ADVISORY NO. 382
###

TOPIC: ANALYSIS OF 2005 REFORM

ARTICLE 1. ORGANIZATION OF DEPARTMENT

Sec. 402.001
The Division of workers' compensation is a "division with the Texas Department of Insurance" (TDI). It is renamed the Workers' Compensation Division.

Sec. 402.00111

(a) The Division is administered by a Commissioner. The Commissioner shall exercise all executive authority, including rule-making authority.

(b) The Commissioner at TDI may delegate to the Division any power or duty regarding workers' compensation including the authority to make final orders or decisions.

(c) The Commissioner of TDI shall develop and implement policies separating the two divisions.

Sec. 402.00112
The Department of Insurance "shall investigate the conduct of the work of the Division."

Sec. 402.00113
The Division is administratively attached to TDI, and TDI shall provide staff and facilities necessary to enable the Division to perform its duties of [budget planning, personnel, computer equipment and support].

Sec. 402.00114
The Division shall have the same administrative oversight presently exercised by TWCC.

Sec. 402.00116
The Commissioner of the Division is the chief executive and administrative officer. All powers previously exercised by the Commissioners and Executive Director of TWCC will now be administered by the Commissioner of the Division, subject to the oversight authority of TDI.

Sec. 402.00117
The Commissioner will serve a two-year term expiring on February 1st of each odd numbered year.

Sec. 402.00118
The Commissioner must have five years of experience as an executive in the administration of business or government or as a practicing attorney, physician, or certified public accountant.

Sec. 402.00124
Disqualifies the appointment of a person employed by a Texas trade association if the person or person's spouse is an employee of a trade association.

Sec. 402.00125
A former Commissioner may not be employed by an insurance carrier or represent other parties before the Division for two years after employment as Commissioner.

Sec. 402.00128
Delegates to the Commissioner the same powers delegated to TWCC.

Sec. 402.002
Establishes Office of Injured Employee Counsel (OIEC).

Sec. 402.021
Describes goals of the workers' compensation system (refers to it as Department – a probable misprint).

Sec. 402.023
Charges the Division with adopting rules regarding filing of complaints, defining frivolous complaints and posting the information on the Internet.

Sec. 402.041
Provides for appointment of deputies, assistants and other personnel as necessary.

ARTICLE 2. GENERAL POWERS AND DUTIES OF DIVISION

Sec. 402.074
Requires the Division to complete a strategic management plan analyzing the effectiveness of the Division in implementing the statutory goals.

Sec. 402.075
Commissioner develops rules providing "incentives for overall compliance in the workers' compensation system" such as improving workplace safety and return-to-work outcomes. The Division shall assess the performance of insurance carriers in meeting key regulatory goals. The Division shall examine overall compliance records, dispute resolution and complaint resolution practices to identify insurance carriers and healthcare providers who adversely impact the workers' comp system and who may "require enhanced regulatory oversight." Based on the performance assessment, the Division shall develop regulatory "tiers" that distinguish among insurance carriers and healthcare providers who are "poor performers," who generally are "average performers" and who are consistently "high performers." The Division shall focus its regulatory oversight on insurance carriers identified as "poor performers."
The Division shall ensure that high performing entities are "publicly recognized" and allow those entities to use that designation as a marketing tool. The Division is also instructed to conduct regular audits of

accident prevention services offered by insurance carriers.

Sec. 402.081
TWCC was previously required to maintain records for fifty (50) years. Now, the Division will be able to propose a records retention schedule and the State Records Administrator and State Archivist shall determine if the period of time is sufficient. This will permit greater flexibility in the retention of records. It may affect the availability of old claim files requested by carriers in the defense of claims.

Sec. 402.092
Provides for the confidentiality of a file developed by the Division in connection with an investigation of fraud. However, the exceptions to the confidentiality have been enlarged to permit an insurance carrier to receive information if the investigation file relates directly to a felony regarding workers' compensation or to a claim in which restitution is required to be paid to the insurance carrier.

ARTICLE 3. <u>GENERAL OPERATION OF WORKERS' COMPENSATION SYSTEM</u>

Sec. 401.011
Incorporates new definitions:

(5-a) "Case management" defined as assessment of, planning, facilitation and advocacy for options to meet an individual's health needs to promote quality cost-effective outcomes.

(18-a) "Evidence-based medicine" means the use of current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based tests, and treatment and practice guidelines in making decisions about the care of individual patients.

(22-a) "Health care reasonably required" means health care that is clinically appropriate and considered effective for the employee's injury and providing in accordance with best medical practices consistent with
- (A) evidenced-based medicine;
- (B) if evidence-based medicine not available then generally accepted standards of medical practice.

(31-a) Defines medical networks to be those certified under Chapter 1305 of the Insurance Code, and rules of the Commissioner of Insurance.

Sec. 401.013
Creates a rebuttable presumption that a person is intoxicated based upon a blood test or urinalysis.

Sec. 404.001-404.057
Creates Office of Injured Employee Council (OIEC) to be appointed by the Governor for a two-year term; prescribes qualifications for public counsel and disqualifying associations.

Sec. 404.101
OIEC shall assist claimants, advocate on behalf of injured employees in regard to rule making, assist employees in presenting complaints, assessing impact of workers' compensation laws in performance of carrier and make recommendations to the Division, but may not appear or intervene on behalf of an individual during dispute resolution. Ombudsmen will still be provided to injured workers and they will be supervised by the public counsel.

Sec. 404.103
The OIEC shall operate the ombudsman program, supervise the work of the ombudsman through staff attorneys, and coordinate the ombudsman program with services provided by the Department of Assistive and Rehabilitative Services.

Sec. 404.104
The ombudsman may appear or intervene as a party regarding rules, policies and forms, may intervene in a judicial proceeding in which the public counsel previously appeared, may appear or intervene on behalf of employees as a class in a proceeding in which the public counsel determines that the interests of injured employees as a class are in need of representation, and may intervene before the Division or before TDI on behalf of injured employees regarding rates, rules, and agency policies.

Sec. 404.105
OIEC, through the ombudsman program, may appear on behalf of an individual injured employee during dispute resolution.

Sec. 404.106
The OIEC shall report to the Governor describing its activities, identifying problems, and analyzing the system with respect to providing adequate, equitable and timely benefits to employees.

Sec. 404.107
Describes the access of information by public counsel permitting the office to have the same access to other parties, and permitting the office the right to obtain discovery.

Sec. 404.108
The OIEC may recommend proposed legislation.

Sec. 404.111
The office is provided broad access to administrative agency information if necessary for the OIEC to perform its functions.

Sec. 405.001
Provides for a workers' compensation research and evaluation group at TDI similar to the current informal research group.

Sec. 405.002 – 406.004
Continues the functions of the old Research and Oversight Council as a group within TDI evaluating the impact of workers' compensation programs, including the healthcare networks, preparing a report to the Legislature.

Sec. 406.033
Limits waivers of causes of action after an employee's injury. This section applies to nonsubscribers and does not affect the workers' compensation program. Under the new limitations, a waiver is invalid unless obtained ten business days after the date of the original injury, and after a medical evaluation, and the waiver must meet certain disclosure requirements.

Sec. 408.001
An employer is entitled to an exclusive remedy, even though workers' compensation benefits may not be owed because of one of the enumerated defenses under 406.032, or the failure to timely report the injury to the employer or the failure to timely file a claim. As now, there will be no exclusive remedy protection for an injury that is noncompensable for any other reason.

Sec. 408.004
Continues to permit an independent medical examination requested by the carrier, but limits the basis for the RME to questions of "appropriateness of health care." Other RME functions will now be performed by the designated doctor. These RME provisions do not apply to health care provided through a health care network. If the carrier disagrees with the designated doctor's opinion, it may request an RME under a different section, Section 408.0041(f). The provisions of Section 408.004 do not apply to a 408.0041(f) request.

Sec. 408.0041

(a) –(d) A designated doctor examination is expanded to include impairment, MMI, extent of compensable injury, whether the injured employee is disabled, the ability of the injured employee to return to work or other similar issues.

(e) The designated doctor's opinion is entitled to presumptive weight based upon the preponderance of the evidence, not (as now) on the basis of the great weight of the credible evidence. If the other evidence simply outweighs the report of the designated doctor, the designated doctor's report is not binding.

(f) Unless otherwise ordered by the Division, the insurance carrier shall pay benefits based upon the opinion of the designated doctor during the pendency of any dispute.

(g) At the carrier's expense, an employee's choice of doctor (non network employees may choose any doctor; network employees limited to treating doctor) may attend the designated doctor exam.

(i) – (j) The failure to attend the exam bars an employee from temporary income benefits and

employee may be fined up to $10,000. However, the employee may receive other benefits during the period of refusal to attend the designated doctor exam.

(k) If employee is found to be at MMI or is released to RTW, the carrier may immediately suspend TIBs.

Sec. 408.0042
The carrier may request an injured employee to submit to a medical exam to define a compensable injury. However, the exam shall be performed by the employee's treating doctor. The carrier shall either accept all injuries identified as related or dispute those injuries as non-related. Treatment for disputed injuries must be preauthorized before the treatment is rendered, which is a significant shift in the paradigm for preauthorization in that preauthorization may now be denied due to extent of injury disputes. Either the employee or the affected healthcare provider may file an extent of injury dispute. If the injury is accepted as compensable, the payment for treatment may not be denied on the basis of compensability. It may be reviewed for medical necessity. The right to this examination does not limit the carrier's right to an RME or a designated doctor's exam including for extent of injury disputes. The provision does not set a deadline for filing extent of injury disputes or require payment of bills incurred after the extent of injury dispute is filed.

Sec. 408.022
Currently prescribes the requirement for an employee to select a treating doctor from the approved doctor list (ADL). That continues, but does not apply to a selection of a doctor under a healthcare network.

Sec. 408.023
Again applies to the ADL, the duties of an ADL doctor, but it contains a specific exception that excludes network doctors. The ADL will expire on September 1, 2007. The Division is further empowered to waive ADL requirements. Doctors not admitted to the ADL or admitted and subsequently removed from the ADL, or suspended by action of TWCC or the Division, may not directly or indirectly deliver health care.

Sec. 408.0231
The Division shall adopt rules regarding doctors performing peer review functions. Those rules may include standards for peer review, sanctions, restrictions or suspensions of the doctor's ability to perform functions, etc. The peer review physician must be licensed by the State of Texas.

Sec. 408.0251
Electronic billing shall be required after January 1, 2008.

Sec. 408.0252
The Division may adopt appropriate standards regarding delivery of healthcare in underserved areas.

Sec. 408.027

(a) A healthcare provider shall submit a claim for payment not later than the ninety-fifth (95th) day after the date on which the health care services are provided. Failure to timely file a claim constitutes a forfeiture of the provider's right to reimbursement.
(b) The carrier must process the payment within forty-five (45) days. If additional documentation is required, it may be requested, and must be provided not later than the fifteenth (15th) day of the date of receipt of the carrier's request. If the carrier audits the claim, the audit must be completed not later than the one hundred sixtieth (160th) day after the date of receipt of the healthcare provider's claim and by that date the carrier must make a determination regarding liability. In the event of an audit, the insurance carrier must pay eight-five percent (85%) of the fee guideline amount or the contracted rate if the healthcare service is provided through a network.
(c) If services are appropriate, carrier to reimburse remaining 15%.
(d) If the compensability is contested, and found not compensable, the carrier may recover from the employee's health plan or other third party responsible for the bills.

Sec. 408.0271
If the healthcare services are determined to be "inappropriate" the carrier shall notify the provider, demand a refund, and the provider must either pay or appeal within forty-five (45) days. The appeal is to the insurance carrier. The insurance carrier must act on the appeal within forty-five (45) days. The health care provider *shall* reimburse the carrier within 45 days after carrier notice.

Sec. 408.028
The Commissioner shall adopt a closed formulary for pharmacy prescriptions. An appeals process shall be permitted for medications determined by a treating doctor to be necessary, but not included in the formulary.

Sec. 408.031
In the event of a conflict between the Workers' Compensation Act and the Insurance Code regarding medical benefits for injured employees, the Insurance Code prevails.

Sec. 408.032
The Division shall study required accreditation for interdisciplinary pain programs and rehabilitation facilities.

Sec. 408.047
State average weekly wage is equal to 88% of the average weekly wage (should approximate $625) in covered employment computed by the Texas Workforce Commission. For September 1, 2005 – August 31, 2006, the state average weekly wage is statutorily prescribed in the amount of $540. After 2006, the Commissioner may increase the state average weekly wage to an amount not to exceed 100%.
Sec. 408.082
Shortens the TIBs waiting period from four weeks to two weeks.

Sec. 408.123
The Division shall adopt a rule requiring notice to an employee of any MMI or impairment rating.

Sec. 408.124
The Commissioner may adopt the *4th Edition of the AMA Guidelines* as used at this time, or any subsequent edition of the Guides.

Sec. 408.1415
For SIBs cases, establishes work search compliance standards, including the number of job applications required to be submitted to meet the good faith criteria; requires “active” participation in vocational rehabilitation; etc.

Sec. 410.002
The Division may conduct a BRC telephonically by agreement with the injured employee.

Sec. 410.023
Parties requesting a BRC must document efforts made to resolve the disputed issues prior to submitting the request.

Sec. 410.026
Following a BRC, the Benefit Review Officer may only reset the BRC once. This provision does not mandate a CCH setting following the second BRC. This provision does not limit requests for future BRCs on other issues (e.g., future quarters of SIBs).

Sec. 410.032
Benefit Review Officer may no longer issue Interlocutory Orders. Interlocutory Orders will be issued before or after a BRC by a Division staff member.

Sec. 410.168
Appeals Panel is retained in present form. However the Appeals Panel shall issue and maintain a precedent manual. The manual should be composed of precedent establishing decisions and may include other information as identified by the Appeals Panel.

Sec. 410.204
The Appeals Panel shall issue a written decision on each “reversed or remanded case.” This relieves the panel of rendering decisions on affirmed cases.

Sec. 411.084
The Division shall provide educational materials to employers and employees.

Sec. 413.011
Retains the current requirement for the Division to adopt medical care reimbursement policies utilized by CMS (Medicare). Fee Guidelines must meet same statutory standards, except that an insurance carrier may provide a different fee schedule under a network contract. Treatment protocols must be evidenced based and outcome focused. Treatment may not be denied solely on the basis that the treatment for the

compensable injury is not specifically addressed by the treatment guidelines.

The Division may adopt disability management rules. The Division shall examine whether employees have reasonable access to "surgically implanted, inserted, or otherwise applied devices or tissues and investigate whether reimbursement rates exist that reduce the ability of an injured employee to access those medical needs."

Sec. 413.0111
Pharmacy benefit managers are expressly authorized to manage prescription medicines.

Sec. 413.014
Specifically provides that a preauthorized service is not subject to retrospective review of medical necessity.

Sec. 413.021
Insurance carriers are required to identify injuries potentially resulting "in lost time from employment as early as practicable to determine if skilled case management is necessary for the injured employee's case." As necessary, case managers shall be used to perform these evaluations. A claims adjuster may not be used as a case manager.

Sec. 413.022
Establishes a return-to-work pilot program for small employers. Employers having at least two employees, but fewer than fifty-one employees, shall be subject to a pilot return-to-work program. Participating small employers will be reimbursed in amounts not to exceed $25,000 for modification or provision of alternative work within a doctor's imposed work restrictions. Allowable expenses may include: modification equipment, devices, furniture or tools, and other costs necessary for reasonable accommodations. These reimbursements shall be funded in part by administrative penalties collected (not to exceed $100,000 annually). This section will be void in September 2009 unless reenacted.

Sec. 413.023
Requires the Division to provide information to employers about enhancing the employee's ability to return to work.

Sec. 413.024
Prescribes the information to be provided to employees by the Division.

Sec. 413.025
Prescribes requirements for the Division to assist claimants to return to the workforce.
Sec. 413.032
IROs' decisions must now include:

(1) List of all medical records reviewed;
(2) Description and source of the screening criteria or clinical basis used in making the decision;

(3) Analysis of and explanation for the decision, *including findings and conclusions*; and
(4) Description of the qualifications of each physician or other health care provider performing the review.

Sec. 413.0511
The Medical Advisor's responsibilities shall include monitoring the quality and timeliness of decisions by designated doctors and IROs and deciding sanctions.

Sec. 415.002
The list of administrative violations committed by an insurance carrier is broadened to penalize a statement by the carrier "denying all future medical care for a compensable injury." Deletes the requirement to prove that the violation was "willful or intentional."

Sec. 415.021
In addition to other penalties permitted by the Act, the Commission may access an administrative penalty against any person committing an administrative violation up to *$25,000 per day* per occurrence.

Sec. 419.001
A business may not deceptively misuse a name similar to the Texas Workers' Compensation Commission, TDI, or other related entity.

Sec. 504.053
A political subdivision must adopt a healthcare network *if* a network is available and practicable. The political subdivision may enter into inter-local agreements with other political subdivisions to establish or contract with networks. If a network is not practical, the medical benefits may be provided under the Act for non-network care or through a health benefits pool. Certain limitations and qualification apply to health benefits pools.

ARTICLE 4. <u>HEALTH CARE NETWORKS (CHAPTER 1305 TEXAS INSURANCE CODE)</u>

Sec. 1305.001
Workers' Compensation Health Care Network Act (Network Act)

Sec. 1305.002
Describes purpose of Network Act.

Sec. 1305.003
Limits the applicability of the Network Act to the Labor Code and resolves conflicts in favor of the Network Act.

Sec. 1305.004
Contains twenty-nine different definitions relating to medical care and operation of networks. It also

adopts a number of 401.011 definitions.

Sec. 1305.005
(a) Employers may elect to participate or not participate in a network
(b) Insurance Carriers may establish or contract with network. At the time that a network is selected by an employer, the employee living within the service area is required to obtain treatment within network.
(d) Carriers to provide employers with form for signed acknowledgments from employees and posters containing network requirements.
(e)-(h) Employer to provide notices; employees must acknowledge receipt; employees not subject to network requirements until notified, but after notice, network requirements are mandatory whether employee signs or not.

Sec. 1305.006
Non network care must be paid by carrier if it resulted from an emergency or involves treatment outside the network service area and approved by carrier.

Sec. 1305.051
Networks must be certified.

Sec. 1305.052
Prescribes application process.

Sec. 1305.053
Prescribes contents of application.

Sec. 1305.054
Describes Commissioner review, approval and renewal of network certification.

Sec. 1305.055
Prohibits network use of the words: insurance, casualty, surety or any other word descriptive of an insurance business.

Sec. 1305.056
Network contracts are not considered to be a conspiracy or restraint of trade in violation of the Business & Commerce Code.

Sec. 1305.101
Except for emergencies and out of network referrals, health care services to be provided within network. A network doctor may not serve as a designated doctor if the employee is receiving care through the doctor's network. Prescription medication may not be delivered through a network.

Sec. 1305.102

A network management contact must be approved by the Commissioner. The bill prescribes requirements of network contracts.

Sec. 1305.103

(a) Network shall determine the specialty or specialties of doctors who may serve as treating doctor. (Note that a network may limit treating doctor to medical doctors excluding chiropractors. In that event, chiropractors may still provide services as referral providers under the supervision of a treating doctor.)
(b) Employees must treat within a network if there are treating doctors in that service area.
(c) Employees treating with a non-network provider must switch to a network provider upon notice of the availability of a network for the employee's area.
(d) Network shall require treating doctor to perform functions and services described by this section.
(e) Treatment to be within network, or physician may request an out of network provider if medically necessary services are not available within network. The request must be approved or denied within seven days after receipt of the request or sooner if expedited approval is required by the circumstances. An employee may appeal this decision through the network complaint process.
(f) Treating doctor shall participate in medical case management process as required by the network including return-to-work planning.

Sec. 1305.104

Employee entitled to an initial choice within network. Statutorily adopts the TWCC rule that emergency doctors and company doctors do not constitute initial choices. An employee may select a second doctor within network as a matter of right. A third choice must be approved by the network. An employee experiencing chronic pain may apply to use a non-primary care physician specialist as the employee's treating doctor. This section prescribes criteria for the application, decision, and appeal.

Sec. 1305.105

If the employee, prior to the injury, designated a primary care physician under the employer's HMO who is not on the carrier's network, the employee may retain the doctor as the employee's treating doctor. However, the doctor must comply with the network contract and services are reimbursed as a network service. Any request for a change of doctor must request a network physician. This provision does not apply to present treating doctors for compensable injures who are not on the carrier's network; it *applies only to HMO doctors*. See Section 1305.103(c). This is a very small exception to the network control of doctors in the network. Most Texas employers use PPO networks and not HMO networks.

Sec. 1305.106

Payments, reductions, denials and audits of health care services are governed under 408.027 (Deadlines of 95, 45, 15, and 160 days etc apply to processing of bills).

Sec. 1305.107

Each network will provide a reasonable business hour telephone access for employees. After hours recording shall permit callers to leave messages, which shall be returned within two business days after the call.

Sec. 1305.151
Networks may not become insurers. The workers' comp carrier must retain the risk of the medical payment.

Sec. 1305.152
Prescribes standards for network contracts. *A network may refuse a provider application for participation if the network determines that the network has contracted with a sufficient number of qualified healthcare providers.* This is a very important component of the network concept under the bill.

Sec. 1305.153
Prescribes provider reimbursement:
(a) Determined by contract between the network and provider.
(b) For preauthorized services, may not deny payment on the basis that it is not medically necessary.
(c) Out of network providers to be reimbursed according to the Act and rules of the Commissioner.
(d) Billing and reimbursement of providers is subject to the Act not inconsistent with the network requirements.
(e) Insurance carriers must notify network providers of contest of compensability. Carrier may not deny payment for services provided prior to notification. The carrier liability for services provided prior to notice is limited to $7,000.

Sec. 1305.154
Prescribes requirements for written contracts between carrier and network.
(a) Contracts are confidential
(b) Functions provided by the network to be negotiated.
(c) Must contain a description of functions delegated to the network, provides for a ninety-day termination of agreement clause. Must reflect that the carrier retains ultimate responsibility for all delegated functions, provides for monthly data usable for audit purposes, contingency plans in the event of network failure, etc

Sec. 1305.1545
Prohibits a discount fee for service reduction of charges unless the carrier has a contract with the provider or unless the network contract provides for the reduction. The network may not lease, sell, or disclose the terms of the contract without written authorization from the provider.

Sec. 1305.155
Requires insurance carriers to monitor network performance and notify network and Commissioner of problems that are hazardous to employees or network noncompliance. It provides for a process that must be followed in the event of a notice.

Sec. 1305.251
The Commissioner shall review the operations of the network to determine compliance.

Sec. 1305.252
Network records to be available for examination.

Sec. 1305.301
Prescribes network organization.

Sec. 1305.302
Prescribes standards for network accessibility and availability.

Sec. 1305.303
Prescribes network quality of care requirements including quality improvement programs, etc.

Sec. 1305.351
Prescribes utilization review and retrospective review requirements adopting provisions of Insurance Code currently applicable to utilization and retrospective review. Screening criteria must be consistent with the network's treatment guidelines. Statutory preauthorization does not apply to in-network services. Preauthorization will be governed by the network contract, but must be consistent with the Texas Department of Insurance Code applying to Utilization Review Agents. Preauthorization shall not be required for a medical emergency.

Sec. 1305.352
Retro-review of health care shall be based on written screening criteria established and periodically reviewed by the network. Retro-review must be performed under the direction of a physician. The section is not clear if this applies to all retrospective review. (The section heading is entitled "General Standards for Retrospective Review" but the preceding section is clearly limited to network standards. The section does not amend Art. 21.58A INS. CODE which probably affects retrospective review only when combined with prospective review.)

Sec. 1305.353
(a) The entity performing utilization review or retro-review shall notify the employee; or
(b) Employee's representative of an adverse determination and include in the notice:
   (1) Principal reasons for adverse determinations;
   (2) Clinical basis;
   (3) Description of the source of screening criteria;
   (4) Description of the procedure for reconsideration;
   (5) Notification availability of independent review.
(c)-(e) Provides for a current three-day and one-day notice requirements.
(f) For post stabilization treatment or life threatening conditions, the URA's decision shall be transmitted within the time appropriate to the circumstances.

Sec. 1305.354
Describes reconsideration of adverse determinations and imposes deadline requirements.

Sec. 1305.355
Provides for independent review of adverse determination by an IRO. In a substantial change from the present law, insurance carriers shall pay for the IRO win or lose. Unresolved disputes may be appealed to judicial review, but the IRO decision is binding during the review. The judicial review appears to be limited by Secs. 413.031 and 410.255 to substantial evidence appeals filed in Travis County.

Sec. 1305.401 - 1305.4405
Prescribes a complaint process permitting an employee or employer to file a written complaint about the network. The network must log and investigate the request.

Sec. 1305.451
Insurance carrier must prepare a written description of the terms and conditions for obtaining healthcare within a network and that must be provided by the employer to the employees.

Sec. 1305.501 – 1305.503
Provides for evaluation of networks and consumer report card measuring certain network metrics.

Sec. 1305.551 – 1305-552
Provides for investigation and disciplinary actions against networks.

ARTICLE 5 RATES AND UNDERWITING REQUIREMENTS AMENDS INSURANCE CODE

Art. 5.55 Sec. 1
Adds definition of insurer to include Lloyd's plans and reciprocal and inter-insurance exchanges. Premium is defined to mean the amount charged for a workers' comp policy, including endorsements after modifiers.

Art 5.55 Sec. 2
Amends the Code to require insurance carriers to consider the effect on premiums of individual risk variations based on loss or expense considerations.

Art 5.55 Sec. 3
Requires the Commissioner to report on the affordability and availability of workers' compensation insurance evaluating costs and benefits of reforms. In particular, the Commissioner will determine whether the rates appropriately reflect the savings associated with the reforms. Insurers shall be required to submit all data and other information necessary for the Commissioner to generate the report.

Art 5.55 Sec. 7
The Commissioner may disapprove a rate or filing and after notice and opportunity for hearing, may impose sanctions including administrative penalties. The Department of Insurance has exclusive jurisdiction over all rates and premiums.

Art. 5.55A
Each insurer shall file with the Department a copy of the insured's underwriting guidelines. Underwriting guidelines of workers' comp insurers must be sound, actuarially justified or otherwise substantially commensurate with the contemplated risk. It may not be unfairly discriminatory.

Art. 5.60A
Prescribes rate hearings, requires each insurer to file the insurers rates and supporting information. The Commissioner shall review the information and shall implement rules as necessary to mandate rate reductions or modify the use of individual variations if the Commission determines the rates do not meet rating standards.

ARTICLE 6 GENERAL CONFIRMING AMENDMENTS AMENDING VARIOUS STATUTES

25.0003 TEX. GOV. CODE
Extends to statutory county courts, civil jurisdiction for appeals of a workers' compensation claim regardless of the amount in controversy.

25.2222 TEX. GOV. CODE
County Courts at Law will have concurrent jurisdiction with District Courts with respect to final rulings and decisions of the Division.

Sec. 31.002 TEX. INS. CODE
The Department of Insurance is required to "administer the workers' compensation system of this state."

Sec. 31.004 TEX. INS. CODE
Amends the Sunset provision applicable to TDI. It was to undergo Sunset review in 2007. That has been extended to 2009. The Division of Workers' Compensation will be Sunsetted on the same date.

Sec. 843.101 TEX. INS. CODE
Permits an HMO to serve as a workers' compensation healthcare network.

ARTICLE 7 REPEALER (CITATIONS ARE TO HB 7)

Sec. 1
Repeals Hazardous Employer Program and abolishes the Medical Advisory Commission.

ARTICLE 8 TRANSITION AND EFFECTIVE DATES (CITATIONS ARE TO HB 7)

Sec. 8.01
TWCC shall be abolished and its functions transferred to the TDI not later than February 28, 2006. The Division of Workers' Compensation within TDI is established September 1, 2005.

Sec. 8.002
The OIEC is established effective September 1, 2005. The Governor shall appoint the public counsel by October 1, 2005. The public counsel shall adopt initial rules not later than March 1, 2006.

Sec. 8.003
The research group at TDI to report to the Governor not later than December 1, 2008.

Sec. 8.004
Policies, procedures and decisions of TWCC continue in effect as a policy or procedure of TDI.

Sec. 8.005
The Commissioner of Insurance and the Commissioner of Workers' Compensation shall adopt rules relating to transfer of programs not later than December 1, 2005.

Sec. 8.007
The Commissioner shall adopt rules to implement the RME and DDR amendments no later than February 1, 2006.

Sec. 8.008
Electronic billing rules shall be adopted by January 1, 2006.

Sec. 8.009
With respect to income benefits, the law will become effective only for claims occurring after the effective date of the Act. A claim based upon an injury occurring prior to the effective date will be governed under the former law.

Sec. 8.010
The pilot return-to-work program will become effective January 1, 2006.

Sec. 8.012
The Medical Advisory Committee is abolished as of the effective date of the Act.

Sec. 8.013
SOAH will discontinue accepting appeals effective September 1, 2005. If not pending for hearing before SOAH on or before August 31, 2005, the case may not be set for hearing.

Sec. 8.014
The Commissioner shall adopt rules implementing healthcare networks not later than December 1, 2005. Applications for a network seeking certification may not be accepted before January 1, 2006. Benefits may be offered through a network after the network is certified by the Commissioner.

Sec. 8.016
Network provisions apply to claimants at the time that a certified network is selected by the employer and

notice provided to employees.

Sec. 8.017
On penalty provisions only apply to acts committed after the effective date of the Act.

Sec. 8.020
The changes in the Act, unless otherwise stated, take effect September 1, 2005.