ in other ways from others in the same group.[182]

Insurers can also affect the overall level of premiums through shifts in the placement of employers among carriers within their group, or among rating tiers within a single insurer. During a hard (i.e., higher priced) market, there may be a tendency to move both new and renewal business to affiliates or tiers with higher rates, resulting in, all else being equal, a higher average premium. The opposite may happen in soft market. In recent years, there has been a general movement of business to higher-rate insurers within carrier groups or higher rating tiers, and this is a factor behind increasing average premiums.[183]

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classifications and Experience Rating Plan for Workers' Compensation and Employers' Liability Insurance.

[181] See Texas Department of Insurance testimony to the Senate Select Committee, October 12, 2004.

[182] A notable exception is Texas Mutual Insurance Company; while Texas Mutual is not a "group" in the sense that term is used with other carriers, Texas Mutual is allowed to use "rating tiers", and these tiers differ in their rates.

[183] Communication between Texas Department of Insurance and Select Committee staff.

TDI is granted statutory authority under the *Insurance Code* to request the underwriting guidelines of insurers writing workers' compensation.[184] However, the *Insurance Code* does not address authority for TDI to hold workers' compensation underwriting guidelines to standards that they be actuarially sound.

It is perhaps appropriate to distinguish between an insurer's underwriting practices for *new* business and *renewal* business. Arguably, underwriting standards within a group of insurers (or for an insurer utilizing rating tiers) might differ between these types of business. Standards for new business might reflect an insurer's desire to limit excessive exposure in certain industries or geographic regions, or to contain or limit growth so as to keep writing within the financial abilities of the insurer. For renewal business, shifts in business among insurers within a group, or among tiers within an insurer, should be based on sound actuarial principles, so as to ensure that the resulting premiums are not excessive, inadequate, or unfairly discriminatory. While underwriting standards should be actuarially sound for both new and renewal business, a greater latitude in underwriting judgment may be justified in the case of new business.

How do Texas' premiums compare?

Comparison of workers' compensation insurance premiums between states is complicated by state-to-state differences in rate setting and the use of pricing tools, as well as differences in industry types. However, two reports seek to minimize these differences and provide useful state-to-state comparisons. Both indicate Texas employers pay among the highest premiums in the country.

The Oregon Department of Consumer and Business Services' Workers' Compensation Premium Rate Ranking most recently ranked state premiums for 2002. In that analysis, Texas ranked sixth highest among the fifty states and the District of Columbia.[185]

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[184] See *Texas Insurance Code* Section 38.003.

[185] See *Oregon Workers' Compensation Premium Rate Ranking, Calendar Year 2002*, Research and Analysis Section, Oregon Department of Consumer and Business Services, March 2003. Previous rankings for Texas were as follows: 1994, 4th; 1996, 10th; 1998, 3rd; and 2000, 7th.

Another comparison is published by Actuarial and Technical Solutions, Inc. of New York. It ranked Texas' workers' compensation costs third-highest among 45 states (the five states providing coverage exclusively through state workers' compensation insurance funds were excluded).[186]

Current state of the Texas workers' compensation market

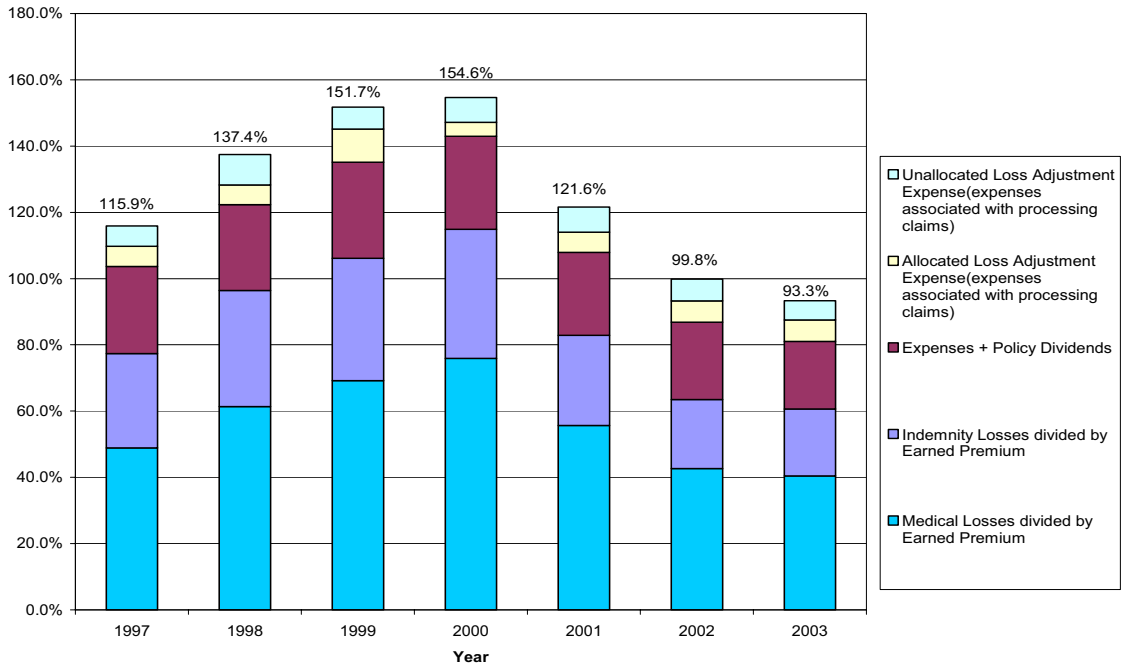
As the numbers shown in Figure 18 demonstrate, the Texas workers' compensation market has experienced extreme fluctuation in the last five years. Employer premiums have increased significantly. Of note as well, and which in large part fueled the interest in a closer examination of workers' compensation insurance pricing and premiums, is that *overall* losses in workers' compensation have decreased during the same period in which premiums have increased.

The relationship between premium collected and losses paid by carriers is often expressed as a "loss ratio." Another relationship, called the "combined ratio," is also an important measure of the health of the workers' compensation insurance industry. The combined ratio expresses the relationship of the carrier's administrative costs *and* workers' compensation claim losses in relation to premium collected.

TDI tracks both loss ratios and combined ratios to remain alert to changes in the market. Figure 21 shows the loss ratios and combined ratios in Texas workers' compensation for 1997 through 2003. Combined ratios are represented by the full bars; the lowest two sections from the bottom of each bar represent the medical and indemnity loss ratios, respectively.

[186] See *Workers' Compensation State Rankings - Manufacturing Industry Costs and Statutory Benefit Provisions*, Actuarial and Technical Solutions, Inc., 2003 Edition.

Figure 21
Texas Workers' Compensation
Combined Ratio by Accident Year
1997-2003



Source: Texas Department of Insurance, testimony to Senate Select Committee, October 12, 2004.
Notes: The combined ratio is the sum of losses and expenses; it does not include investment income. These numbers exclude large deductible policies.

Theoretically, a combined ratio of 100 means that carriers are collecting and paying out (in losses and expenses) exactly the same amount of money; lower combined ratios indicate profitability for carriers, while higher ratios indicate carrier losses. However, while these statistics would suggest workers' compensation carriers have lost money in Texas every year since 1996 except 2002 and 2003, this is not necessarily the case. Combined ratios do not include carriers' investment returns on premium collected, and, particularly in times of good investment returns, carriers are often able to remain profitable writing workers' compensation through returns earned on the premiums they receive upfront for claims that are paid out relatively slowly, over months or years.[187]

[187] See TDI testimony to the Senate Select Committee, October 12, 2004, and the Texas House of Representatives Committee on Business and Industry, January 23, 2004. TDI officials estimated that

Another important point about the ratios shown in Figure 21 is that they do not include large deductible workers' compensation insurance policies. Much of the experience shown, then, represents that of medium and small employers, many of whom have now seen their premiums rise significantly, particularly in the last three years.

It could be argued that the recent downward trend in combined ratios means improvement or stabilization in the workers' compensation market. However, it is important also to remember that the improvements in combined ratios for carriers since 2000 track with increases in premiums charged to employers during that period.

A combination of factors are likely responsible for rising workers' compensation insurance premiums since 1999: a weak economy and investment returns; increased costs for reinsurance; and the very high and rising *average* costs for workers' compensation claims, particularly for medical payments. This period also marked the end of a time of intense competition among workers' compensation carriers during the good economic climate of the mid-to-late 1990s - competition that drove premiums below levels that were sustainable in times of weaker investment returns.[188]

However, in the past four years, carrier losses have decreased while premiums have risen (see Figure 22).

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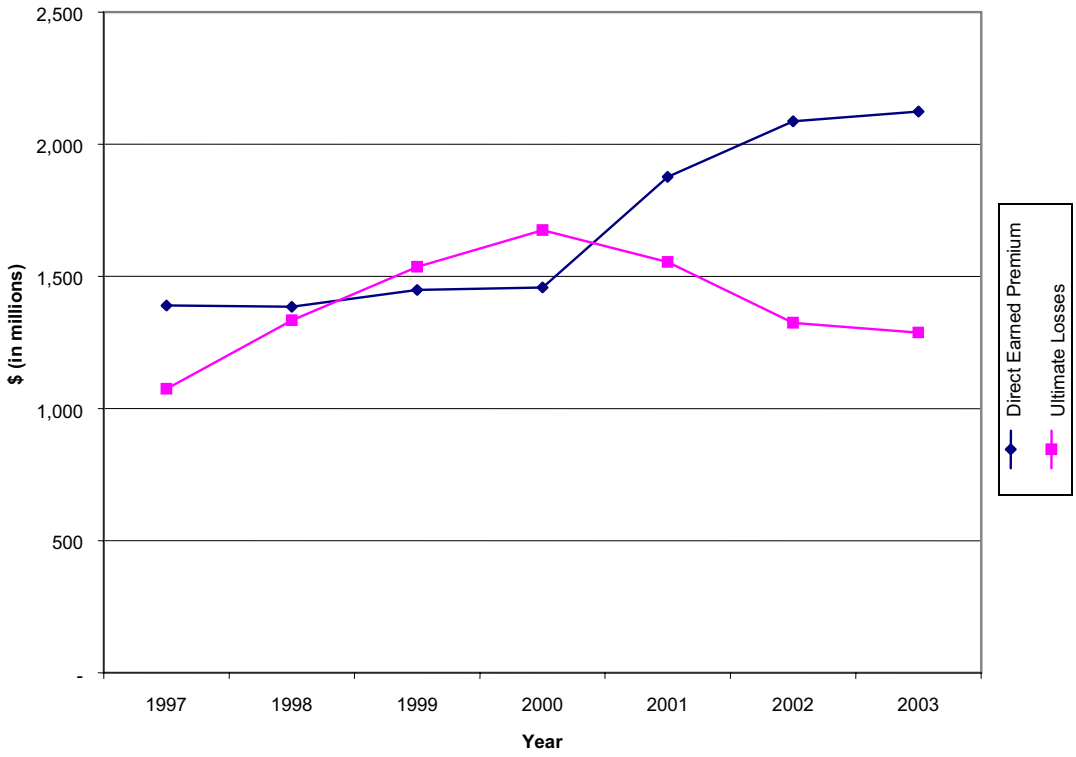
carriers could still earn a reasonable profit at between 104 and 106 percent combined ratios, depending on the investment market.

[188] See *Effects of Reforms on the Texas Workers' Compensation Insurance Market*, ROC, August 1999, p. 16.

Figure 22
Texas Workers' Compensation Premiums and Losses
1997-2003



Source: Texas Department of Insurance, testimony to Senate Select Committee, October 12, 2004.
Notes: Does not include large deductible policies. Losses shown are projections of what will ultimately be paid to or on behalf of injured employees for indemnity and medical benefits based on past payment patterns.

The contrast from 1999 and 2000 to 2003 is stark. The market appears to have gone from a period of underpriced premiums and high losses to one of much higher premiums and significantly lower losses.

In the area of losses the recent data from TDI is perhaps most surprising, given the overall concern about what appear to be high and still rising average costs per workers' compensation claim in Texas. Partly, the decrease in projected overall claim costs in recent years can be attributed to continued decreases in the injury rate - frequency of injuries continued a downward trend, while severity (at least measured in cost per claim) continued to rise. But factors other than a declining injury rate are also likely at play. As

discussed in the analysis of Charge 5, it appears that carriers have significantly increased their scrutiny on claims after awareness of high per-claim costs in Texas grew in 2000 and 2001, culminating in the passage of HB 2600. It is also possible (though yet to be demonstrated) that more recent injury years will show a leveling in the very key measure of *average* medical cost per claim, as the rate of increase slowed somewhat from injury year 2002 to 2003.[189]

Insurance carriers testifying before the Select Committee on this charge advocated caution in drawing conclusions based on the market trends of the last two years. Witnesses pointed out that the workers' compensation insurance market is historically cyclical, with "soft" (i.e., very competitively priced) markets followed by "hard" ones, and that trends in the upcoming years will likely be toward lower premiums.[190] It is undeniable that the market in the last five years or so has been extremely cyclical - particularly considering the trends during the late 1990s, trends which are unlikely to be repeated to that extent.

Witnesses also cautioned that premium underpricing (as clearly occurred in the late 1990s) can be detrimental, also, as it can lead to carrier insolvencies that must be borne by the rest of the market. Employer witnesses, while expressing concerns about high premiums, clearly favored a competitive insurance market over a promulgated one.

Will controlling high costs make a difference in premiums?

In the course of testimony on the state of workers' compensation in Texas, it has been asserted by some that high premiums in Texas are largely unrelated to the state's high workers' compensation costs, particularly medical costs. Insurance carrier pricing for workers' compensation, it is argued, is instead correlated to investment returns and other factors external to the way the system operates. In addition, others have argued, carriers

[189] This issue is discussed in more detail in Charge 5. Research by TDI's Workers' Compensation Research Group showed that average medical costs per claim (measured at 12 months post-injury) increased from $2,288 in 1999, to $2,409 in 2000, to $2,758 in 2001, to $2,951 in 2002, and $3,078 in the first few months of 2003.

[190] See testimony of Russell R. Oliver, President, Texas Mutual Insurance Company, before the Senate Select Committee, October 12, 2004.

are now using denials of medical necessity and other cost control tools to effectively minimize their losses, abrogating the need for other changes to control medical costs. The results from recent TDI analyses of premiums, loss ratios, and combined ratios for 2002 and 2003 have been advanced as support for these arguments.

It is undeniable that factors outside of the direct cost of workers' compensation claims influence the pricing of workers' compensation premiums. These factors include both the general condition of the economy (particularly returns on investments) and the degree of competition in the market. But it is also undeniable, based on numerous analyses, that Texas' real costs for medical care in workers' compensation, on an average cost per claim basis, far exceed that in other states. It is important to remember that reducing these costs will have a *direct* impact on those employers who self-insure, and similarly, on those with large deductible plans who largely pay their own losses. If the high cost of workers' compensation to employers in Texas were purely an issue of carrier pricing, self-insured employers would be unaffected; instead, these employers are some of those most concerned about high system costs and poor outcomes.

Finally, even if carriers are having more success in managing the *cost* of claims, and even assuming that this will be sustained in the long term, this does not mean that the *outcomes* of these claims have improved. Even though it is clear from many previous studies that high medical costs per claim do not mean better outcomes, if denial patterns are focused on the wrong care or the wrong claims, outcomes could be worsened even as the cost of care may decrease.

In addition, strict rate regulation, while appealing as a way to "guarantee" premium reductions, clearly does not insulate high-cost workers' compensation systems from continued high costs. It is interesting to note that two large states that closely regulate workers' compensation insurance rates - Florida and New York - ranked second and eighth-highest in premiums nationally in the most recent Oregon premium rankings.

Findings and Recommendations

The committee finds the following in regard to Charge 7:

- The post-1991 system of workers' compensation pricing, while imperfect, represents an improvement over the promulgated rates and relative inflexibility in the previous period. In comparison with the promulgated rate system, the competitive pricing system offers employers more flexibility in finding coverage. While the state should not return to promulgating workers' compensation rates, improvements in the oversight of premiums charged to Texas employers could be beneficial in ensuring the competitive system works fairly.
- While TDI has clear authority it may exert to disapprove the rates charged by workers' compensation insurance carriers should those rates be deemed excessive, inadequate, or unfairly discriminatory, the agency has more limited oversight on the use of competitive pricing tools such as schedule rating, negotiated experience modifiers and deductibles, and underwriting. Information about rates alone is insufficient to assess whether employers are paying a fair price for workers' compensation insurance.
- Due to a variety of factors both related and unrelated to workers' compensation insurance losses, the Texas workers' compensation insurance market in the last five years has undergone a period of extremes in pricing. Employers in the late 1990s enjoyed intense carrier competition in which coverage was likely underpriced; today, based on the most recent numbers related to carrier loss ratios and combined ratios, the opposite may be true. Since large deductible plans are excluded from these loss and combined ratio statistics, these statistics in large part represent the experience of small and medium-sized employers in Texas.

The committee recommends the following:

- The continuation of the trend of increasing premiums and decreasing losses in workers' compensation during the past two years - as the combined ratio has dropped well below 100 percent - is cause for concern. Employers have yet to

share in the decreased losses in the system through lower premiums. As the state takes steps to enact meaningful reforms in a way that should lower long-term system costs and benefit all stakeholders, scrutiny on rates and premiums is important to ensure that cost savings are shared. TDI should be directed as part of the expected workers' compensation reform proposal to examine carriers' rate filings and pricing with special care to determine if savings are being passed on through lower premiums.

- The competitive pricing tools currently available in workers' compensation should continue to be allowed. However, more information about the use of these tools should be collected and examined by TDI. TDI's statutory mandate to ensure that workers' compensation rates are neither excessive, inadequate, nor unfairly discriminatory is much less meaningful if the agency has little to no oversight on the other factors that comprise a premium. To this end, the *Insurance Code* definition of "rate" should be amended to include consideration of variations applied to individual employers. This change would provide clear authority to TDI to consider the impact of any competitive tools in assessing whether a carrier's rates are compliant with the law.
- Workers' compensation insurance carriers should be required to file their underwriting guidelines with TDI, as are carriers in some other lines. These guidelines should also be held to standards that they must be actuarially justified and not unfairly discriminatory.

Charge 2: Study the potential impact of networks on the workers' compensation health care delivery system. Include in the study:

- *Quality of care;*
- *Network adequacy and access to care;*
- *Disclosure of information to patients, complaint procedures, appeal rights and overall patient satisfaction;*
- *Costs of care;*
- *Provider credentialing, selection, and dispute resolution;*
- *Financial risks to providers, employers, and carriers;*
- *Effects of networks on the Texas Workers' Compensation Commission; and*
- *Quality monitoring systems such as independent report cards.*

Background

The use of provider networks and related features in workers' compensation across the country has become more common in recent years, largely driven by attempts to rein in high costs and improve outcomes. The general term "network" can apply to many different arrangements by which medical providers are selected to treat injured employees - from the current TWCC Approved Doctor List (ADL), on one extreme, to small pools of doctors selected by an employer or insurance carrier, on the other.

Networks can also be focused in different ways, and utilize different strategies to either reduce costs, improve outcomes, or both. Some focus on provider credentialing and selection; others, on negotiation of discounted rates for medical services; others, on encouraging care within treatment guidelines and appropriate utilization of care; others include facets of these and other strategies.

Generally, in order to meet the parameters laid out in this charge, discussion in this section of the report focuses on networks that seek to deliver quality care in a cost

effective manner, to eliminate unnecessary services, to prevent excessive, uncoordinated use of services, and which include the use of specific provider groups.[191]

Following a discussion of the current use of networks in Texas and network provisions in other states, this section of the report addresses each element of the charge generally in the order listed, with some elements combined for ease of discussion.

Current use of Networks in Texas

As discussed in the evaluation of Charges 4 and 5, Texas is generally an "employee choice of doctor" state. While employers and insurance carriers cannot by law require injured employees to receive care from specific doctors or other health care providers, there is no prohibition on offering specific providers or networks of providers that employees may use. There is no comprehensive research on the extent to which these types of "voluntary" networks are used in Texas, but it is not unusual for injured employees to treat with doctors recommended by their employers. A 2003 ROC report indicated that about one-third of employees surveyed chose an initial treating doctor that their employer recommended.[192] An informal poll of insurance carriers conducted by the Insurance Council of Texas (ICT) in early 2003 also found that among 36 companies that responded to the survey - representing about a quarter of the workers' compensation market in Texas - 35 used some form of "voluntary" network.[193]

Insurance carriers and experts familiar with the current use of such networks in Texas indicate that they tend to be broad in scope (i.e., include a large number of providers) and

[191] This definition is similar to one used in the Workers' Compensation Research Institute's report *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002* (see p. 53).

[192] See *Survey of Injured Workers Regarding Work-Related Health Problems: Comparison of State and Private Sector Worker Experiences*, Research and Oversight Council on Workers' Compensation, August 2003. This figure does not speak to whether the injured employee continued to treat with this doctor or later changed doctors.

[193] See letter of Rick Gentry, Executive Director, Insurance Council of Texas, to Scott McAnally, Executive Director, Research and Oversight Council on Workers' Compensation, March 13, 2003.

primarily focused on securing pricing discounts in comparison with the TWCC fee guideline.[194]

Network provisions in other states

Like most aspects of workers' compensation, use of networks varies significantly from state to state. Twenty-five states currently mandate or allow network or managed care programs in workers' compensation *and* provide some requirement that injured employees treat within these programs, if they are offered.[195] These do *not* include states like Texas, which allow network arrangements in workers' compensation, but do not require employees to treat within these networks under any circumstances.

As TDI and WCRI analyses show, a few states mandate managed care programs, while others simply allow and/or regulate them. The term "mandate" in this sense refers to the requirement that employers and/or insurance carriers offer network programs in these states, not necessarily that injured employees are required to use the programs in all cases. In those states that do not mandate managed care, the decision of whether to offer such programs is left to the employer and/or insurance carrier - and, if they are not offered, doctors are selected to treat injured employees under whatever general statutory provisions govern this selection. It is not uncommon, then, for different injured employees in a given state to be treated under "network" and "non-network" medical care systems.

[194] The Insurance Council's informal survey found that 22 of the 35 networks identified were based on discounts from the TWCC fee schedule only; the remaining 13 had some utilization review component. Testimony before the Senate Select Committee in April also indicated that one current network had contracts with more than 12,000 Texas providers prior to the implementation of the new TWCC ADL requirements in September 2003.

[195] See *Comparison of State Workers' Compensation Managed Care Programs and Fee Schedules*, Texas Department of Insurance Workers' Compensation Research Group, testimony before Senate Select Committee on April 29, 2004, citing *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002*, Workers' Compensation Research Institute, and other sources.

In almost all states with networks, managed care organizations or networks must be certified by the state in order to operate.[196] The requirements of this certification vary significantly, but five general areas of network operations are usually addressed: network adequacy; utilization review requirements; medical case management requirements; requirements for the use of treatment guidelines; and internal dispute resolution requirements.[197]

Within these general areas of regulation there is significant variation between states. Of those states that address network adequacy, for example, 11 states require specific numbers and/or types of providers be included in networks; the others simply require that networks provide adequate numbers of providers to treat injured workers, with the specific evaluation of adequacy left to the state certifying agency, assuming certification is required.[198]

Another specific and very important area in which network structures differ between states relates to the ease with which injured employees may treat outside the network structure. While no state model appears to be as permissive as the HNAC model discussed in detail in Charge 1 - a model that would have allowed the employee both to decide prior to injury whether to participate and then to opt out after only 14 days post-injury - a number of states allow employee "opt out" provisions much more favorable than those offered in traditional group health networks, particularly when one also considers that in almost all cases, workers' compensation medical care is fully paid, without deductibles, co-payments, and other features imposed in group health network systems.

Some states, like Oregon, are more strict in requiring that injured employees treat within a network; others, like Rhode Island, allow free employee choice of doctor initially, but

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[196] See *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002*, Workers' Compensation Research Institute, p. 63.

[197] According to the 2001/2002 WCRI *Inventory*, 11 states mandated specific numbers and/or types of providers in statute, while 11 others had some general requirement for adequacy; 18 states required utilization review; 17 required some level of case management; 12 required treatment guidelines; and 17 required internal dispute resolution mechanisms.

[198] The latter approach is most similar to that used in regulation of group health network adequacy in Texas.

require any employee wishing to change doctors to choose a doctor within a network, if one is offered.[199] Models like the latter stretch the limits of what could truly be considered a comprehensive network system. The rationale for such provisions is difficult to evaluate without examining the specific conditions present in each workers' compensation system in each state. However, previous analyses of workers' compensation network and managed care provisions found that allowing employee opt out posed significant barriers to the effective use of these plans.[200]

Further complicating comparisons of state-to-state network programs are the differences in general state laws relating to provider choice in workers' compensation. Some states that do not have managed care or network programs *per se* also allow employer choice of doctor.[201] In addition, some states that allow or mandate networks are also employer-choice-of-doctor states.[202]

The remainder of the evaluation of Charge 2 examines the ability of networks to meet each of the goals outlined in the charge.

Quality and Cost of Care, and Quality Monitoring

Consideration of both the quality and the cost of medical care is necessary in determining its overall value. As discussed previously in this report, the current Texas system is one in which value is at its lowest - high costs coupled with poor outcomes. The best system would possess exactly the opposite characteristics. Because it will be vital to assessing

[199] While Oregon requires that injured employees treat within a network if the employee is enrolled in a network for that injury, the insurance carrier covering the claim has discretion over whether or not to enroll the claim.

[200] See *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002*, Workers' Compensation Research Institute, p. 56.

[201] Examples include Alabama, Indiana, Iowa, Kansas, and South Carolina. See *Comparison of State Workers' Compensation Systems*, Texas Department of Insurance Workers' Compensation Research Group, testimony before Senate Select Committee, March 25, 2004; and *Comparison of State Workers' Compensation Managed Care Programs and Fee Schedules*, Texas Department of Insurance Workers' Compensation Research Group, testimony before Senate Select Committee, April 29, 2004.

[202] Examples include Florida, Missouri, New Jersey, North Carolina, and Oklahoma. See *Comparison of State Workers' Compensation Systems*, Texas Department of Insurance Workers' Compensation Research Group, testimony before Senate Select Committee, March 25, 2004; and *Comparison of State Workers' Compensation Managed Care Programs and Fee Schedules*, Texas Department of Insurance Workers' Compensation Research Group, testimony before Senate Select Committee, April 29, 2004.

the impact of any changes in the delivery of medical care, quality monitoring is also included in the discussion of medical cost and quality.

Quality and Cost

National research

Two studies by the Workers' Compensation Research Institute (WCRI) found that significant savings are possible through the use of networks. The first of these studies, published in 1999, examined the differences in medical and indemnity costs per claim for claims from Texas, California, and Connecticut.[203] It is important to remember that while Texas does not at present mandate that employees treat within networks under any circumstances, employers and insurance carriers can contract with providers to form networks, and that injured workers sometimes treat with these providers.

WCRI examined the differences in costs between claims treated in-network vs. out-of-network in these states, and found that claims treated in network had 14 to 28 percent lower medical costs for medical only claims, and 33 to 46 percent lower medical costs for indemnity claims, than those treated outside.[204] Savings were found to be realized from both reductions in price per service negotiated in-network and lower utilization of services in network. This study also examined the possibility that these lower medical costs resulted in higher indemnity costs for these claims - in other words, that treatment received was inadequate, and drove up long-term costs for lost time from work and disability. The report found that this was not that case - in fact, the findings suggested indemnity savings and shorter absences from work for claims treated in-network.

Further, the WCRI study noted that "the potential savings from an increased reliance on workers' compensation networks are greatest in states like Texas, where networks have a relatively small percentage of the market and providers' margins are likely to be

[203] See *Impact of Workers' Compensation Networks on Medical Cost and Disability Payments*, Workers' Compensation Research Institute, November 1999.
[204] See *Impact of Workers' Compensation Networks on Medical Cost and Disability Payments*, Workers' Compensation Research Institute, November 1999, p. 112.

higher."[205] It should be noted that this statement about provider margins was made prior to the adoption of the 2002 TWCC Medical Fee Guideline, which reduced aggregate payments to providers, and that other WCRI research suggests that the comparatively high average medical cost per claim in Texas is driven largely by higher utilization, not price per service. This in turn suggests that networks in Texas would find their greatest opportunity for reducing cost in reducing utilization of unnecessary services, rather than negotiating lower prices per service.

Follow-up research by WCRI on the use of networks in 2001 also found that networks were associated with lower medical costs, that these costs did not appear to increase indemnity costs, that the initial (non-emergency) visit to a network provider played a key role in determining the extent of network cost savings, and that higher network penetration reduced medical costs.[206]

State-specific network evaluations

While many states have implemented or attempted to implement network or managed care programs, most are only recently turning to how to evaluate those programs.[207] Oregon's workers' compensation managed care system was one of the earliest brought to fruition in the country, as part of that state's overhaul of its workers' compensation system in 1990. Oregon's program is somewhat unusual among network states in that insurance carriers or self-insured employers participating in networks are allowed at the time of injury to decide whether or not to enroll an injured employee in the network program. If enrolled, an employee must seek all medical care related to the injury within the network. Seventy-one percent of employers and 73 percent of employees were covered by networks, in late 2002, and 37 percent of all disabling claims were enrolled in networks.[208]

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[205] See *Impact of Workers' Compensation Networks on Medical Cost and Disability Payments*, Workers' Compensation Research Institute, November 1999, p. 118.
[206] See *Impact of Initial Treatment by Network Providers on Workers' Compensation Medical Costs and Disability Payments*, Workers' Compensation Research Institute, August 2001.
[207] See *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002*, Workers' Compensation Research Institute, p. 19.
[208] See *Coverage and Enrollment in Workers' Compensation Managed Care Organizations in Oregon During 2002*, Research and Analysis Section, Oregon Department of Consumer and Business Services,

Oregon has also conducted meaningful follow-up analyses comparing costs and outcomes of network and non-network treatment. An examination of more than 9,400 workers' compensation claims found that, when all other variables were accounted for, network enrollment resulted in a 12.9 percent reduction in claims cost.[209] It should also be noted that, because of the selective way claims are enrolled in networks in Oregon, there is a natural bias for more rather than less severe injuries to be enrolled.

The overall 12.9 percent reduction in Oregon tracked with reductions found in other areas of cost: medical costs, 12.4 percent reduction for covered claims; "timeloss" (roughly equating to initial lost time from work in Texas, the period in which Temporary Income Benefits (TIBs) would be paid), 9.9 percent; and permanent partial disability (equating to Impairment Income Benefits, or IIBs, in Texas), 17.5 percent.[210]

Research in Oregon also examined worker satisfaction with care. The results showed slightly lower satisfaction with care in a network versus a non-network care setting. Eighty-one percent of workers not covered by networks indicated they were satisfied with the care they received, compared to 79 percent of workers covered.[211]

Outcomes were found to be the same or better for network versus non-network. Return-to-work outcomes were nearly identical for both groups. However, covered workers rated their emotional condition (77 percent vs. 75 percent) and level of physical pain (59 percent vs. 56 percent) slightly better than non-covered.

November 2003, p. 1. In Oregon in 2002, the state insurance fund enrolled 68 percent of its accepted claim in managed care organizations; private insurers enrolled 12 percent; and self-insured employers enrolled 28 percent.

[209] See *Managed Care in the Oregon Workers' Compensation System*, Research and Analysis Section, Oregon Department of Consumer and Business Services, April 1999.

[210] See *Managed Care in the Oregon Workers' Compensation System*, Research and Analysis Section, Oregon Department of Consumer and Business Services, April 1999, p. 19.

[211] See *Managed Care in the Oregon Workers' Compensation System*, Research and Analysis Section, Oregon Department of Consumer and Business Services, April 1999, p. 20.

Washington also conducted a pilot project in the mid-1990s to evaluate the effectiveness of specific types of network programs - capitated payment arrangements rather than fee-for-service. Care in the pilot was also designed around occupational medicine principles, emphasizing coordination of care between occupational medicine experts and focusing on prompt return to work.

The project found no meaningful difference between the two groups (managed care and non-managed care patients) in health outcomes, but did find important, statistically significant differences in medical and indemnity costs. Network patients had medical costs 22 percent lower on average than traditional patients, lower incidence of lost-time from work (15 percent of network patients, versus 19 percent traditional), and 32 percent lower disability costs when they did miss time, suggesting shorter durations of time off work.[212]

As in the Oregon case, lower costs did come at some expense in workers satisfaction. In terms of satisfaction with overall treatment, 47 percent of managed care versus 51 percent of fee-for-service workers indicated they were satisfied. The disparity between the two groups was largest in satisfaction with overall access to care (32 percent and 43 percent, respectively.[213] This suggests that the limited number of clinics operated by the managed care plans may have driven some of the difference in satisfaction between the two groups.

Florida presents other interesting findings as to the ability of workers' compensation networks to improve outcomes and reduce costs. Two pilot programs in Florida in the 1990s found substantial cost savings for both capitated and Preferred Provider Organization (PPO) plans, compared to non-network care.[214] Effective January 1, 1997,

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[212] See Wickizer, Franklin, Plaegar-Broadway, and Mootz, Improving the Quality of Workers' Compensation Health Care Delivery: The Washington State Occupational Health Services Project, *The Milbank Quarterly*, Volume 79, Number 1, 2001.

[213] See Wickizer, Franklin, Plaegar-Broadway, and Mootz, Improving the Quality of Workers' Compensation Health Care Delivery: The Washington State Occupational Health Services Project, *The Milbank Quarterly*, Volume 79, Number 1, 2001.

[214] See *Managed Care in the Oregon Workers' Compensation System*, Research and Analysis Section, Oregon Department of Consumer and Business Services, April 1999. The report cites a study by Milliman

all Florida employers were required to provide workers' compensation medical care through managed care plans, making Florida one of the few states where managed care was mandatory for employers. A 2000 evaluation of the managed care mandate found correlations in some areas between slightly lower costs and the implementation of mandated managed care, but a full analysis was rendered impossible by a lack of available data and benchmarks to which to compare costs and outcomes.[215] Florida also later repealed its mandate of managed care.[216]

While Texas has not utilized networks to the extent these other states have, projections of savings and outcome improvements from the use of networks have been made. MedFX, LLC, which conducted the feasibility study required for the Health Care Network Advisory Committee (HNAC) aspect of HB 2600, estimated that, for state employees in the Austin/San Antonio and Houston areas, a mandatory employee-participation network would save the state about $8.3 million a year in workers' compensation costs. If implemented for all state employees, MedFX estimated the annual savings to the state at about $19.2 million.[217]

Quality Monitoring

As the above discussion indicates, there is ample evidence that well-functioning networks can both lower costs and improve outcomes. Given the poor results and high costs currently present in the Texas system, the potential for improvement here is great. However, as the variations in network models among the states suggest, there is no network model that can be lifted in whole or large part and simply transplanted to Texas.

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and Robertson, Inc., indicating that a managed care pilot programs among state employees in southern Florida found a 54 percent cost per claim reduction compared to a fee-for-service control group; in another study, a preferred provider organization pilot was found to have 23 percent lower costs than two control groups.

[215] See *How Has Managed Care Affected Workers' Compensation Outcomes?*, Annual Report of the Florida Division of Workers' Compensation, 2000.

[216] It is important to recall that in Florida, *employer* choice of doctor is the general rule outside managed care arrangements. In managed care plans, therefore, employees had greater choice of provider than outside such plans. Some of the biggest opponents in Florida to mandatory managed care were employers, particularly self-insured employers. See *How Has Managed Care Affected Workers' Compensation Outcomes?*, Annual Report of the Florida Division of Workers' Compensation, 2000.

[217] See letter of MedFX, LLC, Health Care Network Advisory Commission feasibility consultant to Ron Josselet, Executive Director, State Office of Risk Management, March 15, 2003.

Since statutory parameters alone cannot produce good networks, the importance of follow-up analysis of the performance of networks is even more critical.

The Florida example is particularly pertinent on this point, since the lack of even basic information to compare in- and out-of-network care made evaluation in that state difficult to impossible.[218] Reliable network performance information, in the hands of employers and employees, will be critical to guide informed decisions about network performance in important areas of cost control, outcomes of care, employee satisfaction with care, and others.

Network Adequacy and Access to Care

Given the population size of Texas, the number of large employers, and the size of the workers' compensation market - among the largest in the nation - it is a near certainty that workers' compensation networks would exist to serve the states' employees and employers. Many, in fact, already do, in contracted arrangements with insurance carriers and employers, even given the fact that Texas employees are free to choose any doctor on the TWCC Approved Doctors List (ADL).

As noted, because of the employee choice climate in the state, existing networks tend to be focused on bringing in a wide pool of providers and negotiating discounts from the TWCC fee schedule. If employees were required under all or most circumstances to seek treatment in network, the incentives for networks to participate in the system would increase significantly. Current networks would likely realign themselves to the new system requirements, and new networks would likely be formed.

The experience of the workers' compensation system in incorporating Independent Review Organizations (IROs) into the medical dispute resolution process may be

[218] See *How Has Managed Care Affected Workers' Compensation Outcomes?*, Annual Report of the Florida Division of Workers' Compensation, 2000. To quote from the Florida report, p. 57: "Given that identification of individual workers treated under Managed Care is not collected by the division, the missing information on employer utilization of Managed Care results in an inability to separate Managed Care from non-Managed Care treatment. This very basic identification is essential for assessing the impact of Managed Care."

instructive as to the interest that would build in the workers' compensation network market. Prior to the adoption of the IRO process in workers' compensation in 2002, there were three IROs reviewing medical disputes in the group health HMO setting; today that number has grown to nine, almost entirely based on new business in workers' compensation.

MedFX's analysis of the feasibility of the HNAC also speaks to the potential network market. After issuing a Request for Information (RFI) and discussing the viability of networks with several potential network organizations, MedFX concluded that there was some interest from networks even in the HNAC model, which was tightly defined by statute and contained unique employee opt-out and contracting provisions.

It is also interesting and perhaps encouraging for the prospects of networks that, according to a 2004 survey conducted by the Texas Orthopedic Association (TOA), more than three-quarters of surgeons surveyed indicated they were interested in treating employees of non-subscribers to the workers' compensation system - a market where employer control over medical care is much more pronounced than in workers' compensation.[219]

However, the nature of Texas also makes it likely that networks will not exist in all areas of the state. In extremely rural areas, for example, concentrations of providers may not exist to make networks viable. It is also important to note that these areas are not generally the parts of the state driving medical cost trends.[220] It is important that improvements be made to the workers' compensation system as a whole to address those employers and employees who will not be participating in a network program, and recommendations to this end are included in other sections of this report.

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[219] See testimony of the Texas Orthopedic Association to the Senate Select Committee, April 29, 2004.

[220] Both WCRI and the ROC examined geographic differences in medical costs. WCRI found that costs were highest in the El Paso, Houston, and Dallas/Ft. Worth areas; ROC found similar trends. See *Area Variations in Texas: Benefit Payments and Claim Expenses*, Workers' Compensation Research Institute, May 2000, and "Texas Workers' Compensation Medical Costs: A Geographic Review", Research and Oversight Council on Workers Compensation, *Texas Monitor*, Vol. 6, No. 2, 2001.

Network adequacy is addressed and regulated - to some extent - by almost all states that certify networks. Most states do not establish by statute specific numbers of providers and/or facilities that must be offered, but rather leave specific adequacy for evaluation and follow-up, if necessary, by the certifying entity. This model is also similar to that used for determining adequacy for group health networks in Texas.

Complaints, Appeals, and Dispute Resolution

Most states that certify networks in workers' compensation require those networks to operate internal procedures for dispute resolution. In optimal networks, disputes would be far less common than they are in the current Texas system. However, disputes will never be eliminated entirely, so dispute and complaint resolution remain important facets of network operation.

The potential for networks to minimize disputes may be significant. First, fee disputes - those involving the amount of reimbursement owed to a provider or facility, rather than the necessity of medical services - could be largely eliminated by agreed-to, contracted arrangements.

Even in the area of questions of medical necessity, there is some evidence that networks can minimize disputes. A 2002 study of medical disputes in Oregon found that while 36 percent of workers with accepted disabling claims were enrolled in managed care organizations, only 13 percent of medical disputes processed by the state administrative agency involved claims in these organizations.[221]

The reasons networks may be able to minimize disputes, particularly in Texas, could be related to several factors. In a network setting, the parties providing and paying for medical care should enjoy more constructive working relationships than providers in payers in an open system such as the one in Texas, particularly when overutilization of

[221] See *Medical Dispute Activity, Oregon, Fiscal Year 2002*, Research and Analysis Section, Oregon Department of Business and Consumer Services, February 2002, p. 4.

services (on the whole) and unreasonable denials of services (in specific instances) are common.

Provider Credentialing and Selection

Selection of high-quality providers should be one of the key strategies used by networks to improve outcomes. In the current Texas system, it is one of the strategies most poorly utilized. TWCC's Approved Doctor List (ADL), the "network" of sorts for the entire system, is essentially an "any willing provider" system, in which the main qualification is the doctor's willingness to undergo a relatively simple enrollment process. Those networks that do exist in workers' compensation in Texas at present also tend to "take all comers," since their use by injured employees is entirely optional, and tend to be focused on fee discounts rather than utilization control and quality improvement.

While network adequacy is important and should be regulated by the state to some extent, any requirement that networks accept all willing providers would likely eliminate the network system's ability to focus on quality improvement and appropriate cost and utilization control. If networks are required to enroll all providers, the system is likely to creep back to the current model's focus on price-per-service discounts and away from where the most meaningful improvements can be made. Allowing networks to appropriately credential and select providers - with some controls to ensure fairness for all parties - is essential to allowing networks to perform as envisioned.

Effects of Networks on the Texas Workers' Compensation Commission

A widespread network system in Texas would fundamentally alter the role of the Texas Workers' Compensation Commission (or whatever agency or agencies retain the administrative role in the system). TWCC plays a major role in the day-to-day management of workers' compensation claims in the current system. In a network system, that role would likely remain significant for issues and disputes related to the compensability of injuries, indemnity benefits, impairment ratings, and other system features that, while they may have medical components, are classified as indemnity-related. For in-network medical issues, however, TWCC's role would be greatly reduced.

Over time, this could create opportunities for the agency to focus resources away from medical dispute and review processes and onto return to work, safety, and indemnity-related issues.

When networks are in place and operational, the state will have an important role to play in certification and regulation. Rather than TWCC, however, the most appropriate agency for these functions likely is TDI, which already carries out similar functions for group health networks.

Findings and Recommendations

A well-designed network program could improve the Texas workers' compensation system in many of the areas in which it currently performs most poorly. Such a program could reduce inappropriate utilization of care and lower costs while also improving outcomes, minimizing disputes, and reducing the role of TWCC in micromanaging the system.

The change from the current system of provider selection in Texas to a network system would be regarded as significant by almost all stakeholders. While this perception is valid, it is also vital to remember how poorly the current Texas system, with the TWCC Approved Doctors List (ADL) serving as a "network," has functioned in meeting the basic goals of a network system discussed in the opening to this charge. Costs are very high; overall quality of care, if judged by outcomes, is poor. Network adequacy is questionable and increasingly uncertain. Front-end information about provider or network quality is absent. As for appropriate provider credentialing and selection, the ADL has only recently incorporated any training requirements or attempts to ensure quality, and the system remains essentially "any willing provider," with the exception of a relatively few providers TWCC has specifically excluded.

The Texas workers' compensation system already has a "network" in place - and it has failed to meet the goals of quality, cost-effective care.

While there is no "magic model" that would guarantee these outcomes, several basic features of a new network system emerge as key:

- *Networks should be allowed to contract with carriers or self-insured employers, and if a network contract is in place, injured employees should have an appropriate network panel of doctors from which to choose.* While requiring care to be provided within a network setting is a change from a broader employee-choice system, it is important to remember that an employee's true "choice" of doctor has already been limited significantly as access to care has contracted and fewer providers accept new workers' compensation patients (as the section of this report evaluating Charge 3 details). Networks can offer more certain access to higher-quality care with an assurance of adequacy of the provider pool. Under certain very specific, well-justified situations such as emergency care or necessary care not available in network, non-network care could be allowed, but this should be the rare exception rather than the rule. Without a certainty of employee participation at some high level, the success of the network effort would be necessarily limited. Employees, however, should be free to choose from an adequate panel of network doctors and free to change doctors, within the panel, with reasonable restrictions for multiple changes.
- *Networks should be state-certified, with certification encompassing the general areas of ensuring adequacy, credentialing of providers, provisions for internal dispute resolution (with appeal to an Independent Review Organization (IRO) or other independent body), use of evidence-based treatment guidelines, treatment planning and disability management processes, and other areas as necessary for networks to function well.* State regulation, where needed, should focus on those areas necessary to ensure appropriate network operations and to protect patients and network providers. The most appropriate place for these regulatory duties is likely the Department of Insurance, based on its existing regulation of group health networks.
- *Networks should not be required to accept "any willing provider," but should instead be held to adequacy standards that are part of the certification process.* An "any willing provider" system is likely to lead to broad networks that will be

focused on pricing discounts rather than meaningful utilization control and outcomes improvements. It would also do little to eliminate the distrust in the system that leads to frequent denials and disputes over medical payment.

- *Network performance should be measured by the state through a quality monitoring process conducted by the workers' compensation research function, with publicly-available "report cards" issued to compare network and non-network outcomes, and to compare the performance of different networks.* Data to accomplish such an effort is largely available today through information reported by insurance carriers to TWCC, with the addition of appropriate network identifiers and supplemented by surveys. Necessary enhancements should be made to ensure network bills and claims can be identified. Lessons from other states and from the history of workers' compensation in Texas emphasize the importance of meaningful follow-up analyses of network performance. This information will be vital to system participants and to policymakers in evaluating the results of the implementation of networks.
- *Networks should be free to negotiate reimbursement per service, services subject to utilization review, and other administrative provisions currently dictated by the* Labor Code *and TWCC rule.* Since part of the goal of network implementation is to reduce the adversarial nature of the current system, parties to the network contract should be free to negotiate price, medical review, and other administrative burdens. In the case of a medical dispute, however, access should continue to an external review mechanism such as the current Independent Review Organization (IRO) process (likely after an internal network dispute process). Networks should be structured to reduce the "hassles" and uncertainties for providers through methods such as guarantees of payment to providers prior to a notice that a claim is being denied for compensability, requiring review and consultation with a physician reviewer prior to denials of treatment or payment, and other methods.

Charge 1: Examine the status of the Health Care Network Advisory Committee's (HNAC) and the Texas Workers' Compensation Commission's implementation of the regional workers' compensation health care delivery networks outlined in Article 2 of HB 2600 (77th Legislature, 2001).

Background

House Bill 2600 (77th Legislature, 2001) did not change the general statutory provisions relating to employee choice of doctor, but the bill did introduce the concept of health care delivery networks in a structured, regulated approach, networks from which an injured employee would be bound to receive care under certain circumstances. As discussed previously, the use of networks and managed care has become common in other state workers' compensation systems over the last ten to fifteen years. At least 25 states have some statutorily-described network program in workers' compensation, although the extent to which the programs are utilized varies widely.[222]

The HNAC model was a result of lengthy negotiation and discussion by system stakeholders as part of the broader package of statutory changes to the workers' compensation system included in HB 2600. Since at that time little information was available on the potential use or effects of networks on the system, the bill called first for a feasibility study to "determine the feasibility of, develop, and evaluate" regional workers' compensation networks, and asked that the study also make recommendations on standards of care for such networks and for the evaluation of networks through report cards.[223] The bill also created the HNAC itself, a 14-member advisory body to TWCC comprised of the following, all appointed by the Governor (except for the TWCC Medical Advisor, who was designated by statute as the Chair of the HNAC):

- three employee representatives recommended by a statewide labor federation;
- three employer representatives;

[222] See *Comparison of State Workers' Compensation Managed Care Programs and Fee Schedules*, Texas Department of Insurance Workers' Compensation Research Group, testimony before Senate Select Interim Committee, April 29, 2004.
[223] See *Texas Labor Code* Section 408.0221(d).

- three ex officio (non-voting) insurance carrier representatives, with one member representing state agencies, one member representing the Texas Workers' Compensation Insurance Fund (now Texas Mutual Insurance Company), and one member representing a voluntary market carrier;
- three ex officio (non-voting) health care provider representatives;
- one ex officio (non-voting) independent actuarial expert; and
- the TWCC medical advisor.[224]

The HNAC model as described in HB 2600 was unusual among the state models for workers' compensation networks. It differed from most of the other state models in two basic ways:

1. *Employees were allowed great flexibility not to treat in-network and to opt out of the network, once in.* Specifically, employees could make a decision to enroll in the network or not to enroll at the time of hire or another pre-designated time. Then, even if the employee chose to enroll, an employee who was injured on the job could still opt out of the network within 14 days after the employee first received treatment from a network provider.[225] While some forms of employee "opt out" are allowed in some other states' network arrangements, the level of opt out envisioned for the HNAC is relatively permissive.[226]
2. *The state, through the HNAC and TWCC, were to enter into direct contracts with networks to provide care.*[227] In almost all other states that allow networks, the state's function is limited to certification and/or regulation, rather than direct contracting.[228]

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[224] See *Texas Labor Code* Section 408.0221(c).
[225] See *Texas Labor Code* Section 408.0222 (e). The specific "lock in" to the network would occur 14 days after first treatment *or* at the time the employee received enhanced income benefits based on network participation, whichever came first.
[226] According to information provided by TDI, eleven states with managed care programs allow some form of employee "opt out" of networks. However, four of these states are generally employer-choice of doctor states, anyway. Most of the others that allow opt out require either a pre-existing relationship with a physician or allow opt out after a designated period of time or visits. See *Comparison of State Workers' Compensation Managed Care Programs and Fee Schedules*, Texas Department of Insurance Workers' Compensation Research Group, testimony before Senate Select Interim Committee, April 29, 2004.
[227] See *Texas Labor Code* Section 408.0221(d).
[228] All but six of the 25 states examined require specific certification for workers' compensation managed care networks. See *Comparison of State Workers' Compensation Managed Care Programs and Fee*

While voluntary for employees, incentives were written into the HNAC legislation to encourage participation. One incentive shortened from 28 to 14 days the "retroactive period" for receiving income benefits; the other raised the cap on income benefits for workers participating to 150 percent rather than 100 percent of the State Average Weekly Wage (SAWW) for Temporary Income Benefits (TIBs).[229] Obviously, these benefit enhancements would only impact those injured workers who receive income benefits, and only directly impact certain subsets of those workers (i.e., those who miss more than two weeks of work, and those affected by the cap on TIBs (for fiscal year 2005, $539 a week)).

Other restrictions were also placed on any HNAC-contracted networks. Participation by insurance carriers was voluntary, and the only employers required to offer to their employees any HNAC-created networks were the agencies that provide workers' compensation coverage to state employees - the State Office of Risk Management (SORM), University of Texas System (UT), Texas A&M University System (Texas A&M), and Texas Department of Transportation (TxDOT).[230]

HB 2600 laid a general groundwork for standards to be applied to network care, stipulating that the state's standards for Preferred Provider Organizations (PPOs) should apply, but that the HNAC could also establish additional standards. Other important stipulations were also placed on any HNAC networks, including a requirement that they be "fee for service"-style networks (rather than pay "capitated", or set, fees to network providers regardless of treatment provided), and a requirement that networks offer "a full range of healthcare services" as considered feasible under the feasibility study.[231]

Schedules, Texas Department of Insurance Workers' Compensation Research Group, testimony before Senate Select Interim Committee, April 29, 2004.

[229] See *Texas Labor Code* Section 408.0222(m). Under Texas law (Labor Code Section 408.082(c), an injured employee can only collect income benefits for the first week of disability if the employee misses four weeks or more (a provision referred to as a "retroactive period" for income benefits). Workers participating in the HNAC would receive benefits for the first week after missing only two weeks.

[230] See *Texas Labor Code* Section 408.0222(a).

[231] See *Texas Labor Code* Section 408.0221(b).

These caveats, along with the newness of this type of network approach to the Texas system and the diverse interests represented on the HNAC, made the HNAC's challenge significant. Ambitious deadlines were also called for in the enabling legislation, including a requirement that, if networks were found feasible, TWCC enter into a contract with at least one regional network by December 31, 2002. The deadlines were designed to produce a network program that could be evaluated before the 2005 Legislative session, when, if improvements were not realized, broader changes might be considered.

Progress of the HNAC

The full HNAC met on five occasions between October 2001 and May 2002. A consultant (MedFX, LLC, in conjunction with Peterson Consulting) was hired to perform the statutorily-required feasibility study in June 2002, and presented its findings to the HNAC in final form in February 2003.

The study was encouraging in some respects for the prospect of viable medical networks in workers' compensation, but also contained significant caveats. The general conclusion of the consultants was that networks under the HNAC model were feasible on a limited basis. Further, the feasibility report recommended a phase-in of the HNAC network concept, with initial implementation among state employees in the Austin and Houston areas.[232] Included in this assessment of feasibility was an assumption that 40 percent of the state employees offered care in the HNAC network model would in fact opt-in and receive network care.[233] The feasibility consultant further estimated that a minimum of 15 to 20 percent participation among injured employees was essential for networks to be economically viable - in other words, for the cost of network implementation to be worth the potential savings.[234] These are a critical and somewhat speculative assumptions, in

[232] See *Final Report on the Feasibility of Regional Workers' Compensation Networks Operating in the State of Texas*, MedFX, LLC, February 2003, p. 14.
[233] See *Final Report on the Feasibility of Regional Workers' Compensation Networks Operating in the State of Texas*, MedFX, LLC, February 2003, p. 38.
[234] See *Final Report on the Feasibility of Regional Workers' Compensation Networks Operating in the State of Texas*, MedFX, LLC, February 2003, p. 40; also letter from MedFX, LLC to Ron Josselet, Executive Director, State Office of Risk Management, March 15, 2003.

large part because of the HNAC model's voluntary approach for employees, both before injury and for a designated period post-injury.

While these assumptions may be reasonable, it is critical to note, as did the feasibility consultant, that the true viability of these or any other networks would be determined in large part by the network "market" itself - in other words, the willingness of networks to step forward and offer services under the model presented. Through the feasibility consultant, HNAC offered a Request for Information (RFI) for potential network vendors to provide input on what services they would or could offer under the HNAC model. Response to the RFI was predictably poor, given that potential network vendors would likely be reluctant to release information that could compromise their position in a true Request for Proposal (RFP) setting.[235] Two responses were received to the RFI that answered the consultant's questions regarding network capabilities and readiness to participate in a network setting, neither of which was scored highly by the consultant. One respondent offered a network that did not appear to be comprehensive, as the HNAC model required; the other offered to develop a network but did not appear to have one in place.[236]

To receive more meaningful responses and advance the HNAC project, the consultants recommended issuance of an RFP, the first concrete step in contracting with a network vendor. Given the previous recommendations of the HNAC and consultant, the scope of this RFP would have been limited initially to state employees in the Austin-San Antonio and Houston areas, with some possibility for expansion to private employers in those areas.

In conjunction with accepting the consultant's findings - including the feasibility study and recommendations for networks standards and report card (i.e., network evaluation) measures - the HNAC in March 2003 adopted a set of recommended statutory changes to

[235] See *Final Report on the Feasibility of Regional Workers' Compensation Networks Operating in the State of Texas*, MedFX, LLC, February 2003, p. 46.
[236] See *Final Report on the Feasibility of Regional Workers' Compensation Networks Operating in the State of Texas*, MedFX, LLC, February 2003, p. 47.

enable its efforts to move forward. Among the changes recommended were authority for HNAC networks to use different medical fee and dispute resolution processes than the general workers' compensation system, and a designated state employee pilot program that would allow the HNAC model to be tested and evaluated prior to the 2005 Legislative session. Since a major purpose of the HNAC model was to evaluate whether areas of contention in the workers' compensation system - such as medical fee amounts and medical necessity disagreements - could be better addressed by payors, employers, employees, and providers in a network setting, the statutory changes recommended by the HNAC were particularly important to allow HNAC networks to be freed from the specific requirements of the *Labor Code* in these areas.

These proposed changes were eventually incorporated into legislation - House Bill 3589, by Representative Helen Giddings, and Senate Bill 1576, by Senator John Carona - but neither bill won approval. In terms of legislative attention, the bills were largely overshadowed by broader attempts to modify the workers' compensation system to control escalating medical costs.

Although legislative action was not taken, discussions based on the HNAC's recommendation for a state employee-based pilot program were held on several occasions in late 2003 between TWCC and HNAC representatives and the state workers' compensation entities - SORM, UT, Texas A&M, and TxDOT. In testimony before the Select Committee in February 2004, all four entities expressed that while they saw positive features in the HNAC model, the voluntary nature of the program for state employees would either mitigate or eliminate its advantages. SORM's testimony indicated that while the agency was willing to participate in any HNAC network that moved forward, it had concerns that the voluntary nature of the HNAC model would both limit interest from potential network vendors and would "substantially reduce the effectives of the pilot program, which in turn will substantially reduce the cost savings resulting from the program."[237] Similar concerns were raised by UT, Texas A&M, and TxDOT in those agencies' testimony.

[237] See SORM testimony before the Senate Select Interim Committee, February 26, 2004, pp. 26-27.

TWCC officials further testified before the Select Committee in February that it would be at least six months before the RFP recommended by the feasibility consultant could be issued. The TWCC Medical Advisor and HNAC Chair, Dr. William Nemeth, also stated during questioning at the February hearing that the voluntary nature of the program would limit its effectiveness, and savings realized would probably be very limited. TWCC reiterated this testimony before the House Committee on Business and Industry in August, stating that further implementation of any HNAC pilot program would be "delayed until an improved model of networks is evolved through the legislative process."[238]

Assuming another six months for response to an RFP and for contracting with a network - optimistic estimates, based on the historic pace of the HNAC project - implementation of even the phased-in HNAC model recommended by the consultant would be unlikely to occur until the middle of the 2005 Legislative session.

Pessimism about the HNAC project in testimony before the Select Committee was not universal. The three labor representatives on the HNAC testified in favor of allowing the project to continue, with one representative stating that even though workers tend to be skeptical of networks, issues with quality of care and insurance carrier review in the current system had become so onerous that another option would likely be welcomed.[239] Another labor representative testified that some workers, confronted with the prospect of denials of care and other uncertainties in workers' compensation medical treatment, chose to treat potentially work-related injuries in the group health system.[240] Another testified in favor of the concept of voluntary networks - such as the HNAC model - and in support of network models in Pennsylvania and Ohio.[241]

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[238] See testimony of the Texas Workers' Compensation Commission to the House Committee on Business and Industry, August 25, 2004.
[239] See testimony of Katherine D'Aunno Buchanan before Senate Select Interim Committee, February 26, 2004.
[240] See testimony of David Faith before the Senate Select Interim Committee, February 26, 2004.
[241] Ohio's network model involves contracts between the Ohio exclusive state fund (i.e., state-run workers' compensation insurance carrier) and various managed care plans. Pennsylvania's program requires employees to treat within a managed care-type doctor pool (of at least six doctors) until 90 days post-

Findings

Clearly, despite hard work and good faith on the part of individual members, the HNAC effort did not accomplish as much as was hoped or intended when HB 2600 was passed. System participants and policymakers were aware at that time that the workers' compensation system likely was headed for a comprehensive review in 2005, in conjunction with the Sunset Review of TWCC. HB 2600, in fact, moved TWCC's Sunset Review date to 2005, rather than 2007, as originally scheduled on the 12-year review cycle, to ensure that a prompt analysis of the implementation of the bill's mandates could occur. In the three years since the HNAC began its work, concerns about medical quality and cost in the system have escalated.

At this juncture, the issues facing the workers' compensation system have gone beyond what can be addressed by an HNAC pilot program that, if ever implemented, could only be evaluated in three to four years and would, by design, have limited affect. Further, the loose, voluntary employee-participation nature of the HNAC model, and the other constraints and caveats imposed by the statute, make the already challenging goal of implementation of networks even more questionable. Networks have great potential to both improve outcomes of care and reduce workers' compensation costs, an issue discussed much more fully in Charge 2, and the committee recommends a broader model of network care as described in the recommendations on that charge.

While the HNAC model did not produce results in terms of implementation of networks in the timeframe called for by statute, the work of the HNAC was not in vain. Several lessons have been learned, and information accumulated, that is valuable to the broader discussion of the use of networks discussed in Charge 2. For example:

- The HNAC's work produced a meaningful set of potential standards for network care, along with discussion of how accreditation of networks could be used;

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injury. See *Comparison of State Workers' Compensation Managed Care Programs and Fee Schedules*, Texas Department of Insurance Workers' Compensation Research Group, testimony before Senate Select Interim Committee, April 29, 2004. See also testimony of John Nash before the Senate Select Committee, February 26, 2004.

- The HNAC's work produced information on how network performance, and the performance of other system participants, could be measured and improved through the use of report cards; and
- Given that most of the concern about the feasibility of workers' compensation networks in Texas centered on the unique features of the HNAC model - such as the voluntary structure and direct state-contracting component - removing these features is likely to generate significant interest in the network market.

Charge 3: Study the impact of the Texas Workers' Compensation Commission's 2002 Medical Fee Guideline on access to quality medical care for injured workers and medical costs, including recommendations on whether the legislature should statutorily prescribe a methodology for calculating the workers' compensation conversion factor.

Background

Even in workers' compensation - where controversy about medical issues is common - the issue of setting prices for medical services through the adoption of medical fee guidelines is particularly difficult and adversarial. In workers' compensation in Texas, prices for medical services generally are set in one of two ways: by TWCC, in its adoption of fee guidelines; or by system participants themselves through agreement or through the medical dispute process, for those services for which TWCC's guidelines do not determine a price. In the latter case, reimbursement is required to be "fair and reasonable."[242]

Fee guidelines (also called fee schedules in many states) are one of the most common tools used in workers' compensation systems to control costs. As of 2001, 41 states and the District of Columbia used workers' compensation provider fee schedules; as recently as 1991, only 27 states did.[243] Texas first adopted a fee guideline in 1988.

Methods for setting reimbursement without fees schedules are often based on "usual and customary" provider charges, or payment of a percentage of billed charges. Neither non-fee schedule pricing method has shown particular success in containing costs. Some states also use standard or customary provider charges as the basis for setting the reimbursements in a fee schedule.[244] In most states, however, as in Texas, fee schedules serve two basic purposes: one, to act as a medical cost containment tool by ensuring reasonable pricing in accordance with standards set by statute and rule; and two, to limit

[242] Fair and reasonable reimbursement is required by *Texas Labor Code* Section 413.011 and the various TWCC rules that implement that statute.
[243] See *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002*, Workers' Compensation Research Institute, p. 22.
[244] Two examples include Idaho and Wisconsin. See *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002*, Workers' Compensation Research Institute.

the need for costly and inevitable disputes and litigation in areas where fees are not explicitly set.

In Texas, it is also important to keep in mind that the fee schedule acts as a *ceiling* on reimbursement rather than a *floor*. By TWCC rule, even for services covered by the fee schedule, providers are to be paid the lesser of the fee schedule amount, any negotiated amount, or their "usual and customary" charge.[245] Reimbursement above the fee schedule, by contrast, is not allowed.

Outside of simple association - the fact that states without fee schedules tend to pay higher fees - there is limited evidence about the effectiveness of fee schedules in controlling costs.[246] In addition, the true impact and success or failure of a fee schedule cannot be determined solely by its impact on cost-per-service. Other factors, particularly utilization of services, must also be considered, and all fee schedules must seek to balance effective cost control with access to high-quality care for injured workers. With these competing interests in mind, it is not difficult to see why fee schedules are so frequently contentious.

TWCC's Fee Guidelines and HB 2600

Prior to the passage of HB 2600, most medical services were priced under a TWCC professional services fee guideline that had been most recently revised in 1996, incorporated Current Procedural Terminology (CPT) codes in use at that time, and used the McGraw-Hill Relative Value for Physicians as its "Relative Value System". Relative Value Systems (RVS) are commonly used in workers' compensation and other health care system fee schedules, and are designed to set the value of medical procedures (in terms of reimbursement) based on the time and skill involved in performing the procedure and other factors. Many states also augment whatever relative value system is

[245] See Texas Workers' Compensation Commission Rule 134.202(d).
[246] See *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002*, Workers' Compensation Research Institute, p. 21.

used to set values with consideration of other factors, including data on actual provider charges.[247]

HB 2600 made a significant change in the methodology used by TWCC to adopt fee guidelines and set the accompanying fees. The bill required TWCC to adopt the billing, coding, and payment rules of the Medicare system, and incorporate Medicare's Resource-Based Relative Value System (RBRVS).[248] In doing so, Texas became one of 16 states to use the Medicare RBRVS in some form in setting provider fees.[249] HB 2600 limited TWCC's ability to modify the Medicare reimbursement structure to allow only "minimal modifications" as necessary for treating occupational injuries.[250]

However, HB 2600 did not specify the appropriate level for medical fees, but rather laid out the methodology for TWCC to use in adopting new fee guidelines.[251] Several factors were to be considered, including that guidelines:

- consider "economic indicators in health care";[252]
- must be "fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control";[253]
- must not "provide for payment of a fee in excess of the fee charged for similar treatment to an injured individual of an equivalent standard of living and paid of by that individual or by someone acting on that individual's behalf";[254]
- consider the "increased security of payment afforded by this subtitle."[255]

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[247] See *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002*, Workers' Compensation Research Institute, p. 22.
[248] See *Texas Labor Code* Section 413.011.
[249] See *Managed Care and Medical Cost Containment in Workers' Compensation: A National Inventory, 2001-2002*, Workers' Compensation Research Institute, p. 23. While many states use the Medicare RBRVS at least in some fashion, significant caveats are not uncommon. For example, 15 states also consider charge data from payors, and 14 use input from a committee or expert panel, among other considerations, in actually setting the fee amounts.
[250] See *Texas Labor Code* Section 413.011 (a).
[251] HB 2600 also required TWCC to "adopt the rules and fee guidelines under Section 413.011, Labor Code … not later than May 1, 2002."
[252] See *Texas Labor Code* Section 413.011(b), as added by HB 2600, 77th Legislature, 2001.
[253] See *Texas Labor Code* Section 413.011(d).
[254] See *Texas Labor Code* Section 413.011(d).
[255] See *Texas Labor Code* Section 413.011(d).

The latter three considerations pre-dated the change to a Medicare-based fee guideline. Most other states - by either statute, rule, or practice - also lay out considerations to be used in setting the pricing of services, commonly referred to as the basis for "conversion factors" to be applied to the relative value system to produce an actual payment amount.

While TWCC chose first to address the professional services fee guideline, the new requirements for Medicare-based guidelines applied to other TWCC fee guidelines, as well. These include facility fees for hospital inpatient and hospital outpatient settings, and facility fees for Ambulatory Surgery Centers (ASCs). Of the three facility settings, only hospital inpatient fees (which are reimbursed based on a per-diem payment) were subject to a TWCC fee schedule at the time HB 2600 was passed. Since then, TWCC has adopted a fee schedule for ASCs, setting reimbursement at 213.3 percent of the Medicare payment amount, effective September 1, 2004.[256] Other Medicare-based facility fee schedules (for hospital inpatient and outpatient services) are not yet in place.

The 2002 TWCC Fee Guideline process

TWCC first proposed a new HB 2600-based professional services fee guideline (the guideline that would set the pricing for most services provided by doctors and other health care providers) in June 2001. The guideline called for workers' compensation services to be paid at 125 percent of the amount paid by Medicare; at the time, this was believed, based on an analysis conducted for TWCC by a consultant (Milliman USA) to be a five percent reduction in the aggregate amount providers were receiving (estimated at 130 percent of Medicare).

Notable also was the fact that TWCC's proposal did not include the "payment policies" of the Medicare system, which contain guidance as to the appropriateness of treatments provided to Medicare patients. HB 2600 had required these policies to be adopted as part

[256] While the ASC fee guideline changes apply to facility fees rather than professional service fees, cuts in ASC reimbursement are felt by physicians directly, in the case of physician-owned ASCs. One large medical group providing both ASC and other workers' compensation medical care testified before the Sunset Advisory Commission in May 2004 that while it had continued participating in the workers' compensation system following the implementation of the 2002 TWCC Medical Fee Guideline, it may not continue to do so if the ASC guideline was implemented. In September 2004, this group announced it would no longer treat workers' compensation patients.

of the change to a Medicare methodology. In part because of its exclusion of the payment policies, TWCC abandoned the June 2001 proposal and instead proposed in December 2001 a fee guideline incorporating by reference all Medicare's payment policies, and setting a reimbursement rate of 120 percent of Medicare. Updated analysis of reimbursement rates to providers at the time suggested that Texas workers' compensation was paying about 140 percent of Medicare, so the aggregate cut proposed was now 20 percent.

After much debate and discussion, including significant concern voiced by health care providers that a cut in fees was not justified, TWCC in April 2002 adopted the new fee guideline and a slightly increased (from the December 2001 proposal) reimbursement rate of 125 percent of Medicare.

In response, the Texas Medical Association (TMA) and Texas AFL-CIO sued TWCC to block implementation of the new guideline, arguing that the conversion factor was not determined in a method consistent with the statute and would adversely impact injured workers' access to quality health care.[257] The Texas Association of Business (TAB) in turn intervened in the suit on behalf of TWCC. Implementation of the guideline was enjoined on August 21, 2002, just ten days before it was scheduled to take effect. TWCC subsequently readopted the Medical Fee Guideline in December 2002 with a supplemental preamble to the rule to provide a stronger explanation of how the required statutory factors were considered in arriving at the 125 percent rate.

After months of debate and a hearing on the issues with the new guideline in Travis County District Court, the court ruled in June 2003 in TWCC's favor - meaning that the 125 percent conversion rate was found to be compliant with the statutory requirements - and set an implementation date for the new guideline of August 1, 2003. A state appeals court later upheld this decision, and of August 16, 2004, the deadline to further appeal the

[257] See Texas Medical Association and Texas AFL-CIO v. Texas Workers' Compensation Commission, Cause No. GN2-02203, 250th District Court, 126th Judicial District, Travis County.

case to the Texas Supreme Court passed, effectively ending the litigation over the 2002 fee guideline.

Medical Cost and Utilization and the 2002 Medical Fee Guideline

As noted, medical fee guidelines and schedules are used in part as cost containment tools. In Texas, where higher than average medical costs per claim and higher utilization of medical services have been present for some time, measuring the impact of new guidelines and policies on costs is even more key.

During the debate and subsequent litigation over the fee guideline, many providers argued that the true "cost driver" in Texas workers' compensation was not the amount paid per procedure (the amount specifically controlled by the fee guideline), but the overall utilization of care. Research from WCRI and other entities bear out that in general, utilization is the culprit in higher medical costs per claim, rather than price per service. A 2004 WCRI analysis (based on claims from 2000 and 2001, measured at a set point in 2002, and based on the reimbursement set under the 1996 TWCC Fee Guideline), found that Texas' average price per medical service and average payment per medical visit were 27.2 percent and 12.5 percent lower than the median of the 12-state WCRI comparison, respectively. However, in all areas of the analysis driven by utilization of services (average services per claim, average visits per claim, and others) Texas was significantly higher than the median.[258]

TWCC in turn argued in defense of the guideline that while utilization was the primary driver of high costs in Texas, unreasonably high fees could drive high utilization by encouraging providers to overutilize highly-reimbursed procedures. Aligning the reimbursement structure of workers' compensation with that of Medicare, it was argued, would apply a more reasonable relative value to medical procedures.

[258] See *The Anatomy of Workers' Compensation Medical Costs and Utilization: Trends and Interstate Comparisons, 4th Edition*, Workers' Compensation Research Institute, 2004, p. 341. It is important to note that this WCRI analysis does not control for differences in the mix of services provided between the states; so if, for example, Texas had higher utilization of more low cost services, this could depress the overall average payment per service.

It is important to note that while the 2002 TWCC Medical Fee Guideline can be fairly described as a cut in provider fees in the aggregate, its impact on fees for particular procedures is quite disparate. For all types of office visits, for example - from the simplest kind of visit to the most complex - the 2002 fee guideline pays more than the 1996 fee guideline.[259] In the surgical area, however, the decrease in reimbursement was significant - payment was at least cut in half for all CPT codes relating to laminectomies (a common type of spinal surgery), for example, and decreased as well for other types of surgery.[260]

The differences in reimbursement under the "old" (1996) and "new" (2002) fee guideline can generally be described by looking at the impact on each of seven "service groups," or classifications, for medical services. For Evaluation and Management services (including services such as office visits) and Anesthesiology, reimbursement increased; in all other areas, reimbursement decreased, with the Surgery and the Medicine categories (the latter including some testing and measurement services and non-surgical specialty services) both decreasing about 35 percent, and Pathology decreasing about 58 percent. Table 19 shows TWCC estimates of the overall reimbursement differences that would result from the change to the Medicare-based, 125 percent conversion factor guideline for each service group.

[259] See testimony of the Texas Workers' Compensation Commission before the Senate Select Committee, April 29, 2004, p. 11.
[260] See testimony of the Texas Workers' Compensation Commission before the Senate Select Committee, April 29, 2004.

Table 19
Impact of Change from 1996 to 2002 TWCC Fee Guideline on Various Medical Service Groups

Service Group	Percentage Change
Evaluation and Management	+31.20%
Surgery	-35.11%
Radiology	-28.85%
Physical Medicine	-12.98%
Medicine	-35.40%
Pathology	-58.33%
Anesthesiology	+13.13%

Source: Texas Workers' Compensation Commission, Estimated Converstion Factors, Payments, and Impact, December 7, 2001.
Note: All estimates assume constant utilization of medical services.

Other estimates were also made of the potential aggregate savings under the new guideline. The National Council on Compensation Insurance (NCCI) initially estimated a 7.8 percent reduction in overall fees and a 2.3 percent reduction in *overall* workers' compensation benefit costs.[261] Both the NCCI and TWCC estimates of potential savings are hampered by the uncertain impact of changes in utilization on overall medical payments under a new guideline. Both estimates assumed in computing savings that utilization of services would remain constant, and this is speculative.

At the present time, more than a year after the implementation of the 2002 Medical Fee Guideline, assessing its impact on system costs remains difficult. As discussed further in the portion of this charge related to access to care, the implementation of the guideline occurred almost concurrently with a major change to the way doctors register with TWCC to provide care, and shortly after structural changes to the medical dispute resolution process and apparent changes in carrier patterns in reviewing claims and medical bills. Along with the other changes brought by HB 2600, all these factors greatly complicate the process of attributing broad system trends to any one policy change.

[261] Communication from Larry Hochstetler, National Council on Compensation Insurance (NCCI), August 2004.

That said, on the key measure of average medical cost per claim, no significant changes have occurred through the most recent period that can be measured (i.e., early portions of injury year 2003). As discussed previously in Charge 5, the average medical cost per workers' compensation claim rose significantly even through injury year 2002 - a portion of which included bills submitted and (presumably) paid under the new fee guideline. It is significant perhaps that for the early part of injury year 2003, average costs increased very little from injury year 2002, suggesting in the most preliminary sense that the average medical cost increase trend could be leveling off, but this is far from conclusive.

In addition to decreases in reimbursement per service, use of the Medicare-based payment policies could also have impacted medical costs through changes in utilization. The Medicare payment policies provide some guidance as to the appropriateness of medical procedures for a given condition, as well as what procedures should be reimbursed together for the same claim, for example, and a variety of other issues that relate to both utilization and payment. TWCC has clarified on several occasions that these payment policies, however, do not in and of themselves constitute limitations on workers' compensation *coverage*, and that the policies should not be used as the sole basis for denying a medical bill.[262] In addition, it appears that the trend toward increasing medical denials by carriers began in 2002, prior to the implementation of the new guideline, so while the fee guideline and accompanying payment policies may be providing additional rationale for some denials, they do not appear to have been the driver of a general pattern.

Access to Care and the 2002 Medical Fee Guideline

One of the primary concerns with any fee guideline is whether it provides adequate reimbursement to ensure access to high-quality medical care. The impact of the fee

[262] See testimony of the Texas Workers' Compensation Commission before the Senate Select Committee, April 29, 2004, p. 30. In addition, Senate Bill 1804 (78th Legislature, 2003) modified *Texas Labor Code* Section 413.031 to stipulate that Independent Review Organizations must consider the reimbursement policies and guidelines of TWCC (at present, the Medicare payment policies), if these policies are raised by a party to a medical dispute, and that IROs state the basis for diverging from the medical policies in their decisions.

guideline on medical costs is difficult to assess given other major system changes, and the impact of the guideline on access to care is even more so. On September 1, 2003 - only one month after the implementation of the new fee guideline - doctors in the system were required to have re-registered for the TWCC Approved Doctor List (ADL) in order to provide care to injured workers on a non-emergency basis.

It is important to keep in mind that even prior to the fee guideline and ADL registration changes, access to care in the Texas workers' compensation system may have been comparatively poor. This is suggested by a WCRI four-state comparison of access and other medical issues in Texas, California, Massachusetts and Pennsylvania conducted in 2002 and 2003.[263] A survey of workers in those four states found that Texas injured workers were the most likely to report "big problems" with access to desired medical services - 15 percent of workers in Texas reported encountering such problems, compared with 14 percent in California, 10 percent in Pennsylvania, and nine percent in Massachusetts.[264] Another interesting caveat to this finding is that Texas injured workers are free to choose their own doctors, while workers in California and Pennsylvania are bound by employer choice of doctor provisions for 30 and 90 days, respectively, and workers in Massachusetts must initially treat within a managed care program, if one is offered. In addition, recall that Texas injured workers on average receive significantly more medical services than injured workers in these states - and yet still reported *more* problems with access to desired medical care.

Clearly, there are fewer doctors treating workers' compensation patients in Texas as of mid-2004 than were treating prior to the implementation of the new fee guideline and registration requirements. This can be measured through the number of doctors on the TWCC ADL - more than 30,000 under the old list, about 16,800 as of June 30, 2004.[265] However, simply comparing these two numbers does little to answer the question about

[263] See *Outcomes for Injured Workers in California, Massachusetts, Pennsylvania, and Texas*, Workers' Compensation Research Institute, December 2003. Workers surveyed were injured in 1998 or 1999.
[264] See testimony of the Workers' Compensation Research Institute to the Senate Select Committee, March 25, 2004, page 31.
[265] See testimony of the Texas Workers' Compensation Commission before the Senate Select Committee, August 26, 2004.

whether access to care in the system is adequate. TWCC officials have contended on multiple occasions in testimony before the committee that access is adequate, and that there are "sufficient providers available in the system to initiate appropriate care and make any specialty referrals as needed."[266]

TWCC officials further testified to the Select Committee that the real access to care issue is not general but specific, and related to "very complicated chronic patients (not doing well, with little hope of recovery from chronic conditions) (who) comprise the overwhelming majority of the population having difficulty with placement."[267] TWCC has also used with relative frequency an exception process allowing a doctor not on the ADL to treat a specific claimant - often, perhaps, a longtime patient of that doctor, or a patient in a group health setting. TWCC reported that this case-by-case exception process has been approved in 1,594 cases as of August 31, 2004, and denied in 222 others.[268]

Other individuals and groups testifying before the Select Committee have expressed starkly different views about the state of access to care. The TMA testified that a 2004 survey of Texas physicians found that only 23 percent had no limits on taking new work-related injury patients, down from 46 percent two years prior.[269] Among orthopedic surgeons (along with other surgical specialties, among those most impacted by the fee guideline reduction), only 21 percent reported no limits in 2004, compared to 73 percent in 2002.

Interestingly, according to the TMA survey, the percentage of family practice doctors with no limits on new work-related injury cases also dropped to 23 percent in 2004 from 36 percent in 2002, even though reimbursement per service for these providers may have increased under the new guideline. This suggests that other factors in addition to the

[266] See testimony of the Texas Workers' Compensation Commission before the Senate Select Committee, April 29, 2004, p. 2.
[267] See testimony of the Texas Workers' Compensation Commission before the Senate Select Committee, April 29, 2004, p. 2.
[268] Communication from Dr. William Nemeth to Select Committee staff, August 31, 2004.
[269] See testimony of Texas Medical Association to the Senate Select Committee, April 29, 2004.

payment amounts under the fee guideline are likely playing key roles in doctors' decisions to participate or not participate in the system.

A survey by the Texas Orthopedic Association (TOA) also indicated that while the majority (72 percent) of orthopedic surgeons surveyed were registered for the new ADL, only 55 percent of these indicated they intended to see new patients.[270] In an interesting survey finding not directly related to the fee guideline issue, more than three-quarters of surgeons surveyed by TOA also indicated they were interested in treating employees of non-subscribers to the workers' compensation system - a market where employer control over medical care is much more pronounced than in workers' compensation.

In addition to examining the raw numbers of doctors registered for the ADL, TWCC further examined the registration trends among doctors who were more extensively involved in treating workers' compensation patients. Doctors who plan to treat more than 18 patients per year are required by TWCC to register for "Level 2" designation on the ADL. In testimony before the Select Committee in April 2004, TWCC indicated that in all areas of service, the number of doctors designated as ADL Level 2 was higher than the number that actually provided services to more than 18 workers in 2001 or 2002. Table 20 shows the overall numbers reported by TWCC as of April 15, 2004 for particular specialties thought to be in shorter supply; since more doctors have registered for the ADL since, the numbers in the ADL Level 2 column are now somewhat higher.

[270] See testimony of Texas Orthopedic Association to the Senate Select Committee, April 29, 2004.

Table 20
Comparison of MD Specialties - Doctors Previously Serving More Than 18 Patients and Those with ADL-2 Credential

Specialty	Served More than 18 Patients, 2001	Served More than 18 Patients, 2002	Approved as ADL Level 2
Neurology	178	179	228
Neurological Surgery	183	170	193
Occupational Medicine	59	58	82
Orthopedic Surgery	964	985	1,008
Physical Medicine/Rehab	178	186	279

Source: Texas Workers' Compensation Commission, Testimony before Select Committee, April 29, 2004.
Note: ADL counts as of April 15, 2004.

Of course, there is no guarantee that simply because a doctor registers for the ADL, he or she intends to see new workers' compensation patients - a key factor in assessing whether access to care remains adequate. The discussion about the number of doctors registered for the ADL, their expected level of participation in the system, and their intentions in terms of seeing new patients is an important one, but is by its nature subject to speculation on both sides of the access to care issue. Because the new fee guideline and new ADL requirements are both still quite recently implemented, it is only recently possible to examine actual data on practice patterns after August 1, 2003.

To do so, TWCC examined billing data for patients with dates of injury between Sept. 1, 2003 and July 9, 2004, to compare the number of doctors who are on the ADL and therefore eligible to provide treatment with the number of doctors who actually *billed* for new patients. Medical bills related to Designated Doctor exams, Required Medical Examinations, and evaluations of Maximum Medical Improvement and Impairment Rating were excluded, since they do not constitute treatment in the purest sense, as were medical services provided in an emergency room setting.

The results show that for MDs, chiropractors, and osteopaths - the three groups who provide the vast majority of care in the system - between 66 and 75 percent of doctors on

the ADL have billed for at least one new patient. While these percentages include only medical bills received by TWCC as of July 9, 2004, the percentages would only increase as more bills are submitted. See Table 21.

Table 21
Percentages of Doctors on ADL
who have Billed for Patients Injured
on or after September 1, 2003

	MD[271]	DC[272]	DO[273]	Total[274]
Number of doctors approved to provide treatment as of 6/30/04	12,248	3,141	908	16,765
Number of above who have billed for patients injured on or after 9/1/03 (as of 7/9/04)	8,219	2,067	683	11,158
% of doctors approved to provide treatment who have billed for these patients	67%	66%	75%	67%

Source: Texas Workers' Compensation Commission, testimony before the Senate Select Committee, August 26, 2004.
Notes: Medical billing data for Designated Doctor appointments, Required Medical Examinations, and MMI/IR exams are removed from the above. Medical services provided in an emergency room are also removed. TWCC billing information also indicates that 141 of the 241 podiatrists (59 percent) on the ADL as of June 30, 2004 had billed for at least one patient injured on or after Sept. 1, 2003, as had 48 of 137 optometrists (35 percent).

TWCC further examined the numbers of new patients seen by those doctors who had billed for new patients. These results are shown in Table 22. The distribution suggests that significant segments of the provider population who are seeing new patients are either seeing few new patients (almost a third of MDs and about 47 percent of chiropractors, for example, billed for less than three patients injured after Sept. 1, 2003), or seeing many (for example, 24 percent of MDs saw 21 or more patients). Iit is important to remember that, over time, the distribution will skew away from the smaller numbers of patients treated to the larger, as more patients are treated and more medical

[271] Medical Doctor.
[272] Doctor of Chiropractic.
[273] Doctor of Osteopathy.
[274] Totals include podiatrists and optometrists, also (see note under table).

bills submitted. The mean and median number of post-Sept. 1, 2003 patients treated for each doctor type (MD, chiropractor, DO) are also shown in Table 22.

Table 22
Distribution by Number of Claimants Treated
for Doctors Billing for Services Provided
to Claimants with Dates of Injury on or after 9/1/2003

Number of Claimants	MD[275]	DC[276]	DO[277]	Total[278]
1	14.0%	21.1%	11.7%	15.6%
2-5	29.4%	41.0%	20.9%	31.5%
6-10	16.4%	15.0%	15.1%	15.9%
11-20	15.5%	10.6%	16.0%	14.4%
21-30	7.6%	5.3%	9.3%	7.1%
More than 30	16.4%	6.3%	26.2%	14.8%
Mean # Treated	22.5	9.3	38.1	20.7
Median # Treated	7	4	12	6
Total Number of Doctors	8,219	2,067	683	11,518

Source: Texas Workers' Compensation Commission, Testimony to the Select Committee, August 26, 2004.

Both "sides" of the discussion about access to care could point to the results of billing by doctors for new patients as evidence to support their claims. The billing data, while preliminary, do suggest that a significant (although uncertain) number of primary doctors continue to see new workers' compensation patients. However, access to care is significantly more limited than it was prior to August-September 2003. As TWCC officials indicated in testimony before the Select Committee, this is particularly problematic for claimants with longstanding medical issues or those whose claims are in dispute in some fashion.[279] The reasons such claimants may have more difficulty finding a treating doctor in recent months likely have more to do with the prospect of denial of payment and controversy over claims than to the reimbursement amount *per se*.

[275] Medical Doctor.
[276] Doctor of Chiropractic.
[277] Doctor of Osteopathy.
[278] Totals include patients treated by 141 Doctors of Podiatric Medicine and 48 Doctors of Optometry.
[279] See testimony of the Texas Workers' Compensation Commission before the Senate Select Committee, April 29, 2004.

Conversely, reimbursement is more likely to be the main factor in doctors' non-participation in the system for specialty care, including surgery.

It is also important to consider access to care issues for individual communities rather than at the state level. Access to care problems would likely be felt most acutely in rural communities where access was already poor or minimal. To examine the impact of access issues in particular communities, TWCC conducted an unscientific phone survey of doctors on the ADL in one rural Texas town (population between 10,000 and 15,000). Of the five doctors in this town on the ADL who could be considered primary care providers (i.e., not providing specialty care such as anesthesiology only), four responded that they were still treating workers' compensation patients. Of those four, however, only one indicated he or she had "no limitations" on taking new workers' compensation patients; two did not take "older" claims (those more likely to confront denial and dispute issues); and one indicated he or she would review the medical records of a prospective new patient before deciding whether or not to treat.

While it is difficult and perhaps oversimplified to label access to care "adequate" or "inadequate," the current status of access in the system is clearly not ideal. Imagine, for example, the situation that confronts an individual injured worker, particularly one in a medium or small community in Texas with relatively few providers. If that injured worker either does not have a previous treating relationship with a doctor, or if that doctor is not on the ADL or not willing to seek an exception to treat, the worker is left to either rely on the assistance and advice of others (their employer, or TWCC) to find care, or to try and navigate a list of ADL doctors - at least one-third of whom do not appear to be taking new patients, although there is no easy means for the worker to determine this - without any meaningful information about provider quality. Contrast this potentially bewildering and counterproductive experience with what the worker would encounter in their group health plan, where providers would be much more readily available, and it becomes more clear why workers in Texas are often less satisfied with their care than workers in other states despite the theoretical ability to choose their own doctor.

Medical Fee Guideline provisions in other states

Charge 3 also asks the committee to consider whether the legislature should "statutorily prescribe a methodology for calculating the workers' compensation conversion factor." This suggests a methodology more specific than the one already laid out in statute - or one that actually sets the conversion factor in statute, as legislation filed in the 78th session attempted to do.[280]

Among the 41 states (and the District of Columbia) that use provider fee schedules, most provide a similar degree of specificity in statute to that provided in Texas, leaving the determination of specific conversion factors to state agency rule-making. Only two states - Hawaii and Maine - set specific reimbursement amounts by statute.[281] Most of the states that leave determination of conversion factors to agency rule-making, however, set parameters of varying specificity that the agency must consider, like those set in the Texas statute.

Findings and Recommendations

Of all the issues of concern that have emerged in workers' compensation in Texas during the last several years, the debate over provider fees is perhaps the most contentious. Discussion of the fee schedule quickly becomes entangled in issues of access to care and other topics of concern to all system stakeholders.

Simply put, many doctors believe that the reduction in fees in the 2002 TWCC Medical Fee Guideline was inappropriate and misguided; conversely, many employers and carriers believed that reducing fees was the only "certain" way to get a handle on system medical costs that were clearly out of control. Labor groups feared that cuts in provider fees would further limit what is already questionable access to high-quality workers' compensation medical care in Texas. All of these groups have valid concerns.

[280] See House Bill 3285, 78th Legislature, 2003.

[281] See testimony of the Texas Department of Insurance before the Senate Select Committee, citing WCRI's Inventory, 2001-2002. According to the WCRI report, only Maine (RBRVS with a conversion factor of $60) and Hawaii (Medicare plus 10 percent), set conversion factors in statute.

Unfortunately, the contentiousness over the 2002 fee guideline severely hampered cooperative efforts between TWCC and the stakeholder groups to confront what all groups had publicly acknowledged as the greatest problem facing workers' compensation medical care - high costs driven by high utilization, accompanied by poor outcomes.

The committee finds the following relating to Charge 3, and offers the following recommendations:

- First, all findings regarding the impact of the 2002 TWCC Medical Fee Guideline must be considered preliminary. The guideline has been in effect only since August 1, 2003, and conclusive data about its impact on access to care and medical costs and utilization is simply not available at the time of this analysis. The findings described here represent the best information available as of late 2004.
- For reasons partly related and partly unrelated to the 2002 fee guideline, access to care in the Texas workers' compensation system is less than desirable. Access to care is more limited today than it was prior to the implementation of the fee guideline on August 1, 2003, and the new ADL registration process one month later. Access problems are most acutely felt for specialty care that was already in short supply in workers' compensation, in rural areas where the same was true, and for patients with long-term, chronic conditions who are dealing with ongoing disputes about medical issues. For the latter group of patients, the fee schedule is at best a compounding factor in access to care problems - the prospect of denials of reimbursement for care and/or the questionable efficacy of further treatment are more primary factors.
- Based on available data as of late 2004, the 2002 fee guideline (implemented on August 1, 2003) appears to have had little impact on the average medical cost per claim in Texas.
- Charge 3 asks for consideration of whether the legislature should more specifically address the methodology by which fee schedules are developed. To ask the legislature to set the conversion factor would simply move the debate over reimbursement amounts from a regulatory setting to a legislative one. Very few

states choose the latter approach and it is difficult to see how it would produce a better outcome than leaving reimbursement *per se* to agency rule.

- However, the legislature could take steps to clarify the methodology by which fees are set. The statute could clarify that the underlying Resource Based Relative Value System (RBRVS) used by Medicare, rather than the Medicare rate, be used to set the workers' compensation payment amount. This would insulate Texas workers' compensation payments from changes in the Medicare conversion factor that may be driven entirely by federal budget issues.
- Elsewhere in this report (Charge 2), the committee recommends the establishment of workers' compensation networks in Texas. Within these network arrangements, providers and payors should be free to negotiate market-based reimbursement amounts similar to the process used for group health networks. The central issues at hand in Charge 3 relate to lowering costs, providing better access to care, and improving outcomes; networks have the potential to do all three.

Charge 6: Study the efficiency and effectiveness of the state's workers' compensation system, including a comparison of the medical and indemnity costs associated with the Texas A&M University System, the University of Texas System, the Texas Department of Transportation, and the State Office of Risk Management. Evaluate the potential costs and benefits associated with state agency participation in workers' compensation networks.

Background

The State of Texas self-insures to provide workers' compensation coverage to its employees. Coverage is provided through one of four state programs, administered by the following entities for the following approximate numbers of employees:

- The Texas A&M University System, providing care for Texas A&M University components and a few state agencies (about 54,000 employees, total);
- The University of Texas (UT) System, providing coverage for UT system components (about 88,735 employees);
- The Texas Department of Transportation (TxDOT), providing coverage for TxDOT's approximately 14,715 employees; and
- The State Office of Risk Management (SORM), which covers all other state employees (about 175,000 total).

Each program is required to follow the statutory requirements for workers' compensation as laid out in the *Labor Code*, and to comply with TWCC rules. However, as the committee's analysis found, the programs are allowed, and exercise, significant variation in claims handling and medical review processes.

There has been occasional legislative interest in whether administering workers' compensation coverage to state employees would be better done through a single program, and as a recently as 2001, legislation was filed to consolidate the four programs under SORM's jurisdiction.[282] Although Charge 6 does not ask for a specific recommendation on the merits of consolidating the four programs or keeping them

[282] See House Bill 1204, 77th Legislature, 2001.

separate, the findings do shed light on the differences between the programs in average costs for the medical and indemnity portions of claims and some of the factors that may be driving these differences.

On the other end of the spectrum in terms of centralization of the state's workers' compensation programs are arguments from some state agencies currently covered by SORM that these agencies should be excluded from the SORM program. Interest in this kind of decentralization grew concurrent with the implementation of a "risk-reward" formula for allocating the state's workers' compensation costs to each SORM-covered state agency, in order to make agencies more directly accountable for their workers' compensation losses.[283] Under this program and formulas implemented by SORM to adopt a "risk-reward" methodology, some agencies paid more in initial assessments for workers' compensation purposes than they had lost in total costs in recent years, and some of those agencies contended that they could pay less through purchasing commercial workers' compensation coverage, or being otherwise removed from SORM's system. A complete evaluation of the risk-reward program is not included in this charge, although initial indications that the program has helped to reduce overall state workers' compensation costs are discussed below.

The implications to the state of the success or failure of its workers' compensation programs in clear. First and foremost, the health and future productivity of state employees, who as a whole perform diverse and sometimes dangerous jobs, is at stake. Second, the cost of care and benefits paid to injured state employees is a direct cost to the state budget and to scarce state resources. The state should have the same goals for its own employees as for the workers' compensation system as a whole - the highest quality medical care at the lowest possible cost. To that end, Charge 6 also asks for an evaluation of what impact networks could have on state employees.

[283] See HB 2600 and HB 2976, 77th Legislative session, 2001.

General research on State employee outcomes

As part of a 2003 survey of injured employees in Texas, the ROC compared the outcomes experienced by state employees (specifically, those covered by SORM) with private sector employees.[284] Overall, a somewhat higher percentage of injured state employees (71 percent) were working, 21 to 33 months post-injury, than were private sector employees (66 percent). However, after controlling for whether the worker's employment status was due to the on-the-job injury (based on the worker's survey response), 26 percent of state workers indicated they were off work due to their injury, compared to 25 percent of private sector workers.[285]

Other findings of the survey indicated that state workers who were employed at the time of the survey were more likely to return to work *for the same employer* than were private sector workers (84 percent vs. 65 percent).[286] State workers also were more likely to report shorter durations of lost time from work than were private sector workers (37 percent of state workers missed less than one month, compared to 28 percent in the private sector). Among private sector workers 37 percent missed six months or more, compared to 24 percent of state workers.

While these findings are encouraging as to the performance of the state program, it should be pointed out that the private sector workforce is more varied, has much more uncertain access to non-occupational health care coverage, and likely faces more return-to-work challenges than does the state employee workforce. It is not possible to determine what percentage of the differences between the state and the private sector workforce reflect better performance by the state in returning injured employees to work

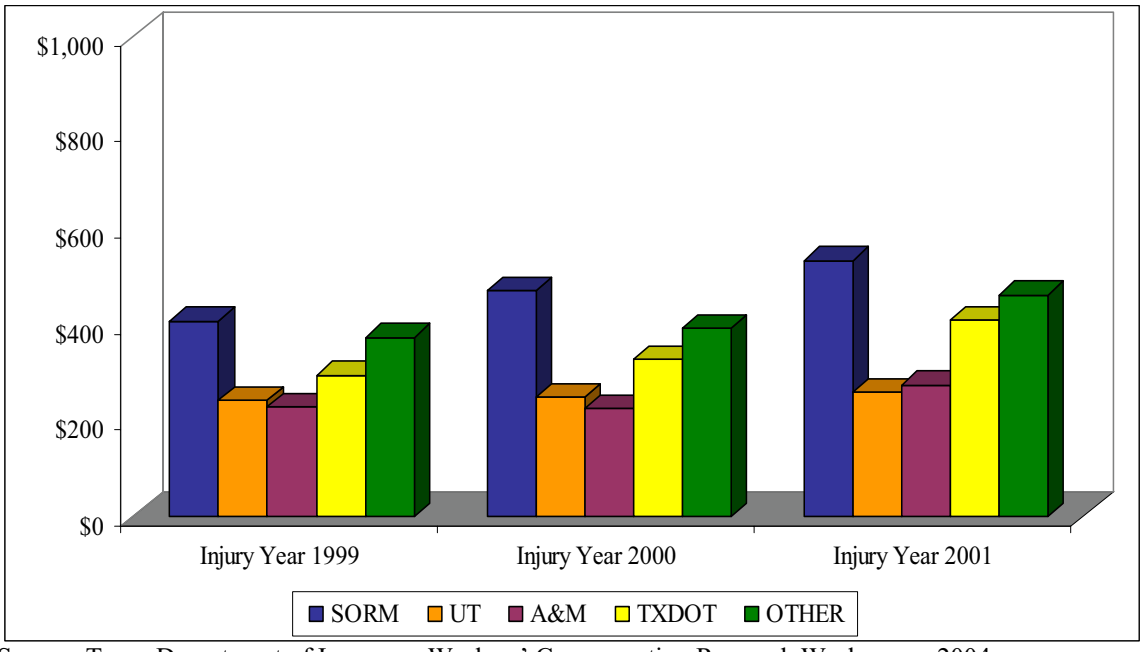
[284] See *Survey of Injured Workers Regarding Work-Related Health Problems: Comparison of State and Private Sector Worker Experiences*, Research and Oversight Council on Workers' Compensation, August 2003.
[285] See *Survey of Injured Workers Regarding Work-Related Health Problems: Comparison of State and Private Sector Worker Experiences*, Research and Oversight Council on Workers' Compensation, August 2003.
[286] See *Survey of Injured Workers Regarding Work-Related Health Problems: Comparison of State and Private Sector Worker Experiences*, Research and Oversight Council on Workers' Compensation, August 2003, p. 31.

and what percentage reflects what may be inherent advantages over the private sector in this area.

Comparison of State Programs - Medical costs

As other sections of this report have shown, the cost of medical care provided to injured employees in Texas has been a growing expense, is higher than that in many other states, and produces comparatively poor outcomes. The state programs as a whole appear to have been affected by the same general cost trends as the rest of the system, although notable differences in average medical costs by program exist. Figure 23 shows the median medical cost of a workers' compensation claim for each of the state programs for three injury years - 1999, 2000, and 2001 - including all costs paid within the first 12 months after injury. Median costs for each state program are shown along with the median for all other (i.e. non-state) public and private workers' compensation insurance carriers.

Figure 23
Median Medical Costs per Claim for State Workers' Compensation Programs, 1999-2001

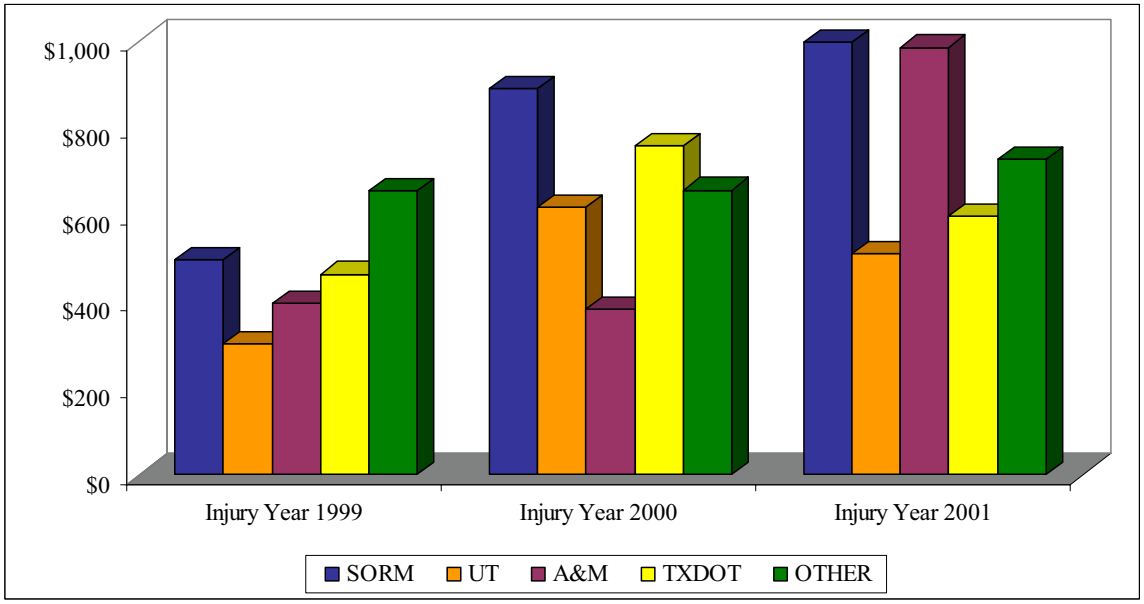


Source: Texas Department of Insurance Workers' Compensation Research Workgroup, 2004.
Note: "Other" represents all other private and public workers' compensation insurance carriers.

As part of its analysis, TDI's workers' compensation research group also examined the distribution of medical costs among the various types of common injuries (i.e., low back, knee, hand and wrist, etc.) to test for the possibility that some of the programs may have had a significantly different risk for more or less costly injuries than others. The results generally found that the mix of medical costs by injury type was similar for the four programs.

However, in order to further minimize the effects of differences in injury type and severity among the state programs, the analysis also examined the median medical cost for only low-back soft tissue injuries. Figure 24 shows the results.

Figure 24
Median Medical Costs per Claim for State Workers' Compensation Programs, Low Back Soft Tissue Injuries Only, 1999-2001



Source: Texas Department of Insurance Workers' Compensation Research Workgroup, 2004.
Note: "Other" represents all other private and public workers' compensation insurance carriers.

As both comparisons show, with the exception of 1999 low-back injuries, SORM's medical costs were significantly higher than the other state programs and the average for all other carriers in the workers' compensation system - even at a time when medical

costs in the system as whole were comparatively very high relative to those in other states.

One exception to SORM's general trend of higher medical costs was Texas A&M's 2001 average for low-back soft tissue injuries. Texas A&M officials suggested in testimony before the Select Committee that these results were the result of one particularly bad year of experience for this injury type. While follow-up analyses may be warranted to look for any long-term trends, it appears based on medical cost trends for Texas A&M for all injuries that the 2001 results are likely to be an aberration.

To further examine the driving factors behind SORM's higher medical costs, TDI's analysis examined utilization of medical services for claims for SORM and the other programs. Since utilization of services generally was known to be the primary driver of high medical costs per claim in Texas, higher utilization on SORM claims was expected to play a major role. The results were not surprising. For physical medicine services, for example, an area where high utilization is the norm systemwide, a higher percentage of SORM's claims (58 percent) had physical medicine services than claims for UT (46.4 percent), Texas A&M (49.4 percent), or TxDOT (28.6 percent).[287] In general, for those claims in which physical medicine services were paid, SORM and Texas A&M showed higher utilization of services.

Similar trends were found in diagnostic testing, where 58.4 percent of SORM's claims had services paid, compared to 49 percent of UT's, 42.5 percent of Texas A&M's, and 42.2 percent of TxDOT's. In this area, SORM and TxDOT appeared to have higher utilization of services in general, for those claims in which some diagnostic testing services were paid.

TDI workers' compensation research staff also examined the possibility that geographic differences in medical practice and utilization played an important role in the differences

[287] The percentages represent injury years 1999, 2000, and 2001, combined, measured an one year post-injury. See Texas Department of Insurance testimony before the Senate Select Committee, February 26, 2004.

observed between the state programs. To do so, the geographic distribution for each program's claims was compared to the areas of the state known from previous research to have the highest medical costs per claim. Based on this analysis, it appeared that UT would have the highest average medical costs, followed by TxDOT, SORM, and Texas A&M - suggesting that geographical differences were not the major driver of differences in medical costs.

What, then, did lead to SORM's significantly higher costs and utilization during the study period, compared to the other programs? Based on the agency's testimony before the Select Committee and a review of data, it appears that lax or entirely absent retrospective review of medical bills was a major factor. SORM officials testified in February 2004 to the Select Committee that the agency had historically made in-house management of the indemnity side of claims a greater priority, and relied on a contract with an outside vendor to review and pay medical bills appropriately.[288]

What cost containment did occur on the medical side involved little if any substantive review. For example, while SORM reported a $51.7 million savings to the state through medical cost containment in fiscal year 2003, more than 95 percent of these savings were due simply to reducing bills to the maximum amount allowed under the TWCC fee guidelines (the "Maximum Allowable Reimbursement," or MAR).[289]

In response to significantly increased awareness of poor cost control practices and scrutiny from this and other committees, SORM has attempted to improve review of claims and reduce claims costs. It is too early to tell from data analysis if these efforts have been successful and can be sustained in the long term, and whether potential decreases in average costs per claim reflect denials of inappropriate care. SORM has presented some early indicators that agency officials believe reflect improvements. First, SORM's *overall* (not average) costs for workers' compensation claims for fiscal year

[288] See testimony of the State Office of Risk Management before the Senate Select Committee, February 26, 2004.
[289] See testimony of the State Office of Risk Management before the Senate Select Committee, February 26, 2004.

2004 was significantly lower than in the preceding years. Much of the decrease appears to have been driven by a reduction in the number of claims; SORM reports that 1,000 fewer state employees (covered by SORM) were injured in 2003, and again in 2004, than were in 2002.[290] To a large extent, SORM attributes this to the success of the risk-reward agency allocation mechanism implemented by the 77th Legislature.[291] Table 23 shows the total estimated expenses of SORM for workers' compensation claims for fiscal years 2001 to 2004.

Table 23
Total Workers' Compensation Expenses, SORM claims,
Fiscal Years 2001-2004

Fiscal Year	Total expenses
2001	$65.6 million
2002	$67.5 million
2003	$69.9 million
2004	$55.9 millon

Source: State Office of Risk Management, communication with Select Committee, September 3, 2004.
Note: Reflects amounts paid during each fiscal year, not amounts paid for claims occurring in that fiscal year.

SORM also reports improvements in its own practices in managing claims. Chief among these is a new contract (effective Sept. 1, 2004) with cost containment vendors to improve scrutiny over medical bills and allow more flexibility for the agency in improving vendor performance.

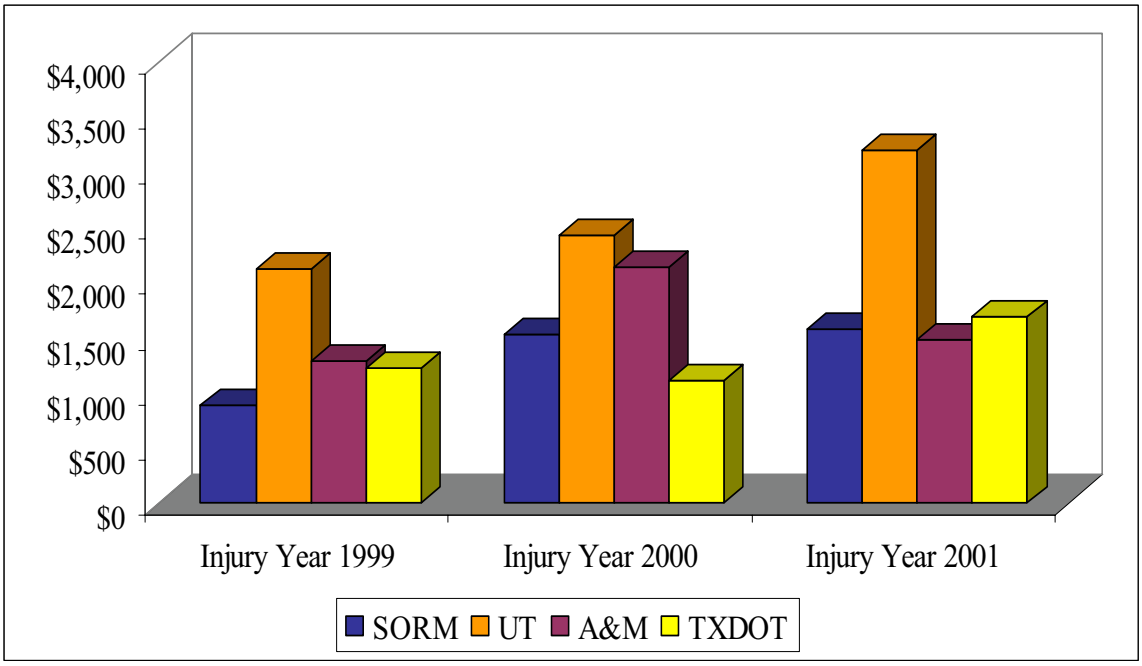
Comparison of State Programs - Indemnity Costs and Lost Time from Work

The analysis also examined indemnity benefit cost differences between the state programs. Since Temporary Income Benefits (TIBs) are the primary income benefit paid to injured workers who miss time, the study focused on comparisons in the average amount of TIBs paid for injuries occurring in 1999, 2000, and 2001. TIBs are also a useful proxy for analyzing return-to-work trends, since they are typically the primary

[290] See letter of SORM Executive Director Jonathan Bow to Select Committee, August 19, 2004.
[291] See letter of SORM Executive Director Jonathan Bow to Select Committee, August 19, 2004.

lost-time benefit for employees who qualify for indemnity benefits. Figure 25 shows the average TIBs cost differences between the four programs.

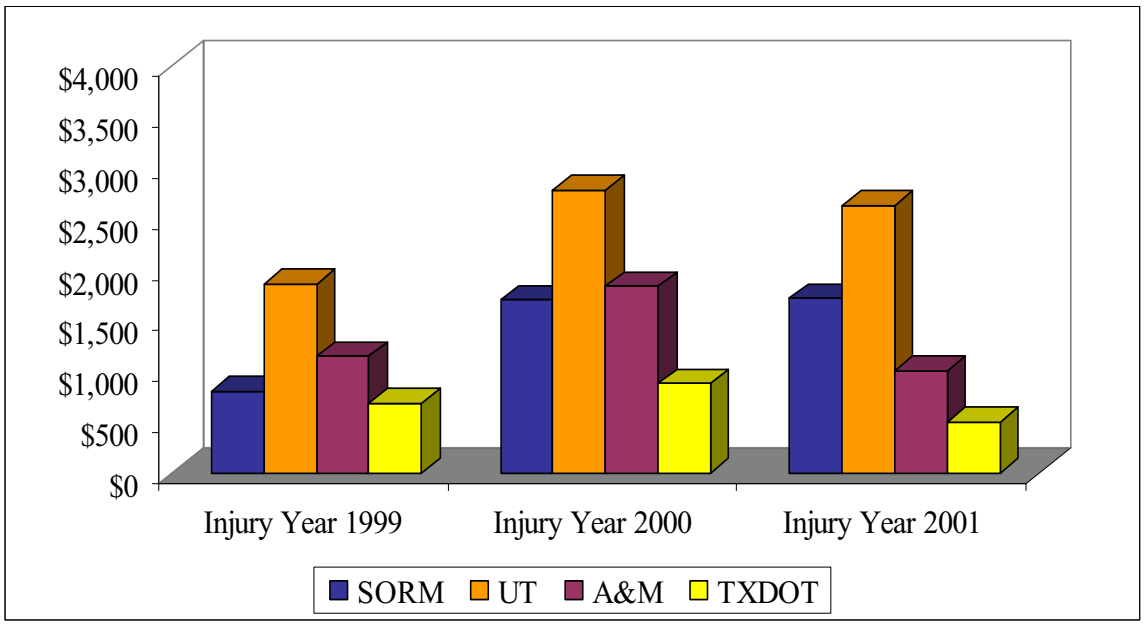
Figure 25
Average Amount of Temporary Income Benefits (TIBs)
Paid to Injured Employees Receiving TIBs,
State Workers' Compensation Programs,
Injury Years 1999 to 2001



Source: Texas Department of Insurance Workers' Compensation Research Workgroup, 2004.

Again, in an attempt to minimize differences in injury type and severity, average TIBs costs per claim for only low-back soft tissue injuries were also examined. Figure 26 shows these comparisons.

Figure 26
Average Amount of Temporary Income Benefits (TIBs)
Paid to Injured Employees Receiving TIBs,
State Workers' Compensation Programs,
Low Back Soft Tissue Injuries,
Injury Years 1999 to 2001

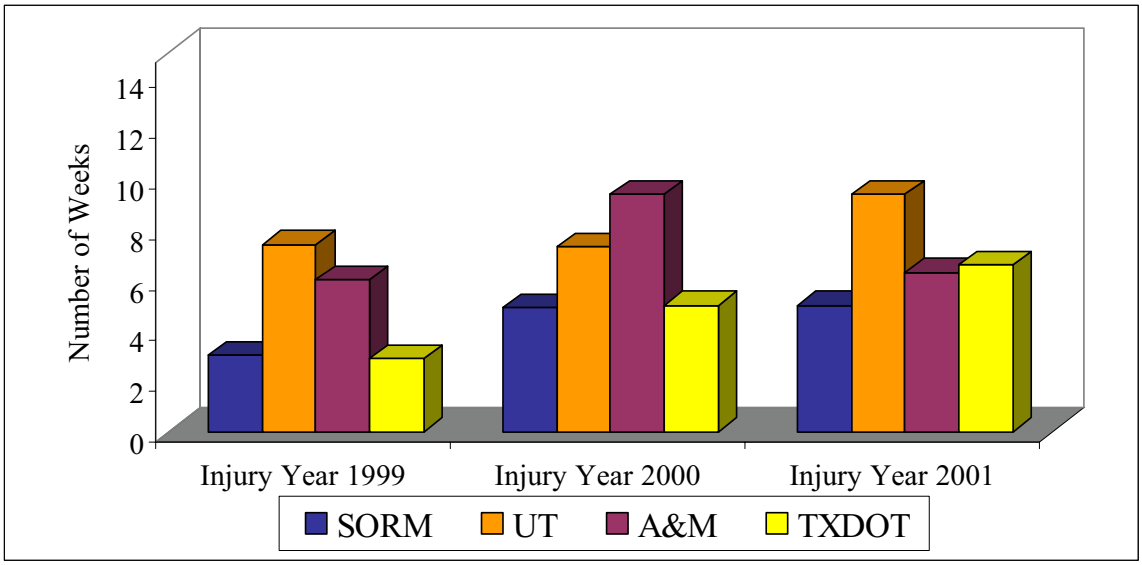


Source: Texas Department of Insurance Workers' Compensation Research Workgroup, 2004.

For both all injuries and low back soft tissue injuries, UT's average TIBs payments were higher than the other three programs. Total TIBs costs are a product of the duration of time lost from work and the injured employee's average weekly wage. It is possible, then, that the higher costs at UT stem from higher wages paid to UT employees. TDI's analysis showed that UT injured employees' salaries (calculated based on the average weekly rate paid for TIBs) were in fact the highest among the four programs in injury years 2000 and 2001, but were only slightly higher than the average TIBs rate of the second highest program ($13 per claim higher than SORM in 2000, and $5 higher per claim in 2001). Based on this analysis, it seems unlikely that higher average TIBs costs for UT were due in large part to wage differences.

To further explore possible causes, the duration of TIBs for the four state programs was also considered. Figure 27 shows the results.

Figure 27
Median Duration of Temporary Income Benefits (TIBs)
for Injured Employees Receiving TIBs,
State Workers' Compensation Programs,
Injury Years 1999 to 2001



Source: Texas Department of Insurance Workers' Compensation Research Workgroup, 2004.

In addition to the generally longer durations found for UT - suggesting again that longer durations of TIBs, rather than higher wages, are responsible for the differences in TIBs costs - it is also interesting to note that the median durations of TIBs generally grew for each program throughout the three years examined. Similar duration differences were found for low back soft tissue injuries.

There are, however, important caveats to the analysis of TIBs costs and durations for the four state programs. The TIBs comparison is complicated by the divergent practices among the four state programs regarding the use of sick and annual leave by injured state employees, and how this leave transitions to TIBs. All state employees may elect to use sick and annual leave (and therefore receive full salary) in lieu of receiving TIBs.[292] However, due to differences in the practices of the four programs, the consequences of

[292] See *Texas Labor Code* Sections 501.044 (for SORM), 502.041 (for Texas A&M), 503.041 (for UT), and 505.060 (for TxDOT).

this election vary depending on which workers' compensation program covers the agency for which that employee works. For employees covered by SORM (most state employees) and TxDOT, the decision to use sick leave in lieu of TIBs requires the employee to exhaust all sick leave before becoming eligible for TIBs. For employees covered by UT and Texas A&M, employees may elect to use sick leave or annual leave but are not required to *exhaust* sick leave prior to receiving TIBs.

To the extent injured state employees elect to use sick leave, the difference in the way this leave may be used could serve to lower the TIBs durations of SORM and TxDOT in comparison to UT and Texas A&M - and while the TIBs durations may be lower, they would not reflect all lost time due to injury. It should also be noted also that the statutory provision extending the requirement to exhaust sick leave to TxDOT employees only occurred in 2001, which means the provision would have very limited (if any) effect for TxDOT claims during the study period (1999-2001).

In fact, for all injuries, SORM did have lower TIBs duration medians through the study period, suggesting that the use of sick leave may have had some effect. When only similar injuries were considered - low-back soft tissue injuries - TxDOT showed the shortest TIBs durations, with SORM second in two of the three study years.

At the Select Committee's request, TDI research staff attempted to examine this issue further by reviewing data from each of the state programs on the use of sick and annual leave in lieu of TIBs. However, further examination proved impossible based on available data. Each of the four programs collects data on sick and annual leave usage in a different way, and the availability of the data for given years varied from program to program.

Potential Participation in Networks

As discussed in the section of this report devoted to Charge 1, the specific potential cost implications of state participation in a network system was estimated by the consultant examining the feasibility of the HNAC project. The consultant estimated that, for state

employees in the Austin/San Antonio and Houston areas, a mandatory employee-participation network would save the state about $8.3 million a year. If implemented for all state employees, the annual savings to the state were estimated at $19.2 million.[293]

State agency participation was a key consideration in the HNAC project. State agencies were the only entities required to participate in any networks created under the HNAC charge, and the feasibility study consultant recommended that state employees in Austin/San Antonio and Houston serve as the population for a pilot program to test the HNAC model. While all four state programs expressed varying degrees of concern about being required to participate in the HNAC network system, these concerns almost entirely centered on the very flexible employee opt-out provisions of the HNAC model, rather than the general concept of networks.

The advantages and challenges of a network system are discussed in detail in Charge 2 and, unless otherwise noted, these same considerations would apply to state agency participation in networks.

Findings and Recommendations

An examination of the state's four workers' compensation programs - SORM, UT, Texas A&M, and TxDOT - and their performance in serving the state and its employees was an overdue exercise. Particularly at a time when state government must be more cognizant than ever of the scarcity of its resources, a periodic evaluation of the state's unique system of covering its own employees is worthwhile. The analyses conducted under this charge should serve as baseline information against which to compare the programs in the future and assess improvements.

Administration of the state programs is a difficult balancing act for the agencies involved. While high claims costs are a major concern at present, particularly high average medical costs, lowering these costs alone is not a complete solution. State employees in general

[293] See letter of MedFX, LLC, Health Care Network Advisory Commission feasibility consultant to Ron Josselet, Executive Director, State Office of Risk Management, March 15, 2003.

are faced with some of the same poor claims outcomes as their counterparts in the private sector and other public employees. The state programs at present have many well-developed (if not well-functioning) tools to control costs, but comparatively few to improve outcomes.

The committee finds the following:

- There is no inherent logic behind the current four-program structure, aside from the fact that historically, UT, Texas A&M, and TxDOT have retained jurisdiction over their own programs, and the remainder of state agencies have been covered by another entity (SORM since 1997, the Attorney General's office and Texas Workers' Compensation Commission prior to 1997). That said, it is also difficult to argue at present that the UT, Texas A&M, and TxDOT programs, or the state as a whole, would be better served by placing them under SORM's or another overarching agency's jurisdiction. Each of the smaller programs seems to have devised its own unique processes for managing claims and encouraging return to work. Not surprisingly, the agency with the smallest and probably the least diverse workforce in terms of job duties, TxDOT, may have had the most success during the study period in combining more rapid return to work and comparatively reasonable medical costs. However, it would be extremely premature to suggest that self-administered and self-funded programs would work for all state agencies, or even all large state agencies.
- Of the four programs, SORM has clearly had the most difficulty in managing medical costs in recent years. SORM officials assert a combination of better in-house claim scrutiny, better performance by outside contractors, and improvements in covered state agency practices encouraged by the risk-reward assessment methodology will produce greatly improved results. It is clear the *overall* cost of workers' compensation claims for agencies covered by SORM will come in well under actuarial estimates for fiscal year 2004, and this is a promising development. However, the extent to which this reflects lasting, meaningful improvement by SORM in administering claims is uncertain and can only be assessed in time. Fortunately, the agency's scheduled Sunset Review in 2007

provides a good opportunity for meaningful follow-up once the immediate and short term effects of changes in agency policy are more clear.

- While the Select Committee was able to examine the medical cost issue in some detail, statutory differences between the programs and other factors related to the use of sick and annual leave by injured state employees made the indemnity comparisons preliminary, at best. While the University of Texas System seems to show longer durations of Temporary Income Benefits (TIBs) and larger payouts of TIBs, it is not clear whether this truly reflects more lost time by UT employees or simply less use of other leave in lieu of TIBs.

The committee recommends the following:

- To ensure that future analyses are able to compare the programs in terms of lost-time from work, and to provide uniform rules for state employees on the use of other leave in lieu of TIBs, the committee recommends that consistent policies be in place among the four programs regarding how sick and annual leave may be used by state employees. Further, it is imperative that the programs collect information on the use of sick and annual leave by covered injured employees in lieu of TIBs in a way that is both administratively useful in ensuring that more than the statutory maximum 104 weeks of TIBs are not paid, and also analytically useful for comparing the programs.
- In terms of the use of networks, the potential cost savings from applying such provisions to state employees are clear. The state programs should be required to participate in networks, where available, both to maximize savings to the state and "jump-start" network implementation.

Section III: Summary of Findings and Recommendations

This section of the report highlights the Select Committee's findings and recommendations on each of its charges.

Charge 5: Conduct a cost-benefit analysis, to the extent possible, comparing the Texas workers' compensation system to systems operating in other states. Make recommendations to improve the quality of care for injured workers, reduce fraud and inefficiencies, reduce overall claim costs, and streamline the administration of the system. Recommendations should address data exchange, advisory groups and review panels, dispute resolution, enforcement issues, paperwork reduction, and billing and administrative efficiencies.

Findings and Recommendations

Workers' compensation is an issue on which agreement between diverse stakeholder groups can be extremely difficult. Despite this fact, the current state of medical care in workers' compensation seems to have united stakeholders like none other, in one sense: every major stakeholder group - employers, employees, insurance carriers, and various types of providers - has expressed dissatisfaction with the current system.

The dissatisfaction focuses on different aspects of the system. Employers and carriers take issue with the continued relatively high medical cost of claims, while employees and providers tend to focus on an increasing percentage of claims in which medical care or bills are denied. All sides seem to have valid points, and all sides seem to agree that outcomes of care in the current system are far from optimal.

Because Charge 5 is very broad, the findings and recommendations offered for this charge blend with those offered on charges to be discussed later.

The committee finds the following:

- While no workers' compensation system can be complacent about workplace safety issues, Texas appears to do a comparatively good job of reducing on-the-job injuries. Injury rates have been consistently below the national average and

have helped to hold down overall (though not average) workers' compensation costs.

- The most recent findings regarding employer participation in Texas workers' compensation should be cause for concern about the health of the system, particularly its continued viability for employers. For the first time ever measured since the state began examining participation rates in the early 1990s, employer participation has decreased, from 65 percent in 2001 to 62 percent in 2004. The percentage of employees covered by workers' compensation policies in Texas (76 percent) is the lowest ever measured and is 8 percent lower than just three years ago.
- There is no meaningful, evidence-based standard of reasonable care for a work-related injury. Care is provided on what could be described as an "anything goes, but anything may get denied" basis that emphasizes back-end argument and dispute over front-end best practices. Partly as a result, average medical costs per claim are extremely high, outcomes are poor, and denials, disputes and controversy about the medical necessity of care are increasingly common. Carrier denials of medical bills have increased in attempts to reduce high medical costs and utilization; however, even if these attempts are successful in containing costs, they can do little to proactively improve the quality of care or to restore injured employees to function and work, and they create more friction and conflict in the system.
- Texas workers' compensation medical costs per claim, based on the most recent available data, remain far out of line with other comparable states, and have increased in each recent year. High costs are driven largely by high utilization rather than high prices per service.
- Dispute processes in Texas - both for medical and indemnity issues - struggle to provide rapid, definitive answers for participants with issues in controversy.
- Texas' system on the whole remains one of particularly poor value in comparison with others nationwide, combining high costs and poor outcomes. Numerous analyses show Texas workers are more likely to miss time from work than workers in other states, that those workers who do miss time are off work longer

than are workers in other states and are less likely to return to work, that workers do not recover as well, and are no more satisfied and, in some cases, less satisfied with the care they receive. The high cost and poor outcomes in the Texas system encourage employers to leave the system and hinder expansion of business and location of new business in Texas.

- Three and a half years after the passage of HB 2600, TWCC has accomplished little to broadly address medical quality and cost issues. In addition to the policy recommendations offered in this charge and others, improved performance and accountability from TWCC or whatever state agency is charged with administering the workers' compensation system will be vital to better outcomes.

Based on these findings, and in conjunction with findings and recommendations discussed for other charges, the committee recommends the following:

1. The Texas workers' compensation system should define medical necessity in a manner that encourages evidence-based treatment focused on return to work and function. Decisions about medical necessity ultimately revolve around how the statute defines necessity, and linking the definition more closely to the principles of evidence-based care and return to work and function would support medical practice that adheres to those principles.

2. To further enhance the day-to-day application of evidence-based care, TWCC should adopt treatment guidelines that meet the statutory standards and are evidence-based, to the greatest extent possible. To encourage appropriate return to work, such guidelines should be adopted in conjunction with return-to-work guidelines. Although the primary purpose of guidelines would be to improve front-end medical care in workers' compensation claims through education about best practices, these guidelines should also be used in reviewing claims, both prospectively and retrospectively. It is important, however, to recognize that guidelines are not absolute limits on coverage, and that they be challengeable through an accessible dispute resolution process. It is appropriate that the medical

dispute process consider the evidence-based guidelines adopted for the system for the care those guidelines address, although the dispute process should be allowed to overrule guideline recommendations in cases that are sufficiently persuasive.

Since a major purpose of guidelines is education, TWCC and other appropriate system stakeholders should take steps to more strongly emphasize education of employers and employees about the benefits of early return to work. Even more specifically, educational efforts could target low back injuries and produce information designed to educate employees about back complaints and how to manage back pain (both before and after any particular injury has occurred).

3. As noted in the discussion of Charge 2, the committee also recommends allowing workers' compensation networks. In keeping with the concept of allowing agreement between providers, networks, and carriers on issues that would otherwise be managed more closely by the state, within network arrangements it may be advisable to allow other treatment guidelines and treatment planning or disability management processes to be used, as long as these meet the general statutory standards. However, networks should still be monitored and held accountable for their performance in reducing disability and providing effective care, as discussed in Charge 2.

4. For care provided outside of networks, TWCC's role in medical management will remain more significant. While treatment guidelines and statutory standards provide good general guideposts and educational tools, a more intensive treatment planning process focused on specific claims that are or may become "outliers" seems to hold the most promise for settling disputes about appropriate medical care on a case-by-case, prospective basis. TWCC should continue discussion with stakeholders on how to implement such a treatment planning process designed to prospectively review problem claims *on a pilot program basis*, thereby reducing retrospective disputes and denials.

5. Most system stakeholders appear to favor a more rapid, efficient dispute resolution process. Sunset Commission staff devoted significant attention to dispute resolution improvements and made some reasonable suggestions for streamlining dispute processes. On the medical dispute side, one common suggestion is to eliminate the ability of a party to a medical dispute to appeal an IRO decision to the State Office of Administrative Hearings (SOAH), thereby eliminating a process in which a medical decision is reviewed by an authority without any particular medical expertise (a state Administrative Law Judge). On the indemnity dispute side, options exist to insert independent medical expertise into an evaluation of frequently-disputed issues such as the extent of an employee's injury, ability to work, and others, through a review by a TWCC designated doctor. If implemented, these changes should be accompanied by greater scrutiny and enforcement from TWCC on the quality of both IRO and designated doctor decisions, as outlined in the recommendation to follow.

6. While the implementation of networks will significantly reduce or eliminate TWCC's need to "police" the Approved Doctors List (ADL), the TWCC Medical Advisor and Medical Quality Review Panel (MQRP) functions should continue with a redirected focus. Important medical quality aspects in the system, including ensuring the quality of Designated Doctor and Independent Review Organization decisions, are appropriate functions for the expertise of the MQRP and are much more manageable than ADL enforcement. Important opportunities will also remain for Medical Advisor/MQRP intervention into specific cases with medical quality concerns in the non-network and perhaps in-network systems, as well. Further, TWCC should ensure greater accountability for its own decision makers at the hearing officer level and other levels, as data suggest significant variation in rulings between different commission field offices.

7. Enhancements should be made to income benefits in the Texas workers' compensation system to approach the national medians. Texas' retroactive period for income benefits is among the longest in the nation, and the cap on weekly

income benefits is in the bottom third nationally. The retroactive period should be shortened from 28 to 14 days. In addition, the cap on weekly income benefits should be raised to more closely approximate the national median state (currently Tennessee, at about $600 a week, compared to Texas' $539). In at least the case of shortening the retroactive period, to avoid increasing workers' compensation costs prior to savings from other reforms, the benefit enhancement should be tied to the expected implementation of networks and other provisions expected to lower overall system costs.

8. To encourage greater accountability, the committee recommends that the workers' compensation administrative agency operate under a single commissioner structure, with the commissioner appointed by the Governor with the advice and consent of the Senate.

9. Workers' compensation is a system with a myriad of rules and regulations designed to protect system stakeholders and ensure fairness. These rules and regulations are only as effective as their enforcement; unfortunately, ineffective enforcement is one of the main weaknesses of the current structure. As other system changes are implemented, state agency enforcement activities must be enhanced to better ensure appropriate incentives are in place for compliance.

10. The system should retain a workers' compensation research function, adequately staffed to complete a similar level of research projects to the former Research and Oversight Council (ROC). The most appropriate location for this function is likely TDI (its current location), although other options could be considered. In any case, the function, through the head of its agency, should propose and adopt an annual research agenda as did the ROC, with input from the public and stakeholders. In the next several years, much of the function's efforts should involve evaluation of the proposed new network care model and report card requirements, along with other legislative changes expected in the 79th session.

11. TWCC should take steps to implement electronic billing for health care providers, along the lines discussed earlier in this charge. TWCC should also continue efforts to eliminate administrative hassles and uncertainties for providers, consistent with implementation of a treatment planning process focused on "outlier" claims. However, it is important that the legislature and administrative agency not take decisive action to eliminate review of medical bills until the system can reasonably expect better up-front medical care - whether through a network system, use of treatment guidelines, a treatment planning process for out of network claims, or combinations of all these elements. While the denial of medical bills by insurance carriers is a legitimate complaint by providers and injured workers, and may or may not be in keeping with effective cost and quality control, simply requiring payment for questionable medical care with little or no review is no better an outcome for the system as a whole.

Charge 4: Survey the costs and benefits of other health system cost-containment strategies as they relate to medical, therapeutic, and pharmaceutical care, including but not limited to, doctor selection, deductibles, co-payments, preauthorization of services, and return-to-work programs.

Findings and Recommendations

In seeking ways to better control workers' compensation costs, it is appropriate to examine the successes and failures of other health care delivery systems, as well as those controls traditionally used in workers' compensation. The potential use of other health system cost-containment strategies can best be considered in conjunction with the general committee recommendations that a network medical care system be allowed (Charge 2) and that changes and improvements be made to the system in general to enhance its overall value (Charge 5).

The committee finds and recommends the following in regard to Charge 4:

- In the area of *doctor selection*, Charge 2 offers specific recommendations on how networks of providers could lower costs, improve outcomes, and improve accountability for quality medical care. Within the network panel, the injured

employee should retain the right to select his or her own treating doctor. Such an arrangement would more closely mirror doctor selection practices currently allowed in group health networks.

- While *deductibles and co-payments* could have some effect in controlling workers' compensation medical costs, their use on a significant enough scale to make a difference would represent a major departure from the longstanding full coverage of workers' compensation. There is better, more comprehensive evidence from other states to suggest that network care systems, coupled with the encouragement of evidence-based medicine, can better control costs and improve outcomes. Workers' compensation medical care should continue to be fully paid but should be provided in a network setting, where networks are available and where the employer elects to participate.
- *Preauthorization and retrospective review,* when used appropriately, can be important cost-containment tools. Their historical success in containing workers' compensation costs in Texas, however, has been limited, and they have added significant cost and administrative burdens to the system with uncertain returns. Within a network setting, negotiation should be allowed as to what services should or should not be preauthorized and otherwise reviewed, much the same as medical fees and other medical care delivery aspects can be negotiated. In addition, just as evidence-based treatment guidelines should be used in the front-end treatment of injuries, it is important that carriers and utilization review agents use evidence-based criteria in their decision-making about payment.
- Effective *return-to-work programs* have great potential to both improve outcomes and better control medical costs. While improved medical care should in and of itself improve return-to-work outcomes, employers, assisted by insurance carriers, also must play a key role in encouraging and supporting return to work. It will remain a greater challenge for some employers, particularly smaller employers, to return injured employees to the job. The Legislature should consider incentive programs, perhaps funded through administrative penalties collected by TWCC or another funding source, to encourage smaller employers to employ injured workers. The most logical approach would be a pilot program evaluated by the

workers' compensation research function and modified or expanded as indicated by the results.

- The Vocational Rehabilitation program administered by the Department of Assistive and Rehabilitative Services (DARS) plays a key role in returning injured workers to the workforce. With modifications to how injured workers are referred to the program, and improvement in how outcomes of referrals are measured, improved service to injured workers and improved outcomes are possible. Any statutory or rule barriers to effective communication between TWCC and DARS should be identified and eliminated, and the agencies should be required to further enhance their interaction and report on the results to the Legislature.

Charge 7: Study and make recommendations relating to the pricing of workers' compensation insurance premiums in Texas, including, but not limited to, the impact of rating tools such as schedule rating, negotiated experience modifiers, negotiated deductibles, and underwriting.

Findings and Recommendations

The committee finds the following in regard to Charge 7:

- The post-1991 system of workers' compensation pricing, while imperfect, represents an improvement over the promulgated rates and relative inflexibility in the previous period. In comparison with the promulgated rate system, the competitive pricing system offers employers more flexibility in finding coverage. While the state should not return to promulgating workers' compensation rates, improvements in the oversight of premiums charged to Texas employers could be beneficial in ensuring the competitive system works fairly.
- While TDI has clear authority it may exert to disapprove the rates charged by workers' compensation insurance carriers should those rates be deemed excessive, inadequate, or unfairly discriminatory, the agency has more limited oversight on the use of competitive pricing tools such as schedule rating, negotiated experience modifiers and deductibles, and underwriting.

Information about rates alone is insufficient to assess whether employers are paying a fair price for workers' compensation insurance.

- Due to a variety of factors both related and unrelated to workers' compensation insurance losses, the Texas workers' compensation insurance market in the last five years has undergone a period of extremes in pricing. Employers in the late 1990s enjoyed intense carrier competition in which coverage was likely underpriced; today, based on the most recent numbers related to carrier loss ratios and combined ratios, the opposite may be true. Since large deductible plans are excluded from these loss and combined ratio statistics, these statistics in large part represent the experience of small and medium-sized employers in Texas.

The committee recommends the following:

- The continuation of the trend of increasing premiums and decreasing losses in workers' compensation during the past two years - as the combined ratio has dropped well below 100 percent - is cause for concern. Employers have yet to share in the decreased losses in the system through lower premiums. As the state takes steps to enact meaningful reforms in a way that should lower long-term system costs and benefit all stakeholders, scrutiny on rates and premiums is important to ensure that cost savings are shared. TDI should be directed as part of the expected workers' compensation reform proposal to examine carriers' rate filings and pricing with special care to determine if savings are being passed on through lower premiums.
- The competitive pricing tools currently available in workers' compensation should continue to be allowed. However, more information about the use of these tools should be collected and examined by TDI. TDI's statutory mandate to ensure that workers' compensation rates are neither excessive, inadequate, nor unfairly discriminatory is much less meaningful if the agency has little to no oversight on the other factors that comprise a premium. To this end, the *Insurance Code* definition of "rate" should be amended to include consideration of variations applied to individual employers. This change

would provide clear authority to TDI to consider the impact of any competitive tools in assessing whether a carrier's rates are compliant with the law.

- Workers' compensation insurance carriers should be required to file their underwriting guidelines with TDI, as are carriers in some other lines. These guidelines should also be held to standards that they must be actuarially justified and not unfairly discriminatory.

Charge 2: Study the potential impact of networks on the workers' compensation health care delivery system. Include in the study:

- *Quality of care;*
- *Network adequacy and access to care;*
- *Disclosure of information to patients, complaint procedures, appeal rights and overall patient satisfaction;*
- *Costs of care;*
- *Provider credentialing, selection, and dispute resolution;*
- *Financial risks to providers, employers, and carriers;*
- *Effects of networks on the Texas Workers' Compensation Commission; and*
- *Quality monitoring systems such as independent report cards.*

Findings and Recommendations

A well-designed network program could improve the Texas workers' compensation system in many of the areas in which it currently performs most poorly. Such a program could reduce inappropriate utilization of care and lower costs while also improving outcomes, minimizing disputes, and reducing the role of TWCC in micromanaging the system.

The change from the current system of provider selection in Texas to a network system would be regarded as significant by almost all stakeholders. While this perception is valid, it is also vital to remember how poorly the current Texas system, with the TWCC Approved Doctors List (ADL) serving as a "network," has functioned in meeting the basic goals of a network system discussed in the opening to this charge. Costs are very high; overall quality of care, if judged by outcomes, is poor. Network adequacy is questionable and increasingly uncertain. Front-end information about provider or

network quality is absent. As for appropriate provider credentialing and selection, the ADL has only recently incorporated any training requirements or attempts to ensure quality, and the system remains essentially "any willing provider," with the exception of a relatively few providers TWCC has specifically excluded.

The Texas workers' compensation system already has a "network" in place - and it has failed to meet the goals of quality, cost-effective care.

While there is no "magic model" that would guarantee these outcomes, several basic features of a new network system emerge as key:

- *Networks should be allowed to contract with carriers or self-insured employers, and if a network contract is in place, injured employees should have an appropriate network panel of doctors from which to choose.* While requiring care to be provided within a network setting is a change from a broader employee-choice system, it is important to remember that an employee's true "choice" of doctor has already been limited significantly as access to care has contracted and fewer providers accept new workers' compensation patients (as the section of this report evaluating Charge 3 details). Networks can offer more certain access to higher-quality care with an assurance of adequacy of the provider pool. Under certain very specific, well-justified situations such as emergency care or necessary care not available in network, non-network care could be allowed, but this should be the rare exception rather than the rule. Without a certainty of employee participation at some high level, the success of the network effort would be necessarily limited. Employees, however, should be free to choose from an adequate panel of network doctors and free to change doctors, within the panel, with reasonable restrictions for multiple changes.
- *Networks should be state-certified, with certification encompassing the general areas of ensuring adequacy, credentialing of providers, provisions for internal dispute resolution (with appeal to an Independent Review Organization (IRO) or other independent body), use of evidence-based treatment guidelines, treatment planning and disability management processes, and other areas as necessary for*

networks to function well. State regulation, where needed, should focus on those areas necessary to ensure appropriate network operations and to protect patients and network providers. The most appropriate place for these regulatory duties is likely the Department of Insurance, based on its existing regulation of group health networks.

- *Networks should not be required to accept "any willing provider," but should instead be held to adequacy standards that are part of the certification process.* An "any willing provider" system is likely to lead to broad networks that will be focused on pricing discounts rather than meaningful utilization control and outcomes improvements. It would also do little to eliminate the distrust in the system that leads to frequent denials and disputes over medical payment.
- *Network performance should be measured by the state through a quality monitoring process conducted by the workers' compensation research function, with publicly-available "report cards" issued to compare network and non-network outcomes, and to compare the performance of different networks.* Data to accomplish such an effort is largely available today through information reported by insurance carriers to TWCC, with the addition of appropriate network identifiers and supplemented by surveys. Necessary enhancements should be made to ensure network bills and claims can be identified. Lessons from other states and from the history of workers' compensation in Texas emphasize the importance of meaningful follow-up analyses of network performance. This information will be vital to system participants and to policymakers in evaluating the results of the implementation of networks.
- *Networks should be free to negotiate reimbursement per service, services subject to utilization review, and other administrative provisions currently dictated by the* Labor Code *and TWCC rule.* Since part of the goal of network implementation is to reduce the adversarial nature of the current system, parties to the network contract should be free to negotiate price, medical review, and other administrative burdens. In the case of a medical dispute, however, access should continue to an external review mechanism such as the current Independent Review Organization (IRO) process (likely after an internal network dispute

process). Networks should be structured to reduce the "hassles" and uncertainties for providers through methods such as guarantees of payment to providers prior to a notice that a claim is being denied for compensability, requiring review and consultation with a physician reviewer prior to denials of treatment or payment, and other methods.

Charge 1: Examine the status of the Health Care Network Advisory Committee's (HNAC) and the Texas Workers' Compensation Commission's implementation of the regional workers' compensation health care delivery networks outlined in Article 2 of HB 2600 (77th Legislature, 2001).

Findings

Clearly, despite hard work and good faith on the part of individual members, the HNAC effort did not accomplish as much as was hoped or intended when HB 2600 was passed. System participants and policymakers were aware at that time that the workers' compensation system likely was headed for a comprehensive review in 2005, in conjunction with the Sunset Review of TWCC. HB 2600, in fact, moved TWCC's Sunset Review date to 2005, rather than 2007, as originally scheduled on the 12-year review cycle, to ensure that a prompt analysis of the implementation of the bill's mandates could occur. In the three years since the HNAC began its work, concerns about medical quality and cost in the system have escalated.

At this juncture, the issues facing the workers' compensation system have gone beyond what can be addressed by an HNAC pilot program that, if ever implemented, could only be evaluated in three to four years and would, by design, have limited affect. Further, the loose, voluntary employee-participation nature of the HNAC model, and the other constraints and caveats imposed by the statute, make the already challenging goal of implementation of networks even more questionable. Networks have great potential to both improve outcomes of care and reduce workers' compensation costs, an issue discussed much more fully in Charge 2, and the committee recommends a broader model of network care as described in the recommendations on that charge.

While the HNAC model did not produce results in terms of implementation of networks in the timeframe called for by statute, the work of the HNAC was not in vain. Several lessons have been learned, and information accumulated, that is valuable to the broader discussion of the use of networks discussed in Charge 2. For example:

- The HNAC's work produced a meaningful set of potential standards for network care, along with discussion of how accreditation of networks could be used;
- The HNAC's work produced information on how network performance, and the performance of other system participants, could be measured and improved through the use of report cards; and
- Given that most of the concern about the feasibility of workers' compensation networks in Texas centered on the unique features of the HNAC model - such as the voluntary structure and direct state-contracting component - removing these features is likely to generate significant interest in the network market.

Charge 3: Study the impact of the Texas Workers' Compensation Commission's 2002 Medical Fee Guideline on access to quality medical care for injured workers and medical costs, including recommendations on whether the legislature should statutorily prescribe a methodology for calculating the workers' compensation conversion factor.

Findings and Recommendations

Of all the issues of concern that have emerged in workers' compensation in Texas during the last several years, the debate over provider fees is perhaps the most contentious. Discussion of the fee schedule quickly becomes entangled in issues of access to care and other topics of concern to all system stakeholders.

Simply put, many doctors believe that the reduction in fees in the 2002 TWCC Medical Fee Guideline was inappropriate and misguided; conversely, many employers and carriers believed that reducing fees was the only "certain" way to get a handle on system medical costs that were clearly out of control. Labor groups feared that cuts in provider fees would further limit what is already questionable access to high-quality workers' compensation medical care in Texas. All of these groups have valid concerns.

Unfortunately, the contentiousness over the 2002 fee guideline severely hampered cooperative efforts between TWCC and the stakeholder groups to confront what all groups had publicly acknowledged as the greatest problem facing workers' compensation medical care - high costs driven by high utilization, accompanied by poor outcomes.

The committee finds the following relating to Charge 3, and offers the following recommendations:

- First, all findings regarding the impact of the 2002 TWCC Medical Fee Guideline must be considered preliminary. The guideline has been in effect only since August 1, 2003, and conclusive data about its impact on access to care and medical costs and utilization is simply not available at the time of this analysis. The findings described here represent the best information available as of late 2004.
- For reasons partly related and partly unrelated to the 2002 fee guideline, access to care in the Texas workers' compensation system is less than desirable. Access to care is more limited today than it was prior to the implementation of the fee guideline on August 1, 2003, and the new ADL registration process one month later. Access problems are most acutely felt for specialty care that was already in short supply in workers' compensation, in rural areas where the same was true, and for patients with long-term, chronic conditions who are dealing with ongoing disputes about medical issues. For the latter group of patients, the fee schedule is at best a compounding factor in access to care problems - the prospect of denials of reimbursement for care and/or the questionable efficacy of further treatment are more primary factors.
- Based on available data as of late 2004, the 2002 fee guideline (implemented on August 1, 2003) appears to have had little impact on the average medical cost per claim in Texas.
- Charge 3 asks for consideration of whether the legislature should more specifically address the methodology by which fee schedules are developed. To ask the legislature to set the conversion factor would simply move the debate over

reimbursement amounts from a regulatory setting to a legislative one. Very few states choose the latter approach and it is difficult to see how it would produce a better outcome than leaving reimbursement *per se* to agency rule.

- However, the legislature could take steps to clarify the methodology by which fees are set. The statute could clarify that the underlying Resource Based Relative Value System (RBRVS) used by Medicare, rather than the Medicare rate, be used to set the workers' compensation payment amount. This would insulate Texas workers' compensation payments from changes in the Medicare conversion factor that may be driven entirely by federal budget issues.
- Elsewhere in this report (Charge 2), the committee recommends the establishment of workers' compensation networks in Texas. Within these network arrangements, providers and payors should be free to negotiate market-based reimbursement amounts similar to the process used for group health networks. The central issues at hand in Charge 3 relate to lowering costs, providing better access to care, and improving outcomes; networks have the potential to do all three.

Charge 6: Study the efficiency and effectiveness of the state's workers' compensation system, including a comparison of the medical and indemnity costs associated with the Texas A&M University system, the University of Texas system, the Texas Department of Transportation, and the State Office of Risk Management. Evaluate the potential costs and benefits associated with state agency participation in workers' compensation networks.

Findings and Recommendations

An examination of the state's four workers' compensation programs - SORM, UT, Texas A&M, and TxDOT - and their performance in serving the state and its employees was an overdue exercise. Particularly at a time when state government must be more cognizant than ever of the scarcity of its resources, a periodic evaluation of the state's unique system of covering its own employees is worthwhile. The analyses conducted under this charge should serve as baseline information against which to compare the programs in the future and assess improvements.

Administration of the state programs is a difficult balancing act for the agencies involved. While high claims costs are a major concern at present, particularly high average medical costs, lowering these costs alone is not a complete solution. State employees in general are faced with some of the same poor claims outcomes as their counterparts in the private sector and other public employees. The state programs at present have many well-developed (if not well-functioning) tools to control costs, but comparatively few to improve outcomes.

The committee finds the following:

- There is no inherent logic behind the current four-program structure, aside from the fact that historically, UT, Texas A&M, and TxDOT have retained jurisdiction over their own programs, and the remainder of state agencies have been covered by another entity (SORM since 1997, the Attorney General's office and Texas Workers' Compensation Commission prior to 1997). That said, it is also difficult to argue at present that the UT, Texas A&M, and TxDOT programs, or the state as a whole, would be better served by placing them under SORM's or another overarching agency's jurisdiction. Each of the smaller programs seems to have devised its own unique processes for managing claims and encouraging return to work. Not surprisingly, the agency with the smallest and probably the least diverse workforce in terms of job duties, TxDOT, may have had the most success during the study period in combining more rapid return to work and comparatively reasonable medical costs. However, it would be extremely premature to suggest that self-administered and self-funded programs would work for all state agencies, or even all large state agencies.
- Of the four programs, SORM has clearly had the most difficulty in managing medical costs in recent years. SORM officials assert a combination of better in-house claim scrutiny, better performance by outside contractors, and improvements in covered state agency practices encouraged by the risk-reward assessment methodology will produce greatly improved results. It is clear the *overall* cost of workers' compensation claims for agencies covered by SORM will come in well under actuarial estimates for fiscal year 2004, and this is a promising

development. However, the extent to which this reflects lasting, meaningful improvement by SORM in administering claims is uncertain and can only be assessed in time. Fortunately, the agency's scheduled Sunset Review in 2007 provides a good opportunity for meaningful follow-up once the immediate and short term effects of changes in agency policy are more clear.

- While the Select Committee was able to examine the medical cost issue in some detail, statutory differences between the programs and other factors related to the use of sick and annual leave by injured state employees made the indemnity comparisons preliminary, at best. While the University of Texas System seems to show longer durations of Temporary Income Benefits (TIBs) and larger payouts of TIBs, it is not clear whether this truly reflects more lost time by UT employees or simply less use of other leave in lieu of TIBs.

The committee recommends the following:

- To ensure that future analyses are able to compare the programs in terms of lost-time from work, and to provide uniform rules for state employees on the use of other leave in lieu of TIBs, the committee recommends that consistent policies be in place among the four programs regarding how sick and annual leave may be used by state employees. Further, it is imperative that the programs collect information on the use of sick and annual leave by covered injured employees in lieu of TIBs in a way that is both administratively useful in ensuring that more than the statutory maximum 104 weeks of TIBs are not paid, and also analytically useful for comparing the programs.
- In terms of the use of networks, the potential cost savings from applying such provisions to state employees are clear. The state programs should be required to participate in networks, where available, both to maximize savings to the state and "jump-start" network implementation.

Appendix A

The Senate of The State of Texas

Senator Royce West
District 23

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November 30, 2004

The Honorable Todd Staples
State Senator
Capitol Building
Room E1.808
Austin, Texas 78701

Dear Senator Staples:

I would like to express my thanks to you and your committee staff for your hard work on the Select Interim Committee on Workers' Compensation and its interim report. Although I agree in principal with many of the Committee's recommendations, I must express my disagreement with one of its recommendations in particular.

Regarding Recommendation #8, under Charge 5, I cannot agree with the Committee's recommendation to restructure the Workers' Compensation Commission into a single commissioner agency. Although some change in the structure may be necessary, I cannot agree to eliminating the current structure simply in the hope of accommodating a *significant interest in creating more direct accountability through a "single commissioner" structure.*

Although I recall some testimony and discussion about the slowness of the process at TWCC, I do not remember hearing significant testimony or evidence that the structure at TWCC caused a significant problem with the accountability of the system.

If, as the report suggests, structural change is needed, I believe that a three member structure, consisting of one member representing employers, one member representing employees, and one public member, will provide a more streamlined process while ensuring input from all the stakeholder in the workers' compensation system. Additionally, if accountability is a goal, this structure will provide accountability to those with the most interest in the system, employers, employees, and the public.

Again, I thank you for your hard work in addressing this difficult issue and look forward to continuing working with you through the process.

Sincerely,

Royce West

RW/cc

cc: The Honorable David Dewhurst, Lieutenant Governor
Members, Select Interim Committee on Workers' Compensation

Appendix B

Frank Madla
Texas State Senate
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November 30, 2004

The Honorable Todd Staples
Chair, Senate Interim Committee on Workers' Compensation
P.O. Box 12068
Austin, TX 78711

Dear Chairman Staples:

The hard work and dedication you and your staff contributed to the Senate Select Committee on Workers' Compensation interim report is greatly appreciated. Clearly, much time and effort went into the production of the report.

Although I support the worthwhile recommendations in the report and do offer my signature to forward the process of the Committee, I have a major concern regarding Charge #5, Recommendation #8 which states:

> *To encourage greater accountability, the committee recommends that the workers' compensation administrative agency operate under a single commissioner structure, with the commissioner appointed by the governor with the advice and consent of the Senate.*

Given the recent problems at the Texas Workers' Compensation Commission, the desire to increase accountability is understandable. However, a single commissioner structure decreases the necessary representation of those who utilize and are affected by the workers' compensation system. A structure that utilizes three commissioners; one representing labor, the second representing employers, and the last being a public member would increase accountability, yet still provide for proper representation. This is especially important as the workers' compensation system addresses a large number of recommended changes by both this Committee and the Sunset Advisory Committee.

Again, I appreciate your efforts to address many of the difficult subjects discussed in the report. Please do not hesitate to contact me if you wish to discuss this concern further.

Yours truly,

Frank Madla

FM/sg
CC: The Honorable David Dewhurst, Lieutenant Governor
Members, Select Committee on Workers' Compensation

Appendix C

COMMITTEES
ADMINISTRATION, Vice Chair
CRIMINAL JUSTICE

THE SENATE OF TEXAS
JUAN "CHUY" HINOJOSA
DISTRICT 20

COMMITTEES
NATURAL RESOURCES
NOMINATIONS

December 2, 2004

The Honorable Todd Staples
State Senator
Capitol Extension, Rm. E1.808
Austin, Texas 78711

Dear Senator Staples:

I want to thank you and your staff for the effort that went into producing the Senate Select Committee on Workers' Compensation Interim Report. The comprehensive and deliberative approach you take on this complex issue is immediately evident in the report. I am confident that it will serve as a firm foundation when the legislature tackles workers' compensation during the 79th legislative session.

Though I agree with the report in principle, I feel that recommendation #8 under charge #5, which recommends that the commission be restructured under a single commissioner, is not the best course of action.

While I understand your desire for accountability, I strongly believe that the working people of Texas need a voice on the commission. A three member commission might be one solution to simultaneously increase accountability, while maintaining a diversity of perspectives on the commission. I believe such diversity would best suit the needs of all Texans.

Thank you again for the highly professional manner in which you and your staff approached this issue. I look forward to working with you and our colleagues on this issue.

Sincerely,

Juan "Chuy" Hinojosa
State Senator, District 20

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Appendix E

Translation and Definition of Commonly-used Acronyms

ADL	Approved Doctors List *List maintained by TWCC of doctors who treat workers' compensation patients*
AFL-CIO	American Federation of Labor/Congress of Industrial Organizations
AIA	American Insurance Association
ASC	Ambulatory Surgical Center *Facility that performs outpatient surgical procedures*
AWW	Average Weekly Wage *Used to determine amount of injured employee's income benefits*
BLS	Bureau of Labor Statistics
BRC	Benefit Review Conference *Informal mediation-style review of a workers' compensation dispute; precedes CCH*
BRO	Benefit Review Officer *TWCC employee who oversees BRC*
C&P	TWCC Division of Compliance and Practices *Assesses administrative violations of the Labor Code and TWCC rules, investigates fraud and abuse*
CCH	Contested Case Hearing *Formal TWCC hearing on a disputed issue*
CMS	Center for Medicare and Medicaid Services *Federal agency that administers the Medicare system*
CPT	Current Procedural Terminology (Code) *Used on a medical bill to describe services provided to a patient*
DBs	Death Benefits
DD	Designated Doctor *TWCC-appointed doctor used to assess Maximum Medical Improvement and assign an Impairment Rating*

DDL	Designated Doctor List *TWCC-maintained list of doctor certified as DDs*
DME	Durable Medical Equipment
DOI	Date of Injury
EOB	Explanation of Benefits *Provided by insurance carriers with response to a medical bill, often to explain a denial or reduction on payment*
HCP	Health Care Provider
HNAC	Health Care Network Advisory Committee *Labor-management committee created under HB 2600 (77th Legislature) to study use of networks in workers' compensation*
HO	Hearing Officer *TWCC employee who presides at CCH*
IAB	Industrial Accident Board (defunct) *Predecessor agency to TWCC*
IIBs	Impairment Income Benefits *Compensate injured employee for extent of permanent impairment related to compensable injury*
IR	Impairment Rating *Percentage assessment of impairment that determines duration of an injured employee's IIBs and eligibility (in part) for SIBs*
IRO	Independent Review Organization *Independent organization used to review and rule on disagreements over the necessity of medical care*
LIBs	Lifetime Income Benefits *Income benefits paid for life of injured employee for certain defined injuries*
MAC	Medical Advisory Committee *Advisory body to the TWCC*
MAR	Maximum Allowable Reimbursement *Amount of reimbursement for a medical service set by the TWCC Medical Fee Guideline(s)*

MDR	Medical Dispute Resolution *Process for adjudicating disputes over necessity of and/or payment for medical care*
MFG	Medical Fee Guideline(s) *TWCC schedules of rules for and amounts of reimbursement for medical services*
MMI	Maximum Medical Improvement *Assessment that an injured employee has recovered to the greatest extent possible from his or her injury; precedes assignment of Impairment Rating*
MQRP	Medical Quality Review Panel *Panel established by HB 2600 to assist TWCC with reviewing practices of health care providers and insurance carriers*
NCCI	National Council of Compensation Insurers
OSHA	Occupational Health and Safety Administration
PCIAA	Property and Casualty Insurance Association of America
RME	Required Medical Examination
ROC	Research and Oversight Council on Workers' Compensation (defunct) *State agency that conducted research on and provided oversight in the workers' compensation system; research functions transferred to TDI, 2003*
RTW	Return to Work
SAWW	State Average Weekly Wage *State wage benchmark historically used to set the cap on weekly income benefits in Texas workers' compensation*
SIBs	Supplemental Income Benefits *Long-term income benefits that compensate injured employees for high Impairment Ratings coupled with ongoing inability to work*
SIF	Subsequent Injury Fund *TWCC-administered state fund used to compensate injured employees who qualify for LIBs based on two separate injuries*

SOAH	State Office of Administrative Hearings *State agency; in workers' compensation, serves as appeal body for a medical dispute after ruling by an IRO*
SORM	State Office of Risk Management *State agency that administers most state employee workers' compensation claims*
TAB	Texas Association of Business
TCA	Texas Chiropractic Association
TD	Treating Doctor *An injured employee's primary care doctor; generally, must be on TWCC ADL*
TDI	Texas Department of Insurance
THA	Texas Hospital Association
TIBs	Temporary Income Benefits *Initial lost-time income benefit for injured employees; may be paid for up to two years*
TMA	Texas Medical Association
TPA	Third Party Administrator *Entity used to pay or administer workers' compensation claims*
TPCIGA	Texas Property and Casualty Insurance Guaranty Association *Assumes responsibility for workers' compensation claims of insurers that become insolvent*
TRC	Texas Rehabilitation Commission (defunct) *Now part of Department of Assistive and Rehabilitative Services*
TSIA	Texas Self-Insurance Association *Organization of self-insured employers who carry workers' compensation coverage - these employers are distinct from nonsubscribers (see TXANS)*
TCSIGA	Texas Certified Self-Insurer Guaranty Association *Assumes responsibility for workers' compensation claims of self-insured employers that become insolvent*
TTLA	Texas Trial Lawyers Association

TWC	Texas Workforce Commission
TWCC	Texas Workers' Compensation Commission
TWCR	Texans for Workers' Compensation Reform
TXANS	Texas Association of Responsible Nonsubscribers *Association of employers who do not carry workers' compensation insurance*
WCRI	Workers' Compensation Research Institute

Appendix F

Features of the Texas workers' compensation system, 2004

How coverage is provided	Employers are not required to carry insurance coverage. Those who do not (nonsubscribers) assume greater liability risks for on-the-job injuries. As of 2004, 62 percent of Texas employers covering 76 percent of the workforce purchased workers' compensation coverage. Employers who do purchase coverage may do so individually or as a group from commercial property and casualty insurers; self-insure, if qualified (through TWCC); or self-insure as a group, if qualified (through TDI). Texas Mutual Insurance Company (formerly the Texas Workers' Compensation Insurance Fund) is the "insurer of last resort" (i.e., must offer coverage) and the state's largest market-share insurer (per TDI, 26 percent of the market in 2003).
How doctors are selected	An insured employee may choose any doctor on the TWCC Approved Doctors List willing to treat the employee. An injured employee may also change treating doctors with TWCC approval. Medical networks are allowed by the state but do not affect the injured employee's ability to choose any willing ADL doctor.
How income benefits are provided	Injured employees may be eligible for: • *Temporary Income Benefits (TIBs)* to compensate for initial lost wages due to inability to work. Payable up to two years. • *Impairment Income Benefits (IIBs)* to compensate for permanent impairment due to compensable injury; duration depends on % of impairment. • *Supplemental Income Benefits (SIBs)* for employees with high impairment ratings (15% or greater) and an ongoing inability to work; eligibility must be demonstrated on ongoing basis, with all income benefits ceasing at 401 weeks post-injury. • *Lifetime Income Benefits (LIBs)* for employees who sustain certain catastrophic injuries defined by statute (notwithstanding 401-week limit). • *Death and Burial Benefits* for eligible survivors of employees killed on the job (also notwithstanding

	401-week limit). Amount of all benefits are based on the employee's pre-injury Average Weekly Wage (AWW), subject to caps.
How medical benefits are provided	There is no statutory time limit on reasonable and necessary medical care. Injured employees may not agree to waive the insurance carrier's future liability of care for a settlement. Injured employees are not liable for paying any portion of the cost of reasonable and necessary care. Injured employee's treating doctor or other health care providers bill insurance carrier for care or request preauthorization for care, as required. Insurance carrier reviews necessity of care and compliance with relevant rules. Providers whose bills or requests are denied may seek Medical Dispute Resolution through the process described below. Amount of payment for medical care is determined by TWCC fee guidelines, as applicable; for most professional services, current allowed fee is 125 percent of the amount paid by Medicare. Facility fee guidelines are also applicable to fees of Ambulatory Surgical Centers (ASCs), (currently 213.3 percent of Medicare) and hospital inpatient procedures (set on a per diem basis).
Indemnity Dispute process	Governs issues related to income benefit eligibility, as well as broad issues such as the compensability of an injury or extent of injury. Administered by TWCC. Begins with discussion at a Benefit Review Conference (BRC), an informal mediation where agreement may be reached on an issue in dispute. Proceeds if necessary to a Contested Case Hearing (CCH), an official TWCC hearing. CCH ruling may be appealed to TWCC Appeals Panel, which may reverse, uphold, remand, or not rule. Appeals Panel decision may be appealed to District Court.
Medical Dispute process	Governs issues related to necessity of medical care or amount to be paid for medical care. Decided by Independent Review Organizations (IROs) for necessity issues; TWCC for fee issues. Provider (or in some cases, injured employee) may seek reconsideration of a denial with the insurance carrier. If denied on reconsideration, appeal is allowed to an IRO. The IRO decision may be appealed to the State Office of Administrative Hearings (SOAH), and the SOAH decision

	to District Court. For fee issues, determination is made by TWCC, with appeal also allowed to SOAH and District Court.