Setting the Standard

An Analysis of the Impact of the 2005 Legislative Reforms on the Texas Workers' Compensation System, 2014 Results

Texas Department of Insurance

December 2014

Texas Department of Insurance
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December 1, 2014

The Honorable Rick Perry, Governor
The Honorable David Dewhurst, Lieutenant Governor
The Honorable Joe Straus, Speaker

Dear Governor Perry, Lieutenant Governor Dewhurst and Speaker Straus:

In accordance with Insurance Code, Section 2053.012 and Labor Code, Section 405.0025, the Texas Department of Insurance and the Division of Workers' Compensation present the biennial report on the impact of the 2005 House Bill (HB) 7 reforms on the affordability and availability of workers' compensation insurance for Texas employers and the impact of certified workers' compensation health care networks on return-to-work outcomes, medical costs, quality of care issues and medical dispute resolution.

Please contact either of us or Melissa Hamilton, Associate Commissioner of Government Relations at 512-463-6123, if you have any questions or to request a briefing on this information.

Sincerely,

Julia Rathgeber
Commissioner of Insurance

W. Ryan Brannan
Commissioner of Workers' Compensation

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Executive Summary

Texas Insurance Code, Section 2053.012, and Texas Labor Code, Section 405.0025, require the Texas Department of Insurance (TDI) to issue biennial reports to the Texas Legislature no later than December 1 every even-numbered year on the impact of the 2005 House Bill (HB) 7 reforms on the affordability and availability of workers' compensation insurance for Texas employers and the impact of certified workers' compensation health care networks (networks) on return-to-work outcomes, medical costs, access and utilization of health care, injured employee satisfaction, health-related outcomes, complaints, and medical dispute resolution. The following are key findings from this analysis of the 2005 HB 7 reforms:

Rates and Premiums in the Insurance Market

- Workers' compensation insurance has been profitable each year from 2005 to 2013, as measured by the industry's combined ratios and return on net worth.
- Since 2003, rates decreased just over 50 percent through 2013.
- Average premiums decreased from a high of $2.34 per $100 of payroll in 2003 to $1.02 per $100 of payroll in 2012. This is a reduction of over 50 percent.
- The average premium-weighted rate indication from rate filings requested for the 2014 biennial rate hearing is -3.5 percent. This suggests that the industry estimates the need for a 3.5 percent decrease in current premium levels to cover losses and expenses and produce the targeted profit.
- Undeveloped loss ratios are lower for claims in a network than for non-network claims (non-network). The loss ratios suggest that the filed credits for networks, which range up to 20 percent, are reasonable.

Workers' Compensation Health Care Networks

- The number of employers participating in networks and employees being treated by networks has significantly increased; approximately 42 percent of new claims are treated in networks.
- Since TDI began accepting applications for networks on January 2, 2006, the agency has 29 active certified networks covering 254 counties.
- Data calls conducted with 10 of the largest insurance company groups (almost 80 percent of 2013 direct workers' compensation premiums written in Texas) indicate that most large insurance companies have contracted with or established a network.

- An estimated 61,436 policyholders (employers) in 2013 (compared to 56,344 in 2012) have agreed to participate in networks in exchange for premium credits up to 20 percent. However, insurance carriers predict slower growth in the number of policyholders participating in networks over the next biennium.
- The vast majority of policyholders (84 percent) participating in networks are small to mid-sized employers with an annual premium of less than $25,000.
- Results from data calls with networks indicate that as of February 2014, approximately 536,772 injured employees have been treated in networks since 2006.
- One network (Texas Star) and one workers' compensation insurance carrier (Texas Mutual Insurance Company) in Texas account for 67 percent of all policyholders participating in networks and 35 percent of all injured employees treated in networks.

Satisfaction with Care and Health-Related Outcomes

- The results of recent injured employee surveys conducted by TDI show that a higher percentage (56 percent) of injured employees surveyed in 2014 reported "no problem" in getting the medical care they felt they needed for their work-related injury, compared with 52 percent of injured employees surveyed in 2005. That rate, however, is lower than the 60 percent reported in 2008.
- When compared to injured employees who received non-network medical care, most networks were able to get an injured employee in to see a non-emergency doctor sooner than non-network claims and a slightly lower percentage of injured employees in networks reported "a big problem" with getting to see a specialist.
- While injured employees were able to access medical care faster in 2014 compared to 2005, injured employees generally reported slightly lower satisfaction levels with the medical care they received compared to 2005 results.
- A slightly higher percentage (27 percent) of injured employees surveyed in 2014 reported that the medical care they received for their work-related injury was worse than their routine medical care when compared to injured employees surveyed in 2005 (19 percent).
- The physical and mental functioning scores for injured employees in networks were higher than the scores reported by injured employees who received non-network care.

Medical Costs and Utilization of Care

- Total medical costs for professional services decreased significantly from its peak in 2002 until 2007, but they were in an increasing trend since 2008. More recent data indicates a leveling off or a slight decrease in costs since 2011.
- Total hospital costs decreased from 2002 until 2005, but increased since 2006. They have remained in a level or marginally decreasing trend since 2011. Total pharmacy costs have stayed at about the same level until 2011 but decreased significantly since the 2011 pharmacy closed formulary.
- The average professional cost per claim also decreased from its peak in 2002 until 2007, but increased significantly by 21 percent between 2007 and 2013 injury years. Primary causes for these increases were increased fees for service in the 2008 Medical Fee Guideline, decreases in the number of claims, and increases in utilization for some services.
- Since the adoption of the 2003 professional services fee guideline, the percentage of injured employees receiving physical medicine services decreased substantially, which accounted for the majority of the cost decrease between 2002 and 2007. Costs generally increased since 2008 but utilization decreased for most services except for diagnostic services.
- Average medical costs were higher for claims in WC health care networks than for those that were not in network until 2011. However, cost differences are narrowing down, and network and non-network average costs are about even in 2013.
- Medical cost differences between network and non-network claims appear to be driven primarily by higher hospital fees, higher pharmacy utilization, and higher utilization of E/M and diagnostic tests in networks.

Access to Care

- Total number of physicians actively practicing in Texas increased steadily until 2011, but it remained stagnant in the last two years. The number of WC participating physicians fluctuated, but decreased significantly in the last two years. As a result, workers' compensation participation rate is decreasing among all physicians. However, the total number of claims reported is also decreasing. As a result, the average number of patients per participating physician is also decreasing. There were 21 patients per participating physician in 2000, which decreased to 17 patients per physician in 2013 (a 19 percent decrease).
- Primary care physician participation rate decreased from 62 percent in 2000 to 39 percent in 2013 even though 2003 medical fee schedule increased reimbursement

rates for evaluation and management services. In absolute numbers, there were 5,847 in 2000 and 4,571 primary care physicians in 2013 (a 22 percent decrease). The number of claims also decreased by 22 percent since 2000. Decreasing participation by primary care physicians is in part alleviated by increasing participation by emergency medicine specialists that increased from 611 in 2000 to 1,875 in 2013.

- Overall WC physician retention rate is high and stable. About 80 percent of physicians who participated in workers' compensation also treated WC patients in the following year.
- 'Top 20%' WC physicians in terms of claim volume account for 87 percent of total MD/DO costs in 2013, and have higher retention rates: 98 percent or more of these physicians continue to treat workers' compensation patients year after year. 'Top 20%' participation rate as a whole appears unaffected by changes in fee schedule and rules.
- Non-metro areas have higher physician participation rates than metro areas because of the low total number of physicians practicing in these areas. Border areas and Fort Worth have the highest number of claims per physician.
- Overall, initial access (timeliness of care) measures show that WC patients are getting non-emergency treatments faster in 2013 than in 2000: 81 percent of patients received initial care in seven days or less in 2013, up from 74 percent in 2000.
- Initial access for network patients is slightly better than non-network patients despite a perception that closed nature of networks may delay medical treatment.
- Compensability/extent of injury denials and/or initial disputes tend to be associated with delayed initial care: 65 percent of disputed cases received initial care in 7 days or less in 2013, up from 52 percent in 2000. Despite delays, initial access to care has improved for denied and/or disputed claims.

Return-to-Work Outcomes

- Overall, return-to-work rates have improved since the HB 7 reforms in 2005.A higher percentage of injured employees receiving income benefits went back to work within six months in 2012 (77 percent), compared to 2004 (74 percent).
- Additionally, there has been a marked increase in the percentage of injured employees who have initially returned to work and remained employed, compared to the pre-HB 7 reforms (in 2004, the sustained return-to-work rate was only 66 percent at six months post-injury, compared to an estimated 74 percent in 2012).

- The median number of days away from work has also decreased since the implementation of HB 7 from 28-29 days for injury years 2004-2005 to 20-21 days for injury years 2008-2012 (20-21 days).
- The sustained return-to-work rate within six months post-injury fluctuated slightly from 68 percent for 2009 injuries to 68 percent for 2011 injuries. That value increased to 74 percent for 2012 injuries, but these results should be viewed as preliminary since it is based on immature data.
- Improved return-to-work rates have resulted in lower income benefit costs for Texas workers' compensation claims. The median total TIBs payments decreased from $2,677 for 2008 injuries to $2,384 for 2012 injuries. However, final TIBs payments vary considerably by initial return-to-work status.
- The median total number of weeks of TIBs payments follows a similar pattern. Returning to work within six months of an injury results in approximately five weeks of payments, while those who do not return to work within six months of an injury receive TIBs payments for 16 more weeks.
- A higher percentage (73 percent) of injured employees surveyed in 2014 reported that they were currently employed at the time of the survey (compared with 65 percent in 2008). A lower percentage of injured employees surveyed in 2014 (11 percent compared with 19 percent in 2008) reported that they had not yet returned to work from nine to 21 months after their work-related injury.
- A higher percentage (64 percent) of injured employees surveyed in 2014 who had not returned to work reported that they were released by their treating doctor to go back to work with no or some physical restrictions, compared to injured employees surveyed in 2008 (52 percent).
- With few exceptions, more network injured employees generally reported that they had been released to go back to work by their treating doctor when compared to non-network claims.

Dispute Resolution and Complaints

Most dispute measures have been on a downward trend since 2003:

- The number of whole-claim denials/disputes is down 43 percent, while the number of medical disputes decreased 71 percent.
- The number and percentage of claims with dispute proceedings are at the lowest level since 2008.
- The number of benefit review conference (BRC) requests fell by 76 percent from 2003 to 2013.

Some dispute measures increased in 2011-2012, but slowed in 2013:

- The number of concluded BRCs increased 32 percent in 2012 but decreased in 2013 and is still 48 percent lower than in 2003.
- The number of scheduled and concluded contested case hearings (CCHs) increased sharply in 2011, but slowed by 2013.
- The number of medical disputes has declined from more than 17,000 in 2003 to approximately 5,100 in 2013.
- TDI has received relatively few complaints about networks since 2005 (818 total complaints – of which approximately 30 percent were deemed justified) given that 536,772 injured employees have been treated in networks as of February 1, 2014.

Employer Participation

- Private-sector employer participation rates remained at 67 percent in 2014, which is among the highest rates since the first employer survey was conducted in 1993.
- Employer participation rates, especially among large employers, have resulted in an employee workers' compensation coverage rate of 80 percent.
- Approximately 75 percent of the non-subscriber employee population is covered by some form of an alternate occupational benefit plan. An estimated 5 percent of private-sector employees (approximately 470,000) either do not have workers' compensation coverage or coverage through a non-subscriber occupational benefit plan in the case of a work-related injury in 2014.
- The most frequently cited reasons by non-subscribing employers for not purchasing workers' compensation coverage included that they had too few employees (21 percent), they had few-on-the-job injuries (20 percent), and they were not required to have workers' compensation insurance by law (19 percent).
- Employers' perception that workers' compensation insurance premiums were too high increased slightly to 17 percent in 2014, but that is almost half of the 32 percent in 2010.
- The most frequently cited reasons subscribing employers gave for participating in the Texas workers' compensation system were that the employer was able to participate in a network, and that they thought it was required by law (22 percent for both reasons). Another 20 percent said they purchased workers' compensation coverage because they were concerned about lawsuits.

1. Introduction

Medical costs have been a concern in the Texas workers' compensation system since the 76th Legislature passed House Bill (HB) 3697 in 1999 mandating a series of studies comparing the cost, quality, and utilization of medical care provided to injured employees in Texas with those in other states and other health care delivery systems. The results from these and other studies showed that Texas had some of the highest average medical costs per claim and that these costs were primarily driven by the amount of medical care provided to injured employees (also known as the utilization of care).[1] Additionally, these studies highlighted that compared with similarly injured employees in other states, Texas injured employees had poorer return-to-work outcomes and satisfaction with care. Growing concerns from policymakers and system participants about high medical costs and poor outcomes led to the passage of HB 2600 by the 77th Legislature in 2001, which included key components, such as:

- treatment guidelines,
- eliminating the spinal surgery second opinion process and requiring preauthorization for spinal surgeries,
- requiring medical necessity disputes to be reviewed by Independent Review Organizations (IROs), which are certified by TDI and have panels of independent doctors,
- instituting a registration and training requirement for doctors treating injured employees, which is the Approved Doctor's List,
- increasing training requirements for doctors performing impairment rating examinations, and
- requiring the use of Medicare's reimbursement structure, payment policies, and coding requirements for medical billing.

Since the passage of HB 2600, a significant amount of attention has been placed on lowering medical costs through a reduction in the overutilization of medical care provided to injured employees. The issue of reducing medical costs and improving the quality of medical care provided to injured employees was also a key component driving the passage of a new health care delivery model in HB 7 – workers' compensation health care delivery networks (networks). In 2005, the 79th Legislature passed HB 7, which

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

represented the most comprehensive organizational and policy reforms to the Texas workers' compensation system since 1989. Key aspects of these reforms included:

- the abolishment of the former Texas Workers' Compensation Commission and transfer of its administrative duties to the Texas Department of Insurance, Division of Workers' Compensation (DWC),
- the creation of the Office of Injured Employee Counsel to serve as a voice for injured employees during rulemaking and assist them during dispute resolution,
- the formation of networks approved by TDI to improve the quality of medical care received by injured employees at a reasonable cost for Texas employers,
- the adoption of evidence-based medical treatment guidelines designed to provide guidance to health care providers about appropriate treatment protocols for work-related injuries,
- the streamlining of medical and income benefit dispute resolution processes to improve the timeliness of dispute resolution, and
- an increased focus on improving return-to-work outcomes in Texas.

HB 7 contained several provisions requiring TDI to evaluate the impact of these reforms on a biennial basis and to report the results to the Governor, Lieutenant Governor, Speaker of the House of Representatives, and the Legislature. Section 2053.012, Texas Insurance Code, and Section 405.0025, Texas Labor Code require TDI and the Workers' Compensation Research and Evaluation Group to issue these biennial reports to the Texas Legislature no later than December 1st every even-numbered year on the impact of these legislative reforms on the affordability and availability of workers' compensation insurance for Texas employers and the impact of networks on return-to-work outcomes, medical costs, access and utilization of health care, injured employee satisfaction, health-related outcomes, complaints, and medical dispute resolution.

Specifically, this report examines the impact of the 2005 legislative reforms on:

- the affordability and availability of workers' compensation insurance for Texas employers (per Section 2053.012, Texas Insurance Code), including:
  - projected workers' compensation premium savings realized by Texas employers,
  - employer participation in the system,
  - economic development and job creation,
  - market competition, including an analysis of how loss ratios, combined ratios, and individual risk variations have changed since the implementation of the reforms, and
  - network participation by small and medium-sized employers; and
- the impact of networks (per Section 405.0025, Texas Labor Code) on:
  - medical costs and utilization of care,
  - access to and satisfaction with medical care,

- return-to-work outcomes,
- health-related functional outcomes, and
- the frequency, duration, and outcome of medical disputes and complaints.

TDI and DWC continue to track the results of these reforms in order to fulfill the legislature's intent to improve both the cost and quality of medical care provided to injured employees in Texas, as well as the affordability and availability of workers' compensation insurance for Texas employers.

Following the introduction, Section 2 provides an overview of the status of the Texas workers' compensation insurance market prior to and after the implementation of networks under HB 7, including workers' compensation insurance rates and premiums, market competition, financial solvency, and loss and combined ratios. This section also summarizes recent rate filings submitted by workers' compensation insurance companies.

Section 3 of the report presents the most current information available regarding network participation in the Texas workers' compensation system. This section includes the number of networks certified, as well as the geographic distribution of network coverage by county.

Section 4 provides an analysis of how access to care, satisfaction with care, and health-related outcomes have changed in the workers' compensation system since 2005. This section also compares the perceptions of injured workers who were treated in networks with those of injured workers who received non-network medical care.

Additionally, Section 4 summarizes the results of a data call issued to 12 of the largest Texas workers' compensation insurance companies and a data call issued to all networks regarding their estimates of the number of employers (policyholders) that are participating in networks, as well as the number of injured employees being treated in networks. Section 4 also provides information about the premium credits certain insurance companies are offering to Texas policyholders in exchange for network participation.

Section 5 presents information about medical cost and utilization of care trends pre- and post-HB 7, including information about how these trends vary by type of medical service. This section examines how fees for individual medical services have changed over time and how injury rates, claim frequency, disputes and denials, and networks have affected medical payments in the system. This section also includes results from TDI's *2014 Workers' Compensation Network Report Card*, which compares the medical care and utilization of care results between network and non-network claims.

Section 6 of the report provides a detailed analysis of how access to care has changed in the workers' compensation system since 2005, including an overview of physician participation and retention rates by provider speciality and geographic area. Section 7 examines how return-to-work trends have improved in Texas over time and provides

preliminary information about income benefit savings as a result of reductions in lost time, as well as differences in return-to-work outcomes for network and non-network claims.

Section 8 of this report considers the effect of HB 7 reforms on the frequency, duration, and outcomes of disputes in the Texas workers' compensation system. Additionally, this section examines the number and type of complaints that TDI has received since 2005 regarding networks.

Section 9 provides estimates of overall employer participation in the Texas workers' compensation system and the percentage of the Texas workforce employed by non-subscribing employers. Section 9 also includes non-subscription rates categorized by industry and employer size and explores the reasons both subscribing and non-subscribing employers gave for their respective workers' compensation coverage decisions. Additionally, this section looks at the percentage of Texas employers who are knowledgeable about the HB 7 reforms and how this knowledge is currently affecting their perceptions regarding economic development in Texas.

2. Effects of Reforms on the Insurance Market

Introduction

HB 7 requires the commissioner to report on the affordability and availability of workers' compensation insurance for employers of Texas. This chapter looks at the effects of the HB 7 reforms by reviewing the workers' compensation insurance market's concentration and profitability, insurers' rate filings, insurers' use of competitive rating tools, and insurers' participation in networks.

Market Concentration

In 2013, nearly 290 insurance companies had positive direct written premium for workers' compensation insurance in Texas. The total direct written premium for the Texas workers' compensation insurance market was about $2.66 billion. Table 2.1 shows the direct written premium since 2005. Calendar years 2009 and 2010 both experienced significant decreases in direct premium. This drop was likely a byproduct of the recession, since the recession affected employer payrolls, which are the exposure used to price workers' compensation insurance. Premiums then increased significantly for the next three years and are now close to pre-recession levels.

Table 2.1: Direct Written Premium

Calendar Year	Direct Written Premium	Change in Direct Written Premium
2005	$2,702,011,275	
2006	$2,801,145,442	3.7%
2007	$2,730,265,013	-2.5%
2008	$2,581,298,283	-5.5%
2009	$2,183,885,939	-15.4%
2010	$1,922,770,862	-12.0%
2011	$2,163,990,743	12.5%
2012	$2,445,279,924	13.0%
2013	$2,658,287,438	8.7%

Source: The Texas Department of Insurance's compilation of the Texas Statutory Page 14 of the NAIC Annual Statement for Calendar Years Ending December 31, 2005 – 2013.

The top ten insurance company groups write 79.2 percent of the market, and the top writer, Texas Mutual Insurance Company, has 38.6 percent of the market based on its 2013 direct written premium. Texas Mutual, formerly the Texas Workers' Compensation Fund, wrote just over one billion dollars in direct written premium. The Legislature created Texas Mutual in 1991 to serve as a competitive force in the marketplace, to guarantee the availability of workers' compensation insurance in Texas, and to serve as an insurance company of last resort. While Texas Mutual is the insurer of last resort, it

predominately writes voluntary business, competing with the rest of the workers' compensation market. The involuntary market makes up less than a quarter of one percent of the workers' compensation insurance market.[2]

Table 2.2 shows historic market shares for the top 25 insurance company groups, based on each group's ranking in 2013. These groups wrote over 90 percent of the direct written premium for workers' compensation insurance in 2013. The table shows the market share for these same groups back to 2009, even though they may not have all been in the top 25 or at the same rank during those years. Additionally, the table does not show some groups, which may have been top writers historically but are no longer active or a top 25 writer in 2013. However, these top groups and their respective total market share each year have been generally consistent historically.

Table 2.2: Market Share by Group

Group	Rank (2013 Annual Statement)	2009	2010	2011	2012	2013
Texas Mut Ins Co	1	29.1%	31.1%	33.8%	37.1%	38.6%
Travelers Grp	2	7.8%	7.9%	7.4%	7.3%	7.4%
Zurich Ins Co Grp	3	7.3%	7.2%	6.6%	7.1%	6.4%
American Intl Grp Inc	4	8.1%	7.7%	7.0%	6.2%	6.2%
Liberty Mutual Grp	5	10.9%	10.0%	9.2%	7.7%	6.2%
Hartford Fire & Cas Grp	6	7.4%	8.1%	7.4%	6.2%	5.7%
Service Life Grp	7	2.2%	2.3%	2.2%	2.4%	2.5%
CNA Ins Grp	8	2.8%	2.6%	2.6%	2.1%	2.1%
Ace Ltd Grp	9	4.3%	2.1%	3.4%	2.6%	2.1%
Chubb Inc Grp	10	1.8%	2.1%	2.0%	2.0%	2.0%
Old Republic Ins Grp	11	1.6%	1.5%	1.4%	1.5%	1.7%
Amerisure Co Grp	12	1.9%	1.4%	1.4%	1.5%	1.4%
BCBS of MI Grp	13	0.2%	0.5%	0.8%	1.0%	1.2%
Fairfaix Fin Grp	14	1.2%	1.0%	0.6%	1.2%	1.2%
WR Berkley Corp Grp	15	0.5%	0.7%	0.7%	0.7%	0.9%
Berkshire Hathaway Grp	16	0.2%	0.5%	0.6%	0.7%	0.9%
Houston Intl Ins Grp	17	0.1%	0.2%	0.3%	0.4%	0.7%
Sentry Ins Grp	18	0.8%	0.7%	0.6%	0.6%	0.7%
Farmers Ins Grp	19	0.0%	0.0%	0.0%	0.0%	0.7%
AmTrust NGH Grp	20	0.3%	0.3%	0.3%	0.4%	0.6%
American Financial Grp	21	0.5%	0.5%	0.4%	0.5%	0.6%
Amerisafe Grp	22	0.5%	0.5%	0.5%	0.6%	0.6%
Tower Grp	23	0.4%	0.3%	0.2%	0.7%	0.5%
Markel Corp Grp	24	0.0%	0.0%	0.3%	0.6%	0.5%
QBE Ins Grp	25	0.2%	0.4%	0.4%	0.5%	0.5%
Total		**90.0%**	**89.6%**	**90.3%**	**91.6%**	**91.9%**

Source: The Texas Department of Insurance's compilation of the Texas Statutory Page 14 of the NAIC Annual Statement for Calendar Years Ending December 31, 2009 - 2013.

[2] Texas Mutual writes the involuntary market in its START program. Market share data is from the Texas Quarterly Legislative Report on Market Conditions.

One indicator of a competitive market is a lack of concentration by those participants in the market. A commonly accepted economic measure of market concentration is the Herfindahl-Hirschman Index, or HHI, which considers the relative size and distribution of firms, or insurers, in a market. A market with an HHI index between 1,500 and 2,500 is considered moderately concentrated and one with an HHI index above 2,500 is considered highly concentrated. The HHI, based on insurance company group market shares in 2013 for Texas is 1,726, thus the Texas workers' compensation market is considered moderately concentrated.

Profitability

Two important measures of the financial health of the Texas workers' compensation insurance market are the loss ratio and the combined ratio. The loss ratio is the relationship between premium collected and the losses incurred (loss amounts already paid and amounts set aside to cover future loss payments). The combined ratio is similar to the loss ratio, except that it compares the premiums collected with both the losses and expenses incurred by the insurance company.

Each year the Department analyzes historical loss ratios and combined ratios on an accident year basis. In an accident year analysis, the losses tie back to the year in which the accident occurred, regardless of when the claimant reports the loss or the company pays the loss. For example, accident year 2008 reflects claims or losses from all accidents that happened in 2008 even if, for example, a loss was initially reported in 2009 and paid at a later date. In other words, all payments associated with a particular accident are associated with the year in which the accident occurred, 2008 in this case, regardless of when the company pays for the covered loss.

The loss ratio used in the Department's analysis equals the projected direct ultimate incurred losses divided by the direct earned premium. This ratio is a widely accepted metric that gauges underwriting results by comparing losses to premium. In its analysis, the Department uses ultimate incurred losses, which is an estimate of the cost of claims from a given accident year when they are ultimately or finally settled. It may take many years for a company to settle a claim because there may be ongoing payments for medical treatment or income benefits. The ultimate cost of these payments must be estimated using actuarial techniques.

To ascertain overall profitability, it is necessary to factor in other types of expenses. The combined ratio literally combines the loss ratio with the expense ratio to gauge overall profitability before consideration of insurance companies' investment earnings. The expense ratio includes loss adjustment expenses, other types of expenses, and policyholder dividends. Loss adjustment expenses are those costs incurred in processing, investigating, and settling claims. Other types of expenses include insurance company administrative overhead, commissions, taxes, licenses, and fees. Policyholder dividends

are a return of a percentage of the premiums in excess of losses and expenses to policyholders by certain types of insurance companies.

A combined ratio of less than 100 percent indicates that the insurance company earned a profit on its insurance operations (also called an underwriting profit). A ratio greater than 100 percent indicates a loss on insurance operations, although this loss may be more than offset by earnings on investments. For example, if the projected ultimate combined ratio is 110 percent, then for every $1.00 in premium the insurance company collects, it expects that it will use $1.10 to pay losses and expenses it incurs. The insurance company will need to find other sources to pay the 10 cents that is in excess of the premium. This may be earnings from investments or even a direct charge against the insurance company's surplus. In 2013, the projected accident year combined ratio was 89.6 percent. This means that for every dollar collected by the insurance company, it will pay an estimated 89.6 cents to cover losses and expenses and keep the remaining amount as profit.

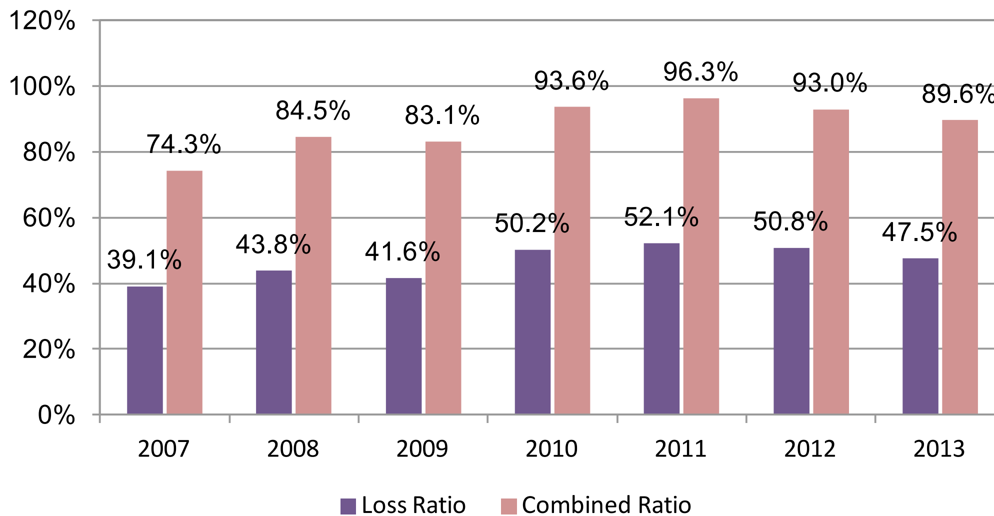
Table 2.3 and Figure 2.1 show the loss ratio and the combined ratio, both of which reflect that the last seven years have been profitable for insurance companies writing workers' compensation insurance. The combined ratio averaged 74.5% from 2003 to 2007. In 2008, concurrent with the recession, this ratio deteriorated and continued to do so until 2012 when it started to rebound.

Table 2.3: Projected Ultimate Calendar/Accident Year Loss and Combined Ratios

Accident Year	Direct Earned Premium	Ultimate Losses	Loss Ratio	Combined Ratio
2007	$2,199,889,123	$860,742,498	39.1%	74.3%
2008	$2,210,268,795	$967,884,307	43.8%	84.5%
2009	$1,945,668,267	$808,876,095	41.6%	83.1%
2010	$1,724,553,041	$866,200,706	50.2%	93.6%
2011	$1,809,776,728	$943,756,300	52.1%	96.3%
2012	$2,028,964,954	$1,030,843,040	50.8%	93.0%
2013	$2,212,617,271	$ 1,051,085,244	47.5%	89.6%

Source: NCCI Workers' Compensation Financial Data Call (Valuation Year 2013), 2013 Texas Compilation of Statutory Page 14, 2013 Texas Compilation of the Insurance Expense Exhibit. Loss development factors used in determining the ultimate losses are from the NCCI Annual Statistical Bulletin, 2014 edition.

Figure 2.1: Projected Ultimate Calendar/Accident Year Loss and Combined Ratios



Source: NCCI Workers' Compensation Financial Data Call (Valuation Year 2013), 2013 Texas Compilation Statutory Page 14, 2013 Texas Compilation of the Insurance Expense Exhibit. Loss development factors used in determining the ultimate losses are from the NCCI Annual Statistical Bulletin, 2014 edition.

Note that these ratios exclude the experience for large deductible policies, which represent approximately 14 percent of 2013 direct written premium and an average of 18 percent of direct written premium historically. Additionally, the ratios shown in Table 2.3 and Figure 2.1 do not fully reflect insurers' recent rate changes. Reflection of the rate changes in the recent past would increase the loss ratios and combined ratios since the average rate change has been downward.

Another measure of industry profitability is the return on net worth. The return on net worth is the ratio of net income after taxes to net worth and indicates the return on equity. It includes income from all sources, including investment income, and reflects all federal taxes whereas the combined ratio reflects only the income from the insurance operations and does not reflect investment income or federal taxes. The return on net worth can also be used to compare insurance companies with firms in other industries. Table 2.4 shows the return on net worth for workers' compensation insurance for Texas and countrywide, along with the return on net worth based on Fortune's Industrial and Service sectors. Texas has consistently outperformed the rest of the country in the workers' compensation market.

Table 2.4: Return on Net Worth

Year	Workers' Compensation Insurance		All Industries
	Texas	Countrywide	Countrywide
2003	9.8%	6.9%	12.6%
2004	17.7%	10.1%	13.9%
2005	12.9%	9.6%	14.9%
2006	13.0%	10.0%	15.4%
2007	11.5%	9.0%	15.2%
2008	9.6%	5.1%	13.1%
2009	11.2%	4.2%	10.5%
2010	9.5%	3.9%	12.7%
2011	11.0%	6.2%	14.3%
2012	10.6%	5.9%	13.4%
10-Year Average	11.7%	7.1%	13.6%

Source: NAIC Report on Profitability by Line by State in 2012.

Another difference between the combined ratios shown in this report and the return on net worth is the way the data is collected. The combined ratio used in this report is on an accident year basis (as described earlier) while the return on net worth is on a calendar year basis. Calendar year analysis includes all activity that occurred during the calendar year regardless of when the accident giving rise to the activity occurred. Calendar year values do not change whereas accident year values change over time as claim experience emerges and estimates of ultimate activity evolve.

Rates

A company may choose to base its rates on the Texas workers' compensation classification relativities (relativities) established by the department; its own independent company-specific relativities filed by the company (none are on file currently); or loss costs filed by the National Council on Compensation Insurance (NCCI). NCCI filed loss costs in Texas for the first time in 2011.

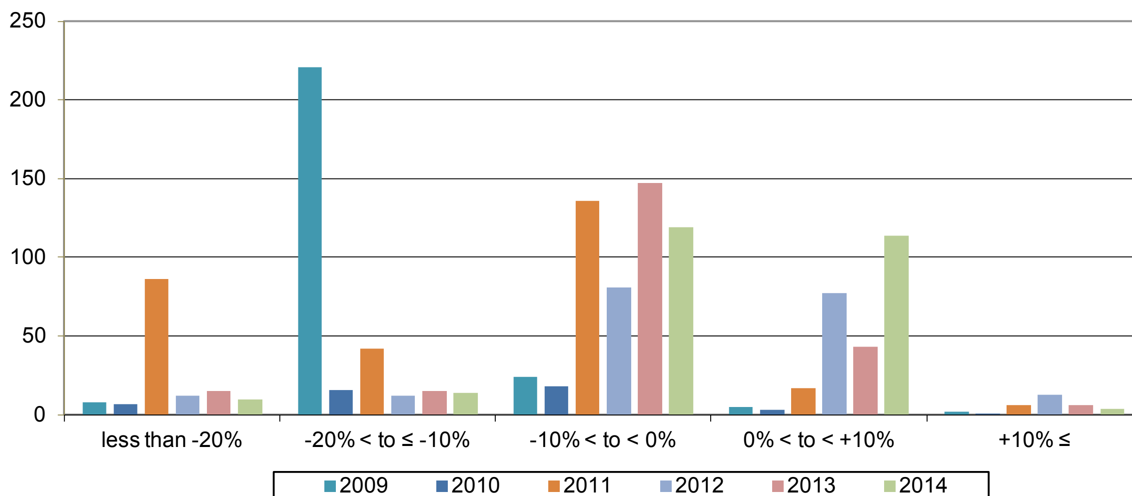
The relativities established by the Commissioner and the independent company-specific relativities filed by the company represent the relationship between classifications. Companies that choose to use the relativities as a basis for their rates file a deviation factor, which takes into consideration the company's experience. The relativities and the company's deviation are intended to cover the indemnity and medical benefits provided under the workers' compensation system in Texas, as well as profits, taxes and expenses for the company.

The loss costs filed by NCCI for each classification are intended to cover the indemnity and medical benefits provided under the workers' compensation system in Texas, as well as the expenses associated with providing these benefits. Companies that choose to use the loss costs as a basis for their rates file a loss cost multiplier (LCM), which contemplates any other expenses associated with providing workers' compensation insurance, such as agents' commissions, profits and taxes for the company.

Figure 2.2 shows the number of workers' compensation rate filings, by range of average rate change, effective from January 1, 2009, through October 1, 2014 (submitted through August 28, 2014). Insurers continued to file more rate decreases than rate increases through 2014. In 2014 thus far, there has been 143 rate filings to lower rates and 118 rate filings to increase rates. Most of these rate changes effective in 2014 fall between a 10 percent decrease and a 10 percent increase, which is in line with historical filings. The number of rate filings does not include those that were revenue neutral, such as those for schedule rating plans or the introduction of a network premium credit or those provided in response to a data call (if no rate change was taken).

Note that in 2011, the initial NCCI loss cost filing resulted in 264 filings to lower rates and 23 rate filings to increase rates, although not all companies converted from using relativities to loss costs at that time. Since then, approximately 77 percent of insurance companies are using loss costs as their rate basis. These companies represent nearly 54 percent of the direct written premium volume.

Figure 2.2: Rate Filings Effective from 1/1/2009 through 10/1/2014 by Amount of Change



Source: Insurance company rate filings received by the Texas Department of Insurance. The figure does not include filings that were revenue neutral.

Since 2003, rates have come down just over 50 percent. From September 1, 2003 through August 31, 2007, rates decreased by 21.7 percent followed by a 24.9 percent decrease through December 31, 2009. The annual rate decreases since then have been small except for in 2011 when rates decreased by 12.6 percent. These figures include changes in companies' deviations as well as overall changes in the classification relativities established by the Department. These decreases also include the impact from companies using NCCI loss costs along with any changes to these companies' loss cost multipliers. See table 2.5.

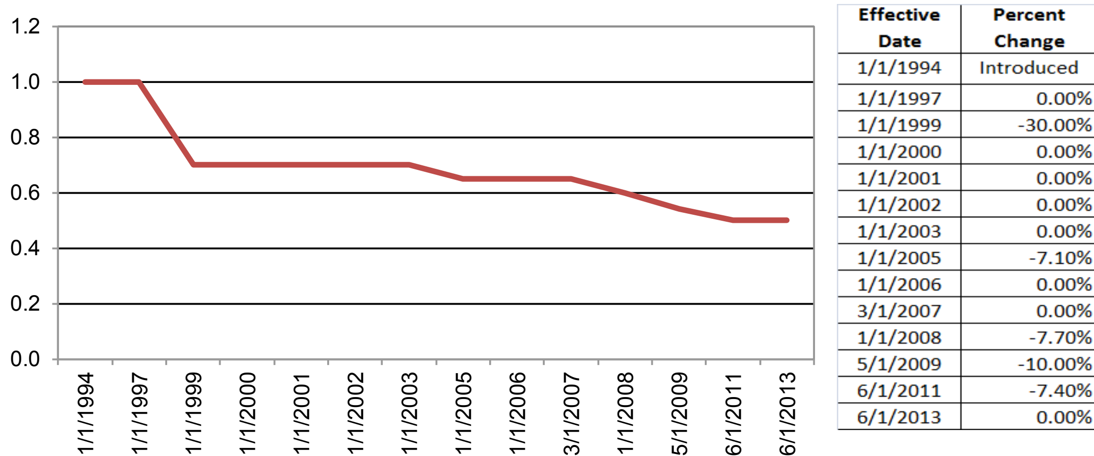
Table 2.5: Rate Trends Report

Time Period	Rate Change	Cumulative Rate Change
9/1/03 - 8/31/07	-21.7%	-21.7%
9/1/07 - 12/31/09	-24.9%	-41.2%
1/1/10 - 12/31/10	-1.7%	-42.2%
1/1/11- 12/31/11	-12.6%	-49.5%
1/1/12 - 12/31/12	-0.04%	-49.5%
1/1/13 - 12/31/13	-3.2%	-51.1%
1/1/14 - 10/1/14	-0.7%	-51.5%

Source: Insurance company rate filings received by the Texas Department of Insurance. The figures do not include filings that were revenue neutral.

The department has revised the relativities about every two years in recent years; whereas, the revision was done almost annually prior to 2010. The department usually revises the relativities so that on average, the change in relativities is revenue neutral, even though a particular class' relativity may change by plus or minus 25 percent. The department has however, lowered the classification relativities a few times, as shown in Figure 2.3. Figure 2.3 also depicts that relativities have come down about 50 percent since their inception.

Figure 2.3: Cumulative Changes in Classification Relativities



Effective Date	Percent Change
1/1/1994	Introduced
1/1/1997	0.00%
1/1/1999	-30.00%
1/1/2000	0.00%
1/1/2001	0.00%
1/1/2002	0.00%
1/1/2003	0.00%
1/1/2005	-7.10%
1/1/2006	0.00%
3/1/2007	0.00%
1/1/2008	-7.70%
5/1/2009	-10.00%
6/1/2011	-7.40%
6/1/2013	0.00%

Source: Texas Department of Insurance.

Since its initial loss cost filing in 2011, NCCI has filed updated loss costs each year, which have decreased by 0.3 percent overall in 2012 and 3.8 percent in 2013. In 2014, they increased slightly by 0.1 percent. Thus, relative to the initial filing in 2011, loss costs have decreased by 4 percent.

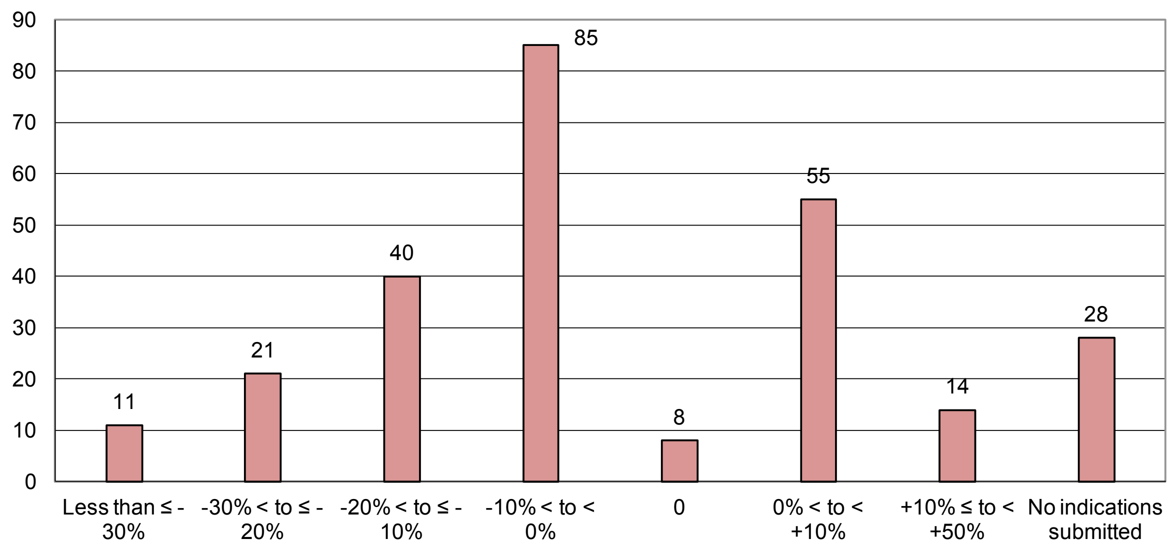
In preparation for the 2014 biennial rate hearing on workers' compensation insurance, insurance companies were required to submit rate filings in August 2014, which were to include the company's "rate indication." A company's rate indication is the actuarial

determination of how its rate or premium level should change going forward. Rate indications, unlike the loss and combined ratios, but similar to the return on net worth, reflect investment income in determining appropriate premium levels, and will reflect estimates of future income needs. They also reflect current rate and premium levels.

The department received 234 insurance company rate filings with rate indications. These indications are based on the insurance companies' calculations, using their assumptions, and do not reflect any judgments or assumptions made by the Department. Figure 2.4 shows how many of these companies had indications within the specified ranges shown. For example, 85 companies filed indications that were between –10 percent and 0 percent. If a group of companies filed an indication based on the group's experience, the figure reflects the group indication for each individual insurance company within the group. For example, a group with three companies may have filed indications of -16 percent. In the histogram, they would contribute three counts in the category for rate filings with indications between -20 percent and -10 percent. Twenty-eight companies filed information but did not submit rate indications. These companies were generally small or wrote only large deductible policies.

For the companies that filed rate indications, the average premium-weighted indication is -3.5 percent. This suggests that the industry estimates the need for a 3.5 percent decrease in current premium levels to cover losses and expenses and produce the targeted profit. As noted earlier, the indications vary significantly by company and reflect the companies' assumptions. Even though the companies' indications suggest a small decrease in premium levels on average, no companies proposed a rate change with their filing.

Figure 2.4: Summary of Insurance Companies' Indications Filed in August 2014 Based on Experience through 12/31/2013



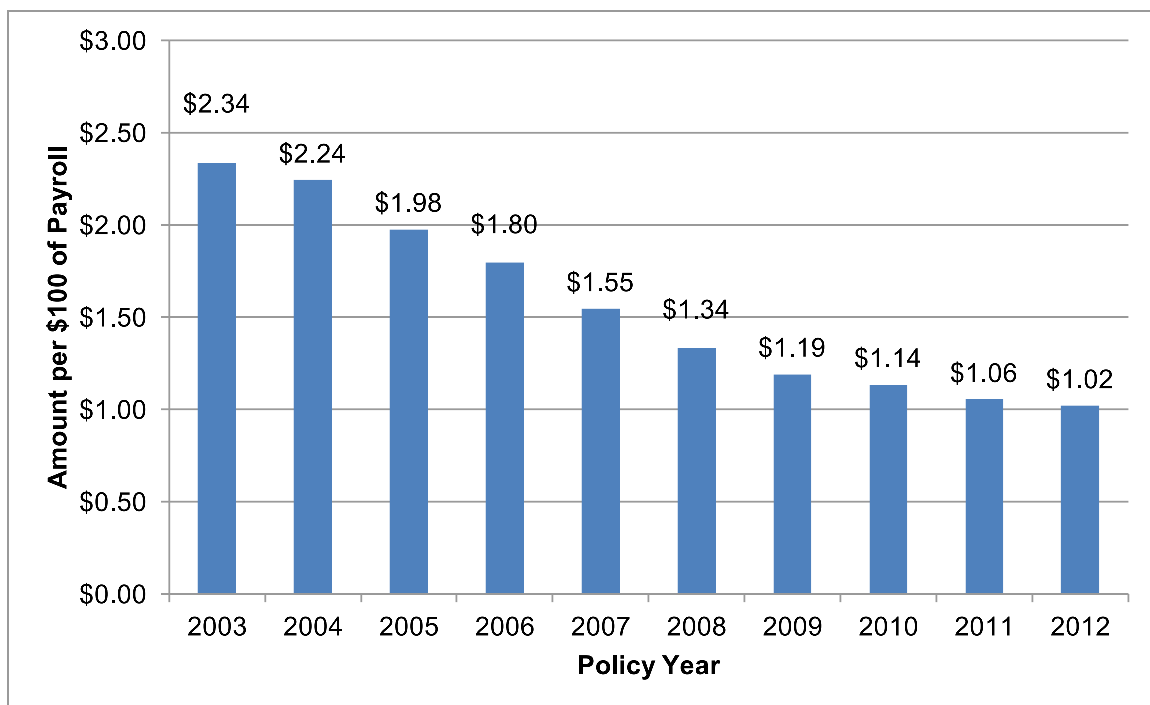
Source: Insurance company rate filings received by the Department in response to a request for rate filings for the 2014 biennial rate hearing (Commissioner's Bulletin B-0015-14).

Premium

While the rate changes filed by the companies in the last few years show how much rates have come down, the rates are just the start of the workers' compensation pricing process. What employers actually pay, the premium, reflects not only rates but also mandated rating programs such as experience rating and premium discounts, as well as optional rating tools such as schedule rating plans and negotiated experience modifiers to recognize individual risk variations. Insurance companies use these rating tools to modify rate changes to achieve desired premium levels.

Figure 2.5 shows the average premium per $100 of payroll for policy years 2003 through 2012. This information is on a policy year basis, which is different from the calendar year and accident year data discussed earlier. In a policy year, the premiums and losses tie back to the year in which the policy was effective. In 2003, the average premium was $2.34 per $100 of payroll, which represents the highest point in this time period. Prior to this time, the industry had suffered underwriting losses and the average premium had been increasing. Beginning with policy year 2004, the average premium per $100 of payroll began to decrease steadily as insurance companies lowered their rates and increased the use of rating tools, such as schedule rating. As of 2012, the average premium per $100 of payroll was down to $1.02. This overall steady decrease coincides with the average rate reductions that have taken place, resulting in employers seeing the benefits of the insurance companies' filed rate decreases.

Figure 2.5: Average Premium per $100 of Payroll by Policy Year



Source: The Texas Workers' Compensation Financial Data Call and data compiled by NCCI.

Prior to 2011, the average premium per $100 of payroll was calculated based on the average relativity weighted by class payroll, adjusted to a net premium basis. Beginning in 2011, insurance companies were allowed to use either relativities or loss costs as a basis for their rates. As a result, this metric now utilizes the average rate weighted by class payroll, adjusted to a net premium basis. The values for policy years prior to 2011 were recalculated using the updated methodology to ensure average premium per $100 of payroll for those years were comparable to the policy years beginning in 2011.

The updated methodology also accounts for the impact of experience rating adjustments whereas previously it did not, although previous reports erroneously stated that experience rating adjustments were incorporated in the calculation. The incorporation of experience rating in the revised calculation is the primary reason the restated values are lower than those shown in previous reports. However, the pattern exhibited by the year over year changes is consistent with previous reports.

The average premiums reflect insurance companies' manual rate deviations as well as adjustments for experience rating, schedule rating, and retrospective rating. In addition, they reflect network premium credits, deductible credits for promulgated deductible plans, and premium discounts. They do not reflect policyholder dividends or the impact of other smaller rating modifications such as small employer premium incentives and increased limits premium. Additionally, since workers' compensation is an audit line, which means that audited payrolls determine final premiums, the average premiums may change over time, especially for the most recent years.

Rating Tools Recognizing Individual Risk Variations

One of the revisions that HB 7 made to the workers' compensation statutes was that insurance companies shall consider the effect on premiums of individual risk variations based on loss or expense considerations when setting rates. Additionally, the revisions to the statutes state that neither rates, nor premiums, may be excessive, inadequate, or unfairly discriminatory. Therefore, the department evaluates insurance companies' rates and premiums based on the rate filings made by the insurance companies, as well as on the use of available rating tools used to reflect individual risk variations. Since insurance companies did not file the use or effect of these rating tools in their rate filings prior to HB 7, the department issues periodic data calls to gather this information. The Texas Workers' Compensation Financial Data Call also provides information, which the department uses in gauging the effect of these tools.

Once an insurance company determines an employer's rate based on its classification (which depends on the type of business, such as office, construction, or manufacturing) and the employer's loss experience, the insurance company can further modify the policy's premium through the use of optional rating tools such as schedule rating and negotiated experience modifiers.

Schedule rating reflects characteristics of the employer, which may not be fully reflected in the employer's past experience. The general categories that are often used in schedule rating include the care and condition of premises; classification peculiarities; medical facilities; safety devices; selection, training, and supervision of employees; and management's cooperation with the insurance company and safety organization. A credit or debit can be applied to the premium based on the underwriter's evaluation of the insured employer relative to each of these categories (or other categories in the insurance company's schedule rating plan as filed with the Department) up to an aggregate maximum modification, generally plus or minus 40 percent.[3] Insurance companies must file their schedule rating plan with the Department. An insurance company must also be able to support, with documentation maintained by the insurance company, the schedule ratings it uses in calculating premiums for employers.

Application of schedule rating to a policy can result in significant changes to the premium charged even though there has been no change in the insurance company's filed rate. Based on the filings received for the biennial rate hearing, the weighted average schedule rating adjustment in 2013 was a credit of 12.6 percent. Since 2003, the average schedule rating adjustment has been a credit that has increased gradually each year until peaking in 2010 and 2011 and then slowly decreasing. Relative to 2003, the average schedule rating credit has increased 6 percent. Also note that market forces and conditions often influence the use of schedule rating and the size of credits or debits given.

Another rating tool used to reflect individual risk variations in pricing is a negotiated experience modifier. Experience modifiers reflect an employer's past losses. The greater the losses compared to the losses expected for that type of business, the higher the employer's experience modifier will be, which produces a higher charged premium, and vice versa. An employer and its insurance company can also negotiate a lower experience modification, and thus a lower premium. Only a few companies report that they use negotiated experience modifiers. For these companies in 2013, the average modifier used to rate policies was 2 percent to 15 percent lower than the average calculated modifier.

Another cost saving tool, which is not reflected in the earlier analyses of loss ratios, combined ratios, and average premiums, but which is worth mentioning for completeness, is a deductible, wherein the employer reimburses the insurance company for all or part of a given loss. Promulgated deductible plans and negotiated deductibles are two types of deductible options available for use by Texas employers.[4] Negotiated

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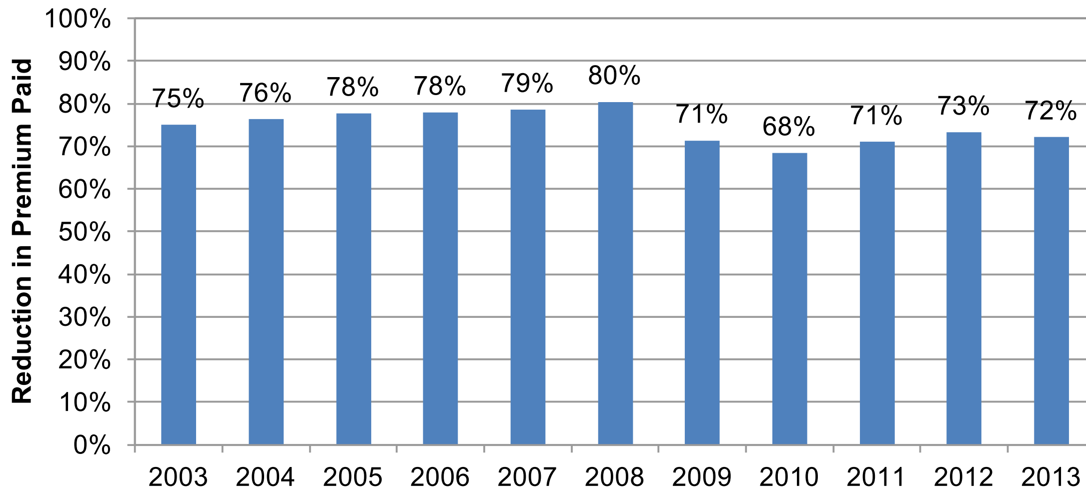
[3] In the case of Texas Mutual Insurance Company's START program, the aggregate maximum modification is plus or minus 75 percent.

[4] The Texas Workers' Compensation Financial Data Call excludes large deductible policies. Insurance companies report losses for all other deductible policies on a gross basis. That is, if the total loss is $20,000 and the employer has a deductible of $5,000, the amount reported in the Department's Financial Data Call is $20,000, even though the insurance company ultimately pays only $15,000 of the loss. The direct earned premium is the amount of premium actually earned prior to the payment of policyholder dividends and the application of credits for deductible policies.

deductible credits are available for employers with larger premiums or larger deductible amounts that effectively allow the employer to self-insure. Approximately 4 percent of policies were written using a negotiated deductible plan in 2013. For these policies, the average overall premium credit is substantial, at 72 percent. Figure 2.6 shows the average premium credit since 2003 for employers with a negotiated deductible.

Figure 2.6: Average Negotiated Deductible Credit by Policy Year



Source: Texas Department of Insurance, Quarterly Legislative Report on Market Conditions.

Certified Workers' Compensation Health Care Networks

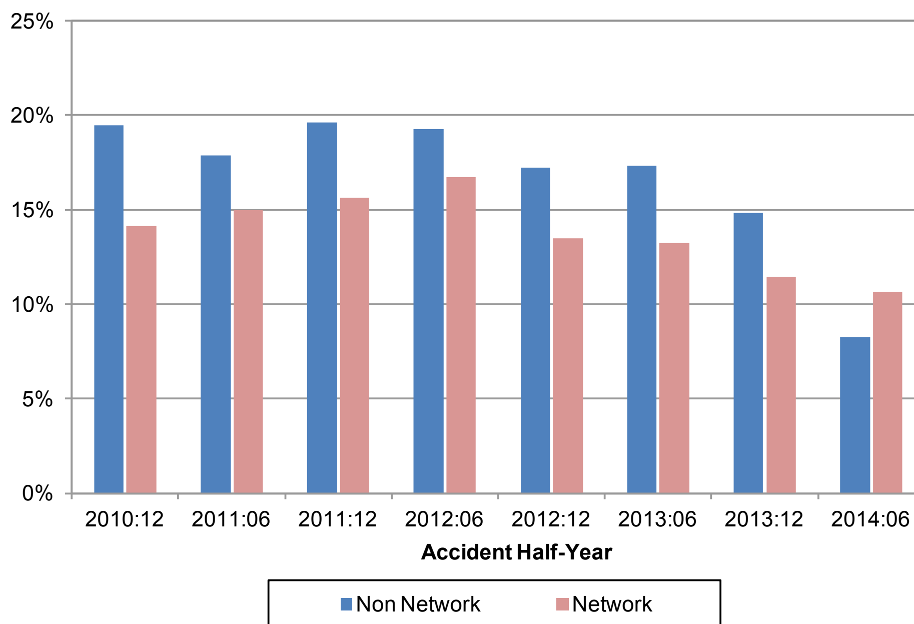
Another way for employers to reduce their premiums is through participation in a Department-certified health care network, the focus of the HB 7 reforms. The objective of these networks is to improve the quality of medical care received by injured workers at a reasonable cost for Texas employers and to improve outcomes from injuries.

For those employers that elect to participate in one of these networks, they receive a credit, or discount, on their premium. Credits filed with the Department range up to 20 percent but the majority of actual credits used are between 5 and 12 percent. Insurance companies initially established the credits based on judgment, rather than on experience, since there was no experience. Based on a review of undeveloped loss ratios for companies or groups that had reported their network experience in response to the annual network data call, and that had more than 20 percent of their policies in networks, it appears that, on average, the credits are reasonable. The average dollar savings per policy for those policies receiving a network discount is about $2,400, but ranges significantly by company or group. Section 3 of this report provides additional information about the premium credits filed by insurance companies with the Department.

Figures 2.7 and 2.8 show the undeveloped (to ultimate) indemnity and medical loss ratios for the most recent eight half-accident years for insurance companies that reported their network experience in response to the annual network data call and that had more than 20 percent of their policies in networks. The loss ratios are determined using premium before application of the network premium credit.

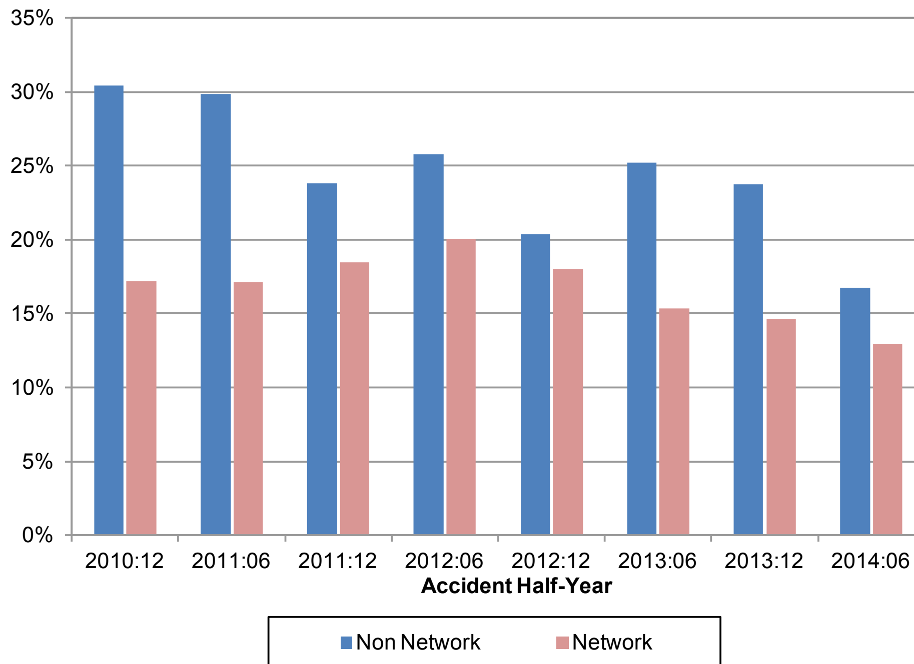
Overall, the accident half-year loss ratios for claims in a network have better results than for claims outside a network. This is generally the case for both medical and indemnity losses; however, as expected, the impact on medical is greater than the impact on indemnity. Further, the older, more mature accident years that are closer to ultimate value generally show a little wider difference between the non-network and network loss ratios, suggesting that the network loss ratios are even more favorable relative to the non-network loss ratios as losses develop to their ultimate value.

Figure 2.7: Indemnity Undeveloped Incurred Loss Ratios for Network and Non-Network Experience



Source: The Texas Department of Insurance's annual network data call.

Figure 2.8: Medical Undeveloped Incurred Loss Ratios for Network and Non-Network Experience



Source: The Texas Department of Insurance's annual network data call.

Summary

The last nine years since the enactment of HB 7 have been profitable for the workers' compensation insurance industry, which has responded by lowering rates, increasing schedule-rating credits, and providing discounts for participation in networks. The result is that average premiums charged to employers have decreased significantly. Based on the rate indications filed by insurance companies in August 2014 for the biennial rate hearing, the industry is poised to continue these trends.

3. Workers' Compensation Health Care Networks

An important component of evaluating the impact of the HB 7 reforms on the Texas workers' compensation system is the implementation of the cornerstone of these reforms - workers' compensation health care networks. In the years prior to the adoption of these reforms, rising average medical costs per claim, poor return-to-work outcomes, and high workers' compensation premiums resulted in an increase in the percentage of Texas employers that chose to leave the workers' compensation system (see section 9 of this report for a discussion about employer participation trends in the Texas workers' compensation system).

Research studies published by the former Research and Oversight Council on Workers' Compensation, the Department, and the Workers' Compensation Research Institute (WCRI) highlighted that Texas' high medical costs were being driven primarily by the amount of medical care provided to injured employees (often referred to as "the utilization of medical care"). Despite high medical costs, Texas injured employees were not more satisfied with their medical care compared to injured employees in other states.[5]

In response to these trends and stakeholders' (e.g., insurance carriers, employers, injured employees, health care providers etc.) concerns, the 79th Legislature introduced a new employees' compensation health care delivery model, which allows insurance carriers to establish or contract with managed care networks that are certified by the Department using a method similar to the certification of health maintenance organizations (HMOs).

Overview of the Network Provisions in HB 7

Under HB 7, workers' compensation insurance carriers (including insurance companies, certified self-insured employers, group self-insured employers, and governmental entities) may elect to contract with or establish workers' compensation health care networks (networks), as long as those networks are certified by the Department. The Department's certification process includes a financial review, validation that the network meets the health care provider credentialing and contracting requirements established in the Department's rules, and a detailed analysis of the adequacy of health care providers available to treat injured employees in each proposed network's service area. If an employer chooses to participate in the insurance carrier's workers' compensation network, the employer's injured employees are required to obtain medical

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

care through the network, provided that the injured employee lives in the network's service area and receives notice of the network's requirements from the employer (including a network provider directory).[6]

Employees receiving network notices are asked to sign an acknowledgment form that indicates which certified network the employer is participating in, and acknowledges that the employee understands how to choose a treating doctor, seek medical care within the network or from a network-approved referral provider (with the exception of emergency care), and file a complaint with the network or with the Department.

Health care providers and networks negotiate fees under this new network model rather than utilize the Division's adopted fee guidelines. Additionally, workers' compensation networks may operate under their own treatment guidelines, return-to-work guidelines and preauthorization requirements, although these treatment and return-to-work guidelines must meet minimum statutory criteria.[7]

Under this new model, networks are required to have case management and return-to-work coordination services, as well as provide annual quality assurance and financial reports to the Department to ensure that these networks continue to provide high quality medical care to injured employees.

Additionally, HB 7 requires the Department to publish and disseminate an annual workers' compensation network report card that evaluates networks on measures including medical costs and utilization, return-to-work outcomes, and injured employee satisfaction with and access to medical care.[8]

Growth in Workers' Compensation Networks

The Department began accepting applications for the certification of workers' compensation health care networks on January 2, 2006. As of February 1, 2014, the number of Department-certified networks is 29, 21 of which have treated 536,772 injured employees since the first network was certified in March 2006.

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[6] By statute, pharmacy services are exempted from workers' compensation networks. Injured workers will continue to obtain pharmaceuticals from any pharmacist willing to accept workers' compensation patients, regardless of whether or not the worker is participating in network (see § 1305.101(c), Insurance Code).
[7] Treatment and return-to-work guidelines utilized by networks must be "scientifically valid, evidence-based, and outcome-focused" (see §1305.304, Insurance Code).
[8] In accordance with Section 1305.502, Insurance Code, the Department is required to produce annual workers' compensation network report cards on key cost, utilization, and outcome measures. The sixth report card was published in September 2014 (see http://www.tdi.texas.gov/reports/wcreg/documents/2014_report_card.pdf to view these report cards).

Currently, 29 certified networks cover 254 Texas counties, up from 234 counties in 2008. Most Texas counties support multiple networks, allowing insurance carriers and their policyholders various options for network coverage. Larger metropolitan areas such as Houston, Dallas-Ft. Worth and Austin-San Antonio support more than 21 networks.

A list of every certified network, along with a map of their respective coverage areas can be found here: http://www.tdi.state.tx.us/wc/wcnet/wcnetworks.html

Public Entities and Political Subdivisions

In addition to TDI-certified networks, certain public entities and political subdivisions (such as counties, municipalities, school districts, junior college districts, housing authorities, and community centers for mental health and mental retardation services) have the option to:

1) use a workers' compensation health care network certified by TDI under Chapter 1305, Texas Insurance Code;

2) continue to allow their injured employees to seek heath care as non-network claims; or

3) contract directly with health care providers if the use of a certified network is not "available or practical," essentially forming their own health care network.

This report includes Alliance, a joint contracting partnership of five political subdivisions (authorized under Chapter 504, Texas Labor Code) that chose to directly contract with health care providers. While not required to be certified by the Department under Chapter 1305, Texas Insurance Code, the Alliance network must still meet TDI's workers' compensation reporting requirements.

Network Participation Rates

The Department tracks the participation of both Texas policyholders (employers) and injured employees in networks created by HB 7. According to the results of a 2013 data call with twelve of the largest workers' compensation insurance company groups (representing 80 percent of the 2013 direct workers' compensation premium written in Texas), 61,436 policyholders (18 percent of Texas employers) have agreed to participate in workers' compensation networks in exchange for premium credits that range up to 20 percent.

The increase in the number of policyholders represents a 9 percent increase over the past year. While eleven of the top twelve insurance company groups have contracted with or established a certified network for their policyholders, usage of networks among insurance companies varies widely.

While network participation among Texas policyholders has grown considerably since 2006 (7,551 policyholders in 2006, 34,040 in 2008, 39,643 in 2010, 56,344 in 2012 and 61,436 in 2013), it remains to be seen how differences in insurance company marketing strategies, the concentration of high deductible policies within a company's book of business, the level of premium credits offered for network participation, employer requirements to provide employee network notices, and the impact of the economy on insurance company profitability and market competition will affect the participation rates for Texas policyholders over the next biennium.

Some insurance companies indicated that some policyholders are interested in the networks, but are concerned about the administrative responsibility associated with providing employees notice of the network requirements and securing a signed acknowledgment form at the time of hire and separately at the time the employee reports the injury. Insurance companies also reported that some large deductible policyholders (i.e., large employers who have a workers' compensation insurance policy with a large, negotiated deductible on a per accident basis in exchange for a large premium credit) are reluctant to participate in networks because these policyholders often have multi-state operations, with minimal exposure in Texas.

Additionally, since these policies already have significant premium credits applied to them in exchange for the large deductible, some insurance companies are not offering additional premium credits for network participation. For these policyholders as well as for certified self-insured employers, premium credits are not the enticement needed to participate in networks. Rather, if networks can reduce medical and/or indemnity costs and improve return-to-work outcomes, these larger policyholders may increase their participation in networks.

All of the insurance companies with a network reported that they were offering their workers' compensation network to both new and existing policyholders and the vast majority of these companies reported that they were offering network participation during the middle of the policy period for policies that have not yet expired or been renewed. This is an area that the Department intends to monitor further since workers' compensation policies are typically renewed annually, and any reluctance on behalf of an insurance company to initially offer its network plan to policyholders during the middle of the policy period will delay the implementation of networks.

Additionally, all of the insurance companies with a certified workers' compensation health care network reported that they were offering this option to all workers' compensation policyholders with employees who live in their network's service area, regardless of premium size, employee classifications, and experience modifier.

As Table 3.1 indicates, the number of Texas policyholders participating in networks has increased significantly since 2006 (from 7,551 policyholders in 2006 to 61,436 policyholders in 2013). The current number of policy holders represents approximately

26 percent of all Texas subscribing employers. Fifty three percent of policyholders participating in networks have an annual premium of less than $5,000 and 84 percent have an annual premium of less than $25,000, indicating that the policyholders participating in networks are mostly small to mid-sized employers.

Table 3.1: Total Number of Policyholders That Are Participating in Workers' Compensation Networks over Time for the Top 13 Insurance Carrier Groups

Network Participation Measures	As of Fall 2006	As of Fall 2008	As of Fall 2010	As of Fall 2012	As of Fall 2013
Total Number of Policyholders Participating	7,551	34,040	39,643	56,344	61,436
By Premium Size (Texas only premium) Less than $5,000 in premium	3,473 (46%)	15,937 (47%)	19,896 (50%)	30,016 (53%)	32,422(53%)
$5,000-$24,999 in premium	2,522 (33%)	11,659 (34%)	13,389 (34%)	17,596 (31%)	19,107(31%)
$25,000-$100,000 in premium	1,158 (15%)	4,940 (15%)	5,006 (13%)	6,602 (12%)	7,313(12%)
More than $100,000 in premium	398 (5%)	1,509 (4%)	1,344 (3%)	2,104 (4%)	2,567(4%)

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

While the number of policyholders participating in workers' compensation networks has increased 814 percent from 2006 to 2013, the top 12 insurance company groups estimated slower growth in the number of policyholders participating in networks over the next year (6 percent growth from in policyholders from 2014 to 2015) (see Table 3.2).

Table 3.2: Number of Policyholders to Participate in Workers' Compensation Networks, Estimated by the Largest Insurance Companies

Network Participation Measures	Estimate at End of CY 2014	Estimate at End of CY 2015
Overall Estimate	67,389	71,589

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Although insurance companies do not anticipate a significant increase in the number of policyholders that will participate in workers' compensation networks over the next couple of years, they estimate that the number of workers' compensation claims treated in networks will increase 46 percent from 2013 to 2015 (see Table 3.3).

Table 3.3: Number of Claims to Be Treated in Workers' Compensation Networks, Estimated by the Largest Insurance Companies

Network Participation Measures	Estimate at End of CY 2013	Estimate at End of CY 2014	Estimate at End of CY 2015
Overall Estimate	283,562	355,325	413,897

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Premium Credits for Policyholders

Before an insurance company begins using a network, the Department requires that the insurance company provide notification of the level of premium credits that will be granted for employer network participation. The premium credits on file with the Department currently range up to 20 percent with some insurance companies offering a standard credit to all policyholders who participate in the network, and other companies varying the credit depending on the percentage of the policyholders' employees that live within the network's service area.

Table 3.4 summarizes the amount or ranges of premium credits that have been filed with the Department as of October 1, 2014. Section 2 of this report examines some preliminary data regarding the impact of network participation on company loss ratios and estimates the average premium savings per workers' compensation insurance policy for network participation.

Table 3.4: Insurance Companies' Filed Network Premium Credits (as of October 1, 2014)

Group or Company Name	Credit
Allianz Group	15%
American Financial Group	10%
American International Group	0-5%
Amerisafe Group	2-10%
Amerisure Group	0-12%
Arch Insurance Company	0-12%
Berkshire Hathaway Group	10%
Chubb Insurance Group	5%
CNA Insurance Group	12%
Columbia Insurance Group	0-12%
EMC Insurance Group	12%
Employers Holdings Group	15%
Everest National Insurance Company	5%
Fairfax Financial Group	5-7%
Farmers Insurance Group	10%
Hallmark Financial Services Group	5-20%
Hartford Insurance Group	10%
Imperium Insurance Company	10%
Liberty Mutual Group	0-12%
Lumbermens Underwriting Alliance	10%
Meadowbrook Insurance Group	10%
National American Insurance Company	1%
Nationwide Corporation Group	12%
Old Republic Group	10%
Retailers Casualty Insurance Company	10%
Samsung Fire & Marine Insurance Company Ltd	5%
Sentry Insurance Group	0-12%
Service Lloyds Group	12%
Starr Group	5%
State Auto Mutual Group	5-10%
Texas Mutual Insurance Company	12%
Tokio Marine Holdings Inc Group	10%
Torus National Insurance Company	10%
Travelers Group	12%
Utica Group	10%
White Mountains Group	10%
WR Berkley Corp Group	12%
Zurich Insurance Company Group	0-8%

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Number of Injured Workers Treated in Networks

In addition to tracking the participation of Texas policyholders in networks, the Department also tracks the number of injured employees who have been treated by networks through separate semi-annual data calls with each certified network. As of February 1, 2014, networks had treated approximately 536,772 injured employees since the first network was certified (see Table 3.5 and Table 3.6).

Table 3.5: Total Number of Injured Workers Treated by Workers' Compensation Networks Since the First Network Was Certified

Network Participation Measures	As of February 1, 2012	As of February 1, 2014
Total Number of Workers Treated	327,373	536,772
Total Number of Networks Treating Workers	27	29

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

While the number of injuries being treated by networks and the number of networks treating injured employees continues to grow, the overall percentage of injuries being treated by networks is still relatively low. The Department estimates that as of February 1, 2014, roughly 42 percent of all new injuries (those that occurred between June 1, 2012 and May 31, 2013) were treated by networks. The lost-time claims among those represent approximately 46 percent of all lost-time claims for that timeframe.

Table 3.6: Frequency of Injured Employees Treated as of February 1, 2014 by Workers’ Compensation Networks

TDI-Certified Network	Total	Percent
Alliance	19,721	20%
Broadspire Workers’ Comp	492	<1%
Bunch TX HCN-FH	597	<1%
Chartis TX HCN	1,278	1%
City of Edinburg	41	<1%
Coventry Workers’ Comp Network	10,017	10%
Dallas County Schools	1,749	2%
Donna ISD	77	<1%
Corvel Health Care Corporation	1,897	2%
First Health TX HCN	2,368	2%
First Health/Travelers HCN	7,260	7%
First Health/CSS	259	<1%
Forte, Inc./Compkey Plus	2,324	2%
Genex Health Care Network	1,285	1%
HISD	38	<1%
IMO Med-Select	854	1%
Hartford Workers’ Compensation Health Care Network	1,147	1%
Lone Star Network/Corvel	417	<1%
Liberty Health Care Network	5,328	5%
Majoris Health Systems	46	<1%
Prime Health Services	17	<1%
River View Provider Group	76	<1%
Sedgwick CMS	3,029	3%
Sharyland ISD	36	<1%
Texas Star Network	34,585	35%
Trinity Occupational Program	522	<1%
Valley Healthcare Network	102	<1%
Zenith Health care Network	1,339	1%
Zurich Services Corporation	1,295	1%

Source: Texas Department of Insurance, Workers’ Compensation Research and Evaluation Group, 2014.
Note: Totals may not add up to 100 percent due to rounding.

Summary

HB 7 introduced a new workers’ compensation health care delivery model, which allows insurance carriers to establish or contract with managed care networks that are certified by the Department using a method similar to the certification of HMOs. Under this new system, injured employees whose employers have contracted with a certified network are required to obtain medical care through the network, if the injured employee lives in the network’s service area and receives notice of the network’s requirements from the employer.

The Department began accepting applications for the certification of workers’ compensation networks on January 2, 2006, and as of February 1, 2014, 29 certified networks cover 254 counties across Texas. According to the information gathered in periodic insurance company and network data calls, the number of Texas policyholders and claims participating in workers’ compensation networks has increased significantly since networks first became available in 2006.

The majority of these participating policyholders are small employers with annual premium averaging less than $5,000. Premium credits are being offered to Texas policyholders in exchange for network participation, but it is uncertain, at this point, whether the other large insurance company groups in Texas will increase their policyholder participation in networks significantly over the next couple of years.

Insurance companies report that policyholders are somewhat reluctant to participate because of administrative burdens associated with providing network notices to employees and obtaining signed acknowledgment forms, while others report that policyholders are concerned about directing their employees to selected doctors and are waiting to see if networks can reduce claims costs.

Another issue that may be affecting both the marketing of networks and the network participation rates among Texas employers is the decreasing losses experienced by the Texas workers' compensation system over the past few years and resulting decreases in premiums, which may be reducing the perceived need to offer and utilize workers' compensation networks. Other sections of this report will examine the trend of decreasing claims costs, which may have resulted in lower loss ratios for insurance companies and lower premiums for Texas employers.

4. Satisfaction with Care and Health-Related Outcomes

Ensuring high quality medical care for injured employees at reasonable costs for Texas employers continues to be the focus for the Texas workers' compensation system. As the number of claims decrease and costs begin to stabilize in the system, additional pressure is placed on ensuring that every dollar spent on claims is "value-added," meaning that the benefits being provided to injured employees enhance their ability to return to work as quickly and safely as possible. Section 3 highlighted how network participation has changed over time. This section examines quality of care issues and whether the system has seen improvements in these issues over the past few years. While many elements of HB 7, including networks, are showing the positive impact, this section also provides some indications of the impact of networks on access to care, satisfaction with care, and health-related outcomes.

Survey Design and Data Collection

The REG conducted an injured employee survey to compare injured employees' experiences with their medical care (access to care, satisfaction with care, and health-related outcomes), as well as to collect information regarding their experiences returning to work after their work-related injuries post-HB 7 implementation. The survey was conducted in the spring of 2014. For the survey, the REG drew a random probability sample of injured employees who received at least one Temporary Income Benefit (TIBs) payment (i.e., those injured employees with more than 7 days of lost time). The sample was further stratified by injury type, and injured employees were surveyed at approximately 9-21 months post-injury.[9] The survey instrument utilized standardized questions from the Consumer Assessment of Health Plans Study, Version 3.0, the Short Form 12, Version 2, the URAC Survey of Worker Experiences and previous surveys conducted by the REG.

Selection of Treating Doctors Recommended by Employers

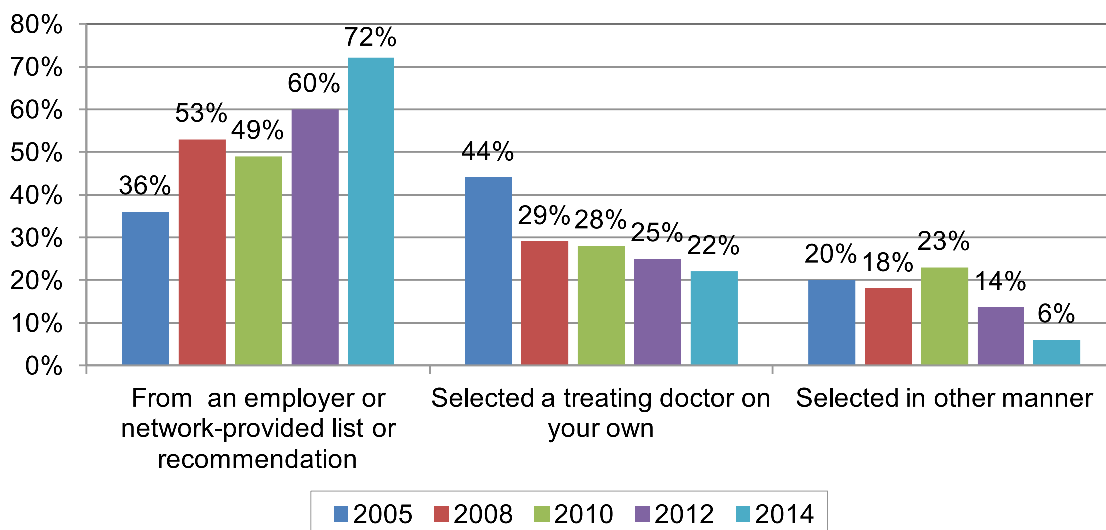
Prior to the passage of HB 7 in 2005, injured employees had the ability to select a treating doctor from the list of doctors who registered and received approval from the DWC to participate on the DWC's Approved Doctor List (ADL). The ADL contained approximately 14,000 medical doctors (MDs), osteopaths (DOs), chiropractors (DCs), and other doctors (i.e., dentists, podiatrists, etc.) who agreed to participate at some level in the Texas workers' compensation system. In an effort to improve access to care for non-network claims and to reduce administrative burdens for doctors treating injured

[9] A total of 3,346 injured employees were surveyed in 2014 by the University of North Texas, Survey Research Center.

employees, HB 7 eliminated the ADL.[10] At the same time, HB 7 paved the way for networks to treat injured employees. Injured employees, whose employers had agreed to participate in these networks, who lived in the networks' service area, and received notice of the networks' requirements, were required to select a treating doctor from the networks' list of contracted doctors. Interestingly, while injured employees were allowed to select their own treating doctors prior to the passage of HB 7, a significant percentage of injured employees reported (in this and in previous studies in Texas) that they selected a doctor recommended to them by their employer or insurance carrier.

As Figure 4.1 shows, a higher percentage of injured employees surveyed in 2014 (72 percent) reported that they selected a treating doctor that was recommended to them by their employer or part of their network's list of treating doctors, compared to injured employees surveyed in 2005 (36 percent). This finding is not surprising given the rising usage of networks in Texas during this time.

Figure 4.1: Methods Injured Employees Reported Using To Select Their Treating Doctor



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, Survey of Injured Workers 2005, 2008, 2010, 2012, 2014. Note: "Selected in other manner" includes recommendations from family or friends or other coworkers, among others.

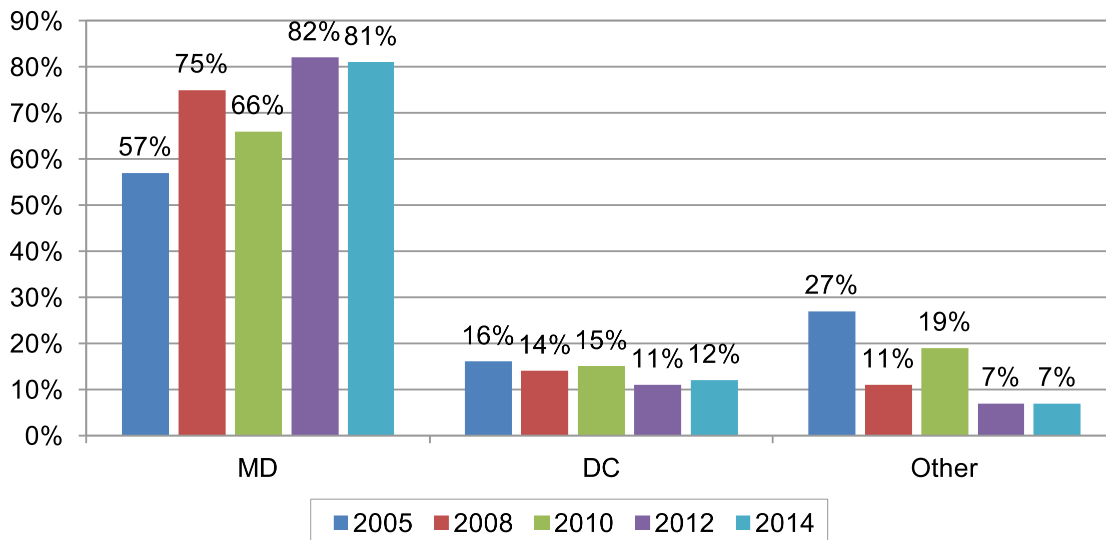
The Texas Workers' Compensation Act and Rules allow a variety of medical specialties, including MDs, DOs, DCs, dentists, podiatrists, and optometrists to serve as treating

[10] Even though the Approved Doctors List (ADL) expired on August 31, 2007, TDI continues to regulate health care providers treating injured workers in the system. Doctors must continue to disclose financial interest in other providers, practitioners and facilities, etc. to TDI, as well as obtain training and testing for the assignment of impairment ratings and maintain a medical license in good standing in the jurisdiction where care is being provided.

doctors for non-network claims. However, HB 7 allowed networks to select or designate certain medical specialties to serve as treating doctors for network claims. In 2014, a significantly higher percentage of injured employees surveyed reported that they selected an MD as their first treating doctor (81 percent), compared with 2005 (57 percent).

Interestingly, even with the increased usage of networks, the percentage reporting that they selected a DC as their treating doctor has changed very little between 2005 and 2014. A significantly smaller percentage of surveyed injured employees, however, continue to report that they selected a DO or other type of doctor as their treating doctor when compared to 2005 (see Figure 4.2).[11]

Figure 4.2: Type of First Non-Emergency Treating Doctor Selected by Injured Employees

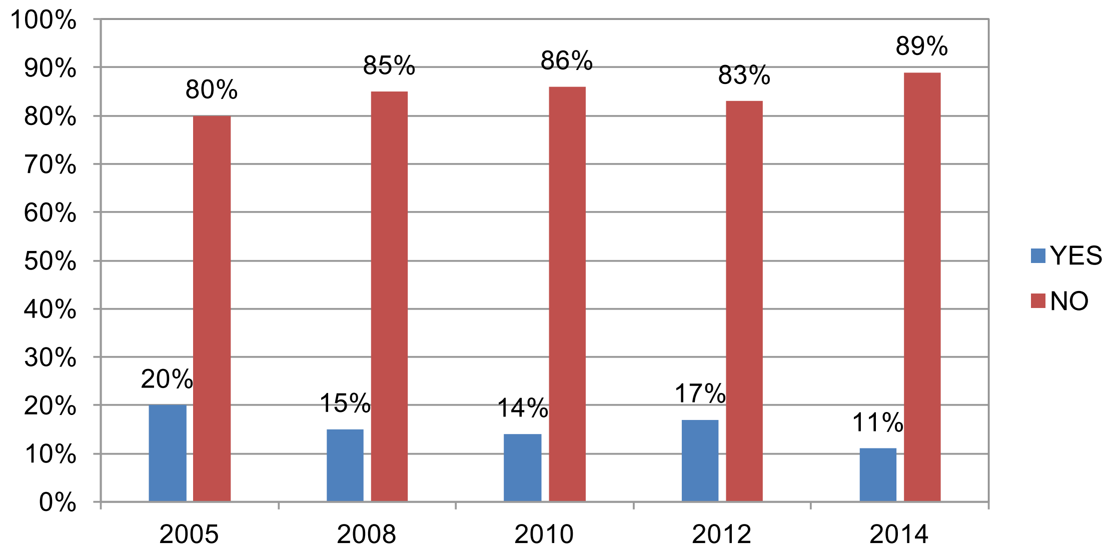


Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, Survey of Injured Workers 2005, 2008, 2010, 2012, 2014.

A higher percentage of injured employees surveyed in 2014 (89 percent) indicated that the doctor they saw for their workers' compensation medical care was not the doctor they normally saw for their routine medical care compared with 2005 (80 percent). This change may be the result of more injured employees seeking medical care through networks, which to date, are not generally associated with group health plans that provide routine medical care (see Figure 4.3).

[11] As of November 1, 2014, none of the networks certified by TDI utilizes chiropractors as treating doctors.

Figure 4.3: Was the Doctor Who Saw You for Your Work-Related Injury or Illness the Doctor That You Normally See for Your Routine Medical Care?



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, Survey of Injured Workers 2005, 2008, 2010, 2012, 2014.

Improvements and Perceptions in Access to Care in Networks

Before the 2005 legislative session, concerns were rising about injured employees' access to care within the Texas workers' compensation system. Doctors, particularly surgical specialists such as neurosurgeons and orthopedic surgeons, were refusing to take new workers' compensation patients because of administrative burdens related to treating workers' compensation cases and inadequate reimbursement levels resulting from the Texas Workers' Compensation Commission's adoption of the 2003 Medicare-based Medical Fee Guideline.[12]

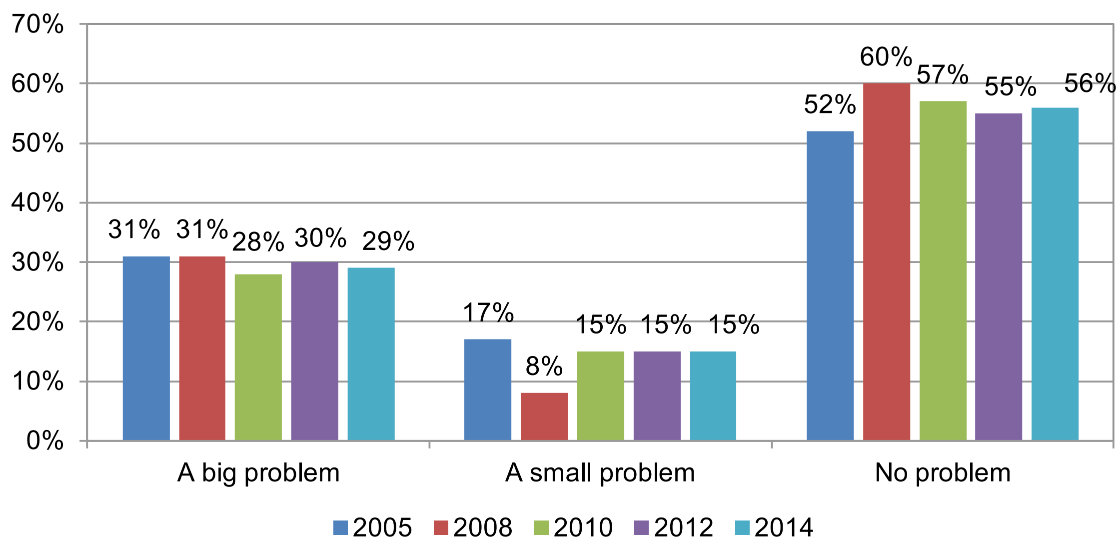
In an attempt to increase health care provider participation in the Texas workers' compensation system, DWC adopted a new professional services medical fee guideline (effective March 1, 2008). The new professional services medical fee guideline raised reimbursement levels for doctors and added an annual inflation adjustment based on the annual Medicare Economic Index, the weighted average of price changes for goods and services used to deliver physician services. Additionally, changes made by HB 7, including the adoption of evidence-based treatment guidelines (effective May 1, 2007)

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

and the elimination of ADL registration requirements (effective September 1, 2007) were made to increase certainty regarding the medical necessity of treatments that would be reimbursed in the system and to reduce administrative burdens.

Based on the results of recent injured employee surveys, a higher percentage (56 percent) of injured employees surveyed in 2014 reported "no problem" in getting the medical care they felt they needed for their work-related injury compared to 52 percent of injured employees surveyed in 2005. However, this was down from 60 percent in 2008 (see Figure 4.4). The availability of doctors who are accepting workers' compensation patients is an issue that the REG has and will continue to closely monitor (see Section 6).

Figure 4.4: Percentage of Injured Employees Who Reported Having Problems Getting Medical Care for Their Injury



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, Survey of Injured Workers 2005, 2008, 2010, 2012, 2014.

As Tables 4.1 and 4.2 illustrate, injured employees who received medical care from networks, generally had higher perceptions regarding their access to care, including the ability to see specialists.

A slightly higher percentage of injured employees surveyed in 2014 (17 percent) reported that their ability to schedule a doctor's appointment was worse than their normal health care, compared to 12 percent of injured employees surveyed in 2005 (see Figure 4.5). This is likely the result of differences in injured employees' perceptions about difficulties scheduling doctor's appointments for network and non-network claims. As Table 4.3 shows, with the exception of four networks, a higher percentage of injured employees receiving medical care in networks reported that their ability to schedule a doctor's

appointment was better or about the same than injured employees receiving non-network medical care.

Table 4.1: Since You Were Injured, How Often Did You Get Care as Soon as You Wanted When You Needed Care Right Away?

How often did you get care?	Always	Usually	Sometimes/Never
Non-network	46%	18%	32%
504-Alliance	54%*	19%	23%*
504-Dallas County Schools	62%*	8%*	24%
504-Others	57%*	6%*	32%
Chartis	50%	11%	37%
Corvel	48%	14%	31%
Coventry	49%*	15%*	31%
First Health	42%	13%	42%
Forte	52%	24%	20%
Genex	50%	19%	26%
Liberty	51%	16%	32%*
Sedgwick	58%*	13%*	23%
Travelers	56%*	18%	22%*
Texas Star	46%	17%	32%
Zenith	50%*	10%*	27%
Zurich	50%	17%	32%
Other networks	45%*	21%	24%

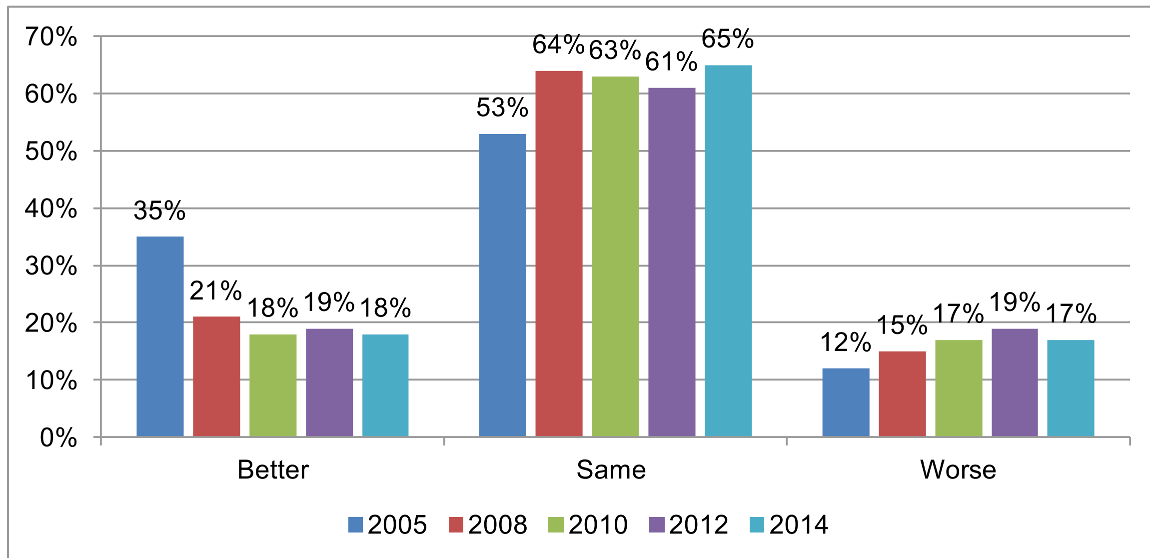
Notes: Asterisks (*) indicate that the differences between the network and non-network are statistically significant. The figures presented above are adjusted for risk factors such as injury type, type of claim, and age differences that may exist between the groups. Percentage for each network may not add up to 100% because of rounding.

Table 4.2: Overall, for Your Work-related Injury or Illness, How much of a Problem, If Any, Was it to Get a Specialist You Needed to See? Was It…

How much of a problem?	Not a problem	A small problem	A big problem
Non-network	61%	13%	24%
504-Alliance	68%*	13%*	19%*
504-Dallas County Schools	65%	4%	29%
504-Others	78%*	8%*	15%
Chartis	57%*	16%*	26%*
Corvel	63%	17%	16%
Coventry	57%	18%	24%
First Health	61%	8%*	31%*
Forte	75%*	9%*	14%
Genex	71%*	8%	18%
Liberty	58%	20%	22%
Sedgwick	60%*	9%*	31%*
Travelers	69%*	11%*	19%*
Texas Star	69%*	13%*	18%*
Zenith	62%	19%	15%
Zurich	83%*	8%	8%*
Other networks	58%	15%*	26%*

Notes: Asterisks (*) indicate that the differences between the network and non-network are statistically significant. The figures presented above are adjusted for risk factors such as injury type, type of claim, and age differences that may exist between the groups. Percentage for each network may not add up to 100% because of rounding.

Figure 4.5: Compared to the Medical Care You Usually Receive When You are Injured or Sick, your Ability to Schedule a Doctor's Appointment for Your Work-Related Injury or Illness Was:



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, Survey of Injured Workers 2005, 2008, 2010, 2012, 2014

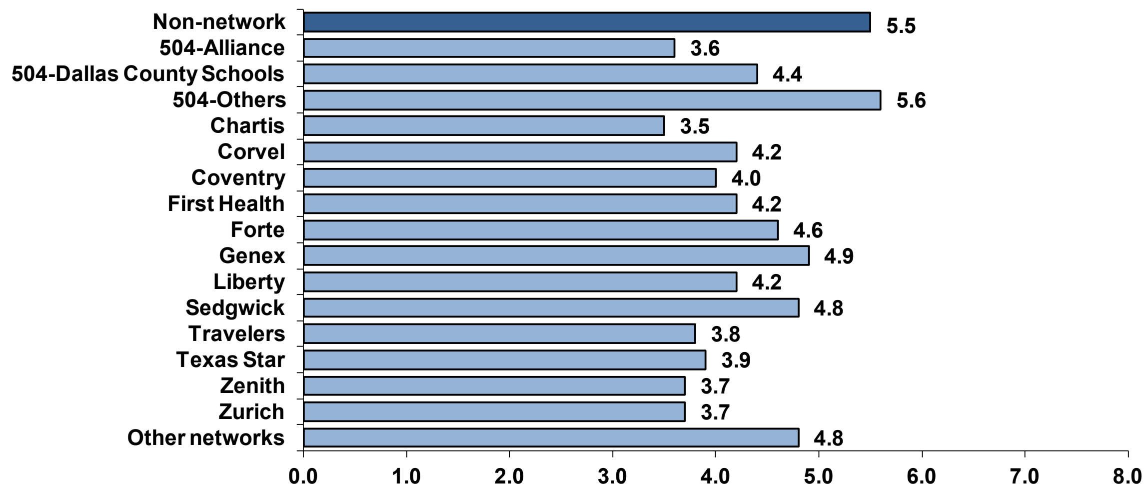
Table 4.3: Injured Employees' Perceptions Regarding Their Ability to Schedule a Doctor's Appointment for Their Work-Related Injuries Compared to the Medical Care They Normally Receive When Injured or Sick

Percentage of injured employees indicating that their ability to schedule a doctor's appointment was:	Better	About the same	Worse
Non-network	20%	64%	15%
504-Alliance	18%*	70%*	10%*
504-Dallas County Schools	15%	65%	19%
504-Others	19%	64%	14%
Chartis	16%	62%	20%
Corvel	25%	57%	14%
Coventry	23%*	53%*	23%*
First Health	22%	55%	21%*
Forte	12%	74%*	10%
Genex	12%	75%	13%
Liberty	17%	68%*	13%
Sedgwick	21%	67%	11%*
Travelers	25%*	60%	14%
Texas Star	20%*	65%*	11%
Zenith	30%*	57%	12%
Zurich	21%	65%	12%
Other networks	13%*	72%*	14%

Notes: Asterisks (*) indicate that the differences between the network and non-network are statistically significant. The figures presented above are adjusted for risk factors such as injury type, type of claim, and age differences that may exist between the groups. Percentage for each network may not add up to 100% because of rounding.

Not only higher perceptions about the ability for injured employees receiving medical care from networks to receive specialist care, 15 networks are able to schedule an injured employee an appointment to see a non-emergency doctor sooner than non-network claims (see Figure 4.6 and Section 6).

Figure 4.6: Average Number of Days from Date of Injury to Date of First Non-Emergency Treatment, Six Months Post Injury



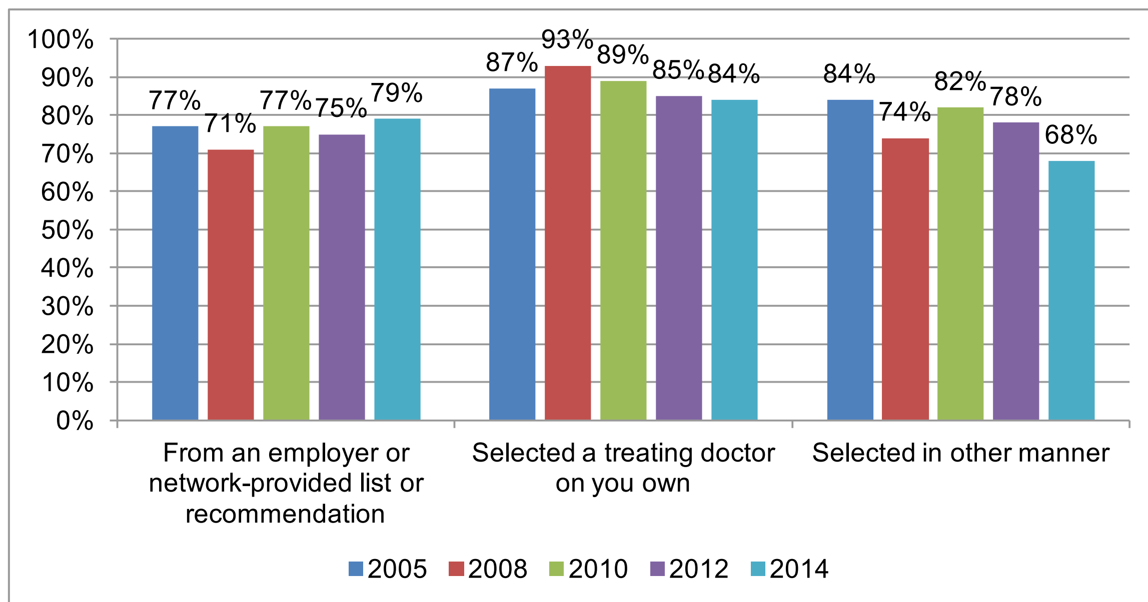
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Treating Doctor Choice and Satisfaction

Previous studies conducted by the REG show that injured employees' perceptions regarding the quality of their medical care are closely associated with their ability to choose their own treating doctor.[13] Not surprisingly then, as networks expand their coverage in Texas and injured employees are increasingly required to choose their treating doctor from a list of in-network doctors, satisfaction levels will be impacted. As Figure 4.7 shows, for injured employees who reported that they selected their own treating doctor, satisfaction levels decreased from 2005 to 2014 (84 percent surveyed in 2014 reported that the doctor they saw most often provided them good medical care compared to 87 percent surveyed in 2005).

[13] See Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, Medical Costs and Quality of Care Trends in the Texas Workers' Compensation System, 2004 and 2005.

Figure 4.7: Percentage of Injured Employees Indicating Agreement That the Doctor They Saw Most Often Provided Them With Good Medical Care By Doctor Selection Method for First Non-Emergency Doctor



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, Survey of Injured Workers 2005, 2008, 2010, 2012, 2014

Meanwhile, satisfaction levels increased in 2014 compared to 2005 for injured employees who indicated that they selected a doctor recommended by their employer or network, satisfaction levels for injured employees who selected a doctor some other way decreased from 84 percent in 2005 to 68 percent in 2014, which includes recommendations from family, friends, and co-workers. In general, though, satisfaction levels remain high for a majority of injured employees. Additionally, a slightly higher percentage (27 percent) of injured employees surveyed in 2014 reported that the medical care they received for their work-related injury was worse than their routine medical care when compared to injured employees surveyed in 2005 (19 percent) (see Figure 4.8).

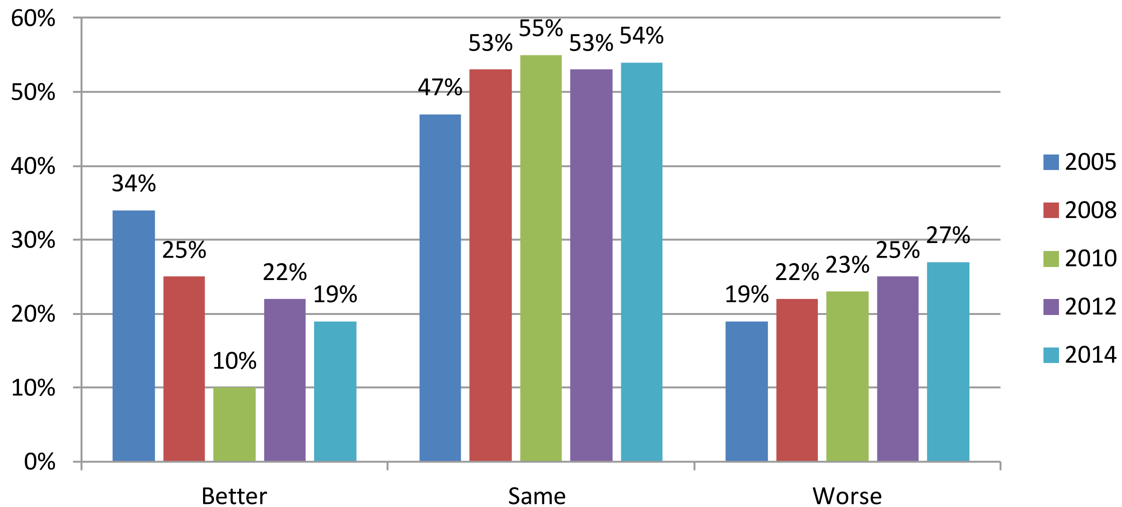
The plan must include the network's goals and plans for measuring health care provider and employee satisfaction, as well as the requirement that the network respond to complaints timely and maintain a complaint log that allows the network to track complaint trends and address those issues in real-time.[14]

Typically, the Department requests each network that had treated injured employees to address the deficiencies highlighted in the Network Report Card and submit an updated

[14] See Texas Insurance Code, Section 1305.403 and Texas Administrative Code, Sections 10.81 and 10.121.

Quality Improvement Plan. The Department works to ensure that networks adequately address complaints, as well as implement their improvement plans.

Figure 4.8: Compared to the Medical Care You Usually Receive When You Are Injured or Sick, Would You Say the Care You Received for Your Work-Related Injury or Illness Was:



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, Survey of Injured Workers 2005, 2008, 2010, 2012, 2014.

It is important to note that while injured employees who received medical care from networks were generally more satisfied with the quality of the care than non-network claims, there are differences in satisfaction levels among individual networks profiled in the 2014 Workers' Compensation Network Report Card (see Tables 4.4 and 4.5). HB 7 included mechanisms to promote quality of care monitoring, including the requirement that every network produce and annually submit to the Department a Quality Improvement Plan.

Table 4.4: The Treating Doctor for Your Work-Related Injury or Illness Overall Provided You with Very Good Medical Care That Met Your Needs…

Treating doctor provided you with very good medical care	Strongly agree/Agree	Not sure	Strongly disagree/Disagree
Non-network	76%	2%	22%
504-Alliance	83%*	2%	15%*
504-Dallas County Schools	68%	1%	30%
504-Others	78%	4%	19%
Chartis	73%	4%	22%
Corvel	77%	1%	21%
Coventry	76%	3%*	21%
First Health	72%	0%*	28%*
Forte	79%	4%*	17%
Genex	80%	1%	18%
Liberty	79%	1%	19%
Sedgwick	78%	3%	19%
Travelers	80%*	0%*	20%
Texas Star	80%*	2%*	18%*
Zenith	74%	2%	22%
Zurich	83%	0%*	16%
Other networks	75%	3%*	22%

Notes: Asterisks (*) indicate that the differences between the network and non-network are statistically significant. The figures presented above are adjusted for risk factors such as injury type, type of claim, and age differences that may exist between the groups. Percentage for each network may not add up to 100% because of rounding.

Table 4.5: Injured Employees' Perceptions Regarding Medical Care for Their Work-Related Injuries Compared to the Medical Care They Normally Receive When Injured or Sick

Percentage of injured employees indicating that the medical care for their work-related injuries was:	Better	Same	Worse
Non-network	26%	50%	23%
504-Alliance	16%*	66%*	17%*
504-Dallas County Schools	9%*	63%*	27%
504-Others	23%	60%	16%
Chartis	20%	57%	24%
Corvel	31%	52%	16%
Coventry	18%*	53%*	29%*
First Health	30%	43%	26%
Forte	16%	58%	26%
Genex	24%	54%	23%
Liberty	24%*	54%	21%
Sedgwick	26%	51%	22%
Travelers	22%	59%*	19%*
Texas Star	25%	58%*	15%*
Zenith	22%	60%*	18%
Zurich	21%	65%*	13%*
Other networks	21%*	55%	22%

Note: Asterisks (*) indicate that the differences between the individual network and non-network are statistically significant. The figures presented above are adjusted for risk factors such as injury type, type of claim, and age differences that may exist between the groups. Percentage for each network may not add up to 100% because of rounding.

Health Outcomes Improve in 2014

While there have been significant changes in the Texas workers' compensation system over the past few years in terms of the amount of medical care provided to injured employees as well as the introduction of new networks, there has been little change in injured employees' perceptions regarding their physical and mental functioning since the passage of HB 7. Physical functioning is used to measure whether an injured employee gets better or physically recovers from the injury, while mental functioning is used to measure whether an injured employee is likely to experience issues such as depression after the injury.

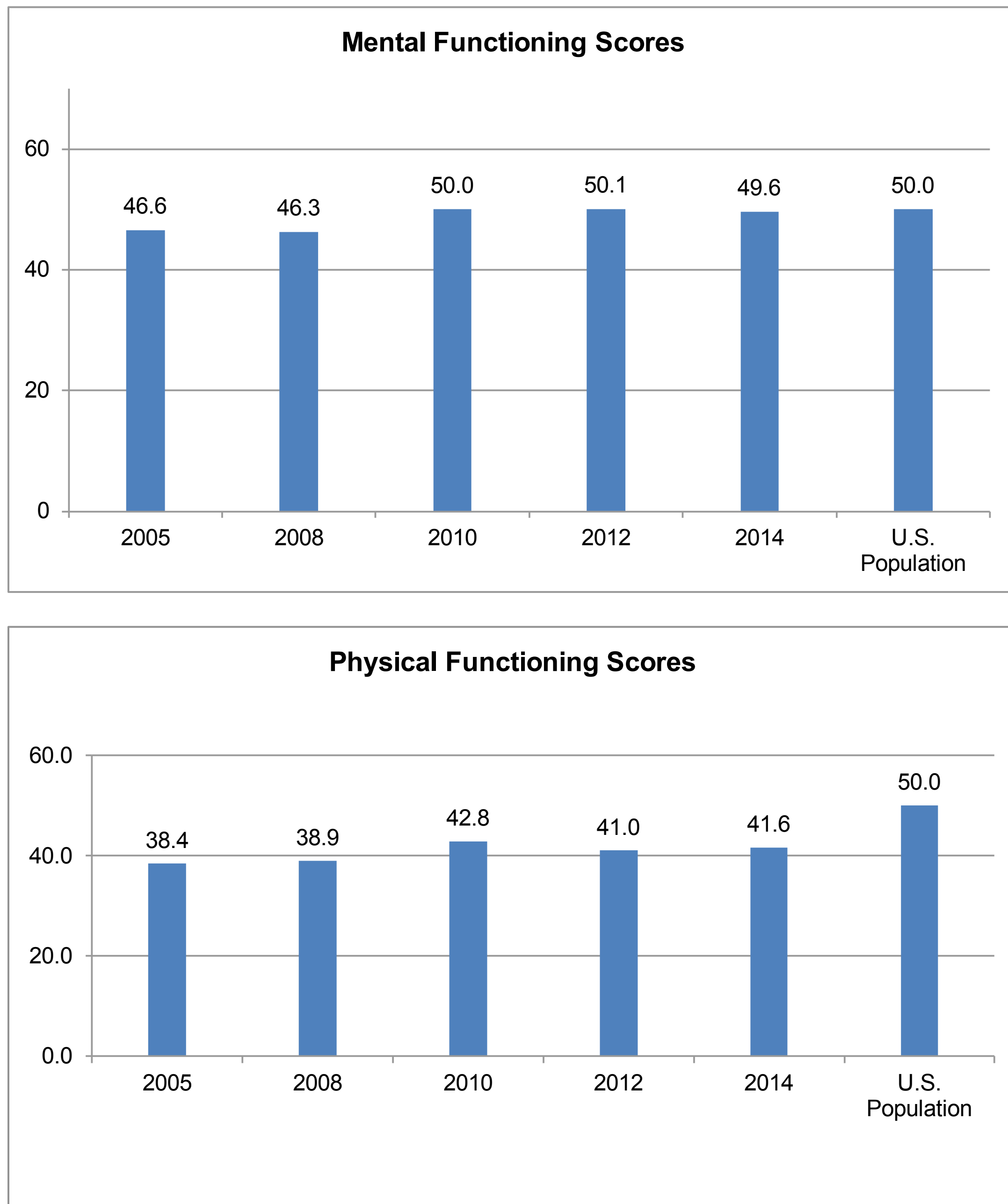
To measure the physical and mental functioning of injured employees, the REG utilized a standardized set of questions, referred to as the Short Form 12 (SF-12) survey instrument, which asks injured employees to rate their current mental health as well as their current abilities to perform certain daily life activities.

The results are calculated into two overall scores: the physical component summary and the mental component summary, which have a range of scores from zero to 100 and a mean score of 50 in a sample of the U.S. general population. Scores greater than 50 represent above average health status, and scores at 40 or lower represent people who function at a level lower than 84 percent of the population (one standard deviation).

As Figure 4.9 indicates, injured employees in Texas have improved their physical or mental functioning status significantly since 2005. The mental functioning score of 49.6 for injured employees are higher than physical functioning scores (41.6). Overall, the physical and mental functioning scores for network are significant higher than those of non-network claims.[15]

[15] For more detailed information about the physical and mental functioning scores for individual health care networks and non-network claims, see the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014 Workers' Compensation Network Report Card Results, 2014, which can be viewed at www.tdi.texas.gov/reports/report14.html.

Figure 4.9: Comparison of Injured Employee Self-Reported Mental and Physical Functioning Scores



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, Survey of Injured Workers 2005, 2008, 2010, 2012, 2014.

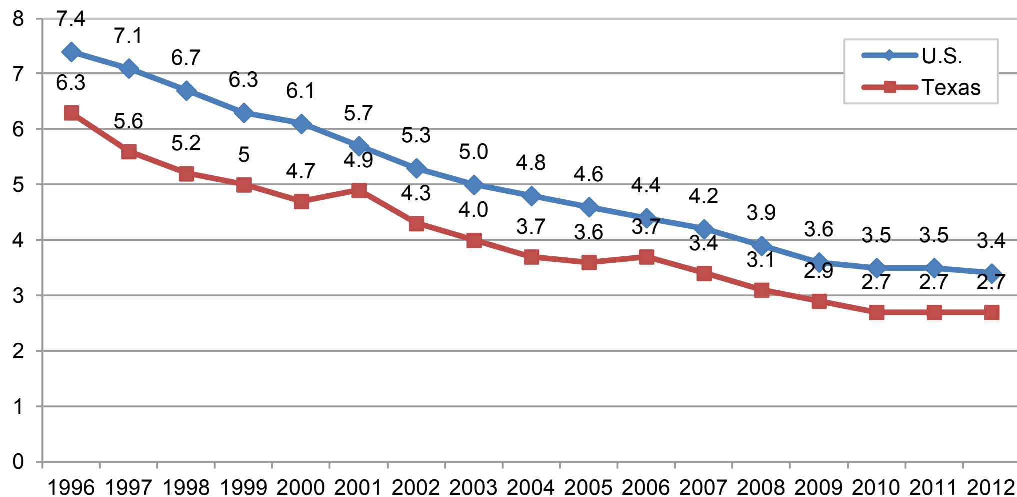
5. Medical Costs and Utilization of Care

The Texas workers' compensation system enacted various legislative and regulatory reforms through House Bill (HB) 2600 in 2001 and HB 7 in 2005, including medical fee guidelines, treatment guidelines, networks, and the pharmacy closed formulary. This section of the report will focus on how medical costs and utilization-of-care trends have changed in the system over time, as well as some of the factors influencing these cost trends.

Injury and Claim Trends

Occupational injury rates have declined steadily during the last two decades both nationally and for Texas according to the nonfatal occupational injury and illness data collected and reported by the Bureau of Labor Statistics and DWC for the *Survey of Occupational Injuries and Illnesses*.[16] Since 1996, the nonfatal occupational injury and illness rate fell by 64 percent for the U.S. and by 57 percent for Texas (see Figure 5.1). The injury rate in Texas has been consistently below the national average.

Figure 5.1: Texas and U.S. Nonfatal Occupational Injury and Illness Rates per 100 Full-Time Employees

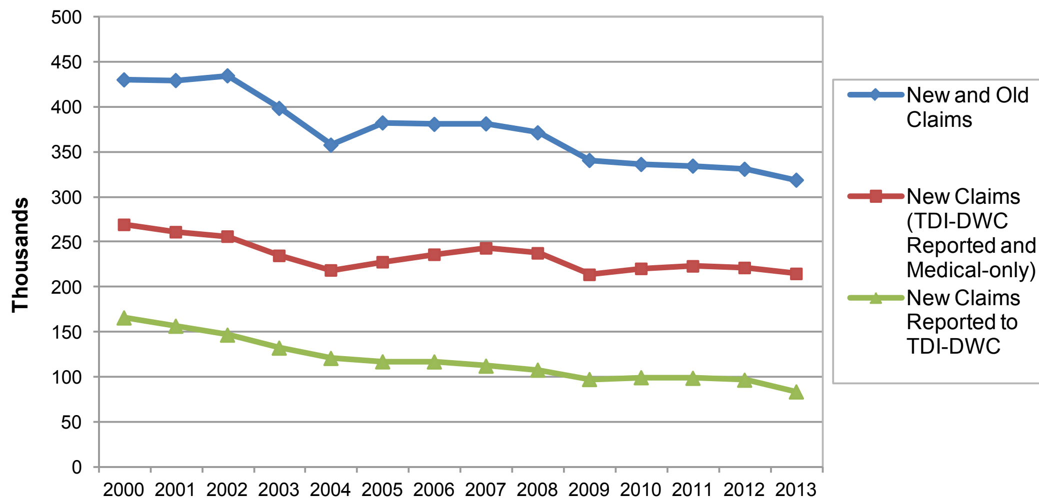


Source: Texas Department of Insurance, Division of Workers' Compensation and U.S. Department of Labor, Bureau of Labor Statistics, *Annual Survey of Occupational Injuries and Illnesses*.

[16] Changes to the OSHA recordkeeping logs in 2002 and the transition from the Standard Industrial Classification (SIC) system to the North American Industry Classification System (NAICS) in 2003 may limit comparability of pre-2003 data series.

The decreasing rate of workplace injuries is also evident in the decreasing number of reportable claims filed with the DWC.[17] In 2010, 165,609 claims with at least one day of lost time were reported to DWC, which decreased to 83,369 in 2013 (see the bottom series in Figure 5.2). Adding medical-only claims without lost time, total new claims were 260,884 in 2000, which decreased to 214,541 in 2013 (see the middle series in Figure 5.2). The top series in Figure 5.2 is the number of all unique claims treated in a given year regardless of the date of injury: 318,676 claims in 2013.

Figure 5.2: Number of Workers' Compensation Claims by Claim Type



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

The number of workers' compensation claims decreased steadily since 2000, with a period of relative stability or slight increases between 2003 and 2008. Among new claims, medical-only claims accounted for 38 percent of total new claims in 2000, and then increased steadily to 61 percent in 2013. Since medical-only claims have lower average costs per claim than those with income benefits or lost time, higher percentages of medical-only claims tends to lower the overall average cost per claim. The number of older workers' compensation claims being treated in a given calendar (or service) year was 37 percent of total claims in 2000 and 33 percent in 2013.

The decline in the number of claims, both nationally and in Texas, can be attributed to a variety of factors. Some factors include increased safety awareness among employers and employees, enhanced health and safety outreach and monitoring efforts at the federal and

[17] The number of claims reported to DWC includes claims with at least one day of lost time, all occupational diseases and all fatalities. 'Lost-time' claims refer to those claims with more than seven days of lost time in which income benefits are due to the injured employee.

state level, improvements in technology, globalization, increased use of independent contractors, and the possibility of under-reporting workplace injuries and illnesses.

A decreasing number of injuries and claims results in lower total medical costs, especially if the average cost per claim remains stable. Total and average medical costs can fluctuate up or down depending on many factors, including frequency and intensity in service utilization, expenses associated with disputes and denials, medical fees, use of managed care arrangements, and changes in injury and claim types. The remainder of this section examines these factors influencing medical costs in the Texas workers' compensation system.

Medical Cost Trends

Medical costs are direct benefits for injured employees and represent a substantial portion of the total costs of the Texas workers' compensation system, accounting for about a third of the total system cost (or premiums paid by employers). DWC collects and maintains medical data submitted by insurers according to the Texas Labor Code, Section 413.007. Medical bills are organized by provider bill type, including professional, hospital, dental, and pharmacy services. A claim is classified as 'lost-time' if it has more than seven days of lost time from work and receives income benefits. A claim is 'medical-only' if it has seven or less days of lost time without income benefits.

Professional Services

The REG examined the number of claims and costs of professional services by claim type and by injury year evaluated at six, 12, and 24 months after the injury date (see Table 5.1). For claims with six months maturity, medical-only claims accounted for 77 percent of all claims and 39 percent of the total cost in 2013.[18] Lost-time claims with more severe injuries accounted for the majority of total medical costs. Please note that the cost information provided in Table 5.1 is unadjusted, meaning that the costs reflected are actual costs reported and have not been adjusted to account for inflation changes over time.

Total costs have continued to decline since 2003 because of a variety of factors, including fewer claims being filed, reductions in medical reimbursement, and decreases in the utilization of services. While average costs per claim increased rapidly prior to 2003, these costs decreased after the implementation of the 2003 Medical Fee Guideline. By 2007, average costs per claim were lower than any of the previous ten years. This decline

[18] Injury year 2013 with six months maturity is evaluated with all medical treatments up to June 30, 2014. Although medical bills are updated by this date, some bills and payments may have not been settled and reported. The total cost figures for 2013 should be considered preliminary subject to future updates. Average cost is similarly affected by the data limit, but the effect of missing bills will be relatively minimal.

coincided with the passage of HB 2600 in 2001. However, more recent data indicate that average medical costs are increasing, albeit at a slower rate than the double-digit increases that the system experienced in the late 1990s and early 2000s. The increase is mainly due to increases in the newly adopted 2008 Medical Fee Guideline, which now contains an annual inflation factor – the Medicare Economic Index.

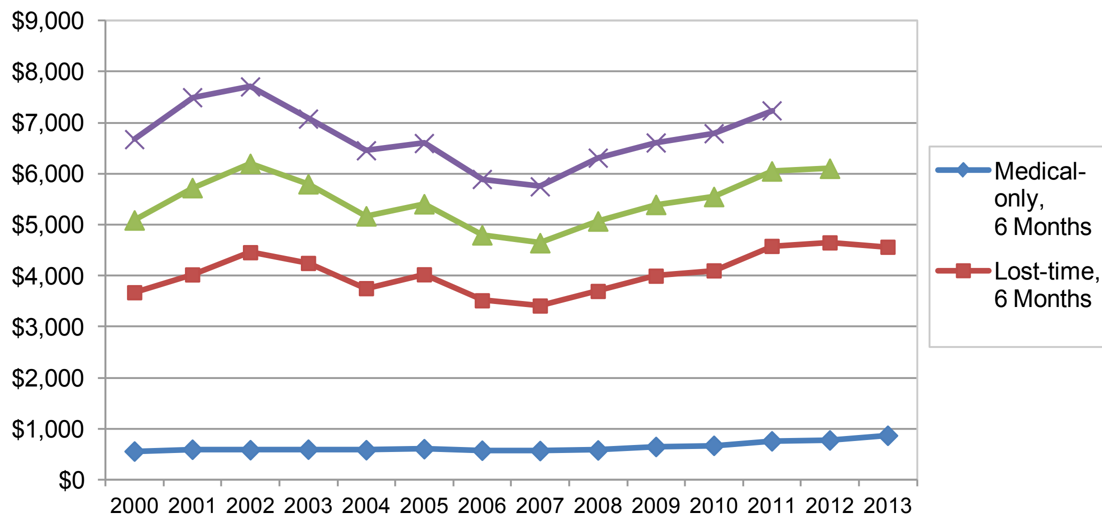
Table 5.1: Total and Average Costs by Claim Type, Professional Services, Unadjusted, by Injury Year

Injury Year	6 Months			12 Months			24 Months		
	Total Cost (Thousand Dollars)	Number of Claims	Average Cost per Claim	Total Cost (Thousand Dollars)	Number of Claims	Average Cost per Claim	Total Cost (Thousand Dollars)	Number of Claims	Average Cost per Claim
Lost-time Claims									
2000	$258,812	70,418	$3,675	$371,488	72,957	$5,092	$499,075	74,752	$6,676
2001	$282,715	70,254	$4,024	$416,033	72,657	$5,726	$554,863	74,001	$7,498
2002	$308,793	69,236	$4,460	$437,334	70,533	$6,200	$548,959	71,212	$7,709
2003	$264,890	62,338	$4,249	$366,710	63,212	$5,801	$457,513	64,636	$7,078
2004	$223,107	59,414	$3,755	$318,021	61,485	$5,172	$400,832	62,070	$6,458
2005	$230,960	57,357	$4,027	$315,232	58,276	$5,409	$387,695	58,749	$6,599
2006	$200,779	57,085	$3,517	$277,233	57,751	$4,800	$342,109	58,032	$5,895
2007	$197,890	57,959	$3,414	$271,920	58,523	$4,646	$338,288	58,825	$5,751
2008	$218,264	58,985	$3,700	$302,283	59,600	$5,072	$377,852	59,857	$6,313
2009	$218,870	54,725	$3,999	$297,881	55,195	$5,397	$365,994	55,367	$6,610
2010	$235,188	57,316	$4,103	$320,452	57,720	$5,552	$392,905	57,850	$6,792
2011	$261,549	57,066	$4,583	$347,606	57,430	$6,053	$416,706	57,559	$7,240
2012	$254,651	54,739	$4,652	$335,963	55,027	$6,105			
2013	$222,079	48,631	$4,567						
Medical-only Claims									
2000	$111,764	198,642	$563	$130,229	201,714	$646	$147,259	204,209	$721
2001	$114,033	190,630	$598	$132,825	193,614	$686	$148,483	195,514	$759
2002	$109,993	186,739	$589	$125,287	188,666	$664	$137,026	189,739	$722
2003	$103,250	172,270	$599	$115,857	173,652	$667	$124,910	174,768	$715
2004	$93,603	158,959	$589	$104,517	160,822	$650	$111,929	161,861	$692
2005	$103,645	170,186	$609	$113,767	171,401	$664	$120,888	172,126	$702
2006	$103,497	178,752	$579	$113,656	179,855	$632	$120,073	180,460	$665
2007	$105,881	184,996	$572	$115,383	186,036	$620	$121,933	186,645	$653
2008	$104,236	178,419	$584	$112,286	179,391	$626	$117,632	179,965	$654
2009	$103,582	158,817	$652	$110,740	159,612	$694	$115,509	160,116	$721
2010	$109,877	162,838	$675	$118,093	163,625	$722	$123,389	164,087	$752
2011	$126,492	165,884	$763	$135,613	166,703	$814	$141,173	167,195	$844
2012	$129,812	166,398	$780	$138,698	167,168	$830			
2013	$144,607	165,910	$872						

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Average costs experienced distinct periods of increase and decrease (see Figure 5.3). Decreased average costs from 2002 to 2007 reflect clear impacts from the adoption of the 2003 Medicare-based professional services medical fee guideline and the 2005 HB 7 reforms. Since 2007, however, professional service costs have been increasing. The average cost evaluated at six months maturity increased by 52 percent for medical-only claims and by 34 percent for lost-time claims.

Figure 5.3: Average Cost per Claim by Claim Type, by Injury Year, Unadjusted, Professional Services



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Hospital Services

For hospital and institutional services, lost-time claims at six months maturity comprised 36 percent of all claims in 2013 but accounted for 80 percent of the total cost (see Table 5.2). Since 2000, total hospital payments evaluated at six months maturity increased 53 percent by 2013 for lost-time claims while it decreased by 9 percent for medical-only claims. Average hospital costs per claim increased for both lost-time and medical-only claims by 94 percent and 42 percent, respectively. Costs were flat or decreased slightly between 2002 and 2005 (see Figure 5.4).

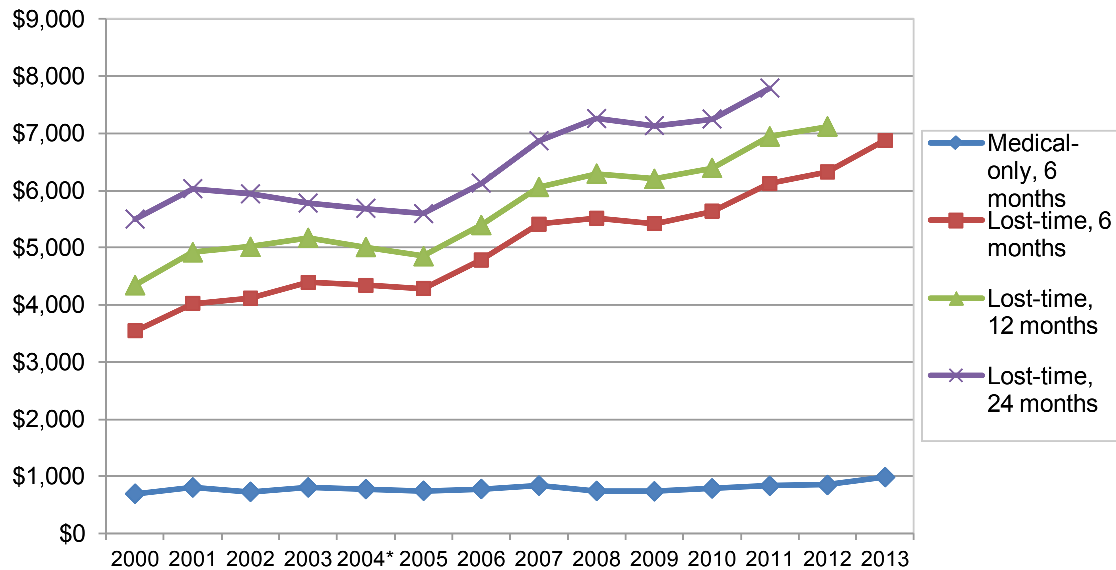
The increase in hospital costs was likely due to the fact that, prior to March 1, 2008, the system did not have an outpatient hospital services fee guideline and the inpatient hospital fee guideline in place was significantly outdated (adopted in 1997), causing an increasing number of inpatient hospital services to be paid at "fair and reasonable" levels. This resulted in a significant number of medical fee disputes between insurance carriers and hospitals in recent years. However, Figure 5.4 indicated that the new hospital fee guideline moderated the growth in per-claim hospital costs in 2008 and 2009, but costs increased significantly since 2010 while the number of claims decreased.

Table 5.2: Total Cost by Claim Type (Thousand Dollars), Hospital Services, Unadjusted, by Injury Year at 6, 12, and 24 Months Post Injury

Injury Year	Lost-time Claims			Medical-only Claims		
	6 Months	12 Months	24 Months	6 Months	12 Months	24 Months
2000	$120,698	$165,704	$226,355	$43,568	$50,635	$58,675
2001	$145,486	$200,634	$262,493	$50,317	$57,715	$64,435
2002	$158,462	$212,738	$262,730	$44,626	$50,865	$55,781
2003	$155,408	$198,164	$228,816	$45,372	$49,593	$52,523
2004	$113,317	$137,415	$165,411	$37,181	$39,890	$42,187
2005	$118,094	$144,038	$173,444	$36,103	$38,754	$40,867
2006	$146,024	$175,128	$204,835	$42,998	$45,468	$47,664
2007	$174,595	$206,806	$241,325	$48,824	$51,313	$53,970
2008	$181,512	$219,224	$259,685	$41,016	$42,721	$44,430
2009	$161,738	$195,137	$230,260	$35,088	$36,889	$38,485
2010	$177,432	$212,023	$246,011	$38,725	$40,805	$43,038
2011	$195,473	$231,718	$265,511	$42,792	$45,393	$46,801
2012	$190,664	$224,239		$41,408	$43,591	
2013	$184,653			$47,346		

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Figure 5.4: Average Cost per Claim for Hospital Services, by Claim Type, Unadjusted, by Injury Year



Note: 2004 figures are shown as an average of 2003 and 2005 due to incomplete data.
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Pharmacy Services

Total pharmacy cost in 2013 was $121 million, 13 percent lower than $139 million in 2005 (see Table 5.3).[19] Payments for lost-time claims decreased by 10 percent since 2005 while those for medical-only claims decreased by 29 percent. Lost-time claims accounted for the majority of pharmacy costs (87 percent of the total in 2013). Pharmacy costs are also concentrated in older claims (see Table 5.4). Claims with four or more years of maturity accounted for 63 percent of all costs in 2013.

Pharmacy costs decreased significantly since 2011. The main factor for the decrease was the pharmacy closed formulary that became effective in September 2011. Specific effects of the closed formulary will be discussed in a section below.

Table 5.3: Total and Average Costs by Claim Type and Service Year, Pharmacy Services

Service Year	Lost-time Claims			Medical-only Claims		
	Number of Claims	Total Costs (Thousand Dollars)	Cost per Claim	Number of Claims	Total Costs (Thousand Dollars)	Cost per Claim
2005	96,780	$117,412	$1,213	80,441	$21,650	$269
2006	94,190	$121,851	$1,294	84,705	$22,478	$265
2007	93,638	$124,106	$1,325	91,386	$22,998	$252
2008	93,213	$131,152	$1,407	88,821	$20,859	$235
2009	89,071	$133,165	$1,495	77,794	$23,218	$298
2010	89,002	$134,683	$1,513	75,167	$18,308	$244
2011	86,658	$130,217	$1,503	73,282	$16,229	$221
2012	81,833	$119,872	$1,465	71,516	$15,359	$215
2013	74,520	$105,341	$1,414	68,828	$15,461	$225

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Table 5.4: Total Pharmacy Cost by Maturity, by Service Year (Thousand Dollars)

Service Year	First Year Maturity	Second Year Maturity	Third Year Maturity	4+ Years Maturity
2005	$27,389	$13,590	$11,540	$86,543
2006	$27,734	$14,075	$10,528	$91,993
2007	$31,388	$13,508	$10,325	$91,884
2008	$32,466	$14,050	$10,252	$95,242
2009	$33,673	$15,946	$11,056	$95,707
2010	$32,698	$15,690	$10,789	$93,815
2011	$30,648	$14,027	$10,312	$91,458
2012	$27,316	$13,539	$9,486	$84,891
2013	$25,170	$11,442	$8,583	$75,607

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

[19] Payment data for pharmacy services began with the new electronic data interchange (EDI) data collection process in 2005.

Utilization of Health Care

Medical costs are affected not only by the fees for individual units of service but also by the amount of medical care provided to injured employees (also known as the utilization of care). Past studies indicated that higher medical costs in Texas during the early 2000s were primarily driven by overutilization of certain types of medical services provided to injured employees in Texas compared with other states.

Specifically, Texas injured employees received more physical medicine services, surgical services, and diagnostic testing than similarly injured employees in other states. Since the adoption of the 2003 Medical Fee Guideline, there have been significant changes in the amount of certain types of medical services provided to injured employees in Texas.

The amount of medical care provided to injured employees can be measured by the percentage of injured employees receiving certain types of medical services, as well as the amount of those services received per injured employee. Table 5.5 shows that, overall, there has been little change over time in terms of the percentage of injured employees receiving professional, hospital, or pharmacy services for their work-related injuries.

Table 5.5: Percentage of Injured Employees Receiving Health Care Services, by Service Year

Service Year	Professional Services	Hospital/ Institutional Services	Pharmacy Services
2000	96.2%	30.7%	
2001	96.1%	31.5%	
2002	97.0%	32.8%	
2003	97.5%	33.1%	
2004	97.5%	31.1%	
2005	92.8%	25.8%	46.3%
2006	92.8%	28.5%	47.0%
2007	92.7%	29.5%	48.5%
2008	92.1%	29.3%	49.0%
2009	92.7%	29.0%	49.0%
2010	94.3%	29.8%	48.8%
2011	94.9%	30.7%	47.8%
2012	95.1%	29.6%	46.3%
2013	94.9%	29.0%	45.0%

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

However, the percentage of injured employees receiving specific services changed significantly. Utilization of services increased slightly in evaluation and management (E/M) services, diagnostic, pathology and laboratory services, and other surgery services (see Table 5.6). Utilization of services in two service groups—"durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)" and "impairment rating (IR) examination and report" services—increased substantially while that of spinal surgery

and other services declined significantly. Utilization of physical medicine services increased until 2004 but by 2006 it had decreased to its 2000 level. As expected, lost-time claims received more services than medical-only claims in all service categories.

Table 5.6: Percent of Claims Receiving Certain Professional Services by Claim Type, by Injury Year at 12 Months Post Injury

Injury Year	DMEPOS	Diag/Path/ Lab	E/M	IR Exam & Report	Other Services	Physical Medicine	Surgery - Other	Surgery - Spinal
Lost-time Claims								
2000	48.7%	79.2%	95.3%	77.6%	59.4%	60.9%	40.5%	10.1%
2001	48.7%	80.7%	95.9%	81.7%	61.0%	62.9%	43.5%	11.2%
2002	54.2%	84.8%	97.3%	85.2%	65.0%	65.0%	46.5%	11.4%
2003	63.9%	86.3%	97.5%	87.1%	63.2%	65.9%	49.0%	10.7%
2004	66.9%	83.2%	96.1%	87.1%	53.9%	64.3%	47.5%	9.5%
2005	65.0%	85.8%	96.9%	88.0%	54.4%	63.2%	51.2%	8.8%
2006	69.8%	86.5%	97.3%	87.6%	54.6%	60.3%	52.3%	7.7%
2007	71.7%	87.2%	97.7%	86.9%	53.8%	59.3%	52.1%	6.3%
2008	70.9%	87.5%	97.9%	87.9%	53.6%	58.6%	52.4%	5.6%
2009	71.9%	88.2%	98.4%	89.3%	53.0%	59.8%	51.8%	5.1%
2010	71.3%	88.0%	98.6%	89.0%	52.2%	59.2%	51.3%	4.8%
2011	71.6%	87.8%	98.7%	89.1%	51.9%	57.9%	52.6%	4.3%
2012	71.8%	87.0%	98.7%	89.0%	50.4%	57.7%	52.0%	3.8%
Medical-only Claims								
2000	24.7%	51.1%	89.0%	54.0%	36.1%	21.1%	17.7%	0.7%
2001	23.4%	51.6%	90.1%	58.1%	36.2%	22.6%	17.7%	0.7%
2002	24.3%	53.3%	91.8%	60.6%	38.2%	22.3%	18.0%	0.6%
2003	32.5%	55.6%	92.3%	63.1%	34.4%	22.9%	19.0%	0.5%
2004	39.9%	55.1%	92.7%	65.6%	22.9%	23.7%	18.3%	0.5%
2005	37.1%	56.3%	93.7%	65.5%	22.5%	22.2%	19.9%	0.4%
2006	41.3%	57.7%	93.9%	66.3%	23.7%	21.2%	20.3%	0.4%
2007	42.8%	59.1%	94.3%	66.0%	23.5%	20.7%	19.7%	0.3%
2008	41.2%	59.2%	94.6%	66.9%	23.5%	19.6%	19.6%	0.2%
2009	41.3%	59.5%	95.2%	69.1%	23.5%	19.6%	19.3%	0.2%
2010	40.7%	59.2%	95.5%	69.2%	23.1%	19.2%	19.5%	0.2%
2011	40.6%	58.9%	95.5%	69.8%	22.6%	18.6%	19.7%	0.2%
2012	41.4%	57.5%	95.6%	70.7%	22.5%	19.2%	19.5%	0.2%

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

In terms of per-claim services provided to injured employees, Table 5.7 shows that there have been significant reductions in the utilization of E/M services, physical medicine services, and other services since the adoption of the 2003 Medical Fee Guideline.[20] Spinal surgeries also decreased but at a more moderate rate. On the other hand, impairment rating (IR) examination and report services and DMEPOS services increased significantly.

Table 5.7: Average Number of Services per Claim Receiving Certain Professional Services by Claim Type, by Injury Year at 12 Months Post Injury

Injury Year	DMEPOS	Diag/Path/ Lab	E/M	IR Exam & Report	Other Services	Physical Medicine	Surgery - Other	Surgery - Spinal
Lost-time Claims								
2000	6.9	8.3	17.3	5.9	6.5	110.6	3.9	4.9
2001	7.4	9.1	18.8	7.6	7.0	125.2	4.3	5.1
2002	7.9	9.8	20.2	8.4	6.9	145.8	4.6	5.3
2003	11.4	10.1	16.8	8.8	6.1	139.1	4.5	4.8
2004	13.1	8.6	13.2	8.3	4.5	118.1	4.5	4.4
2005	13.7	9.1	12.8	9.2	4.5	107.3	5.1	5.0
2006	11.5	8.7	10.9	8.5	4.2	80.2	5.1	4.9
2007	10.9	8.7	10.2	8.3	3.9	72.0	5.0	4.7
2008	10.4	9.1	10.3	8.6	3.9	72.1	5.0	4.5
2009	10.0	8.9	10.2	8.5	3.8	69.6	5.0	4.6
2010	9.0	8.8	10.1	8.3	3.6	68.2	5.1	4.2
2011	8.9	9.6	10.0	8.3	3.6	67.0	5.3	3.9
2012	8.3	9.6	9.9	8.3	3.5	68.4	5.3	4.2
Medical-only Claims								
2000	3.0	2.6	3.8	2.3	3.1	37.8	1.7	3.6
2001	3.0	2.6	3.8	2.8	3.1	38.8	1.8	3.7
2002	3.1	2.6	3.7	2.9	3.1	38.6	1.7	3.7
2003	3.7	2.6	3.4	2.9	2.8	37.9	1.7	3.4
2004	4.1	2.5	3.0	2.9	2.2	31.9	1.7	3.2
2005	4.3	2.7	3.0	3.2	2.1	31.8	1.7	3.4
2006	4.1	2.6	3.0	3.0	2.1	27.2	1.8	3.5
2007	3.8	2.6	2.9	2.8	2.0	25.0	1.8	3.3
2008	3.7	2.5	2.8	2.8	2.0	24.4	1.7	3.1
2009	3.5	2.5	2.8	2.8	1.9	24.7	1.6	3.4
2010	3.3	2.6	2.9	2.8	1.9	25.4	1.6	2.8
2011	3.2	2.7	2.9	2.9	1.9	25.7	1.7	2.8
2012	3.0	2.6	2.9	2.9	1.9	26.7	1.7	2.6

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

[20] While the unit of service is a bill for most services, the unit of service for physical medicine services is a 15-minute session or other billing unit specified by DWC.

Effects of Medical Fee Guidelines

The adoption of the 2003 and 2008 professional services medical fee guidelines not only changed the reimbursement amounts for individual categories of services but also adopted, by reference, Medicare's billing rules and payment policies. This affected how insurance carriers reviewed the medical necessity of certain types of treatments. As a result, the cost impact of the medical fee guidelines varied considerably for individual categories of services.

From August 1, 2003, to March 1, 2008, professional medical services were paid at 125 percent of Medicare's reimbursement rates (conversion factors) under the 2003 medical fee guideline. While the same reimbursement rate was used across the board for all professional services, the difference between the reimbursement rates under the 1996 and 2003 professional services medical fee guidelines varied considerably depending on the category of professional service.

From March 1, 2008, the new professional services medical fee guideline began to use a conversion factor fixed at $52.83 with the exception of surgery services, which used a separate fixed factor at $66.32 as a conversion factor. These factors are adjusted annually using the Medicare Economic Index.

Table 5.8 shows average costs per claim by service group by injury year at 12 months post injury. Until 2007, per-claim costs decreased for diagnostic services, E/M services, physical medicine, and spinal surgeries while costs for DMEPOS, disability exam, non-spinal surgeries, and other services increased. Increasing costs may be the result of two factors: 1) an increase in fees for these services (the case for E/M) as a result of new medical fee guidelines, or 2) an increase in the amount of services provided to injured employees (the case for DMEPOS and IR exam and report services), or both (the case for other surgical services).

For physical medicine services, diagnostic/pathology/laboratory services, and spinal surgery services, lower costs per claim were the result of lower fees for these services under the 2003 medical fee guideline. Additionally, lower costs per claim for physical medicine services, spinal surgical services, and other services were also the result of a decrease in the amount of services provided to injured employees.

More recent data suggest that average medical costs per claim are increasing for most services. From 2007, average costs per claim for all service groups except impairment rating exam/report services increased, in part as a result of annual updates in the 2008 medical fee guideline. To analyze trends in average fees for service, Table 5.9 presents actual average fees for service for selected services. To help compare price trends, Figure 5.5 presents indices of these fees normalized in 2000 prices as 100.

Table 5.8: Average Cost per Claim by Service Type for Professional Services, by Injury Year at 12 Months Post-Injury

Injury Year	DMEPOS	Diag/Path/ Lab	E/M	IR Exam & Report	Other Services	Physical Medicine	Surgery - Other	Surgery - Spinal
Lost-time Claims								
2000	$521	$804	$901	$344	$430	$3,305	$1,318	$2,692
2001	$576	$909	$939	$442	$466	$3,579	$1,395	$2,763
2002	$582	$957	$937	$510	$491	$3,738	$1,429	$2,765
2003	$563	$833	$873	$606	$481	$3,471	$1,161	$1,699
2004	$546	$701	$789	$632	$480	$2,983	$1,220	$1,542
2005	$659	$720	$800	$702	$513	$2,761	$1,498	$1,726
2006	$636	$649	$735	$704	$488	$2,125	$1,473	$1,596
2007	$694	$573	$747	$736	$484	$1,885	$1,486	$1,621
2008	$695	$636	$824	$728	$533	$2,031	$1,865	$1,798
2009	$685	$652	$878	$740	$541	$2,159	$2,138	$1,964
2010	$702	$646	$937	$714	$553	$2,292	$2,262	$2,021
2011	$777	$717	$1,044	$705	$582	$2,566	$2,488	$2,149
2012	$824	$676	$1,049	$699	$577	$2,669	$2,518	$2,316
Medical-only Claims								
2000	$117	$180	$196	$75	$90	$985	$324	$1,815
2001	$131	$193	$199	$91	$85	$990	$326	$1,737
2002	$120	$188	$192	$96	$78	$938	$286	$1,702
2003	$113	$165	$200	$103	$75	$901	$270	$1,016
2004	$106	$144	$214	$98	$78	$806	$284	$1,053
2005	$117	$149	$218	$107	$80	$795	$314	$1,040
2006	$109	$144	$219	$105	$79	$668	$316	$1,056
2007	$115	$133	$231	$102	$75	$626	$290	$943
2008	$111	$139	$244	$95	$73	$644	$298	$874
2009	$113	$151	$270	$106	$76	$746	$314	$1,111
2010	$109	$151	$289	$102	$83	$813	$331	$993
2011	$128	$170	$331	$105	$95	$965	$349	$1,185
2012	$122	$165	$340	$97	$93	$1,036	$356	$931

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Generally, the reimbursement for E/M services (office visits) increased under the 2003 and 2008 Medical Fee Guidelines. However, the reimbursement for certain spinal surgical services varied under the 2003 professional services medical fee guideline. For example, the reimbursement level for low back disc surgery decreased, while the reimbursement level for spinal fusion procedures increased. Most services show an increasing trend since 2008 mainly because the current professional services medical fee guideline adjusts service fees for medical inflation.

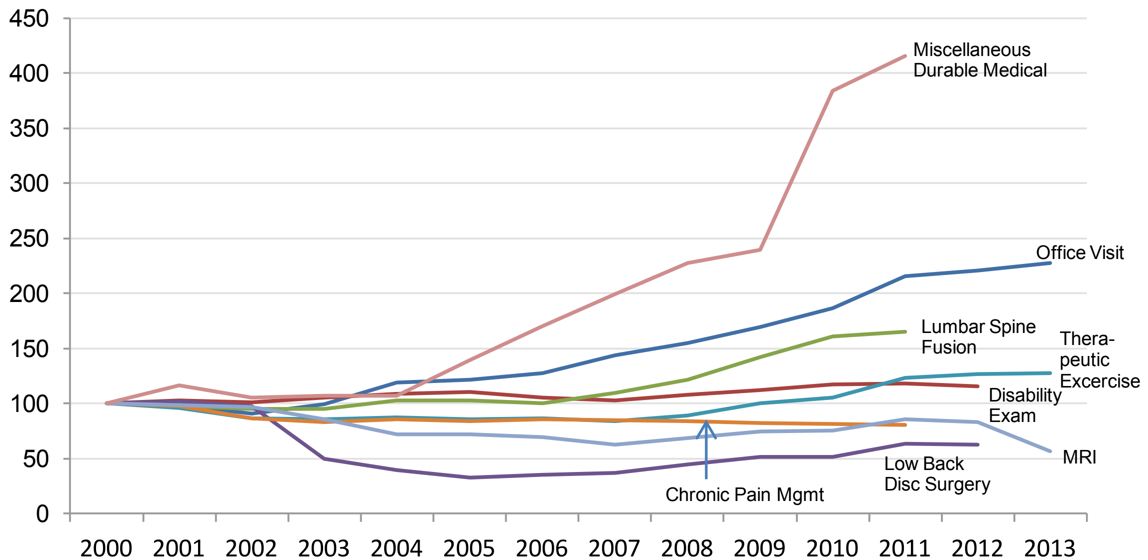
Fees for miscellaneous durable medical equipment increased substantially since 2005, but this category of service includes various types of equipment. Therefore, the increase may be due to a changing mix of more expensive equipment in recent years. The MRI service fee showed a significant decrease in 2013, for which more mature data may be necessary to verify a downward trend.

Table 5.9: Average Cost per Service by Injury Year, Lost-time Claims in Selected Services*

Injury Year	Office Visit	Disability Exam	Lumbar Spine Fusion	Low Back Disc Surgery	Thera-peutic Exercise	Chronic Pain Mgmt	MRI	Miscella-neous DME
2000	$41	$359	$803	$1,565	$30	$113	$541	$59
2001	$40	$369	$786	$1,599	$29	$110	$535	$69
2002	$37	$364	$767	$1,534	$26	$98	$523	$62
2003	$41	$380	$765	$787	$26	$94	$465	$63
2004	$49	$391	$828	$617	$26	$96	$391	$63
2005	$50	$397	$828	$511	$26	$95	$390	$83
2006	$52	$377	$807	$558	$26	$97	$378	$101
2007	$59	$371	$881	$574	$25	$96	$337	$118
2008	$63	$387	$976	$703	$27	$94	$369	$135
2009	$69	$404	$1,139	$809	$30	$93	$405	$142
2010	$76	$421	$1,293	$809	$32	$92	$410	$227
2011	$88	$424	$1,329	$990	$37	$91	$465	$246
2012	$90	$415		$979	$38		$452	
2013	$93				$38		$308	

*Office visit, therapeutic exercise, and MRI services are measured at six months maturity; disability exam and low back disc surgery services at 12 months maturity; and lumbar spine fusion, chronic pain management, and miscellaneous DME services at 24 months maturity.
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Figure 5.5: Average Cost per Service, Selected Services, Normalized in 2000 Price



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Costs and Utilization in WC Networks

Information from the annual workers' compensation network report card produced by TDI in September 2014 provided some insight into the early implementation of

networks.[21] Fourteen networks (504-Alliance, 504-Dallas County Schools, Chartis, Corvel, Coventry, First Health, Forte, Genex, Liberty, Sedgwick, Texas Star, Travelers, Zenith, and Zurich) had sufficient claim volume to be compared with each other and with non-network claims. In addition, the 2014 report card included a separate group of networks authorized under Chapter 504, Texas Labor Code.

This group was referred to in the report as 504-Others and consisted of City of Edinburg, City of McAllen, Brownsville ISD, Donna ISD, Houston ISD, Sharyland ISD, Tarrant County-River View, and the Trinity Occupational Program (Fort Worth Independent School District). The remaining eight networks that had reported treating injured employees according to the TDI's February 2014 certified network data call were combined into an "other networks" category for comparison purposes.

All of the cost and utilization findings presented in the report card had been statistically adjusted to account for differences in injury types or claim types (that is, medical-only and lost-time claims) that might have occurred in these claim populations over time. As a result, changes in costs and utilization over time cannot be attributed to changes in the types of injuries sustained by injured employees or the relative severity of those injuries. Cost and utilization differences between network and non-network outcomes as well as between the networks can be the result of a wide range of factors such as differing methods of medical care delivery, fees, and utilization review.

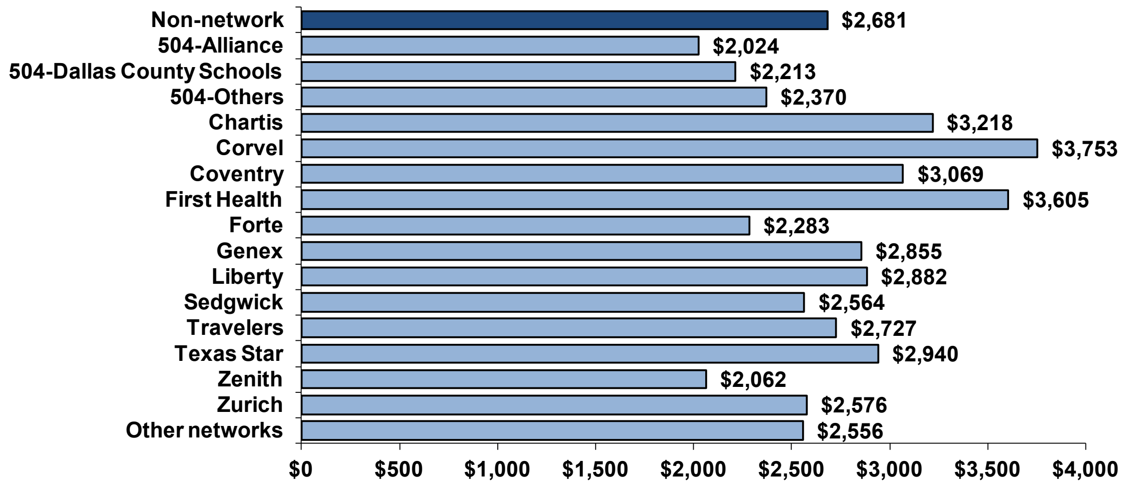
In general, differences began to emerge among individual networks. As Figure 5.6 shows, at six months post injury, the average medical cost per claim for the networks was higher than non-network claims. Generally, in 2014 the average medical cost per network claim was approximately 0.7 percent higher than for non-network claims, down from 7 percent in 2012. Overall, most networks experienced either cost reductions or lower increases than non-network while non-network's average costs increased by 3 percent from the 2012 results.

When medical costs are further broken down into professional, hospital, and pharmacy services, the average medical cost per claim for professional services was higher for network claims than non-network claims at six months post injury (see Figure 5.7). However, network claims had lower hospital and pharmacy costs per claim than non-network claims at six months post injury (see Figure 5.8 and Figure 5.9). In order to be certified by TDI, a network must offer hospital, as well as professional services. HB 7 excluded the delivery of pharmacy services from networks meaning that networks are not allowed to direct injured employees to an "in-network" pharmacy, but rather injured

[21] For more information about how individual networks compare with each other and with non-network claims on a variety of cost, utilization, access to care, satisfaction with care, return-to-work, and health outcomes measurements, see "*2014 Workers' Compensation Network Report Card Results*" by Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, available online at (www.tdi.texas.gov/reports/report14.html).

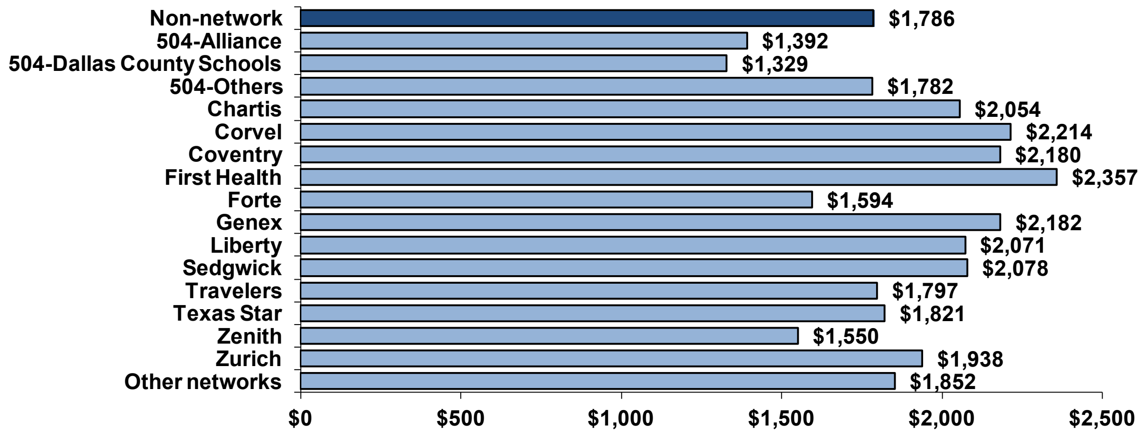
employees are able to get their prescriptions filled at any pharmacy participating in the Texas workers' compensation system. During the initial formation of many of the networks certified by TDI, networks and hospitals engaged in fierce fee negotiations, which resulted in many hospital fee contracts being reimbursed at levels that are higher than what hospitals are paid for similar services under TDI's hospital fee guidelines.

Figure 5.6: Average Medical Cost per Claim, Network and Non-Network Claims, Six Months Post Injury



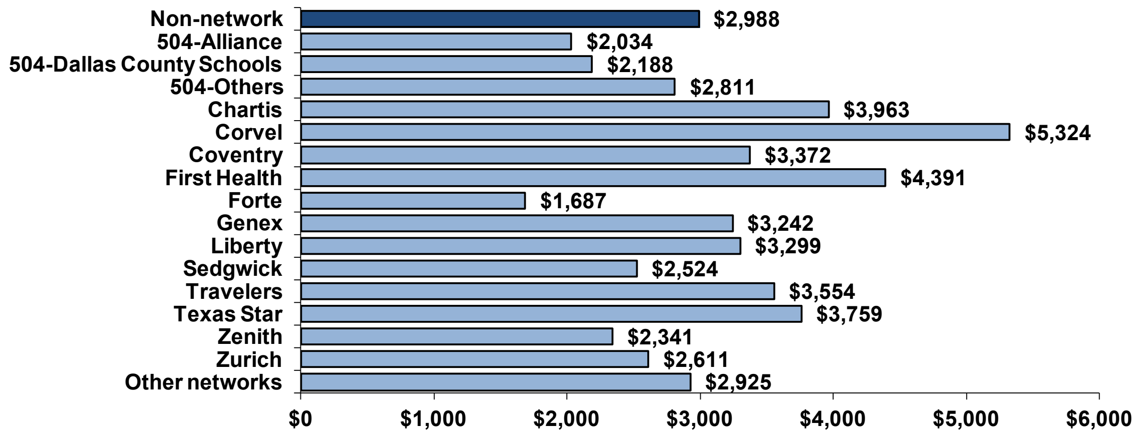
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Figure 5.7: Average Medical Cost per Claim for Professional Medical Services, Network and Non-Network Claims, Six Months Post Injury



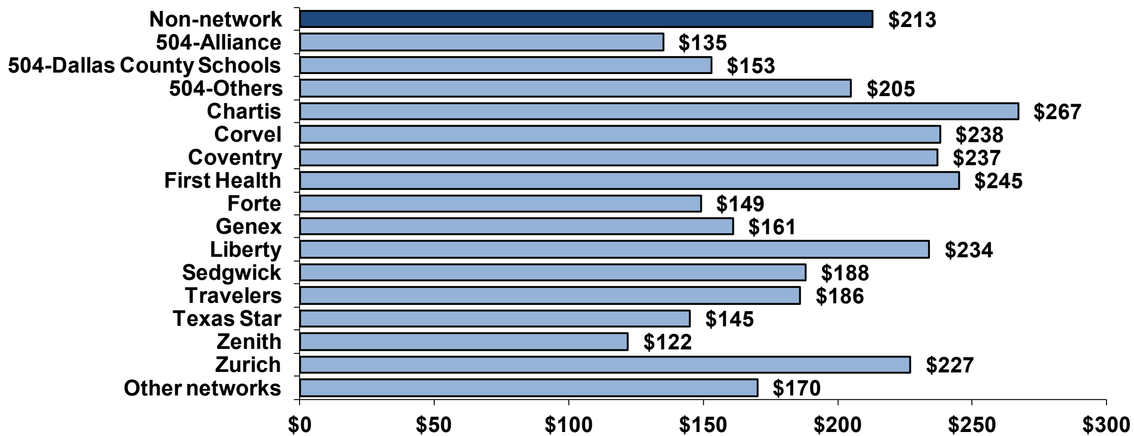
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Figure 5.8: Average Medical Cost per Claim for Hospital Medical Services, Network and Non-Network Claims, Six Months Post Injury



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Figure 5.9: Average Medical Cost per Claim for Pharmacy Medical Services, Network and Non-Network Claims, Six Months Post Injury



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Medical cost differences between network and non-network claims are narrowing. Networks as a group have improved cost performance relative to non-network. Networks' average medical cost fell by 3 percent, from $2,782 in 2012 to $2,700 in 2014. Over the same time frame, non-network average medical cost increased by 3 percent, from $2,602 in 2012 to $2,681 in 2014. Table 5.10 shows the percentage of injured employees receiving professional, hospital, and pharmacy services in the 16 network entities, as well as non-network as highlighted in the *2014 Workers' Compensation Network Report Card*. A higher percentage of injured employees receiving medical treatment in networks received professional and pharmacy services compared with non-network claims, while a lower percentage of network claims received hospital services (services in inpatient or

outpatient hospital settings and ambulatory surgical centers).

Table 5.10: Percentage of Injured Employees Receiving Professional, Hospital, and Pharmacy Services, Six Months Post Injury

Medical Type	Non-network	504-Alliance	504-Dallas Co. Schools	504-Others	Chartis	Corvel	Coventry	First Health	Forte	Genex	Liberty	Sedgwick	Travelers	Texas Star	Zenith	Zurich	Other networks
Professional	94%	99%	98%	99%	97%	98%	97%	97%	96%	97%	97%	98%	97%	96%	96%	97%	98%
Hospital	31%	29%	39%	16%	28%	28%	25%	27%	41%	20%	23%	18%	25%	30%	22%	23%	23%
Pharmacy	32%	35%	40%	47%	33%	43%	38%	40%	37%	31%	41%	36%	38%	40%	32%	36%	35%

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

When the percentage of injured employees receiving professional medical services is examined more closely, it appears that, with some exceptions, a higher percentage of injured employees in networks received E/M services (office visits), other physical medicine services, other diagnostic tests, and other professional services than non-network claims (see Table 5.11).

Networks generally provided more pharmacy services (in terms of writing more prescriptions to a higher percentage of similarly injured employees) than non-network care (see Table 5.12). This is likely due to the statutory provision in HB 7, which allows networks to designate the specialties of doctors who serve as treating doctors (that is, primary care providers). As of 2014, networks have only designated medical doctors (MDs) or Osteopaths (DOs) as network treating doctors.

Chiropractors do not generally serve as network treating doctors, but rather as referral providers. This differs from non-network medical care since the Texas Labor Code and DWC rules allow non-network employees to select chiropractors as well as MDs, DOs, podiatrists, dentists, and optometrists as treating doctors. As a result, the doctors who serve as treating doctors in networks are providers who have the authorization to write prescriptions and utilize pharmacy services as part of their treatment protocols.

In addition to a higher percentage of network employees receiving certain types of professional medical services, networks generally provided higher amounts of service per claim in E/M and pathology/laboratory services than non-network claims (see Table 5.13). Networks provide lower amounts of service per claim in other types of professional services, such as PM-modalities, CT scans, MRIs, nerve conduction studies, and other diagnostic testing services than non-network claims.

Table 5.11: Percentage of Injured Employees Receiving Professional Medical Services, by Type of Professional Service, Six Months Post-Injury

Type of service	Non-network	504-Alliance	504-Dallas Co. Schools	504-Others	Chartis	Corvel	Coventry	First Health	Forte	Genex	Liberty	Sedgwick	Travelers	Texas Star	Zenith	Zurich	Other networks
Evaluation & Management	95%	98%*	99%*	100%*	96%	97%*	97%*	97%*	96%*	96%	97%*	97%	97%	97%	98%*	98%*	98%*
PM-Modalities	7%	7%	0.4%*	9%*	10%*	8%*	9%*	8%*	2%*	7%	6%	9%*	7%	6%*	4%*	7%	9%*
PM-Other	25%	23%*	3%*	32%*	30%*	34%*	34%*	35%*	28%*	36%*	36%*	32%*	30%*	28%*	28%*	34%*	31%*
DT-CT SCAN	2%	2%*	2%	3%	3%	3%	2%	3%*	3%	2%	2%	1%*	2%	3%*	2%	3%	2%
DT-MRI	14%	13%	14%	17%*	13%	15%	15%*	16%*	17%*	14%	14%	17%*	12%*	14%	11%*	12%	15%*
DT-Nerve Conduction	2%	1%*	1%	1%	2%	2%	2%	2%	2%	1%	2%	2%	2%	2%*	2%	2%	4%*
DT-Other	57%	57%	65%*	63%*	58%	62%*	58%*	58%	64%*	57%	61%*	59%*	57%	59%*	53%*	56%	54%*
Spinal Surgery	0.2%	0.1%	0.0%	0.1%	0.3%	0.1%	0.2%	0.2%	0.0%	0.2%	0.2%	0.1%	0.2%	0.2%	0.0%	0.1%	0.2%
Other Surgery	25%	20%*	14%*	19%*	27%	34%*	25%	30%*	20%*	25%	28%*	21%*	28%	30%*	26%	24%	25%
Path. & Lab	10%	8%*	5%*	6%*	9%	8%*	11%*	13%*	6%*	9%	7%*	8%*	10%	9%	11%	15%*	11%
All Others	79%	80%*	96%*	97%*	85%*	89%*	90%*	87%*	76%*	90%*	90%*	91%*	88%*	82%*	88%*	88%*	84%*

Note: * denotes where differences between the network and non-network are statistically significant.
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Table 5.12: Percentage of Injured Employees Receiving Pharmacy Services, by Pharmaceutical Classification Group, Six Months Post-Injury

Type of service	Non-network	504-Alliance	504-Dallas Co. Schools	504-Others	Chartis	Corvel	Coventry	First Health	Forte	Genex	Liberty	Sedgwick	Travelers	Texas Star	Zenith	Zurich	Other networks
Analgesics-Opioid	53%	46%*	60%*	43%*	53%	58%*	52%	58%*	57%*	52%	57%*	57%*	53%	59%*	52%	49%	55%
Analgesics-Anti-inflammatory	55%	56%	58%	70%*	61%*	56%	60%*	61%*	64%*	63%*	61%*	65%*	59%*	55%	55%	58%	61%*
Musculoskeletal therapy	30%	31%	37%*	33%	33%	28%	32%*	36%*	35%*	35%	31%	38%*	31%	29%	29%	33%	30%
Central Nervous System Drugs	6%	5%*	4%	5%	6%	5%	6%	7%	7%	5%	6%	4%*	5%*	7%	5%	5%	6%
Other	42%	36%*	33%*	30%*	46%	39%	39%*	43%	29%*	35%*	40%	34%*	37%*	41%	36%*	46%	40%

Note: * denotes where differences between the network and non-network are statistically significant.
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Table 5.13: Average Number of Professional Services Billed per Claim by Type of Professional Service, Six Months Post-Injury

Type of service	Non-network	504-Alliance	504-Dallas Co. Schools	504-Others	Chartis	Corvel	Coventry	First Health	Forte	Genex	Liberty	Sedgwick	Travelers	Texas Star	Zenith	Zurich	Other networks
Evaluation & Management	4.5	4.1*	5.4*	4.7	4.8	6.4*	5.0*	5.6*	5.0*	4.6	5.3*	4.7*	4.8*	5.2*	4.5	4.8*	5.1*
PM-Modalities	9.5	9.2	3.9	9.5	8.8	8.2	7.9*	8.2	6.4*	6.3*	6.2*	7.8*	8.1*	8.9*	4.7*	9.3	8.2*
PM-Other	38	35*	21*	37	43*	47*	38	46*	39	44*	41*	36	39	38	30*	35	33*
DT-CT SCAN	1.6	1.5	1.4	1.5	1.8	1.8	1.6	1.7	1.6	1.4	1.6	1.7	1.6	1.6	1.6	1.5	1.4
DT-MRI	1.5	1.5*	1.7	1.5	1.4	1.9*	1.6	1.6	1.6	1.4	1.4*	1.3*	1.4*	1.6	1.4	1.5	1.5
DT-Nerve Conduction	8.5	8.1	5.6	5.2	15*	6.8	9.5	8.4	3.5*	10.2	9.1	6.7	6.6*	8.4	4.7	13.6*	7.1
DT-Other	2.6	2.3*	2.5	2.6	2.5	3.0*	2.5*	2.8*	2.6	2.2*	2.4*	2.2*	2.4*	2.7*	2.3*	2.4	2.4*
Spinal Surgery	4.4	3.8	5.0	5.0	10.0	8.5	3.6	7.8	4.0	3.0	3.9	1.7	4.9	5.6	0.0	10.0	4.3
Other Surgery	2.9	2.7*	3.3	3.0	2.9	3.4*	3.5*	3.8*	2.8	2.9	3.2*	2.9	2.9	3.2*	2.7	2.8	3.0
Path. & Lab	8.3	7.5	8.7	4.9	11.7*	10.6*	8.6	11*	8.1	4.3*	11.5*	7.8	8.5	10*	7.7	9.0	7.6
All Others	10.9	8.6*	8.1*	10.9	12.5	14.7*	11.9*	16.4*	9.3	10.4	11.5	9.1*	12.4*	11.7*	9.4	12.8	10.7

Note: * denotes where differences between the network and non-network are statistically significant.
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Effects of the Pharmacy Closed Formulary

DWC adopted one of the nation's first workers'compensation pharmacy closed formularies in September 2011. For injuries on or after September 1, 2011, pharmacy benefits are subject to the closed formulary. The closed formulary includes all FDA-approved drugs, with the exception of drugs identified with a status of "N" in the current edition of the *Official Disability Guidelines Treatment in Workers' Comp, Appendix A – ODG Workers' Compensation Drug Formulary*, or any compound that contains an "N" status drug, and any investigational or experimental drug. By rule, all drugs that are excluded from the closed formulary must be preauthorized by the insurance carrier prior to being dispensed by a pharmacy. As of September 2014, there were 164 drugs on the "N" list. Legacy claims—injuries, which occurred prior to September 1, 2011—became subject to the closed formulary on September 1, 2013.

In general, N-drug usage is higher in older claims and before the formulary. In 2010 prior to the implementation of the closed formulary, N-drugs accounted for 23 percent of the total pharmacy costs among newer claims (with three years or less maturity), and 35 percent of the total pharmacy costs among older claims (with more than three years maturity) (see Table 5.14). After the formulary's implementaiton in 2013, N-drugs accounted for only four percent of the total cost for newer claims and 18 percent for older claims. The average cost per prescription for N-drugs was twice that of other drugs.

Table 5.14: Total and Average Costs, by N-Drug Status by Maturity

Service Year	N-drug					Other				
	Total Cost (Thousand Dollars)	Number of Rx	Number of Claims	Average Cost per Rx	Average Cost per Claim	Total Cost (Thousand Dollars)	Number of Rx	Number of Claims	Average Cost per Rx	Average Cost per Claim
0 to 3 Years										
2005	$8,889	106,517	27,151	$83	$327	$43,631	803,085	141,158	$54	$309
2006	$9,583	112,074	28,420	$86	$337	$42,753	851,624	142,948	$50	$299
2007	$9,505	103,444	27,966	$92	$340	$45,716	868,641	150,635	$53	$303
2008	$10,754	103,536	30,131	$104	$357	$46,014	823,618	148,302	$56	$310
2009	$12,949	106,861	30,545	$121	$424	$47,726	759,445	134,677	$63	$354
2010	$13,413	103,502	29,376	$130	$457	$45,764	741,717	134,044	$62	$341
2011	$10,807	86,089	24,624	$126	$439	$44,180	735,658	132,397	$60	$334
2012	$5,487	41,746	11,537	$131	$476	$44,854	712,003	129,053	$63	$348
2013	$1,897	15,790	5,796	$120	$327	$43,298	656,299	121,219	$66	$357
More than 3 Years										
2005	$29,374	192,828	18,545	$152	$1,584	$57,169	625,279	36,585	$91	$1,563
2006	$33,202	203,470	18,456	$163	$1,799	$58,791	669,462	35,561	$88	$1,653
2007	$33,183	187,961	17,545	$177	$1,891	$58,701	610,206	33,560	$96	$1,749
2008	$33,238	178,500	16,189	$186	$2,053	$62,004	600,278	32,189	$103	$1,926
2009	$33,279	168,838	15,142	$197	$2,198	$62,428	564,110	30,624	$111	$2,039
2010	$32,367	158,135	14,141	$205	$2,289	$61,448	540,558	28,336	$114	$2,169
2011	$29,860	140,142	12,742	$213	$2,343	$61,598	524,996	26,289	$117	$2,343
2012	$22,623	106,026	10,848	$213	$2,085	$62,267	487,697	24,488	$128	$2,543
2013	$13,251	58,889	8,037	$225	$1,649	$62,356	460,023	22,901	$136	$2,723

Note: Rx = prescription.
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

To evaluate the effects of the pharmacy closed formulary on cost and utilization, REG compared a group of pre- and post-formulary claims.[22] Accounting for the first 18 months of service from the injury date, Table 5.15 shows a significant drop in the cost and utilization of N-drugs among the post-formulary group (2011 injury year). Total N-drug costs dropped by 82 percent, and its share in all pharmacy costs decreased by 79 percent (from 21 percent to 3.5 percent) after the adoption of the closed formulary. The total number of N-drug prescriptions decreased by 75 percent and the average cost per N-drug prescription dropped by 28 percent.

While the closed formulary had significant reduction effects on N-drug cost and utilization, it also led to slight decreases in the cost and utilization for other drugs. This indicates that the closed formulary did not simply shift N-drug usage into non-N drugs. The report also shows a significant drop in the N-drug usage among legacy claims that became subject to the formulary in September 2013. The REG will continue to monitor the implementation of the closed formulary on legacy claims.

[22] For more details, see REG's report titled "*Impact of the Texas Pharmacy Closed Formulary: A Preliminary Report Based on 12-month Injuries with 18-month Services and Legacy Status*" (August 2014) available at www.tdi.texas.gov/reports/report14.html.

Table 5.15: Cost and Utilization of N-drugs in Sample Cohorts Before and After the Pharmacy Closed Formulary

Injury Year	2009	2010	2011 (Post Formulary)	2010-2011 Percentage Change
Total cost of N-drug prescriptions	$8,287,773	$6,474,477	$1,152,152	-82%
Total cost of Other drug prescriptions	$31,713,580	$31,961,894	$31,670,955	-1%
Number of N-drug prescriptions	67,002	57,369	14,195	-75%
Number of Other drug prescriptions	575,865	595,126	575,062	-3%
Number of N-drug claims	20,664	19,767	6,847	-65%
Number of Other drug claims	103,375	106,105	105,086	-1%
N-drug cost as a percentage of total drug costs	20.72%	16.84%	3.51%	-79%
Average cost per N-drug prescription	$124	$113	$81	-28%
Average N-drug cost per claim	$401	$328	$168	-49%

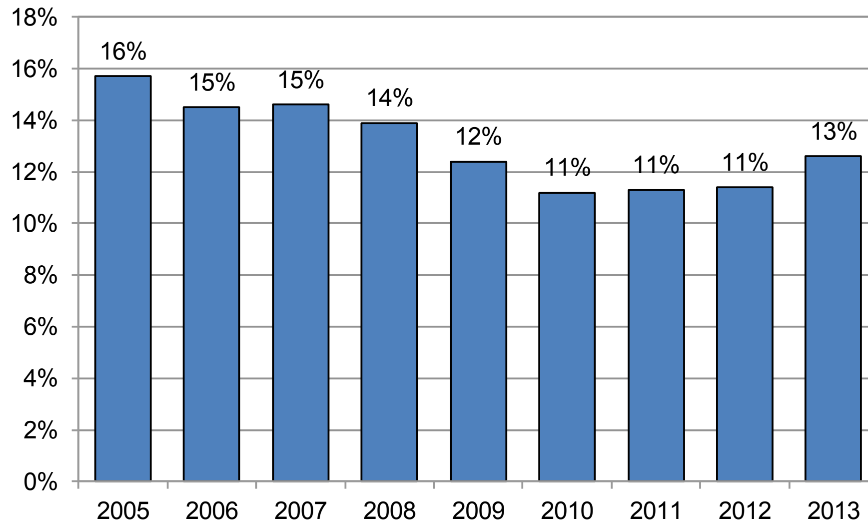
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Effects of Denials and Disputes on Medical Cost

It appears that insurance carrier denials of both workers' compensation claims and medical services began to decrease as total medical costs stabilized in Texas after 2005. Both the percentage of reportable claims and the percentage of professional medical services initially denied/disputed have decreased from their 2005-2006 levels (see Figures 5.10 and 5.11). At first, denials of professional medical services increased significantly with the adoption of the 2003 Medical Fee Guideline (which included the adoption, by reference, of the Medicare billing rules and payment policies into the Texas workers' compensation system). However, when significant lowering and flattening of total medical costs followed, so did both claim and medical service denials. The 2013 increase in initially denied /disputed claims could be revised downward if some of these claims are subsequently approved either through a mutual agreement between the parties or through the administrative dispute process.

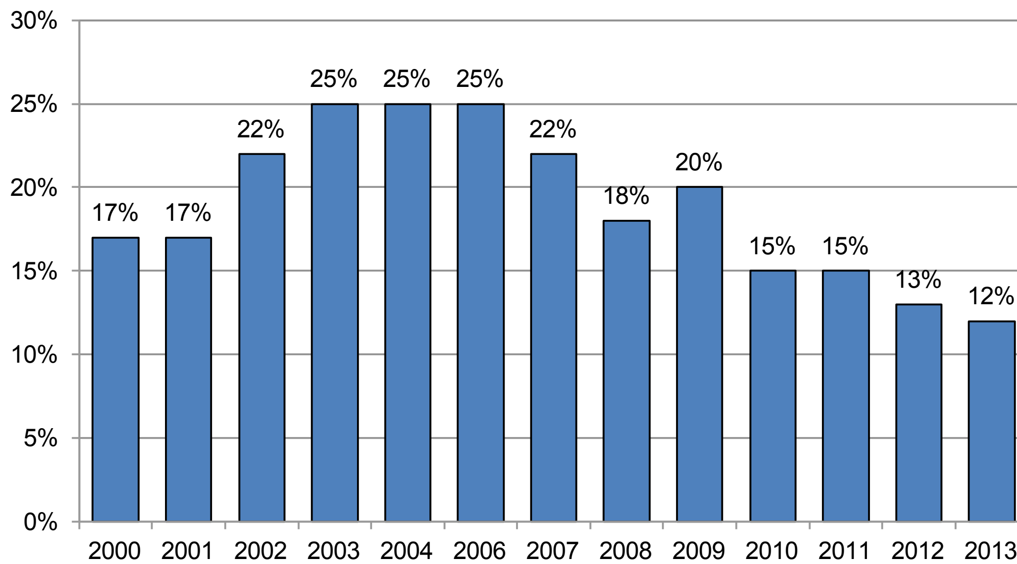
Reduced medical costs (due in part to falling injury rates) and the implementation of fee guidelines and payment policies might have also reduced the conditions that promote overall denials. However, the effects of denials on medical costs may be larger than the billing data show since these professional medical denials represent only the denials for medical treatments and services that have already been rendered. Preauthorization denials are not included in these numbers since denied services at the preauthorization stage will not have bills submitted, and their effects would have further reduced medical costs.

Figure 5.10: Percentage of Reportable Claims That Are Initially Denied/Disputed for the Top 25 Workers' Compensation Insurance Carriers, by Injury Year[23]



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Figure 5.11: Percentage of Professional Medical Services Denied for the Top 25 Workers' Compensation Insurance Carriers, by Service Year



Note: Denial rates for 2005 were excluded due to missing data. Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

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[23] The top 25 insurance carriers represented approximately 84.5 percent of the workers' compensation premiums in 2011 and accounted for 60 percent to 70 percent of the total amount of medical payments made in recent years. For the purpose of this analysis, the same 25 insurance carriers were used in each year to calculate both the claim and medical billing denial rates.

Summary

Overall, the average medical cost per claim decreased significantly from the peak in 2002 until 2007, but has been increasing since 2008. Stabilized costs and the substantial reduction in utilization of care between 2001 and 2007 were directly related to various reform measures of HB 2600 and HB 7, especially the passage of the 2003 professional services medical fee guidelines and the expanded preauthorization requirement for physical medicine services. Over this same time period, much of the reduction in total medical payments occurred because of reductions in injury rates and the total number of reportable claims filed with DWC.

Also, increased scrutiny by insurance carriers in terms of compensability and medical necessity issues as well as changes in reimbursement amounts; the adoption of the Medicare payment policies in 2003; networks; and treatment guidelines have helped reduce overutilization and medical cost inflation in Texas. However, a combination of decreasing number of claims, increasing utilization in some professional and hospital services, and the 2008 professional service medical fee guideline's annual adjustments for inflation resulted in increasing average costs since 2008.

During the 2005 legislative session as well as during the adoption of network rules and certification processes at TDI, various system participants expressed concerns about whether the implementation of a new "managed care" health care delivery model in the Texas workers' compensation system would result in employees receiving significantly less medical care and/or poor quality medical care. Eight years after the implementation of the first network in 2006, it appears that injured employees are receiving as much medical care, and in some cases more medical care, than non-network claims with similar types of injuries.

DWC and REG will continue to monitor the implementation of networks as well as the new medical fee guidelines (effective March 1, 2008), the treatment guidelines (effective May 1, 2007), and the pharmacy closed formulary (effective September 1, 2011) on medical costs and utilization of care outcomes for Texas injured employees.

6. Access to Medical Care

One of the primary goals of an effective workers' compensation program is to ensure that employees with work-related injuries receive prompt and appropriate medical treatment. Delayed medical care may have a negative effect on health outcomes resulting in increased costs and delayed return-to-work. Obtaining timely medical care in workers' compensation can be a complex process as it involves reporting the injury, compensability and extent of injury determination, utilization reviews, preauthorization, and other rules. However, once the workers' compensation claim is found to be compensable, timely and appropriate access to medical care depends on the availability of providers who will accept workers' compensation patients.

Policymakers and system participants continue to express widespread concern that fewer health care providers are participating in the Texas workers' compensation (WC) system. Anecdotal evidence suggests that some injured employees have difficulties finding appropriate health care providers. To assess the condition of access to care, the REG has conducted an extensive study of the availability and participation of treating doctors in the workers' compensation system and evaluated the timeliness of medical care.[24] Covering the period from 2000 to 2013 injury years, the study's results indicate that access to care conditions for workers' compensation patients in Texas have improved during the 13-year period; although, some access to care measures worsened slightly since 2011 as the total number of physicians in Texas stopped growing.

Access to Care Measurements and Data

REG's access to care study focused on injured employees' primary and initial access to physicians for non-emergency care.

For non-emergency professional services, primary access to care is measured by how timely an initial treatment was received after an injury. Timeliness of care is defined by the number of days from the date of injury to the first non-emergency treatment. All claims are evaluated within six months from the injury date. This timeliness measure is influenced by the number of claims (the demand factor) and the number of treating physicians (the supply factor). Therefore, the timeliness measure is also reflected in the claims-to-physician ratio, which is the total number of WC claims divided by the total number of WC participating physicians. When there are fewer doctors treating the same number of WC patients, the number of injured employees treated per physician will increase.

To survey physician supply conditions, the REG obtained annual lists of licensed physicians from the Texas Medical Board (TMB) and the Texas Department of State

[24] For more details, see REG's access to care reports and updates available at www.tdi.texas.gov/reports/report14.html.

Health Services. Then, active physicians in the TMB lists were matched to the DWC medical billing and payment data to measure WC participation.

The REG's access to care analysis is limited to physicians (i.e., M.D. and D.O.) because archived lists were not available for other providers such as chiropractors, osteopaths and physical/occupational therapists. This analysis focused on two primary measures of physician participation in workers' compensation: a participation rate and a retention rate. Participation rate is the number of WC participating physicians divided by the total number of active physicians in Texas. 'Active' physicians are those licensed by TMB, whose registration status is active, not in military practice, directly providing patient care, and whose practice location is in Texas. 'Participating' physicians are those who submitted medical bills for one or more WC patients in a given year.

Retention rate is the percentage of a prior year's WC participants who participate in the following year. These measures are also detailed by physician specialty and geographical region to help identify more specific trends.

Physician Participation in Workers' Compensation

The total number of active physicians in Texas has been increasing steadily during the last ten years, from 20,600 in 2000 to a peak of 42,035 in 2011, and to 41,914 in 2013, at an average *annual* growth rate of 2.4 percent (see Figure 6.1). Since 2011, however, the number of active physicians remained stable, or decreased slightly. At the same time, the number of WC participating physicians fluctuated from 17,318 in 2000 to 18,859 in 2011 and to 16,906 in 2013.

Because the total number of active physicians grew faster than the number of WC participating physicians, the physicians' WC participation rate decreased from 57 percent in 2000 to 40 percent in 2013 (see Figure 6.2).[25] Figure 6.2 shows the WC participation rate for physicians in a service year treating all WC patients (both old and new injuries) and the rate based on new WC patients only. The latter group may also treat old as well as new WC patients but exclude physicians who treat only established WC patients whose injury occurred in prior years.

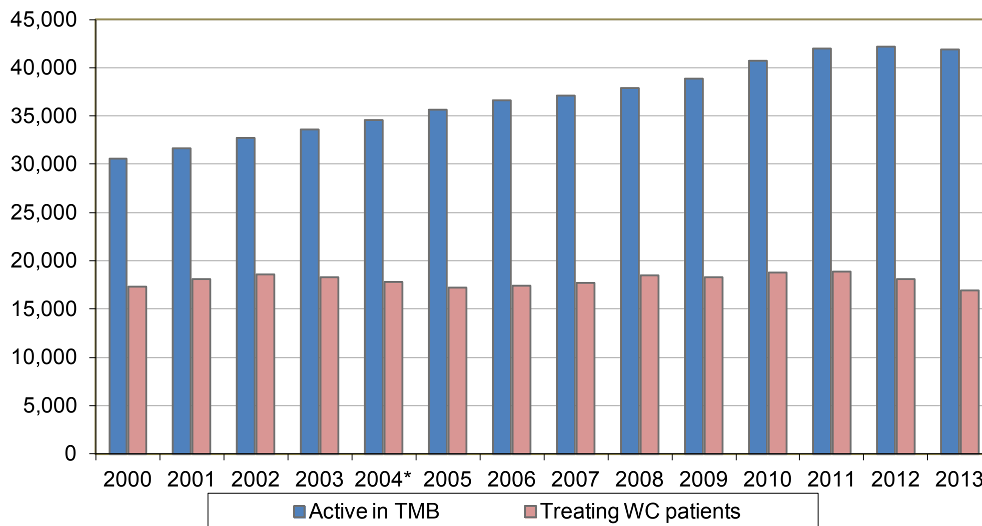
The decrease in the WC participation rate between 2002 and 2005 may have been impacted by the implementation of the Approved Doctors List (ADL) in September 2003, as well as the adoption of the Texas Workers' Compensation Commission's Medical Fee Guideline in 2003. The participation rate was stable until 2009. Participation rates for new WC patients are about 5 percent lower than the overall rates, but the trend indicates

[25] Medical billing and payment data reported to the Division of Workers' Compensation began to use EDI procedures in 2005. Reported data in 2004 were incomplete. Therefore, all figures for 2004 in the following graphs show an average of 2003 and 2005. This is indicated by the asterisk for the year 2004.

that new WC patient acceptance is not a particular and separate issue from the overall physician WC participation.

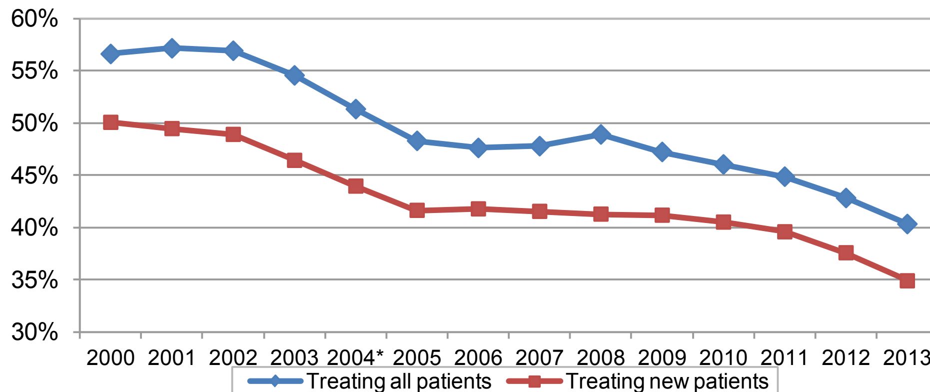
Figures 6.1 and 6.2 combined indicate that a decreasing percentage of Texas physicians are participating in the workers' compensation system but this reduction in participation is more a result of a relatively rapid increase in the overall physician supply than an indication of deteriorating access conditions.

Figure 6.1: Number of Active and WC Participating Physicians



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Figure 6.2: Participation Rate - Percent of WC Treating Physicians among Active Physicians

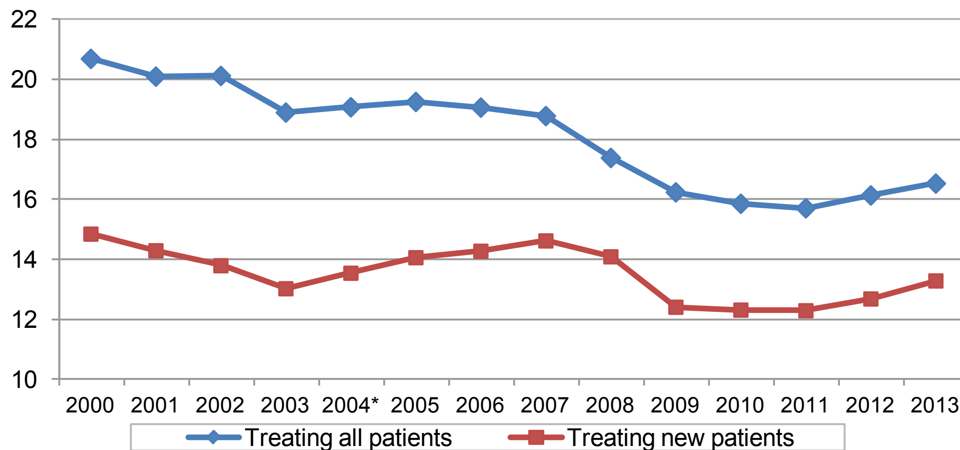


Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

While the number of WC participating physicians was stable, the number of WC claims reported has been decreasing steadily. In 2000, there were 227,448 new medical only-

and lost-time WC claims (358,234 unique claims including all those that received at least one service regardless of injury year), which decreased to 194,444 (279,505 including all injury years) in 2013.[26] As a result, the average number of WC patients per WC participating physician has decreased from 20.7 WC patients per WC participating physician in 2000 to 16.5 WC patients per WC physician in 2013, a 19 percent decrease (see Figure 6.3). For new WC patients only, the average number decreased from 14.8 in 2000 to 13.3 in 2013. This rate changed cyclically and increased slightly in the last two years, but it is in a trend of overall decline since 2000.

Figure 6.3: Average Number of Claims per WC Participating Physician



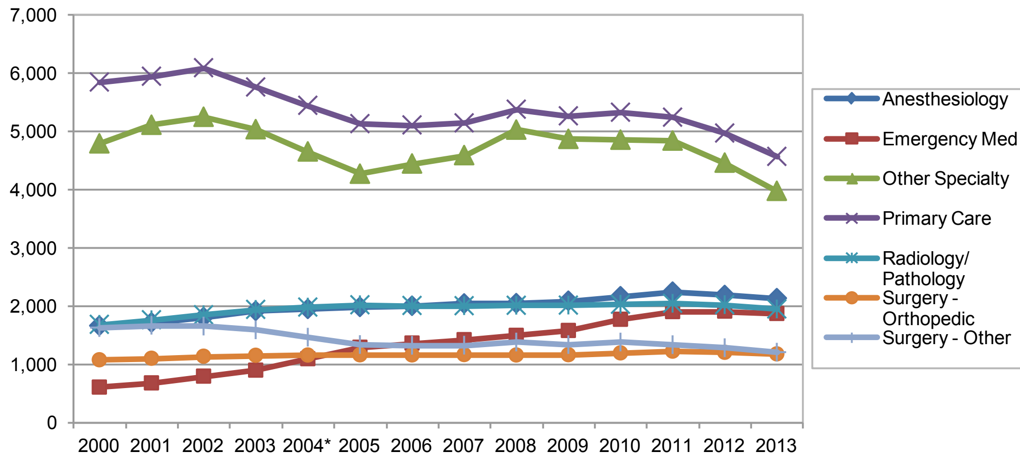
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Physician Workers' Compensation Participation by Specialty

Participation rates are not identical across physicians with different specialties. A critical factor in the initial access to care is the WC participation of primary care physicians. In 2000, there were 5,847 primary care physicians participating in WC. In 2013, this decreased to 4,571 (see Figure 6.4). Participation rate decreased from 61.7 percent in 2000 to 39.4 percent in 2013 (see Figure 6.5). Although the 2003 and 2008 Medical Gee Guidelines raised fees for Evaluation & Management services, primary care physicians' WC participation rate continued to decline, indicating that primary care physician shortage issues that exist across Texas also exist in the Texas workers' compensation system.

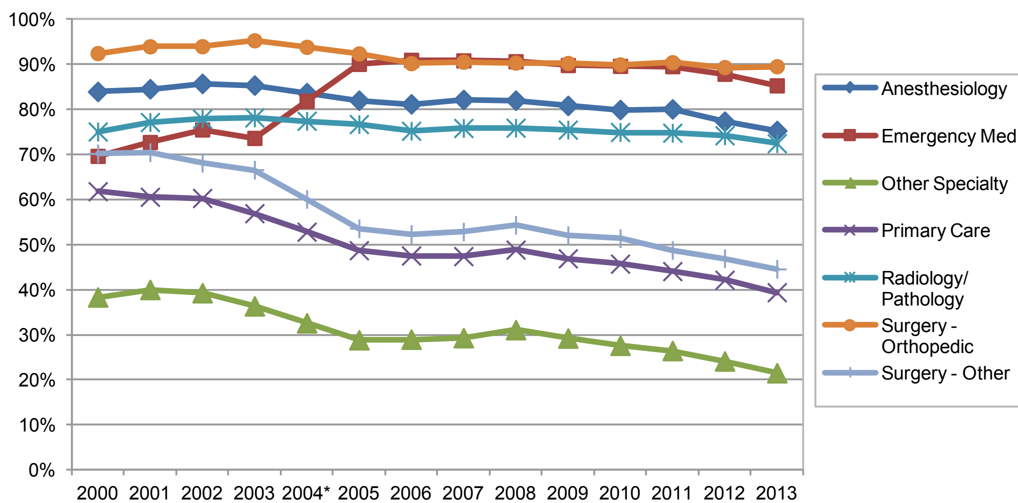
[26] Note that these claim numbers do not match the number of claims reported to the Division of Workers' Compensation since only fatalities, occupational diseases and injuries that result in at least one day of lost time are reportable according to the Workers' Compensation Act.

Figure 6.4: Number of WC Participating Physicians by Specialty



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Figure 6.5: Workers' Compensation Participation Rates by Specialty



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

The decrease in primary care physicians' WC participation is somewhat compensated by emergency medicine specialists whose number increased from 611 in 2000 to 1,875 in 2013, and their WC participation rate increased from 70 percent in 2000 to 85 percent in 2013. Emergency medicine physicians are a small group relative to others but are the fastest growing WC participant group.

Also increasing in number are radiology/pathology, anesthesiology, and orthopedic surgeons. Ninety percent of active orthopedic and emergency medicine physicians were WC participants in 2013 while only 21 percent of other specialty physicians participate in WC. This is to some extent expected since 'others' include specialties that are less relevant for workers' compensation such as pediatrics and OB/GYN.

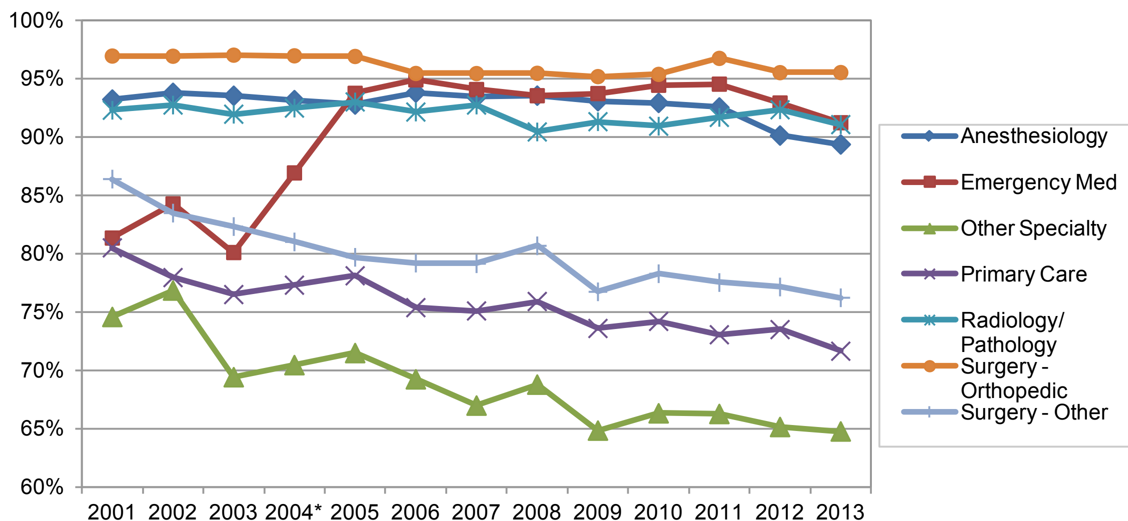
Retaining Physicians as WC Participants

One of the major goals of the workers' compensation system is to maintain a sufficient and effective number of WC participating physicians. However, the group of physicians treating injured employees does not remain static from year to year. In a given year, some physicians decide to exit out of the workers' compensation provider market while others enter as new WC providers. Exit and entry reasons may be external to workers' compensation system—such as changes in practice patterns, relocation, and retirement—or highly correlated with practice incentives due to changes in WC rules and procedures. While it is difficult to identify exact reasons for exit and entry decisions, a general trend for exit and entry can be summarized by retention rates.

Retention rate is measured as the percentage of a prior year's WC participants who also participate in WC in the following year. From 2000 to 2013, the overall retention rate remained stable around 80 percent. In other words, about 80 percent of all WC treating physicians in one year continued to treat injured employees in the following year. That number is a relatively high percentage of retention, considering changes in practice patterns. Although this implies that 20 percent of the current year WC participants did not treat any WC patients in the following year, there were new physicians entering the WC system, which is not reflected in the retention measure.

Lastly, retention rates differ across medical specialties. Retention rates for physicians with specialties in anesthesiology, orthopedic surgery, and radiology/pathology are above 90 percent (see Figure 6.6). Other surgery specialties show a noticeable decline in the retention rate while the rate increased significantly for emergency medicine specialists. The retention rate for primary care physicians decreased from 80 percent in 2000 to 72 percent in 2013.

Figure 6.6: Year-to-Year (Consecutive) Retention Rate by Specialty



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Participation by Top 20% Physicians

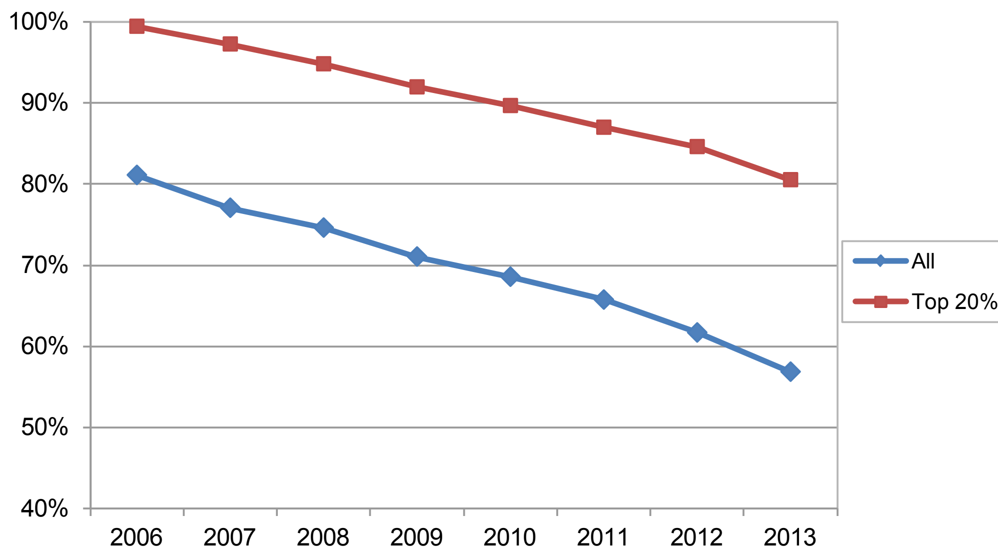
Retention rates presented above are calculated based on all physicians who treated at least one injured employee in a year. How the level of WC participation is defined may influence the number of WC participating physicians and the retention rate since workers' compensation medical expenses, as well as physician WC participation, are highly skewed by a small number of claims and doctors. For this analysis, the REG defined 'top 20%' physicians in terms of the number of WC patients treated in a given year. On average, a top 20% of physician treats at least about 30 to 40 different injured employees in a year. In 2013, there were 3,420 physicians in the top 20% group, and they accounted for 87 percent of the total medical payments to physicians.

Top 20% physicians have higher WC participation and retention rates than the bottom 80% that include those treating injured employees only occasionally. The annual exit rate of top 20% group is only 2 percent, resulting in a 98 percent annual retention rate. In addition, about 85 percent of them continue to be in top 20% in the following year, indicating that a small number of active WC physicians who account for more than 85 percent of total medical payments continue to participate in workers' compensation year in and year out. This reflects the fact that the WC health care market is highly specialized due to the nature of occupational injuries, reimbursement and review process, regulatory rules, and the initial investment costs for the providers (training for exams and reports, adapting to rules and procedures, special devices, etc.). The concentrated nature of workers' compensation health care market is similar across all states.[27]

The static nature of actively participating physicians is shown in Figure 6.7. Beginning with those physicians participating in 2000, the graph shows how many of the same physicians continued to treat injured employees year after year. For top 20% physicians, 80 percent of those participants in 2005 were still treating injured employees in 2013. The comparable cumulative retention rate for all WC participating physicians is 57 percent after eight years—more than half of 2005 WC participating physicians were still treating injured employees in 2013. Also noticeable in Figure 6.7 is that the attrition rate is gradual and does not indicate any particular time period of extraordinary changes.

[27] Bernacki et al. reports that 3.8% of physicians accounted for 78% of medical costs in Louisiana in 1998-2002. See Bernacki, Tao, and Yuspeh, "The impact of cost-intensive physicians on workers' compensation", *Journal of Occupational and Environmental Medicine*, 52(1): 22-29, January 2010.

Figure 6.7: Cumulative Retention Rates for 2005 WC Participating Physicians



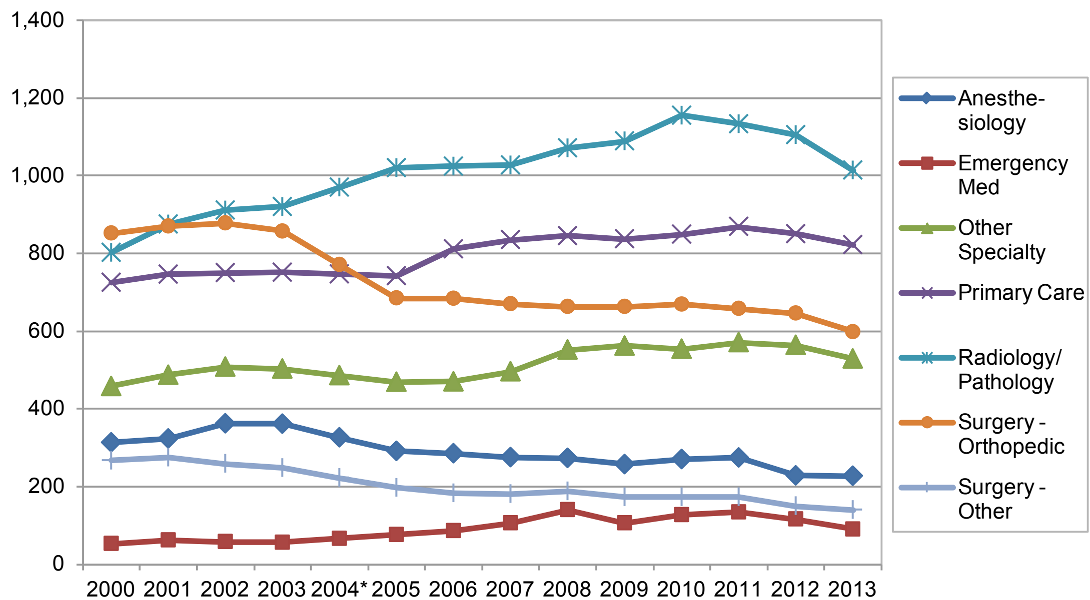
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Top 20% Physician Participation by Specialty

The composition of top 20% WC participating physicians by specialty also indicates that they have market incentives different from those of bottom 80% physicians. Figure 6.8 shows the absolute numbers of top 20% participating physicians by specialty. Primary care, radiology/pathology, emergency medicine, and other specialty physicians actually increased while orthopedic surgery, other surgery, and anesthesiology physicians decreased. Orthopedic surgeons, who were the most numerous group in 2000 (25 percent), decreased to 18 percent of the total in 2013.

Significant changes occurred in 2004 and 2005 when major reforms were implemented. Noteworthy is the fact that primary care physicians represent a larger share of the top 20% since 2006, which is consistent with the fact that deliberate changes were made in the 2008 Medical Fee Guideline to overcompensate for primary care in order to encourage more health care provider participation in the Texas workers' compensation system. Although primary care physicians are participating in WC at a lower rate overall, their share in the most active and vital group of providers has increased.

Figure 6.8: Number of Participating Physicians by Specialty – Top 20%

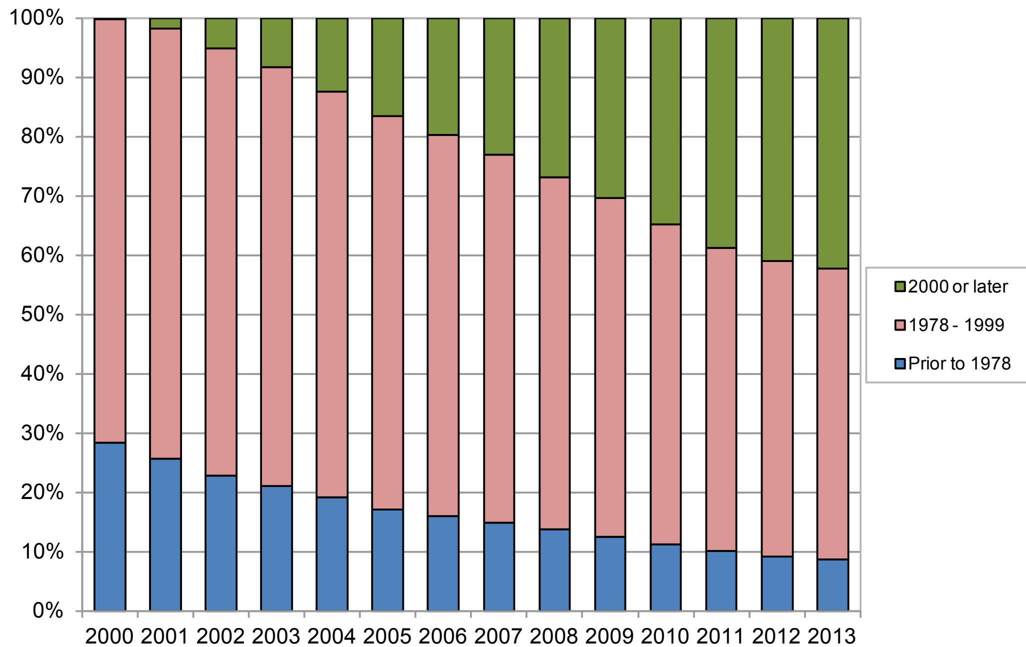


Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Physician WC participation and retention analyses show that there are a number of doctors entering and exiting from the WC health care market. Some of these exits and entries will be associated with changes in rules and policies implemented by the legislature and DWC. However, others may be results of changes in the broader market conditions for physician supply and normal changes in practice.

Figure 6.9 shows relative shares of WC participating physicians by year of license. Physicians licensed prior to 1978 constituted 28 percent of the total in 2000. Their share in 2013 decreased to seven percent. At the same time, those licensed in 2000 or later accounted for 42 percent of the total in 2013. This graph shows a generational change taking effect gradually as expected in any professional group. There may be some factors that facilitate exits of older physicians from workers' compensation and entries by young doctors. These factors may interact with conditions specific to workers' compensation reforms but they seem to work within the overall physician supply conditions such as specialty election and practice preferences in the general medical profession.

Figure 6.9: Shares of Participating Physicians by Year of License



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Access to Care by Geographical Region

Problems related to access to care are often regional, as practicing physicians may not be distributed evenly in relation to the general population. With favorable amenities, urban centers attract more doctors than rural areas. To assess geographical differences in access to care, the distribution of WC participating physicians is compared with the distribution of claims. For geographical boundaries, the REG utilized Hospital Referral Regions (HRRs) created by The Dartmouth Atlas of Health Care.

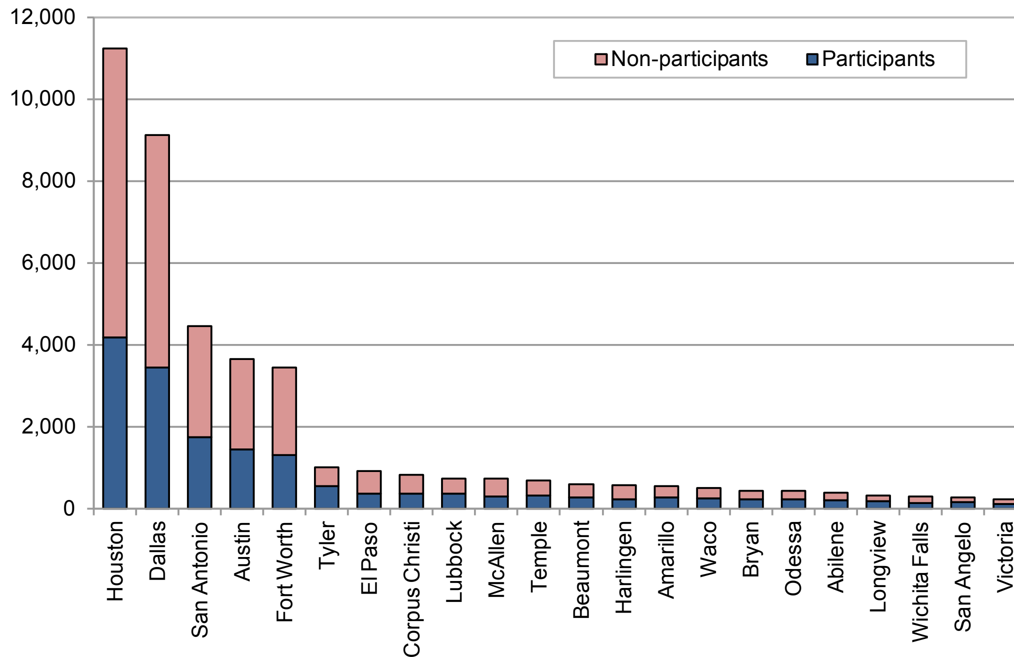
HRRs are constructed using Medicare hospitalization records and patient referral patterns, closely resembling the pattern of medical care and access. There are 24 HRRs in Texas that roughly correspond to major metro areas; two HRRs, whose primary medical centers are in Arkansas and Louisiana, are removed from analysis.

Overall, 40 percent of Texas physicians participated in the workers' compensation system in 2013. Seventy-three percent of WC participating physicians were located in the five largest metro areas: Houston, Dallas, San Antonio, Austin, and Fort Worth (see Figure 6.10). These areas also accounted for 77 percent of all active physicians in Texas, a slightly higher concentration than for WC-participating doctors.

As a result, WC participation rate in large metro areas was 38 percent, slightly lower than the overall 40 percent. However, about 72 percent of all WC claims were filed in these areas. Therefore, for large metro areas, the share of WC participating physicians is only

slightly higher than the share of claims (73 percent physician share vs. 72 percent claim share in 2013).

Figure 6.10: Number of Physicians and WC Participation Status by HRR, 2013

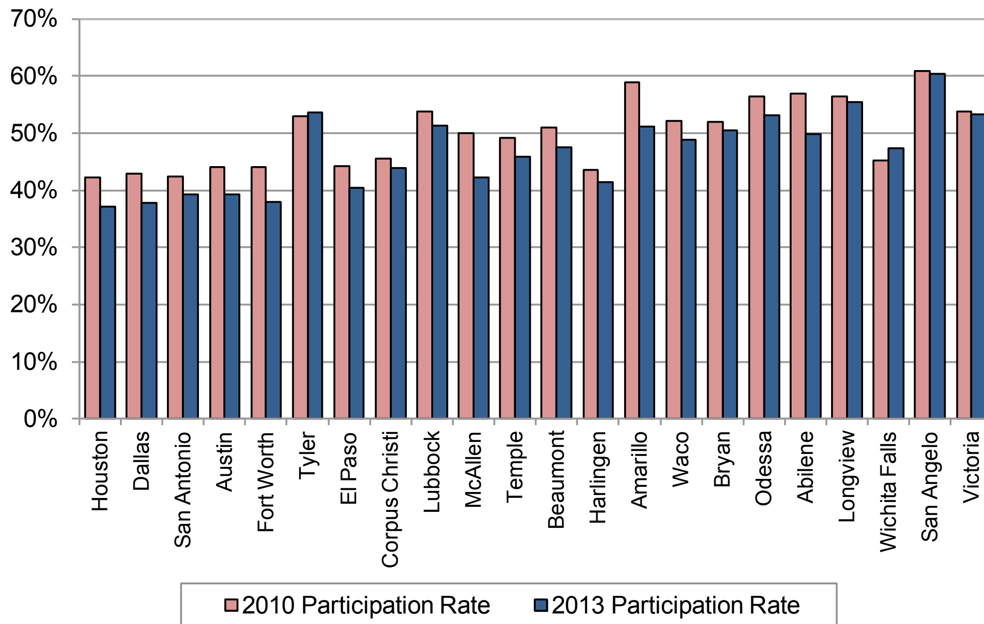


Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

However, some non-metro areas and border regions have more WC patients per physician despite the fact that they have higher WC physician participation rates than metro areas. Lack of access to physicians in those areas is due primarily to the low overall number of practicing physicians rather than a low WC participation rate. Consequently, smaller urban centers generally have higher WC participation rates (see Figure 6.11).

The number of claims per WC participating physician, reported in Table 6.1, shows a great deal of difference across regions. In 2013, Tyler HRR had the lowest ratio of claims to physician while El Paso and Harlingen had the highest. A physician in El Paso treated almost three times more WC claims than a physician in Tyler. Fort Worth and San Antonio had poorer access among metro areas. Conditions in four areas (Harlingen, Lubbock, El Paso, and Amarillo) worsened since 2005 while Longview, Tyler, and San Angelo saw the most improvements.

Figure 6.11: WC Physician Participation Rates by HRR



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Table 6.1: Number of Claims per WC Participating Physician

HRR	2005	2006	2007	2008	2009	2010	2011	2012	2013	Change in 2005-2013
Abilene	17.0	18.4	17.7	16.6	16.8	15.8	15.9	16.2	15.8	-7.22%
Amarillo	16.1	16.2	18.1	15.8	15.2	15.6	16.4	15.9	16.4	1.81%
Austin	15.6	15.8	14.6	12.5	12.2	11.6	11.4	11.4	12.6	-19.41%
Beaumont	17.4	17.4	16.5	16.4	15.1	16.3	16.7	15.8	14.3	-17.64%
Bryan	14.8	13.8	14.3	12.2	11.8	11.8	11.3	10.9	10.4	-29.25%
Corpus Christi	20.7	19.9	19.1	18.2	17.7	18.1	19.8	17.5	18.4	-10.88%
Dallas	18.5	17.8	16.6	15.7	14.0	13.7	13.4	13.8	14.5	-21.68%
El Paso	27.7	30.1	31.6	31.9	28.5	29.4	27.8	27.9	28.9	4.27%
Fort Worth	24.3	25.9	25.9	22.6	21.3	20.3	20.2	20.5	21.5	-11.50%
Harlingen	25.7	25.0	25.4	25.4	25.7	25.9	25.9	28.0	27.7	7.89%
Houston	16.3	16.7	16.8	15.5	14.5	13.6	13.8	14.6	15.0	-8.03%
Longview	20.0	19.9	19.1	16.9	15.2	14.8	14.2	14.1	12.2	-39.19%
Lubbock	16.7	15.9	16.9	16.7	15.7	16.4	16.3	17.4	17.6	4.92%
McAllen	22.6	20.6	22.7	19.7	19.5	19.2	18.7	19.0	20.5	-9.26%
Odessa	25.1	25.2	25.1	22.8	19.6	20.1	21.3	22.1	21.5	-14.19%
San Angelo	16.3	14.7	14.2	13.5	12.0	12.5	11.4	11.6	11.1	-31.66%
San Antonio	21.1	21.8	21.4	20.3	19.3	20.4	19.3	20.5	21.0	-0.51%
Temple	17.7	18.6	18.9	18.2	16.4	13.6	13.7	13.5	13.6	-23.29%
Tyler	14.9	14.8	15.0	13.2	12.4	11.4	11.1	10.8	9.8	-34.18%
Victoria	16.7	16.3	15.2	13.8	12.8	14.7	14.3	14.7	13.8	-17.31%
Waco	22.0	23.7	21.9	21.7	19.1	17.2	19.6	18.6	17.0	-22.89%
Wichita Falls	15.9	15.4	16.9	14.2	13.4	14.2	13.7	13.8	14.2	-10.53%

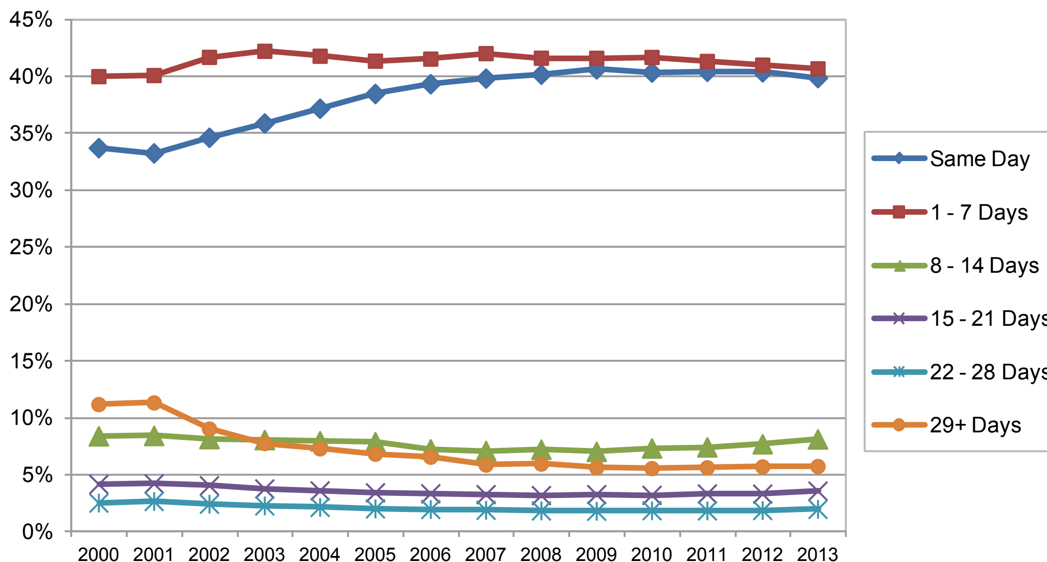
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Timeliness of Care

Workers' compensation participation and retention rates of treating physicians show a general supply condition in the workers' compensation health care market, but other factors are involved in determining how promptly an injured employee receives medical treatment. Factors affecting timeliness of care include promptness in injured employees seeking treatment; procedures and barriers established by employers in reporting worksite injuries; referring to physicians; and appointment and scheduling conflicts with doctors. Timeliness of care is defined as the number of days between the reported injury date and the first non-emergency medical treatment and approximates initial access-to-care conditions influenced by all these factors.

Claims are broken down into six groups by the number of days between injury and first treatment, and the shares of these groups are shown in Figure 6.12. Approximately 81 percent of WC patients received initial care either on the same day of injury or within 7 days in 2013, up from 74 percent in 2000. The percentage of 'same day' treatment group increased steadily reaching 41 percent in 2009. The largest decrease was seen in the share of extreme delays (29 days or more)—decreasing from 11 percent to 6 percent. This delayed group consists largely of disputed and/or denied claims, which nevertheless showed a significant improvement in access to care, which is discussed in the last section below. Disputed cases account for a fraction of all claims and thus have a minimal effect on the overall timeliness of care measures.

Figure 6.12: Percentage of Claims by Number of Days between Injury and First Non-Emergency Visit to Physician

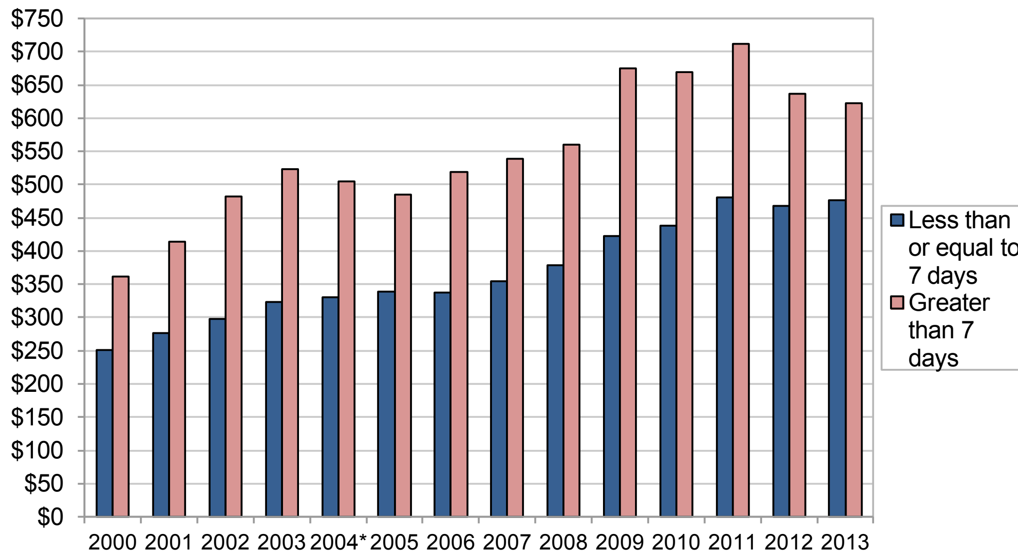


Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Timeliness of Care and Medical Cost

Delayed medical care tends to increase medical costs in the long run. Figure 6.13 compares median total costs at six months maturity between groups with early and delayed initial treatment. In 2013, the median total cost for the delayed group was 31 percent higher than that of those who received initial treatment within 7 days. In addition, median costs fluctuate more for the delayed group. Reasons for delays in treatment may be procedural with no relationship to costs or systemically related to the severity of the injury and costs. In any case, the comparison indicates that prompt medical care is essential not only in limiting the effects of the injury but also in reducing overall medical costs.

Figure 6.13: Median Total Cost per Claim at Six Months Post Injury, by Number of Days until First Non-Emergency Treatment



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

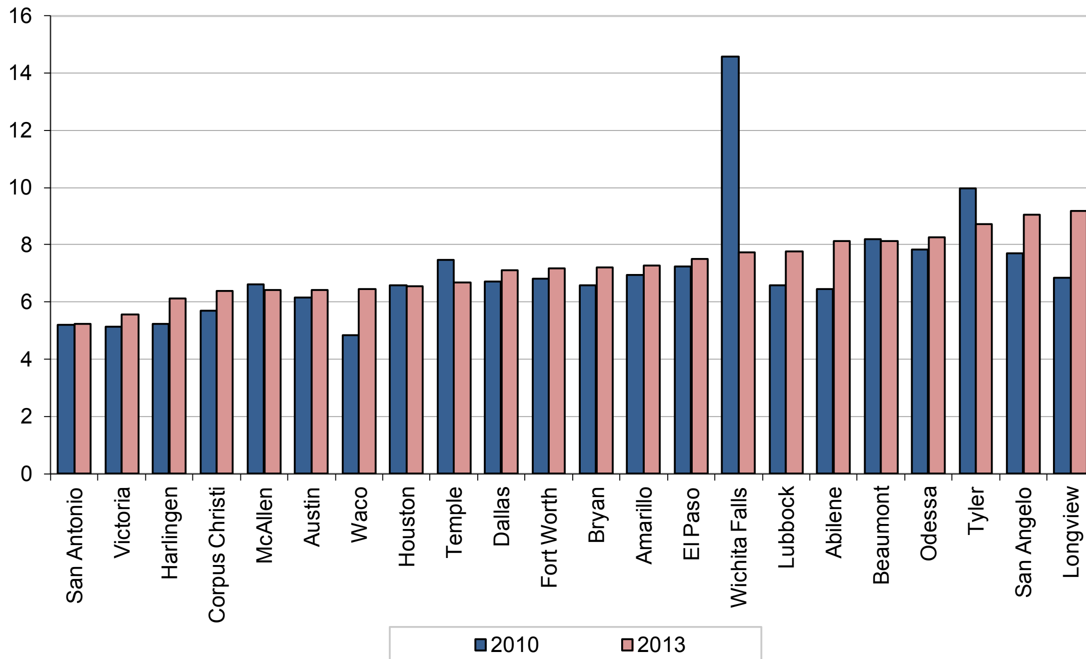
Timeliness of Care by Geographical Region

Timeliness of care varies greatly by geographical region. Figure 6.14 shows the *average* number of days between injury and first treatment by HRRs. The difference between the worst region in terms of timeliness of care and the best is significant: average initial treatment in Longview (9.2 days) is 76 percent later than in San Angelo (5.2 days) in 2013. Although this difference signals an area of needed improvement, the *median* number of days for initial treatment is one day for most regions.

This indicates that the averages are driven by a small number of cases with extreme delays. Proper measures for improvement have to be focused on the specific nature of these extreme cases. Overall, 2013 timeliness measures for most regions increased

slightly from 2010 while Wichita Falls and Tyler HRRs showed a great improvement in the last three years.

Figure 6.14: Average Number of Days, by Injury Year, between Injury and First Non-Emergency Treatment,



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

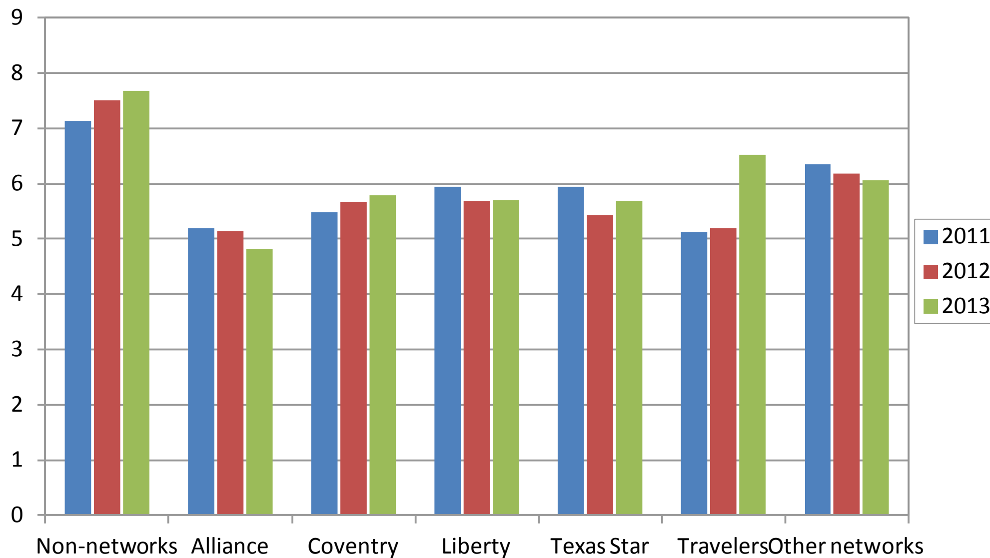
Access to Care in WC Health Care Networks

Under the HB 7 reforms, workers' compensation insurance carriers may contract with networks certified by the Texas Department of Insurance. If an employer elects to participate in a network, such employer's injured employees are required to obtain medical care through the network under most conditions. Since a network normally contracts with a group of health care providers, network usage implies a limited choice of physicians for injured employees. This has raised some concern that the increased use of networks may limit access to care. Figure 6.15 compares the timeliness measure between non-network and network claims. As it indicates, the initial access for network patients is moderately better than for non-network patients. In addition, the timeliness measure worsened in 2013 for non-network claims, but it improved in two of the largest networks, Texas Star and Alliance.

A network potentially limits the number of doctors an injured employee may see as a treating doctor. However, other provisions in the networks—for example, case management practices, return-to-work coordination with employers, and quality

assurance reporting—may give networks more incentives to provide prompt medical care, thereby improving access to care.

Figure 6.15: Average Number of Days between Injury and First Non-Emergency Treatment, Networks and Non-Networks



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

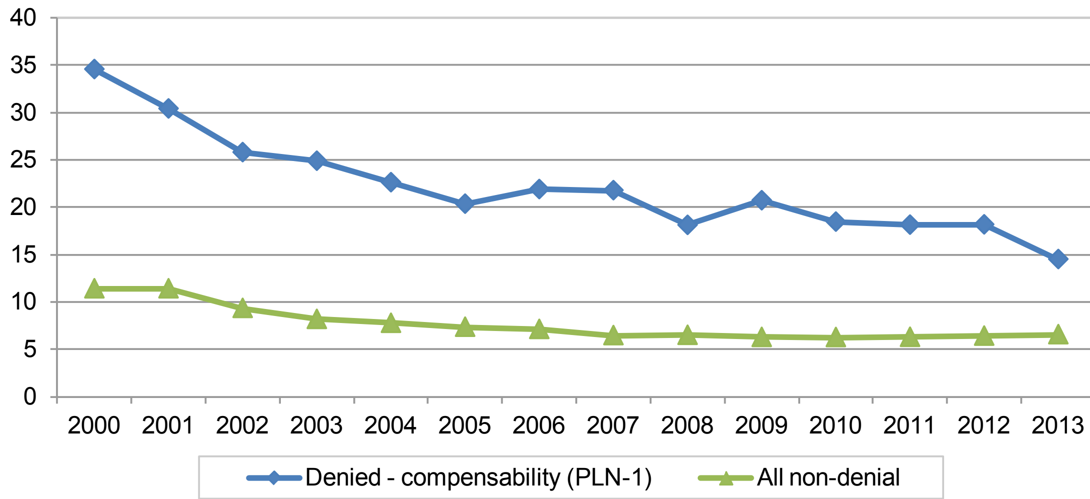
Impact of Claim Denials and Disputes on Access to Care

Denials and/or disputes regarding compensability tend to delay initial care. Initial access to care for claims disputed for compensability was delayed three times longer than non-denial claims in 2000 (see Figure 6.16). However, the average day of delay decreased from 35 days in 2000 to 14 days in 2013. The average for non-denial claims in 2013 was seven days.

About 65 percent of denied/disputed cases received initial care on the same day of injury or within 7 days or less in 2013, up from 52 percent in 2000 (see Figure 6.17). Most improvements had been through an increasing share of the 'same day' group and a decreasing share of the '29+ days' group. The share of 'same day' access group was 20 percent of total in 2000, but this increased to 27 percent by 2013. At the same time, the share of the extreme delay group (29 days or longer delay) decreased from 27 percent to 14 percent during the same period.

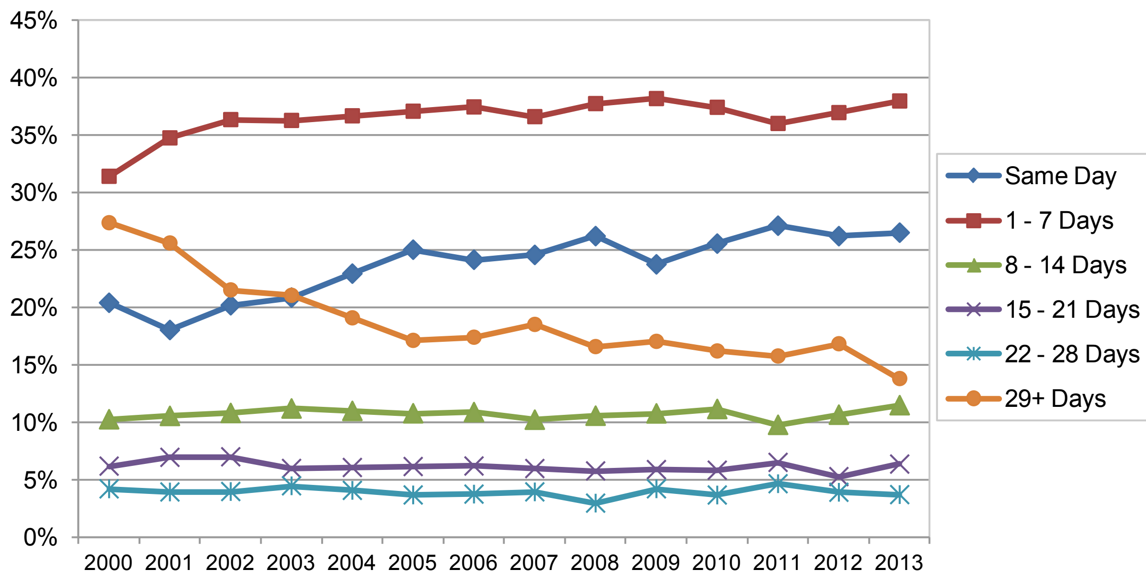
Since 2001, initial treatments occurred more rapidly for an increasing percentage of denied and/or disputed claims. Clearly, disputes and denials adversely affect timeliness of care. However, even for this relatively small number of claims, initial access to care has been improving steadily since 2000. However, even for this relatively small number of claims, initial access to care has been improving steadily since 2000.

Figure 6.16: Average Days between Injury and First Visit to Physician by Dispute Type



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Figure 6.17: Percentage of Injured employees by Number of Days between Injury and First Non-Emergency Treatment, for Denied and/or Disputed Claims



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

7. Return-to-Work Outcomes in the Texas Workers' Compensation System

An important goal of the Texas workers' compensation system is to return injured employees to a safe and productive employment. Effective return-to-work (RTW) programs can help alleviate the economic and psychological impact of a work-related injury on an injured employee, reduce income benefit payments, and increase employee productivity for Texas employers.

Studies conducted by the former Research and Oversight Council on Workers' Compensation and the Workers' Compensation Research Institute indicated that prior to the HB 7 reforms, in comparison to similarly injured employees in other states, Texas injured employees were generally off work for longer periods of time and were more likely to report that their take-home pay was less than their pre-injury pay.[28] Policymakers acknowledged the importance of return-to-work in HB 7 by including the following requirements:

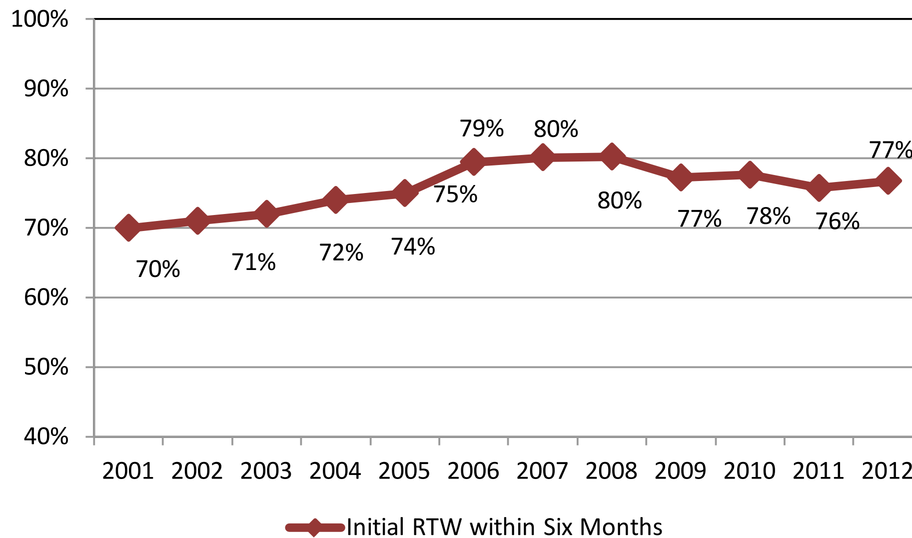
- The adoption of return-to-work guidelines,
- The institution of a return-to-work pilot program geared toward businesses with less than 50 employees,
- Better coordination of injured employee referrals for vocational rehabilitation services between DWC and the Department of Assistive and Rehabilitation Services,
- The referral of injured employees to the Texas Workforce Commission and local workforce development centers for employment opportunities,
- Improving system participant return-to-work outreach efforts, and
- The adoption of rules to implement changes in the work-search requirements for injured employees who qualify for Supplemental Income Benefits (SIBs), as well as disability management rules that include the coordination of treatment plans and return-to-work planning.

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

Return-to-Work Rates Improved Since HB 7; Slightly Higher for 2012 Injuries

When workers' compensation income benefit data is compared with employee wage information from the Texas Workforce Commission, the results show that the percentage of injured employees receiving income benefits who went back to work within six months of sustaining a work-related injury increased from 76 percent of employees injured in 2011 to 77 percent of those injured in 2012. Overall, HB 7 reforms appeared to have helped temper the effects of the economic downturn in Texas. Despite the economic decline in late 2009-2012, a higher percentage of injured employees receiving income benefits went back to work within six months in 2012 (77 percent), compared to 2004 (74 percent). Since 2001, the percentage of injured employees returning to work within six months of their injury has increased by seven percentage points (see figure 7.1).

Figure 7.1: Initial Return-to-Work within Six Months Post-Injury, Injury Years 2001 - 2012



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Over the most recent five-year period, the initial RTW rate declined slightly from 80 percent in injury year 2008 to 78 percent in injury year 2010. That percentage declined slightly to 76 percent for 2011 injuries, but reversed and increased to 77 percent for employees injured in 2012. This change in return-to-work rates between injury years 2008 and 2009 is likely a reflection of the down turn in the U.S. economy, which began in late injury year 2007 or early 2008 in most states and continuing higher unemployment rates nationwide and in Texas. Inconsistent results since injury year 2009 may reflect the residual effects of the downturn or a gradual improvement in the economy.

Table 7.1: Initial Return-to-Work Rates – Percentage of Injured Employees Receiving TIBs Who Have Initially Returned to Work (six months to three years post-injury)

Injury Year	Within Six Months Post Injury	Within One Year Post Injury	Within 1.5 Years Post Injury	Within Two Years Post Injury	Within Three years Post Injury
2008	80%	85%	89%	91%	94%
2009	77%	84%	89%	91%	94%
2010	78%	85%	89%	92%	94%
2011	76%	85%	90%	92%	
2012	77%				

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014. Note 1: The study population consists of 294,732 employees injured in 2008-2012 who also received Temporary Income Benefits (TIBs). Note 2: The third year of 2011, and the 1.5, second, and third years of 2012 are excluded due to insufficient data. Note 3: Initial return-to-work rates for 2012 injuries are subject to change, as more wage data is made available for injuries occurring in the latter quarters of 2012.

While measuring injured employee initial return-to-work outcomes is an important indicator of a state's ability to return employees back to work after a work-related injury, the ability of a state to promote sustained employment among injured employees provides a more complete measure of the system's ability to promote safe and timely return to work. The sustained return-to-work rate is defined as the percentage of injured employees receiving Temporary Income Benefits (TIBs) who have found work within six months and remained employed for at least three successive quarters (or nine months) after a work-related injury. In particular, there has been a marked increase in the percentage of injured employees who have initially returned to work and remained employed, compared to the pre-HB 7 reforms (in 2004, the sustained return-to-work rate at six-months post-injury was only 66 percent, compared to an estimated 74 percent in 2012).

As Table 7.2 indicates, the sustained return-to-work rate has fluctuated between 68 and 69 percent between injury years 2009 to 2011, but the rate for injuries sustained in 2012 increased to 74 percent. Additionally, the sustained return-to-work rates at the one year and 1.5 year milestones for injury years 2010 and 2011 sustained return-to-work rates are essentially unchanged, at 76 and 79 percent respectively.

Sustained return-to-work rates three years from date of the injury have increased steadily from 83 percent for 2008 injuries to 85 percent for 2010 injuries. It is important to note that the sustained return-to-work rate for injury year 2012 is preliminary and subject to change when new wage data becomes available.

Table 7.2: Sustained Return-to-Work Rates – Percentage of Injured Employees Receiving TIBs Who Have Initially Returned to Work and Remained Employed for Three Successive Quarters (six months to three years post-injury)

Injury Year	Within Six Months Post Injury	Within One Year Post Injury	Within 1.5 Years Post Injury	Within Two Years Post Injury	Within Three Years Post Injury
2008	72%	75%	77%	80%	83%
2009	68%	75%	78%	81%	84%
2010	69%	76%	79%	82%	85%
2011	68%	76%	79%	81%	
2012	74%				

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014. Note 1: The study population consists of 294,732 employees injured in 2008-2012 who also received Temporary Income Benefits (TIBs).). Note 2: The third year of 2011, and the 1.5, second, and third years of 2012 are excluded due to insufficient data. Note 3: Sustained return-to-work rates for 2012 injuries are subject to change, as more wage data is made available for injuries occurring in the latter quarters of 2012.

Table 7.3 shows the average TIBs payments per claim has decreased from $2,677 to $2,384 from injury 2008 to injury year 2012. The average number of weeks of TIBs payments decreased by one week as well, from seven weeks in 2008 to six weeks in 2012. When broken down by return-to-work status at six months post-injury, however, injured employees who return to work within six months of their injury receive substantially lower TIBs benefits per claim on average, ranging from 26 percent to 37 percent of those who do not find employment within six months of their injury.

Table 7.3: Median Total Number of Weeks and Total TIBs Benefit Payments by Initial Return-to-Work Status at Six Months Post-Injury

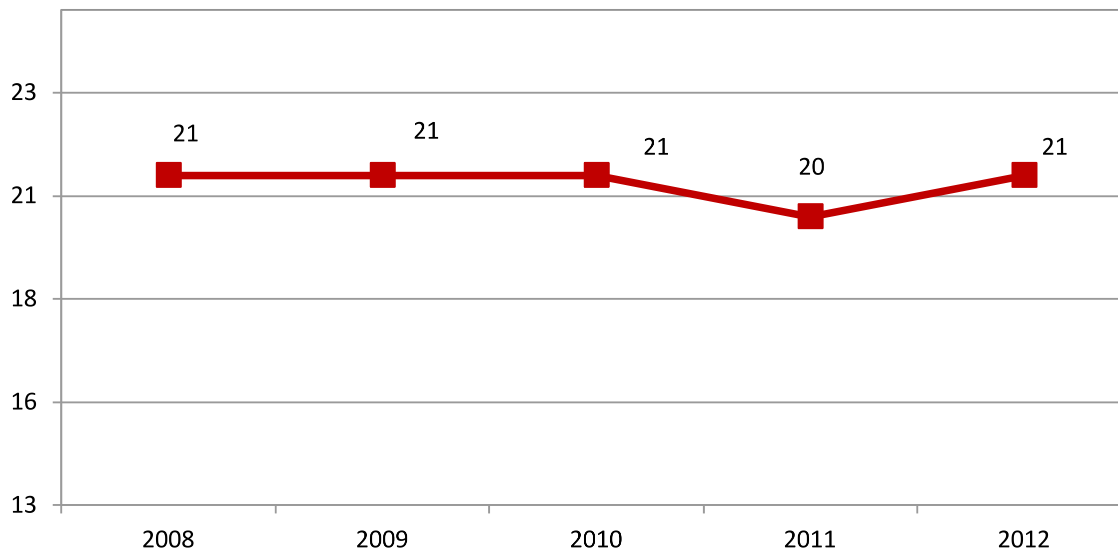
Injury Year	Average TIBs Payments Employed at Six Months	Average TIBs Payments Unemployed at Six Months	Average TIBs Payments per Claim
2008	$2,136.00	$8,145.40	$2,677
2009	$2,036.30	$6,555.30	$2,500
2010	$1,968.00	$6,449.00	$2,429
2011	$2,006.60	$6,234.60	$2,507
2012	$1,988.20	$5,445.40	$2,384
Injury Year	**Average Weeks TIBs Payments Employed at Six Months**	**Average Weeks of TIBs Payments Unemployed at Six Months**	**Average Weeks of TIBs Payments per Claim**
2008	6.0	22.6	7.0
2009	5.4	18.6	7.0
2010	5.3	19.0	7.0
2011	5.0	18.0	6.9
2012	5.0	15.7	6.0

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014. Note 1: The study population is a subset of 294,732 employees injured in 2008-2012 who also received temporary income benefits (TIBs).

The bottom panel of table 7.3 shows the median number of weeks of TIBs benefit payments by injury year and initial return-to-work status. The findings are similar to the benefit payment pattern: the number of weeks between injured employees who return to work within six months is substantially lower than those who do not return to work within six months.

Figure 7.2 shows the median days away from work for injury years 2008 – 2012, which are consistent across injury years. Four out of five injury years have median values of 21 days or approximately three weeks away from work. It should be noted that the median number of days away from work for injury years 2008-2012 (20-21 days) is much lower than the median number of days off work prior to the implementation of HB 7 (28-29 days in 2004 and 2005).

Figure 7.2: Median Days Away from Work



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Comparison of Injured Employee Survey Results Pre- and Post-HB 7 Implementation

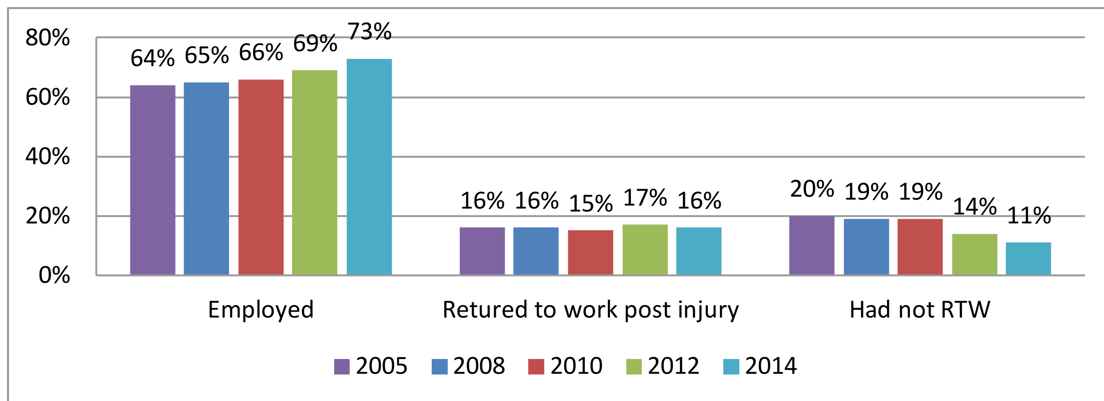
It is clear from both the return-to-work rates shown in Tables 7.1 and 7.2 and recent injured employee surveys those improvements in return-to-work rates have continued since the 2005 passage of HB 7.

As Figure 7.3 shows, a higher percentage (73 percent) of injured employees surveyed in 2014 reported that they were currently employed at the time of the survey (compared with 65 percent in 2008). A significantly lower percentage of injured employees surveyed in 2014 (11 percent in 2014 compared with 19 percent in 2008) reported that they had not yet returned to work nine to 21 months after their injuries. In addition, the percentage of injured employees who had some initial employment after their injuries, but not currently

employed decreased slightly (16 percent in 2014 as compared to 17 percent in 2012 survey).

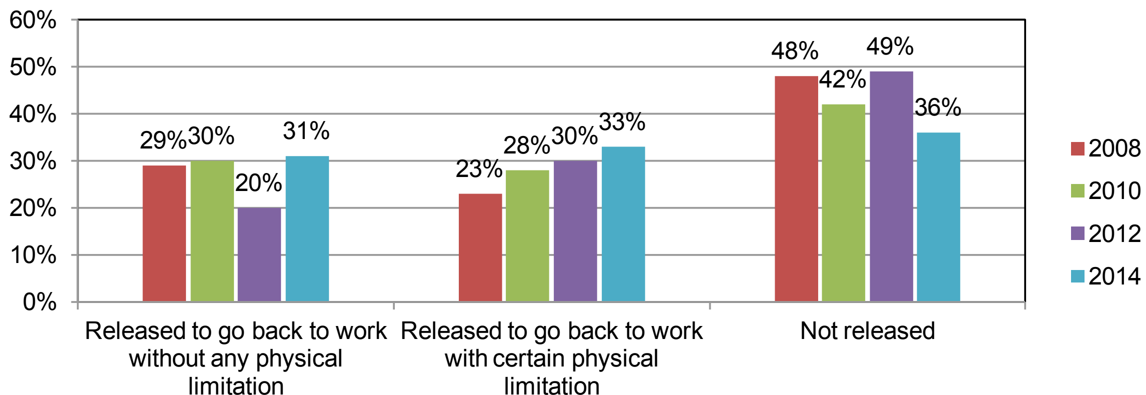
The percentage of injured employees who reported going back to work after their workplace injuries changed significantly from 2005 to 2014. Figure 7.4 shows that a significantly higher percentage (64 percent) of injured employees surveyed in 2014 were released to go back to work with no or some physical restrictions than injured employees surveyed in 2008 (52 percent). That increase may be an indication that certain HB 7 provisions, such as the adoption of return-to-work guidelines coupled with the ability for a Division-selected designated doctor to review an injured employee's ability to return to work. Those provisions may have increased health care provider communications, with injured employees and employers about the importance of injured employees returning to work as quickly and safely as possible.

Figure 7.3: Return-to-Work Experiences of Injured Employees



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, Survey of Injured Workers, 2005, 2008, 2010, 2012, 2014.

Figure 7.4: Percentage of Injured Employees Surveyed Who Reported Being Released to Go Back to Work by Their Doctor



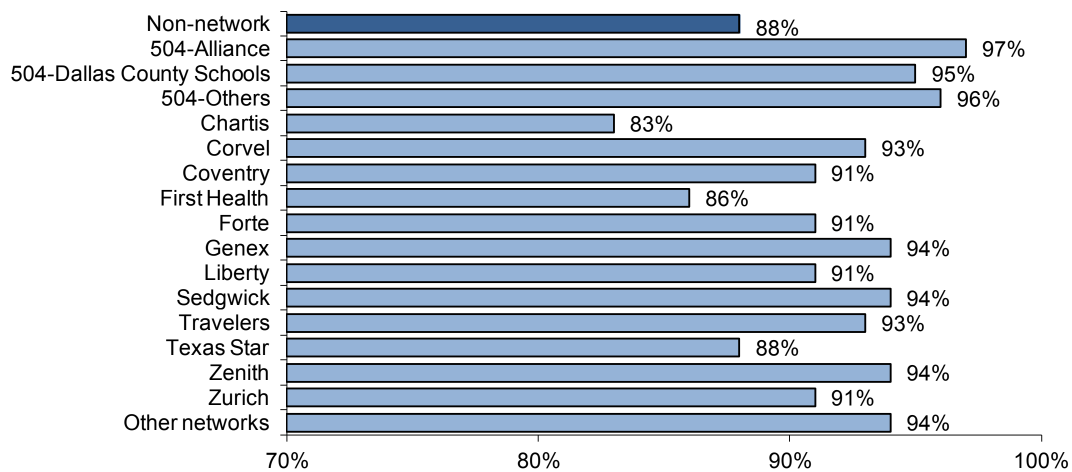
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, Survey of Injured Workers, 2005, 2008, 2010, 2012, 2014.

Comparisons between Network and Non-Network Claims

Return-to-work rates have been improving in the Texas workers' compensation system since 2001, and this trend has continued since the passage of HB 7. One important aspect of HB 7 is the formation of networks, which has seen positive results in terms of improvements in return-to-work outcomes. Legislators increased the focus on disability management in this new health care delivery model by requiring networks adopt return-to-work guidelines and increase the use of case management. Additionally, legislators envisioned that networks would be better positioned to facilitate communication between treating doctors and employers about injured employees' physical abilities to return to work and employers' job requirements or the availability of alternative duty assignments.

Results from the 2014 Workers' Compensation Network Report Card produced by the Department indicate that with two exceptions, injured employees from seventeen network entities (including the Other Networks group of eight smaller networks) had higher or same initial return-to-work rates than non-network (see Figure 7.5).

Figure 7.5: Percentage of Injured Employees Who Indicated That They Went Back to Work at Some Point after Their Injury

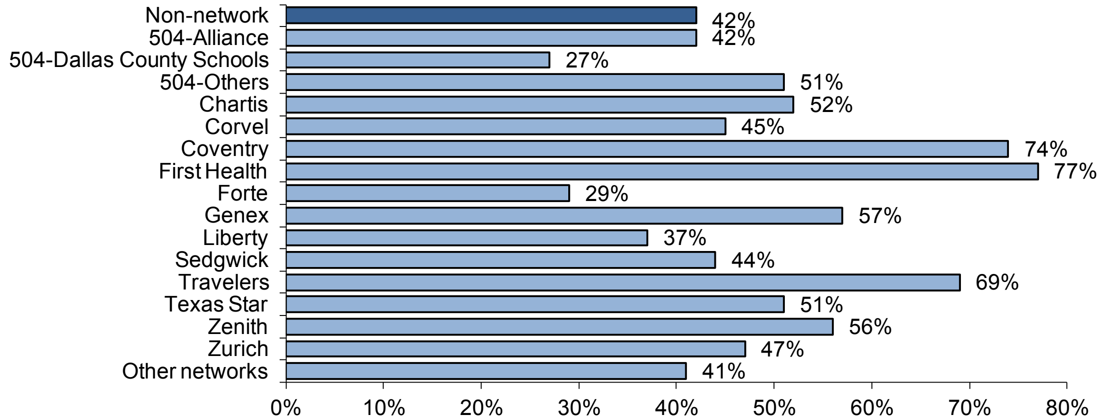


The Network Report Card also reported on injured employees' experience after being released to work with or without limitations by their treating doctors (sees Figure 7.6). Five network entities (including 504-Alliance, 504-Dallas County Schools, Forte, Liberty and Other networks) had equal or more favorable return-to-work results than non-network for injured employees released to work by their treating doctors.

It should be noted, however, that these return-to-work outcomes are heavily affected by whether the employers of these injured employees have effective return-to-work programs and are able to bring injured employees back to safe and appropriate employment. The improved performance of most networks over non-network may be the result of coordination between system participants, including employers to return injured

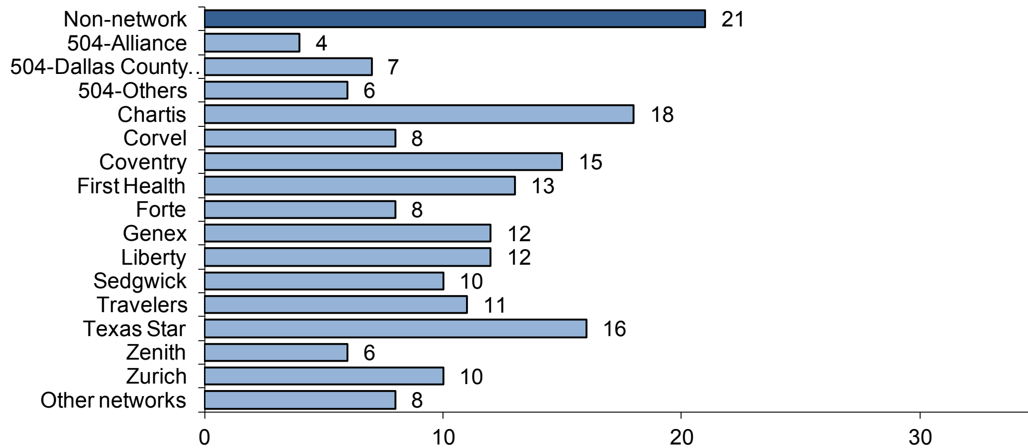
employees to work.

Figure 7.6: Percentage of Injured Employees Who Had Not Returned to Work and Who Reported That Their Doctor Had Released Them to Work with or Without Limitations



In addition to an increased percentage of injured employees being released to return to work by their doctors, report card results indicate that all 16 networks were more effective at returning injured employees to work faster when compared to non-network (see Figure 7.7).

Figure 7.7: Average Number of Weeks Injured Employees Reported Being off Work Because of Their Work-Related Injury



Continual monitoring of these return-to-work measures is necessary to track the effects of the implementation of treatment and return-to-work guidelines, as well as the impact of networks on return-to-work outcomes in Texas. Early return-to-work that accounts for the injured employee's abilities and safety can be conducive to physical recovery. Further, it reduces cost pressures on the system. While system-wide return-to-work rates continue to improve, the increased focus on disability management under the HB 7 reforms seems to have resulted in modest return-to-work improvements in some networks over non-network claims. The REG will continue to monitor and report on annual return-to-work trends.

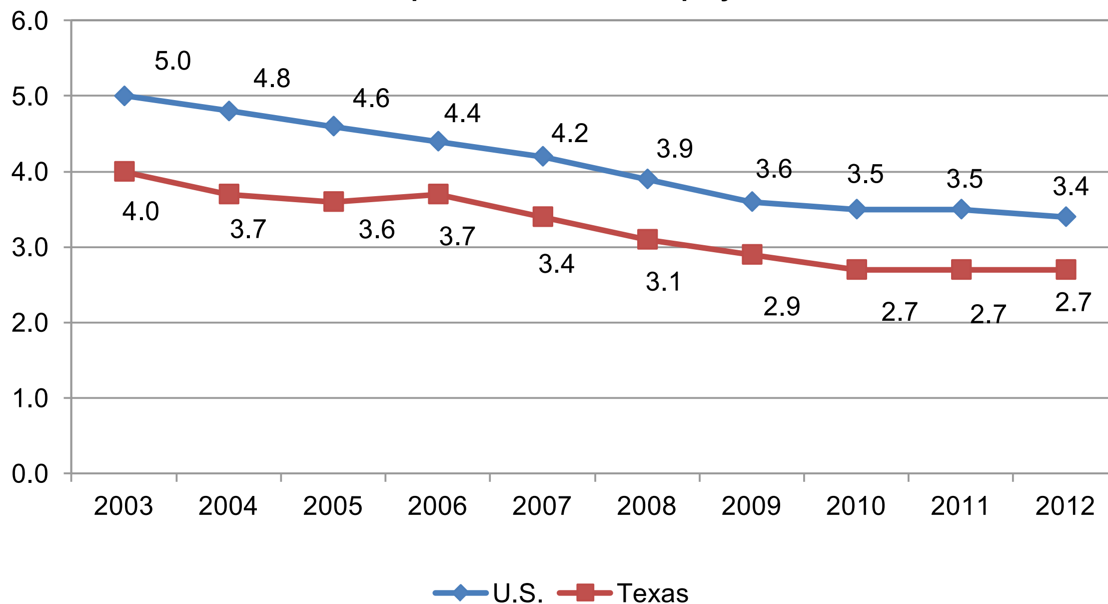
8. Dispute Resolution and Complaint Trends

Background

One of the key goals of the 2005 legislative workers' compensation system reforms is that each injured employee "shall have access to a fair and accessible dispute resolution process."[29] This section examines the trends of disputes and complaints in the system after the passage of these reforms in 2005.

To develop a better perspective of the extent of disputes in the system, it helps to examine them within the context of the total number of injured employees in Texas. According to the latest statistics reported by the U.S. Department of Labor, Bureau of Labor Statistics, Texas had 2.7 injuries or illnesses per 100 full-time employees in 2012 (see Figure 8.1). This rate represents a 33 percent decrease in the injury rate since 2003. In addition, the injury rate in Texas is consistently 20 percent lower than the national average.

Figure 8.1: Texas and U.S. Nonfatal Occupational Injury and Illness Rates per 100 Full-Time Employees



Source: Texas Department of Insurance, Division of Workers' Compensation and U.S. Department of Labor, Bureau of Labor Statistics, *Annual Survey of Occupational Injuries and Illnesses*, 2014

Decreasing injury rates have also impacted the number of reportable claims (injuries with at least one day of lost time due to the work-related injury) in the Texas workers'

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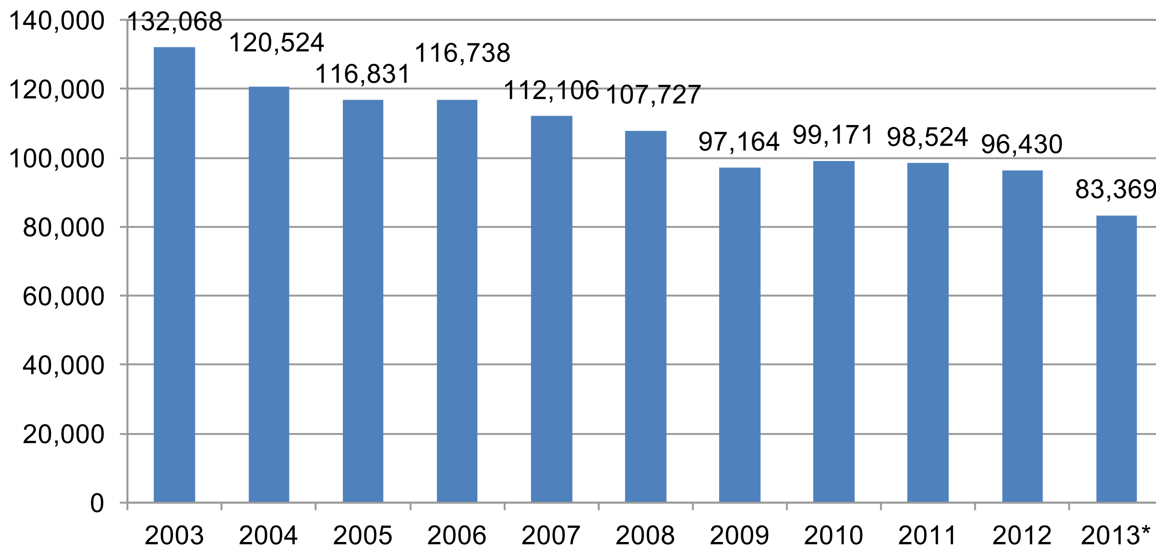
[29] See Texas Labor Code, Section 402.021.

compensation system. Texas is the only state that allows private-sector employers to choose whether or not to participate in the system. While workers' compensation coverage is mandatory for public employers in Texas, approximately 67 percent of private-sector employers opt into the system, and they employ an estimated 80 percent of the private-sector labor force (see Section 9 for more information). In addition to providing necessary and appropriate medical care at no cost to employees for their work-related injuries, the Texas workers' compensation system has a multi-tiered income benefit structure, which compensates injured employees when their injuries lead to permanent impairments and lost wages due to lost time from work. The number of these claims fell from 132,068 in 2003 to 83,369 in 2013, a decrease of nearly 37 percent (see Figure 8.2).

Figure 8.2: Number of Workers' Compensation Claims Reported by Calendar Year of Injury



Source: Texas Department of Insurance, Division of Workers' Compensation and Workers' Compensation Research and Evaluation Group, 2014.

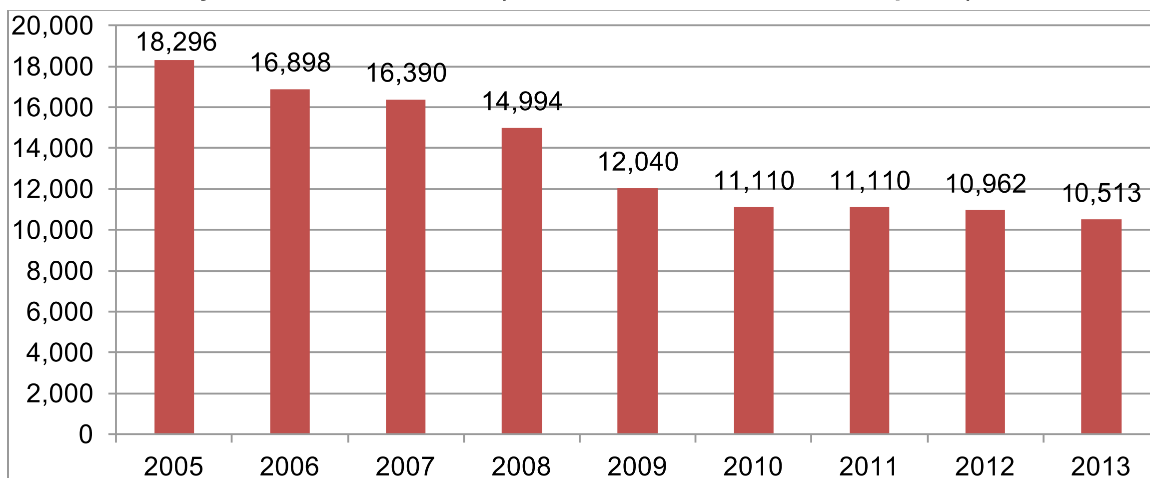
Overall, an estimated 7.2 million private-sector employees in Texas are covered under workers' compensation insurance policies purchased by 238,000 employers from approximately 250 insurance carriers. In addition, 17,000 medical doctors plus other health care professionals provide care to injured employees in Texas.

Claim Denials/Disputes: Compensability and Liability

A system of this magnitude and complexity is not without disagreements between participants. For example, insurance carriers may deny an entire (whole) claim on issues of compensability and liability and refuse to pay benefits. An insurance carrier might

have evidence that the injury occurred outside of the workplace or that the injured employee did not work for an employer with workers' compensation coverage. The number of these workers' compensation claims (initially denied or disputed) decreased in recent years from more than 18,000 in 2005 to approximately 10,500 in 2013 (see Figure 8.3). This was a 43 percent decrease in eight years, a faster rate than the decrease in total claims. In addition, as a percentage of all reportable claims, these whole-claim denials declined from 15.7 to 12.6 percent over the same duration. These numbers reflect initial denials and do not account for denied claims that were eventually approved either through a mutual agreement between the injured employee and the insurance carrier or determined to be "work-related" during Division of Workers' Compensation dispute proceedings.

Figure 8.3: Number of Reportable Claims Initially Denied/Disputed by the Insurance Carrier (Whole Claim Initial Denials/Disputes)



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014. These numbers do not reflect denied and disputed claims that were subsequently approved after the dispute proceedings.

Dispute Proceeding: Income Benefit Denials/Disputes

Income benefit denials and disputes cover all issues that might affect an injured employee's entitlement to income benefits such as Temporary Income Benefits (TIBs), Impairment Income Benefits (IIBs), Supplemental Income Benefits (SIBs), and Lifetime Income Benefits (LIBs).

The disputed issues may include the injured employee's maximum medical improvement (MMI) date, impairment ratings (IR), extent-of-injury, or the calculation of the injured employee's average weekly wage, among others. Disputes might also result over the entitlement to death and burial benefits.

The number of claims with dispute proceedings fluctuated in recent years, but by injury year 2012 (the data for injury year 2013 should be considered incomplete) it was almost

20 percent lower than in injury year 2008 (see Table 8.1). Over the same period, the total number of claims fell by 10 percent, which is half the rate at which the number of claims with dispute proceedings decreased.

Table 8.1 also shows that the percentage of workers' compensation claims involved in dispute at DWC remained relatively stable at around 7 percent until 2011. This means that the vast majority (92-98 percent) of workers' compensation claims are handled without the need for dispute resolution by DWC. The increase and subsequent decreases in 2012 and 2013 may be more of a reflection of their recent injury years and may increase as other claims from those injury years mature.

Table 8.1: Number and Percent of Claims with Workers' Compensation Dispute Proceedings by Calendar Year

Calendar Year of Injury	Total Number of Claims	Number of Claims with Dispute Proceeding	Percent of Claims with a Dispute Proceeding
2008	107,779	7,511	7%
2009	97,164	6,553	7%
2010	99,171	7,240	7%
2011	98,524	7,416	8%
2012	96,430	6,044	6%
2013	83,369	1,914	2%*

Source: Texas Department of Insurance, Division of Workers' Compensation, System Data Report, 2014, data through December 2013.
Note: *The percentage of claims with a dispute proceeding may continue to increase as issues arise on more recent injury claims.

Benefit Review Conferences

The first step in the administrative dispute resolution process is the Benefit Review Conference (BRC), an informal mediation held at DWC field offices located around the state. The BRC is used to explain the rights of the parties and the facts of the claim, review available evidence, and attempt to resolve the disputed issues.

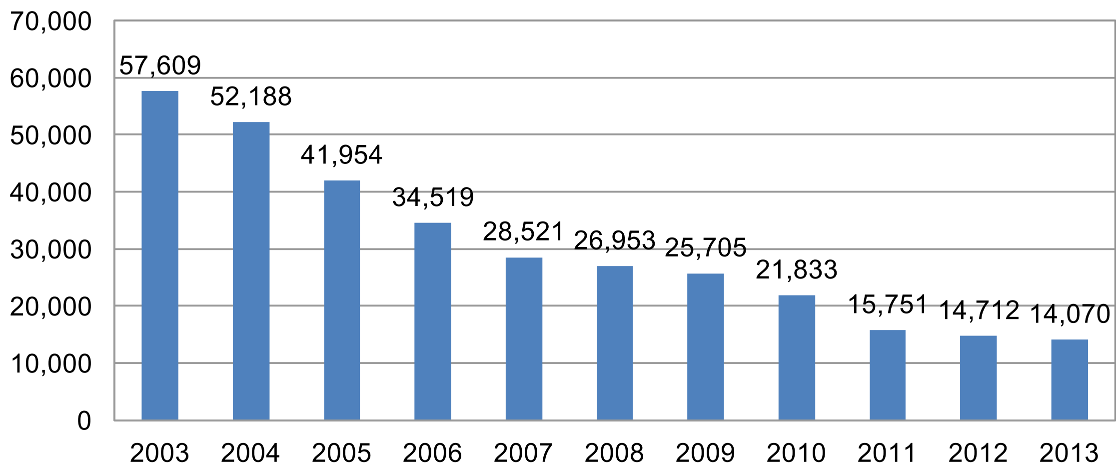
Prior to the request for a BRC, the disputing parties must first certify that they made reasonable efforts to resolve the disputed issues, including the exchange of all information relevant to the dispute. Rescheduled and repeated BRCs sometimes result from inadequate preparation and information.

In addition to the DWC Benefit Review Officer, who presides over the BRC, the injured employee, his or her representative or ombudsman, the employer, or the health care provider may also attend.DWC

Benefit Review Conference (BRC) Requests

The number of BRC requests decreased steadily over the past ten years. In 2003, parties in the workers' compensation system requested a total of 57,609 BRCs. By 2013, that number fell to 14,070 requests, a 76 percent decrease since 2003 (see Figure 8.4).

Figure 8.4: Number of BRC Requests by Calendar Year of Injury



Source: Texas Department of Insurance, Division of Workers' Compensation, System Data Report, 2014, data through December 2013.

Some of the decreases in the number of BRC requests can be attributed to the 37 percent fall in the number of reportable claims between 2003 and 2013. However, the number of BRC requests fell by 76 percent over the same period, which is double the rate of the decrease experienced by reportable claims. Clearly, systemic and regulatory factors, other than claim counts, also contributed to this rapid decrease in the number of BRC requests.

When a BRC concludes with unresolved issues, the remaining issues may be addressed at a second step, a formal hearing called the Contested Case Hearing (CCH) where a DWC Hearing Officer reviews the case and makes decisions on those issues.

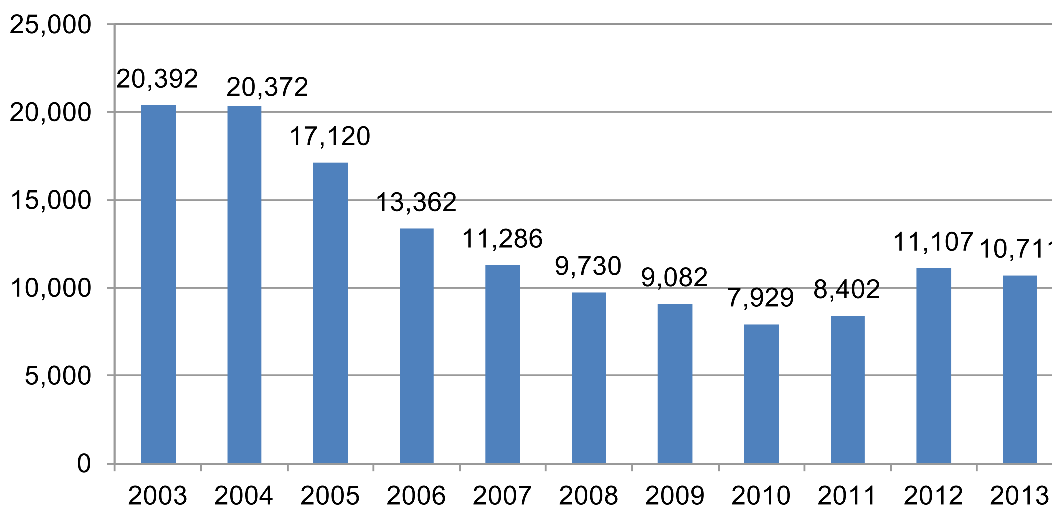
CCHs allow disputing parties to more fully develop their cases on the pertinent evidence, upon which the Hearing Officer can make an impartial and educated decision. Even then, a Hearing Officer's decision can be appealed to the Appeals Panel, where in turn it can be appealed for judicial review for final adjudication in district court. An injured employee in a dispute may choose to be represented by an attorney, receive assistance from an ombudsman assigned by the Office of Injured Employee Counsel (OIEC), or attend the proceedings without representation.

Benefit Review Conferences (BRC) Concluded

The number of BRCs concluded are those BRCs conducted by DWC, with the disputed issues either resolved or forwarded to the next level for resolution. It is also the number of BRCs requested, minus BRCs not yet held and disputes resolved or withdrawn before the requested BRC. The number of concluded BRCs declined steadily from 2003 to 2010 by 61 percent (see Figure 8.5).

However, the trend changed course after 2010, increasing by 40 percent in 2012, followed by a slight decrease (4 percent) in 2013. Despite the more than 10,000 concluded BRCs in 2013, that number was still 47 percent lower than the number of concluded BRCs in 2003. Further, the 4 percent decrease in 2013 raises doubt that the 2012 increase is indicative of a long-term increasing trend.

Figure 8.5: Number of Concluded Benefit Review Conferences by Calendar Year



Source: Texas Department of Insurance, Division of Workers' Compensation, System Data Report, and Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

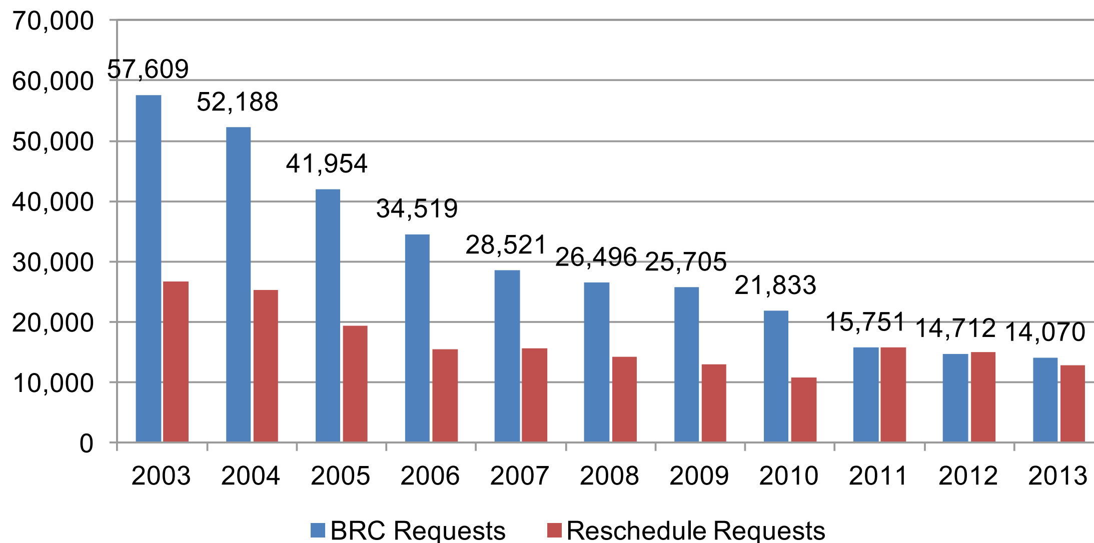
Given the decrease in the number of concluded BRCs in 2013, it seems more likely that the increases in 2011 and in 2012 were temporary responses to new system requirements. In 2011, DWC adopted new BRC rules in accordance with the Texas Workers' Compensation Act. These rules clarified that disputing parties must request a BRC to stop the 90-day finality of the first impairment rating and date of Maximum Medical Improvement (MMI) and follow through on the dispute request. Prior to the 2011 rule adoption, injured employees and insurance carriers would try to stop the 90-day finality of the first impairment rating or date of MMI by submitting a BRC request to DWC and then writing on that request that the party did not want a BRC, which was inconsistent with the statutory intent to dispute the first impairment rating or date of MMI by the 90th

day or it would become final. Also in 2011, the 82nd Legislature passed HB 2605, which required "good cause" and deadlines for rescheduling BRCs and required DWC to hold a BRC if a party fails to appear unless the party demonstrates "good cause."

Requests to Reschedule BRCs

DWC data show recent increases in the number of BRCs where a second BRC session was scheduled because parties were not adequately prepared to resolve the dispute at the first BRC session. The total number of requests to reschedule BRCs decreased from 26,647 in 2003 to less than 11,000 in 2010, but the number of requests increased by 46 percent to more than 15,000 in 2011 and 2012. Interestingly, the number of requests to reschedule BRCs increased at a faster rate (46 percent) than the increase in the number of concluded BRCs (40 percent). However, the sharp decrease in the number of requests to reschedule in 2013 suggests that changes in the trends might be temporary anomalies influenced by the 2011 BRC rules (see Figure 8.6).

Figure 8.6: Number of BRC Requests and Requests to Reschedule Benefit Review Conferences

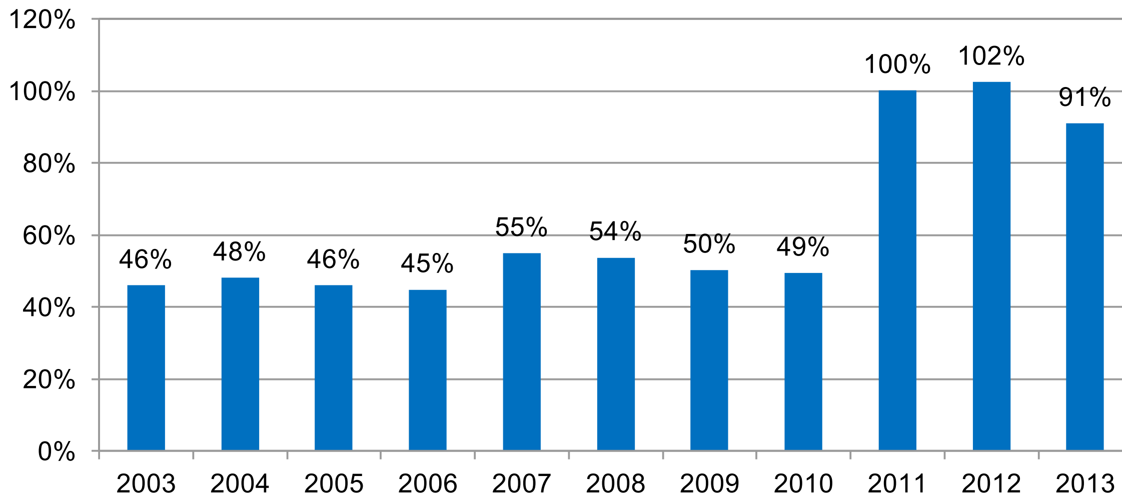


Source: Texas Department of Insurance, Division of Workers' Compensation, System Data Report, and Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

The increase in the number of rescheduled BRCs in 2011 occurred after steep decreases in both the number of requested BRCs and in the number of requests to reschedule BRCs. The number of requests to rescheduled BRCs, as a percent of the number of BRC requests, more than doubled from 46 percent in 2003 to 100 percent in 2011 and 102 percent in 2012. This suggests that an increased percentage of BRCs experienced

multiple requests for rescheduled sessions during those two years. However, this reversed in 2013, as the percentage dropped to 91 percent (see Figure 8.7).

Figure 8.7: Number of Requests to Reschedule Benefit Review Conferences as a Percentage of the Total Number of BRC Requests



Source: Texas Department of Insurance, Division of Workers' Compensation, System Data Report, and Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Reasons for Rescheduling BRCs

Of the 24 reason codes allowed for rescheduling BRCs, five reasons consistently account for a significant majority of all the reasons:

- Requests for more time to prepare
- Scheduling Conflict
- No-shows with unknown reason
- Pertinent information unavailable
- Party will obtain medical to support position.

The share of these five reason-codes averaged less than 60 percent of all reschedule reasons from 2003 to 2011, but by 2013, their share had increased to 68 percent while the share of the other 19 codes fell from 44 percent in 2003 to 32 percent in 2013 (see Table 8.2).

Table 8.2: Percent Shares of Reasons for Rescheduling Benefit Review Conferences by Request Reason

Reasons Given to Reschedule BRCs	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Required More Time to Prepare	11%	10%	8%	11%	12%	12%	12%	13%	12%	10%	9%
Scheduling Conflict	11%	12%	14%	17%	15%	17%	18%	20%	16%	14%	15%
No Show-Unknown Reason	8%	8%	9%	9%	9%	9%	7%	6%	7%	7%	6%
Pertinent Information Unavailable	10%	11%	13%	11%	10%	9%	10%	8%	7%	9%	11%
Party Will Obtain Medical to Support Position	16%	17%	14%	14%	13%	12%	11%	12%	20%	26%	27%
Others	44%	42%	42%	38%	41%	41%	42%	41%	38%	34%	32%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: Texas Department of Insurance Workers' Compensation Research and Evaluation Group, 2014.
Note: The total percentage does not include reason codes not included in the table.

Table 8.3 shows the changes in the number of requests, two years before and two years after the BRC rules and HB 2605 went into effect. Overall, the number of requests to reschedule BRCs experienced steep reductions since 2003. However, the years 2011 and 2012 proved to be the exceptions – both years saw an increase in the number of BRC requests, and the five most frequently used reason codes were disproportionately represented in the number of requests to reschedule BRCs. In the two years prior to 2011 (the year the new BRC rules became effective), all BRC rescheduling reason-codes showed steep decreases. In 2010 for example, 'Pertinent information unavailable' experienced a 31 decrease.

Yet, all reason codes showed equally dramatic reversals in their trends during the year that the new BRC rules and HB 2605 became effective. In 2011, the total number of requests to reschedule BRCs increased by 46 percent. The requests using one reason ('Party will obtain Medical to support position') increased by 155 percent. However, this increase lasted just one year. By 2012, all, except two of the reasons, had returned to their decreasing trends, and by 2013 all the rescheduling reasons experienced measurable declines at rates comparable to their pre-2011 decreases.

Table 8.3: Percent Change in the number of Reason Codes for Rescheduling Benefit Review Conferences by Request Reason

Reasons Given to Reschedule BRCs	Number of Requests and Percentage Change From the Previous Year									
	2009		2010		2011		2012		2013	
Required More Time to Prepare	1,567	-9%	1,412	-10%	1,822	29%	1,457	-20%	1,179	-19%
Scheduling Conflict	2,370	-2%	2,115	-11%	2,558	21%	2,152	-16%	1,901	-12%
No Show-Unknown Reason	923	-25%	656	-29%	1,143	74%	1,003	-12%	797	-21%
Pertinent Information Unavailable	1,222	-5%	842	-31%	1,061	26%	1,375	30%	1,358	-1%
Party Will Obtain Medical to Support Position	1,407	-20%	1,253	-11%	3,198	155%	3,900	22%	3,456	-11%
Other Reason-Codes	5,449	-7%	4527	-17%	6,021	33%	5,208	-14%	4,130	-21%
Total	12,938	-9%	10,805	-16%	15,803	46%	15,095	-4%	12,821	-15%

Source: Texas Department of Insurance, Division of Workers' Compensation, System Data Report, and Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Some of the BRC trends in 2011 and 2012 suggest that requesting parties might have filed BRC requests primarily to stop the 90-day clock and to lock in the dispute option in case future disputes became necessary. A significant number of these BRC requests were characterized by inadequate preparation on behalf of the requesting party. The reschedule data show unprecedented increases in the number of requests to reschedule BRCs with reasons such as needing more time to prepare, lacking pertinent information, and to obtain medical information to support the request. The timing of the increases of these types of requests to reschedule BRCs coincides with the adoption of the new BRC rules and the passage of HB 2605 in 2011.

Issues Raised at BRCs

The number of issues raised at BRCs fell from 21,557 in 2008 to 15,935 in 2011, a 26 percent decrease. However, it jumped to 22,648 (42 percent) in 2012, one year after the new BRC rules became effective. The increases were especially significant in the number of issues over designated doctors' (DD) impairment ratings, DD MMI date, and extent-of-injury (see Table 8.4).

In accordance with the Texas Workers' Compensation Act, DD decisions have presumptive weight in BRCs and CCHs. However, this statutory presumptive weight can be overcome by a preponderance of the evidence. Inadequate preparation on behalf of the parties involved in these disputes, reflected in the types of reasons for rescheduling

BRCs, may have implications for dispute outcomes as the number of these issues increase.

In 2012, the first year after the 2011 BRC rules became effective, the number of issues over DD impairment ratings increased from 2,324 to 4,625 (99 percent), issues over DD MMI date increased from 2,493 to 4,752 (92 percent), and the number of extent-of-injury issues increased from 2,896 to 4,133 issues (43 percent). From reviewing the data, it appears that extent of injury disputes were not being raised as a result of an increase in insurance carrier extent of injury claim denials. Rather, these issues were being raised in conjunction with the DD dispute in an attempt to overcome the DD's presumptive weight by asserting that the DD rated too many or too few medical conditions, diagnoses or body parts on an individual claim.

As a percentage of all dispute issues, DD impairment rating and MMI-date issues almost tripled from 7 percent in 2010 to 20 percent each in 2013, while extent-of-injury issues remained stable at approximately 18 percent over the same period. Meanwhile, the share of other issues fell from 66 percent to 41 percent during the same three years.

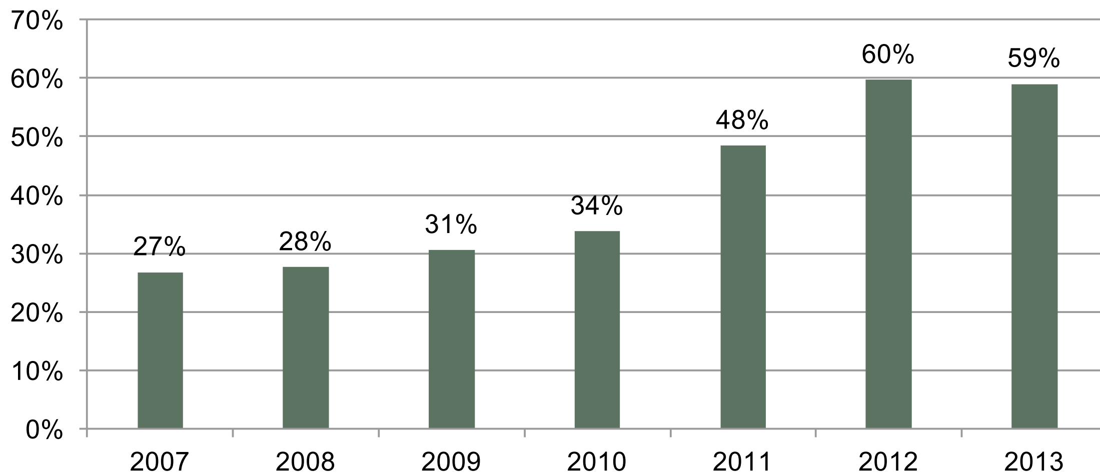
Table 8.4: Number of Issues Raised at the Benefit Review Conference by Issue Type

Fiscal Year	Extent of Injury		Dispute of DD Impairment Rating		Dispute of DD MMI Date		Other Issues		Total
2008	3,315	15%	1,217	6%	1,425	7%	15,587	72%	21,557
2009	3,430	18%	1,150	6%	1,270	7%	13,276	69%	19,137
2010	3,215	20%	1,095	7%	1,216	7%	10,825	66%	16,362
2011	2,896	18%	2,324	15%	2,493	15%	8,216	52%	15,935
2012	4,133	18%	4,625	20%	4,752	21%	9,138	40%	22,648
2013	4,759	19%	5,083	20%	5,015	20%	9,752	41%	24,609

Source: Texas Department of Insurance, Division of Workers' Compensation, System Data Report, and Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

The three primary dispute issues discussed above (DD impairment ratings, DD MMI date, and extent-of-injury) comprised 86 percent of the increased number of issues from 2011 to 2012. The combined share of these three disputed issues increased gradually between 2008 and 2010 (from 28 percent to 34 percent). However, by 2013, their share of all dispute issues had jumped to nearly 60 percent (see Figure 8.8).

Figure 8.8: Percentage share of Total BRC Issues, Extent-of-Injury, DD Impairment Rating, and DD MMI Date



Source: Texas Department of Insurance, Division of Workers' Compensation, System Data Report, and Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

BRC Disputes by Assistance Types

Attorneys assisted injured employees in a majority of BRC disputes from 2003 until 2010, but their share fell during the last three years (see Table 8.5). This recent decrease occurred as Ombudsman assistance from OIEC, which averaged 38 percent from 2003 to 2010, increased to 46 percent in 2011 and 2012. Injured employees with no assistance also increased their share, from an average of about five percent during those first 10 years, to double that percentage of BRC disputes in 2012 and 2013. The increasing percentage of injured employees entering BRCs without assistance may result in unfavorable outcomes, especially in disputes where a preponderance of the evidence is required to overcome DD decisions. It also calls into attention why certain employees starting in 2012 chose to enter dispute resolution unrepresented rather than use an OIEC ombudsman who is available free of charge.

Table 8.5: Percentage of Benefit Review Conferences Concluded by Assistance Type for the Injured Employee

Assistance Type	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Attorney	54%	53%	57%	60%	59%	56%	54%	54%	48%	42%	45%
Ombudsman	38%	41%	39%	36%	35%	37%	38%	40%	46%	46%	43%
None	4%	3%	4%	4%	5%	6%	7%	5%	5%	11%	12%
Others	4%	3%	<1%	<1%	1%	1%	1%	1%	<1%	1%	<1%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: Texas Department of Insurance, Division of Workers' Compensation, System Data Report, and Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

In the absence of other systemic changes, it appears that the key drivers behind the changes in the total and types of issues raised in concluded BRCs were the new BRC rules and the passage of HB 2605 in 2011. Significant among the changes were increases in the DD issues that carry presumptive weight in disputes and increases in BRC reschedule requests that reflect inadequate preparation. This combination could have unfavorable implications for the outcome of these disputes. The REG will continue to monitor these trends, and will report on their outcomes in the near future.

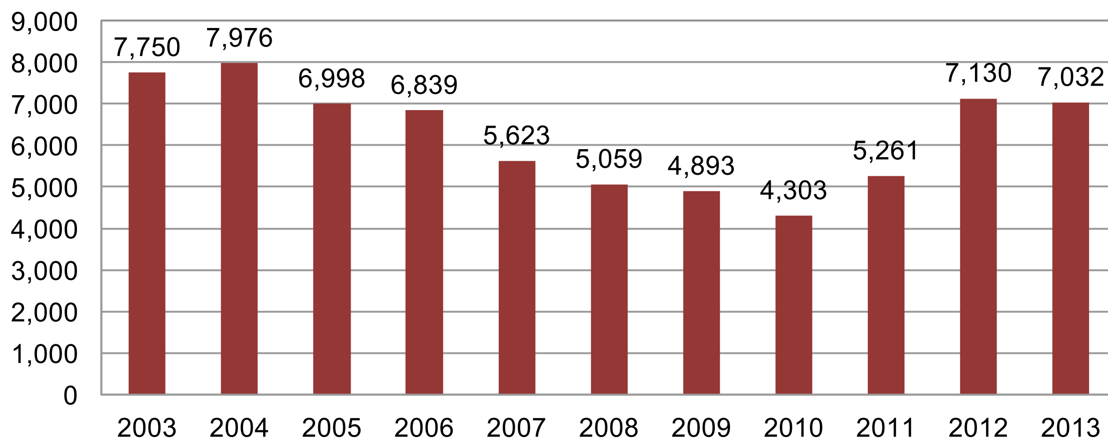
Contested Case Hearings

Contested Case Hearings Scheduled

Issues brought up at BRCs that do not end in resolution are automatically scheduled for a formal hearing called the Contested Case Hearing (CCH) where a DWC Hearing Officer reviews the case and makes decisions on those issues. CCHs allow disputing parties to more fully develop their cases on the pertinent evidence upon which the Hearing Officer can make an impartial and educated decision. A Hearing Officer's decision can be appealed to the Appeals Panel, which in turn can be appealed for judicial review for final adjudication in district court.

The number of scheduled CCHs decreased during the years 2004 to 2010 (see Figure 8.9). However, by 2013, the number of scheduled CCHs was 63 percent higher than in 2010. The steepest increases over this period occurred in 2011 and 2012, by 22 percent and 36 percent respectively. It is too early to determine if the slight decrease in 2013 signals a reversal of this trend.

Figure 8.9: Number of Scheduled CCHs

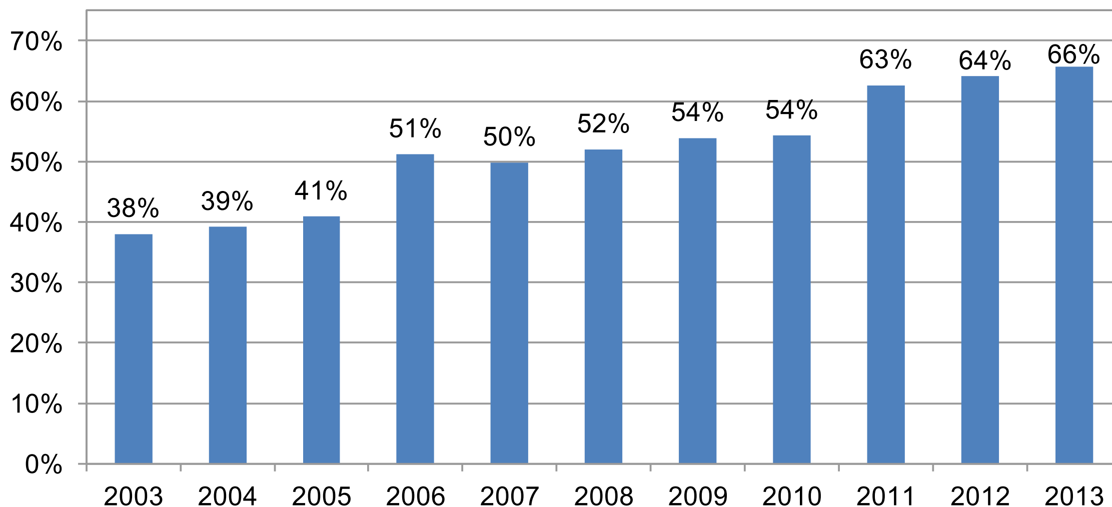


Source: Texas Department of Insurance, Division of Workers' Compensation, System Data Report, and Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Not surprisingly, the number of BRCs concluded (the pool from which CCHs are scheduled), had also increased significantly in 2011 and 2012. Overall, the number of scheduled CCHs increased faster than the number of BRCs concluded. The percentage of concluded BRCs that resulted in scheduled CCHs rose steadily from 38 percent in 2003 to 66 percent in 2013 (see Figure 8.10). However, this was not due to increasing numbers of CCHs alone. Rather, the increasing share of CCHs was driven primarily by the decreasing number of disputes being resolved at the BRC level of dispute resolution.

Several factors contribute to the rise in requests for CCHs to resolve issues that are not concluded at BRCs. As discussed in the BRC section, the most frequent three issues in BRCs are DD MMI date, DD impairment rating, and extent-of-injury. Their share of all BRC issues more than doubled from 27 percent in 2007 to 59 percent in 2013. These DD decisions, by statute, have presumptive weight in DWC dispute proceedings and require a preponderance of the evidence to be overturned. However, the trends in the reasons for rescheduling BRCs show low levels of preparedness that could lead to unfavorable outcomes for parties trying to overturn a DD decision and as a result, the need for more CCHs to try and resolve disputes over a DD report.

Figure 8.10: Percent of Concluded BRCs that Result in Scheduled CCHs

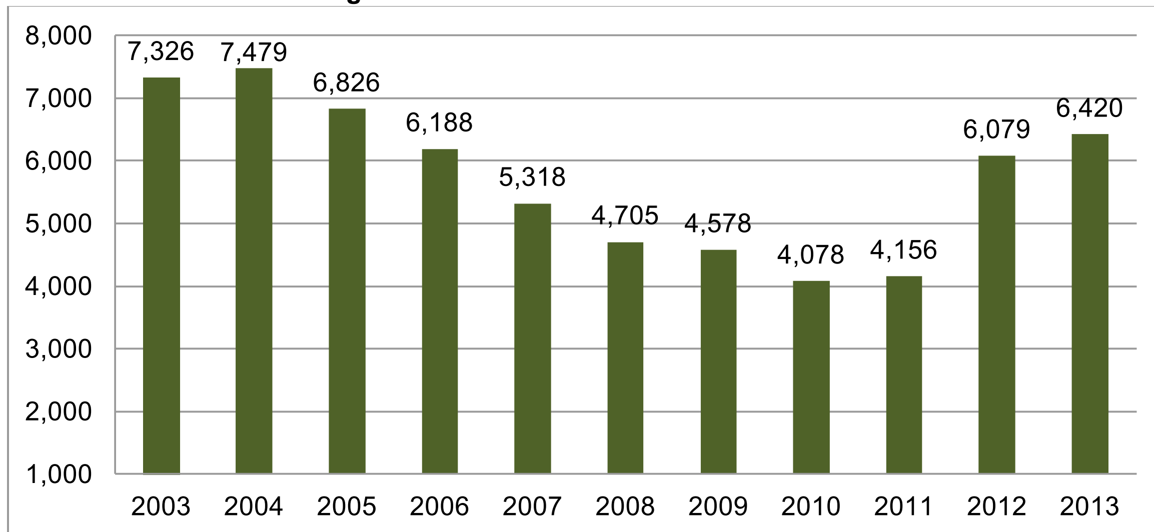


Source: Texas Department of Insurance, Division of Workers' Compensation, System Data Report, and Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

CCHs Concluded

The number of concluded CCHs is less than the number of scheduled CCHs (figure 8.9) because of hearings not yet held and disputes that were resolved by agreement or withdrawn before a CCH. Similar to the trends seen in concluded BRCs, the number of concluded CCHs decreased after 2004 but increased after 2010 (see Figure 8.11).

Figure 8.11: Number of Concluded CCHs



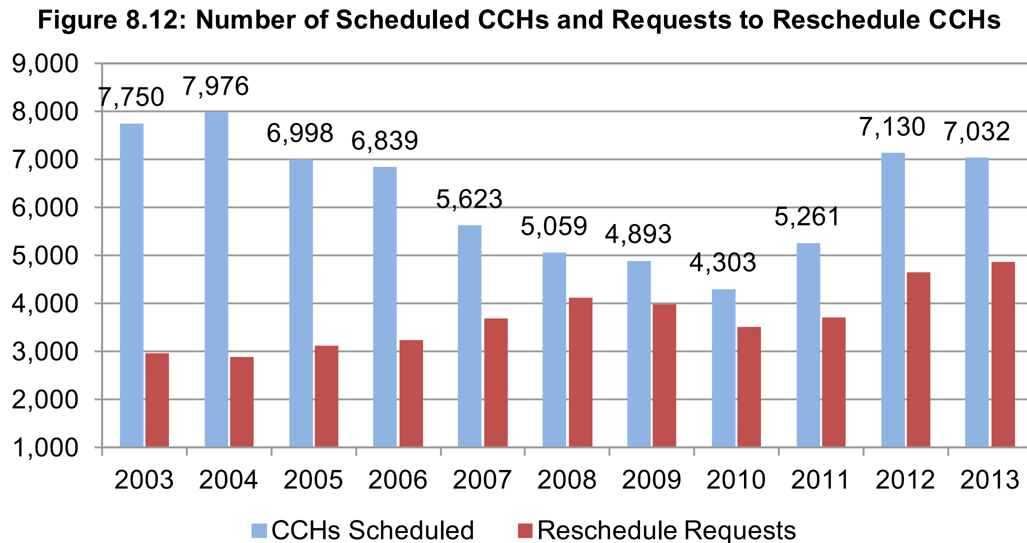
Source: Texas Department of Insurance, Division of Workers' Compensation, System Data Report, and Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

While the number of concluded BRCs increased by 32 percent in 2012, concluded CCHs increased by 46 percent. This is not surprising given that the percentage of concluded BRCs that led to scheduled CCHs increased from 38 percent in 2003 to 66 percent in 2013.

Requests to Reschedule CCHs

The number of requests to reschedule CCHs also increased since 2010. It is possible that some of this increase can be traced to the rescheduling patterns seen in BRCs. Since unresolved issues from BRCs are heard in CCHs, it is conceivable that BRC issues lacking pertinent information and with unprepared parties would also overflow into CCHs. As Figure 8.12 shows, after decreases from 2004 to 2010, the number of requests to reschedule CCHs increased by 200 (7 percent) in 2011 and by 955 (26 percent) in 2012. The number of requests to reschedule CCHs increased slightly by 198, or 4 percent over 2012 requests.

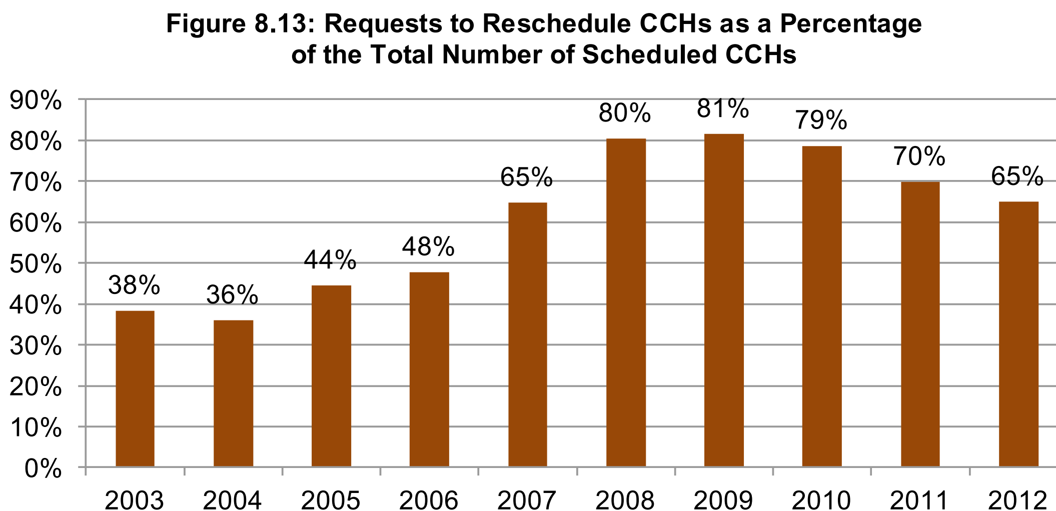
Figure 8.12: Number of Scheduled CCHs and Requests to Reschedule CCHs



Source: Texas Department of Insurance, Division of Workers' Compensation, System Data Report, and Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

After 2010, the number of scheduled CCHs grew at a faster rate than the number of requests to reschedule CCHs. Consequently, as a percentage of the total number of CCH requests, requests to reschedule decreased slightly. In 2009, requests to reschedule represented 81 percent of scheduled CCHs (see Figure 8.13). By 2012, it fell to 65 percent as the increases in the number of scheduled CCH outpaced the increases in requests to reschedule. Yet, the reschedule rate in 2012 was significantly higher than the rates from 2003 to 2006.

Figure 8.13: Requests to Reschedule CCHs as a Percentage of the Total Number of Scheduled CCHs



Source: Texas Department of Insurance, Division of Workers' Compensation, System Data Report, and Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Among the 24 reason codes allowed for rescheduling CCHs, the top three reasons comprised an average 20 percent of the reasons used over the past ten years (see Table 8.6). The share of 'requiring more time' doubled from 9 percent in 2004 to 18 percent in 2010, but returned to 10 percent in 2012. 'No-shows' and 'incomplete documentary evidence' remained relatively stable over the same period at around 4 percent each.

Table 8.6 Shares of Reasons for Rescheduling Contested Case Hearings by Reschedule Request Reason

Reasons Given to Reschedule CCH	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Required More Time to Prepare	10%	9%	10%	12%	11%	13%	14%	18%	17%	10%
No Show-Unknown Reason	6%	5%	3%	3%	3%	2%	3%	3%	4%	5%
Incomplete Documentary Evidence	4%	3%	5%	4%	5%	4%	4%	4%	3%	4%
Others	80%	83%	82%	81%	81%	81%	79%	75%	76%	81%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: Texas Department of Insurance, Division of Workers' Compensation, System Data Report, and Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

In summary, while most claim and income benefit dispute measures decreased steadily between 2003 and 2010, certain disputes increased in 2011 and 2012, coinciding with new BRC rules and the passage of HB 2605 in 2011. However, the increases appear to be temporary responses to the rule and legislative changes, both of which addressed BRC requests and requests to reschedule BRCs. Most of the increases seen in 2011 and 2012, including concluded BRCs and scheduled CCHs, reversed in 2013, but more time is needed to confirm that reversal.

These findings also illustrate the fact that although more disputes were filed in an attempt to overturn a DD report since 2011, parties in these disputes were generally unprepared to dispute the DD report and as a result, a significant number of BRCs and CCHs had to be rescheduled. Additionally, the failure for parties to be prepared to dispute the DD report resulted in more of these DD disputes being pushed to the CCH level for resolution.

Because of the statutory role of the DD in the workers' compensation system, parties who want to dispute the DD opinion must provide a preponderance of the evidence to prevail in these disputes. The statutory design provides that in the absence of a preponderance of the evidence, the DD report has presumptive weight. Further monitoring of these DD disputes in the future will be helpful in determining whether parties who want to dispute the DD report wait until they are more prepared before initiating such disputes.

Medical Denials and Disputes

This section of the report examines how the frequency, duration, and outcomes of medical disputes have changed since the adoption of the 2005 legislative reforms. This section also examines the number of complaints received by TDI including complaints regarding the focal point of the 2005 legislative reforms – namely workers' compensation health care networks.

Number and Time Frame to Resolve Medical Disputes

Generally, there are three types of medical disputes raised in the workers' compensation system:

- fee disputes (which may include a dispute over the application of the DWC's fee guidelines or a dispute over the fee for a service that is not covered in DWC's fee guidelines),
- preauthorization disputes[30] (i.e., disputes regarding the medical necessity of certain medical treatments and services that were denied prospectively by the insurance carrier), and
- retrospective medical necessity disputes (i.e., disputes regarding the medical necessity of medical treatments and services that have already been rendered and billed by the health care provider).

- As Table 8.7 indicates, there has been a significant reduction in the number of medical disputes filed with TDI or DWC as a result of the 2005 legislative reforms. In 2003, TDI received approximately 17,433 medical disputes, but by 2013, that number had fallen by about 70 percent to 5,187.[31] The decline in disputes is related to several factors, such as fewer claims filed, the creation of health care networks in 2006, the adoption of DWC's medical treatment guidelines in 2007, and DWC's adoption of new professional, inpatient and outpatient hospital and ambulatory surgical center fee guidelines in 2008.

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[30] Texas Labor Code, Section 413.014 and 28 Texas Administrative Code, Section 134.600 include a list of medical treatments and services that require preauthorization by the insurance carrier before they can be provided to an injured employee. Networks are not subject to these preauthorization requirements and may establish their own lists of medical treatments and services that require preauthorization. See Texas Insurance Code, Section 1305.351.

[31] From August 2008 to August 2009, one health care provider filed approximately 6,000 pharmacy fee disputes against one insurance carrier. DWC upheld a great majority of these disputes in favor of the insurance carrier (approximately 60 percent of all fee disputes decisions made during those years), and the requestor eventually withdrew all the disputes during the appeal process.

Table 8.7: Number and Distribution of Medical Disputes Submitted to DWC, by Type of Medical Dispute

Year Dispute Received	Pre-authorization	Fee Disputes	Retrospective Medical Necessity Disputes	Total
2003	11%	70%	19%	17,433
2004	13%	60%	27%	14,291
2005	13%	68%	19%	13,257
2006	16%	70%	14%	9,706
2007	27%	72%	1%	8,810
2008	22%	75%	3%	12,244
2009	24%	74%	2%	12,293
2010	41%	58%	1%	7,596
2011	35%	63%	2%	7,795
2012	37%	62%	1%	5,643
2013	26%	73%	1%	5,187

Source: Texas Department of Insurance: Division of Workers' Compensation and Workers' Compensation Research and Evaluation Group, 2014.

Additionally, the percentage of medical disputes associated with preauthorization denials increased from 11 percent of all medical disputes in 2003 to a high of 41 percent in 2010 (Table 8.7). By 2013, 26 percent of all medical disputes were associated with preauthorization denials. Over the same period, the percentage of retrospective medical necessity disputes declined steeply from 27 percent in 2004 to 1 percent in 2013, which is most likely the result of the adoption of DWC's medical treatment guideline rule in May 2007. This rule requires preauthorization for all medical services that are outside of the treatment guideline's recommendations, with the exception of pharmacy services, in addition to the existing preauthorization requirements laid out in DWC's preauthorization rule – 28 Texas Administrative Code, Section 134.600.

In 2011, DWC also adopted one of the nation's first pharmacy closed formularies, which requires preauthorization by an insurance carriers for any prescription drug that is excluded from the closed formulary. The formulary took effect for new claims on September 1, 2011 and for older injuries on September 1, 2013. Although the number of prescription drugs that require preauthorization has increased as a result of the closed formulary, DWC's efforts to facilitate increased communication between insurance carriers and prescribing doctors has resulted in fewer medical necessity disputes since the formulary took effect in 2011.

In an effort to more closely align the process for resolving workers' compensation medical necessity disputes with the process for resolving these same types of disputes in the group health system, DWC adopted a rule in January 2007 to streamline the intake of medical disputes, including preauthorization and retrospective medical necessity disputes. Part of that process included requiring the insurance carrier's utilization review agent to send all of the medical evidence used to make the medical necessity decision directly to

the Independent Review Organization (IRO) assigned by TDI instead of sending multiple copies to TDI to compile for the IRO's review.

Another part of this process was TDI assigning IROs to review disputes instead of DWC, and disputes are assigned within 24 hours of the receipt of an IRO request. Additionally, fewer incoming fee disputes, combined with DWC's efforts to improve the efficiency of fee dispute resolution have resulted in more timely resolution of fee disputes.

As a result of TDI's process improvement efforts, the mean and median time frames to resolve medical disputes have declined significantly since 2005 for all dispute types (see Table 8.8). The average preauthorization dispute duration fell from 59 days in 2005 to 18 days in 2013 (a 69 percent decrease). The average fee dispute duration fluctuated from 335 days in 2005 to 159 days in 2013 (a 53 percent decrease), and the average retrospective medical necessity dispute duration decreased from 123 days in 2005 to 19 days in 2013 (an 85 percent decrease).

The number of active fee disputes that needed to be resolved by DWC reached a peak of approximately 17,000 in August 2009. Issues involving previous inpatient hospital fee guidelines and previous pharmacy fee guidelines accounted for approximately 85 percent of those disputes.

Litigation between health care providers and individual insurance carriers over interpretations of the fee guideline rules prolonged the final resolution of many of these disputes. However, the combination of the aggressive adjudication of backlog disputes by DWC, the adoption of new professional and hospital fee guidelines effective March 2008, and the marked decrease in the volume of disputes have resulted in the resolution of over 11,000 backlog fee disputes since 2009.

The number of new fee disputes received by DWC has decreased as well from approximately 9,183 new fee disputes in calendar year 2008 to approximately 3,787 new fee disputes for calendar year 2013.

Table 8.8: Mean and Median Number of Days to Resolve Medical Disputes, by Type of Medical Dispute, 2002-2013 (as of December 2013)

Year Dispute Received	Days to Resolve Pre-authorization Disputes		Days to Resolve Fee Disputes		Days to Resolve Retrospective Medical Necessity Disputes	
	Mean	Median	Mean	Median	Mean	Median
2002	107	84	265	220	252	223
2003	58	48	582	592	205	168
2004	53	43	478	413	172	128
2005	59	53	335	184	123	79
2006	55	51	309	219	132	95
2007	22	21	205	193	32	26
2008	19	20	197	113	36	34
2009	20	20	120	87	36	37
2010	19	20	166	60	26	22
2011	20	20	197	122	31	27
2012	18	20	225	141	22	20
2013	18	20	159	100	19	20

Source: Texas Department of Insurance: Division of Workers' Compensation and Workers' Compensation Research and Evaluation Group, 2014.
Note: From August 2008 to August 2009, approximately 6,000 pharmacy fee disputes were received by DWC from one doctor against one insurance carrier. They were all subsequently upheld in favor of the insurance carrier.

Over the past few years, the proportion of medical disputes decided in favor of the insurance carrier or the health care provider has changed depending on the type of dispute (see Table 8.9). For fee disputes, decisions in favor of the health care provider decreased from 72 percent in 2005 to 37 percent in 2013. For retrospective medical necessity disputes, the percentage of decisions in favor of the insurance carrier increased sharply from 17 percent in 2006 to 87 percent in 2013. In 2013, insurance carriers prevailed in 87 percent of the medical necessity decisions over preauthorization disputes.

These dispute outcomes, coupled with the decreasing number of new medical disputes being filed may suggest that more health care providers and insurance carriers are utilizing DWC's evidence-based treatment guidelines when making medical necessity decisions and that IROs are also basing their medical necessity determinations on these treatment guidelines (as required by Texas Labor Code, Section 413.031(e-1)). This may mean that the few medical disputes that now exist, compared to previous years, are more complicated and involve situations where there is a lack of clear guidance regarding reimbursement or treatment recommendations. They may also indicate that TDI needs to examine whether IROs are receiving all of the medical documentation relevant to the dispute from the insurance carrier and whether health care providers are providing all of the relevant medical documentation to justify deviating from the guideline recommendations to the insurance carrier.

Table 8.9: Percentage of Concluded Medical Disputes Decided in Favor of Insurance Carrier or Health Care Provider, by Type of Medical Dispute, 2002-2013

Year Dispute Received	Preauthorization Disputes		Fee Disputes		Retrospective Medical Necessity Disputes	
	Carrier	Provider	Carrier	Provider	Carrier	Provider
2002	69%	31%	41%	59%	43%	57%
2003	77%	23%	32%	68%	33%	67%
2004	76%	24%	31%	69%	31%	69%
2005	71%	29%	28%	72%	17%	83%
2006	65%	35%	28%	72%	17%	83%
2007	77%	23%	19%	81%	72%	28%
2008	75%	25%	79%	21%	57%	43%
2009	78%	22%	92%	8%	65%	35%
2010	73%	27%	58%	42%	69%	31%
2011	77%	23%	63%	37%	76%	24%
2012	83%	17%	58%	42%	71%	29%
2013	83%	17%	63%	37%	87%	13%

Source: Texas Department of Insurance: Division of Workers' Compensation and Workers' Compensation Research and Evaluation Group, 2014. Note 1: These dispute resolution outcomes were only calculated for disputes that had been concluded as of December 2013 – disputes that were withdrawn or dismissed were excluded from the analysis. Hospital disputes, disputes submitted without the DWC Form-060, and disputes with incorrect jurisdiction were also excluded. Note 2: From August 2008 to August 2009, approximately 6,000 pharmacy fee disputes were received by DWC from one doctor against one insurance carrier. They were all subsequently upheld in favor of the insurance carrier.

Trends in Complaints Filed

While the number of workers' compensation claims decreased measurably since the passage ofthe 2005 legislative reforms, the number of complaints received by DWC is now following a similar trend. As Table 8.10 shows, the number of complaints fluctuated during the years following the passage of the 2005 legislative reforms. While DWC received a total of 7,433 complaints in 2004, that number fell to 3,820 in 2006, but increased to 8,621 in 2008. Since 2010, the number of complaints has been decreasing.

DWC received 5,402 complaints in 2013. Of those complaints received and closed in 2013, 2,065 (38.2 percent) were "monitoring complaints," meaning that DWC did not investigate the complaint for a violation of the Texas Workers' Compensation Act or Rules. DWC, however, did send a letter to the party that was the subject of the complaint asking them to resolve the complaint and remind them of their compliance duties. A total of 1,683 complaints (31.1 percent) were "not confirmed," meaning that there was not a violation of the Texas Workers' Compensation Act or Rules or a violation could not be substantiated. A total of 1,617 complaints were "confirmed" complaints that were violations of the Texas Workers' Compensation Act or Rules and warranted further

investigation. The remaining complaints were closed in 2014 and not included in the overall closure numbers. [32]

The most frequent types of complaints received by DWC in 2013 include complaints about communication issues (e.g., timely filing of required forms), complaints from health care providers about medical benefits (e.g., prompt payment), and complaints regarding the failure of a system participant to attend a required exam or hearing.

Table 8.10: Total Number of Complaints Received by the Texas Department of Insurance, Division of Workers' Compensation

Complaint Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Number of Complaints	7,433	5,883	3,820	6,715	8,621	6,516	6,808	6,267	5,792	5,402

Source: Texas Department of Insurance, Division of Workers' Compensation, 2014.
Note: Complaint counts for 2005 and 2006 should be viewed with caution since these numbers are incomplete due to the transition of the functions of the former Texas Workers' Compensation Commission to the newly created Division of Workers' Compensation. During the transition, the Division's complaints were placed into TDI's existing complaint tracking system, which initially did not track complaints received through referrals from DWC field office staff. Complaints received through internal referrals are now tracked as part of TDI's complaint tracking system.

Overall, TDI[33] has received relatively few complaints about networks since 2005 (818 total complaints – of which approximately 30 percent were deemed justified) given that 536,772 injured employees have been treated in networks as of February 1, 2014. The most frequent types of complaints raised by health care providers included payment disputes related to preauthorization, failure to pay based on contracted rates, and non-payment based on timely filing and complaints about delayed payment for services provided.

The most frequent types of complaints raised by injured employees included complaints about access to care and quality of care provided by network health care providers. Chapter 1305, Insurance Code, as well as the Department's network rules (Chapter 10 of the Texas Administrative Code) require networks to resolve complaints, including disputes over network fees, internally and to maintain a detailed complaint log that is subject to the Department examination.

[32] Complete results from DWC's System Monitoring and Oversight section are available at www.tdi.texas.gov/wc/pbo/index.html.

[33] The TDI Managed Care Quality Assurance Office certifies networks, and TDI's Consumer Protection Section resolves complaints filed about networks.

The administration of workers' compensation disputes and complaints is a critical component of TDI's mission. Since the adoption of the 2005 legislative reforms, the number of complaints continues to fluctuate while the number of disputes decreased until 2011, when several income benefit disputes regarding designated doctor reports increased. Effective streamlining has led to steep reductions in the average durations to resolve disputes. TDI and DWC will continue to monitor disputes and complaints, and to improve processes where feasible.

9. Employer Participation in the Texas Workers' Compensation System

Introduction

Since the Texas workers' compensation law was first enacted in 1913, private sector employers have been allowed to either obtain workers' compensation coverage or opt out of the Texas workers' compensation system.[34] Prior to the 1970's, many states had elective workers' compensation laws. Since the 1972 publication of the National Commission on State Workmen's Compensation Laws' essential recommendations, 22 states have made workers' compensation coverage mandatory for most private-sector employers. Several states with mandatory workers' compensation laws provide statutory exemptions to allow small employers or employers from select industries to opt out of their workers' compensation systems.[35]

Texas is the only state that permits private-sector employers (regardless of employer size or industry) the option of not obtaining workers' compensation coverage and thus, becoming "non-subscribers" to the workers' compensation system.[36] Employers who do not choose to obtain workers' compensation coverage (either through purchasing a workers' compensation insurance policy or becoming a certified self-insured employer or a member of a certified self-insurance group of employers) lose the protection of statutory limits on liability and may be sued for negligence by their injured employees.

Since 1993, the state has periodically monitored the percentage of employers that are non-subscribers and the percentage of employees employed by non-subscribers, as well as the types of alternative occupational benefit programs utilized by non-subscribers and the reasons employers choose or choose not to participate in the Texas workers' compensation system. Non-subscription rates remain an important indicator of the relative "health" of the workers' compensation system since these roughly measure employers' perspectives regarding whether the benefits of participating in the workers' compensation system are greater than the costs of obtaining coverage. For this reason, the 79th Legislature required TDI to monitor and report the effect of the 2005 legislative reforms on employer participation in the Texas workers' compensation system as part of this biennial report.

The first study of employer participation in the Texas workers' compensation system was published in 1993 by Texas A&M University for the Texas Workers' Compensation Research

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[34] Texas governmental entities, including the state and its political subdivisions are currently required to provide workers' compensation insurance coverage to their employees.

[35] Florida, for example, exempts non-construction employers with less than four employees. New Mexico exempts non-construction employers with less than three employees but allows some service and ranch employers the option to purchase coverage.

[36] In New Jersey, all employers are required to have workers' compensation coverage or be self-insured. Non-compliant employers are fined, and their injured employees receive income and medical benefits through the Uninsured Employers' Fund. Recently, Oklahoma passed legislative reforms that allow certain employers to opt-out of the workers' compensation system if they meet certain financial requirements and offer benefits that are similar to those found in the workers' compensation system.

Center. In 1996, the Research Center's successor agency, the Research and Oversight Council on Workers' Compensation (ROC) assumed the responsibility of calculating non-subscription rates using the same methods. In 2004, TDI acquired this responsibility and currently manages the survey.

Survey Design and Data Collection

A random probability sample, stratified by industry and employment size, was drawn from all year-round private-sector employers in the state using the Texas Workforce Commission's Unemployment Insurance database.[37] To address changing issues in the workers' compensation system, the original survey instrument designed by the Research Center has been modified slightly over the years. Specifically, TDI's Workers' Compensation Research and Evaluation Group (REG) included questions in the 2014 survey to measure the impacts of the HB 7 legislative reforms on business decisions affecting economic development, as well as questions to collect information about the use of arbitration agreements by non-subscribing employers.

During the months of July through August 2014, the Public Policy Research Institute (PPRI) at Texas A&M University, on behalf of TDI, surveyed more than 1,900 Texas employers. The results of the survey serve as the basis for the estimates provided in this report.[38] This report presents highlights of the findings from this survey, including:[39]

- Overall employer non-subscription rates and the percentage of Texas employees employed by non-subscribers;
- The reasons employers gave for purchasing workers' compensation coverage or becoming non-subscribers to the workers' compensation system;
- Texas employers' recent experiences with workers' compensation premium costs;
- Employer satisfaction levels for subscribers and non-subscribers; and
- Employers' perceptions regarding the impact of the HB 7 legislative workers' compensation reforms on economic development.

The survey respondents who provided the information for this report included company owners (68 percent), human resources administrators (24 percent), claim administrators (4 percent), risk managers (3 percent), and other company staff (1 percent). The subscription and non-subscription estimates have a 95 percent confidence interval of +/-2.5 percent.

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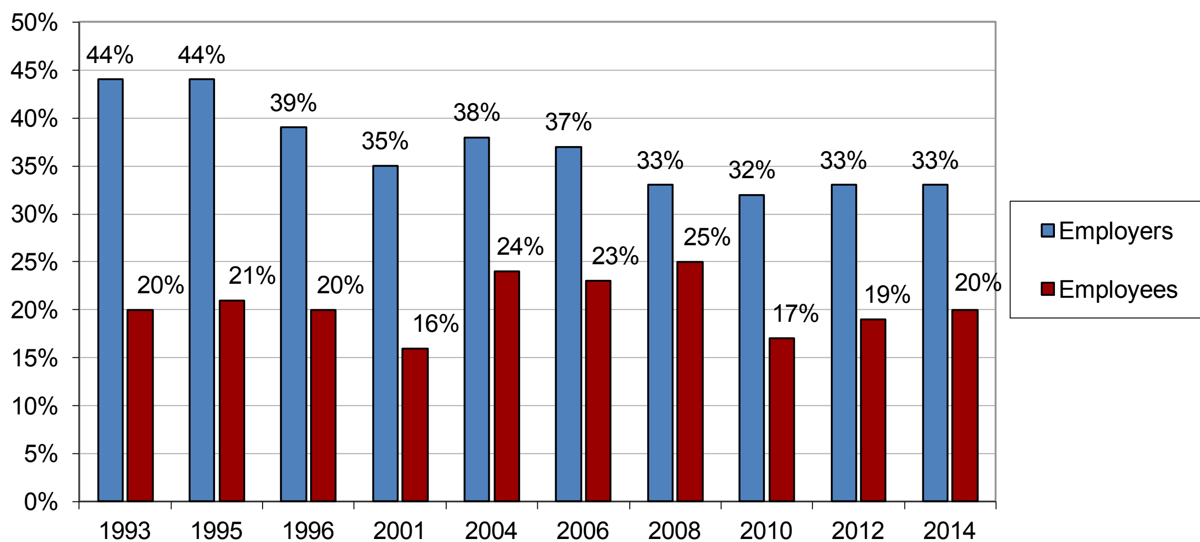
[37] For the purposes of this study, "year-round" employers are employers with reported wages for four consecutive quarters. Employers with only seasonal employees were excluded from this analysis.
[38] The response rate for this survey was 37 percent.
[39] Additional findings from this survey, including information regarding the types of alternative occupational benefit programs offered by nonsubscribers, can be viewed on TDI's website at www.tdi.texas.gov/report14.html.

Employer Participation and Employee Coverage

The percentage of year-round non-subscribing private Texas employers in 2014 remained unchanged since 2012 – 33 percent of employers (approximately 119,000 employers) opted out of the system, which ties 2008 as the second lowest percentage since 1993 . An estimated 20 percent of Texas private-sector employees (representing approximately 1.9 million employees in 2014) worked for non-subscribing employers – the third lowest percentage in the past ten years (see Figure 9.1). Conversely, 80 percent of Texas private-sector employees (an estimated 7.7 million employees) are employed by the 67 percent of employers (an estimated 238,000 employers) that are subscribers to the workers' compensation system.

Although non-subscribing employers have opted not to provide workers' compensation coverage to their employees, some of these employers (approximately 33 percent in 2014) provide an alternative occupational benefit plan. Because these employers who provide an alternate occupational benefit plan tend to be larger employers, they employ approximately 75 percent of the non-subscriber employee population. As a result, an estimated 5 percent of private-sector employees (approximately 470,000) either do not have workers' compensation coverage or coverage through a non-subscriber occupational benefit plan in the case of a work-related injury in 2014.

Figure 9.1: Percentage of Texas Employers that are Non-subscribers and the Percentage of Texas Employees that are Employed by Non-subscribers



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 2004-2014 estimates from the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group and PPRI.

While large employers typically held the lowest non-subscription rates since 1995, this trend changed when large employers (with 500 or more employees) almost doubled their non-subscription rate from 14 percent in 2001 to 26 percent in 2008 (see Table 9.1). This changed sharply to 15 percent in 2010, with slight increases in the following two surveys. In 2014, these large employers reported a 19 percent non-subscription rate. Other large employers (with 100-499 employees) continue to report the lowest non-subscription rate of all employer groups (14 percent).

Interestingly, the smallest employers (with 1-4 employees) increased their non-subscription rate to 43 percent, the highest since 2006, while employers with 5-9 employees reduced their non-subscription rate to 27 percent, the lowest level recorded for that group of employers since 1995. Overall, medium-sized employers changed their non-subscription rates moderately.

Table 9.1: Percentage of Texas Employers that are Non-subscribers by Employment Size

Employment Size	1995	1996	2001	2004	2006	2008	2010	2012	2014
1-4 Employees	55%	44%	47%	46%	43%	40%	41%	41%	43%
5-9 Employees	37%	39%	29%	37%	36%	31%	30%	29%	27%
10-49 Employees	28%	28%	19%	25%	26%	23%	20%	19%	21%
50-99 Employees	24%	23%	16%	20%	19%	18%	16%	19%	18%
100-499 Employees	20%	17%	13%	16%	17%	16%	13%	12%	14%
500+ Employees	18%	14%	14%	20%	21%	26%	15%	17%	19%

Source: Survey of Employer Participation in the Texas Workers' Compensation System, 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 2004-2014 estimates from the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group and PPRI.

Non-subscription Rates by Industry

Two of the eight industry sectors experienced increased non-subscription rates in 2014. The Wholesale Trade/ Retail Trade/Transportation sector had the largest increase from 26 percent of employers reporting that they were non-subscribers in 2012 to 34 percent in 2014 (see Table 9.2). They were followed by employers in the Health Care/Educational Services sector, who increased their non-subscription rate from 35 percent in 2012 to 41 percent in 2014, the highest rate for that sector since 2006.

Employers in the other six sectors decreased their non-subscription rates in 2014, with the Manufacturing and Mining/Utilities/Construction sectors experiencing some of their lowest non-subscription rates in ten years. Employers in the Mining sector, which includes employers involved in oil and gas extraction industry sectors, continue to have the lowest non-subscription rate among industry sectors (20 percent) while the Other Services except Public Administration sector had the highest rate (47 percent).

Table 9.2: Percentage of Texas Employers that are Non-subscribers by Industry

Industry Type	Non-subscription Rate					
	2004	2006	2008	2010	2012	2014
Agriculture/Forestry/Fishing/Hunting	39%	25%	27%	25%	29%	26%
Mining/Utilities/Construction	32%	21%	28%	19%	22%	20%
Manufacturing	42%	37%	31%	31%	29%	25%
Wholesale Trade/ Retail Trade/Transportation	40%	37%	29%	32%	26%	34%
Finance/Real Estate/Professional Services	32%	33%	33%	33%	32%	29%
Health Care/Educational Services	41%	44%	39%	32%	35%	41%
Arts/Entertainment/Accommodation/Food Services	54%	52%	46%	40%	40%	39%
Other Services Except Public Administration	39%	42%	36%	42%	49%	47%

Source: Survey of Employer Participation in the Texas Workers' Compensation System, Public Policy Research Institute at Texas A&M University, and the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.
Note: Industry classifications were based on the 2002 North American Industry Classification System (NAICS) developed by the governments of the U.S., Canada and Mexico, which replaced the Standard Industrial Classification (SIC) system previously used in the U.S. As a result of this change in industry classifications, industry non-subscription rates for 2004-2014 cannot be compared to previous years.

Reasons Employers Opt Out of the Workers' Compensation System

The three primary reasons why employers choose not to purchase or obtain workers' compensation coverage were: their perception that they had too few employees (21 percent), they had few-on-the-job injuries (20 percent), and that they were not required to have workers' compensation insurance by law (19 percent). Employers' perception that workers' compensation insurance premiums were too high increased slightly to 17 percent in 2014, but that was almost half of the 32 percent who reported this reason in 2010 (See Table 9.3).

When these reasons were examined by employer size, the importance of individual reasons varied. For example, 30 percent of large employers with more than 500 employees in 2014 reported the primary reason for opting out of the system was that they felt they could do a better job than the Texas workers' compensation system at ensuring that employees injured on the job receive appropriate medical and income benefits.

Approximately 22 percent of large employers perceived that medical costs in the workers' compensation system were too high, a two percentage-point decrease since 2012, but it was still double the 10 percent reported in 2010. Another 21 percent of large employers reported that their reason for opting out of the workers' compensation system was that premiums were too high, but this is down significantly from 50 percent in 2010.

Table 9.3: Most Frequent Reasons Non-subscribing Employers Gave for not Purchasing Workers' Compensation Coverage

Primary Reasons Given by Surveyed Employers	Percentage of Non-subscribing Employers				
	2006	2008	2010	2012	2014
Workers' compensation insurance premiums were too high	35%	26%	32%	15%	17%
Employer had too few employees	21%	26%	25%	17%	21%
Employers not required to have workers' compensation insurance by law	9%	11%	13%	17%	19%
Medical costs in the workers' compensation system were too high	4%	4%	5%	10%	16%
Employer had few on-the-job injuries	9%	9%	12%	17%	20%

Source: Survey of Employer Participation in the Texas Workers' Compensation System, Public Policy Research Institute at Texas A&M University, and the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Reasons Employers Gave for Purchasing Workers' Compensation Coverage

The two most frequently cited reasons used by Texas employers for participating in the Texas workers' compensation system in 2014 was that the employer was able to participate in a health care network and that they thought having workers' compensation coverage was required by law (22 percent for both reasons). Another 20 percent said they purchased workers' compensation coverage because they were concerned about lawsuits (see Table 9.4 and Section 3 of this report for more information about network participation in the Texas workers' compensation system).

For those employers with 500 or more employees, the ability to participate in a health care network (23 percent in 2014) continues to be the primary reason given for participating in the Texas workers' compensation system (data not shown). This finding indicates a level of employer interest in health care networks, which may impact employers' decisions to remain subscribers, enter, or re-enter the Texas workers' compensation system.

Other key reasons large subscribers gave in 2014 for purchasing workers' compensation coverage included the ability to reduce workers' compensation insurance costs through deductibles, certified self insurance, group self-insurance or other premium discounts (19 percent); that they thought it was required by law (16 percent); and their concerns about lawsuits (14 percent).

Table 9.4: Most Frequent Reasons Subscribing Employers Gave for Purchasing Workers' Compensation Coverage

Primary Reasons Given by Surveyed Employers	Percentage of Subscribing Employers				
	2006	2008	2010	2012	2014
Employer thought having workers' compensation was required by law	22%	25%	22%	19%	22%
Employer was able to provide injured employees with medical care through a workers' compensation health care network	20%	24%	27%	20%	22%
Employer was concerned about lawsuits	20%	14%	18%	21%	20%
Employer needed workers' compensation coverage in order to obtain government contracts	6%	3%	6%	9%	10%
Workers' compensation insurance rates were lower	NA	2%	2%	11%	10%

Source: Survey of Employer Participation in the Texas Workers' Compensation System, Public Policy Research Institute at Texas A&M University, and the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

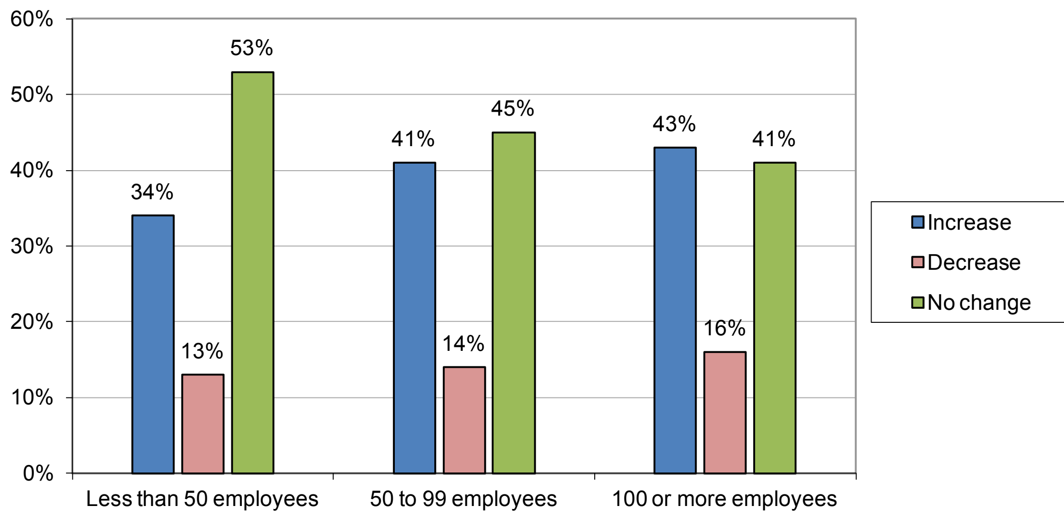
Modest Premium Pressure in 2014

There are indications that the modest premium pressures that began in 2010 have continued into 2014. This is in comparison to the declines Texas employers experienced between 2004 and 2008. While the majority of subscribing employers of all sizes experienced decreases or no changes in their premiums in 2014 (see Figure 9.2), the percentage of those employers reporting increases in their workers' compensation premium has grown after 2008, especially for medium and large employers.

As Figure 9.3 shows, more than 40 percent of medium and large subscribing employers experienced premium increases in 2014, compared to less than 25 percent in 2008. Overall, approximately 65 percent of all subscribers experienced either decreases or no changes in their premium in 2014, compared to 74 percent in 2010.

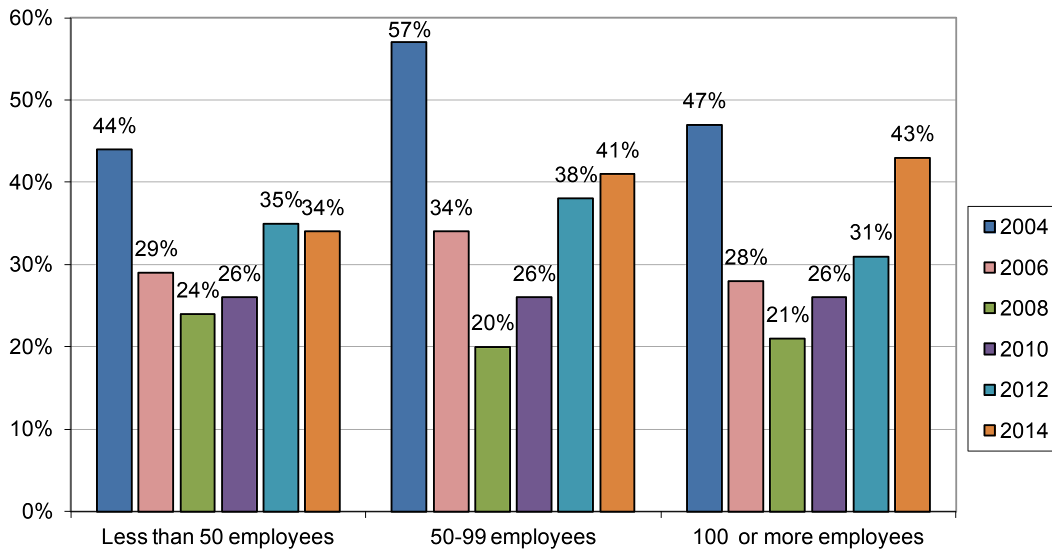
It is not clear from the survey to tell if these premium increases reported are the result of increased workers' compensation rates or the result of payroll increases resulting from the ongoing economic recovery in Texas or both. However, it should be noted that in mid-2006, some insurance companies started offering premium credits for participating in their network. See Section 2 of this report for information regarding the range of premium credits filed by numerous insurance companies and whether premium credits are on the decline.

Figure 9.2: Percentage of Subscribers that Experienced an Increase, Decrease, or No Change in Their Premium, by Employer Size, 2014



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

Figure 9.3: Percentage of Subscribing Employers that Experienced an Increase in Their Workers' Compensation Premiums Compared to Previous Policy Years, by Employer Size



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

Other Types of Insurance Coverage Carried by Texas Employers

Although employer participation in the Texas workers' compensation system is the focus of this section of the report, it is important to note that there may be a general difference in the propensity of certain employers to carry various types of insurance coverage than other types of employers. As Table 9.5 indicates, in 2014, a higher percentage of large subscribers than large non-subscribers (i.e., employers with 500 or more employees) reported offering other types of insurance to their employees, such as general health, life, and disability insurance. Only a slightly higher percentage of non-subscribers than subscribers offer property insurance. An equal percentage (94 percent) of both subscribers and non-subscribers purchase general liability (to protect your company against liability for bodily injuries that might occur on your premises).

However, this reflects abrupt decreases after a general increase in the percentage of large non-subscribers that offered each type of the insurance coverage to their employees over the past six years. For example, the percentage of non-subscribers offering disability insurance to their employees increased from 57 percent in 2008 to 84 percent in 2012, but decreased sharply to 76 percent in 2014. A slightly lower percentage of subscribers also offered some of these types of insurance coverage in 2014 than in 2012, but at a less pronounced decline than with non-subscribers. Industry differences affect the likelihood of an employer offering certain insurance benefits to employees or purchasing various types of insurance coverage, but it is important to note that employers' decisions to be non-subscribers are likely part of broader decisions these employers make regarding their insurance needs.

Table 9.5: Other Types of Coverage Carried by Large Texas Employers (500 or more employees)

Type of Insurance Coverage	2008		2010		2012		2014	
	Subscriber	Non-subscriber	Subscriber	Non-subscriber	Subscriber	Non-subscriber	Subscriber	Non-subscriber
General health insurance for employees (excluding dental or vision insurance coverage)	86%	68%	90%	91%	95%	97%	96%	91%
Life insurance for employees	83%	56%	87%	83%	92%	91%	89%	79%
Disability insurance for employees (short-term or long-term or both)	77%	57%	84%	78%	87%	84%	85%	76%
Voluntary accidental death and dismemberment insurance (A, D &D)	73%	62%	72%	70%	83%	85%	84%	79%
General liability insurance (to protect your company against liability for bodily injuries that might occur on your premises)	92%	76%	87%	91%	95%	87%	94%	94%
Property insurance	83%	75%	84%	91%	90%	94%	91%	92%
Commercial auto insurance	79%	60%	80%	76%	84%	81%	88%	86%

Source: Survey of Employer Participation in the Texas Workers' Compensation System, Public Policy Research Institute at Texas A&M University, and the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Employers' Knowledge about the 2005 Legislative Reforms and Reporting Requirements in Texas

A required element of TDI's evaluation of the impact of the HB 7 reforms on the affordability and availability of workers' compensation insurance is an analysis of the reforms' effect on economic development. Despite the increases in the percentage of employers who reported that the reforms had a positive impact on their business decision-making, the overall knowledge and impact level of the reforms remained low. In previous surveys (until 2012), we asked employers about their perceived impact of these reforms. This question was not asked in 2014, but as recent as 2012 a great majority (between 74 and 79 percent) of Texas employers said the reforms had no impact on their business decisions (see Table 9.6).

However, the percentage of employers reporting that the reforms had a positive effect on their economic decisions had doubled since 2010. The percentage of employers who reported that the reforms positively affected their decisions to hire more employees increased from 5 percent in 2010 to 13 percent in 2012. Likewise, the percentage of employers who reported that the reforms positively affected their decisions to expand operations in Texas (13 percent) and to purchase or maintain workers' compensation coverage (18 percent) showed measureable increases over the 2010 results. The economic-development impact of the 2005 legislative reforms appears to be primarily dependent on employer knowledge about the key component of these reforms, particularly health care networks.

In 2010, 60 percent of Texas employers reported they were not knowledgeable about the availability of health care networks. Previous surveys also showed that employers who reported they were extremely knowledgeable about the availability of health care networks under the 2005 legislative reforms were much more likely to report that they would be more willing to hire more employees, expand business operations in Texas, and to purchase or maintain workers' compensation coverage than employers who were somewhat or not knowledgeable at all about the availability of health care networks in workers' compensation.

While TDI will continue to monitor the impact of the HB 7 reforms in future reports, recent survey results indicate that expanded employer education efforts about key aspects of the HB 7 reforms can positively impact employers' business decisions in Texas.

Table 9.6: Impact of the 2005 Workers' Compensation Reforms on Texas Employers' Business Decisions

Employers' Decisions	Percent of all Employers Surveyed								
	Positive			Negative			No Change		
	2008	2010	2012	2008	2010	2012	2008	2010	2012
Employer's plan to hire more employees	6%	5%	13%	2%	3%	8%	92%	92%	79%
Employer's plan to expand business operations in Texas	9%	6%	13%	7%	2%	3%	89%	91%	78%
Employer's decision to purchase or maintain its workers' compensation coverage	14%	10%	18%	10%	2%	8%	84%	87%	74%

Source: Survey of Employer Participation in the Texas Workers' Compensation System, Public Policy Research Institute at Texas A&M University, and the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2012.

The 2014 employer survey also asked a series of questions regarding employers' knowledge about their workers' compensation reporting requirements (see Table 9.7). Less than 35 percent of employers reported that they were extremely knowledgeable about any of the four reporting requirements. When asked about the requirement that all employers without workers' compensation insurance coverage have to notify the Texas Department of Insurance, Division of Workers' Compensation of their coverage status at least annually through the filing of the DWC Form-005, only 15 percent of the surveyed employers reported that they were extremely knowledgeable about it.

Similarly, only 17 percent of those surveyed reported they were extremely knowledgeable that employers without workers' compensation insurance coverage but with at least five employees are required to report all work-related deaths, occupational diseases, and injuries resulting in at least one day of lost time to the Division of Workers' Compensation through the filing of the DWC Form-007.

The results were higher for employers' knowledge about two other requirements. Approximately 29 percent of those surveyed said they were extremely knowledgeable that employers with workers' compensation insurance coverage are required to report all work-related deaths, occupational diseases, and injuries resulting in at least one day of lost time to their insurance carrier through the filing of the DWC Form-001. Nevertheless, a higher percentage (32 percent) said they were not at all knowledgeable about this requirement.

Finally, when asked if they knew that employers with workers' compensation insurance coverage are required to provide a copy of the employer's first report of injury to the injured employee as well as a copy of the employee's "rights and responsibilities," 33 percent of the surveyed employers said they were extremely knowledgeable while 28 percent said they were not at all knowledgeable about this requirement.

Table 9.7: Impact of the 2005 Workers' Compensation Reforms on Texas Employers' Business Decisions

Employers' Knowledge in 2014	Percent of all Employers Surveyed		
	Not at all knowledgeable	Somewhat knowledgeable	Extremely knowledgeable
All employers without workers' compensation insurance coverage are required to notify the Texas Department of Insurance, Division of Workers' Compensation of their coverage status at least annually through the filing of the DWC Form-005	52%	33%	15%
Employers without workers' compensation insurance coverage that have at least 5 employees are required to report all work-related deaths, occupational diseases and injuries resulting in at least one day of lost time to the Division of Workers' Compensation through the filing of the DWC Form-007 form	48%	35%	17%
Employers with workers' compensation insurance coverage are required to report all work-related deaths, occupational diseases and injuries resulting in at least one day of lost time to their insurance carrier through the filing of the DWC Form-001 form	32%	39%	29%
Employers with workers' compensation insurance coverage are required to provide a copy of the employer's first report of injury to the injured employee as well as a copy of the employee's "rights and responsibilities"	28%	39%	33%

Source: Survey of Employer Participation in the Texas Workers' Compensation System, Public Policy Research Institute at Texas A&M University, and the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Non-subscribers' and Subscribers' Satisfaction with Their Programs

Subscribers reported higher levels of satisfaction with their programs in 2012, but those levels fell in 2014. Meanwhile, non-subscribers reported higher levels of satisfaction than subscribers across all four measures, though some of the results were lower than in previous surveys (see Table 9.8). On their perceptions of benefit adequacy and value, non-subscribers reported satisfaction levels 11 percent higher than subscribers. Sixty-five percent of non-subscribers reported that they were overall extremely or somewhat satisfied, compared to 54 percent for subscribers.[40]

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[40] Complete results from the *Employer Participation in the Texas Workers' Compensation System: 2014 Estimates* are available at www.tdi.texas.gov/reports/report14.html.

Table 9.8: Percentage of Employers that Indicated They Were Extremely or Somewhat Satisfied with Their Programs

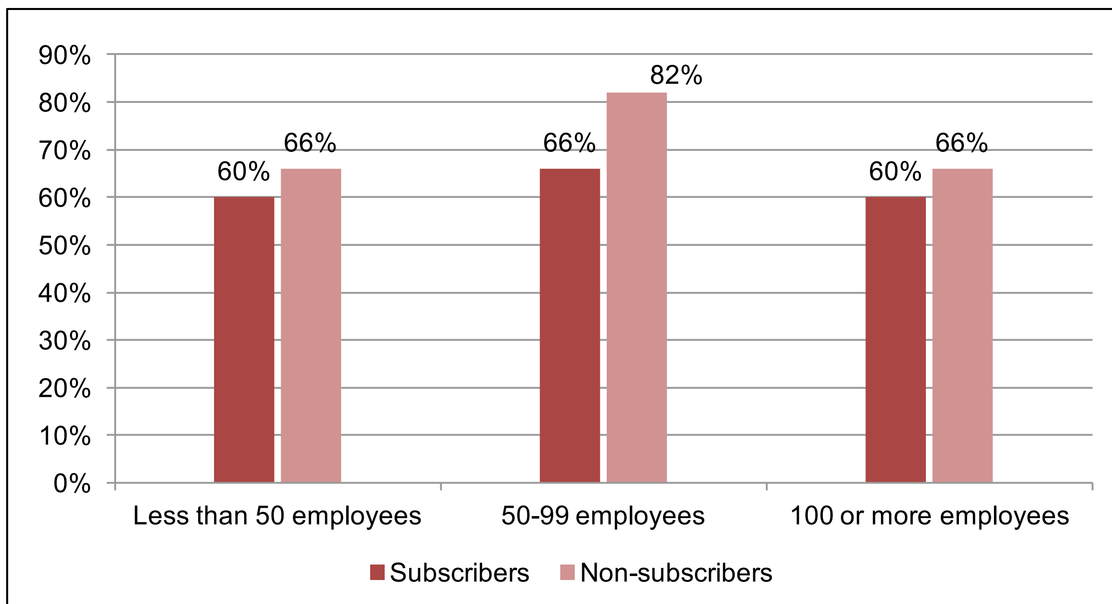
Areas of Satisfaction	2006		2008		2010		2012		2014	
	Sub-scriber	Non-sub-scriber	Sub-scriber	Non-sub-scriber	Sub-scriber	Non-sub-scriber	Sub-scriber	Non-sub-scriber	Sub-scriber	Non-sub-scriber
Overall Satisfaction	56%	70%	61%	69%	59%	68%	72%	63%	61%	67%
Adequacy of occupational benefits paid to injured employees	53%	66%	53%	62%	54%	60%	61%	47%	54%	65%
Whether workers' compensation or occupational benefits plan is a good value for company	54%	73%	56%	69%	58%	68%	73%	58%	53%	71%
Ability to manage medical and wage replacement costs	50%	63%	50%	68%	48%	65%	62%	54%	50%	63%

Source: Survey of Employer Participation in the Texas Workers' Compensation System, Public Policy Research Institute at Texas A&M University, and the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Overall, employer satisfaction levels vary by employer size. Gaps in satisfaction between non-subscribers and subscribers became more pronounced with the medium-sized employers (by 16 percent) than with small or large employers (by 6 percent). Sixty-six percent of large non-subscribers with 100 or more employees indicated that they were extremely or somewhat satisfied with their experience as non-subscribing employers, compared to 60 percent of large subscribers (see Figure 9.4).

However, satisfaction alone may not be the overriding factor in employers' decisions to be subscribers or non-subscribers in the workers' compensation system. Employers' premium experience appears to be a more decisive factor in subscription rates. The highest subscription rates coincide with years when less than 35 percent of subscribers experience premium increases.

Figure 9.4: Percentage of Employers that Indicated They Were Extremely or Somewhat Satisfied, by Employer Size



Source: Survey of Employer Participation in the Texas Workers' Compensation System, Public Policy Research Institute at Texas A&M University, and the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2014.

Summary

Overall, the 2014 employer subscription rate remained unchanged from 2012 (67 percent), while the percentage of employees who work for subscribers slipped a percentage point (from 81 to 80 percent). Except for 2010, when the employer subscription rate was 68 percent, it has remained unchanged since 2008. The 2010-2014 subscription rates are among the highest for employers and employees since Texas conducted the first survey in 1993. Although the subscription rate for employers remains relatively high, there is still a portion of the employee population (approximately 5 percent) that do not have any type of coverage, either through workers' compensation or through a non-subscriber occupational benefit plan, in the case of a work-related injury.

Subscribers cite the option to participate in health care networks and their concerns about lawsuits among their primary reasons for opting into the system. However, premium experience might also contribute to subscribing trends. While 32 percent of non-subscribers cite high premiums as their primary reason for opting out in 2010, that percentage fell to 17 in 2014. Almost 65 percent of subscribers continue to experience either premium decreases or no premium changes from previous years.

While subscribers report that the health care network option under HB 7 was their primary reason for subscribing, previous surveys show that less than 10 percent of Texas employers are

knowledgeable about the 2005 legislative reforms, including the availability of health care networks. There is some evidence that employers knowledgeable about the reforms view them as having a positive impact on their decisions to hire more employees, expand business operations in Texas, and purchase or obtain workers' compensation coverage. Over all, the percentage of employers reporting that the reforms had a positive effect on their economic decisions has doubled since 2010.

Given the uncertain economic climate and federal health care reforms that employers face, it is difficult to fully isolate the impact of the recent HB 7 reforms on employers' decisions to obtain workers' compensation coverage or opt out of the system. Even as subscribing employers report favorably on the health care network option, they reported lower levels of satisfaction than non-subscribers. The stable subscription rates suggest that premium experience may have a more pivotal role than overall satisfaction with the workers' compensation system in employers' decisions to opt-in or opt-out of the workers' compensation system.