SUBJECT: Revising the workers' compensation insurance system and benefits

COMMITTEE: Business and Industry — committee substitute recommended

VOTE: 7 ayes — Brimer, Dukes, Corte, J. Davis, Elkins, George, Woolley

0 nays — None

2 absent — Giddings, Solomons

WITNESSES: For —Jeff Cunningham

Against — Pam Carroll; Ramon Class; Christian Hill

On — Scott McAnally, Research and Oversight Council on Workers' Compensation

BACKGROUND: The Texas Workers' Compensation Act (Labor Code, Title 5, Subtitle A) governs the administration of Texas' workers' compensation system, including computation of benefits (chapter 408), compensation procedures (chapter 409), adjudication of disputes (chapter 410), medical review (chapter 413), and administrative violations (chapter 415).

DIGEST: CSHB 2600 would revise various aspects of Texas' workers' compensation insurance system, including duties of the Texas Workers' Compensation Commission (TWCC); approval and certification of doctors to perform or be paid for workers' compensation services; sanctions against doctors for violations; employment of a medical advisor to TWCC; creation of regional networks for delivery of workers' compensation health-care services; return-to-work reporting and services; preauthorization and concurrent review of medical services; required medical examinations and designated doctors; medical benefit regulation and dispute resolution; multiple employment; and the subsequent injury fund.

The bill would take effect September 1, 2001, and would apply only to a claim for workers' compensation benefits based on a compensable injury that occurred on or after that date, except as otherwise provided.

Approved doctors and medical review. CSHB 2600 would provide that each doctor licensed in Texas on September 1, 2001, could be on TWCC's list of approved doctors if the doctor registered with TWCC and complied with the commission's requirements. A doctor licensed in another state or jurisdiction who treated employees or performed utilization review of health care for an insurance carrier could apply for registration.

TWCC would have to establish rules for reasonable training, impairment rating testing, and financial disclosure for all types of doctors who provided services in the workers' compensation system, including treatment, referral, required examinations, peer review, and utilization review.

TWCC would have to issue to an approved doctor a certificate of registration valid for a period provided by rule. The commission would have to notify each approved doctor of the pending expiration of that doctor's certificate of registration at least 60 days before the expiration date.

Except in an emergency or for immediate post-injury medical care, a doctor would have to be registered and be on the list of approved doctors to perform or receive payment for workers' compensation services. The commission could grant exceptions to this requirement if necessary to ensure employees' access to health care and insurers' access to evaluations of an employee's health care and income benefit eligibility.

TWCC would have to modify registration and training requirements for doctors who infrequently provided health care, performed utilization review or peer review functions for insurers, or participated in regional networks. A utilization review agent that used doctors to perform reviews of workers' compensation health-care services would have to conduct the reviews under the direction of a doctor licensed in Texas.

TWCC would have to collect information regarding return-to-work outcomes, patient satisfaction, and the cost and utilization of health care provided or authorized by a treating doctor. The commission could adopt rules to define the role of the treating doctor and to specify outcome information to be collected for a treating doctor.

TWCC would have to establish criteria for removing a doctor from the list of approved doctors, imposing sanctions for violations, and monitoring utilization review agents, as provided by a memorandum of understanding between TWCC and the Texas Department of Insurance (TDI), and for authorizing increased or reduced utilization review and preauthorization controls on a doctor.

CSHB 2600 would specify seven conditions for which TWCC could delete a doctor from the approved list or recommend imposing sanctions on a doctor:

- a sanction for a violation under the Workers' Compensation Act;
- a sanction under the Medicare or Medicaid program;
- evidence that the insurer's utilization review practices or the doctor's charges, fees, diagnoses, treatments, evaluations, or impairment ratings were substantially different from those TWCC found to be fair and reasonable;
- a suspension or other relevant practice restriction of the doctor's license;
- professional failure to practice medicine or provide health care, including chiropractic care;
- findings of fact and conclusions of law made by a court, an administrative law judge of the State Office of Hearing Examiners (SOAH), or a licensing or regulatory authority; or
- a criminal conviction.

TWCC would have to establish procedures under which a doctor could apply for reinstatement to the list of approved doctors or for restoration of the doctor's practice privileges.

TWCC and TDI would have to enter into a memorandum of understanding to coordinate the regulation of insurers and utilization review agents to ensure compliance with applicable regulations and to achieve appropriate health-care decisions. TWCC could recommend or impose the following sanctions:

- reduction of allowable reimbursement;
- mandatory preauthorization of all or certain health-care services;
- required peer review monitoring and audit;
- deletion from the approved doctor list and the designated doctor list;
- restrictions on appointment as a designated doctor;

- conditions or restrictions on an insurer regarding actions by the insurer in connection with the memorandum or understanding adopted between TWCC and TDI; and
- mandatory participation in training classes or other courses established or certified by TWCC.

TWCC would have to adopt the appropriate rules not later than February 1, 2002. A doctor would not have to hold a certificate of registration before the date provided by commission rules.

Medical advisor. CSHB 2600 would require TWCC to employ or contract with a doctor who would serve as a medical advisor. The advisor would have to make recommendations regarding the following rules:

- developing, maintaining, and reviewing health-care and fee guidelines;
- reviewing compliance with guidelines;
- regulating other acts related to medical benefits as required by TWCC;
- imposing sanctions or deleting doctors from TWCC's list of approved doctors;
- imposing conditions or restrictions as authorized by the memorandum of understanding between TWCC and TDI; and
- determining modifications to the reimbursement provisions used by the Medicare system as necessary to meet occupational injury requirements.

The advisor would have to establish an independent medical quality-review panel of health-care providers as an advisory body. The advisor would have consider appointing some members of the panel from lists developed by the Texas State Board of Medical Examiners and the Texas Board of Chiropractic Examiners, and could consider nominations made by labor, business, and insurance organizations.

The medical quality-review panel would have to recommend to the advisor appropriate action regarding doctors, health-care providers, insurers, and utilization review agents, as well as the addition or deletion of doctors from the list of approved doctors or the list of designated doctors.

A person who served on the medical quality-review panel would not be liable in a civil action for an act performed in good faith as a member of the

panel. The action of a person serving on the panel would not constitute utilization review.

Information maintained by or on behalf of TWCC and considered confidential under law could not be disclosed except in a criminal proceeding; in a hearing conducted by or on behalf of TWCC; in a hearing conducted by another licensing or regulatory authority, as provided in an interagency agreement; or on a finding of good cause in an administrative or judicial proceeding involving enforcement of disciplinary action.

Confidentiality. Confidential information developed by TWCC in connection with these provisions would not be subject to discovery or court subpoena in any action other than an enforcement action by TWCC, an appropriate licensing or regulatory agency, or an appropriate enforcement authority.

Medical network participation. CSHB 2600 would establish the Health Care Network Advisory Committee to advise TWCC on the implementation of regional workers' compensation health-care delivery networks. The advisory committee, which would be appointed by and serve at the pleasure of the governor, would be chaired by the medical advisor and would comprise three employer representatives, three employee representatives, two ex-officio insurance carrier representatives, and two ex-officio health-care provider representatives.

TWCC, on behalf of the advisory committee, would have to establish and contract through competitive bidding with regional networks to provide health care. TWCC also would have to contract through competitive procurement with one or more organizations to determine the feasibility of, develop, and evaluate regional networks. These organizations would have to recommend to the advisory committee appropriate network standards and application requirements and would have to assist the advisory committee during the procurement process.

The advisory committee would have to make recommendations to the commission regarding the development of the standards by which the regional networks provided health-care services; regional network application requirements and fees; contract proposals; the feasibility of

establishing one or more regional networks; the use of consultants as necessary to help the commission procure regional network contracts; and the selection of administrators to build and manage the regional networks and to report on their progress.

The advisory committee would have to gather information from the Research and Oversight Council on Workers' Compensation (ROC), the Texas Health Care Information Council, TDI, the Texas Department of Health, and the Employees Retirement System of Texas.

The standards adopted for preferred provider networks under the Insurance Code, art. 3.70-3C would apply as minimum standards and would be adopted by reference unless they were inconsistent. The advisory committee also could recommend additional standards, including:

- access to an adequate number of providers;
- the right of an employee to receive treatment by a regional network provider within a reasonable amount of time;
- a reasonable effort by the regional network to attract health-care providers who would reflect the ethnic and cultural background of the regional employee population;
- availability of board-certified occupational medicine specialists;
- accreditation of regional networks or a commitment to seek accreditation;
- use of strict credentialing criteria by regional networks for health-care providers;
- satisfactory evidence of the regional network's ability to comply with any financial requirements and to ensure delivery of services;
- compliance with ongoing training and educational requirements established by the commission;
- the use of nationally recognized, scientifically valid, and outcome-based treatment standards as guidelines for health care;
- disclosure of the availability of interpreter services;
- timely and accurate reporting of data; and
- a process for reconsidering medical-necessity denials and resolving medical-necessity of disputes within the regional network.

CSHB 2600 would require the advisory committee and ROC to develop evaluation standards and specifications necessary to implement a report card

for regional networks. The report card, at a minimum, would have to be based on contracted reviews and would have to include a risk-adjusted evaluation of:

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

The regional network administrators would have to report quarterly and to submit consolidated annual reports to TWCC and to the advisory committee on the progress of implementing the regional networks. ROC would have to report to the Legislature by January 1 of each odd-numbered year on the status of the implementation of regional networks.

The cost of assessing the feasibility of, developing, and evaluating the regional networks would have to be funded through an assessment on the subsequent injury fund. This cost could not exceed $250,000 per regional network, or a total of $1.5 million for up to six regional networks. The cost of ongoing regional network administration and management services would be included in the fees for health-care services paid by insurers participating in the regional network.

The bill would establish that a public employer, other than a political subdivision, would have to participate in a regional network, and that an insurer who elected to participate in regional networks would have to agree to abide by the terms of the contracts between TWCC and the regional networks. An insurer could limit its election to participate in a regional network to a particular employer or region of the state until January 1, 2006.

Once an insurer elected to participate in a regional network, employees covered by that insurance carrier could opt into the networks. Employees could opt into regional networks at the time of hire or at a later date with the insurer's permission. Employees could rescind their election to participate in these networks at any point until the date the employee received enhanced income benefits or until 14 days after the date of the employee's injury. This 14-day period would correspond with the time for receiving one of the enhanced income benefits.

TWCC would have to establish the form and manner by which injured workers received notice of their rights. Before an employee elected to participate in a network, the employer would have to provide the employee with a plain-language description of the regional network's services, benefits and restrictions, a list of doctors for the network, and the most recent network report card.

An employee could elect to participate in a regional network at any time with the insurer's permission but would not be bound by that choice if the insurance carrier waived the election, if TWCC determined that the election was the result of coercion, or if the employee moved outside of the network's service area and the network could not identify alternate providers in the new location.

An employer could not discharge an employee who elected not to participate in a regional network if the employer's action would not have occurred in the absence of the employee's election not to participate. An employee could bring suit against an employer for a violation. Damages in such an action would be limited to lost wages, attorney fees, and court costs.

Employees who elected to participate in regional networks would receive their medical treatment from network providers. Out-of-network referrals would be allowed with the approval of the network. If medically necessary services were not available through the network, the network would have to allow a referral to an out-of-network provider.

Employees who elected to participate in regional networks would have to select their initial treating doctor from the list of doctors within the network. At the discretion of the network, employees could select a treating doctor

outside of the network if the doctor and the employee had a documented pre-existing relationship and the doctor agreed to abide by the network contract. Employees also could change their treating doctors within the network in accordance with the network contract.

TWCC would have to adopt rules for network participation not later than October 1, 2001, and would have to convene the first meeting of the Health Care Network Advisory Committee no later than that date.

Unless determined to be unfeasible, TWCC would have to contract for regional workers' compensation health-care delivery networks not later than December 31, 2002. Workers' compensation benefits an employee could receive for participating in a regional network would take effect when TWCC certified that the regional network was operational.

Return-to-work reporting and services. An employer, on written request of an employee, a doctor, an insurer, or TWCC, would have to notify the employee, the employee's treating doctor, if known to the employer, and the insurer of the existence or absence of opportunities for modified duty or a modified duty return-to-work program available through the employer. If opportunities or a program existed, the employer would have to identify the employer's contact person and provide other information to help the treating doctor, the employee, and the insurer assess options.

CSHB 2600 would require an insurer to notify an employer of the availability of return-to-work coordination services. In offering the services, insurers and TWCC would have to target employers without return-to-work programs and would have to focus return-to-work efforts on workers who began to receive temporary income benefits. Return-to-work coordination services could include job analysis to identify physical demand; job modification and restructuring assessments as necessary to match job requirements with functional capacity of an employee; and medical or vocational case management to coordinate the efforts of the employer, the treating doctor, and the injured employee to achieve timely return to work. An insurer would not have to provide physical workplace modifications and would not be liable for the cost of modifications made to facilitate an employee's return to employment.

TWCC would have to use certified rehabilitation counselors or other appropriately trained or credentialed specialists to train TWCC's staff regarding the coordination of return-to-work services. Also, TWCC would have to adopt rules necessary to collect data on return-to-work outcomes to allow full evaluation. TWCC would have to report annually to ROC regarding the implementation and outcome of required return-to-work initiatives.

TWCC could not adopt rules necessary to implement these requirements before January 1, 2004.

Preauthorization, concurrent review, and certification requirements. Except in a medical emergency, an insurer would be liable for medical costs related to spinal surgery only if the insurer preauthorized the surgery as provided by TWCC rules. The bill would eliminate language in current law relating to a second opinion on spinal surgery.

TWCC would have to adopt rules requiring preauthorization and concurrent review for:

- spinal surgery;
- work-hardening or work-conditioning services provided by a health-care facility that was not credentialed by an organization recognized by TWCC rules;
- inpatient hospitalization, including any procedure and length of stay;
- outpatient or ambulatory surgery; and
- any investigational or experimental services or devices.

Each insurer would have to allow health-care providers to ask the insurer to certify coverage for health-care services, including pharmaceutical services, that did not require preauthorization and concurrent review. Regardless, the insurer would retain the right to review health-care services retrospectively and to contest certification of those services.

TWCC could require an insurer to provide for payment of specified pharmaceutical services sufficient for the first seven days following the date of injury if the health-care provider requested and received verification of insurance coverage and a verbal confirmation of an injury from the employer

or the insurer. Rules adopted by TWCC also would have to provide that an insurer was eligible for reimbursement for pharmaceutical services paid from the subsequent injury fund in the event the injury was determined not compensable.

TWCC would have to adopt the rules to implement these requirements not later than February 1, 2002.

Required medical examinations and designated doctors. CSHB 2600 would limit TWCC's authority to require an employee to submit to medical examinations to issues involving appropriateness of health care received. It would change language that requires the insurer to pay reasonable expenses associated with submitting to a required examination and would specify instead that the insurer pay only reasonable mileage expenses.

For any question about impairment, attainment of maximum medical improvement, ability to return to work, compensability and extent of injury, or similar issues, TWCC would have to order an examination by a designated doctor at the request of either the insurance carrier or the employee. The bill would direct workers to designated doctor exams first. TWCC would have to assign a designated doctor not later than the 10th day after the date of a request, and the designated doctor would have to conduct the examination not later than the 21st day after the date on which TWCC issued its order for examination.

An employee's treating doctor or an insurer would have to send to the designated doctor any medical records relating to the issue that the doctor was to evaluate. The treating doctor and insurer also could send the designated doctor an analysis of the injured worker's medical condition, functional abilities, and return-to-work opportunities.

An insurance carrier could request its own examination, as in current law, but only following an examination by a designated doctor. TWCC would have to allow the insurer reasonable time to obtain and present the opinion of its chosen doctor before making a final decision on the merits at issue.

If the report of a designated doctor indicated that an employee could return to work immediately or had reached maximum medical improvement, the

insurer could suspend or reduce the payment of temporary income benefits immediately.

CSHB 2600 would change the qualifications for selection as a designated doctor. Current law requires that the designated doctor be of the same specialization as the employee's treating doctor, if possible. This bill would stipulate that the designated doctor's qualifications would have to be appropriate to the issue under consideration and to the injured employee's medical condition. The bill would strike language that limits the designated doctor's consideration and presumptive weight determination to issues of maximum medical improvement.

ROC would have to report to the Legislature not later than December 31, 2002, regarding issues related to medical examinations.

Medical benefit regulation and dispute resolution. A physician, rather than a health-care provider, would have to prescribe for an employee necessary prescription drugs and over-the-counter alternatives. TWCC would have to develop an open formulary, or list of medicines, that required the use of generic medications and clinically appropriate over-the-counter alternatives. TWCC would have to adopt rules that allowed an employee to buy over-the counter alternatives to prescription medications and to obtain reimbursement from the insurer for those medications.

TWCC would have to adopt the reimbursement methodology and model used by the Medicare system with as few modifications as necessary to meet occupational injury requirements and would have to adopt other Medicare requirements, rules, and standards to meet required documentation and billing standards. The commission could adopt a treatment guideline, but any such guideline would have to be nationally recognized, scientifically valid, and outcome-based.

CSHB 2600 would expand existing provisions relating to medical dispute resolution. TWCC's role in disputes over payment due for services determined to be medically necessary would be to adjudicate the correct payment given the relevant statutory provisions and TWCC rules. TWCC would have to publish its medical dispute decisions on its Internet web site, including decisions of independent review organizations and any subsequent

SOAH decisions. Before publication, TWCC could edit out information only as necessary to prevent identification of the injured worker.

An independent review organization could conduct a review of the medical necessity requiring preauthorization. TWCC would have to specify the appropriate dispute resolution process for disputes in which a claimant had paid for medical services and sought reimbursement. The bill would require an insurer to pay the cost of a review arising out of a dispute in connection with a request for health-care services that required preauthorization. In other cases, the losing party would have to pay the cost of a review.

Each doctor would have to disclose to TWCC the identity of any health-care provider in which the doctor or the health-care provider that employed the doctor had a financial interest. TWCC would have to require a doctor to disclose financial interests in other health-care providers as a condition of registration for the approved doctor list. The bill would direct TWCC to adopt the federal standards that prohibit payment or acceptance of payment in exchange for health-care referrals. Also, the bill would set penalties for a doctor or health-care provider who failed to comply with these provisions and would require TWCC to publish all final disclosure enforcement orders on its Internet web site.

An insurer or health-care provider would commit an administrative violation if that person violated a rule, order, or decision of TWCC. An insurer or health-care provider would be subject to administrative penalties for a repeat violation after a prior notice of noncompliance. Prior notice would not be required if the violation were committed willfully or intentionally or if a TWCC decision or order were violated. TWCC could adopt a schedule of specific monetary administrative penalties for specific violations.

The commission could adopt rules providing for a referral and petition to the appropriate licensing authority for appropriate disciplinary action, including the restriction, suspension, or revocation of a violator’s license.

TWCC would have to adopt the required rules and fee guidelines not later than May 1, 2002. Unless subsequently readopted by TWCC, the treatment guidelines would not apply to health-care services provided on or after January 1, 2002.

TWCC would have to adopt rules for drug prescriptions and disclosure of financial interests not later than June 1, 2002. The penalty provisions for a doctor or health-care provider that failed to comply with financial disclosure requirements would apply only to a violation that occurred after June 1, 2002. The provisions on administrative violations would apply only to a violation that occurred on or after September 1, 2002. The changes regarding medical dispute resolution would apply only to a request for a review of medical services received on or after January 1, 2002.

Sunset review and audit. CSHB 2600 would move up from September 1, 2007, to September 1, 2005, the date on which TWCC would be abolished unless continued by the Legislature under the Texas Sunset Act.

The bill would specify that TWCC was subject to audit by the state auditor and would specify issues that the state auditor should consider, including:

- structure and internal controls;
- the level and quality of service provided to system participants;
- implementation of statutory mandates;
- employee turnover;
- access to public information;
- adoption and implementation of administrative rules; and
- assessment of administrative violations and penalties for violations.

Attorney's fees. An insurer that sought judicial review of a final decision by a TWCC appeals panel regarding compensability of eligibility for income or death benefits would be liable for reasonable and necessary attorney's fees incurred by the claimant as a result of the insurer's appeal if the claimant prevailed. This provision would expire September 1, 2005.

Lifetime income benefits. CSHB 2600 would expand the current definition of eligibility for lifetime income benefits to include employees who suffered third-degree burns over 40 percent of the body.

Multiple employment and subsequent injury fund. CSHB 2600 would expand the liabilities of the subsequent injury fund. It would supplement maintenance taxes paid by insurers, other than governmental entities, if TWCC determined that the funding was not adequate. TWCC's actuary or

financial advisor would have to report biannually to ROC on the financial condition, projected assets, and liabilities of the subsequent injury fund and make the reports available to the Legislature and the public. TWCC could buy annuities to provide for payments due to claimants if it determined that the purchase was financially prudent for administering the fund.

The bill would set forth procedures for computing the average weekly wage of an employee with multiple employment for the purpose of determining temporary income benefits, impairment income benefits, supplemental income benefits, lifetime income benefits, and death benefits. The changes would allow an employee with more than one job to collect benefits based on his or her wages reportable to the U.S. Internal Revenue Service, rather than only on the wages at the job where he or she was injured. The employee would have to document and verify these wage payments.

TWCC would have to determine the manner by which wage information was collected and distributed to implement these provisions. The bill would entitle an insurer to apply for and receive reimbursement at least annually from the fund for the amount of income benefits paid to a worker that was based on employment other than the employment during which the compensable injury occurred. TWCC could adopt rules governing the documentation, application process, and other administrative requirements necessary for implementation.

SUPPORTERS SAY:

Texas' workers' compensation medical costs are higher than other states' and other health-care delivery systems' costs. More costly and intensive medical care, however, has not resulted in greater worker satisfaction or speedier return to work. CSHB 2600 would address these problems by strengthening the role of TWCC and creating a managed health-care delivery network to ensure higher-quality medical care at lower cost. The bill would require TWCC to adopt nationally recognized fee and treatment guidelines.

This omnibus bill relating to medical treatment and benefits under the Texas workers' compensation system is the result of long and difficult negotiations among various stakeholders in the system, including workers, employers, medical professionals, and insurance carriers. It has the potential to benefit significantly injured workers who are struggling with the weaknesses of the current system.

This bill would give TWCC the tools it needs to regulate medical care in the workers' comp system effectively by focusing scrutiny on doctors who drive up medical costs and provide substandard care. It also would provide safeguards against insurers who consistently deny necessary care.

CSHB 2600 would recognize the need for better monitoring of doctors who regularly participated in the system and would require these doctors to register with TWCC if they wished to provide services. All registered doctors would be subject to training and monitoring requirements, whether they treated workers or performed reviews for insurance carriers.

TWCC could tailor its regulations by increasing scrutiny of doctors whose practice patterns were unreasonable, while simultaneously rewarding good doctors by lifting their administrative burdens.

The bill would align the medical portion of Texas' workers' comp system with the best elements of other health-care delivery systems. At the same time, it would offer choices to both employees and insurance carriers.

Health-care networks are an opportunity to improve medical care and to save money at the same time. Networks create patient volume. That alone saves money, but the networks also would also actively monitor the quality of health care. This would help get injured employees back to work and would save the state money. The bill's fiscal note projects that it would save the state $20 million in all funds over five years. Savings from the health-care networks would generate $10.4 million for the state over the next five years.

CSHB 2600 would encourage employers to build return-to-work programs by requiring insurance carriers to provide return-to-work coordination services to their policyholders. It also would allow TWCC to hire experts to train the commission staff on these issues and to report biannually to ROC on the implementation.

The bill would eliminate the costly and time-consuming second-opinion process for spinal surgery and would replace it with the more efficient preauthorization process. It also would set up minimum requirements for preauthorization and concurrent review for certain expensive and controversial medical procedures that recent ROC research has found to be

cost drivers. The bill also would establish a voluntary certification process for doctors and insurance carriers that should help minimize disputes and encourage communication between parties. In addition, it would make it easier for injured workers to get their prescriptions filled for the first seven days after injury.

Currently, a worker may receive one impairment rating from his or her own doctor, a second impairment rating from the insurance carrier's doctor, and a third impairment rating from TWCC's designated doctor. CSHB 2600 would reinforce the idea that issues such as impairment rating should be decided by an independent and objective designated doctor who is trained in these issues. Rather than continuing to subject injured workers to multiple examinations that probably would end up at a designated doctor exam anyway, employees would be better off with determinations as to impairments ratings made by designated doctors. The bill would streamline the dispute process by securing a presumptive decision faster and saving money for carriers, including the State of Texas, since they no longer would be paying for unnecessary and duplicative exams.

CSHB 2600 would require TWCC to set up a pharmaceutical formulary or list of medicines that would give preference to generic drugs and allow certain appropriate over-the-counter medications. This would save the comp system and the state millions of dollars by helping to bring Texas pharmaceutical costs into line with those in other states.

TWCC also would have to align its fee schedule with the Medicare model. This would save health-care providers and insurance carriers from having one documentation structure for Medicare and a separate one for workers' compensation.

CSHB 2600 would move up the sunset date for TWCC by two years and would highlight several areas for the state auditor to examine, if the auditor decided to pursue a formal audit of TWCC. This would enable the Legislature to monitor the implementation of this bill, as well as TWCC's ability to meet its statutory requirements.

The bill would help to even the playing field by allowing injured workers to get their attorneys' fees paid for when insurance carriers appealed disputes

into district court and did not prevail. The bill would expand the definition of lifetime income benefits to a very small, but seriously injured group of workers with third-degree burns over more than 40 percent of their bodies.

CSHB 2600 would allow workers with multiple jobs to receive income benefits based on all their IRS-reportable wages. The statutory benefit cap, now $533 a week, would remain on these benefits. TWCC, rather than the employer, would verify any additional wages. This would ensure that workers got adequate benefits without unduly burdening employers.

OPPONENTS SAY:

Nothing in CSHB 2600 would penalize insurance carriers for delays in making decisions. Dollars not spent on medical treatment would continue to earn interest for insurers while injured workers would continue to suffer and try to claw through procedural layers. Rather than ensuring injured employees their rights, the bill would create a bureaucracy of hearings and appeals within TWCC. “Good cause” simply would be an escape hatch to justify delays in the course of treatment.

Local doctors would not want the hassle of becoming certified by TWCC, the risk of censure, and the possibility of not being paid. This bill could result in regional workers’ compensation clinics and hospitals that treat only injured workers because fewer independent physicians would have the resources to risk the inherent delays in payment for services adequately and timely rendered.

If enacted, CSHB 2600 would shift losses due to Texas job injuries onto the federal government. Inevitable delays in obtaining treatment would cause delays in rehabilitation of workers. Injured workers who cannot return to work timely often are forced into bankruptcy. On many occasions, the only other remedy would be to seek relief under the Social Security disability laws or through Medicare. Under this bill, insurers would continue a practice they have mastered — delaying treatment.

NOTES:

The committee substitute would provide that the certificate of registration for approved doctors would expire as provided by TWCC rules, rather than in four years or a period determined by TWCC, as in the filed version of HB 2600. The substitute would expand TWCC’s rulemaking authority and would establish the health-care network advisory committee to advise

TWCC on the implementation of regional health-care delivery networks. Also, the substitute would require, rather than authorize, the medical advisor to establish a medical quality-review panel.

The substitute would establish provisions for an employee's decision about whether to participate in a regional network that the original bill did not include. The substitute would prohibit an employer from taking negative employment action against an employee because the employee elected not to participate in a regional network and would provide for a limited cause of action for a violation.

The substitute would allow funding of regional networks and would require TWCC to ensure that regional network contracts provided insurers with reasonable rights to conduct audits.

The substitute would require TWCC and TDI to enter into a memorandum of understanding to coordinate the regulation of insurance carriers and utilization review agents. It would set forth requirements for a workers' compensation medical regional network report card.

The substitute would require TWCC to publish its medical dispute decisions and final disclosure enforcement orders on the Internet and would require TWCC to adopt the reimbursement methodology and model used by the Medicare system, with minimal changes necessary to meet occupational injury requirements.

The committee substitute would expand provisions regarding return-to-work coordination services and pharmaceutical coverage. It would clarify the order of required examination, in that employees would be directed to TWCC-designated doctors, rather than to doctors selected by insurers, for an initial required medical examination related to most issues.

The substitute would move TWCC's sunset date from 2007 to 2005 and would provide direction for any audit of TWCC by the state auditor. It would include provisions related to attorney's fees in certain instances of judicial review of a final decision of a TWCC appeal's panel, and it would include a provision for lifetime income benefits for certain employees who suffer third-degree, catastrophic burns. The substitute would provide for the

computation of benefits for employees with multiple employment, and it would expand the liabilities of the subsequent injury fund and set forth provisions related to ensuring the financial soundness of the fund.

According to the fiscal note, CSHB 2600 would result in a net gain of $2.7 million in general revenue-related funds during fiscal 2002-03 and a net gain of $11.2 million over five years.

The companion bill, SB 1476 by Duncan, has been referred to the Senate Business and Commerce Committee.