Recommendations for Reformation of the Texas Workers' Compensation System

1. Texas employers pay approximately two billion dollars per year in workers' compensation premiums. From that amount insurance carriers must pay administrative costs and claims. A significant amount of the administrative costs are related to the denial and dispute of medical charges and other benefits. Adjustors must be paid to scrutinize the claims; investigators are paid to investigate them; doctors are paid to justify the denials and disputes ─ both peer review doctors and required medical exam doctors; independent review organizations and designated doctors, all must be paid. Attorneys are paid to defend the disputes and denials, including payment for their presence at virtually every contested case hearing (CCH) and benefit review conference (BRC). If the case reaches judicial review the carrier must pay its attorney, win or lose, and pay claimants' attorneys' fees in some situations.

   Additionally, a maintenance tax is levied against the insurance carriers for the funding of the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) and the Office of Injured Employee Counsel (OIEC), among others.

2. During 2011, there were 7,575 disputes concluded at a CCH. In 2012, there were 11,959 disputes concluded and for the first six months of 2013 there were 7,963. If as many disputes are concluded during the second half of 2013 as were concluded in the first half, the projected total for the year is 15,926. The number of disputes and denial of claims will have more than doubled in three years.

   In June 2012, the Texas Supreme Court essentially abolished the cause of action for a carrier's breach of the duty of good faith and fair dealing in adjusting with workers' compensation claimants. *Texas Mutual Ins. Co v. Ruttiger, 381 S.W.3d 430 (Tex.2012), Rehearing denied Sept. 21, 2012.* In essence, the only restraint on the carrier's failure to deal fairly with claimants would be through the administrative procedures at TDI-DWC. Claimants cannot pursue an individual remedy for the carrier's unreasonable delays, denials, or disputes. The court pointed out that the Legislature had provided for assistance to a claimant through the administrative maze by creating OIEC. In 2012 and the first half of 2013 OIEC prevailed on behalf of injured workers in only 29 percent of the CCHs. The standard for a successful evidentiary presentation at CCHs continues to change and with that change has come an increased level of participation by expert witnesses to address causation issues. The increase has not been matched with additional resources available to OIEC.

3. "Extent of injury" issues have increased to the point that the issue presently dominates the disputes and denials. An extent of injury issue is one where the carrier is not denying

that the claimant has received a minor injury, usually characterized as a strain/sprain, but denies that the injury extends to a more significant area of damage. For fiscal year (FY) 2011, the carrier prevailed at a CCH on extent issues 59 percent of the time and the claimant prevailed 41 percent of the time. During 2012, the carriers prevailed 67 percent of the time and claimants prevailed 33 percent of the time. For FY 2013 (September 2012 through February 2013) the carrier prevailed 71 percent of the time and the claimant prevailed 29 percent of the time. Not only will the number of disputes and denials have more than doubled in the past three years, the carriers will have won the dispute 71 percent of the time during the current fiscal year.

4. In the constitutional challenge to the 1989 Texas Workers' Compensation Act before the Texas Supreme Court, the issue of identifying the "general scheme" and purpose of the Act was addressed. Chief Justice Phillips wrote:

> "…the Act carrying forward the general scheme of the former act—provides benefits to injured workers without the necessity of proving negligence and without regard to the employer's potential defenses. In exchange, the benefits are more limited than the actual damages recoverable at common law. We believe this quid pro quo, which produces a more limited but **more certain recovery,** renders the Act an adequate substitute for purpose of the open courts guarantee." *Texas Workers' Compensation Commission v. Garcia, 893 S.W.2d 504, (Tex. 1995)* (emphasis added)

In a more recent decision by the Texas Supreme Court it was stated in the *Ruttiger* case in 2012 *(supra paragraph 2.)*

> "The purpose of the Act [Workers' Compensation Act] is to **provide employees with certainty that their medical bills and lost wages will be covered if they are injured.** An employee benefits from workers' compensation insurance because it saves the time and litigation expense inherent in proving fault in a common law tort claim. But a subscribing employer also receives a benefit because it is then entitled to assert the statutory exclusive remedy defense against the tort claim of its employees for job related injuries." (emphasis added)

5. The purpose of the Workers' Compensation Act has been clearly articulated by the Legislature in passing the Act and the Supreme Court in its interpretation of it. However, as has been pointed out, disputes and denials have rendered the purpose of the Act diminished ─ if not virtually meaningless ─ by the carriers in their denials and by the Hearings Division of TDI-DWC in their decisions against payment of claims.

   A common assertion by the carrier is that the claimant has a duty to prove by expert testimony "how" the compensable event caused the condition in question. The Texas

Supreme Court long ago addressed that contention in favor of the claimant but arguments to that effect fall on deaf ears at the Hearings Division.

The Texas Supreme Court in the case of *Western Casualty v. Gonzales, 518 S.W.2d 524 (Tex. 1975)* the court pointed out that it has never required that:

> "… the medical expert explain or even understand the precise biochemistry or mechanism by which the initial trauma affects the health or organs of the injured party…**If every episode in the chain of degeneration within the body of a person had to be established in medical probability, the available expert witnesses, of either rare expertise or dishonesty, would be so few that injured persons could seldom make that proof."** (Emphasis added.)

In the majority of cases where the injury is serious and the medical treatment extensive, the denial is made that the expert did not explain how the event caused the injury. Not only do the courts not require that explanation, except in complex medical situations where there is a valid cause and effect issue, OIEC is not provided resources to recruit and pay medical experts to make that causal connection. Taking into consideration that the Supreme Court has abolished the good faith and fair dealing remedy because OIEC assistance was available, the lack of authority or resources provided to OIEC brings into question the constitutionality of the dispute resolution process.

6. As previously stated, Texas employers pay approximately two billion dollars annually in workers' compensation premiums. Imagine for a moment that all medical claims incurred as a result of an on-the-job injury were paid by a standard health care insurance policy. Imagine for a moment that all of the expenses incurred in the denial of medical claims could be eliminated. How much could premiums be reduced to employers if all of the adjustors who scrutinize medical claims were gone; the investigators' costs would go away; the lawyers who defend the denials would have to find other work; the doctors who have full time employment testifying against injured workers; the administrative people at the Division of Workers' Compensation and the Office of Injured Employee Counsel who deal every day with medical denials and disputes could be eliminated. Millions of dollars in employer premiums could be eliminated. When OIEC can only realistically provide successful assistance in a CCH to 29 percent of the injured employees that it is statutorily mandated to assist, how can the system be justified?

   If only someone would do a study that would address these issues. But wait, studies have been done. Leave it to the academics to muck up the game.

7. George Washington University School of Public Health and Health Services did a study on our very subject that was published on May 29, 2013. Their conclusions were:
   a. "Nearly 40% of work related injuries and illnesses seen in U.S. emergency rooms are not billed to workers' compensation—the insurance program that's

designed to cover them. An increasing number of patients suffering from injuries or illnesses caused by exposures at work are using their private insurance, paying out of pocket or billing Medicaid or Medicare, instead of filing the appropriate claim to the employers' workers compensation insurer." Those are the findings of a new study published in the journal *Health Services Research* by researchers with CDC's National Institute for Occupational Safety and Health (NIOSH). It included studies of 22 of the states with the largest amount of workers covered by workers' compensation, including Texas. [I wish we could get our numbers in Texas up to that level.]

b. Of the 3,881 cases identified as work related, 39.65 percent were not expected to be paid by workers' compensation insurance. For work-related injury cases, an estimated 37 percent were not expected to be paid by workers' compensation, and for work-related illness cases, the estimate was a whopping 47 percent.
c. Researchers who have studied the system provide some hints about why some injured workers would rather use their private insurance or pay out of pocket than file a claim with their employers' workers' compensation carrier. It was noted that workers "risk disciplinary action, denial of overtime or promotion opportunities, stigmatization, drug testing, harassment or job loss for reporting an injury."
d. Other researchers have found pursuit of a workers' compensation claim to be "cumbersome, frustrating and demeaning." It was stated that "for many workers, the workers' compensation system is dizzying and frustrating in its complexity and apparent irrationality. While the rules may be understandable to repeat players ─ particularly insurers and third party administrators of claims ─ they are obscure to many who are caught up in the delay and denials."
e. Another consequence is shifting the cost of work-related injuries from the parties responsible (i.e. employers and workers' compensation insurers) to other payment sources… Imagine the hundreds of millions in cost-shifting if a share of those cases billed to private insurers (21.4 percent) belonged in the workers' compensation system.

8. Don't change that dial—we are just getting started. The Worker' Compensation Research Institute has done two comprehensive studies, *Comparing Workers' Compensation and Group Health Hospital Outpatient Payments* and *A New Benchmark For Workers' Compensation Fee Schedules: Prices Paid by Commercial Insurers?"* Both studies were published in June 2013.

   The study on fee schedules paid by commercial insurers found that Texas payments for common treatments under workers' compensation were significantly higher than under

group health insurance. For instance, in Texas the workers' compensation fee schedule for a common knee arthroscopy was 24 percent higher than for group health in 2009. Payment for a common office visit was 21 percent higher in Texas under workers' compensation than under group health. During the years between 2009 and 2012, Texas was one of three states (Maryland and Michigan being the others) that had workers' compensation payments for office visits increase between 11 percent and 28 percent over group health.

The analysis of the impact of the 2005 Act on medical services acknowledges the cost increases for workers' compensation services. In the "Setting the Standard" report published in December 2012 by the Texas Department of Insurance it is stated:

> Total medical costs for professional services evaluated at six months post-injury decreased by 36 percent between its peak in 2002 and 2007, but they increased by 26 percent since 2007…
>
> Similarly, total hospital costs decreased from 2002 until 2004, but increased during the years 2005 and 2008. They have remained in a level or marginally increasing trend since 2008…
>
> The average professional cost per claim also decreased between its peak in 2002 and 2007, but increased significantly by 31 percent between injury years 2007 and 2011. Primary causes for these increases were increased fees for services in the 2008 professional services fee guideline, and increase in utilization for some services…
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> The results of recent injured employee surveys conducted by TDI show that a higher percentage (55 percent) reported 'no problem' in getting the medical care they felt they needed for their work-related injury, compared with 52 percent in 2005…
>
> Additionally, a slightly higher percentage (25 percent) of employees surveyed in 2012 reported that the medical care they received for their work-related injury was worse than their routine medical care when compared to employees surveyed in 2005 (19 percent)…
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> The number of medical disputes has declined from more than 13,000 in 2005 to less than 8,000 in 2011." (Supra, PP.viii-xi.) [Stay tuned. We will revisit this later herein.]

It was also reported in the "Setting the Standard" paper that "Medical only claims accounted for 75 percent of all claims and 34 percent of the total costs in 2011. Lost time claims with more severe injuries accounted for the majority of total medical costs." The hospital costs for lost time claims comprised 38 percent of all claims but accounted for 81 percent of the total costs. Average hospital claims increased for both lost-time and medical only claims by 77 percent and 28 percent respectively. (supra p. 34)

Thirty to thirty-one percent of injured employees reported that between 2005 and 2012 they had a "big problem" getting medical care for their injuries.." (supra p. 61)

In the study entitled "Comparing Workers' Compensation and Group Health Hospital Outpatient Payments" published by the Workers' Compensation Research Institute in June 2013, it is stated in the paragraph with the heading **Interpreting The Results in the Context of Workers' Compensation Policy:**

> "The comparison of workers' compensation and group health hospital outpatient payments raises the question in many states as to whether workers' compensation hospital outpatient rates are higher than necessary to assure injured workers access to good quality care….
> Given that there is no obvious reason why treating an injured worker should be cheaper, and given that providers can choose whether or not to treat patients injured under workers' compensation, policymakers in those lower cost states might want to inquire about problems with access to hospital care for injured workers." (Supra p. 11)

As an example, comparative rates for workers' compensation payments and group health payments for outpatient shoulder surgery in Texas during 2008 shows that workers' compensation payments per claim were on average $6,920 and group health was $4,853. Group health payments were $2,067 less than workers' compensation payments. Workers' compensation payments were 43 percent higher than group health coverage. (supra p. 12, 43)

Workers' compensation payments for outpatient knee surgery in 2008 was 28 percent higher than group health payments. (supra p.13, 44)

9. So what is the cause of higher payments for workers' compensation medical care in Texas than for group health coverage? As has been stated in TDI's "Setting the Standard" report in 2008 a new fee schedule was enacted that raised the compensation for health care providers who treated injured workers. Prior to that time health care providers in droves left the practice of treating injured workers. Why did that happen? It happened because of the administrative hassle of dealing with payment for services and acceptance of the recommended treatment. It was easier to just not take workers' compensation patients than go through the difficulty of dealing with workers' compensation carriers. But, that still leaves the question of why didn't the increased fee schedule make it worthwhile to provide treatment when they were paid so much more than what they received from group health carriers.

   That question has already been answered. Returning to page one of this paper, we saw that disputes and denials began skyrocketing near the time that the schedule went into effect. If the fee schedule increased payment for services, then services would be denied and disputed as a means of defeating the higher cost per claim. Disputes and denials of

claims will have doubled within the past three years to over 16,000 per year. Justification for those denials range from "the doctor not explaining how the event caused the injury" to the doctor's explanation being "conclusory" and not sufficient to prove causation. Limiting the injury to a mere strain/sprain when a serious injury was clearly present is also a frequent assertion in a denial of treatment.

How about the reduction in the number of claims? The studies quoted herein provide the explanation. It is easier and less risky to a workers' employment to just file on other coverage. It is also much more likely that he will receive prompt care. Please recall that 45 percent of injured workers report problems getting medical care with 31 percent reporting "big problems." That is one out of three injured workers reporting "big problems" getting medical care.

10. What possible justification can there be in continuing a system that denies care to injured workers at a higher cost than private provider coverage? The most defensible justification is that it provides protection to employers from defending lawsuits every time someone is injured. "Exclusive remedy" protection must be an essential factor in reforming the system. Nothing would work that eliminated that feature. There is hardly any type of employment that does not involve some risk of injury. I will come back to that shortly, but let's consider some alternatives to our present system before we do.

    If group health can provide more responsive medical care at less cost to employers what would be the down side to that? There is a provision in standard health care policies that exclude on-the-job injuries. Could health care carriers charge an additional fee for taking workers who maybe at some higher risk of injury because of their employment? Perhaps some additional fee may be required but compare it to the present system that supports so many people who do nothing but add to the costs of claims through the denial and dispute process. Millions of dollars in costs would be eliminated by eliminating the medical dispute process all together. Those reduced costs could supplement health care that provides coverage twenty four hours a day, seven days a week and still reduce costs to employers substantially. Workers would get treatment for what ails them regardless of how they sustained it. No more disputes about whether he was hurt on the job or playing softball. No more disputes because the treating doctor cannot explain "how" his injury occurred. No more disputes over the extent of his injury. No more disputes because a peer review doctor, who makes a full-time living writing reports, disagrees with the recommended treatment that would be involved.

11. Now let's return to the issue of providing "exclusive remedy" protection to employers and shielding them from lawsuits. First of all, many employers choose to be non-subscribers under the present workers' compensation system. Many provide coverage

through an ERISA approved health care plan. Since this takes us where my expertise leaves me I would defer to others on this point. Some employers remain as subscribers but provide their own network of health care. Some unions provide care through their negotiated benefits plans. My primary concern is that the plan must provide health care 24-7 regardless of how the injury occurred. To do otherwise would put us right back where we are now: disputing causation or choice of treatment.

Clearly there are those whose expertise would be enlightening and provide solutions that would address all of these issues.

12. The subject of indemnity for lost wages sustained in lost-time injuries or permanent impairment has been avoided herein. There must be a provision for indemnity benefits in any reformation of the system. It is felt that if the issue of disputing medical benefits is resolved then the remaining indemnity disputes will be addressed more fairly with less controversy. In other words, if the injury is realistically evaluated, then any residual impairment or disability will be more apparent with less justification for disputes. At least that was the rationale of the Texas Supreme Court in the *Garcia* decision, supra, in deciding the question of the constitutionality of the 1989 Act.

13. It has become clear by now that I have raised many questions and provided few solutions. I am not qualified to address specific details about reforming the workers' compensation system. That will be left to the experts who are so qualified. However, with nearly 200,000 new workers' compensation claims every year at a cost of nearly two billion dollars a year in premiums, this is not an insignificant issue.

    Finding a correct balance between the competing interests of all stakeholders in the business of workers' compensation insurance has always been difficult. It is a process that may never have an end. Each point has a counterpoint that provides the moving target. That is not to say that the issue should be ignored. It requires a system that is agile enough to make adjustments as the need becomes apparent. Vigilant oversight by the courts and regulators is necessary to assure that stakeholders that seek to "game the system" are held accountable.

    The system now in place is not working, and it is time for the debate about how to reform workers' compensation to begin.