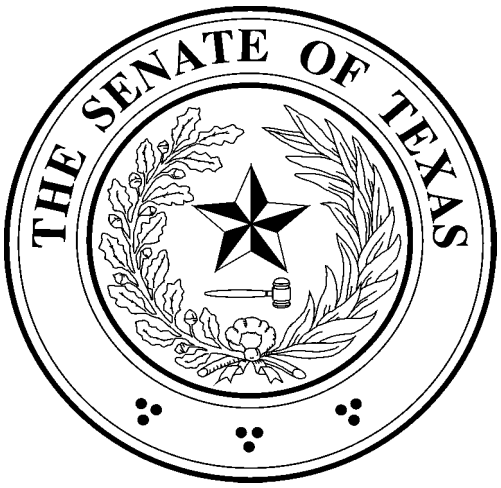
Senate Committee on State Affairs

Interim Report
to the
83rd Legislature



December 2012

SENATE COMMITTEE ON STATE AFFAIRS

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The Honorable David Dewhurst
Lieutenant Governor of Texas
Members of the Texas Senate
Texas State Capitol
Austin, Texas 78701

Dear Lieutenant Governor Dewhurst and Fellow Members:

The Committee on State Affairs of the Eighty-Second Legislature hereby submits its interim report including findings and recommendations for consideration by the Eighty-Third Legislature.

Respectfully submitted,

Senator Robert Duncan, Chair

Senator Robert Deuell, Vice-Chair

Senator Rodney Ellis

Senator Troy Fraser

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Senator Mike Jackson

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Senator Tommy Williams

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January 23, 2013

The Honorable Robert Duncan
Chair, State Affairs Committee
Texas Senate
Room 3E.18
Austin, Texas 78701

The Honorable Jane Nelson
Chair, Health and Human Services Committee
Texas Senate
Room 1E.5
Austin, Texas 78701

Dear Chairs Duncan and Nelson:

Thank you for your leadership and work on the Committees' joint report to the 83rd Legislature regarding the Affordable Care Act (ACA). We know that the joint report reflects months of hard work by the Committees, and we appreciate the diligence and efforts of both you and your staffs. Through this letter, we would respectfully like to add a few additional points to encourage continued policy discussions that weigh both the costs and benefits of implementing key provisions of the ACA.

As you know, Texas leads the nation in the percentage of uninsured, has one of the highest poverty and food insecurity rates, and has vast shortages of health care providers. Through the ACA, we have a historic opportunity to address these significant challenges.

The report notes that Governor Perry sent letters to U.S. Secretary of Health and Human Services Kathleen Sebelius noting his position as it relates to a health insurance exchange for Texas. While Texas will most likely have a federally-facilitated exchange starting in 2014, the opportunity for Texas to create its own exchange or partner with the federal government still remains. During this legislative session, it will be important to engage in a healthy policy discussion that encourages all parties to come to the table to ensure that no one is left out and that Texas has an exchange that will meet its needs.

Even if Texas decides not to run its own exchange, individuals at or above 100 percent of the federal poverty level (FPL) will have the ability to purchase health insurance with subsidies through a federal health exchange, thus ensuring these populations will have access to quality, affordable health insurance. Unfortunately, there is no safeguard for most individuals below 100 percent FPL who are not currently covered by Medicaid.

Medicaid expansion would provide coverage for low-income adults who are at or below 133 percent FPL, are less than 65 years old, and do not otherwise qualify for Medicaid. For these individuals, Medicaid will mean the opportunity to have a primary doctor and continuity in care, thereby reducing their reliance on the expensive care currently provided in emergency rooms.

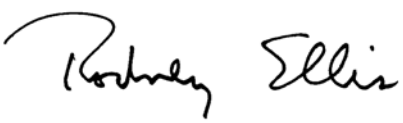
The federal matching contribution for expansion costs will also result in a large net influx in federal tax dollars returned to our state. If implemented, Texas will receive 100 percent of expansion costs for

the first three years, which will gradually reduce to a 90 percent match by 2020. From recently revised estimates from the Health and Human Services Commission, the state's share of $15.6 billion will draw down $100.1 billion in federal matching funds over ten years. These extra federal funds flowing to our state have a dramatic multiplier effect, as Texas economists have estimated that every one dollar in federal matching Medicaid funding will result in $3.25 worth of local economic activity. According to well-respected Texas economist Dr. Ray Perryman, for every $1 spent by the state, we will see a return of $1.29 in dynamic state government revenue over the first ten years of the expansion.

The expansion of Medicaid costs less in four years than what Texas hospitals spend on the uninsured population in one year. The needs of these individuals will not disappear if we fail to expand Medicaid, but we will lose out on a nine-to-one match that other states will utilize with Texans' taxpayer dollars, and we will continue to pass the cost of the uninsured down to local hospitals and ultimately to taxpayers.

We thank you in advance for considering our concerns, and we look forward to working together during the 83rd Legislative Session. We are confident that under your leadership we will continue to prioritize providing all Texans access to affordable health insurance.

Sincerely,



Rodney Ellis

Eddie Lucio, Jr.

Leticia Van de Putte, R.Ph.

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Interim Charges

1. Study the policies and actions the State can pursue to preserve state authority and protect Texas citizens from federal overreach in the form of conditional federal grants, conditional federal preemption, and excessive legislation and regulation interfering with states' enumerated powers by Congress.

2. Examine the Texas Workers Compensation system and make recommendations for changes to meet the needs of Texas employers and employees. Specifically, review the following:
   - the dispute resolution process and benefits available from employers that do not subscribe to workers compensation;
   - the adequacy of income benefits in the workers' compensation system, specifically on high wage earners receiving the maximum compensation rate;
   - identify and report on fatalities in the Workers' Compensation System, including the amount of death and burial benefits paid to beneficiaries and the Subsequent Injury Fund since 2000;
   - the return-to-work numbers and results for injured employees in the Workers' Compensation System that are referred to the Department of Assistive and Rehabilitative Services.

3. Study the feasibility and fiscal impact to consumers of altering the insurance code to allow for the purchase of health insurance across state lines.

4. Monitor the potential impact of the Patient Protection and Affordable Care Act (PPACA) on insurance regulations, Medicaid and CHIP, health care outcomes and overall health of all Texans, and the state budget in Texas. Additionally, monitor the current constitutional challenges to PPACA, and other court cases associated with PPACA, and ensure that the state does not expend any resources until judicial direction is clear. (Joint charge with Senate Health & Human Services Committee).

5. Study and make recommendations on statutory provisions and judicial decisions relating to the statute of limitations on a cause of action relating to consumer debt.

6. Examine establishing a workforce retention program or deferred retirement option plan (DROP) for Texas Department of Public Safety commissioned peace officers and whether any plan can be built with actuarially sustainable factors while meeting the needs of officers.

7. Examine the feasibility of implementing Health Reimbursement Accounts and Medicare exchanges for Medicare eligible participants currently covered by and receiving health coverage through the Employees Retirement System, the Teachers Retirement System, the University of Texas, and Texas A&M University. Identify any cost savings to the state and to retirees that would occur under such a plan.

8. Consider the costs and benefits of the creation of liability protection for private companies and individuals when commissioned by the Texas Forest Service to assist in fighting a fire that is not on the company's or individual's own land. Examine whether state policy should prohibit an employer from terminating an employee who is a volunteer firefighter on the grounds that the employee missed work because the employee was responding to an emergency. Identify any appropriate limitations that should apply to such a policy.

9. Examine the effectiveness of the Private Real Property Rights Preservation Act (Chapter 2007, Government Code), and whether it should apply to municipalities.

10. Monitor the implementation of legislation addressed by the Senate Committee on State Affairs, 82nd Legislature, Regular and Called Sessions, and make recommendations for any legislation needed to improve, enhance, and/or complete implementation. Specifically, monitor the following:
    - implementation of SB 100, relating to the implementation of the MOVE Act, and the impact on local and statewide elections and military voters;
    - implementation of the Interstate Health Care Compact.

Senate Committee on State Affairs Interim Hearings

August 1, 2012, Room E1.036
The Committee met jointly with the Senate Committee on Health & Human Services and received invited and public testimony on Charge No. 4.

August 30, 2012 Senate Chamber
The Committee received invited and public testimony on Charge Nos. 3, 5 and 8.

November 19, 2012, Senate Chamber
The Committee received invited and public testimony on Charge Nos. 6 and 7.

December 10, 2012, E1.016
The Committee received invited and public testimony on Charge Nos. 1, 2, 9 and 10.

Audio/Video recordings, minutes and witness lists for the above referenced hearings may be found online at: http://www.senate.state.tx.us/75r/senate/commit/c570/c570.htm

Interim Charge Discussions and Recommendations

Charge No. 1

Study the policies and actions the State can pursue to preserve state authority and protect Texas citizens from federal overreach in the form of conditional federal grants, conditional federal preemption, and excessive legislation and regulation interfering with states' enumerated powers by Congress.

Background

The issue of state sovereignty is often a topic of discussion by legal experts and in college classrooms, but it has come to the forefront of public policy discussions in recent years due to actions taken by the federal government. In the last decade, the federal government has promulgated several policies that many view as infringing upon states' rights, for instance, the Affordable Care Act, the "Race to the Top" initiative by the federal Department of Education, and regulations by the Environmental Protection Agency implementing the Clean Water Act and the Clean Air Act. These statutes and programs often tie the implementation of federal policy to the distribution of federal funds.

States have looked to the Tenth Amendment to the Constitution to support their efforts to retain state sovereignty.[1] In fact, the 82nd Legislature took up and considered both House and Senate Concurrent Resolutions to that effect.[2]

The text of the Tenth Amendment reads: "the powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the State respectively, or to the people." Only under rare circumstances has the Supreme Court struck down a federal law because Congress exceeded its authority.[3] However, more commonly, the Supreme Court has held that the states may maintain limited ability to refuse implementation of a federal law, but in some instances such refusal may not be without consequences.[4] The recently litigated federal Affordable Care Act provides an excellent example of the current legal status quo.

Affordable Care Act

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, collectively referred to as the Affordable Care Act (ACA), was adopted by Congress in March of 2010.[5] Generally speaking, the ACA contains two major provisions related to states' rights: (1) the individual mandate which requires individuals to obtain health

[1] *See* Senate Committee on State Affairs hearing, Dec. 10, 2012 (testimony of Vickie Sutton, Professor at Law, Texas Tech University School of Law; Mario Loyola, Texas Public Policy Foundation). *See* Appendix to Charge 1.
[2] H.C.R. 50, 82nd Leg. (2011); S.C.R. 1, 82nd Leg. (2011); S.C.R. 14, 82nd Leg. (2011).
[3] *See e.g.* U.S. v. Lopez, 514 U.S. 549 (1995).
[4] *See e.g.* South Dakota v. Dole, 483 U.S. 203 (1987).
[5] Patient Protection Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), *as amended* by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

insurance coverage or face a federal income tax penalty;[6] and (2) the requirement that states expand Medicaid eligibility to individuals and families with incomes at or below 133 percent of the federal poverty level (FPL) or lose all federal Medicaid funds.[7]

The Supreme Court took up and considered several states' challenges to the ACA and issued its opinion on June 28, 2012, affirming in part and reversing in part the lower courts' opinions.[8] The Court held that the individual mandate is not a valid exercise of power under the Commerce Clause or the Necessary and Proper Clause; however it is a valid act under Congress' power to "lay and collect taxes".[9] With regard to the Medicaid expansion component, the Court evaluated the requirement in light of Congress' authority under the Spending Clause under which it had previously affirmed the concept of tying federal funds to the implementation of federal law in *South Dakota v. Dole*.[10] In distinguishing *Dole*, the Court stated:

> It is easy to see how the *Dole* Court could conclude that the threatened loss of less than half of one percent of South Dakota's budget left that State with a "prerogative" to reject Congress's desired policy, "not merely in theory but in fact." 483 U.S., at 211-212. The threatened loss of over 10 percent of a State's overall budget, in contrast, is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.[11]

In addition, the Court noted that the expansion of Medicaid provisions also amounted to a shift in kind, not merely degree, stating:

> As we have explained, "[t]hough Congress' power to legislate under the spending power is broad, it does not include surprising participating States with post-acceptance or 'retroactive' conditions." *Pennhurst, supra*, at 25, 101 S.Ct. 1531. A State could hardly anticipate that Congress's reservation of the right to "alter" or "amend" the Medicaid program included the power to transform it so dramatically.[12]

The Court concluded that the expansion of Medicaid provision is constitutional, but only as long as states not complying with the expansion may continue to receive existing Medicaid funds.[13]

Some view the Supreme Court's decision as a step forward in strengthening states' rights; however, many commentators do not believe the Court went far enough. One thing is clear though -- absent a coalition of states united in asserting federal overreach, the Supreme Court would not have invalidated the portion of the ACA that it did.

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[6] 26 U.S.C.A. § 5000A (2011).
[7] 42 U.S.C.A. §§ 1396a(a)(10)(A)(i)(VIII), 1396c, 1396d(y)(1) (2012).
[8] Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 183 L.Ed.2d 450 (2012).
[9] *Id.* at 2593, 2600.
[10] *Id.* at 2604.
[11] *Id.* at 2604-05.
[12] *Id.* at 2606.
[13] *Id.* at 2608.

Recommendations

The Committee recommends that the Legislature continue to monitor and follow federal legislation and administrative actions that serve to limit state authority. In the event the federal government infringes upon state sovereignty, the State should take action in federal court to contest such overreach.

Charge No. 2

Examine the Texas Workers Compensation system and make recommendations for changes to meet the needs of Texas employers and employees. Specifically, review the following:

- *the dispute resolution process and benefits available from employers that do not subscribe to workers compensation;*
- *the adequacy of income benefits in the workers' compensation system, specifically on high wage earners receiving the maximum compensation rate;*
- *identify and report on fatalities in the Workers' Compensation System, including the amount of death and burial benefits paid to beneficiaries and the Subsequent Injury Fund since 2000;*
- *the return-to-work numbers and results for injured employees in the Workers' Compensation System that are referred to the Department of Assistive and Rehabilitative Services.*

Background

Significant changes were made to the Texas workers' compensation system in 2005 by the adoption of H.B. 7.[14] The subsequent years have seen new policies and new procedures adopted by the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) and the industry. Some of the key trends in the system that were presented to the Committee include:[15]

- injury rates continue to decline placing Texas below the national average;
- the number of claims filed between 2004 and 2011 have decreased 22 percent;
- workers' compensation insurance rates have come down almost 50 percent since 2003;
- medical costs per claim continue to decline;
- return-to-work numbers have gone up since the 2005 reforms; and
- access to medical care has improved since 2005.

Nonsubscribers' Dispute Resolution Process and Benefits

Employers in Texas have the option not to carry workers' compensation insurance and forego statutory protections against liability. Those that opt out of the system are classified as "nonsubscribers." Employers choose to be nonsubscribers for various reasons: unsatisfactory access to health care providers treating injured workers; low return-to-work rates for injured workers participating in the system; high costs of workers' compensation insurance premiums;

[14] Acts 2005, 79th Leg., ch. 265.

[15] Senate Committee on State Affairs hearing, Dec. 10, 2012 (testimony of Commissioner Rod Bordelon, Texas Department of Insurance, Division of Workers' Compensation). *See also* Appendix to Charge 2.

few on-the-job injuries; or dissatisfaction with the level of benefits available through workers' compensation policy.[16]

The Workers' Compensation Research and Evaluation Group at the Department of Insurance (WCREG) is charged with conducting a biennial survey of Texas employers to gather information relating to employer participation in the Texas workers' compensation system.[17] Based on its most recent survey, the WCREG estimated that although the number of nonsubscribers remains steady at around 33 percent of Texas employers, the number of employees working for those nonsubscribers has increased from 17 to 19 percent (approximately 1.7 million employees in 2012).[18] It should be noted that the number of large employers (>500 employees) choosing nonsubscription has slowed its increase since 2008.[19]

Among the information gathered by the WCREG is data relating to the benefits found in nonsubscriber occupational benefit plans. Nonsubscribers may choose to "go bare" and provide no benefits to their workers, or they may opt to provide medical and/or wage replacements benefits through their own, independent benefit plans.[20] As shown below, the percentage of nonsubscribing employers offering benefits and the percentage of employees covered by benefit plans continue to decline. However, it should be noted that the lower number of nonsubscribing employers with plans continue to employ a significant number of employees.

[16] Senate Committee on State Affairs hearing, Dec. 10, 2012 (testimony of Margaret Greenshield, Texas Alliance of Nonsubscribers); Texas Dept. of Insurance Workers' Compensation Research and Evaluation Group, *Employer Participation in the Texas Workers' Compensation System: 2012 Estimates* at 13 (Oct. 2012). *See also* Appendix to Charge 2.

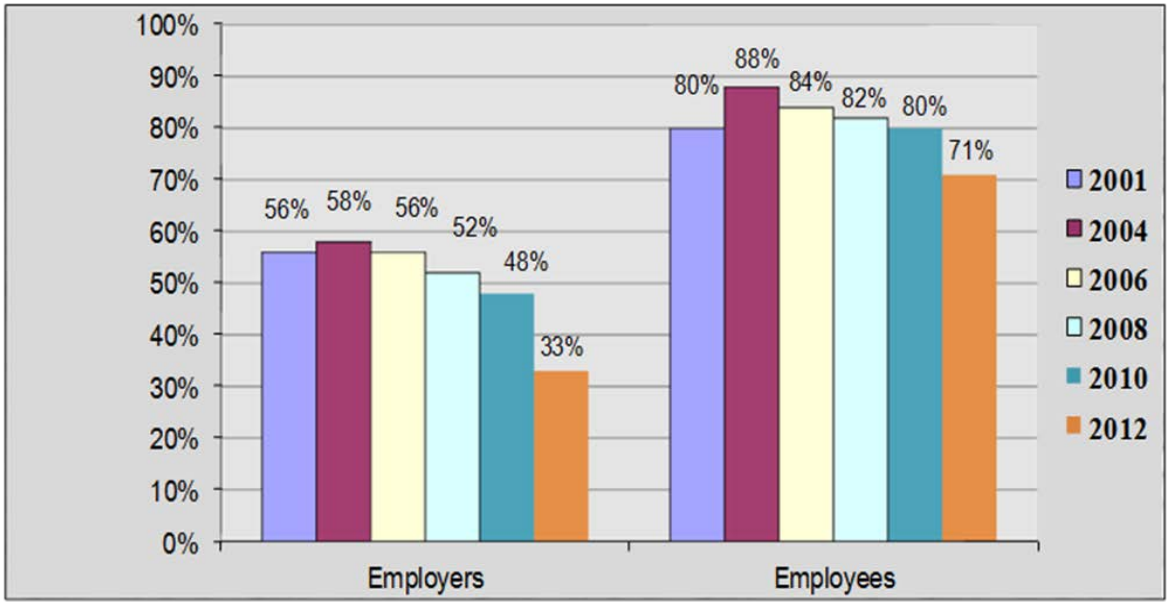
[17] Texas Dept. of Insurance Workers' Compensation Research and Evaluation Group, *Employer Participation in the Texas Workers' Compensation System: 2012 Estimates*, (Oct. 2012).

[18] *Id.* at 6-7; Texas Dept. of Insurance, Division of Workers' Compensation, *Biennial Report of the Texas Department of Insurance to the 83rd Legislature* at 12 (Dec. 2012).

[19] Texas Dept. of Insurance Workers' Compensation Research and Evaluation Group, *Employer Participation in the Texas Workers' Compensation System: 2012 Estimates* at 8 (Oct. 2012).

[20] Senate Committee on State Affairs hearing, Dec. 10, 2012 (testimony of Margaret Greenshield, Texas Alliance of Nonsubscribers).

Percentage of Nonsubscribing Employers That Pay Occupational Benefits and Percentage of Nonsubscribing Employees Covered by Occupational Benefit Plans2011-2012 Estimates



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

The WCREG survey also indicated that the benefits included in nonsubscriber benefit plans vary. Seventy-five percent of such plans cover medical costs; however, approximately half pay medical benefits only as long as they are medically necessary or cap medical benefits based on the duration of treatment or the amount of money spent on treatments or both.[21] Additionally, only 55 percent of benefit plans include wage replacement benefits, and a third of those include a waiting period before the benefits begin.[22] In the event of serious injury, 31 percent of nonsubscriber occupational benefit plans include wage replacement benefits for permanent physical impairments and 38 percent include accidental death, dismemberment, or other benefits.[23] Death benefits are paid by 41 percent of nonsubscriber plans and 11 percent of those include burial benefits.[24]

The WCREG's survey also included questions to nonsubscribers regarding the use of arbitration agreements. Such agreements may be a part of a general employment agreement and encompass any and all disagreements between the employer and employee, or they may be specific and address only work-related injuries.[25]

[21] Texas Dept. of Insurance Workers' Compensation Research and Evaluation Group, *Employer Participation in the Texas Workers' Compensation System: 2012 Estimates* at 23 (Oct. 2012).
[22] *Id.* at 24.
[23] *Id.* at 26-28.
[24] *Id.* at 29.
[25] Nonsubscriber occupational benefit plans are governed by the federal Employee Retirement Income Security Act (ERISA) and ERISA prohibits the use of arbitration absent consent by both parties. 29 U.S.C. § 1002 *et. seq.*; 29 C.F.R. § 2560.503-1(c)(4) and (d). However, it should be noted that the ERISA provisions only apply to disputes relating to plan benefits. Disputes relating to plan coverage (e.g. whether the injury was sustained on the job) may

With regard to the dispute resolution process utilized by nonsubscribers, WCREG's survey of nonsubscribers revealed that 14 percent of all nonsubscribers ask their employees to sign an arbitration agreement and of those 14 percent, 63 percent are large employers (>500 employees) and 81 percent specify that the arbitration is binding and cannot be appealed.[26]

Ninety percent of the employers who utilize arbitration agreements ask the employee to sign the agreement upon hiring (pre-injury); however, only 68 percent allow continued employment to those who do not agree to sign an agreement.[27] Forty-one percent of nonsubscribers that use arbitration agreements deny employees medical and/or wage replacement benefits if the employee does not agree to arbitration.[28]

In the event of a dispute that continues to arbitration, 34 percent require that the employee pay all or a portion of the arbitration costs.[29] Twenty-three percent utilize members of the American Arbitration Association or the National Arbitration Forum as arbitrators, 15 percent use a designated company employee, and 39 percent of the respondents "don't know" what type of arbiter is used.[30]

In summary, the results of the WCERG survey reveal that more than 80 percent of Texas workers are covered by a traditional workers' compensation insurance policy. On the other hand, 19 percent of workers are employed by nonsubscribers and two-thirds of those nonsubscribers "go bare" and provide no workers' compensation-type benefits to their employees. The nonsubscribers providing coverage through an occupational benefit plan do so to varying degrees with regard to benefits as well as the use of arbitration agreements.

Adequacy of Benefits

The adequacy of benefits to injured workers is an ongoing topic of discussion by the Texas Legislature, TDI-DWC, and participants in the state's workers' compensation system.[31] In particular, this Committee's interim report to the 82nd Legislature contained an extensive discussion of the various income benefits available in Texas: Temporary Income Benefits (TIBs); Impairment Income Benefits (IIBs); Supplemental Income Benefits (SIBs); and Lifetime Income Benefits (LIBs).[32] Since that report was issued, there have been no significant changes relating to income benefits other than an increase in the State Average Weekly Wage as detailed below.[33]

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be controlled by an arbitration agreement outside the jurisdiction of ERISA. The questions posed by the WCREG survey were intended to gauge the use of such arbitration agreements.

[26] Texas Dept. of Insurance Workers' Compensation Research and Evaluation Group, *Employer Participation in the Texas Workers' Compensation System: 2012 Estimates* at 32 (Oct. 2012).

[27] *Id.* at 33.

[28] *Id.*

[29] *Id.* at 34.

[30] *Id.* at 35.

[31] Texas Dept. of Insurance, Division of Workers' Compensation, *Biennial Report of the Texas Department of Insurance to the 83rd Legislature* (Dec. 2012).

[32] Senate Committee on State Affairs Interim Report to the 82nd Legislature at 38 (Dec. 2010).

[33] *See also* Appendix to Charge 2.

State Average Weekly Wage/Maximum and Minimum Weekly Benefits

Fiscal Year	SAWW* State Average Weekly Wage	Temporary Income Benefits (TIBs) max	TIBs min	Impairment Income Benefits (IIBs) max	IIBs min	Supplemental Income Benefits (SIBs) max	SIBs min	Lifetime Income Benefits (LIBs) max	LIBs min	Death Benefits max	Death Benefits min
2013 (10/01/12-09/30/13)	$817.94	818.00	123.00	573.00	123.00	573.00	N/A	818.00	123.00	818.00	N/A
2012 (10/01/11-09/30/12)	$787.47	787.00	118.00	551.00	118.00	551.00	N/A	787.00	118.00	787.00	N/A
2011 (10/01/10-09/30/11)	$766.34	766.00	115.00	536.00	115.00	536.00	N/A	766.00	115.00	766.00	N/A
2010 (10/01/09-09/30/10)	$772.64	773.00	116.00	541.00	116.00	541.00	N/A	773.00	116.00	773.00	N/A
2009 (10/01/08-09/30/09)	$749.63	750.00	112.00	525.00	112.00	525.00	N/A	750.00	112.00	750.00	N/A
2008 (10/01/07-09/30/08)	$712.11	712.00	107.00	498.00	107.00	498.00	N/A	712.00	107.00	712.00	N/A

Source: Texas Department of Insurance, Division of Workers' Compensation

Each of the income benefits is provided under a separate statutory provision and each has its own parameters and caps.[34] The various benefits are intended to operate in a tiered system whereby one tier is exhausted before another tier begins. High wage earners are impacted by the varying methods of calculation and the caps applicable to each of the different tiers of benefits.

In its report to the Legislature, the TDI-DWC noted that the majority of injured employees receiving income benefits (roughly two-thirds) generally receive only TIBs.[35] TIBs tend to have higher income replacement rates and a lower percentage of injured employees capped at the statutory maximum benefit than other benefits (IIBs or SIBs).[36] Additionally, the current rate for TIBs is set at approximately 70 percent of the pre-injury wage; higher than many other states which generally compensate at 66 ⅔ percent.[37] As a result, in 2011, the TIBs income replacement rate was 93 percent and 13 percent of TIBs recipients were capped at the statutory weekly maximum of $766.[38]

The statutory maximum for IIBs and SIBs is lower than the maximum for TIBs (70 percent vs. 100 percent of the SAWW) therefore, the benefit caps effect more injured employees.[39] Based on available data, between 30 and 40 percent of SIBs recipients injured before 2005 were capped. Since SIBs benefits do not start until at least three or more years after the injury, it is difficult to determine what impact the changes in the calculation of the SAWW starting in 2007 will have on SIBs recipients injured after that point.[40] Data shows that injured employees who

[34] TEX. LAB. CODE ANN. ch. 408 (Vernon 2006 & Supp. 2011). *See also* income benefit fact sheets in Appendix to Charge 2.
[35] Texas Dept. of Insurance, Division of Workers' Compensation, *Biennial Report of the Texas Department of Insurance to the 83rd Legislature* at 33 (Dec. 2012).
[36] *Id.*
[37] *Id.* at 34.
[38] *Id.* at 35.
[39] *Id.* at 36.
[40] *Id.* at 37.

have had their benefits capped only replace approximately 60 to 65 percent of their pre-injury wages with SIBs, compared to an income replacement rate of 70 to 78 percent for employees who have not had their SIBs capped.[41]

In the discussion of adequacy of benefits, it is always helpful to remember that the workers' compensation benefit system was never designed to make the injured worker whole from a tort damage perspective. The original purpose was to compensate for lost wages due to permanent impairment caused by workplace injury or illness. Benefits have generally been considered inadequate when compared to the remedies available in the tort system; however, this disparity is intentional. The Legislature could consider changing the benefit design to increase benefits, but as recommended in previous reports from this Committee, such increases in benefits should be limited to catastrophically injured workers.

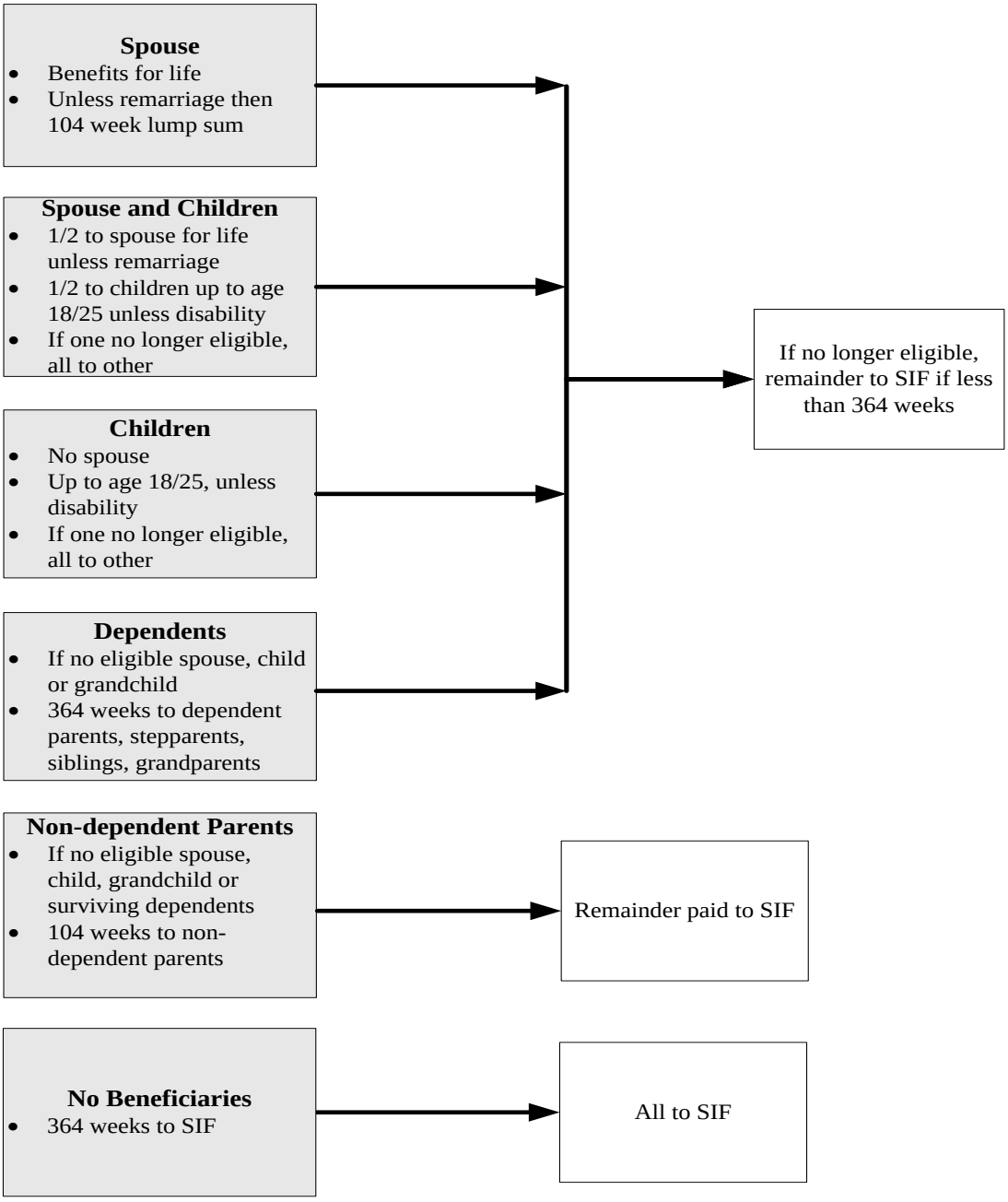
Fatalities/Death Benefits/Subsequent Injury Fund

According to data collected by TDI-DWC, work-related fatalities decreased by six percent in 2011 going from 461 in 2010 to 433 in 2011.[42] The leading cause of workplace fatalities in 2011 were transportation incidents.[43] Additionally, 93 percent of fatal work injuries involved employees in the private sector, with construction accidents accounting for the highest number of fatalities, 83.[44] Fatal injuries to wage and salary employees decreased by 10 percent in 2011, while fatalities among self-employed individuals increased by 21 percent.[45]

The workers' compensation system provides death and burial benefits to the workers' family members as set out below. The Subsequent Injury Fund (SIF) was created in 1947 and has the primary purpose of providing lifetime income benefits to workers disabled as a result of a second injury.[46] The SIF is funded by the payment of death benefits from insurance carriers where a compensable death occurs and there is no eligible beneficiary, or where the beneficiary is a non-dependent parent.[47] Payments to and disbursements from the SIF are detailed in the cash flow chart included in the Appendix to Charge 2.

[41] *Id.*
[42] Press Release, Texas Dept. of Insurance, Work-Related Fatalities Decreased in Texas in 2011 for the Second Year in a Row (Oct. 19, 2012) http://www.tdi.texas.gov/news/2012/news2012104.html. *See also* Appendix to Charge 2.
[43] *Id.*
[44] *Id.*
[45] *Id.*
[46] TEX. LAB. CODE ANN. § 408.162 (Vernon 2006).
[47] TEX. LAB. CODE ANN. §§ 403.007 and 408.182(e) (Vernon 2006 & Supp. 2011).

Texas Department of Insurance
Division of Workers' Compensation
Distribution of Death Benefits to Qualified Beneficiaries
and the Subsequent Injury Fund



Related Statutes:
Texas Labor Code
§ 408.181 Death Benefits
§ 408.182 Distribution of Death Benefits
§ 408.183 Duration of Death Benefits
§ 408.184 Redistribution of Death Benefits

Return-to-Work for DARS Referrals

The Texas Labor Code requires TDI-DWC to identify injured employees that would be assisted by vocational rehabilitation services and refer those injured employees to the Texas Department of Assistive and Rehabilitative Services (DARS).[48] The TDI-DWC has adopted rules setting forth the criteria for DARS Referral.[49] On average, TDI-DWC refers 24,500 injured workers to DARS annually.[50]

Once an injured employee is referred to DARS, the employee must apply to receive services and be deemed eligible to receive those services by DARS. The referrals are processed and referred to the appropriate DARS field office.[51] DARS processed approximately 15,291 referrals during Fiscal Year 2011. The disparity in referral numbers indicated by TDI-DWC is due to a variety of factors, including duplicate referrals.[52] DARS indicated that approximately 72 percent of referred workers are determined to be eligible for services and nine percent of those workers successfully return to work.[53]

Recommendations

Based on the foregoing discussion, the Committee makes no recommendations for legislative action relating to this charge.

Charge No. 3

Study the feasibility and fiscal impact to consumers of altering the insurance code to allow for the purchase of health insurance across state lines.

Background

The federal McCarran-Ferguson Act (1945) protects insurance firms from interstate competition and grants each state the right to regulate health insurance plans which operate within their state.[54] An exception from this state-based regulation is provided to large employers who self-insure or self-fund. These large (500+ employees) employers are guided by the federal Employee Retirement Income Security Act of 1974 (ERISA) which is administered by the U.S. Department of Labor.[55]

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[48] TEX. LAB. CODE ANN. §§ 408.150 and 409.012 (Vernon 2006 & Supp. 2011).
[49] 28 TEX. ADMIN. CODE § 136.1 (2011).
[50] Texas Dept. of Insurance, Division of Workers' Compensation, *Referrals of Injured Employees for Vocational Rehabilitation Services to the Department of Assistive and Rehabilitative Services (DARS)*. *See also* Appendix to Charge 2.
[51] Dept. of Assistive and Rehabilitative Services, *TDI-DWC Referral Letter Information to DARS* (Dec. 17, 2012). *See also* Appendix to Charge 2.
[52] *Id.*
[53] *Id.*
[54] Richard Cauchi and Steven Landess, National Conference of State Legislatures, *Allowing the Purchase of Health Insurance from Out-of-State Insurers* (Sept. 2012), http://www.ncsl.org/issues-research/health/out-of-state-health-insurance-purchases.aspx.
[55] *Id.*

According to the Texas Department of Insurance (TDI), 1,133 companies are licensed to write health insurance in Texas, however, only 86 of those licensed companies wrote premiums for comprehensive health insurance coverage in 2011 in the state of Texas. [56]

Because health insurance is regulated on a state-by-state basis, a variety of regulatory standards exist across the nation. This variation results in inconsistent premium costs from state to state. Such disparity in premium cost from state to state has led many states, including Texas, to explore and debate legislation that would allow health insurance products to be sold and marketed across state lines. This would allow, for example, a resident of Texas to purchase a health insurance product that is licensed, marketed, and regulated by another state, but not licensed in the state of Texas.

Policy Discussion in Other States and Federal Legislation

Since 2009, five states have enacted statutory changes that would allow for some version of across state lines health insurance purchasing and sixteen states have considered, but failed to pass, such legislation.[57] The following is a summary of legislation that has successfully passed in other states:

Georgia 2011 Signed Law	**H 47** by Ramsey M (R) Relates to individual health insurance coverage, so as to authorize insurers to offer individual accident and sickness insurance policies in the state that have been approved for issuance in other states; provides for legislative findings; provides for a definition; provides for minimum standards for such policies; allows insurers authorized to transact insurance in other states to issue individual accident and sickness policies in the state. *(Enacted by House and Senate; **signed into law** as Act No. 249, 5/13/11)*
Kentucky 2012 Signed Law	H 265 by Rep. Rand (D) Authorizes the state to seek "to explore the feasibility of an Interstate Reciprocal Health Benefit Plan Compact (IRHBPC) with contiguous states" to allow Kentucky and residents of contiguous states to purchase health benefit plan coverage among the states participating with the compact. The purposes of this compact are, through means of joint and cooperative action among the compacting states to promote and protect the interest of consumers purchasing health benefit plan coverage. The compact generally is authorized in section 1333 of the PPACA. *(Enacted & **signed into law** as Act No. 144, 4/13/2012)*
Maine 2011 Signed Law	**H 979** by Richardson (R) Gradually modifies the community rating provisions for individual and small group health plans; expanding in 3 increments the rating bands from the current ratio of 1.5:1 to 3:1 by January 1, 2014; allows financial incentives except for emergency care services; maintains the requirement that plans must provide reasonable access to services for all members; allows plans to provide financial incentives to members to reward providers for quality and efficiency. Also provides, "Notwithstanding any other provision of this Title, a domestic insurer or licensed health

[56] Annual data reported to the National Association of Insurance Commissioners.
[57] Richard Cauchi and Steven Landess, National Conference of State Legislatures, *Allowing the Purchase of Health Insurance from Out-of-State Insurers* (Sept. 2012), http://www.ncsl.org/issues-research/health/out-of-state-health-insurance-purchases.aspx .

	maintenance organization authorized to transact individual health insurance in this State may offer for sale in this State an individual health plan duly authorized for sale in Connecticut, Massachusetts, New Hampshire or Rhode Island by a parent or corporate affiliate of the domestic insurer or licensed health maintenance organization. *(Enacted & **signed into law** as Public Law 2011-90, 5/17/2011)*
Rhode Island 2008 Signed Law	**S 2286** by Sen. Sheehan (D) Amends the Health Insurance Market Expansion Act; provides for establishing a regional health insurance market with other New England states to expand opportunities for regional insurers to offer insurance in the state; includes health insurance corporations, health maintenance organizations, nonprofit hospital service corporations and nonprofit medical service corporations; provides for a study of laws to enable insurers licensed in other states to do business in the state without separate licensure. *(Filed and Enacted; **signed into law,** 6/26/08)* *NOTE: This structure resembles the federal Health Reform law enacted in March 2010. It may be an early example of applying state and federal regulation to a new type of insurance policy.*
Wyoming 2010 Signed Law	**H 128** by Rep. Simpson (R) Authorizes the sale of health insurance by out-of-state insurers; provides for more limited regulation of policies; provides for oversight by the insurance commissioner; provides for cooperation by the insurance commissioner with other states with consistent insurance laws; specifies legislative intent to pursue a multi-state consortium to enter into reciprocal agreements to reduce health insurance costs through removal of duplicative regulation. *(Passed House and Senate; **signed into law** as Chapter No. 86, 3/11/10)*

Source: National Conference of State Legislatures

While categorized as across state lines purchase, Kentucky, Maine and Rhode Island legislation actually relates to the creation of regional markets or compacts that are restricted to carriers in a set list of states or region, not a total opening to all carriers from any state. Wyoming and Georgia enacted legislation that allows the sale of any out-of-state insurance to their residents. However, no carriers have entered the markets in either of those two states intending to provide a policy under the provisions that allow for out-of-state carriers.[58]

On a federal level, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act known as the Affordable Care Act (ACA) also addresses this issue. The ACA includes a provision which authorizes states to enter into multistate agreements referred to as Health Care Choice Compacts.[59] These Health Care Choice Compacts allow two or more states to enter into a compact under which individual market plans could be offered in all states belonging to the compact. Insurers must be licensed in all states in the compact, but are only subject to laws and regulations of the state where the policy was written or issued. However, issuers would be required to adhere to the laws of the **purchasers** home state relating to the following:

[58] Sabrina Corlette, Christine Monahan, Katie Keith and Kevin Lucia, The Center on Health Insurance Reforms, Georgetown University Health Policy Institute, *Selling Health Insurance Across State Lines: As Assessment of State Laws and Implications for Improving Choice and Affordability of Coverage* (Oct. 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401409.

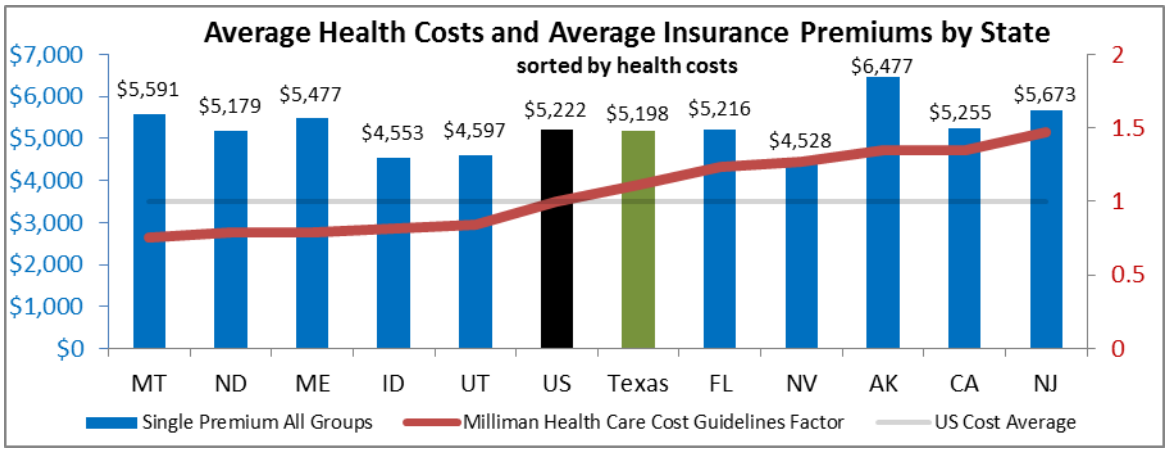
[59] Patient Protection Affordable Care Act § 1333(a), 42 U.S.C.A. § 18053 (2010).

- market conduct;
- unfair trade practices;
- network adequacy; and
- consumer protection standards.[60]

The ACA also requires the issuers to "clearly notify consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides."[61] The effective date for the Health Care Choice Compacts section of the ACA is January 1, 2016, and it only applies to compacts created by state legislation enacted after that effective date.[62]

Policy Discussion in Texas

Health care costs have continued to rise and impact the ability for individuals and businesses in Texas to afford health insurance. Although Texas' health care costs are higher than the national average, the average total premiums are slightly lower than the national average.[63]



Source: Texas Department of Insurance

A variety of factors can impact a state's premium rates -- guaranteed issue, community rating, prompt pay requirements, mandates, prevalence of employers providing health insurance, how many carriers in the state, and the health status of the residents.[64]

To address these rising costs a variety of legislative proposals have been introduced, including S.B. 2416 in the 81st Regular Session and S.B. 1855 in the 82nd Regular Session; both would have allowed the sale of out-of-state health insurance products to Texans. Neither legislation passed.

[60] Senate Committee on State Affairs hearing, Aug. 30, 2012 (testimony of Commissioner Eleanor Kitzman, Texas Department of Insurance).
[61] Patient Protection Affordable Care Act § 1333(a)(B)(iii), 42 U.S.C.A. § 18053 (2010).
[62] Patient Protection Affordable Care Act § 1333(a)(2), 42 U.S.C.A. § 18053 (2010).
[63] Senate Committee on State Affairs hearing, Aug. 30, 2012 (written testimony of Commissioner Eleanor Kitzman, Texas Department of Insurance).
[64] Senate Committee on State Affairs hearing, Aug. 30, 2012 (testimony of Commissioner Eleanor Kitzman, Texas Department of Insurance).

Supporters of the sale of insurance across state lines cite the opportunity to escape the regulatory environment of one state for that of another. Specifically discussed during the hearing was the ability to be relieved of costs associated with providing state-mandated benefits. Each mandate increases the premiums in order for the insurer to provide the care mandated.

To better understand the cost impact of state-mandated benefits, TDI annually conducts a study to measure the costs associated with state-mandated health benefits. In the most recent *Texas Mandated Benefit Cost and Utilization Report, October 2008 - October 2009*, TDI collected data from a total of 51 insurers and HMOs on 20 mandated benefits and two mandated offerings.[65]

The TDI report provides the average annual premium cost of including the 20 mandated benefits covered in the study. For the 2008-2009 reporting period the average annual premium costs associated with the coverage of those 20 mandates were:

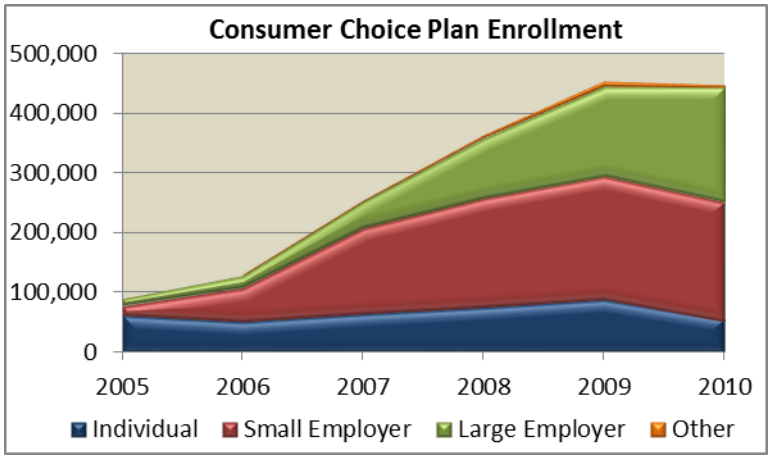
- $140.12 annually for individual with single coverage (i.e., employee-only) and;
- $364.56 annually for family coverage.[66]

In the most recent publication TDI lists Texas as having 64 state-mandated benefits, offers, and coverages.[67] It is important to note that not all of these state-mandated benefits are required across all lines of insurance. For example:

- only 13 of the 64 mandates are required across all lines, including individual, small and large group Fee-for-Service, PPO, HMO and Consumer Choice plans;
- 2 mandates are either entirely or largely impacted by a federal mandate;
- 7 mandates only require the benefits to be offered to enrollees; and
- 17 mandates are not required if a policy holder purchases a Consumer Choice Plan.

Consumer Choice Plans were created by S.B. 541, 78th Regular Session. These plans provide health insurance products in the individual, small and large group health insurance markets that are exempted, in whole or in part, from state-mandated health benefits. According to TDI, 2011 enrollment for Consumer Choice Plans was 419,766 covered lives.

[65] TDI is directed to collect data only from the largest providers for this study. In addition, due to the nature of the data collection capabilities, TDI must limit their study to the 20 mandated benefits and 2 offers with distinct medical procedures or diagnosis codes.
[66] Texas Department of Insurance, *Texas Mandated Benefits, Offers, and Coverages Minimum Required Benefits* at 1 http://www.tdi.texas.gov/hmo/documents/manbenchartcomb.pdf.
[67] *Id.*



Source: Texas Department of Insurance[68]

These Consumer Choice Plans provide relief from state-mandated benefits without diminishing the authority of TDI to regulate and protect consumers for health insurance products sold to residents of the state because all issuers are required to be licensed by the state.

The benefit of maintaining Texas' regulatory authority was also raised as a concern during the hearing. Opponents question which state would an enrollee of a policy purchased from an insurer not licensed in Texas utilize if they have a complaint against or need to access consumer protections from a state regulatory agency. For example, if a Texas resident purchases a policy licensed in Oklahoma and needs to file a complaint against that insurer, which state's insurance department has jurisdiction, Texas or Oklahoma? It is unclear as to whether the Oklahoma insurance regulatory agency would have the ability to intervene on behalf of a Texas resident, whether TDI has legal authority to advocate for their resident against a carrier licensed in Oklahoma, and finally, whether the insurance department in that other state has the capacity to take on the demands of a large number of Texans. Concerns were also raised that if there was a question of regulatory authority between states, the federal government could prevail or step in to assume regulatory authority. In that case, Texas' authority could not only come into question but also be lost to the federal government.

Further discussion at the hearing lead to the issue of what costs other than state-mandated benefits could actually be a bigger factor in creating higher premiums. Certainly costs associated with state-mandated benefits are a portion of a premium, however, the underlying cost structure of the health care system in each state often has a much more significant impact on premiums. While the licensing of the insurer may be elsewhere, the actual provision of that health care is very local. The health care infrastructure, such as establishing adequate networks and contracting with physicians at an acceptable rate in that state, has a substantial impact on the cost of premiums.[69] Therefore, even if a health plan is licensed in a state with fewer mandates or

[68] Senate Committee on State Affairs hearing, Aug. 30, 2012 (written testimony of Commissioner Eleanor Kitzman, Texas Department of Insurance).

[69] Sabrina Corlette, Christine Monahan, Katie Keith and Kevin Lucia, The Center on Health Insurance Reforms, Georgetown University Health Policy Institute, *Selling Health Insurance Across State Lines: As Assessment of State*

regulatory requirements, the cost relief could be quickly erased by the higher cost to set up a meaningful network of providers with comparable reimbursement rates in the actual state or region where the enrollee lives and seeks medical care.

Recommendations

Recognizing the ongoing issue of rising health insurance costs, but being mindful of the concerns associated with the sale of out-of-state licensed health plans in the state, the Texas Legislature should continue to investigate policies that help reduce or control the cost of health insurance premiums in this state. Policies should focus on meaningful reforms that empower consumers to make cost effective choices and encourage health insurers to improve cost transparency without creating new administrative or regulatory burdens on the market. Discussion should continue with regard to health care compacts and their potential for reducing health care insurance premiums for Texans without diminishing the authority of the Texas Department of Insurance to protect Texas consumers. Additionally, the Legislature should continue to monitor the cost of current state-mandated health benefits and any potential mandate expansion.

Charge No. 4

Monitor the potential impact of the Patient Protection and Affordable Care Act (PPACA) on insurance regulations, Medicaid and CHIP, health care outcomes and overall health of all Texans, and the state budget in Texas. Additionally, monitor the current constitutional challenges to PPACA, and other court cases associated with PPACA, and ensure that the state does not expend any resources until judicial direction is clear. (Joint charge with Senate Health & Human Services Committee).

Background

In March 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act into law. Taken together, these acts are referred to as the Affordable Care Act (ACA).[70]

Texas joined a majority of states in challenging the constitutionality of the ACA. The states' legal challenge focused on two of the law's major provisions, the individual mandate and Medicaid expansion.[71] Beginning in 2014, the individual mandate requires U.S. citizens and legal residents to obtain health insurance coverage or pay a penalty assessed and collected by the federal Internal Revenue Service (IRS). The law allows several exemptions to this requirement, including for financial hardship and religious objections.[72] The law also requires state Medicaid

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Laws and Implications for Improving Choice and Affordability of Coverage (October 2012) http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401409.

[70] Patient Protection Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), *as amended* by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

[71] Senate Committee on State Affairs and Senate Committee on Health & Human Services joint hearing, Aug. 1, 2012 (testimony of Commissioner Thomas Suehs, Health & Human Services Commission at 2).

[72] The Henry J. Kaiser Foundation, *A Guide to the Supreme Court's Affordable Care Act Decision* at 2 (July 2012) http://www.kff.org/healthreform/upload/8332.pdf .

programs to expand Medicaid eligibility to 133 percent of the federal poverty level (FPL) in 2014 for individuals under the age of 65, including adults with no dependent children.[73]

On June 28, 2012, after a number of lower court decisions, the U.S. Supreme Court issued its ruling on the ACA. The Supreme Court determined that the individual mandate is a constitutional exercise of Congress' power to tax. The Court also determined that the Medicaid expansion is constitutional, as long as states not complying with the expansion can continue to receive existing Medicaid funds. While originally a mandatory provision, the Court's decision on Medicaid expansion rendered the provision voluntary for states.

On August 1, 2012, the Senate Committee on Health and Human Services and the Senate Committee on State Affairs held a joint hearing to receive an update from the Health and Human Services Commission (HHSC) and the Texas Department of Insurance (TDI) on the ACA, including the impact of the Supreme Court's ruling, implementation activities, and issues facing the 83rd Legislature. The archived video of the hearing can be found online: http://www.senate.state.tx.us/75r/senate/commit/c610/c610.htm.

Analysis

Provisions Relating to the Private Health Insurance Market

Individual Mandate

The Supreme Court upheld the individual mandate as constitutional under Congress' taxing authority. As such, beginning January 1, 2014, U.S. citizens and legal residents, with certain exemptions, will be required to purchase health insurance coverage or pay a penalty assessed and collected by the IRS. As indicated below, the penalties more than double each year between 2014 and 2016, and continue to increase based on cost of living in 2017 and beyond.[74]

ACA Penalties

Year	Penalty
2014	$95 per adult and $47.50 per child (up to $285 for a family) or 1% of family income, whichever is greater.
2015	$325 per adult and $162.50 per child (up to $975 for a family) or 2% of family income, whichever is greater.
2016	$695 per adult and $347.50 per child (up to $2,085 for a family) or 2.5% of family income, whichever is greater.
2017 and Beyond	Penalty amount is increased each year by cost of living.

Source: The Henry J. Kaiser Foundation

[73] Senate Committee on State Affairs and Senate Committee on Health & Human Services joint hearing, Aug. 1, 2012 (testimony of Commissioner Thomas Suehs, Health & Human Services Commission at 7).
[74] The Henry J. Kaiser Foundation, *The Requirement to Buy Coverage Under the Affordable Care Act*, http://healthreform.kff.org/the-basics/requirement-to-buy-coverage-flowchart.aspx (last visited Dec. 2, 2012).

Health Insurance Exchange

One of the major ACA requirements affecting the private health insurance market is the creation of health insurance exchanges in each state by January 1, 2014. The health insurance exchanges will serve as marketplaces where individuals and small businesses will be able to compare health plans, determine whether they are eligible for tax credits or health programs such as Medicaid/CHIP, and purchase health insurance.[75]

States have three options for implementing the health insurance exchange: a state-operated exchange, a state-federal partnership exchange, or a federally facilitated exchange operated by the federal government. States unable to implement, or choosing not to implement, a state-operated or state-federal partnership exchange will have a federally facilitated exchange established for them by the federal government.[76]

The ACA required that states planning to establish a state-operated or state-federal partnership exchange submit a blueprint for their exchange, including a declaration letter signed by the Governor, to the federal Department of Health and Human Services (HHS) by November 16, 2012. Federal HHS has since delayed that deadline until December 14, 2012, for state-operated exchanges and February 15, 2013, for state-federal partnership exchanges.[77]

On July 9, 2012, Governor Rick Perry wrote a letter to HHS Secretary Sebelius providing notice that Texas will not establish an exchange.[78] Governor Perry sent another letter to Secretary Sebelius on November 15, 2012, reiterating his position. Specific federal guidance on how the federally facilitated exchanges will operate is still pending.

States choosing not to establish a state-operated or state-federal partnership exchange at this time will have the option to transition to one of these exchanges in the future. The state would need to apply for federal funds no later than October 2014 in order to cover the state's start-up costs and submit a transition plan for federal approval one year before the anticipated start date of the state exchange. Because federal funds must be used within three years, the state's transition would need to be completed by 2017.[79] At this time, it is unclear whether the state will choose to transition to a state-based or state-federal partnership exchange in the future; however, the state's decision to do so could influence legislative and appropriations decisions as early as next session.

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[75] Congressional Research Services, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act* at 2-3 (Aug. 15, 2012) http://www.fas.org/sgp/crs/misc/R42663.pdf .
[76] The Henry J. Kaiser Foundation, *Establishing Health Insurance Exchanges: An Overview of State Efforts* at 1-2 (Nov. 2012) http://www.kff.org/healthreform/8213.cfm (last visited Dec. 2, 2012).
[77] *Id.*
[78] Letter from Governor Rick Perry to Secretary Kathleen Sebelius, U.S. Department of Health and Human Services (July 9, 2012) http://governor.state.tx.us/files/press-office/O-SebeliusKathleen201207090024.pdf .
[79] Senate Committee on State Affairs and Senate Committee on Health & Human Services joint hearing, Aug. 1, 2012 (testimony of Commissioner Eleanor Kitzman, Texas Dept. of Insurance).

Essential Health Benefits

The ACA requires all individual and small group plans inside and outside of the health insurance exchange to cover an "essential health benefits package." The essential health benefits package must cover ten broad categories of coverage:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance abuse disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.[80]

To better define the specific services that will be required under these ten broad coverage categories, and any quantitative limits on services, states have the option of selecting a "benchmark plan" (a currently existing health insurance plan) that will act as the minimum standard of coverage for all individual and small group health plans in the state beginning January 1, 2014.[81]

Federal HHS gave states ten benchmark plans to choose from: the three largest small group plans, the three largest state employee health benefit plans, the three largest national federal employee health benefit plans, and the largest commercial non-Medicaid health maintenance organization (HMO).[82] The table below outlines these ten benchmark options in Texas.[83]

Texas Essential Health Benefits Benchmark Options

Benchmark Categories	**Three Largest Small Group Plans in Texas**			**Three Largest State Employee Plans in Texas**			**Three Largest Federal Employee Health Benefit Plans**			**Largest Non-Medicaid HMO in Texas**
Benchmark Plans	BCBS Best Choice PPO	BCBS Blue Edge HSA	UHC Choice Plus PPO	ERS Health Select	TRS Active Care	UT Select Plan	BCBS Standard Option	BCBS Basic Option	GEHA Standard Option	Aetna Large Group POS

Source: Texas Department of Insurance

[80] *Id.*
[81] *Id.*
[82] *Id.*
[83] Texas Dept. of Insurance, *Essential Health Benefits - Analysis of Benchmark Plan Options in Texas by Required PPACA Coverage Categories and State Mandated Benefits and Offers* (Sept. 27, 2012) http://www.tdi.texas.gov/health/documents/fhrebhanalysis.pdf .

If a state chooses not to select a benchmark plan, the default benchmark will be the small group plan with the largest enrollment in the state. For Texas, this default plan would be the Blue Cross Blue Shield (BCBS) Best Choice PPO, which provides health insurance coverage to more than 345,000 Texans.[84]

At the time of the August 1st hearing, TDI was still in the early stages of analyzing these ten benchmark options to determine which plan best meets the needs of Texans while fulfilling the ACA requirements. There was significant discussion during the hearing about potential costs to the state resulting from existing state health insurance mandates. The concern stemmed from a requirement in the ACA that states pay for any state insurance mandates not covered by the benchmark plan. Since the hearing, TDI has completed further analysis of the benchmark options, and the agency's latest analysis indicates that four of the benchmark options (including the default BCBS Best Choice PPO plan) would not create a cost to the state.[85] However, because federal HHS has yet to provide final guidance to states on submitting a benchmark plan, TDI's analysis is based on its best interpretation of federal guidance available at this time.

States were required to submit a benchmark plan by September 30, 2012; however, in light of missing federal guidance, many states including Texas have not submitted a benchmark plan. It is still unclear when states will receive final guidance.[86]

Private Market Provisions Already in Effect

A number of ACA provisions related to private health insurance coverage have already gone into effect and were not impacted by the Supreme Court's ruling. Private market provisions already in effect include:

- Young adult coverage on parents' health insurance plan until age 26;
- Prohibition of lifetime dollar limits on benefits;
- Prohibition against rescinding coverage if policyholder gets sick;
- Prohibition against denying children coverage due to a pre-existing condition;
- Small businesses tax credits to help purchase employee health coverage;
- Pre-Existing Condition Insurance Plan (PCIP) created as a new coverage option for individuals who are uninsured due to a pre-existing condition;
- Health plans required to provide certain preventive services at no cost to the patient; and
- Insurance companies not meeting required minimum medical loss ratios (85 percent for large employer plans and 80 percent for small employer plans) must send rebates to consumers.[87]

[84] *Id.*
[85] *Id.*
[86] Texas Department of Insurance, *Opportunities for Public Input on Federal Health Reform Issues: Essential Health Benefits*, http://www.tdi.texas.gov/health/fhrstakeholders.html (last visited Nov. 3, 2012).
[87] U.S. Department of Health and Human Services, *What's Changing and When* http://www.healthcare.gov/law/timeline/ (Last visited Oct. 14, 2012).

Provisions Relating to Medicaid

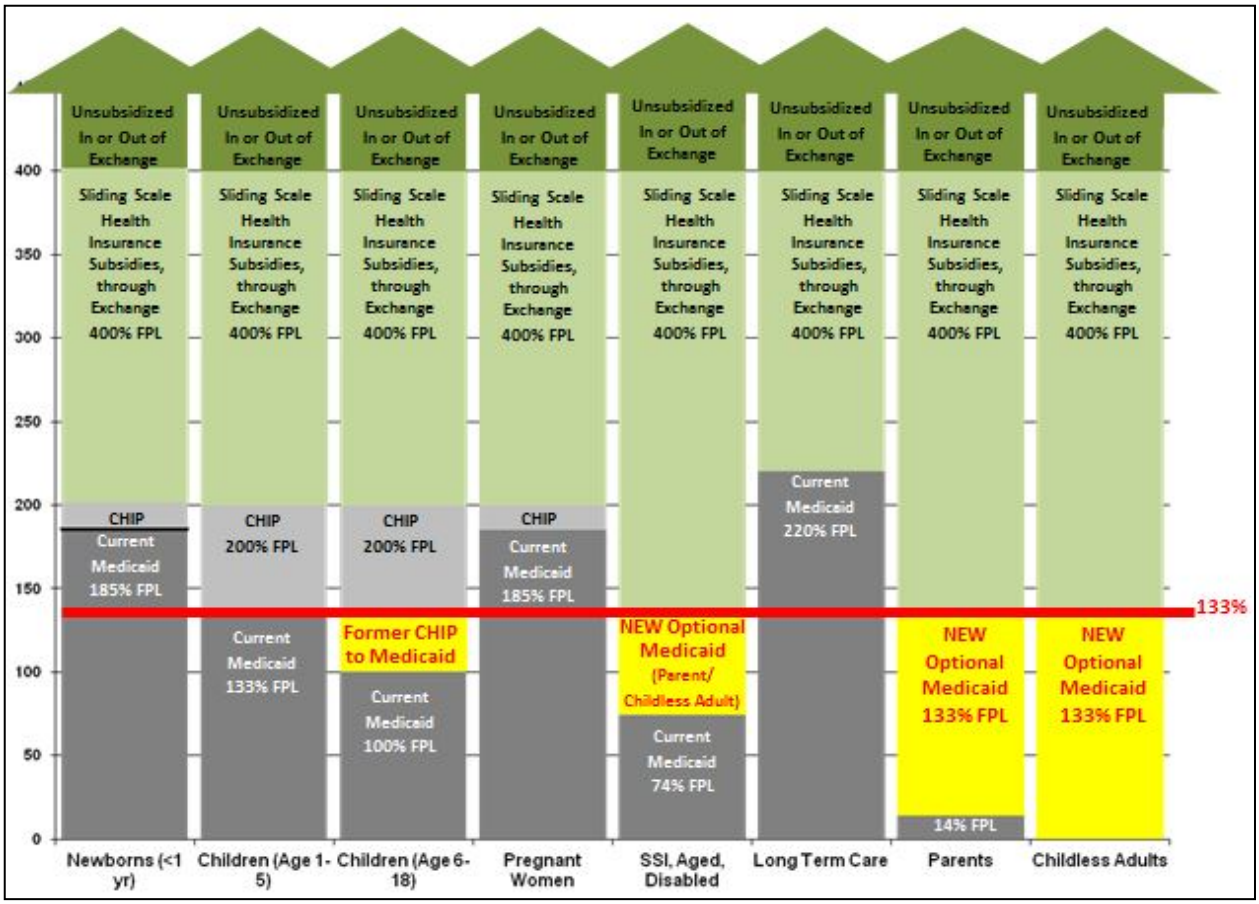
Medicaid Expansion

As a result of the Supreme Court's ruling, Medicaid expansion is now optional for states. At the August 1st hearing, HHSC provided the committees with estimates of the expansion's impact on Medicaid caseload and cost in Texas.

Caseload

The ACA expansion would extend Medicaid coverage to all individuals under age 65, including adults with no dependent children, who have a family income at or below 133 percent FPL and meet citizenship and immigration requirements. The following graph compares current Medicaid income eligibility requirements in Texas with the income requirements under the ACA expansion.[88] Childless adults, currently not covered under the Texas Medicaid program at any income level, would make up the largest expansion group under ACA expansion.

Medicaid Income Eligibility -- Current and ACA Expansion



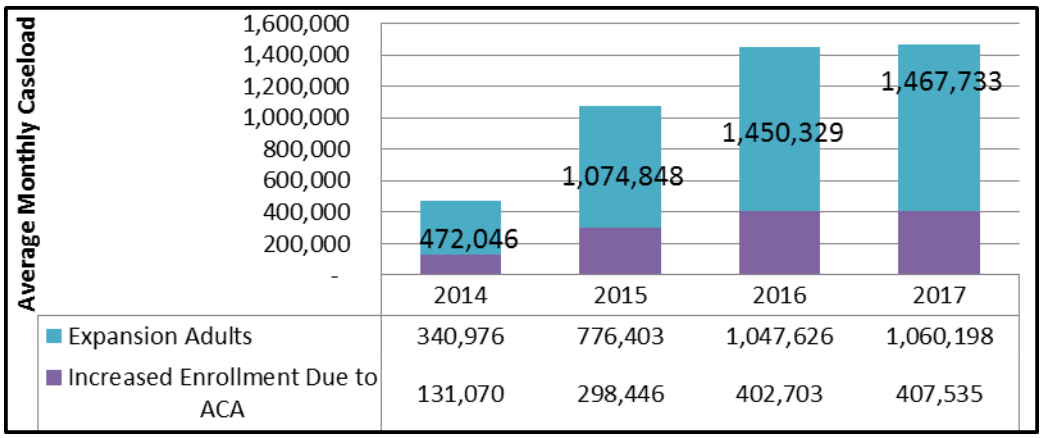
Source: Texas Health & Human Services Commission

[88] Senate Committee on State Affairs and Senate Committee on Health & Human Services joint hearing, Aug. 1, 2012 (testimony of Commissioner Thomas Suehs, Health & Human Services Commission at 8).

The Texas Medicaid program currently covers approximately 3.5 million individuals. Under Medicaid expansion, HHSC estimates that by 2017, the average monthly caseload of the Medicaid program will increase by nearly 1.5 million individuals. This increase is a combination of the expansion population (1.1 million individuals) and increased enrollment of individuals who are already eligible for Medicaid but not enrolled (400,000 individuals).[89] It is believed that this latter group, individuals already eligible but not enrolled, will have increased Medicaid enrollment due to the individual mandate and increased awareness of the Medicaid program as a result of the ACA. This increased enrollment of individuals already eligible for Medicaid (commonly referred to as the Medicaid "take-up" rate) will occur regardless of Medicaid expansion.

The following graph depicts HHSC's Medicaid caseload increase estimate due to ACA for calendar years 2014-2017. In addition to the total estimated caseload increase, the graph provides a breakdown between increased enrollment due to the Medicaid expansion and increased enrollment of individuals already eligible under the current Medicaid program (increased "take-up" rate).[90]

Medicaid ACA Caseload Estimates, 2014-2017

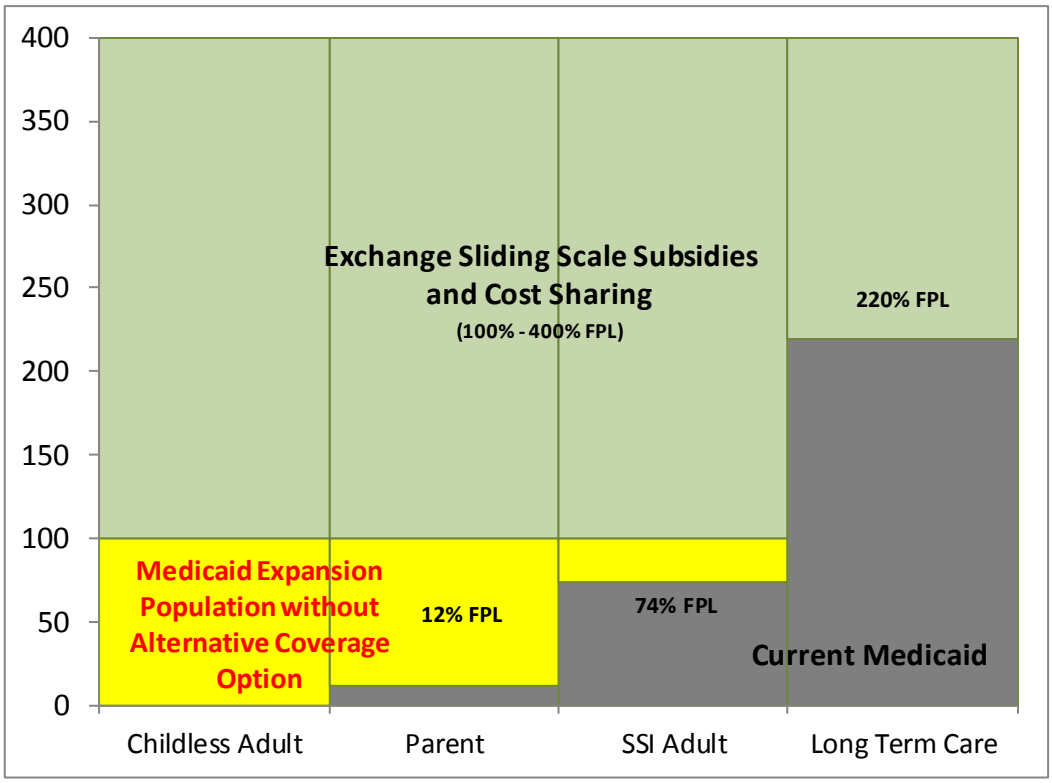


Source: Texas Health & Human Services Commission

As indicated by the graph below, if Texas chooses not to expand Medicaid, adults between 100 and 133 percent of the federal poverty level (FPL) would still be eligible for insurance subsidies through the health insurance exchange. Childless adults between 0 and 100 percent of FPL will not be eligible for Medicaid or insurance subsidies. Texas Medicaid currently covers parents of Medicaid eligible children up to 12 percent of FPL. If the state chooses not to implement the Medicaid expansion, parents between 12 and 100 percent of FPL will not be eligible for Medicaid or subsidies through the exchange.[91]

[89] *Id.* at 12.
[90] *Id.* at 12-13.
[91] *Id.* at 7.

Adult Medicaid Coverage - Current and ACA Expansion



Source: Texas Health & Human Services Commission

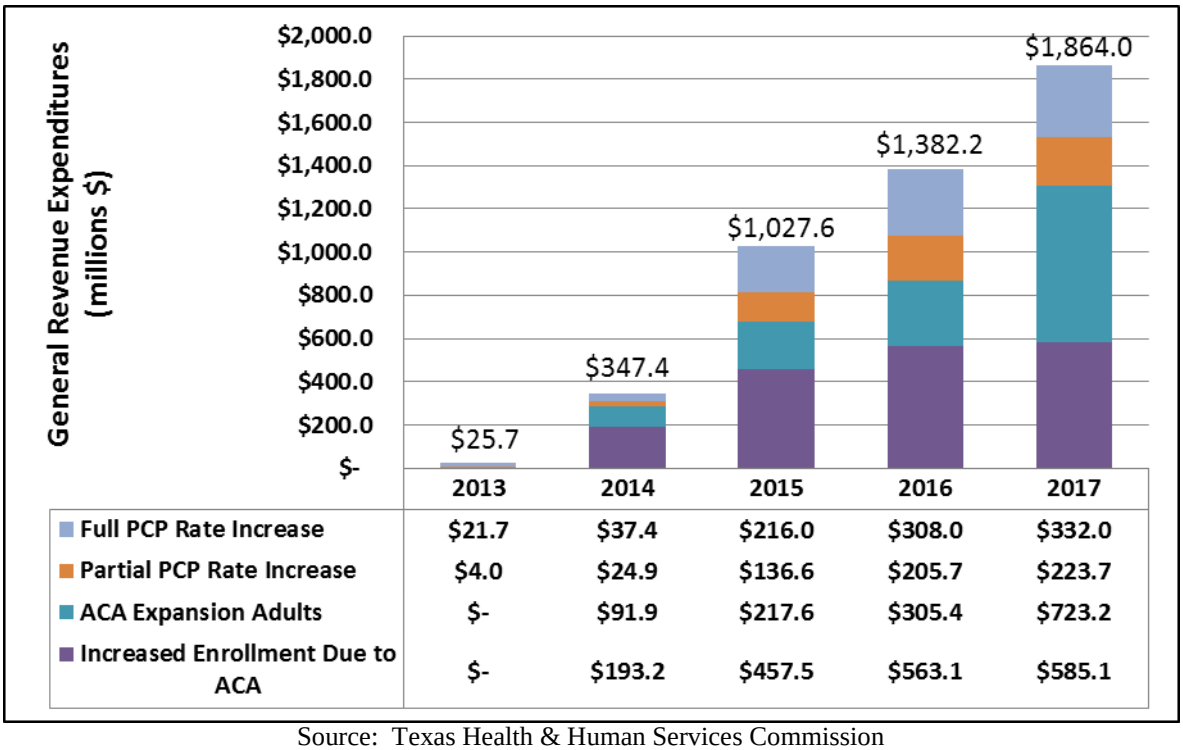
Cost Estimate

At the August joint hearing, HHSC presented the committees with a new estimate for ACA costs related to Medicaid. HHSC estimates that Medicaid-related provisions of the ACA will cost the state approximately $15 billion in general revenue (GR) over ten years (2014-2023).[92]

The following graph reflects HHSC's cost estimate specifically for years 2013 through 2017.[93] This estimate is a combination of administrative costs, increased caseload due to Medicaid expansion and increased take-up rate, and increases in primary care rates. Decreases in federal matching funds, referred to as the federal medical assistance percentage (FMAP), cause significant increases to the state after 2014 for costs associated with the primary care rate changes, and after 2016 for costs associated with the Medicaid expansion population. Administrative costs and primary care rate increases are discussed in further detail below.

[92] House Appropriations Committee Subcommittee on Article II hearing, July 12, 2012 (Testimony of Health & Human Services employees).
[93] Senate Committee on State Affairs and Senate Committee on Health & Human Services joint hearing, Aug. 1, 2012 (testimony of Commissioner Thomas Suehs, Health & Human Services Commission at 16).

Medicaid Expenditures Estimate by Level of ACA Implementation, 2013-2017



	2013	2014	2015	2016	2017
Full PCP Rate Increase	$21.7	$37.4	$216.0	$308.0	$332.0
Partial PCP Rate Increase	$4.0	$24.9	$136.6	$205.7	$223.7
ACA Expansion Adults	$-	$91.9	$217.6	$305.4	$723.2
Increased Enrollment Due to ACA	$-	$193.2	$457.5	$563.1	$585.1

Source: Texas Health & Human Services Commission

Administrative Costs

The state would receive the traditional 50 percent FMAP for administrative costs related to the expansion population. For this reason, HHSC's estimate includes costs for the expansion population in years 2014-2016 (when there is a 100 percent FMAP for medical services). This estimate assumes an eight percent across the board administrative cost related to ACA implementation and a 50 percent FMAP for those costs.[94]

Primary Care Rate Increases

Another cost consideration for the 83rd Legislature will be costs related to increases in Medicaid primary care provider (PCP) rates.

Required Rate Increase ("Partial PCP Increase") The ACA *requires* states to increase Medicaid rates for *certain primary care providers and services* to the Medicare rate. The rate increase is 100 percent federally funded for calendar years 2013 and 2014; however, states must first increase rates for these services and providers back to the state's 2009 Medicaid rate (at the regular FMAP) before the federal government will fully fund the required increase to the Medicare rate. HHSC initially estimated that it will cost the state $4 million GR in 2013 and

[94] E-mail from Health and Human Services Commission to Senate Committee on Health & Human Services staff (Sept. 18, 2012) (on file with Committee staff).

$24.9 million GR in 2014 to fund these rates back to 2009 levels for the existing Medicaid eligible population (referred to as "Partial PCP Rate Increase" in graph above). However, final federal rules published on November 1, 2012, may result in an increase to these cost estimates. States are required to implement this rate increase with a January 1, 2013, effective date; however, the State Plan Amendment (SPA) is due to the federal Centers for Medicare and Medicaid Services (CMS) as of March 31, 2013. SPAs submitted by that date, once approved, would be approved retroactively to January 1, 2013.[95]

Optional Rate Increase ("Full PCP Rate Increase") HHSC also estimated costs to extend the PCP rate increase beyond what was required under the ACA. This cost estimate includes primary care services delivered by *any Medicaid provider* to existing Medicaid populations and the optional expansion population (assuming 100% FMAP for the optional population). This *optional* increase is referred to as "Full PCP Rate Increase" in the graph above. HHSC initially estimated this increase would cost the state $21.7 million GR in 2013 and $37.4 million GR in 2014. However, final federal rules published on November 1, 2012, may result in an increase to these cost estimates.[96]

State Options Relating to Medicaid Expansion

Rather than accepting or rejecting the Medicaid expansion in its entirety, some states have discussed using the voluntary nature of the expansion to leverage additional federal flexibility for existing and expansion Medicaid populations. Actions by the 83rd Legislature will determine which direction the Texas Medicaid program will take.

Medicaid Provisions Already Implemented

HHSC has already implemented a number of smaller ACA requirements related to the Texas Medicaid program that were not part of the Supreme Court decision:

- Allowing children enrolled in Medicaid and CHIP to elect hospice care without waiving their rights to treatment for their terminal illness;
- Allowing freestanding birthing centers to be eligible for Medicaid reimbursement;
- Claiming federal matching funds for children of school and state employees who are enrolled in CHIP;
- Adding tobacco cessation counseling as a Medicaid benefit for pregnant women;
- Making changes to the drug rebate formulary; and
- Implementing several provisions related to Medicaid program integrity.[97]

Conclusion

Instead of providing answers, the Supreme Court's ruling on the ACA, particularly the Medicaid expansion, has created additional questions for states. States also continue to wait for additional

[95] E-mail from Health and Human Services Commission to Senate Committee on Health & Human Services staff (Nov. 20, 2012) (on file with Committee staff).
[96] *Id.*
[97] Senate Committee on State Affairs and Senate Committee on Health & Human Services joint hearing, Aug. 1, 2012 (testimony of Commissioner Thomas Suehs, Health & Human Services Commission at 5).

federal guidance on provisions with fast approaching implementation deadlines, such as the health insurance exchange and essential health benefits package. As a result, the 83rd Legislature will face a number of challenges and issues related to the ACA when it convenes in January 2013.

Charge No. 5

Study and make recommendations on statutory provisions and judicial decisions relating to the statute of limitations on a cause of action relating to consumer debt.

Background

There is no statute that specifically addresses the statute of limitations on a consumer credit card account. Courts have looked to two different subsections of Civil Practice & Remedies Code Section 16.004. Subsection (a) reads:[98]

> (a) A person must bring suit on the following actions not later than four years *after the day the cause of action accrues . . .*
>
> (3) debt;

However, Subsection (c) reads:[99]

> A person must bring suit against his partner for a settlement of partnership accounts, and must bring an action on an open or stated account, or on a mutual and current account concerning the trade of merchandise between merchants or their agents or factors, not later than four years after the day that the cause of action accrues. For purposes of this subsection, the cause of action accrues on the *day that the dealings in which the parties were interested together cease*.

As shown below, appellate courts in Texas vary in their interpretation of which subsection controls as it relates to consumer credit card accounts, thereby assigning different dates for the accrual of the statute of limitations.

Type	Period	Applicable Statute of Limitations	Triggering Event
Breach of Contract	4 years	Civ. Prac. & Rem. Code § 16.004(a)	At time of breach[100]
Debt	4 years	Civ. Prac. & Rem. Code § 16.004(a)(3)	Date money was borrowed[101]
Open Account	4 years	Civ. Prac. & Rem. Code § 16.004(c)	Dealing between parties cease[102]
Account Stated	4 years	Civ. Prac. & Rem. Code § 16.004(c)	Dealing between parties cease[103]

[98] TEX. CIV. PRAC. & REM CODE ANN. § 16.004(a) (Vernon 2002) (emphasis added).
[99] TEX. CIV. PRAC. & REM CODE ANN. § 16.004(c) (Vernon 2002) (emphasis added).
[100] Matthiessen v. Shaefer, 900 S.W.2d 792, 796 (Tex. App.--San Antonio 1995, writ denied).
[101] Alice Roofing & Sheet Metal v. Halleman, 775 S.W.2d 869, 870 (Tex.App.--San Antonio 1989).
[102] Facility Insur. Corp. v. Employers Insur. of Wasuau, 357 F.3d 508, 513 (5th Cir. 2004).
[103] *Id. See also*, LTD Acquisitions v. Cook, 2011 WL 6134, 2011 Tex.App. LEXIS 20 (Tex.App.--San Antonio 2011).

Source: Michael J. Scott, Attorney at Law

The Committee's hearing on this issue clearly illustrated the conflict present in the courts as the witnesses providing testimony were unable to agree on which subsection controls the statute of limitations on a credit card account.[104] This disagreement, among both the witnesses and the courts, stems from the classification of a credit card account as a "debt" or an "open account," or whether the dispute is viewed as a breach of contract.

Discussion

The purpose of a statute of limitations is to establish a point of repose and to prevent the litigation of stale claims.[105] In a trial on an action to collect a credit card debt, questions of fact such as when the last payment was made or when the account was closed are appropriate. However, in the interest of judicial efficiency alone, the calculation of a statute of limitations should be a straight-forward act rather than a question of law to be answered by a court in each case brought before them. It is to the advantage of all parties involved to reduce confusion on this matter.

Credit card accounts that are the subject of a debt collection action have several dates of significance that are recorded across the credit industry. For example, the last charge on the account, the last payment on the account (full, partial, etc.), or the "charge off date" (180 days after the last payment is received).[106] Less defined is the date of breach of contract; while more case specific, it is also a more fact intensive question and provides parties less certainty prior to litigation.[107]

Recommendation

The Committee recommends that the Legislature take up and consider amendments to Section 16.004 of the Civil Practice & Remedies Code that provides for the following:

- Classification of a debt collection action under a credit card as either a "debt" or "open account";
- No change to the current four year statute of limitations; and
- Identification of a standard industry-wide recorded date as the trigger date for the accrual of the statute of limitations.

Charge No. 6

Examine establishing a workforce retention program or deferred retirement option plan (DROP) for Texas Department of Public Safety commissioned peace officers and whether any plan can be built with actuarially sustainable factors while meeting the needs of officers.

[104] Senate Committee on State Affairs hearing, Aug. 30, 2012 (testimony of Michael Scott, Texas Creditors Bar Association; Tracey Whitley, Texas Consumers).
[105] Kerlin v. Sauceda, 263 S.W.3d 920 (2008).
[106] Senate Committee on State Affairs hearing, Aug. 30, 2012 (testimony of Michael Scott, Texas Creditors Bar Association).
[107] Senate Committee on State Affairs hearing, Aug. 30, 2012 (testimony of Michael Scott, Texas Creditor Bar Association; Tracey Whitley, Texas Consumers).

Discussion

State employee benefits have long been a key workforce recruitment and retention tool. In lieu of significant salary adjustments, the State has relied on its benefit package over the past decade to continue to attract quality employees. Today, benefits compose approximately 32.3 percent of a state employee's total compensation.[108] As the salary component of compensation has become less competitive with other public entities and private sector employers, pressure to increase state benefits has become greater.

Agencies like DPS are currently experiencing recruitment and retention problems largely because direct compensation for Texas' law enforcement personnel is 20.6 percent below the seven largest law enforcement departments in the state.[109] Over the last five years, the Texas Department of Public Safety (DPS) has averaged annually more than 300 vacant officer positions and currently has more than 400 vacancies.[110]

Other state agencies are also experiencing retention problems. According to a recent report from the State Auditor's Office, state employee turnover rate for FY 2012 was 17.3 percent (the highest since FY 2008) with voluntary separations, including retirements, accounting for the majority (74.8 percent).[111] According to that same report, the lower an employee's salary, the more likely the employee was to leave state employment. Those earning less than $30,000 annually (approximately 25.4 percent of state agency employees) left state employment at even higher rates.

To address these issues, some have looked to targeted changes to the pension benefit structure, such as the creation of a deferred retirement option plan (DROP) as a way to become more competitive. Other ideas have also been offered that would alter various aspects of the public employee pension structure so as to become more competitive with the private sector.

In order to more fully evaluate these proposals, state lawmakers directed the Employees Retirement System (ERS) and the Teachers Retirement System (TRS) via a General Appropriations Act rider to research and report on the impact of potential changes to the retirement plans.[112] Pursuant to the rider, ERS and TRS delivered these studies to the

[108] Tex. State Auditor's Office, *A Report on State Employee Benefits as a Percentage of Total Compensation Report No. 12-705* (Feb. 2012).
[109] Tex. State Auditor's Office, *A Report on the State's Law Enforcement Salary Schedule (Salary Schedule C) for the 2014-2015 Biennium Report No. 13-702* (Oct. 2012).
[110] Dept. of Public Safety, *Legislative Appropriation Request for Fiscal Year 2014 and 2015* (Sept. 7, 2012).
[111] Tex. State Auditor's Office, *An Annual Report on Classified Employee Turnover for Fiscal Year 2012 Report No. 13-704* (Dec. 2012).
[112] Acts. 2011, 82nd Leg. R.S., ch. 1355, Art. IX § 18.03 ("Pension Plan Changes Study. Out of funds appropriated elsewhere in this Act, the Employees Retirement System and the Teacher Retirement System shall each individually report on the actuarial and fiscal impacts from potential changes to the state, university and school district pension plans as of August 31, 2011, including but not limited to: retirement eligibility; final average salary; benefit multiplier; and the creation of a hybrid plan that includes defined benefit and defined contribution features such as a two-part plan or a cash balance plan. The report shall be submitted to the Legislative Budget Board and the Governor no later than September 1, 2012. A pension plan study is required of the Employees Retirement System and the Teacher Retirement System only if the legislature does not otherwise implement actuarially significant

Legislative Budget Board and Governor on September 1, 2012. The agencies presented their findings to the Senate State Affairs Committee at a hearing on November 19, 2012.[113] Summaries of the reports were provided by both agencies and are included in the Appendix. In addition, both reports are available on each agency's respective websites.[114]

Charge No. 7

Examine the feasibility of implementing Health Reimbursement Accounts and Medicare exchanges for Medicare eligible participants currently covered by and receiving health coverage through the Employees Retirement System, the Teachers Retirement System, the University of Texas, and Texas A&M University. Identify any cost savings to the state and to retirees that would occur under such a plan.

Discussion

Healthcare costs are a major budget driver each biennium. In addition to Medicaid and CHIP, healthcare for state employees and retired teachers drives a need for significant dollars.

For the 2014-15 biennium, the Employees Retirement System (ERS) has reported a need of approximately $3.1 billion in ALL FUNDS to cover costs associated with the current program design. Included in that request is funding to address an eight percent increase in healthcare costs. This projected trend is generally consistent with ERS' costs trend over the past several biennia. However, because appropriations have generally not fully covered these projected expenditures, once realized, ERS has had to make benefit design changes and utilize reserve fund balances to align revenue with costs. At the beginning of FY 2011, ERS implemented benefit design changes that shifted approximately $143 million worth of program costs onto plan participants.

At the Teacher Retirement System (TRS), TRS-Care, the healthcare program for retired educators, the State is statutorily required to appropriate one percent of active member payroll. To fund this obligation, the State will need to appropriate approximately $500 million in ALL FUNDS for the 2014-15 biennium. The State's one percent contribution, when combined with payments made by local employers (0.55 percent of payroll), active members (0.65 percent of payroll), and premiums paid by retirees, has been enough to cover program costs for a decade without benefit adjustments or premium increases. However, the agency is requesting supplemental funding of $110 million in fiscal year 2015 to cover expected costs in excess of available revenue. According to the agency, this is because of a misalignment of funding tied to

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changes that increase the total plan contribution rate for the pension plans; make plan design changes to the current defined benefit plan structure for the pension plans; or establish a new plan structure for the pension plan in the form of a hybrid pension plan. The Legislative Budget Board will confirm for each agency by September 1, 2011 whether or not these conditions have been met, and if a pension plan study is required.").

[113] Senate Committee on State Affairs hearing (Nov. 19, 2012) (testimony of Ann Bishop, Employees Retirement System and Brian Guthrie, Teacher Retirement System). *See also* Appendix to Charges 6 and 7.

[114] Employees Retirement System of Texas, *Updates on Legislative Implementation, Interim Benefits Studies, and Legislative appropriation Request* (Nov. 2012) http://www.ers.state.tx.us/About_ERS/Reports/; Teacher Retirement System of Texas, *Senate Committee on State Affairs* (Nov. 19, 2012) http://www.trs.state.tx.us/info.jsp?&page_id=/about/legislative_studies.

payroll which grows generally at five percent, with medical and prescriptions drug costs typically increasing at eight to ten percent per year.[115]

To help mitigate these cost increases at ERS and TRS, the agencies and the State have implemented a variety of cost containment strategies over the past decade. When faced with finding new ideas and options for maintaining the viability of these programs, the agency and the Legislature often struggle to evaluate the full impact of many of the concepts offered.

In order to more thoroughly evaluate these types of proposals, state lawmakers directed ERS and TRS via General Appropriations Act riders to research and report on the impact of potential plan design changes and other modifications that would improve the long-term sustainability of these health insurance programs.[116]

Pursuant to the riders, ERS and TRS delivered these studies to the Legislative Budget Board and Governor on September 1, 2012. The agencies presented their findings to the Senate State Affairs Committee at a hearing on November 19, 2012.[117] A summary of the report findings was provided by both agencies and is included in the Appendix X. In addition, both reports are available on each agency's respective website.[118]

Charge 8, Part 1

Consider the costs and benefits of the creation of liability protection for private companies and individuals when commissioned by the Texas Forest Service to assist in fighting a fire that is not on the company's or individual's own land.

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[115] Teacher Retirement System¸ *TRS-Care Sustainability Study* (Sept. 1, 2012) http://www.trs.state.tx.us/about/documents/trscare_sustainability_study.pdf.

[116] Acts. 2011, 82nd Leg. R.S., ch. 1355, Art. I, Employees Retirement System, Rider 13 ("Group Insurance Program Study. Out of amounts appropriated elsewhere in this Act for the Group Insurance Program, the Employees Retirement System shall conduct a study of the current group insurance program that includes, but is not limited to, the current plan design and funding of the group insurance program. The study shall include potential plan design and other changes that would improve the long-term sustainability of the group insurance program. A report of the study shall be submitted by the Employees Retirement System to the Legislative Budget Board and the Governor no later than September 1, 2012."); Acts. 2011, 82nd Leg. R.S., ch. 1355, Art. III , Teacher Retirement System, Rider 16 ("Texas Public School Retired Employees Group Insurance Program Study. From administrative funds appropriated above, the Teacher Retirement System shall conduct a study of the current Texas Public School Retired Employees Group Insurance Program. The study shall include a comprehensive review of potential plan design and other changes that would improve the long-term sustainability of the health insurance program. A report of the findings and recommendations shall be submitted by the Teacher Retirement System to the Legislative Budget Board and the Governor no later than September 1, 2012.").

[117] Senate Committee on State Affairs hearing (Nov. 19, 2012) (testimony of Ann Bishop, Employees Retirement System and Brian Guthrie, Teacher Retirement System). *See also* Appendix to Charges 6 and 7.

[118] Employees Retirement System of Texas, *Updates on Legislative Implementation, Interim Benefits Studies, and Legislative appropriation Request* (Nov. 2012) http://www.ers.state.tx.us/About_ERS/Reports/; Teacher Retirement System of Texas, *Senate Committee on State Affairs* (Nov. 19, 2012) http://www.trs.state.tx.us/info.jsp?&page_id=/about/legislative_studies.

Background

Texas firefighters battled 22,541 wildfires that scorched more than 3.8 million acres of Texas land during a nine-month period in 2011.[119] Unprecedented drought conditions, coupled with high temperatures, created record breaking fire dangers that stretched the state's wildfire fighting resources.

During extreme wildfire conditions, the Texas A&M Forest Service (TFS) regularly requests assistance from large private landowners, also known as cooperators, to help battle the blazes.[120] These private landowners represent diverse industries and lands including timberland investment management organizations (TIMO's),[121] the petrochemical industry and large ranch and farm operations.[122] Most of these private landowners have access to their own firefighting resources including radios, fire resistant clothing and fire shelters.[123] In the past, TFS has provided fire training to these private landowners. TFS is currently in the process of establishing operating and training agreements with some of the larger potential cooperators.[124]

These private landowners have expressed civil liability concerns if they are asked to assist with fire management off their private property. Some of the liability concerns include having to repair fences, timber damage, and destruction to the land caused by firefighting equipment.[125] Due to these concerns, many of the private landowners have standing policies to only provide fire management assistance to TFS if the fire danger is located on their own property.[126] The Committee heard testimony that a wildfire in September 2011, in Northeast Texas, could have been half of its final size had all available private resources been utilized.[127]

Due to the belief that they are not protected from civil action under current law, private landowners would like the Texas Civil Practice and Remedies Code strengthened to clarify civil immunity for private landowners assisting with wildfire management.

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[119] Office of The Governor, *Wildfire Impact on Texas* http://governor.state.tx.us/wildfires/ (last visited Dec. 10, 2012).

[120] The Texas A&M Forest Service assumes direction of all forest interests and all matters pertaining to forestry within the jurisdiction of the state. *See* The Texas A&M Forest Service, *About TFS* http://txforestservice.tamu.edu/main/ (last visited on Dec. 20, 2012).

[121] "A TIMO is an organization that finds, acquires and manages timberland properties on behalf of institutional investors. The timberland assets are typically held as part of an investor's overall diversification strategy." Senate Committee on State Affairs hearing, Aug. 30, 2012 (testimony of David Green, Hancock Forest Management).

[122] Senate Committee on State Affairs hearing, Aug. 30, 2012 (testimony of Don Galloway, Texas A&M Forest Service).

[123] Senate Committee on State Affairs hearing, Aug. 30, 2012 (testimony of David Green, Hancock Forest Management).

[124] Senate Committee on State Affairs hearing, Aug. 30, 2012 (testimony of Don Galloway, Texas A&M Forest Service).

[125] Senate Committee on State Affairs hearing, Aug. 30, 2012 (testimony of David Green, Hancock Forest Management).

[126] *Id.*

[127] Senate Committee on State Affairs hearing, Aug. 30, 2012 (testimony of David Green, Hancock Forest Management) (HFM had crews that wanted to assist with the Bear Creek Fire in Marion and Cass Counties, but were unable to work off HFM property per company policy).

Discussion

Section 79.003 of the Texas Civil Practice and Remedies Code provides civil immunity protection for individuals who are asked by an authorized representative of a local, state or federal agency to help respond to a disaster.[128]

> **Sec. 79.003. DISASTER ASSISTANCE**. (a) Except in a case of reckless conduct or intentional, wilful, or wanton misconduct, a person is immune from civil liability for an act or omission that occurs in giving care, assistance, or advice with respect to the management of an incident:
>
> (1) that is a man-made or natural disaster that endangers or threatens to endanger individuals, property, or the environment; and
>
> (2) in which the care, assistance, or advice is provided at the request of an authorized representative of a local, state, or federal agency, including a fire department, police department, an emergency management agency, and a disaster response agency.
>
> (b) This section does not apply to a person giving care, assistance, or advice for or in expectation of compensation from or on behalf of the recipient of the care, assistance, or advice in excess of reimbursement for expenses incurred.[129]

Proponents of strengthening liability protection for private landowners assisting with wildfire management suggest adding additional definitions to section 79.001 of the Texas Civil Practice and Remedies Code. Many private landowners believe the current code does not include adequate definitions and they propose including definitions for "man-made" and "natural disaster".[130] Further, proponents suggest language clean-up in section 79.003 of the Texas Civil Practice and Remedies Code to clarify civil immunity for disaster assistance.[131]

Currently, private landowners are protected from civil action under Sec. 79.003 of the Civil Practice and Remedies Code as long as the landowners are asked to help respond to a disaster by a local, state or federal agency - this includes TFS.[132] Testimony received by the Committee suggested that private landowners would not respond to a fire off their property unless they were asked for assistance by TFS.[133]

Statutory changes may provide further clarification of liability protection to some individuals, but do not appear to be necessary to achieve liability protection for private landowners if they are asked by TFS to assist in wildfire management.

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[128] TEX. CIV. PRAC. & REM. CODE ANN. § 79.003 (Vernon 2003).
[129] *Id.*
[130] *See* Appendix to Charge 8.
[131] *Id.*
[132] TEX. CIV. PRAC. & REM. CODE ANN. §79.003 (Vernon 2003).
[133] Senate Committee on State Affairs hearing, Aug. 30, 2012 (testimony of David Green, Hancock Forest Management).

Recommendation

The Legislature should continue to investigate and weigh this issue to ensure that the language in the Texas Civil Practice and Remedies Code sufficiently provides liability protection to private landowners when they are asked for fire management assistance by a local, state or federal agency.

Charge 8, Part 2

Examine whether state policy should prohibit an employer from terminating an employee who is a volunteer firefighter on the grounds that the employee missed work because the employee was responding to an emergency. Identify any appropriate limitations that should apply to such a policy.

Background

The State Fireman's and Fire Marshals' Association (SFFMA) has worked for years to institute a statewide policy to prevent employers from terminating or penalizing an employee who misses work because the employee was acting as a volunteer firefighter and responding to an emergency.

In 2007, H.B. 1205 by Rep. Jim Keffer, passed both the House and Senate Chambers.[134] The bill would have protected volunteer emergency responders from being discriminated against by their employers if they were to miss work while responding to an emergency.[135] The legislation was modeled after the policy of the Texas National Guard.[136] Governor Rick Perry vetoed the bill articulating that it was a government mandate and that it unnecessarily created a new civil cause of action.[137]

Discussion

Seventy-seven percent of the State of Texas is protected by volunteer fire departments.[138] Their dedicated and voluntary service is crucial to the safety of Texans. There are few documented reports of volunteer firefighters being discriminated against or threatened with termination due to responding to an emergency.[139] If the Legislature decides to address this issue, stipulations need to be included to balance the rights of business owners and volunteer firefighters.

SSFMA and various business groups have discussed including the following stipulations in potential legislation: volunteer firefighter needs to file and notify their employer that they are a volunteer firefighter; any mandate would not apply to employers who employ less than 50

[134] Acts 2007, 80th Leg., ch. 1195.
[135] *Id.*
[136] Senate Committee on State Affairs hearing, Aug. 30, 2012 (testimony of Bill Gardner, State Fireman's and Fire Marshals' Association).
[137] Veto Message of Gov. Perry, Tex. H.B. 1205, 80th Leg., R.S. (2007).
[138] Senate Committee on State Affairs hearing, Aug. 30, 2012 (testimony of Bill Gardner, State Fireman's and Fire Marshals' Association).
[139] *Id.*

employees; and the employee would only be eligible for such leave for a total of 14 days in any calendar year.[140]

Recommendation

Due to the fact that there are few documented instances of voluntary emergency responders being discriminated against by their employers, the Committee suggests the Legislature, business community and SFFMA continue to work together and monitor this issue.

Charge No. 9

Examine the effectiveness of the Private Real Property Rights Preservation Act (Chapter 2007, Government Code), and whether it should apply to municipalities.

Background

In 1995 the Texas Legislature joined the property rights movement by enacting the Private Real Property Rights Preservation Act.[141] The Act requires the applicable governing body to conduct a Takings Impact Assessment prior to enforcing a regulation that could impact the value of private real property; and allows a property owner whose property is diminished in value at least 25 percent by a regulation to sue the governmental entity. The Act generally does not apply to municipalities.[142]

Inverse condemnation occurs when a public entity takes property for public use without proper condemnation proceedings, and the owner sues to recover some type of compensation. The taking may be the result of a direct physical taking of or interference with the use of the property. Witnesses testifying before the Committee agreed that the provisions of the Act allowing a property owner to sue in the event their property is diminished in value at least 25 percent are a workable solution to inverse condemnation by counties and other political subdivisions.[143] Additionally, the Act is effective in increasing communication between governing bodies and members of their communities.[144]

A private property owner's protections against an unlawful taking by political subdivisions are not limited to those included in the Act. Article I, Section 17 of the Texas Constitution provides that, "no person's property shall be taken, damaged or destroyed for or applied to public use without adequate compensation being made…." From this provision, the Legislature has adopted a number of protections and procedures surrounding the power of eminent domain.[145]

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[140] Senate Committee on State Affairs hearing, Aug. 30, 2012 (testimony of Bill Gardner, State Fireman's and Fire Marshals' Association and Cathy Dewitt, Texas Association of Business).
[141] Acts 1995, 74th Leg., ch. 517; TEX. GOV'T CODE ANN. ch. 2007 (Vernon 2008).
[142] TEX. GOV'T CODE ANN. § 2007.003 (Vernon 2008).
[143] Senate Committee on State Affairs hearing Dec. 10, 2012 (testimony of Jim Allison, County Judges & Commissioners Association; Bill Peacock, Texas Public Policy Foundation; Seth Terry, Texas Farm Bureau; Dan Wheelus).
[144] *Id.*
[145] *See* TEX. GOV'T CODE ANN. ch. 2206 (Vernon 2005 & Supp. 2012).

Additionally, Texas courts have upheld common law principals of inverse condemnation.[146] All of these apply to municipalities.

Applicability of the Act to Municipalities

Municipalities are Texas' local governing bodies and are arguably the governmental entities closest to their constituents; thus, the majority of governmental actions affecting property owners are undertaken by municipalities.[147] This is because a municipality has the power to adopt and enforce local ordinances including zoning restrictions.[148] Zoning ordinances govern a variety of issues, such as the placement of pawnshops or sexually oriented businesses, the height or number of stories for buildings, and the designation of places of historical, cultural, or architectural significance.[149]

Municipalities are not required to adopt zoning ordinances; however, they do so at the behest of their citizens and their desire to shape the development of their community. Furthermore, the exemption for municipalities in the Act does not mean that a municipality's zoning power goes unchecked. As mentioned above, municipalities are required to abide by eminent domain statutes as well as common law prohibitions against inverse condemnation.

One specific type of taking generally associated with municipalities is a "regulatory taking." A regulatory taking may occur when a regulation, such as a zoning ordinance, rises to the level of a landowner being deprived of the economically beneficial use of their property. Courts recognize a property owner's right to sue a governmental entity, including a municipality, if they believe a regulatory taking has occurred. The Supreme Court has held that a regulatory takings case is heavily fact intensive and the court must consider all of the surrounding circumstances.[150]

Similar to zoning ordinances, some landowners are concerned about a municipality's ability to obtain conservation easements.[151] Pursuant to Chapter 183 of the Natural Resources Code, a municipality may obtain an easement designed to retain or protect "natural, scenic or open-space" property; protect natural resources; maintain or enhance air or water quality; or preserve property with historical, architectural, archeological, or cultural significance.[152] Such easements may be secured in the same manner as any other easement, including by gift or by eminent domain.[153]

In the event a municipality adopts a policy towards preserving property through conservation easements, landowners impacted by those easements are compensated for the taking with

[146] *See e.g.* Singer v. State, 2012 WL 6725876 (Tex.App.--El Paso 2012).
[147] Senate Committee on State Affairs hearing Dec. 10, 2012 (testimony of Bill Peacock, Texas Public Policy Foundation).
[148] *See* TEX. LOCAL GOV'T CODE ANN, Title 7 *Regulation of Lane Use, Structures, Businesses, and Related Activities.*
[149] TEX. LOC. GOV'T CODE ANN. § 211.003 (Vernon 2008).
[150] *See e.g.* Hallco Texas v. McMullen County, 221 S.W.3d 50 (2007); Sheffield Development Co. v. Glenn Heights, 140 S.W.30 660, 672 (2004).
[151] Senate Committee on State Affairs hearing, Dec. 10, 2012 (testimony of Dan Wheelus).
[152] TEX. NAT. RES. CODE ANN. § 183.001(1) (Vernon 2011).
[153] TEX. NAT. RES. CODE ANN. § 183.002(a) (Vernon 2011).

taxpayer dollars. Presumably, the governing body of a municipality would only expend their constituents' money to effectuate the conservation policies supported by the residents. If they are not in fact supported by the residents, the council members will undoubtedly be replaced by others who are more representative of the views of a majority of the municipality's residents.

Recommendation

The Committee makes no recommendations as to the expansion of the Private Real Property Rights Act to municipalities.

Expanding the Act to include municipalities would place an undue, and in some circumstances impossible, burden on municipalities. It would not result in a workable, balanced solution to address alleged regulatory overreach by municipalities.

Municipalities are governed by elected officials who then adopt ordinances and obtain easements consistent with the desires of their constituents. These actions are the essence of local control and it would be inappropriate for the Legislature to enact statutes which interfere with local authority.

Charge No. 10

Monitor the implementation of legislation addressed by the Senate Committee on State Affairs, 82nd Legislature, Regular and Called Sessions, and make recommendations for any legislation needed to improve, enhance, and/or complete implementation. Specifically, monitor the following:

- *implementation of SB 100, relating to the implementation of the MOVE Act, and the impact on local and statewide elections and military voters;*
- *implementation of the Interstate Health Care Compact.*

Implementation of S.B. 100

The 82nd Legislature passed S.B. 100 amending the Election Code to implement the federal Military Overseas Voters Empowerment Act (MOVE Act).[154] The two central pieces of the MOVE Act required that all ballots be sent to voters 45 days prior to the election and that upon request, a qualified voter may receive their blank ballot via e-mail. In order to comply with the new 45-day deadline, S.B. 100 modified Texas' election calendar by moving the primary filing deadline to the third Monday in December and moving the primary runoff to the fourth Tuesday in May. The bill also reduced the burden on County election officials by removing their obligation to conduct a May uniform election in even-numbered years.

45-Day Deadline

The elections held in 2012 were the first under the post-MOVE Act election calendar. However, due to extensive litigation relating to decennial redistricting, the election calendar was modified by a court order which moved the primary to May 29, 2012 and the primary run-off election to

[154] Acts 2011, 82nd R.S., ch. 1318.

July 31, 2012. In recognition of the Act, the Court included the extended timelines in the temporary calendar.[155]

Most of the counties in Texas were able to comply with the new 45-day deadline for the primary, runoff and general elections. A handful of counties were unable to mail their ballots on the required Saturday, however, they were able to send them out on the following Monday. Additionally, those counties were able to compensate by allowing additional time for the return of ballots.[156]

E-mailed Ballots

Both the counties' and voters' experiences with the new e-mailed ballots revealed practical hurdles inherent in any new process. The first hurdle was the increase in paperwork that was to be processed by both the election officials as well as the voters. From the election official point of view, the new requirements increased the number of man hours necessary to handle mail-in ballots. Election officials were faced with additional tasks such as scanning in ballots and other attachments such as the cover letter, instructions and mailing envelope, as well as tracking the requests and transmittals of ballots. The Secretary of State's Office adopted guidelines for the new process, however, each county implemented a process best suited to their circumstances.[157]

As presented at the Committee hearing, the mail-in ballot process includes several steps that must be done in a specific order to maintain the integrity of the ballot.[158] From the voter's perspective, any confusion inherent in a mail-in ballot was amplified when the process was transferred to an electronic format. This was compounded when some overseas voters, especially military personnel, had difficulty receiving attachments or printing out their ballot due to software issues or availability of paper and/or envelopes.[159] However, any voter who communicated their problems to the Secretary of State's Office or another election official was eventually able to open and print their ballot.[160]

Testimony before the Committee noted that the Secretary of State's Office is conferring with County Clerks and Election Administrators across the state to develop new procedures to assist both election officials and voters with this new process.[161] The Secretary of State's Office is also working with military bases in Texas to increase communication about this new process to the voters via the voting assistance officers provided to assist military personnel with voting.[162]

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[155] Order, Perez v. Texas, No. 11-CV-360-OLG-JES-XR (W.D.Tex. Mar 1, 2012).
[156] Senate Committee on State Affairs hearing, Dec. 10, 2012 (testimony of Keith Ingram, Office of the Secretary of State).
[157] Senate Committee on State Affairs hearing, Dec. 10, 2012 (testimony of Keith Ingram, Office of the Secretary of State; Dana DeBeauvoir, Travis County Clerk).
[158] *Id.*
[159] *Id.*
[160] Senate Committee on State Affairs hearing, Dec. 10, 2012 (testimony of Keith Ingram, Office of the Secretary of State).
[161] Senate Committee on State Affairs hearing, Dec. 10, 2012 (testimony of Keith Ingram, Office of the Secretary of State; Dana DeBeauvoir, Travis County Clerk).
[162] *Id.*

Recommendations

The Committee makes no substantive recommendations. As noted above however, the Committee does recommend amendments to Election Code §§ 172.054 and 202.004 to make conforming changes. These sections were inadvertently left out of S.B. 100.

APPENDIX TO CHARGE 1

TESTIMONY
VICKIE SUTTON
PAUL WHITFIELD HORN PROFESSOR OF LAW,
TEXAS TECH UNIVERSITY SCHOOL OF LAW
BEFORE THE COMMITTEE ON STATE AFFAIRS
CHAIRMAN, SENATOR ROBERT DUNCAN
PUBLIC HEARING
9:00 AM, MONDAY, DECEMBER 10, 2012

State sovereignty was at the heart of the controversy to ratify the U.S. Constitution, and the Tenth Amendment was the solution to ensure that states were empowered to respond where the people lived, not be governed by a remote centralized and powerful government. That same idea persisted from the Articles of Confederation to the Constitution. Agreement to ratify the U.S. Constitution was based on the promise that a Bill of Rights including the Tenth Amendment concept would be passed later. Fortunately, they were all true to their promises and that may be the biggest miracle of the Constitution. Here is the text of the Tenth Amendment: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

Some Constitutions like the Canadian one, expressly describes the powers of the provinces and dictate that all other powers are held by the federal government. The corollary is true for the U.S. Constitution. The powers of the federal government are expressly described, while all other powers "not delegated" to Congress belong to the states or the individuals. The list of enumerated powers of the federal government is in Art. 1, Sec. 8:

U.S. Const., Art. 1, Section 8
1: The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States; but all Duties, Imposts and Excises shall be uniform throughout the United States;
2: To borrow Money on the credit of the United States;
3: To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes;
4: To establish an uniform Rule of Naturalization, and uniform Laws on the subject of Bankruptcies throughout the United States;
5: To coin Money, regulate the Value thereof, and of foreign Coin, and fix the Standard of Weights and Measures;
6: To provide for the Punishment of counterfeiting the Securities and current Coin of the United States;
7: To establish Post Offices and post Roads;
8: To promote the Progress of Science and useful Arts, by securing for limited Times to Authors and Inventors the exclusive Right to their respective Writings and Discoveries;
9: To constitute Tribunals inferior to the supreme Court;
10: To define and punish Piracies and Felonies committed on the high Seas, and Offences against the Law of Nations;
11: To declare War, grant Letters of Marque and Reprisal, and make Rules concerning Captures on Land and Water;
12: To raise and support Armies, but no Appropriation of Money to that Use shall be for a longer Term than two Years;

13: To provide and maintain a Navy;
14: To make Rules for the Government and Regulation of the land and naval Forces;
15: To provide for calling forth the Militia to execute the Laws of the Union, suppress Insurrections and repel Invasions;
16: To provide for organizing, arming, and disciplining, the Militia, and for governing such Part of them as may be employed in the Service of the United States, reserving to the States respectively, the Appointment of the Officers, and the Authority of training the Militia according to the discipline prescribed by Congress;
17: To exercise exclusive Legislation in all Cases whatsoever, over such District (not exceeding ten Miles square) as may, by Cession of particular States, and the Acceptance of Congress, become the Seat of the Government of the United States, and to exercise like Authority over all Places purchased by the Consent of the Legislature of the State in which the Same shall be, for the Erection of Forts, Magazines, Arsenals, dock-Yards, and other needful Buildings;--And
18: To make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers, and all other powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof.

Federal Powers that can Limit State Sovereignty

Federalism is the model which describes the shared powers of state, tribal and federal governments. To be workable, the structure of the Constitution provides for the balance of powers between governments, with an objective of limited federal powers. I will focus on the federal powers that limit state sovereignty and some of the approaches for avoiding federal encroachment on state sovereignty.

In the Constitutional structural design, the powers of Congress which can limit state sovereignty are (1) the Commerce Clause authority; (2) the taxing and spending power; (3) the Supremacy Clause and its power of preemption; (4) intergovernmental immunities; and (5) treaty power. These powers can be used with the "necessary and proper clause" and similarly with the "general welfare" clause in the preamble.

Commerce Clause Power

From the early 1900s to 1936, with the action by the federal government to attempt to reach nationwide problems, state sovereignty was challenged in areas of labor law and commercial activity, but the court limited Congress's power. *Hammer v. Dagenhart* (1918) and *Schechter Poultry v. United States* (1935) were successful challenges to limit federal expansion of power. However, after 1936 and President Roosevelt's New Deal, the expansion of federal power began, and in the most unusual of actions by the U.S. Supreme Court, it overruled *Dagenhart* in *United States v. Darby* (1941) giving the federal government control over labor standards. Then in the landmark case, *Wickard v. Filburn* (1942), the court upheld the federal statute which prohibited the practice of home grown wheat on the basis that it had an effect on interstate commerce about which Congress could regulate. The 1960s with civil rights legislation and the landmark case *Heart of Atlanta Motel, Inc. v. United States* (1964) found that for example, the interstate sale of bread was affected by the racially discriminatory actions of hotel managers, upholding the enforcement of the Civil Rights Act of 1964 against individuals, based on Commerce Clause power. Even the Mann Act prohibiting the interstate transport of women by men, which clearly was admittedly legislating to remedy a moral wrong, was based on the Commerce Clause. It seemed that the U.S Supreme Court found no set of facts that would limit Congress's power to infringe on state sovereignty based on the expansive definition of the

Commerce Clause. This continued until 1995 in United States v. Lopez where the U.S. Supreme Court found that Congress had exceeded its authority when it legislated the possession of guns within a particular zone of school districts and the federal law was found to be unconstitutional. This was the beginning of a new era in Commerce Clause jurisprudence. It was followed by *United States v. Morrison* (2000) which found unconstitutional the federal civil remedy for the victims of gender-motivated violence, finding it too removed from having a substantial effect on interstate commerce.

The interpretation of the Commerce Clause, finding a "dormant Commerce Clause" power tested the limits of state power to legislate where legislation or actions placed a burden on interstate commerce. State laws which were determined to burden interstate Commerce were found to be unconstitutional based on Commerce Clause power. Further, the court found that just because the federal government had not regulated in a particular area, it did not mean that it was up for jurisdictional capture by states to regulate and fill any gap.

The shift in federalism which saw the passage of federal environmental legislation of the 1970s and 1980s was all based on Commerce Clause authority. When *United States v. Lopez* signaled a shift in now reigning in Congress's Commerce Clause authority, several environmental statutes were challenged including the Clean Water Act, wetlands section which had reached into areas that were traditional state property law areas. However, the court did not find any of these statutes to exceed Congress's authority under the Commerce Clause.

An area of traditional state authority which has seen great expansion of federal control is the forced acceptance by states of hazardous waste despite the state's legitimate and traditional role in rejecting it based on public health and safety governmental purposes, a traditional state authority, beginning a line of cases with *Philadelphia v. New Jersey* (1978). The U.S. Supreme Court held that this unconstitutionally burdens interstate commerce, and that one state's hazardous waste could not be distinguished from another state's hazardous waste. I would propose that if a state could make this distinction, for example with a unique treatment requirement, it would present a formidable obstacle to finding that the state could not limit the flow of hazardous waste from other states into its jurisdiction.

Taxing and Spending Power

Taxing and spending power has been recognized as a "necessary and proper" means to enforce its regulatory powers as a way to raise revenue which carries out its powers. It was not until the federal power based on the Commerce Clause began to be reined in by the U.S. Supreme Court, did the federal government turn to the taxing and spending power with renewed importance.

The most important case to use the taxing power was in the U.S. Supreme Court's interpretation of the Patient Protection and Affordable Care Act as a tax, despite the text of the Act itself describing the payment as a penalty against the individual who failed to obtain health insurance, in *National Federation of Independent Business v. Sebelius* (2012). This is a landmark opinion in part because of its focus on *mandating* an activity, rather than *regulating* an activity. But even more unusual is that the basis is the Necessary and Proper Clause as "necessary" to the Act's insurance reforms, but arguably not a "proper" exercise of power.

The spending power was limited in *United States v. Butler* (1946) to use the grant of power to tax and spend for the general national welfare by confining those legislative activities

to the enumerated powers of Congress. This Act sought to raise farm prices by reducing supply and collected benefit payments to the farmers from a tax on processors of that commodity. This, the court opined, was not among the enumerated powers.

The case which draws the line between constitutional power and coercion is where the federal government power relies on the dependency on federal grants. In *South Dakota v. Dole* (1987), the federal government used what some might call coercion to compel states to comply with a federal requirement to limit the age for purchase or public possession of alcoholic beverages to twenty-one. Failure to pass legislation to effect this standard would result in the withholding of 5% of federal highway funds to the state. The U.S. Supreme Court held that the spending power must be in pursuit of the general welfare and for one of the main purposes of highway funds – safe interstate travel. The Court opined that "the spending power may not be used to induce the States to engage in activities that would themselves be unconstitutional," and concluded that making the drinking age 21 would not violate the constitutional rights of anyone.

So what is coercion? The fact that the withholding of funds which amounted to 5% of total highway funds seemed to factor into the weakness of any perceived coercion. The transformation of the Medicaid program in *NFIB v. Sebilius* involved 10% of the state budget, and the Court opined that while it was not clear where coercion begins but this was certainly far beyond that limit.

The Supremacy Clause and Preemption

The Supremacy Clause stands alone as a federal power to regulate in areas with a national scope or purpose. Preemption occurs where state laws interfere with federal laws and one of three conditions exist: (1) federal legislation expressly intends to preempt state law; (2) federal law preempts state law whenever there is a conflict; and (3) federal law preempts state law, even if the federal law conflict does not exist, if the federal law has manifested the intent to occupy the field in which it is regulating.

Intergovernmental immunities

A line of U.S. Supreme Court cases attempted to draw a line between activities that are regulated by the federal government and those by the state government, where the activities are traditionally in the area of state government. In *Garcia v. San Antonio Metropolitan Transit Authority* (1985), the U.S. Supreme Court upheld federal labor standards against a local municipality; abandoning the "traditional" state activity standard. The test to emerge seems to be whether the action of the federal government is "destructive to state sovereignty" and abandoned the criteria for traditional state activities. The Court opined that this expanded power of the federal government to regulate in areas that may have been state activities was a process because of the changing activities of states.

Treaties as Congressional Power to limit State Sovereignty

The landmark case for this power is *Missouri v. Holland* (1920), and is worth discussing because as one power may become more limited, another power may become useful to Congress. Such may be the case for the future of using treaties as Congressional powers. Art. 6 declares treaties to be the law of the land, requiring Senate ratification, and authorizes Congressional implementation through the "necessary and proper" means to implement those powers. In *Missouri v. Holland*, Congress sought to implement the Migratory Bird Treaty, which required imposing protection of the birds on state sovereign jurisdiction over the land where the birds flew. While the court raised concerns about the Tenth Amendment, they found nothing about the Tenth Amendment that would forbid this Congressional action. The court opined that as long as the treaty did not give Congress the power to do something it could otherwise not do, then implementing the treaty, if a legal one, was within the power of Congress. With the increasing participation of the United Nations in international law and the adoption of international law in opinions by the U.S. Supreme Court, this may be another power on the horizon for Congressional empowerment.

Conclusion

The Tenth Amendment jurisprudential law has interpreted the Tenth Amendment to be a weak protection to state sovereignty where the question asked is not, whether state sovereignty is infringed by this legislation; but rather the question the courts are asking is the corollary --- whether anything in the Tenth Amendment forbids the legislation. This is probably the wrong question since the Tenth Amendment is not a prohibitory, proscriptive directive.

APPENDIX TO CHARGE 2

Texas Department of Insurance
Commissioner of Workers' Compensation, Mail Code MS-1
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609
512-804-4000 • 512-804-4001 fax • www.tdi.state.tx.us

December 10, 2012

The Honorable Robert Duncan, Chair
Members, Senate State Affairs Committee

Dear Chairman Duncan and Members:

I'm pleased to provide you with information regarding the various workers' compensation interim charges before the committee in anticipation of the December 10, 2012 hearing, as well as provide you with an overall summary of the state of the Texas workers' compensation system.

It's been seven years since the 2005 landmark House Bill (HB) 7 legislative reforms and two years since the adoption of the Texas Department of Insurance, Division of Workers' Compensation's (TDI-DWC's) Sunset legislation (HB 2605), and the Texas workers' compensation system has shown significant improvements in a variety of areas, including injury rates, employer participation, claims costs, return-to-work outcomes, access to care, and insurance rates and premiums. In fact, with the anticipated adoption of one rule in December, TDI-DWC will have fully implemented all of its Sunset recommendations as well as fully implemented all other workers' compensation legislation from last session.

Here is a brief summary of some of the key trends for the Texas workers' compensation system:

Injury Rates and Frequency of Filed Workers' Compensation Claims

- Injury rates continue to decline and Texas continues to be lower than the national average.
- Between 2004 and 2011, the nonfatal occupational injury and illness rate in Texas decreased 27 percent from 3.7 to 2.7 injuries per 100 full-time employees.
- Despite a growing workforce in Texas, between 2004 and 2011, the number of workers' compensation claims filed with TDI-DWC decreased 22 percent.

Workers' Compensation Rates and Premiums and Employer Participation in the Texas Workers' Compensation System

- Workers' compensation insurance rates have come down almost 50 percent since 2003, making Texas more competitive economically with other states.

- Average workers' compensation premiums have come down over 50 percent from a high of $2.85 per $100 of payroll to $1.38 per $100 of payroll in 2010.
- As a result of rate decreases, more employers have opted to participate in the system. The percentage of private year-round Texas employers with workers' compensation coverage has improved from 62 percent in 2004 to 67 percent in 2012, while the percentage of Texas employees covered by workers' compensation has increased from 76 percent to 81 percent over the same time.

Medical Costs

- Medical costs, which were a primary driving force behind the 2005 and previous legislative reforms, have declined. According to a 16-state comparison of claims with more than 7 days of lost time by the Workers' Compensation Research Institute (WCRI), in 2001, Texas was among the highest nationally in terms of medical costs per claim. By 2010, Texas was almost 23% below the median cost of those same 16 states, including Florida, Pennsylvania, Louisiana and Illinois.
- The average professional and hospital medical cost per claim (one-year post-injury) has generally stabilized since 2005, despite continuing medical cost inflation. After accounting for medical inflation, the average medical cost per claim increased approximately 3.9 percent since 2005 from $2,626 in injury year 2005 to $2,729 in injury year 2010.
- Adjusted for inflation, the combined total of professional and hospital costs in the Texas workers' compensation system decreased by 30 percent from 1998 to 2011, mostly due to a decline in workers' compensation claims.
- The use of opioids and other "not recommended" drugs have been significantly reduced for new claims under the TDI-DWC closed pharmacy formulary (in effect for new claims as of September 1, 2011). The percentage of new claims receiving "not recommended" drugs was reduced by 56 percent from 2010 to 2011 and the total prescription drug costs associated with "not recommended" drugs was reduced by 81 percent over that same time.
- Overall opioid prescription use has also declined with the new formulary: the frequency of all opioid prescriptions was reduced by 10 percent and the frequency of "not recommended" opioid prescriptions was reduced by 57 percent between 2010 and 2011.

Return-to-Work Outcomes

- A higher percentage of employees are returning to work now than before the 2005 reforms. The percentage of Temporary Income Benefits recipients that have returned to work within 6 months from the date of injury has increased from 74 percent in 2004 to 78 percent in 2010.

- Employees are going back to work faster as well. The number of days lost from work due to work-related injuries fell from an average of 97 days (a median of 26 days) for employees injured in 2004 to 62 days (a median of 21 days) for employees injured in 2010.
- Improved return-to-work rates have resulted in a reduction of the number of weeks that Temporary Income Benefits are paid to injured employees in Texas. The median number of weeks of TIBs paid to injured employees declined from a median of 7.3 weeks in injury year 2004 to 6.0 weeks in injury year 2010.

Access to Care

- Access to medical care has also improved since 2005. The number of physicians treating workers' compensation claims has improved over time (17,647 in 2004 and 18,284 in 2010), the average # of claims treated by physicians has decreased from 18.3 claims per physician in 2004 to 16.1 claims per physician in 2010.
- Injured employees have access to non-emergency medical care faster now than they did before the 2005 reforms. The percentage of workers' compensation claims that received non-emergency medical care within the first week after the injury has increased from 78 percent in 2004 to 82 percent in 2010.

In terms of the interim charges, I've included a copy of our recently published *Biennial Report to the 83rd Legislature*, which provides an overview of the state of the Texas workers' compensation and provides some basic information on employer participation, income benefit adequacy (including the percentage of income benefit recipients capped at the state maximum benefit rate, which affects high wage earners), and return-to-work rates. I've also included a copy of the *2012 Oregon Workers' Compensation Premium Rate Ranking Summary* published by the Oregon Department of Consumer and Business Services that shows Texas as the most improved state in terms of changes in workers' compensation premium rates among states ranked in 2010.

For the charge on non-subscribing employers, I am including a complete copy of the recent study entitled *Employer Participation in the Texas Workers' Compensation System: 2012 Estimates* by the Workers' Compensation Research and Evaluation Group, which details the results of a biennial survey of Texas employers to estimate employer participation in the Texas workers' compensation system. It also includes the results of questions on issues such as the use of arbitration agreements by non-subscribers and the types of income benefits found in non-subscriber benefit plans.

For the charge on fatalities and the Subsequent Injury Fund (SIF), I am including a press release of the most recent fatality information compiled by TDI-DWC for the U.S.

Department of Labor, Bureau of Labor Statistics as well as a table that outlines the current balance, revenues and expenses for the SIF. I've included a brief history for the SIF as well as a diagram showing how death benefits are currently distributed in the Texas workers' compensation system.

For the charge involving return-to-work outcomes and referrals to the Department of Assistive and Rehabilitative Services (DARS), I've included a summary of the workers' compensation statutory requirements for referrals to DARS, as well as the numbers of referrals made by TDI-DWC to DARS in recent years. Overall return-to-work estimates for workers' compensation claims can be found in TDI-DWC's *Biennial Report*; however, information regarding the return-to-work outcomes for injured employees referred to DARS is not separately reported to TDI-DWC by DARS.

I am available if you have any questions or need any additional information.

Sincerely,

Rod Bordelon
Commissioner of Workers' Compensation

Attachments

Employer Participation in the Texas Workers' Compensation System: 2012 Estimates

Texas Department of Insurance
Workers' Compensation Research and Evaluation Group

October 2012

Brief History of Non-subscription in Texas

- Private sector employers have been allowed the option of whether to purchase workers' compensation (WC) insurance since 1913.
- Texas is currently the only state that allows any private-sector employer the option of not purchasing WC insurance or become "non-subscribers" to the state WC system.
- Several states' laws have numerical exceptions that allow small private sector employers to be "non-subscribers."
- The first study in Texas to estimate the percentage of employers that are "non-subscribers" to the Texas WC system took place in 1993 with 8 follow up studies conducted between 1995 and 2012.

Presentation Overview

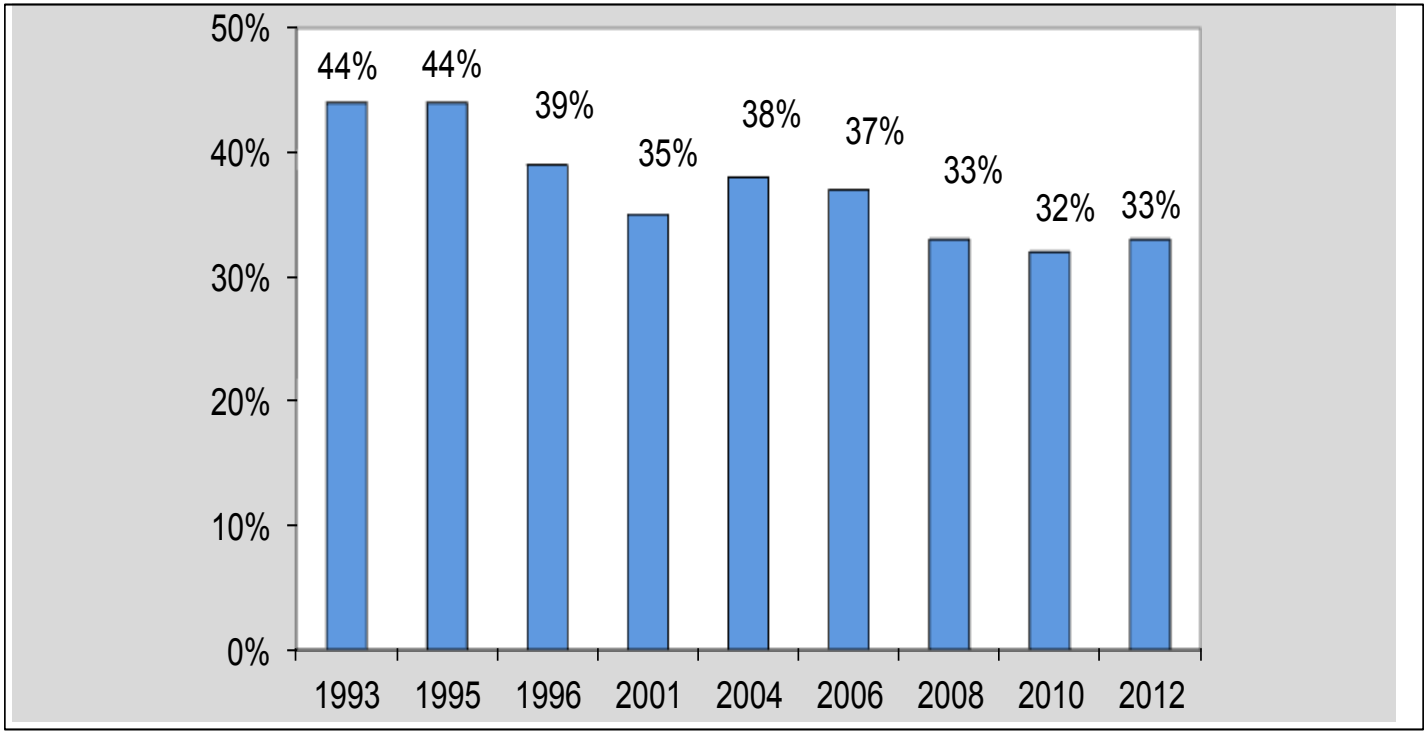
- Overall employer non-subscription rates and employee WC coverage rates;
- Primary reasons why employers purchase workers' compensation or become non-subscribers;
- Satisfaction levels of Texas employers;
- Income benefits provided by non-subscribing employers

Survey Sample and Administration

- TDI made slight modifications to the survey instrument first developed by the Research and Oversight Council on Workers' Compensation (ROC)
- TDI pulled a random probability sample (stratified by industry and employment size) of Texas employers from Texas Workforce Commission (TWC) data
- TDI and the Public Policy Research Institute (PPRI) at Texas A&M University completed 2,528 interviews with year-round private sector Texas employers during June –August 2012
- Employer non-subscription estimates have a +/- 2.4% margin of error at the 95% confidence interval

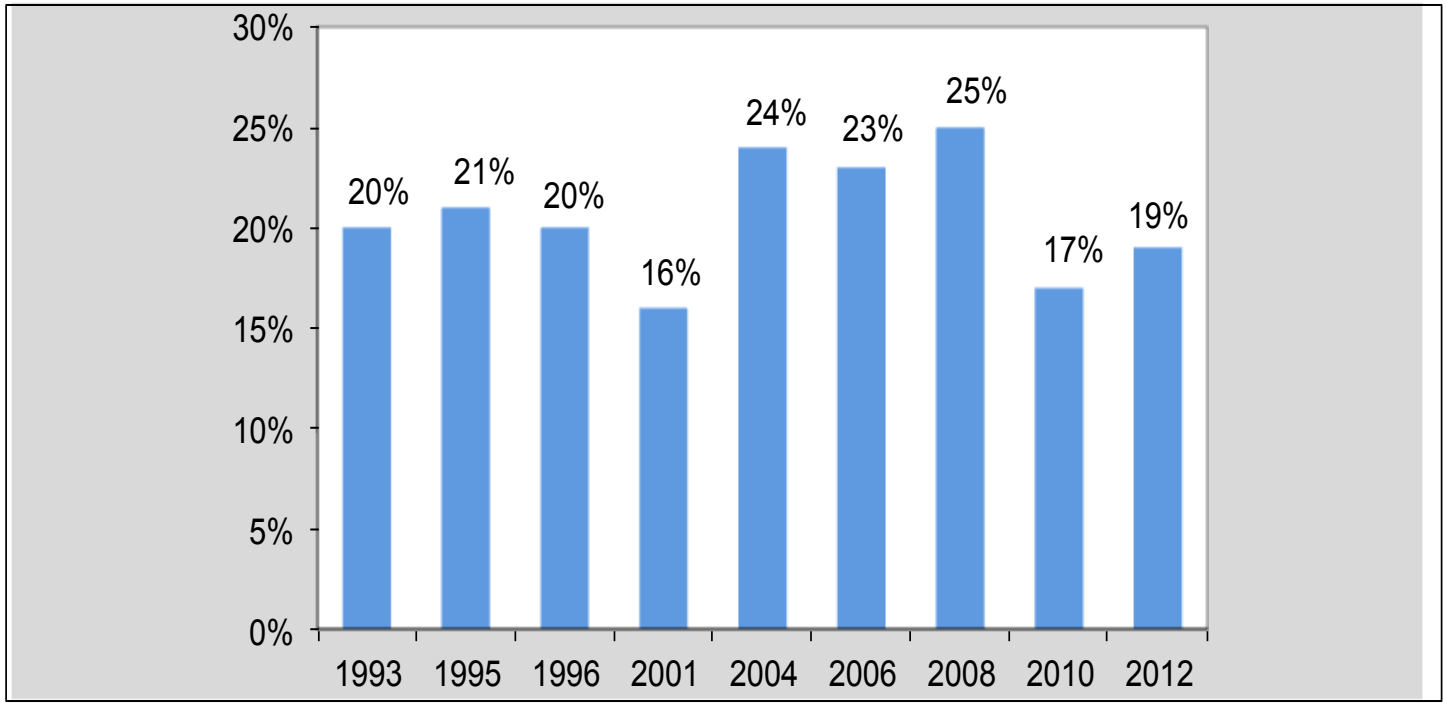
Overall Non-subscription Estimates

Percentage of Texas employers that are non-subscribers: 1993-2012



Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, 1993 and 1995 estimates from the Texas Workers' Compensation Research Center and the Public Policy Research Institute (PPRI) at Texas A&M University; 1996 and 2001 estimates from the Research and Oversight Council on Workers' Compensation and PPRI; and 2004 - 2012 estimates from the Texas Department of Insurance Workers' Compensation Research and Evaluation Group and PPRI.

Percentage of Texas employees that are employed by non-subscribers: 1993-2012



Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, 1993 and 1995 estimates from the Texas Workers' Compensation Research Center and the Public Policy Research Institute (PPRI) at Texas A&M University; 1996 and 2001 estimates from the Research and Oversight Council on Workers' Compensation and PPRI; and 2004 - 2012 estimates from the Texas Department of Insurance Workers' Compensation Research and Evaluation Group and PPRI.

Percentage of Texas employers that are non-subscribers, by employment size: 1993-2012

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

Note: Non-subscription estimates for 1993 were based on different employer size categories than were used in later years so they are not directly comparable.

Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, 1993 and 1995 estimates from the Texas Workers' Compensation Research Center and the Public Policy Research Institute (PPRI) at Texas A&M University; 1996 and 2001 estimates from the Research and Oversight Council on Workers' Compensation and PPRI; and 2004 -2012 estimates from the Texas Department of Insurance Workers' Compensation Research and Evaluation Group and PPRI.

Percentage of Texas employers that are non-subscribers, by industry: 2004 - 2012

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

Note: Industry classifications were based on the 2002 North American Industry Classification System (NAICS) developed by the governments of the U.S., Canada and Mexico, which replaced the Standard Industrial Classification (SIC) system previously used in the U.S. As a result of this change in industry classifications, industry non-subscription rates for 2004 - 2012 cannot be compared to previous years.
Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, Public Policy Research Institute at Texas A&M University and the Texas Department of Insurance Workers' Compensation Research and Evaluation Group, 2012.

Reasons why employers purchase workers' compensation or become non-subscribers

Primary reasons why subscribing employers said they purchase workers' compensation coverage

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

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

Primary reasons why large subscribing employers (500+ employees) said they purchase workers' compensation coverage

Primary reasons given by surveyed employers with 500+ employees	Percentage of large subscribing employers		
	2008	2010	2012
Employer was able to provide injured employees with medical care through a workers' compensation health care network	28%	29%	20%
Employer thought having workers' compensation coverage was required by law	16%	17%	17%
Employer was concerned about lawsuits	13%	12%	17%
Employer was able to reduce its workers' compensation insurance costs through deductibles, certified self insurance, group self-insurance or other premium discounts	3%	13%	17%
Employer needed workers' compensation coverage in order to obtain government contracts	NA	NA	11%

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

Primary reasons why non-subscribing employers said they did not purchase workers' compensation coverage

Primary reasons given by surveyed non-subscribing employers	Percentage of large non-subscribing employers			
	2006	2008	2010	2012
Workers' compensation insurance premiums were too high	35%	26%	32%	15%
Employer had too few employees	21%	26%	25%	17%
Employer not required to have workers' compensation insurance by law	9%	11%	13%	17%
Medical costs in the workers' compensation system were too high	4%	4%	5%	10%
Employer had few on-the-job injuries	9%	9%	12%	17%

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

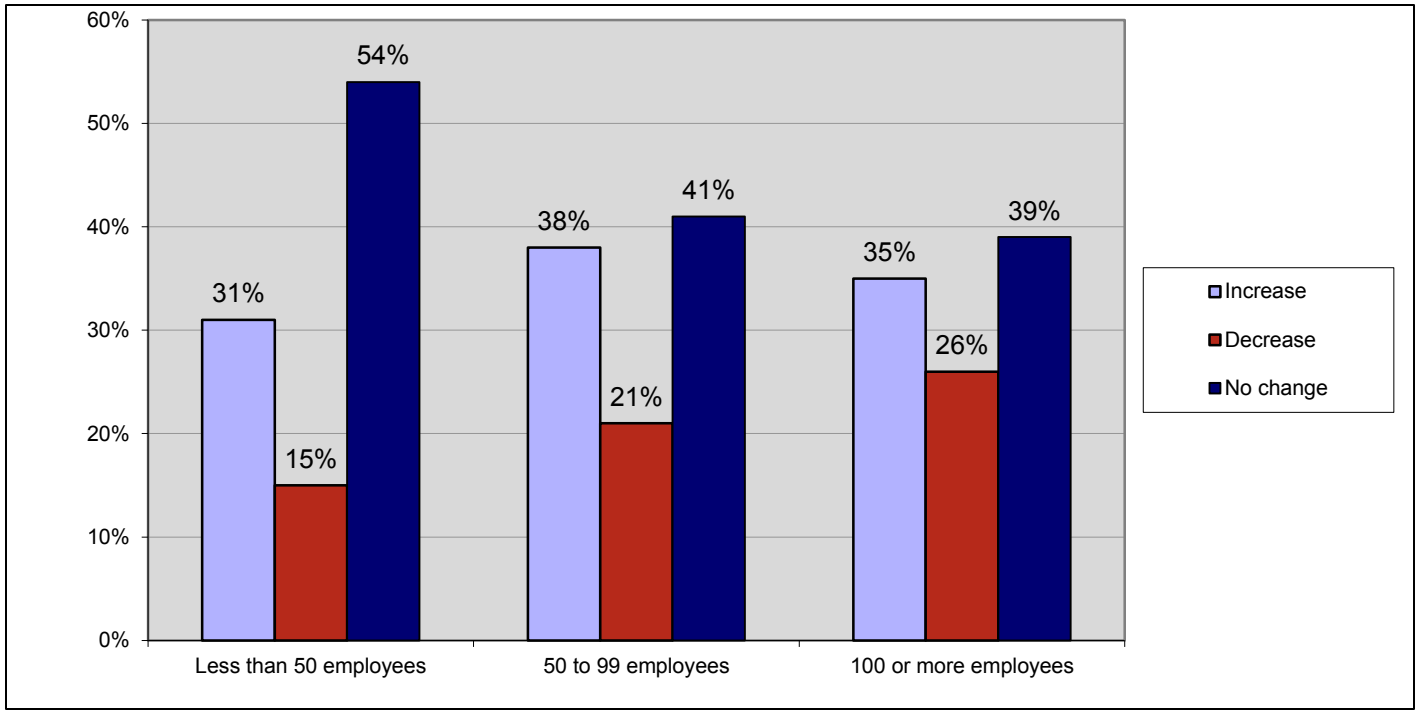
Primary reasons why large non-subscribing employers (500+ employees) said they did not purchase workers' compensation coverage

Primary reasons given by surveyed non-subscribing employers with 500+ employees	Percentage of large non-subscribing employers		
	2008	2010	2012
Workers' compensation insurance premiums were too high	49%	50%	23%
The employer felt the company could do a better job than the Texas workers' compensation system at ensuring that employees injured on the job receive appropriate benefits (medical and wage loss)	NA	28%	20%
Medical costs in the workers' compensation system were too high	13%	10%	24%
Employer not required to have workers' compensation insurance by law	NA	2%	14%

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

Texas employers' experiences with workers' compensation insurance costs

Percentage of Subscribers That Indicated They Experienced a Premium Increase, Decrease, or No Change in Their Premium, by Employment Size: 2012



Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, 1993 and 1995 estimates from the Texas Workers' Compensation Research Center and the Public Policy Research Institute (PPRI) at Texas A&M University; 1996 and 2001 estimates from the Research and Oversight Council on Workers' Compensation and PPRI; and 2004 - 2012 estimates from the Texas Department of Insurance Workers' Compensation Research and Evaluation Group and PPRI.

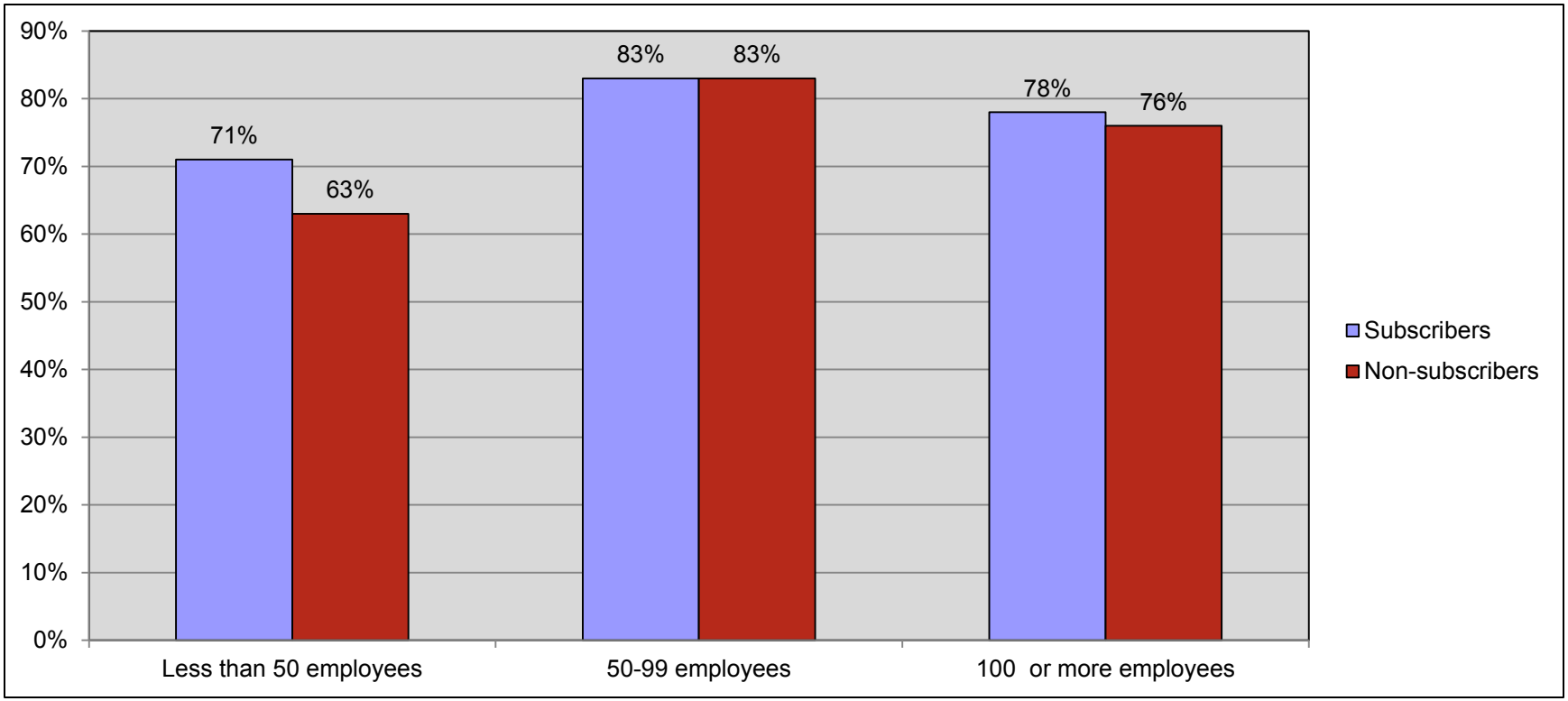
Satisfaction levels of subscribing and non-subscribing employers

Percentage “extremely” or “somewhat” satisfied: subscribers and non-subscribers

Satisfaction with subscription/non-subscription experience	Subscribers	Non-subscribers
Overall Satisfaction	72.1%	63.3%
Adequacy and equity of benefits paid to injured workers through the Texas WC System	61.1%	47.0%
Degree to which WC insurance coverage or occupational benefits plan is a good value for the company	73.4%	58.3%
The ability to effectively manage medical and wage replacement costs	62.9%	54.3%

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

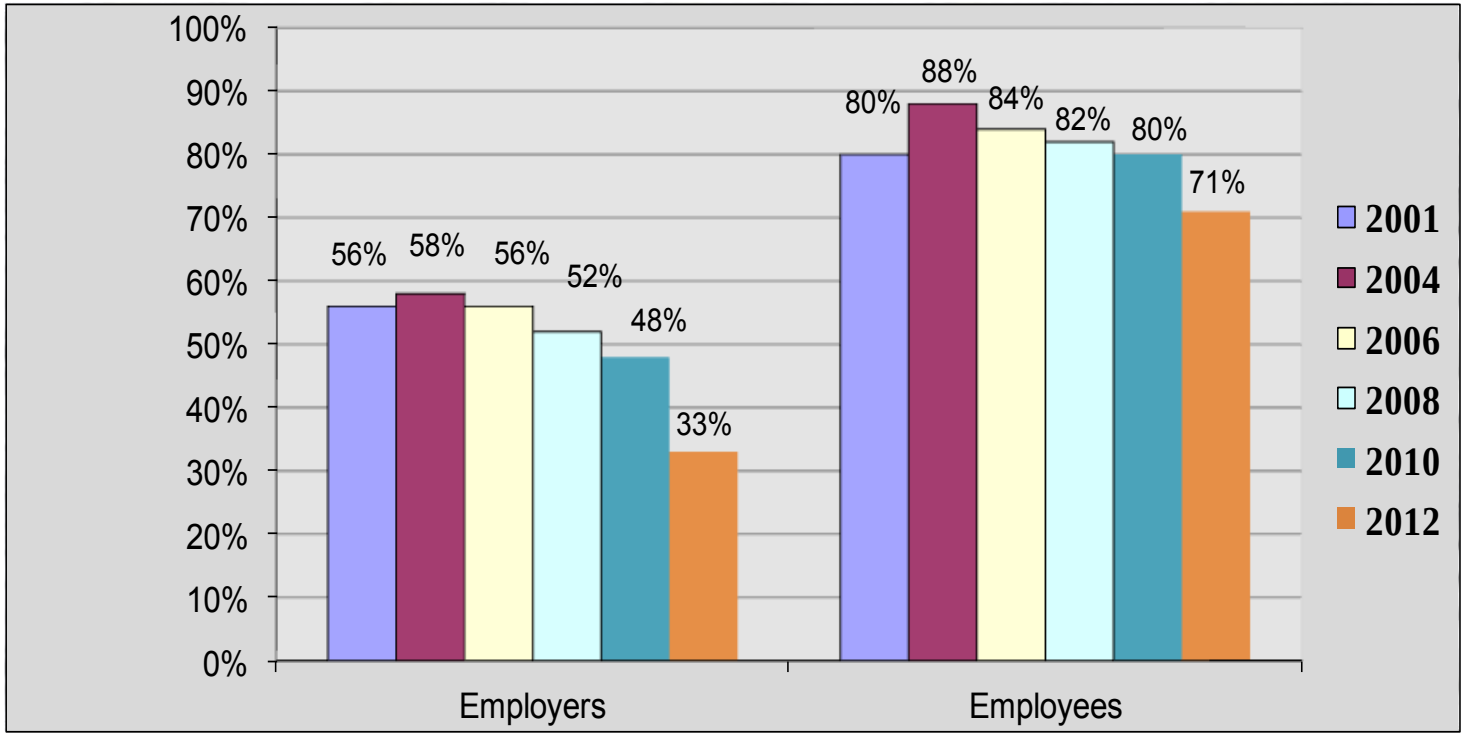
Overall Satisfaction of Subscribers and Non-subscribers by Employment Size



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

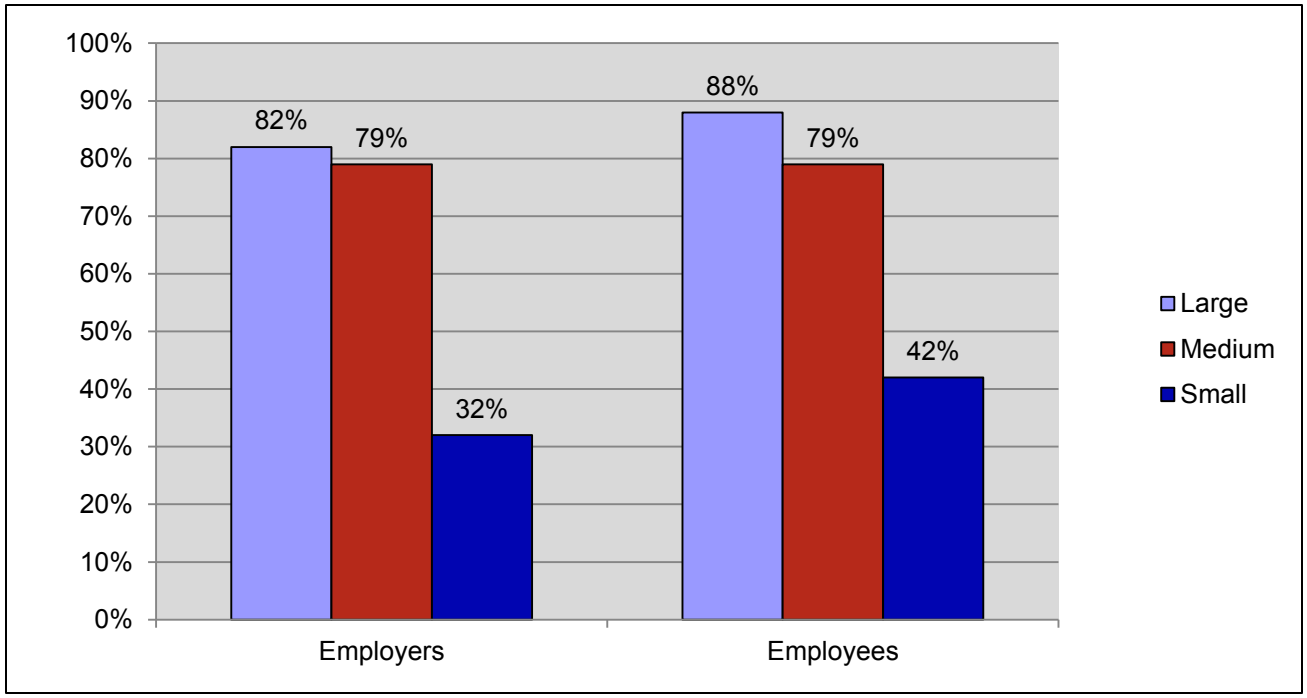
Benefits provided by non-subscribers

Percentage of non-subscribing employers that pay occupational benefits and percentage of non-subscriber employees covered by occupational benefit plans, 2001 – 2012 estimates



Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, 1996 and 2001 estimates from the Research and Oversight Council on Workers' Compensation and the Public Policy Research Institute (PPRI) at Texas A&M University; and 2004 - 2012 estimates from the Texas Department of Insurance Workers' Compensation Research and Evaluation Group and PPR, 2012.

Percentage of non-subscribing employers that pay occupational benefits and percentage of non-subscriber employees covered by occupational benefit plans by employer size, 2012 estimates



Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, 1996 and 2001 estimates from the Research and Oversight Council on Workers' Compensation and the Public Policy Research Institute (PPRI) at Texas A&M University; and 2004 - 2012 estimates from the Texas Department of Insurance Workers' Compensation Research and Evaluation Group and PPR, 2012.

Medical benefits paid by non-subscribers

- Of those non-subscribing employers that say they pay occupational injury benefits, 75 percent (71 percent in 2010) cover medical costs

- Of those non-subscribing employers that pay medical benefits:
  - 49 percent said they pay medical benefits for as long as they are medically necessary; and
  - 51 percent cap medical benefits based on the duration of treatment and/or amount of money spent on medical treatments or both

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

Wage replacement benefits paid by non-subscribers

- Of those non-subscribing employers that say they pay occupational injury benefits, 55 percent (62 percent in 2010) said they pay wage replacement benefits
- Approximately 66 percent (78 percent in 2010) of non-subscribing employers who pay wage replacement benefit said their injured employees are immediately compensated for lost wages, while 34 percent (22 percent in 2010) said there is a waiting period before wage replacement benefits begin
- Of those non-subscribing employers that pay wage replacement benefits:
  - 55 percent said they pay wage replacement benefits for the entire duration of the injured employee's lost time; and
  - 45 percent cap wage replacement benefits based on the duration of lost time or amount of money spent on wage replacement benefits or both.

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

How soon after an employee has been injured must he or she report the injury to be eligible for benefits?

Waiting Periods Given by Non-subscribing Employers	Percent of Non-subscribing Employers
Immediately/Same day	62%
Within 24 hours/Next Day	24%
Other (includes timeframes within 2 to 60 days)	12%
No Policy	2%

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

Non-subscribers with permanent impairment benefits (i.e., permanent partial benefits)

Non-subscribers with occupational benefit plans	Percentage of Non-subscribers
Non-subscribers with occupational benefit plans	33%
Non-subscribers with occupational benefits who also have income benefits separate from wage replacement benefits for permanent physical impairments	31%
Non-subscribers with income benefits for permanent physical impairments who pay these benefits if employee is back at work	70%

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

How do non-subscribers pay permanent impairment income benefits?

Non-subscribers with occupational benefit plans	Percentage of Non-subscribers
Pay permanent impairment income benefits to an employee in a lump sum	28%
Pay permanent impairment income benefit payments to an employee in installments over specified period of time	58%
Other/Don't know	14%

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

Non-subscribers with accidental death, dismemberment or other benefits (i.e., permanent total benefits)

Non-subscribers with occupational benefit plans	Percentage of Non-subscribers
Non-subscribers that pay accidental death, dismemberment, or other benefits for serious injuries	38%
Non-subscribers that pay accidental death, dismemberment, or other benefits to injured employees who return to work	82%

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

Non-subscribers with death and burial benefits

Benefit plans among non-subscribers	Percentage of Non-subscribers
Death benefits in the case of a work-related fatality	41%
If company has death benefits they are paid to the deceased worker's spouse	94%
If company has death benefits they are paid to the deceased worker's dependent children	72%
If company has death benefits they are paid to others (grandchildren, non-dependent parents)	19%
If death benefits paid, benefit plan covers burial benefits to help pay burial expenses	11%
If burial benefits paid, average benefit paid to help pay burial expenses is higher than $6,000	39%

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

How non-subscribers finance occupational benefits to injured employees

Primary ways nonsubscribing employers finance benefits for on-the-job injuries	Percent of Non-subscribers
Through a special account that is self-funded and supplemented with non-subscriber insurance, including excess indemnity insurance, standard occupational accident insurance or some other alternative occupational benefits insurance	30%
Through a special account that is self-funded exclusively by the non-subscriber	19%
Using the non-subscriber's group health insurance	17%
Other (Company's account, sick leave, cash, savings plan between company and employee, etc.)	34%

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

Use of arbitration agreements

Use of arbitration by non-subscribing employers

- Overall, 14% (9% in 2010) of current non-subscribers said that they ask their employees to sign an agreement stating that the employee will resolve disputes through arbitration.
- Approximately 63% (76% in 2010) of large non-subscribers use arbitration agreements.
- Approximately 90% (98% in 2010) of non-subscribers that use arbitration asked their employees to sign arbitration agreements when the employee is first hired (pre-injury).

Use of arbitration by non-subscribing employers

- Approximately 41% (43% in 2010) of non-subscribing employers that use arbitration agreements said that an employee would not receive medical and/or wage replacement benefits if the employee did not agree to resolve disputes through arbitration.

- Overall, 68% of non-subscribers that use arbitration said an employee can continue to be employed by the company even if the employee does not agree to resolve any disputes that arise from the work-related injury through mediation or arbitration.

- Approximately 81% of non-subscribers that use arbitration agreements said the agreement specifies that the mediation or arbitration is binding, meaning that the arbiter's decision is final and cannot be appealed in most cases.

Arbitration agreements by non-subscribing employers

Does the arbitration agreement include the following:	Percent
A requirement that the employee pay all or a portion of the arbitration costs	34%
A requirement that the employer is also required to submit to arbitration for any disputes that arise from the work-related injury	54%
A requirement the employee's continued employment constitutes acceptance of the employee's agreement to mediate or arbitrate any disputes that arise from work-related injuries	46%
A requirement that the employer is also bound by the result of the mediation or arbitration of the dispute	53%
A requirement that the employee voluntarily waives his or her right to arbitration if the employee fails to submit a written request for arbitration to the employer or respond to the selection of an arbiter within a pre-determined time frame	38%
A requirement that the arbitration take place in a specific geographic location	25%
A requirement that the employee forego recovery of his or her attorney fees	63%

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

Who generally serves as the arbiter in these disputes?

Types of Arbiters Used by Non-subscribers	Percentage of Non-subscribers
A member of the American Arbitration Association (AAA) or the National Arbitration Forum	23%
A single person who works for the company, mutually agreed upon by the employer and the employee	3%
A single person who works for the company, who always serves as the company's arbiter	15%
A panel of people who work for your company, who are mutually agreed upon by you and the employee	4%
Other	16%
Don't know	39%

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

Other types of insurance coverage purchased by Texas employers

Other types of insurance coverage purchased by Texas employers: 2010-2012

Type of Insurance Coverage	2010		2012	
	Subscriber	Non-subscriber	Subscriber	Non-subscriber
General health insurance for employees (excluding dental or vision insurance coverage)	62%	31%	60%	30%
Life insurance for employees	46%	21%	46%	19%
Disability insurance for employees (short-term or long-term or both)	39%	18%	39%	13%
Voluntary accidental death and dismemberment insurance (A, D &D)	40%	18%	40%	15%
General liability insurance (to protect your company against liability for bodily injuries that might occur on your premises)	92%	69%	94%	74%
Property insurance	89%	70%	90%	76%
Commercial auto insurance	68%	46%	72%	46%

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

Other types of insurance coverage purchased by large Texas employers (500+ employees): 2010-2012

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

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

Texas Department of Insurance
Division of Workers' Compensation
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512-804-4000 telephone • 512-804-4001 fax • www.tdi.texas.gov

State Average Weekly Wage / Maximum and Minimum Weekly Benefits

Fiscal Year	SAWW* State Average Weekly Wage	Temporary Income Benefits (TIBS) max	TIBs min	Impairment Income Benefits (IIBs) max	IIBs min	Supplemental Income Benefits (SIBs) max	SIBs min	Lifetime Income Benefits (LIBs) max	LIBs min	Death Benefits max	Death Benefits min
2013 (10/1/12-09/30/13)	$817.94	818.00	123.00	573.00	123.00	573.00	N/A	818.00	123.00	818.00	N/A
2012 (10/1/11-09/30/12)	$787.47	787.00	118.00	551.00	118.00	551.00	N/A	787.00	118.00	787.00	N/A
2011 (10/1/10-09/30/11)	$766.34	766.00	115.00	536.00	115.00	536.00	N/A	766.00	115.00	766.00	N/A
2010 (10/1/09-09/30/10)	$772.64	773.00	116.00	541.00	116.00	541.00	N/A	773.00	116.00	773.00	N/A
2009 (10/1/08-09/30/09)	$749.63	750.00	112.00	525.00	112.00	525.00	N/A	750.00	112.00	750.00	N/A
2008 (10/1/07-09/30/08)	$712.11	712.00	107.00	498.00	107.00	498.00	N/A	712.00	107.00	712.00	N/A
2007 (10/1/06-9/30/07)	$673.80	674.00	101.00	472.00	101.00	472.00	N/A	674.00	101.00	674.00	N/A
2006 (9/1/05-9/30/06)	$540.00	540.00	81.00	378.00	81.00	378.00	N/A	540.00	81.00	540.00	N/A
2005 (9/1/04-8/31/05)	$539.00	539.00	81.00	377.00	81.00	377.00	N/A	539.00	81.00	539.00	N/A
2004 (9/1/03-8/31/04)	$537.00	537.00	81.00	376.00	81.00	376.00	N/A	537.00	81.00	537.00	N/A
2003 (9/1/02-8/31/03)	$536.74	537.00	81.00	376.00	81.00	376.00	N/A	537.00	81.00	537.00	N/A
2002 (9/1/01-8/31/02)	$535.62	536.00	80.00	375.00	80.00	375.00	N/A	536.00	80.00	536.00	N/A
2001 (9/1/00-8/31/01)	$533.00	533.00	80.00	373.00	80.00	373.00	N/A	533.00	80.00	533.00	N/A
2000 (9/1/99-8/31/00)	$531.00	531.00	80.00	372.00	80.00	372.00	N/A	531.00	80.00	531.00	N/A
1999 (9/1/98-8/31/99)	$523.31	523.00	78.00	366.00	78.00	366.00	N/A	523.00	78.00	523.00	N/A
1998 (9/1/97-8/31/98)	$508.26	508.00	76.00	356.00	76.00	356.00	N/A	508.00	76.00	508.00	N/A
1997 (9/1/96-8/31/97)	$490.92	491.00	74.00	344.00	74.00	344.00	N/A	491.00	74.00	491.00	N/A

Fiscal Year	SAWW* State Average Weekly Wage	Temporary Income Benefits (TIBS) max	TIBs min	Impairment Income Benefits (IIBs) max	IIBs min	Supplemental Income Benefits (SIBs) max	SIBs min	Lifetime Income Benefits (LIBs) max	LIBs min	Death Benefits max	Death Benefits min
1996 (9/1/95-8/31/96)	$480.13	480.00	72.00	336.00	72.00	336.00	N/A	480.00	72.00	480.00	N/A
1995 (9/1/94-8/31/95)	$471.66	472.00	71.00	330.00	71.00	330.00	N/A	472.00	71.00	472.00	N/A
1994 (9/1/93-8/31/94)	$464.10	464.00	70.00	325.00	70.00	325.00	N/A	464.00	70.00	464.00	N/A
1993 (9/1/92-8/31/93)	$456.36	456.00	68.00	319.00	68.00	319.00	N/A	456.00	68.00	456.00	N/A
1992 (9/1/91-8/31/92)	$437.65	438.00	66.00	306.00	66.00	306.00	N/A	438.00	66.00	438.00	N/A
1991 (1/1/91-8/31/91)	$428.25	428.00	64.00	300.00	64.00	300.00	N/A	428.00	64.00	428.00	N/A

The table provides the maximum (max) and minimum (min) weekly benefits established in the Texas Workers' Compensation Act applicable to dates of injuries on r after January 1, 1991.

*The state average weekly wage (SAWW) since 10/1/06 has been 88% of the average weekly wage in covered employment for the preceding year as computed by the Texas Workforce Commission (TWC).

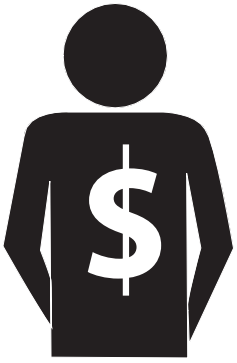
The SAWW in 2004, 2005, and 2006 were established statutorily. Prior to 2004, the SAWW was based on the average weekly wage of manufacturing production workers in Texas.

Temporary Income Benefits (TIBs) BEN

Information for Injured Employees from the Division of Workers' Compensation

Income benefits replace a portion of wages you lose because of a work-related injury or illness. There are four types of income benefits:

- temporary income benefits (TIBs);
- impairment income benefits (IIBs);
- supplemental income benefits (SIBs); and
- lifetime income benefits (LIBs).



Income benefits may not exceed the maximum weekly amount set by state law. Temporary income benefits, impairment income benefits, and lifetime income benefits are also subject to a minimum amount set by state law. The maximum and minimum benefit amounts are based on the state average weekly wage. A copy of the maximum and minimum benefits for each benefit type can be found on the Texas Department of Insurance website at www.tdi.texas.gov/wc/employee/maxminbens.html.

You must report any income (other than workers' compensation benefits you may be receiving) to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) and the insurance carrier so an adjustment can be made to your income benefit payments. You may be fined and/or charged with fraud if you receive temporary income benefits or supplemental income benefits while also receiving wages from an employer without informing the TDI-DWC and the insurance carrier.

Income benefits are not payable following the death of an injured employee. In the case of an injured employee's death, the injured employee's beneficiaries may be eligible to file a claim for and receive death benefits if the injured employee's death was due to the work-related injury or illness.

Temporary Income Benefits (TIBs)

[Texas Labor Code §§408.101 – 408.105, 28 Texas Administrative Code §§129.1 – 129.11]

You may be paid TIBs if your work-related injury or illness causes you to lose all or some of your wages for more than seven (7) days. If you work more than one job, you may be paid TIBs if you lose all or some of your wages from other employers. (See "Average Weekly Wage Calculations" fact sheet under Multiple Employment).

Amount of Temporary Income Benefits

TIBs equal 70 percent of the difference between your average weekly wage and the wages you are able to earn after your work-related injury. If you earned less than $8.50 per hour before you were injured, your temporary income benefits for the first 26 weeks of payments will equal 75 percent of the difference between your average weekly wage and the wages you are able to earn after your work-related injury.

The amount of TIBs is subject to maximum and minimum benefit amounts. For example, if your average weekly wage was $500, and your injury or illness caused you to lose all of your income, your TIBs would be $350 a week:

Your average weekly wage	$500
Minus your wages after the injury	- 0
Lost wages	$500
70 percent of $500 (.70 x $500) equals	$350

After an injury, your doctor may release you to return to work at modified duty; i.e., changes made to your regular job, or a temporary or alternate work assignment. You may still be entitled to TIBs if your employer provides the modified duty at reduced wages.

For example, if your average weekly wage prior to the work-related injury was $500, and you returned to work doing a modified job after the work-related injury and you are now earning $200 per week working only 4 hours per day, your temporary income benefits would still be $210 a week.

For further assistance, call
1-800-252-7031
or visit
www.tdi.texas.gov/wc/employee/index.html

Your average weekly wage	$500
Minus your wages after the injury	- 200
Lost wages	$300
70 percent of $300 (.70 x $300) equals	$210

By returning to work, you are able to receive a total of $410 per week. This includes the wages you are able to earn ($200) plus the TIBs ($210) paid to you by the insurance carrier for lost wages.

When TIBs Begin and End

You become eligible for TIBs after you miss more than seven (7) days from work. Remember, disability refers to your inability to earn an income, not to a physical handicap. You have disability if your work-related injury or illness causes you to lose all or some of your usual pay. Benefits are not paid for the first week of lost wages unless disability lasts for two (2) weeks (14 days) or more.

TIBs end at the earlier of:

- the date you reach maximum medical improvement (the point that your work-related injury or illness has improved as much as it is going to improve);
- the date you are again physically able to earn your average weekly wage which would be the same wages you were earning prior to being injured on-the-job; or
- at the end of 104 weeks.

Definitions

Average Weekly Wage (AWW) typically is the average amount of weekly wages you earned during the 13 weeks immediately before your work-related injury or illness occurred. Income and death benefit payments are based on your average weekly wage.

Disability occurs when a work-related injury or illness causes you to lose the ability to earn your normal weekly wages. Disability refers to your ability to earn an income, not to a physical handicap.

Maximum Medical Improvement (MMI) is the earlier of:

- the point in time when your work-related injury or illness has improved as much as it is going to improve; or
- 104 weeks from the date you became eligible to receive income benefits or any approved extension based upon approval for spinal surgery.

If you have had spinal surgery or have been approved for spinal surgery within 12 weeks of the expiration of the statutory MMI period, you may request an extension of MMI from the TDI-DWC in accordance with the 28 Texas Administrative Code §126.11.

Maximum Weekly Income Benefit may not exceed 100 percent of the state average weekly wage rounded to the nearest whole dollar. The TDI-DWC will compute the maximum weekly income benefit for October 1 through September 30 of each year no later than October 1st of each year.

Minimum Weekly Income Benefit is 15 percent of the state average weekly wage rounded to the nearest whole dollar. The TDI-DWC will compute the minimum weekly income benefit for October 1 through September 30 of each year no later than October 1st of each year.

For more information on Workers' Compensation Benefits see the following fact sheets:

- Workers' Compensation Benefits
- Dispute Resolution
- Average Weekly Wage Calculation

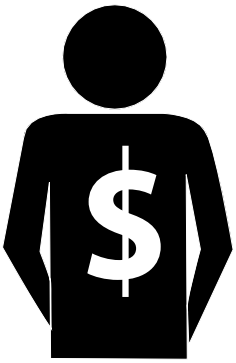
Impairment Income Benefits (IIBs) BEN

Information for Injured Employees from the Division of Workers' Compensation

Income benefits replace a portion of wages you lose because of a work-related injury or illness. There are four types of income benefits:

- temporary income benefits (TIBs);
- impairment income benefits (IIBs);
- supplemental income benefits (SIBs); and
- lifetime income benefits (LIBs).

Income benefits may not exceed the maximum weekly amount set by state law. Temporary income benefits, impairment income benefits, and lifetime income benefits are also subject to a minimum amount set by state law. The maximum and minimum benefit amounts are based on the state average weekly wage.



You must report any income (other than income benefits you may be receiving) to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) and the insurance carrier so an adjustment can be made to your income benefit payments. You may be fined and/or charged with fraud if you receive temporary income benefits or supplemental income benefits while also receiving wages from an employer without informing the TDI-DWC and the insurance carrier.

Income benefits are not payable following the death of an injured employee. In the case of an injured employee's death, the injured employee's beneficiaries may be eligible to file a claim for and receive death benefits if the injured employee's death was due to the work-related injury or illness.

Impairment Income Benefits (IIBs)

[Texas Labor Code §§408.121 – 408.129; 28 Texas Administrative Code §§130.1 – 130.11]

You may be entitled to Impairment Income Benefits (IIBs) if you have permanent impairment from a work-related injury or illness. Generally, Maximum Medical Improvement (MMI) is reached when you are as well as you are going to be from the work-related injury or illness. This does not mean that you will not need follow up care with your health care provider, be completely pain free, or that you are released to return to work. When the health care provider determines you have reached MMI, the health care provider will determine if there is any permanent physical or functional damage. The health care provider will assign an impairment rating (IR) using the 4th Edition of the *American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment*. The impairment rating describes the degree of permanent damage to your body as a whole.

If you have not previously reached maximum medical improvement, the workers' compensation law generally establishes MMI at 104 weeks from the 8th day of disability. A doctor that is certified by the TDI-DWC to do Impairment Rating examinations must make an assessment of permanent impairment, if any. If an IR has not been assigned before the 104-week date when your temporary income benefits (TIBs) end, you may not receive IIBs until a doctor assigns an IR. TIBs can no longer be paid after 104 weeks (or maximum medical improvement). Your impairment rating determines whether you are eligible for IIBs. Three (3) weeks of IIBs are paid for each percentage of impairment.

For example, if you receive a 10 percent Impairment Rating, you will receive 30 weeks of IIBs because 3 weeks of IIBs are paid for each percentage of impairment (10 x 3 = 30 weeks of IIBs).

Amount of Impairment Income Benefits

Impairment Income Benefits equal 70 percent of your average weekly wage (AWW). There is a state maximum for impairment income benefits just as there is for TIBs. The maximum for IIBs is 70 percent of the state AWW. A copy of the current maximum and minimum benefits for each type of income benefit can be found on the TDI website at http://www.tdi.texas.gov/wc/employee/maxminbens.html.

For example, if your average weekly wage was $539, your weekly IIB rate would be $377.

For further assistance, call
1-800-252-7031
or visit
www.tdi.texas.gov/wc/employee/index.html

Average weekly wage =	$539
70 percent of $539 =	$377

If your average weekly wage was $500, your weekly IIB rate would be $350.

Average weekly wage =	$500
70 percent of $500 =	$350

If your IIB rate is greater than the maximum benefit amount ($541), you will only receive the maximum benefit amount.

State Average Weekly Wage =	$787
Your average weekly wage =	$836.42
70 percent of $836.42 =	$585.49
($551 maximum limit for IIBs)	
You will receive $551	

When Impairment Benefits Begin and End

You become eligible for Impairment Income Benefits (IIBs) the day after you reach maximum medical improvement (MMI). IIBs end after you have received a total of three (3) weeks of payments for each percentage point of your impairment rating.

For example, if you have an impairment rating of 6 percent, you would receive a total of 18 weeks of IIBs. Because IIBs are not wage replacement benefits, you can work while receiving IIBs.

Definitions

Average Weekly Wage (AWW) typically is the average amount of weekly wages you earned during the 13 weeks immediately before your work-related injury or illness occurred. Income and death benefit payments are based on your average weekly wage.

Disability occurs when a work-related injury or illness causes you to lose the ability to earn your weekly wages. Disability refers to your inability to earn an income, not to a physical handicap.

Impairment Rating is the percentage of permanent physical damage to your body that resulted from a work-related injury or illness.

Maximum Medical Improvement (MMI) is the earlier of:

- the point in time when your work-related injury or illness has improved as much as it is going to improve; or
- 104 weeks from the date you became eligible to receive income benefits (also known as "statutory MMI") or any approved extension based upon approval for spinal surgery.

If you have had spinal surgery or have been approved for spinal surgery within 12 weeks of the expiration of the statutory MMI period, you may request an extension of MMI from the TDI-DWC in accordance with 28 Texas Administrative Code §126.11.

Maximum Weekly Income Benefit may not exceed 100 percent of the state average weekly wage rounded to the nearest whole dollar. The TDI-DWC will compute the maximum weekly income benefit for October 1 through September 30 of each year no later than October 1st of each year.

Minimum Weekly Income Benefit is 15 percent of the state average weekly wage rounded to the nearest whole dollar. The TDI-DWC will compute the maximum weekly income benefit for October 1 through September 30 of each year no later than October 1st of each year.

For more information on Workers' Compensation Benefits see the following fact sheets:

- Workers' Compensation Benefits
- Dispute Resolution

Supplemental Income Benefits (SIBs) BEN

Information for Injured Employees from the Division of Workers' Compensation

Income benefits replace a portion of wages you lose because of a work-related injury or illness. There are four types of income benefits:

- temporary income benefits (TIBs);
- impairment income benefits (IIBs);
- supplemental income benefits (SIBs); and
- lifetime income benefits (LIBs).

Income benefits may not exceed the maximum weekly amount set by state law. Temporary income benefits, impairment income benefits, and lifetime income benefits are also subject to a minimum amount. The maximum and minimum benefit amounts are based on the state average weekly wage.

Income benefits are no longer payable following the death of an injured employee. The injured employee's beneficiaries may be eligible to file a claim for and receive death benefits if the injured employee's death was due to the work-related injury or illness.

Supplemental Income Benefits (SIBs)

[Texas Labor Code §408.141 – 408.151, 28 Texas Administrative Code §130.100 – 130.109]

Supplemental Income Benefits (SIBs) are income benefits paid monthly by the insurance carrier after your IIBs have ended. You may apply for SIBs quarterly (4 times per year, or every 3 months) if you meet the requirements. The period of time you are receiving SIBs is called the "SIBs quarter."

You may be eligible to receive SIBs if you meet the following entitlement requirements:

- you have an impairment rating of 15 percent or more;
- you have not elected to have any of your impairment income benefits paid in a lump sum;
- you have not returned to work, or you have returned to work, but are earning less than 80 percent of your average weekly wage, as a direct result of your work-related injury; and
- you have demonstrated an active effort to comply with Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) work search requirements.

When Supplemental Income Benefits Begin and End

If you are eligible, SIBs will begin the day after your IIBs end. Unlike TIBs, IIBs and LIBs, you must apply for SIBs to be considered for entitlement. The TDI-DWC may send you notice if your impairment rating is 15 percent or greater and inform you of what information is necessary to support your application (DWC Form-052, *Application for Supplemental Income Benefits*) for the 1st quarter of SIBs. This 13-week period is called the "qualifying period," during which you must look for work or meet one of the other TDI-DWC work-search requirements.

Your entitlement to receive SIBs ends at 401 weeks (approximately 7 ½ years) from the date of your injury. If you have an occupational illness, entitlement for SIBs ends at 401 weeks from the date you first became eligible to receive income benefits. If you are not entitled to SIBs for four consecutive quarters (one year), you may permanently lose entitlement to those benefits.

Determining Entitlement

The TDI-DWC will make a determination of entitlement for the 1st quarter based on the information on your application. The TDI-DWC will review your work search efforts during the qualifying period, any possible job offers, current medical documentation provided by your doctor supporting why you are unable to work (if applicable), and whether your inability to earn your pre-injury wage is a direct result of your impairment.

The insurance carrier will provide you with an application for future quarters of SIBs. After you apply for the 1st quarter through TDI-DWC, you must send your application and documentation for all subsequent quarters directly to the insurance carrier for consideration. If the insurance carrier finds that you are eligible, you will receive benefits for the quarter. If you disagree with a decision that you are not entitled to SIBs or if you disagree with the amount of the payment, contact your local TDI-DWC field office.

For further assistance, call
1-800-252-7031
or visit
www.tdi.texas.gov/wc/employee/index.html

Work Search Requirements

To qualify for SIBs, you must show an active effort to comply with the TDI-DWC work search requirements. You must maintain and provide supporting documentation (applications, letters and notes) to clearly demonstrate your active efforts to meet one or any combination of the following TDI-DWC work search requirements **each week** during your entire qualifying period:

- you have returned to work in a position that is equal to your ability to work; or
- you have actively participated in a vocational rehabilitation program [such as those offered by the Department of Assistive and Rehabilitative Services (DARS) or a private vocational rehabilitation program]; or
- you have been unable to perform any type of work in any capacity as documented by a doctor; or
- you have actively participated in work search efforts through the Texas Workforce Commission (TWC) appropriate for the injured employee's county, or by other documented job searches. SIBs applicants are now required to perform at least the minimum number of weekly work searches required for their county of residence.

Information about the SIBs application process, including the number of mandatory weekly work search requirements by county, is available on the TDI website at www.tdi.texas.gov/wc/employee/sibs.html#.

If you do not meet at least one of the work search requirements described above **each week** during the entire qualifying period, you will not be entitled to SIBs, unless you can show that you had reasonable grounds for failing to comply with the TDI-DWC work search requirements. Please note that when you are looking for work, you may combine work search efforts done on your own with those done through TWC during each week of the qualifying period.

Amount of Supplemental Income Benefits

Supplemental Income Benefits equal 80 percent of the difference between 80 percent of your average weekly wage (earned prior to your work-related injury or illness) and your weekly wages (if you have any earnings or offered wages during this 13-week period) after the work-related injury or illness.

For example, if your average weekly wage was $500 before you were injured, and your injury caused you to lose all of your income, your SIBs rate would be $320 a week:

Your average weekly wage	$500
80 percent of $500 (.80 x $500)	$400
Minus wages earned or offered	-0
Equals	$400
80 percent of $400 (.80 x $400) equals	$320

To determine the amount of your monthly SIBs, multiply the weekly benefit amount by the average number of weeks in a month (4.34821). In this example, your monthly supplemental income benefit would be $1,391.43: $320 x 4.34821 equals $1,391.43.

If you earn any wages during the qualifying period, the wages are deducted when calculating your SIB rate.

Example:

Your average weekly wage	$500
80 percent of $500 (.80 x $500)	$400
Minus your wages earned or offered	- $200
Equals	$200
80 percent of $200 (.80 x $200) equals	$160

$160 x 4.34821 equals $695.71 (monthly SIB rate)

Definitions

Average Weekly Wage (AWW) typically is the average amount of weekly wages you earned during the 13 weeks immediately before your work-related injury or illness occurred. Income and death benefit payments are based on your average weekly wage.

Impairment Rating is the percentage of permanent physical and functional damage to your body that resulted from a work-related injury or illness.

Maximum Benefit Amount may not exceed 100 percent of the state average weekly wage rounded to the nearest whole dollar. The TDI-DWC will compute the maximum weekly income benefit for each state fiscal year no later than October 1st of each year.

Minimum Benefit Amount is 15 percent of the state average weekly wage rounded to the nearest whole dollar. The TDI-DWC will compute the minimum weekly income benefit for each state fiscal year no later than October 1st of each year.

Lifetime Income Benefits (LIBs)

BEN

Information for Injured Employees from the Division of Workers' Compensation

Income benefits replace a portion of wages you lose because of a work-related injury or illness. There are four types of income benefits:

- temporary income benefits (TIBs);
- impairment income benefits (IIBs);
- supplemental income benefits (SIBs); and
- lifetime income benefits (LIBs).

Income benefits may not exceed the maximum weekly amount set by state law. Temporary income benefits, impairment income benefits, and lifetime income benefits are also subject to a minimum amount set by state law. The maximum and minimum benefit amounts are based on the state average weekly wage.

You must report any income (other than workers' compensation benefits you may be receiving) to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) and the insurance carrier so an adjustment can be made to your income benefit payments. You may be fined and/or charged with fraud if you receive temporary income benefits or supplemental income benefits while also receiving wages from an employer without informing the TDI-DWC and the insurance carrier.

Income benefits are no longer payable following the death of an injured employee. In the case of an injured employee's death, the injured employee's beneficiaries may be eligible to file a claim for and receive death benefits if the injured employee's death was due to the work-related injury or illness.

Lifetime Income Benefits (LIBs)

[Texas Labor Code §§408.161 – 408.162, 28 Texas Administrative Code §§131.2 – 131.4]

Certain work-related injuries may result in a condition for which you are entitled to income benefits for your lifetime.

Lifetime Income Benefits are paid if you incur:

- total and permanent loss of sight in both eyes;
- loss of both feet at or above the ankle;
- loss of both hands at or above the wrist;
- loss of one foot at or above the ankle and the loss of one hand, at or above the wrist;
- an injury to the spine that results in permanent and complete paralysis of both arms, both legs, or one arm and one leg;
- a physically traumatic injury to the brain resulting in incurable insanity or imbecility; or
- third degree burns that cover at least 40 percent of the body and require grafting, or third degree burns covering the majority of either both hands or one hand and the face.

Note: For purposes of this law, the total and permanent loss of use of a body part is an injury to that body part that ceases to possess any substantial utility as a member of the body.

Amount of Lifetime Income Benefits

Lifetime income benefits equal 75 percent of your average weekly wage, with a 3 percent increase each year.

For example, if your average weekly wage is $500, your lifetime income benefits would be $375 a week:

75 percent of $500 (.75 x $500) equals $375

There are maximum and minimum rates for LIBs. The maximum and minimum changes on October 1st of each year based on the state average weekly wage.

When Lifetime Income Benefits Begin

Lifetime income benefits are paid from the time it is determined that your injury has resulted in a condition that meets one of the qualifying conditions for lifetime income benefits. If there is a dispute over eligibility for lifetime income benefits, the issue is addressed through TDI-DWC's dispute resolution process.

When Lifetime Income Benefits End

You may receive Lifetime Income Benefits for the rest of your life.

For further assistance, call
1-800-252-7031
or visit
www.tdi.texas.gov/wc/employee/index.html

Texas Department of Insurance

FOR IMMEDIATE RELEASE – October 19, 2012

FOR MORE INFORMATION – Michelle Banks (512)804-4203 or (media) John Greeley (512)463-6425
pio@tdi.state.tx.us – http://www.tdi.texas.gov/wc/news/index.html

Work-Related Fatalities Decreased in Texas in 2011 for the Second Year in a Row

AUSTIN, TX — Texas recorded a six percent decrease in work-related fatalities in 2011, the second consecutive year of decrease and the lowest level in a decade. There were 433 fatalities in 2011 compared to the 2010 total of 461 fatalities. Nationally, there were a preliminary total of 4,609 fatal work injuries in 2011, according to the most recently available data released on September 20, 2012, by the U.S. Department of Labor, Bureau of Labor Statistics (BLS), Census of Fatal Occupational Injuries (CFOI).

From 2003 to 2011, Texas recorded the lowest work-related fatalities in 2011 (Table 1).

Table 1. Annual Number of Fatal Occupational Injuries in Texas, 2003-2011

2003	2004	2005	2006	2007	2008	2009	2010	2011
491	440	495	489	528	463	482	461	433

The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) compiles detailed information on all work-related fatalities occurring in Texas for the CFOI, a program jointly administered with the BLS. The TDI-DWC annually releases total fatality counts and descriptive data in an effort to provide information to assist employers, safety professionals, and policymakers in identifying occupational safety and health issues in the state.

Causes of Fatalities

Transportation incidents were the leading cause of workplace fatalities in Texas in 2011, with 168 incidents (39 percent of the total fatalities). Of those, 106 were roadway transportation incidents, 32 were pedestrian vehicular accidents, and 14 were nonroadway incidents involving a motorized land vehicle occurring entirely off of a public roadway.

Of the roadway incidents, 70 occurred on a state or U.S. highway. A freight hauling and utility truck such as a tractor trailer truck or dump truck was involved in 51 percent of the roadway incidents (54 incidents) and 42 percent of the incidents involved collisions with another highway vehicle (45 incidents). Sixty percent of the employees involved were in the transportation and material moving occupations (64 incidents), followed by 17 percent in construction and extraction occupations (18 incidents). Employees between the ages of 35 to 54 years were involved in 50 percent of the roadway incidents (53 incidents). Over one-third of the roadway incidents (36 incidents) occurred during the morning and afternoon rush hours, with 19 percent between 7 a.m. to 9 a.m. (20 incidents) and 15 percent between 4 p.m. to 6 p.m. (16 incidents).

Over half of the pedestrian vehicular accidents occurred on a street or highway (18 incidents) followed by 28 percent at an industrial place or premise (9 incidents). Pedestrians were struck by a freight hauling and

utility truck such as a tractor trailer truck or dump truck in 31 percent of the accidents (10 incidents), followed by a passenger vehicle in 25 percent (8 incidents). Forty-seven percent of the employees involved were in the transportation and material moving occupations (15 incidents). Pedestrians between the ages of 45 to 54 years were involved in 41 percent of the vehicular accidents (13 incidents). The highest number of pedestrian vehicular accidents occurred May through August and in November, with 4 incidents each month; the deadliest hours were 11 a.m. to 11:59 a.m. and 8 p.m. to 8:59 p.m.

The second leading cause of workplace fatalities was violence and other injuries by persons or animals, with 70 incidents. Workplace homicides accounted for 60 percent of the fatalities (42 incidents), workplace suicides accounted for 30 percent (21 incidents), and struck by an animal 4 percent (3 incidents). The motive for 48 percent of the workplace homicides was robbery (20 incidents). One-third of the employees involved were security guards and retail sales occupations (14 incidents). Almost half of the workplace homicides occurred at a public building such as a convenience store, restaurant, or pawn shop (20 incidents) followed by 17 percent at an employer's parking lot or garage (7 incidents).

Fatalities resulting from falls accounted for 15 percent of the total fatalities, with 67 incidents. Of these, 84 percent (56 incidents) were falls to a lower level and 15 percent (10 incidents) were falls on the same level. Falls to a lower level from a roof accounted for 21 percent (12 incidents), followed by falls from ladders 16 percent (9 incidents). Thirty-two percent of falls to a lower level occurred at residential and commercial construction sites (18 incidents), and 52 percent of the employees were in construction and extraction occupations (29 incidents). Forty-three percent of the falls to a lower level involved employees between the ages of 45 to 64 years (24 incidents), and 55 percent of the employees were Hispanic or Latino (31 incidents).

Table 2. Annual Number of Fatal Occupational Injuries in Texas by Event or Exposure, 2011

Event or Exposure	2011
Total	433
Violence and other injuries by persons or animals	70
Intentional injury by person	63
Homicides	42
Suicides	21
Injury by person—unintentional or intent unknown	4
Animal and insect related incidents	3
Transportation incidents	168
Aircraft incidents	4
Rail vehicle incidents	3
Pedestrian vehicular incident	32
Pedestrian struck by vehicle in work zone	7
Pedestrian struck by vehicle in roadway	7
Pedestrian struck by vehicle on side of road	3
Pedestrian struck by vehicle in nonroadway area	14
Water vehicle incident	7
Roadway incident involving motorized land vehicle	106
Roadway collision with other vehicle	46
Roadway collision with object other than vehicle	23
Roadway noncollision incident	32

Event or Exposure	2011
Nonroadway incident involving motorized land vehicle	14
Nonroadway noncollision incident	12
Fire or explosion	18
Fire	7
Forest or brush fire	3
Explosion	11
Explosion of pressure vessel, piping, or tire	6
Fall, slip, trip	67
Fall on same level	10
Fall to lower level	56
Other fall to lower level (from ladders, roofs, scaffolds, structural steel, trees, nonmoving vehicles, stairs)	47
Other fall to lower level 6 to 10 feet	7
Other fall to lower level 11 to 15 feet	7
Other fall to lower level 16 to 20 feet	7
Other fall to lower level 21 to 25 feet	4
Other fall to lower level 26 to 30 feet	5
Other fall to lower level more than 30 feet	6
Exposure to harmful substances or environments	43
Exposure to electricity	16
Exposure to temperature extremes	9
Exposure to other harmful substances	16
Nonmedical use of drugs or alcohol unintentional overdose	10
Contact with objects and equipment	66
Struck by object or equipment	52
Struck by powered vehicle nontransport	19
Struck by falling object or equipment	25
Struck by discharged or flying object	4
Struck by swinging or slipping object, other than handheld	3
Caught in or compressed by equipment or objects	8
Caught in running equipment or machinery	7
Struck, caught, or crushed in collapsing structure, equipment, or material	6

Notes for Table 2

- *The Census of Fatal Occupational Injuries (CFOI) has published data on fatal occupational injuries for the United States since 1992. During this time, the classification systems and definitions of many data elements have changed. Please see the CFOI Definitions page on the BLS website at* http://www.bls.gov/iif/oshcfdef.htm *for a more detailed description of each data element and their definitions.*
- *Based on the BLS Occupational Injury and Illness Classification System (OIICS) 2.01 implemented for 2011 data forward. The violence and other injuries by persons or animals category include violence by persons, self-inflicted injury, and attacks by animals.*
- *Total includes data for fatalities that do not meet publication criteria.*

Fatalities by Industry

Overall, 93 percent of fatal work injuries (401 incidents) in Texas involved employees in the private sector in 2011 (Table 3). Service providing industries in the private sector recorded 52 percent of all fatal work injuries (227 incidents), while 40 percent (174 incidents) occurred in the goods producing industries. The other 7 percent (32 incidents) were spread among governmental industries (Table 4).

Among the goods producing industries in the private sector, construction had the highest number of fatal work injuries, with 83 incidents. This was the lowest number in this industry since 2003 (106 incidents) and represented a decrease of 7 percent from 2010. Fifty-three percent of the construction industry fatalities were evenly distributed between transportation incidents (22 incidents) and falls (22 incidents). Construction trade contractors had the highest number of fatalities (58 incidents), a decrease of 3 percent from 2010.

Private sector manufacturing experienced a total of 28 fatal work injuries in 2011, but unlike construction, experienced a 6 percent increase from 2010. Thirty-six percent of the manufacturing industry fatalities were due to transportation incidents (10 incidents). First-line supervisors of production and operating workers had the highest number of fatalities (5 incidents).

Among the service providing industries in the private sector, transportation and warehousing had the highest number of fatal work injuries in 2011; the total (76 incidents) represented a decrease of 18 percent from 2010. There were a total of 58 fatal transportation incidents in the transportation and warehousing sector; of those, 59 percent were roadway incidents involving a motorized land vehicle (45 incidents) and 11 percent involved pedestrians being struck by a vehicle (8 incidents). The truck transportation subsector had the highest number of fatalities (54 incidents), an increase of 2 percent from 2010.

Table 3. Annual Number of Fatal Occupational Injuries in Texas by Industry, Private Sector, 2010-2011

Industry	2010	2011
Total	461	433
Private Industry	419	401
Goods Producing	189	174
Agriculture, Forestry, Fishing and Hunting	28	22
Mining	45	41
Oil and Gas Extraction	3	5
Support Activities for Mining	40	36
Construction	89	83
Construction of buildings	9	12
Heavy and Civil Engineering Construction	20	24
Specialty Trade Contractors	60	46
Manufacturing	27	28
Service Providing	230	227
Wholesale Trade	13	17
Retail Trade	25	25
Transportation and Warehousing	93	76
Truck Transportation	53	54
Utilities	4	--
Information	3	--

Industry	2010	2011
Finance and Insurance	7	--
Real Estate and Rental Leasing	8	6
Professional, Scientific, and Technical Services	12	6
Administrative and Support and Waste Management and Remediation Services	17	38
Education and Health Services	13	14
Health Care and Social Assistance	11	12
Arts, Entertainment, and Recreation	5	8
Accommodation and Food Services	14	15
Other Services, except Public Administration	16	16

Notes for Table 3

- *Industry data from 2003 to 2008 are based on the North American Industry Classification System, 2002. Industry data from 2009 to the present are based on the North American Industry Classification System, 2007.*
- *Includes all fatal occupational injuries meeting this ownership criterion across all specified years, regardless of industry classification system.*
- *Includes fatal injuries to workers employed by governmental organizations regardless of industry.*
- *Includes all fatal occupational injuries meeting this ownership criterion across all specified years, regardless of industry classification system.*

Table 4. Annual Number of Fatal Occupational Injuries in Texas by Industry, Public Sector, 2010-2011

Industry	2010	2011
Government	42	32
Federal Government	7	7
State Government	6	3
Local Government	29	22
Police Protection	15	12
Fire Protection	--	6

Employee Demographics

Fatal work injuries to wage and salary employees decreased by 10 percent from 398 in 2010 to 357 in 2011, while fatalities among the self-employed increased by 21 percent from 63 in 2010 to 76.

Women accounted for 7 percent of the total fatalities (32 incidents). They were involved in fatal transportation incidents in 31 percent of the cases (10 incidents) and were victims of an assault or a violent act in 25 percent of the cases (8 incidents). The leading cause of fatalities among men was transportation incidents with 158 incidents (39 percent), followed by contact with objects and equipment with 64 incidents (16 percent).

The number of fatal work injuries decreased among White, non-Hispanic employees from 257 incidents in 2010 to 217 incidents in 2011, but increased from 26 to 34 incidents for Black, non-Hispanic (31 percent) and from 165 to 171 incidents in 2011 for Hispanic or Latino employees (4 percent).

This release is the first in a series of three releases of data collected by the TDI-DWC in cooperation with the BLS. Incidence rates for nonfatal injuries and illnesses by industry for 2011 will be published in October 2012, and detailed case circumstances and worker characteristics for nonfatal workplace injuries and illnesses for cases that result in days away from work will follow in November 2012. In 2010, the Texas incidence rate for nonfatal occupational injuries and illnesses was 2.7 per 100 full-time workers. The Texas rate has been below the national average since data collection began in 1990.

The TDI-DWC provides various safety and health services to assist employers in providing safe and healthy workplaces, including free safety and health consultations on Occupational Safety and Health Administration (OSHA) regulations; regional and onsite safety training; free safety training DVD/video loans; the Safety Violations Hotline; and free safety and health publications. For more information on these services, visit the TDI website at http://www.tdi.texas.gov/wc/safety/index.html or call 800-687-7080. For more information about fatal work-related incidents, contact the TDI-DWC by telephone at 512-804-4658 or send an e-mail to cfoi@tdi.state.tx.us.

Regarding the data reported in this news release:

- *Sources include the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC), Census of Fatal Occupational Injuries (CFOI) in cooperation with the Bureau of Labor Statistics (BLS), U.S. Department of Labor.*
- *Data for 2011 are preliminary. Data for prior years are revised and final.*
- *Totals for major categories may include subcategories not shown separately.*
- *Dashes indicate no data or data that do not meet publication criteria.*
- *CFOI fatal injury counts exclude occupational illness-related deaths unless precipitated by an injury event.*
- *Changes to the OIICS Structure: Information in this release incorporates a major revision in the Occupational Injury and Illness Classification System (OIICS), which is used to describe the characteristics of fatal work injuries. Because of the extensive revisions, data for the OIICS case characteristics for reference year 2011 represent a break in series with data for prior years. More information on OIICS can be found at www.bls.gov/iif/oshoiics.htm.*

# # #

TEXAS DEPARTMENT OF INSURANCE
Public Information Office | 333 Guadalupe | P.O. Box 149109 | MC113-1A | Austin, TX 78714 | Phone (512) 463-6425 | Fax (512) 463-6141 | www.tdi.texas.gov

Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC)
Referrals of Injured Employees for Vocational Rehabilitation Services to the
Department of Assistive and Rehabilitative Services (DARS)

Texas Labor Code, Sections 408.150 and 409.012 and 28 Texas Administrative Code Section 136.1 require TDI-DWC to identify injured employees that would be assisted by vocational rehabilitation services and refer those injured employees to DARS.

Types of TDI-DWC Vocational Rehabilitation Referrals:

- Automatic referrals using TDI-DWC claim data based on certain referral triggers
- Manual referrals made by TDI-DWC staff based on individual discussions with injured employees

Automatic Referral Triggers:

- Claims with equal to or greater than 12 weeks of Temporary Income Benefits (TIBs)
- Claims with a 15% or greater impairment rating assigned
- Claims with the criteria laid out in TDI-DWC Rule 136.1 – provided below

Total Number of Referrals Made by TDI-DWC Staff to DARS
Fiscal Years 2009-2012

Referral FY	Total # of TDI-DWC Referrals
2009	26,960
2010	23,583
2011	21,188
2012	26,380

Source: Texas Department of Insurance, Division of Workers' Compensation, 2012.

TDI-DWC Rule 136.1 DARS Referral Criteria:

(1) an amputation of:
    (A) an arm or leg;
    (B) three fingers or more; or
    (C) the large toe or one-third of the foot or more;
(2) the loss of use of an arm or leg;
(3) a permanent spinal cord injury;
(4) a head injury;
(5) a heart attack or heart disease;
(6) an occupational disease;
(7) blindness or significant vision loss;
(8) severe or extensive burns;
(9) any other condition that indicates an impairment is likely; or
(10) any injury resulting in more than 30 days lost time. Such injury shall be reviewed and a determination made as to the degree of impairment and the appropriateness of vocational rehabilitation services.

Statutory Authority for TDI-DWC Referrals to DARS (Texas Labor Code Citations)

Sec. 408.150. VOCATIONAL REHABILITATION.

(a) The division shall refer an employee to the Department of Assistive and Rehabilitative Services with a recommendation for appropriate services if the division determines that an employee could be materially assisted by vocational rehabilitation or training in returning to employment or returning to employment more nearly approximating the employee's preinjury employment. The division shall also notify insurance carriers of the need for vocational rehabilitation or training services. The insurance carrier may provide services through a private provider of vocational rehabilitation services under Section 409.012.

(b) An employee who refuses services or refuses to cooperate with services provided under this section by the Department of Assistive and Rehabilitative Services or a private provider loses entitlement to supplemental income benefits.

Sec. 409.012. VOCATIONAL REHABILITATION INFORMATION.

(a) The division shall analyze each report of injury received from an employer under this chapter to determine whether the injured employee would be assisted by vocational rehabilitation.

(b) If the division determines that an injured employee would be assisted by vocational rehabilitation, the division shall notify:

(1) the injured employee in writing of the services and facilities available through the Department of Assistive and Rehabilitative Services and private providers of vocational rehabilitation; and

(2) the Department of Assistive and Rehabilitative Services and the affected insurance carrier that the injured employee has been identified as one who could be assisted by vocational rehabilitation.

(c) The division shall cooperate with the office of injured employee counsel, the Department of Assistive and Rehabilitative Services, and private providers of vocational rehabilitation in the provision of services and facilities to employees by the Department of Assistive and Rehabilitative Services.

(d) A private provider of vocational rehabilitation services may register with the division.

(e) The commissioner by rule may require that a private provider of vocational rehabilitation services maintain certain credentials and qualifications in order to provide services in connection with a workers' compensation insurance claim.

(f) Repealed by Acts 2011, 82nd Leg., R.S., Ch. 1083, Sec. 25(127), eff. June 17, 2011.

Referral Letter Information to DARS

- The chart below details referral letter information received from September 2010 through August 2011

September 2010 Through August 2011: 15,291[1] TDI-DWC Referrals to DARS Received											
Maximum time available from September 2010 for a claimant to advance through the VR process beyond Application= 24 months. (September 1, 2010 to August 31, 2012)											
Sequence of DWC Referral and VR Case	Summary of Activity by 8/31/2012				Status at 8/31/2012						
	Number / Percent of Referrals **Applied** for VR Services	Number / Percent of Applicants **Eligible**	Number / Percent of Applicants with **IPE**	Number / Percent Applicants **Successfully Employed**	Application *includes Extended Evaluation*	Eligibility	Closed Before Eligibility	Closure Before Plan	Plan Initiated	Unsuccessful Closure with Plan	Rehab Rate
DARS Combined Vocational Rehabilitation Divisions Snapshot[2]											
Number Routed to DARS Field Offices				**14,933**							
VR Application **Before** DWC Referral Date	194	164	129	**38**	1	1	29	34	54	37	50.67%
	1.30%	84.54%	66.49%	19.59%							
VR Application **After** DWC Referral Date	678	488	300	**61**	34	59	156	129	219	20	75.31%
	4.54%	71.98%	44.25%	9.00%							
Column Total	***872***	***652***	***429***	***99***	***35***	***60***	***185***	***163***	***273***	***57***	***63.46%***

[1] a total of 223 injured workers were referred more than once and accounted for 455 referrals

[2] Divisions include Rehabilitation Services and Blind Services. A total of 26 persons applied more than once and accounted for 52 VR cases

Differences between DARS referral letter data and TDI-DWC

- TDI-DWC previously sent the following chart to the committee on total number of referrals

Total Number of Referrals Made by TDI-DWC Staff to DARS
Fiscal Years 2009-2012

Referral FY	Total # of TDI-DWC Referrals
2009	26,960
2010	23,583
2011	21,188
2012	26,380

Source: Texas Department of Insurance, Division of Workers' Compensation, 2012.

- There are differences between the number of referral letters that DWC sends to injured workers in a State Fiscal Year in comparison to the number of injured

employee information DARS receives electronically from DWC and subsequently sends to field staff.

- Of particular note is SFY2011 and SFY2012 when DWC, at DARS' request, instituted a 30 day lag on Temporary Income Benefits (TIBS) referrals to try to eliminate those injured employees who had already returned to work and were, therefore, not in need of DARS' services. That process resulted in approximately a 25 percent to 30 percent reduction per month of referrals sent to DARS.
- The number that DWC reports is the total number of letters, which includes some duplicates and those who are no longer receiving income benefits when the 12 week criteria for the TIBS letter is reached. Any duplicate names that appear in the data file for a month are reduced by DWC to a single entry when sent to DARS.
- DWC's count is for the month in which the letter was sent. DARS's count is based on the date that the referral information is received from DWC, a one to three month difference. The different monthly counts have an impact on the SFY totals.
- There are months when DARS does not receive a data file from DWC. For example, there were two months in 2012 that DARS did not receive data files. In these cases, DWC continues to include the letters in their count but DARS does not.

APPENDIX TO CHARGES 6 & 7

Updates on Legislative Implementation, Interim Benefits Studies, and Legislative Appropriation request

ERS
Employees Retirement System of Texas

November 2012

ERS AT A GLANCE **FISCAL YEAR 2011: Snapshot on August 31, 2011**

RETIREMENT

Retirement plans for state employees, elected officials, law enforcement and custodial officers (LECOSRF) and two plans for judges (JRS 1 and JRS 2)

- $22.1 billion trust fund
- 82.8% Funded Ratio
- 12.6% One-year rate-of-return on investments* (Actuarial assumed rate is 8%)
- 137,861 active members (ERS 137,293; LECOSRF 36,806; JRS 1 22; JRS 2 546)
- 84,085 retirees (ERS 83,430; LECOSRF 7,728; JRS 1 447; JRS 2 208)
- $1.6 billion in retirement payments

Note: LECOSRF is included in ERS count.

Texa$aver Program

Tax-deferred supplemental retirement program

- $1.7 billion in assets
  - $1.3 billion in 401(k)
  - $381 million in 457
- 109,613 401(k) accounts
- 21,153 457 accounts

INSURANCE

Texas Employees Group Benefits Program provides coverage for health, life, dental, voluntary accidental death & dismemberment (AD&D), long-term care, long and short-term disability

- $2.3 billion estimated in health plan expenditures
- $608.4 million estimated in member expenditures (does not include member costs to cover dependents)
- 526,957 health participants (Employees 214,369, Retirees 83,739; Dependents 223,373; COBRA 1,690; Survivors 3,786)
- 396,947 participants enrolled in two dental plans (Employees 166,443; Retirees 41,322; Dependents 185,898; COBRA 1,522; Survivors 1,762)

TexFlex

(Health/Dependent Care Reimbursement Accounts)
Flexible spending accounts for health and dependent care expenses

- $93.7 million contributed to TexFlex accounts by state employees
- 52,493 accounts
- $482.4 million in insurance premiums redirected
  - $109.2 million estimated tax savings for participants (FICA and FIT)
  - $36.9 million estimated tax savings for state (FICA)

**FY2012 return is 8.24% (unaudited, gross of fees).*

To view the 2011 Comprehensive Annual Financial Report go to www.ers.state.tx.us/About_ERS/Reports/

INVESTMENTS

ERS manages a $22.1 billion retirement trust on behalf of state employees and retirees who are the beneficiaries of the trust. Investment returns are an important part of funding for the ERS retirement plan. Over the last 20 years, 63.5% of the value of the ERS Retirement Trust came from investment earnings.

A healthy 12.6% investment return for FY2011 helped the ERS Retirement Trust moderate some of the losses incurred in recent years. ERS also continues to surpass its long-term investment goals with a 30-year rate-of-return of 8.6%.

Day-to-day investment decisions are managed by ERS' professional investment staff within the policies, procedures, and risk management guidelines set by the ERS Board of Trustees. The ERS Board and Investment Advisory Committee are exploring options for adjusting long-term asset allocation targets to increase investment diversity while maintaining an acceptable level of risk.

ERS Retirement Trust Asset Allocation

Asset Class	August 31, 2011	Long-Term Target
Global Equity	55.4%	45%
Fixed Income	36.3%	33%
Private Equity	3.1%	8%
Diversified Real Estate	3.6%	8%
Hedge Funds	0.0%	5%
Cash	1.4%	1%

Internally Managed	78.1%	Externally Advised 21.9%

To view ERS Investments information go to www.ers.state.tx.us/about_ers/ers_investments/

(Over)

ERS
Employees Retirement System of Texas

RETIREMENT

The State of Texas provides retirement benefits to retired employees, law enforcement officers and judges as part of the state's overall compensation package.

The ERS retirement plans are designed to provide a stable source of income for state employees during retirement. The typical state agency retiree worked for the state for 22 and one half years, is 68 years old, and receives $18,614 a year in ERS retirement benefits.

Both the state and state employees contribute a portion of monthly salary to the pension trust fund. State employees are enrolled in the defined benefit plan 90 days after they begin working. Employees share responsibility for pre-funding their retirement, a key factor toward maintaining a sustainable retirement plan. State and employee contributions are professionally invested to pay for future retirement benefits. The state's contribution toward its employees' retirement during the 2010-2011 biennium accounted for less than 0.5% of the state's total two-year budget.

Retirement Monthly Contribution Rates

	FY 2011 % of salary	FY 2012 % of salary	FY 2013 % of salary
Employees Retirement System of Texas			
State contribution	6.95%	6.00%	6.50%
Employee contribution	6.50%	6.50%	6.50%
Law Enforcement & Custodial Officers Supplemental Retirement Fund			
State contribution	1.59%	0.00%	0.50%
Officer contribution	0.50%	0.50%	0.50%
Judicial Retirement System of Texas Plan II			
State contribution	16.83%	6.0%	6.5%
Judge contribution	6.00%	6.0%	6.0%

TEXAS EMPLOYEES GROUP BENEFITS PROGRAM

ERS lowered health plan costs $7.3 billion in FY11 with tough cost-management practices, aggressive negotiation of contracts, and low administrative overhead. Third-party Administrative costs for the self-funded health insurance plan is only three cents on every health care dollar. And at 8%, the HealthSelect℠ of Texas benefit cost trend is 2.7% lower than the national trend. Just a few of our accomplishments:

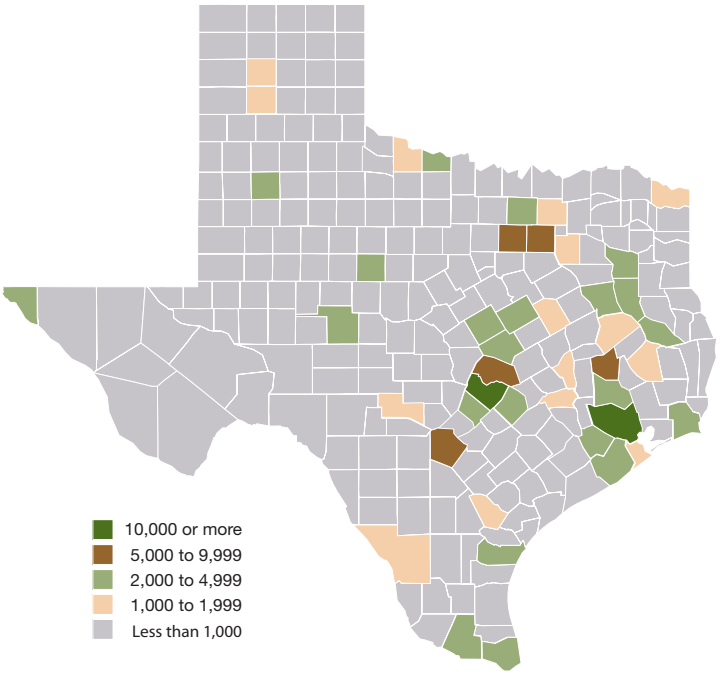
- Saving $333 million over four years on the Pharmacy Benefit Manager Contract.
- The Group Benefits Plan has a new third-party administrator for the HealthSelect employee insurance plan, with an estimated value approximately $41 million lower than the other proposals over the four-year term of the contract.
- Medicare-eligible retirees were automatically enrolled in a Medicare Advantage preferred provider organization (MA-PPO) plan, which provides the same level of coverage at a lower cost to both the State and retirees. Although members are allowed to opt out, 62% remained enrolled in the MA options in FY2012, resulting in an expected cost savings of approximately $18.4 million for FY 2012.
- Holding the line on provider increases. Doctor payments have increased slower than inflation for the past six years.
- Cutting administrative overhead. About 97 cents of every GBP dollar is spent on health care, not administration.
- Piloting accountable care initiatives, which cut the health care cost trend in half for the population served and generated shared savings payments to the providers.

Several FY12 initiatives will help control costs and save members money. Starting January 1, 2012, tobacco users began paying more for health insurance, and ERS added two Medicare Advantage programs—a regional HMO for the Houston area and a statewide PPO.

The Medicare Advantage Plans will save retirees money and could reduce plan costs up to $42.5 million.

To view the ERS Retirement Valuation report go to www.ers.state.tx.us/About_ERS/Reports/

Number of ERS Members and Annuitants by County



Insurance Legislation:

ERS has implemented the following General Appropriations Act riders related to the Texas Employees Group Benefits Program (GBP):

- Medicare Advantage Plans – Two Medicare Advantage (MA) plans were implemented in the Texas GBP: a Medicare health maintenance organization (HMO) in the Houston area in September 2011; and a state-wide Medicare Advantage preferred provider organization (PPO), known as HealthSelect Medicare Advantage Plan, in January 2012. Both plans provide benefits similar to HealthSelect, but at a reduced monthly premium.

  More than 74,000 Medicare-primary participants were eligible for enrollment in the MA plans, and as of July 20, 2012, 46,498 participants (37,055 members and 9,443 dependents) are enrolled in the plans. Estimated plan cost savings for FY 2012 are expected to be $18.4 million.

- Tobacco User Premiums – Tobacco users in the GBP began self-reporting and paying tobacco user premiums in January 2012. Tobacco users pay an additional $30 per tobacco-using participant per month – up to $90 per month per household, depending on how many covered family members use tobacco. Around 25,000 members and their dependents have certified themselves as tobacco users. The GBP expects to collect an additional $5.1 million in FY 2012 and about $8.8 million in FY 2013 as a result of the premiums.

- Insurance Payroll Contributions – State agencies and participating higher education institutions began paying 1% of their base payrolls to the GBP in September 2011. The payroll contribution leverages the salaries of employees paid in whole or part by federal funds. ERS expects to collect approximately $86.5 million for FY 2012.

- Alternate Provider Payment Systems – Alternative reimbursement pilot programs were established in the GBP with Austin Regional Clinic in Austin, Kelsey-Seybold in Houston, and Trinity Clinic in East Texas, which together cover approximately 43,000 HealthSelect participants. Each of these primary care practices hired care coordination personnel to manage care of HealthSelect participants', as a way to improve quality and lower medical costs. The practices are measured on their effectiveness in lowering the health benefit cost trend for their participants while also satisfying chronic disease, preventive, and other quality-of-care metrics. ERS considers the pilot programs to be successful, with calculated savings exceeding $11 million in FY 2011.

The following legislation expanded eligibility criteria for GBP participation:

- Dependent children up to age 26 – SB 1664
- Disabled adult dependents previously covered under another statewide plan – HB 755
- Survivors of law enforcement trainees killed in the line of duty – SB 423
- Graduate students and postdoctoral fellows at state universities other than the University of Texas and Texas A&M University – SB 29
- Wrongfully imprisoned individuals – HB 417 and SB 1686

Other Legislation:

- ERS Investment Advisory Committee – Members of the Investment Advisory Committee have been informed of the new statutory eligibility criteria and conflict-of-interest restrictions that now apply to them. The required annual compliance review is underway and will be reported on at the December 2012 meeting of the ERS Board of Trustees. – HB 2193

- Annuity Deductions for State Employee Charitable Campaign (SECC) – This legislation requires the SECC to pay for administrative costs for implementation because ERS is constitutionally prohibited from diverting trust funds for this purpose. ERS and the SECC are still working out cost issues. – HB 1608

The 82nd Texas Legislature directed ERS to study and report on the State of Texas retirement program. The report is the result of a year-long research process designed to be transparent and inclusive to all stakeholders with an interest in the future of the state retirement plans.

The report analyzes 14 options to increase revenue, modify benefits, or establish an alternative plan. It also compares the state's pension benefits to other large defined benefit plans.
The findings are:

Without action, the unfunded liability will continue to increase and make today's situation unmanageable.

- The ERS pension plans have enough assets to pay benefits for the next 70 years, but they are not operating on an actuarially sound basis.
- Investment returns alone cannot fill the funding gap.
- State contributions of 10% and employee contributions of 6.5% could pay down the unfunded liability within a measurable period of 55 years.

A good balance can make the current plan sound.

- The report analyzes options to increase plan revenue, lower expenses through plan design modifications, and create alternative plan designs. Balancing options could move the plan in the right direction while decreasing the likelihood of unintended consequences.

Establishing an alternative retirement plan could fulfill specific workforce needs; however, it does not erase the unfunded liabilities in the existing defined benefit (DB) plan and could cost more.

- An alternative retirement plan—such as a defined contribution (DC) plan (like a 401(k)), cash balance, or hybrid plan—could be valuable to employees who do not plan a career with the state, or those who like controlling their own investments.
- The value of a DC plan depends on how well the individually controlled investments perform. Studies show that individually managed accounts have higher fees and lower overall performance than any type of retirement plan.
- Implementing an alternative plan structure does not automatically lower costs or erase the existing unfunded liability. In fact, all the alternative plan structures modeled in the report show increased costs in order to achieve a sound new benefit structure.

Prefunded pooled investing increases value to the members and the state.

- Employee contributions and investment earnings do most of the work, producing 82% of the benefits.
- The state contribution is lower and member contribution higher than the median public sector pension plan.
- Pooled trust fund dollars are invested in Texas companies through stock, bond, and real estate portfolios.
- Private equity investments provide capital to local companies.
- About 30% of the trust's equity investments are in companies with Texas headquarters or with 200 or more Texas workers.

Retirement benefits are critical to attracting and retaining qualified employees.

- The state agency workforce is already lean, having grown by only 2% over the past decade, even as Texas' population grew 20%—10 times faster.
- Turnover rates in Texas agencies increased significantly in FY2011, with employees citing new jobs with better pay and benefits as their primary reason for leaving. Some positions and locations face 40% turnover rates.
- Turnover costs money—agencies lose training in terms of dollars and time when valuable knowledge walks out the door. For example, the state invests about $30,000 over seven months to train each Department of Public Safety trooper. That investment is lost if the trooper goes to work for a county or municipal employer.
- State employers say that lowering benefits will increase these costly turnover rates.

It is difficult to make direct comparisons between private- and public-sectors workers.

- Manufacturing and sales jobs, a large part of private industry work, typically do not exist in state government. A 2010 State Auditor's Office market analysis showed that almost 40% of state jobs do not have a close equivalent in the rest of the job market.
- According to SAO, almost one-fifth of general state employees in positions that can be compared to private-sector positions are paid salaries more than 20% behind market rates.
- Private employer compensation packages often include rewards not available to public employees, such as stock options, expense accounts, and annual bonuses.

Changes to other parts of the employee compensation package can impact the retirement plan.

- Changes to the insurance benefits that encourage employees to work longer can help the retirement plans. For example, tying insurance coverage to tenure will encourage employees to work longer. On the other hand, changing insurance eligibility could cause a "rush to retirement" that could cost the pension plan.
- Any plan modification or structural change carries legal risks that increase as more members are included.
- Benefits for vested members have a number of protections, and changing them could have legal and tax consequences.

For a copy of the full report, please visit our website **www.ers.state.tx.us.**

Options to Increase Revenue (Section 3)		Description
3.1	Increase state and/or employee contribution rates	Increase the state contribution, the employee contribution, or both. Rate increases could be fixed or variable.
3.2	Consider the use of obligation bonds	Issue either general obligation bonds or a state bond with repayment funded by a consistent, regular funding source owned by the state.
3.3	Consider using a one-time revenue source	Make a one-time payment for the full amount or some other amount to pay off or significantly reduce the unfunded liability.
3.4	Consider using alternate, ongoing funding sources	Direct lapsed general revenue dollars or a dedicated revenue source to the retirement trust fund.

Options to Modify Plan Design (Section 4)		Description
4.1	Change the final average salary calculation to 60 months	Increase the number of months for final average salary calculation to 60 for affected employees – effectively lowering the monthly benefit annuity.
4.2	Eliminate the use of unused leave to establish retirement eligibility or increase service time	Eliminate the ability to use sick and annual leave balances to increase service time or increase annuity benefits – effectively increasing the length of time a person is required to work to be eligible for retirement.
4.3	Reduce the benefit multiplier for future service and allow employees to “buy up” to increase their multiplier	Reduce the multiplier for future service from 2.3% to 2% for non-grandfathered employees. Affected employees can pay an increased contribution rate to “buy up” their multiplier to the 2.3% level at the actuarial cost.
4.4	Apply September 1, 2009 changes to all employees	Increase the number of months for final average salary calculation to 48 and implement an annuity reduction of 5% per year if retiring before age 60, capped at 25% reduction.
4.5	Reduce the interest paid on retirement account balances	Reduce the interest paid on employee account withdrawals from 5% per year to a lower level authorized by the ERS Board of Trustees.
4.6	Eliminate the 25% cap on the 5% per year under 60 reduction	Implement an unqualified 5% per year reduction on annuities for employees who meet the rule of 80 and retire prior to age 60, removing the current cap that limits the total reduction to 25%.

Options to Establish an Alternative Plan (Section 5)		Description
5.1	Employee choice plan	Provide the member with a one-time choice between a defined contribution (DC)-only plan and a defined benefit (DB)-only plan within first 90 days of employment. Present the DB option as in the current plan or with design modifications.
5.2	Mandatory cash balance plan	Provide a cash balance plan, a DB-type plan that pools investments and pays lifetime annuities, but that defines the retirement benefit in terms of a stated account balance at time of retirement.
5.3	Mandatory two-part hybrid plan	Provide a DB plan with reduced benefits combined with DC plan. Split contributions equally between the plans.
5.4	Mandatory DC only (DB closed)	New employees participate in a 401(k)-style plan that provides benefits based on account balance at time of retirement, with no lifetime benefit assurance.
5.5	Other combinations	Offer other combination(s) of the above plans or plan designs.

ERS
Employees Retirement System of Texas

Insurance Benefits Study Findings

September 2012

Sustainability of the Texas Employees Group Benefits Program (GBP)

The 82nd Texas Legislature directed ERS to study and report on the State of Texas health insurance program. The report is the result of a year-long research process designed to be transparent and inclusive to all stakeholders with an interest in the future of the state employees insurance plan.

The report analyzes 37 options to improve the sustainability of the GBP for the Legislature's consideration. It compares state health insurance benefits to other large public and private sector employer benefit plans. These are the report findings.

Health insurance benefits are key to attracting and retaining qualified employees.

- Benchmarking analysis shows as a whole the HealthSelect out-of-pocket cost to members is comparable to the typical private sector health plan.
- However, the 100% employer-paid premium for employee-only and retiree-only coverage is outside of the norm.
- Employees and retirees who want to cover their families pay a higher percentage of their premium cost than the typical private sector plan member.
- Employers say that health insurance benefits help offset lower salaries in attracting and retaining employees.

We all share responsibility for the sustainability of the plan.

- ERS, the Legislature, employees, retirees, covered family members, health care providers, employers, and taxpayers – we all have a role to play in ensuring that high-quality, comparable benefits are available to the state workforce.

A sustainable plan would have predictable rate increases.

- Rate increases would occur at a predictable, controlled level, providing the State a reliable way to budget for the plan.
- Adequate revenue would allow the GBP to avoid routine reliance on the contingency fund as a substitute for contribution revenue.
- Plan design changes would occur on a predictable basis, allowing GBP members the ability to plan and budget for cost shifts and out-of-pocket increases.

A flexible approach that offers choice and financial incentives will facilitate behavior change.

- When the State pays 100% for member-only coverage, members have no incentive to choose anything but the most generous benefit.
- Choice costs money and adds risk. When multiple plan choices are offered, the risk of adverse selection comes into play.
- A flexible contribution strategy could support allocating some GBP funds toward wellness and other cost-savings initiatives.

There's a difference between cost management and cost shifting.

- Sharing costs can encourage members to make more responsible choices, but excessive cost sharing can discourage them from getting necessary care.
- Reducing health care claims is the only way to reduce the contributions needed to run the plan.
- Employers fear the aftermath of a significant benefit cut.
- Many low-wage state employees do not take family coverage because they can't afford it.

ERS provides quality benefits at a lower-than-average cost.

- Professional cost management programs lowered plan charges by $7.3 billion in FY11.
- GBP costs are much lower than the national average for other employer-sponsored plans.
- ERS spends 97 cents of every HealthSelect dollar on health care claims.
- ERS is already implementing industry best practices and study recommendations.

A long-term view is essential.

- Many of the options with the greatest potential for managing costs will not show immediate savings.
- Long-term solutions, such as wellness incentives, require upfront investments, rigorous ongoing management, and time to deliver results.
- Designing systems that share risk with providers and increase member responsibility all take time.
- Lasting change depends upon individual members taking an increased role in managing their health outcomes and changing unhealthy behavior.

For a copy of the full report, please visit our website **www.ers.state.tx.us**

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	LEGISLATIVE ACTION/SUPPORT	ERS BOARD OF TRUSTEES
Limit (or eliminate) eligibility for coverage	*Eliminate coverage for all participants* 1.1 End the state health insurance coverage and end participants to the federal exchange in 2014 to purchase individual policies *Eliminate coverage for all retirees* 1.2 Eliminate health insurance coverage for retirees	ERS does not have the authority to make these changes.
Options for raising revenue	*Employees* 2.1 Base employee premium contributions on salary 2.2 Base employee premium contributions on years of employment *Retirees* 2.3 Defined contribution with HRA and connector model 2.4 Charge retirees full actuarial cost of insurance 2.5 Tier retiree premium contribution on years of service *Employees and Retirees* 2.6 Raise premium contribution for member-only coverage *All participants* 2.7 Raise premium contribution for people who don't enroll in disease management, when appropriate *Dependents* 2.8 Raise premium contribution for all dependent coverage 2.9 Charge more for spouses who could enroll in their employer's health coverage	ERS does not have the authority to make these changes.
Options for managing costs	*High performance networks* 4.3 Restricted networks based on cost and quality *Alternative Payment Systems* 4.6 Accountable Care Organizations *Multiple plan choices* 5.1 Basic benefit with the option to buy up (change in the contribution strategy to allow for pricing flexibility) 5.2 Consumer driven health plan (change in the contribution strategy to allow for pricing flexibility; HSA implementation would require authorization for payroll deduction and employer deposits to the account) *Generic drug incentives* 5.10 Reference-based pricing 5.12 Therapeutic substitution	*Medicare Part D claims processing* 4.1 Retiree drug subsidy (RDS) past claims reprocessing 4.2 EGWP + Wrap *Alternative Payment Systems* 4.7 Patient-centered medical home *High performance networks* 4.3 Restricted networks based on cost and quality 4.4 Results-based hospital contracts using quality metrics 4.5 Surgical centers of excellence and/or medical tourism *Generic drug incentives* 5.10 Reference-based pricing 5.11 Step therapy 5.12 Therapeutic substitution *Plan choices and design* 5.1 Basic benefit with the option to buy up 5.2 Consumer-driven health plan 5.3 Managed care plan with a deductible 5.8 Value-based insurance design 5.9 Minimally invasive procedures
Investing in tools for program efficiency		*Management tools* 4.8 Management tools (predictive modeling, risk analysis) 4.9 Data mining tools (group profiling, benefit modeling)
Investing upfront for potential long-term savings	*Data collection efforts* 4.10 Perform a cultural assessment of all or a portion of the GBP membership to develop a strategic plan to improve employee responsibility for their individual health 4.11 Require health risk assessments or biometric screenings to increase employee understanding of health conditions and start early intervention	*Carve-outs* 5.5 Coordinate disease management, behavioral health and social services for pre-65 retirees 5.6 Partial carve out of behavioral health 5.7 Outsource tobacco cessation program management *Value-based benefits* 5.8 Benefit-based copays (reduced copays to increase medication adherence)
Efforts to increase productivity and personal responsibility	*Worksite wellness* 4.12 Incentives for healthy behaviors and lifestyle management programs at work 4.13 Require non-tobacco users to self-certify, or pay higher tobacco premium *Worksite clinics* 5.13 Provide health or wellness clinics to employees at the work place staffed by a nurse practitioner	

#	INSURANCE OPTION	AUTHORITY	DESCRIPTION
SECTION 1 – ELIGIBILITY: Who should be eligible for coverage under the plan?			
1.1	Eliminate coverage for all participants	Legislature	The state would send all participants to the Federal Exchange in 2014; employers would pay $2,000 penalty per employee. The state could also give employees a set amount to use when buying insurance.
1.2	Eliminate coverage for all retirees	Legislature	This costs the impact of ending insurance coverage for all retirees.
SECTION 2 – CONTRIBUTIONS: How should the employer and the member share the cost of coverage?			
Employee contributions			
2.1	Base employee premium contributions on salary	Legislature	Employees would contribute 2% of their salary, up to a cap of 20% of the monthly rate (in FY13, $94). Employees earning about $60,000/yr or more would pay the full 20%.
2.2	Base employee premium contributions on tenure	Legislature	New employees would contribute 20% of the monthly contribution rate (in FY13, $94), with a 2% reduction for every year of service. At 10 years of employment, their contribution would = $0.
Retiree contributions			
2.3	Defined contribution for Medicare-primary retirees deposited into a Health Reimbursement Account with a "connector model"	Legislature	Employer would contribute $256 per month to a Health Reimbursement Arrangement (HRA) for each retiree (member-only rate of the lowest-cost Medicare Advantage plan) and 50% for each dependent to purchase insurance through a connector model (works like an exchange, where many plans are sold in a centralized location).
2.4	Charge retirees full actuarial cost of their insurance	Legislature	Retirees could buy GBP insurance, but they would pay the full actuarial cost. HealthSelect member-only coverage would be $306/mo. for Medicare retirees; $750/mo. for <65 retirees.
2.5	Tier retiree premium contributions on years of service	Legislature	The longer a retiree worked for the state, the more the employer would contribute toward his/her insurance coverage. <10 years of service = retiree pays full cost 10-15 years of service = retiree pays 50% of cost 15-20 years of service = retiree pays 25% of cost 20+ years of service = employer pays 100%
Member contributions			
2.6	Raise member-only premium contributions (currently 0%, costed at 10% and 20%)	Legislature	Would reduce the employer's contribution from 100%, to 80% or 90%. Each one-percent decrease in the employer's contribution would shift $16.6 million annually to members. In FY13, a 10% contribution rate would cost $47/mo.; a 20% rate would cost $94/mo.
Contributions for participants with chronic illness			
2.7	Raise member premium contributions for eligible participants who don't enroll in disease management	Legislature	Would requires participants to pay an extra $30 per month if they were identified for a disease management program, but chose not to participate. The free programs are conducted via telephone and mail. The TPA would determine eligibility through claims analysis and Health Risk Assessments.
Dependent contributions			
2.8	Raise member premium contributions for dependent coverage (currently 50%, costed at 60% and 70%)	Legislature	Reduces the employer's contribution for dependent coverage from 50%, to 30% or 40%. Each one-percent decrease in the employer's contribution for dependent coverage would shift $7.8 million annually to members with dependents.
2.9	Surcharge for spouses with access to other coverage who enroll in GBP	Legislature	Spouses of active employees would pay an extra 20% if they chose GBP coverage when they had access to other insurance coverage through their employer.
SECTION 4 – PROFESSIONAL MANAGEMENT: How do cost management initiatives save the plan money?			
Retiree solutions			
4.1	Retiree Drug Subsidy (RDS) past claims reprocessing	ERS Board of Trustees	Contract with a vendor to reopen past RDS claims, with the goal of identifying and reclaiming missed reimbursements. Contract effective November 1, 2012.
4.2	Employer Group Waiver Program + Wraparound Supplemental Plan (EGWP + Wrap)	ERS Board of Trustees	Transfer Medicare retirees to an EGWP + Wrap drug plan (Medicare Part D plan plus a wrap-around plan) that closely matches HealthSelect prescription drug program benefits. A pharmacy benefit manager administers the program. All GBP Medicare retirees will be moved to the HealthSelect Medicare Rx program on January 1, 2013.
Contracting solutions			
4.3	High-performance networks	Legislature/ ERS Board of Trustees	Structure the HealthSelect network to steer participants to high-performing providers. The TPA ranks providers, usually specialists, into three "tiers" based on cost and quality. Participants can look up provider rankings online to help them decide who to see and how much it will cost.
4.4	Results-based hospital contracts using quality metrics	ERS Board of Trustees	"Pay for performance" contracting that rewards hospitals for achieving quality metrics (e.g., fewer hospital acquired infections and so-called "never events", and lower readmission rates). Hospitals can be penalized for missing targets, but they can also earn bonuses for good performance.
4.5	Surgical Centers of Excellence and/or medical tourism	ERS Board of Trustees	Incentivize (or require) participants to use facilities (domestic or international) with the best outcomes, usually for high cost procedures (e.g. transplants, cardiac or bariatric surgery).
Alternative payment models			
4.6	Accountable Care Organizations (ACOs)	Legislature/ ERS Board of Trustees	Fully-integrated delivery model including PCPs, specialists, and hospitals. The provider group agrees to take on more risk in exchange for shared savings when cost and quality targets are met.
4.7	Patient Centered Medical Homes (PCMHs)	ERS Board of Trustees	Integrated delivery model with a multi-specialty practice (no hospitals) that agrees to take on more financial risk in exchange for shared savings when cost and quality targets are met.

#	INSURANCE OPTION	AUTHORITY	DESCRIPTION
Administrative tools			
4.8	Management tools	ERS Board of Trustees	Vendor tools that offer a data-driven approach to benefit design, including benchmarking benefits against other plans, cost/benefit and risk analysis, and predictive modeling.
4.9	Data mining tools	ERS Board of Trustees	Vendor tools that perform group profiling using claims data, health risk assessments, and/or biometric screenings. Forecasting tools can target cost drivers and model benefit changes.
4.10	Cultural assessment of targeted segments of the GBP population	Legislature/ ERS Board of Trustees	Vendor would conduct an organizational assessment of a targeted portion of the state workforce (interviews, surveys, demographic and health analyses, review of agency wellness policies and readiness for change), then design a 3-5 year intervention plan for employee engagement.
4.11	Required health risk assessments (HRAs) and/or biometric screenings	Legislature/ ERS Board of Trustees	Would require all participants to take HRAs and/or get biometric screenings. The data would identify people with health issues who could benefit from disease management or other interventions.
4.12	Incentives for healthy behaviors and lifestyle management programs at work	Legislature/ ERS Board of Trustees	This would require upfront investments by the state to support worksite wellness initiatives, such as efforts to encourage exercise, weight loss, or smoking cessation.
4.13	Require non tobacco users to opt out of premium differential	Legislature/ ERS Board of Trustees	Instead of a passive enrollment process (i.e. requiring tobacco users to self-certify tobacco usage and pay the extra $30 tobacco user rate), all GBP participants would be charged as if they used tobacco, unless they self-certify as non-tobacco users.
SECTION 5 – PLAN DESIGN: How can the plan design ensure quality, provide choice, and align incentives with health risks?			
Plan choices			
5.1	Basic benefit with the option to buy up	Legislature/ ERS Board of Trustees	The GBP would provide a choice of multiple plans at varying coverage levels and contribution rates. To mitigate adverse selection and allow ERS flexibility in pricing, the Legislature would need to change the 100% employer contribution for member-only coverage.
5.2	Consumer-driven health plan (High deductible plan with health savings account)	Legislature/ ERS Board of Trustees	This would offer a high deductible plan (minimum of $1,250) with an employer contribution to a Health Savings Account (HSA) for medical expenses. Employees would pay a high deductible, then a percentage of their costs up to the out-of-pocket maximum, after which the state would pay 100%. Any remaining balance would rollover into the next year's account and members could take the account balance with them if they left state employment.
5.3	Managed care plan with deductible	ERS Board of Trustees	This would add a deductible to the existing HealthSelect plan, shifting costs to those participants who use more health care services.
5.4	Indemnity plan with deductible	ERS Board of Trustees	Open plan with no referrals or restrictions on choice of providers. Participants pay a deductible, then coinsurance (usually 20%). Sometimes participants pay the full cost for a service up front and wait for reimbursement. Sometimes providers collect the 20% and file claims on the patient's behalf. Rarely offered by employers anymore because of the high cost.
Carve outs			
5.5	Care coordination for early (<65) retirees	ERS Board of Trustees	Vendor would take over comprehensive disease management for pre-65 retirees. Would require an up-front investment from the GBP, with the long-term goal of improving health status, reducing costs, and easing transition to Medicare. Ideally a short term investment would help retirees and the plan avoid future medical costs, but savings are often difficult to measure.
5.6	Partial carve-out for behavioral health	ERS Board of Trustees	Vendor would act as a "triage service" for behavioral health claims. Savings would come from diverting participants to lower cost interventions before they incur additional medical or pharmacy costs. Operates much like an employee assistance program (EAP).
5.7	Carve-out for tobacco cessation	ERS Board of Trustees	Vendor would promote and manage tobacco cessation activities for the GBP population, including counseling and free nicotine replacement therapy. (Cost of $285 per quit attempt)
Incentive-based pricing			
5.8	Value-based insurance design (VBID)	ERS Board of Trustees	VBID can provide either positive incentives (lower copays for prescription drugs proven to lower overall costs for people with chronic illness such as diabetes), or negative incentives (increased copays for high cost services, such as the emergency room or an MRI).
5.9	Minimally invasive procedures (MIPs)	ERS Board of Trustees	Members would pay less to have an MIP, when appropriate, rather than another type of surgical intervention. Because MIPs require no incision, they are shown to reduce infections, shorten hospital stays, and speed recovery/return to work.
Generic drug incentives			
5.10	Reference-based pricing	Legislature/ ERS Board of Trustees	Reference-based pricing is a form of price regulation used to limit plan spending on drugs that vary widely in cost within a therapeutic class. The plan would pay a fixed price for certain drugs, passing the remainder of the cost to the patient.
5.11	Step therapy	ERS Board of Trustees	Step therapy requires a patient to try a less expensive (usually a generic) drug first, before an expensive brand name drug is covered (e.g., simvastatin instead of Zocor for high cholesterol).
5.12	Therapeutic substitution	Legislature/ ERS Board of Trustees	Therapeutic substitution would allow a pharmacist to substitute a chemically different drug – generic or brand name – within the same therapeutic category, without the permission of the prescribing doctor.
Employer solutions			
5.13	Onsite nurse practitioner clinics	Legislature	Would provide state employees with health clinics at their worksite, staffed by a nurse practitioner.

ERS serves as a fiduciary for the programs we administer for employees and officials of the State of Texas. The requested funding is necessary to make our programs actuarially sound, supporting our mission to provide competitive benefits at a reasonable cost.

Retirement Request

Sustainability and actuarial soundness remain key objectives of ERS, and are reflected in our request. The 82nd Legislature decreased state contributions to ERS-administered retirement programs, and the base request assumes contribution rates will continue at the lower levels that were appropriated in FY 2013. As of September 1, 2012, the State is contributing 6.5% and members continue to contribute 6.5% to the ERS retirement fund, for a total of 13%, which slightly exceeds the normal cost. It does not however, meet the actuarial sound contribution (ASC) rate set by state law and accounting standards; that is, it is not enough to amortize the unfunded accrued liability, or even pay the interest on the liability. We also assume State contributions to the Law Enforcement and Custodial Officers Supplemental Retirement Fund (LECOSRF) and to the active Judicial Retirement System of Texas (JRS 2) will remain at 0.5% and 6.5%, respectively. The combined member contributions—0.5% for LECOSRF and 6.0% for JRS 2—and State contributions fall well below the normal costs for those plans and are not enough to amortize the unfunded accrued liability over a measurable period. As a result, the funded ratios for LECOSRF and JRS 2 will decline and the State's unfunded liabilities will grow. The exceptional item request is the most economical way for the State to address the outstanding liabilities, since it would leverage investment earnings over the long term and pay down the unfunded balance.

Base request maintains the current 6.5%, 0.5%, and 6.5% State contribution for ERS, LECOSRF, and JRS 2, respectively, and assumes no growth in payroll.

Exceptional items:

- **ERS:** Additional State contribution of 3.5% of payroll, which meets the constitutional maximum of 10% funding by the State, but falls short of the ASC by about 1%.
- **LECOSRF:** Additional state contribution of 1.72% of payroll needed to meet the ASC.
- **JRS 2:** Additional state contribution of 9.26% of payroll needed to meet the ASC.

Insurance Request

The base request is calculated on the funding ERS received last session, but it is not enough to cover current benefit costs or expected health plan cost increases. It also does not replace supplemental funding from the contingency reserve fund and one-time funding sources the plan relied on during the past biennium, such as reimbursement from the federal Early Retirement Reinsurance Program (ERRP).

Base request of $2.7 billion is prescribed by the Legislative Budget Board which is below FY 2013 spending levels. Although prescribed, this funding level is not enough to maintain the existing plan benefits or structure.

Exceptional Items:

- $382.4 million is needed to maintain existing benefits and cover the state agency portion of expected 8% increases in health plan costs, including: $55.6 million in increased health care costs as a result of health care reform and $23 million to replace one-time ERRP revenue. It assumes that ERS will draw $148.5 million ($83.9 million of which is the state agency portion) from the projected $198.5 million contingency reserve fund.
- $297.8 million is requested for a 60-day contingency reserve fund as required by Texas Insurance Code, Sec. 1551.21.

This LAR request is based on data available on August 30, 2012. These figures will change as valuation updates occur throughout the year.

Employees Retirement System of Texas
Legislative Appropriations Request Summary

Fiscal Year 14-15 Base Request (08/30/12)
Assuming Current Levels With LBB Adjustments as Base for All Programs

Goal/Objective/STRATEGY:	Estimated 2012	Budgeted 2013	Requested 2014	Requested 2015	Requested 2014-15 Biennium
1 To Administer Comprehensive and Actuarially Sound Retirement Programs					
1 Ensure Actuarially Sound Retirement Programs					
1 ERS - RETIREMENT @ 6.5%	351,007,060	374,880,438	374,880,438	374,880,438	749,760,876
2 LECOS RETIREMENT PROGRAM @ 0.5%	0	7,520,372	7,520,372	7,520,372	15,040,744
3 JRS - PLAN 2 @ 6.5%	4,148,151	4,389,743	4,389,743	4,389,743	8,779,486
4 JRS - PLAN 1	26,566,486	26,566,486	26,566,486	26,566,486	53,132,972
5 PUBLIC SAFETY BENEFITS	4,895,494	6,048,207	5,471,850	5,471,851	10,943,701
6 RETIREE DEATH BENEFITS	8,660,924	8,088,040	8,374,482	8,374,482	16,748,964
TOTAL, GOAL 1	**$395,278,115**	**$427,493,286**	**$427,203,371**	**$427,203,372**	**$854,406,743**
2 Provide Employees & Retirees with Quality Health Program					
1 Manage GBP for State & Higher Education Employees					
1 GBP - GENERAL STATE EMPLOYEES	1,251,432,211	1,409,486,940	1,330,459,575	1,330,459,576	2,660,919,151
TOTAL, GOAL 2	**$1,251,432,211**	**$1,409,486,940**	**$1,330,459,575**	**$1,330,459,576**	**$2,660,919,151**
TOTAL, AGENCY BASE STRATEGY REQUEST	**$1,646,710,326**	**$1,836,980,226**	**$1,757,662,946**	**$1,757,662,948**	**$3,515,325,894**

Fiscal Year 2014-15 Exceptional Items (08/30/12)
Assuming Current Levels With LBB Adjustments as Base for All Programs

			Requested 2014		Requested 2015		2014-15 Biennium	
#	Strategy	Exceptional Item	GR and GR Dedicated	All Funds	GR and GR Dedicated	All Funds	GR and GR Dedicated	All Funds
1	1-1-1	ERS Constitutional Maximum Level, Increase of 3.5%	130,226,347	201,802,250	130,226,346	201,471,582	260,452,693	403,273,832
2	1-1-2	LECOS Actuarially Sound Level Increase of 1.72%	23,373,617	25,870,080	23,373,617	25,870,080	46,747,234	51,740,160
3	1-1-3	JRS II Actuarially Sound Level, Increase of 9.26%	3,752,217	6,253,695	3,752,217	6,253,695	7,504,434	12,507,390
4	2-1-1	GBP Cost Increases	78,348,173	124,434,143	162,419,097	257,957,274	240,767,270	382,391,417
5	2-1-1	GBP Needed to Fund 60 Day Reserve Fund	89,794,013	142,612,657	97,733,309	155,222,007	187,527,322	297,834,664
		TOTAL, AGENCY EXCEPTIONAL ITEMS	**$325,494,367**	**$500,972,825**	**$417,504,586**	**$646,774,638**	**$742,998,953**	**$1,147,747,463**

Teacher Retirement System of Texas

Senate Committee on State Affairs

11/19/2012

TRS Legislative Update

- TRS-Care for retirees
- TRS-Care Interim Study
- TRS-ActiveCare
- Pension Fund Actuarial Valuation
- Pension Benefit Design Study
- Budget Update

TRS TEACHER

TRS-Care for Retirees

TRS-Care

- Texas Insurance Code, Chapter 1575 requires that a basic health care plan be offered at no cost to retirees.
- Optional plans may be offered, including coverage for eligible dependents. Retirees selecting an optional plan pay a premium based on the plan selected, years of service, and Medicare status.
- TRS-Care currently offers three plan options. TRS-Care 1, the basic plan, provides catastrophic coverage. TRS-Care 2 and TRS-Care 3 offer more comprehensive benefits, including a carve-out prescription drug benefit.
- TRS-Care participants across plans:
  (as of July 2012)

Plan Option	Participants
TRS-Care 1	31,653
TRS-Care 2	41,911
TRS-Care 3	152,635
Total	**226,199**

TRS TEACHER

TRS-Care Plan Design

Program Redesigned Effective September 1, 2004

- TRS-Care 1
  - Catastrophic plan with different deductibles for retirees (1) under 65, (2) with Medicare Part B Only, and (3) with Medicare Parts A&B
- TRS-Care 2
  - Comprehensive plan with $1,000 deductible and $35 office visit copay and includes managed pharmacy program
- TRS-Care 3
  - Comprehensive plan with $300 deductible and $25 office visit copay and includes managed pharmacy program
- Retiree premium structure based on years of service and Medicare status
- Coinsurance limit $3,000 effective 9/1/2007

TRS TEACHER

TRS-Care

Funding sources

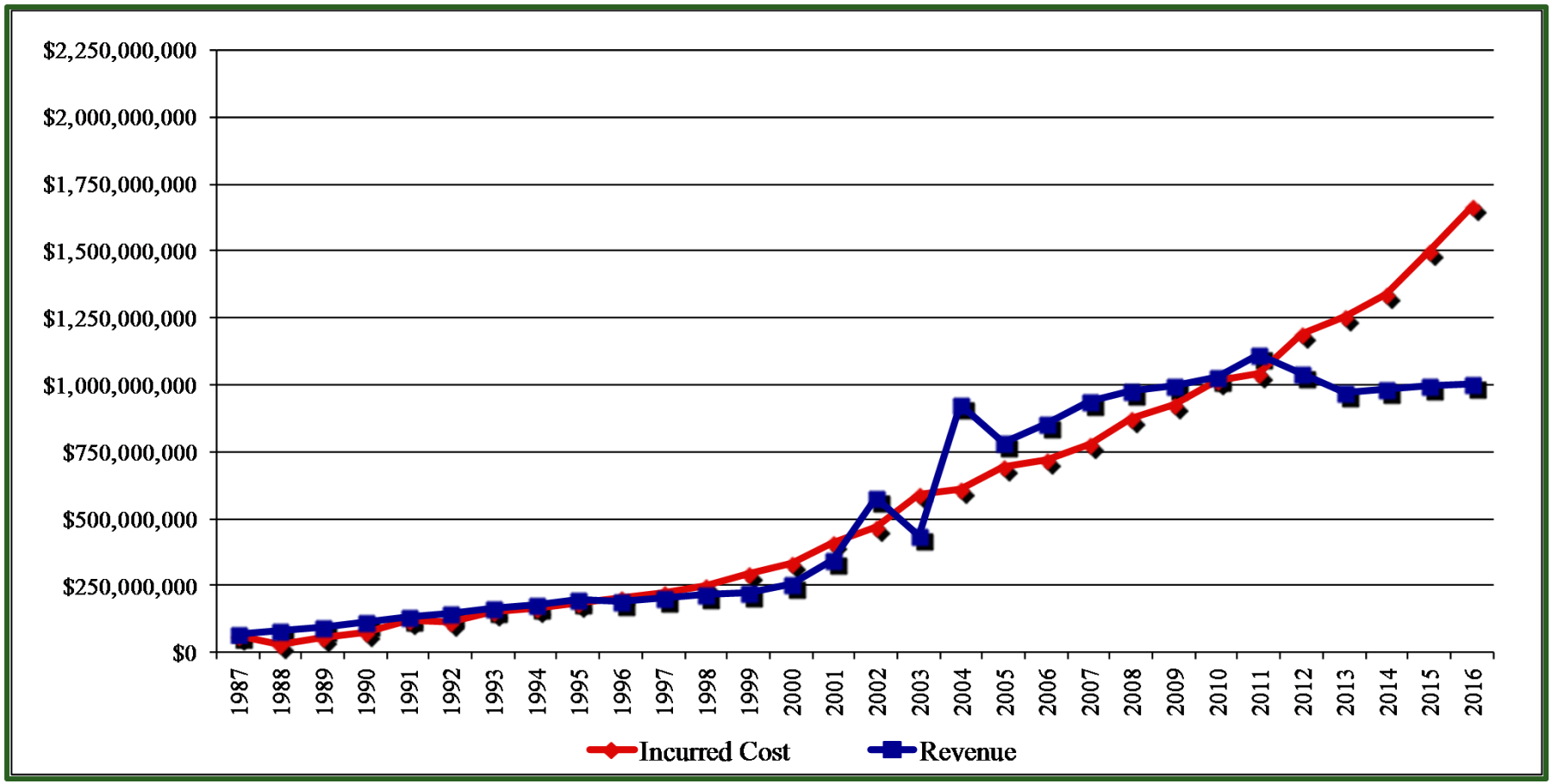
- The law provides that the state contribute 1.0% of active district payroll.
- School districts contribute between 0.25% and 0.75% of active district payroll. The current contribution rate is 0.55%.
- Active school district employees contribute 0.65% of payroll.
- Retirees pay premiums for any plan option other than TRS-Care 1 retiree-only coverage. Retiree premiums have not increased since 2005.
- Medicare Part D retiree drug subsidy.
- Investment income.
- Supplemental funding was provided from 2001 through 2005.

Assuming that the retirees' share of total costs includes both premiums and out-of-pocket costs, the projected retiree contribution for FY 2012 is 46.5% and the state contribution is 20.5%.

TRS TEACHER

TRS-Care Funding

Revenue Versus Incurred Cost



TRS TEACHER

TRS Care Cost Drivers

- Increase in medical costs
- Increase in Rx costs
- Maintaining access and choice in managing providers
- Increased utilization due to aging population
- Potential increase in number of retirees (Non-Medicare)
- Potential plan changes in Medicare program
- Technology increases and development of new biogenetic drugs

TRS-Care

- TRS added Aetna Medicare Advantage option for health care to begin January 1, 2013.
- In 2012, TRS selected Express Scripts for prescription drugs, achieving better pricing beginning September 1, 2012, and is offering a new Medicare Part D option beginning January 1, 2013.
- Assuming 80% participation rate in both plans, the fund is now projected to be solvent through 2014-2015 biennium with a balance of $14.5 million.
- However, the **shortfall** for the 2016-2017 biennium is projected to be **approximately $1.2 billion.**

TRS TEACHER

TRS-Care

Significant savings to TRS-Care from Medicare Advantage and Medicare Part D plan options

	Participation Assumption				
Fiscal Year	**60%**	**70%**	**80%**	**90%**	**100%**
FY2013	$78.6 million	$93.6 million	$108.6 million	$123.5 million	$138.4 million
FY2014	$148.1 million	$172.8 million	$197.6 million	$222.4 million	$247.2 million

LAR Based on

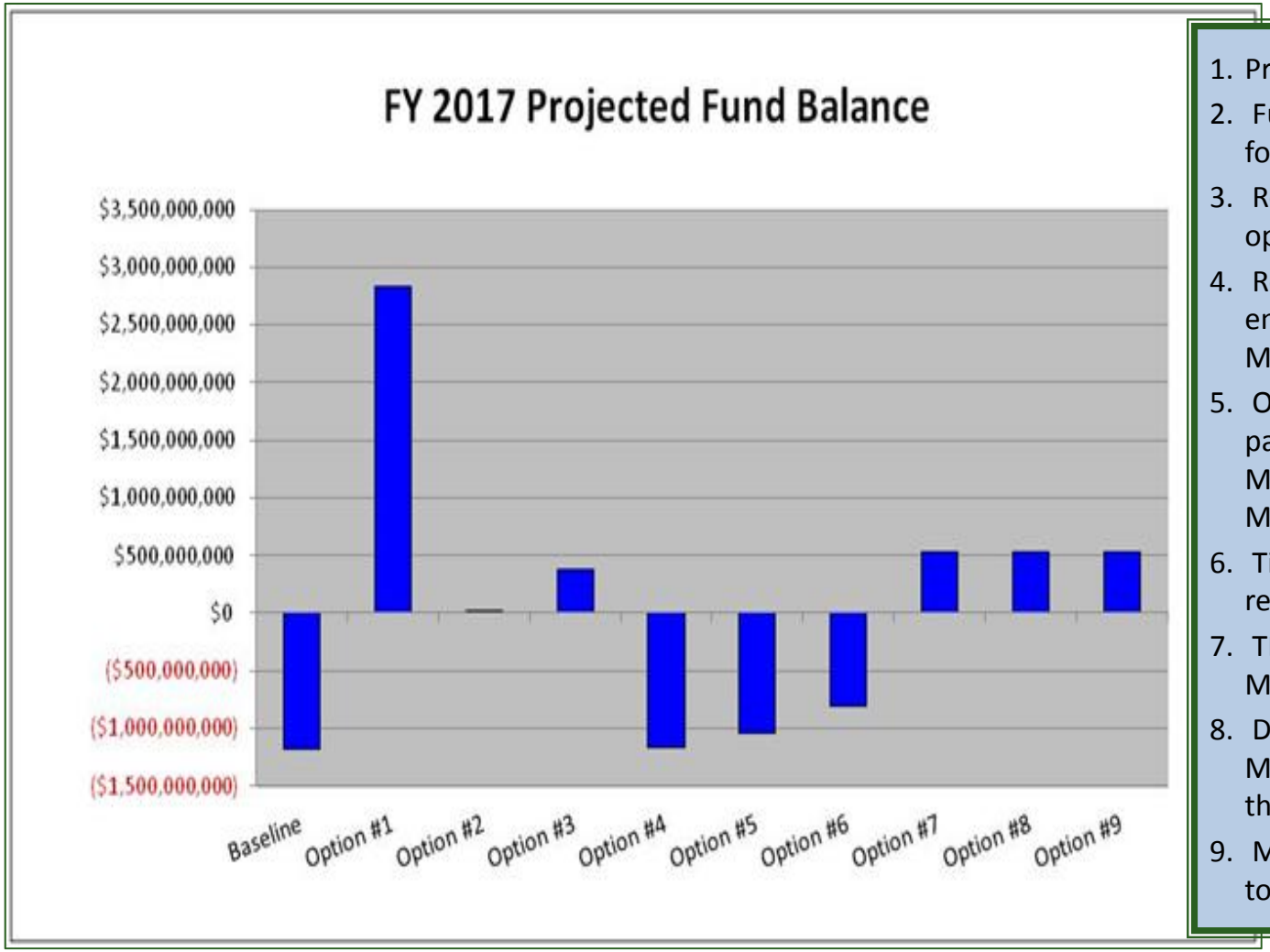
TRS TEACHER

Interim Studies

- In 2011, the Texas Legislature directed TRS to conduct studies on the **sustainability of TRS-Care** for retirees and **pension benefit design**.
- For both studies, TRS presented updates at four TRS Board meetings and two town hall meetings. Three of the six meetings offered the public an opportunity to provide input and ask questions, in person and on the web site. All six of the meetings were web cast and archived at www.trs.state.tx.us.
- Full studies are online at: www.trs.state.tx.us

TRS TEACHER

TRS-Care Study Overview



1. Pre-fund the long-term liability
2. Fund on a pay-as-you-go basis for the biennium
3. Retiree pays full cost for optional coverage
4. Require Medicare eligible enrollees to purchase Medicare Part B
5. Opt out consequence for participants eligible for the Medicare Advantage and Medicare Part D plans
6. Tighten eligibility requirements
7. TRS-Care 1 only for non-Medicare retirees
8. Defined contribution for non-Medicare retirees to shop in the private market
9. Move non-Medicare retirees to TRS-ActiveCare

Some options can be combined to increase the financial impact.

TRS TEACHER

TRS-Care Study Options 1 & 2

Increase funding to TRS-Care and align the funding to medical costs

Option 1: Pre-fund the long-term liability.

Current 2.2% contribution increases to 5.34% with 80% participation in Medicare plans.

Option 2: Fund on a pay-as-you-go basis for the biennium.

Required Contribution Rates						
Biennium	Increase Begins FY 2014			Increase Begins FY 2016		
	State (Current Rate 1%)	Active Employee (Current Rate 0.65%)	District (Current Rate 0.55%)	State (Current Rate 1%)	Active Employee (Current Rate 0.65%)	District (Current Rate 0.55%)
FY 2014-15	1.49%	0.97%	0.82%	1.00%	0.65%	0.55%
FY 2016-17	1.49%	0.97%	0.82%	1.98%	1.29%	1.09%

This chart projects no retiree premium increases. Note the rates if delay until FY 2016.

TRS TEACHER

TRS-Care Study Options 3-5

For all retirees

Option 3: Retiree pays full cost for optional coverage.

For Medicare retirees

Option 4: Require participants to purchase Medicare Part B.

The standard Part B premium is $99.90 per month for 2012.

Option 5: Opt out of Medicare plans consequence.

If 80% participation rate in initial year, the remaining 20% would be automatically enrolled in the Medicare plans in the following year and those who opt out would be enrolled in TRS-Care 1.

TRS-Care Study Options 6-9

For non-Medicare retirees – Options 6-9:

Non-Medicare retirees, which make up 34% of the TRS retiree population, cost almost 6 X more than Medicare-eligible retirees.

Option 6: Tighten eligibility requirements.

Add a minimum age requirement of 62 or 60 for new retirees to enroll in TRS-Care.

Option 7: TRS-Care 1 only for non-Medicare Retirees

Option 8: Defined contribution for non-Medicare Retirees; establish a Health Reimbursement Account.

Option 9: TRS-ActiveCare for non-Medicare Retirees

Projections indicate that TRS-ActiveCare premiums would need an overall increase of 5% in FY 2014.

TRS TEACHER

TRS Active-Care

- TRS-ActiveCare was created in 2001 and is funded by:
  - State contribution $ 75 per month
  - School district contribution $150 per month (minimum)
  - Employees Premiums
- The state contribution has remained the same since 2001 and is funded to the districts through the school finance formula.
- Premium increases
  - Since 2002, there have been five rate increases--- approximately 5% in 2003-2004, 7.5 % in 2007-2008, 4.5% in 2009-2010, 7% in 2010-2011, 9.5% in 2010-2011, and effective September 1, 2012, increases are 4%, 6%, and 9% for ActiveCare 1,2,3.

TRS Active-Care Plan Design

- TRS-ActiveCare 1
  - $1,200 deductible; 80% network/60% non-network plan coinsurance; $2,000 coinsurance maximum
- TRS-ActiveCare 1-HD
  - $2,400 deductible; 80% network/60% non-network plan coinsurance; $3,000 coinsurance maximum
- TRS-ActiveCare 2
  - $750 deductible; $150 per day hospital copay; 80% network/60% non-network plan coinsurance; $30 office visit copay/$50 specialist copay; $2,000 coinsurance maximum; managed drug card program
- TRS-ActiveCare 3
  - $300 network deductible, $500 non-network deductible; $150 per day hospital copay; $20 office visit copay/$30 specialist copay; $1,000 network coinsurance maximum, $3,000 non-network coinsurance maximum; managed drug card program

TRS TEACHER

TRS-ActiveCare Participation

Entities Participating

Entity Type	# Eligible	# Participating	% Participating
Less than 500	820	805	98.2%
500 – 1,000	111	96	86.5%
More than 1,000	98	48	49.0%
Charter	190	146	76.8%
RSC	20	20	100.0%
Other Ed	5	5	100.0%
Total	**1,244**	**1,120**	**90.0%**

TRS TEACHER

TRS Active-Care Cost Drivers

- Increase in number of participating entities and employees
- Increase in medical costs
- Increase in pharmacy costs
- State and district contribution toward premium not linked to industry trend
- Technology increases and development of new biogenetic drugs

Pension Trust Fund Status

- With the global economic decline, the TRS pension trust fund had decreased to $70.6 billion, as of February 28, 2009.
- As of August 31, 2012, the fund was valued at $111.5 billion.
- While the fund is secure, it is not “actuarially sound.” This means that the Legislature may not increase benefits to members or retirees.
- As of August 31, 2012, the fund could make benefit payments to 2065 under current funding.

TRS TEACHER

Actuarial Valuation

- Investment rate of return decreased to 7.4% in 2012 (from 15.5% in 2011). The assumed rate of return is 8.0%.

- The trust fund's unfunded liability is $26.1 billion (from $24.1 billion in 2011) with a funded ratio of 81.9% (from 82.7 % in 2011).

- 30-year Annual Required Contribution rate (ARC) for the state increased to 8.62% of pay (from 8.13% in 2011).
  - Assumes member rate continues at 6.40%
  - Effective split rate between employers and employees would be 7.60%.

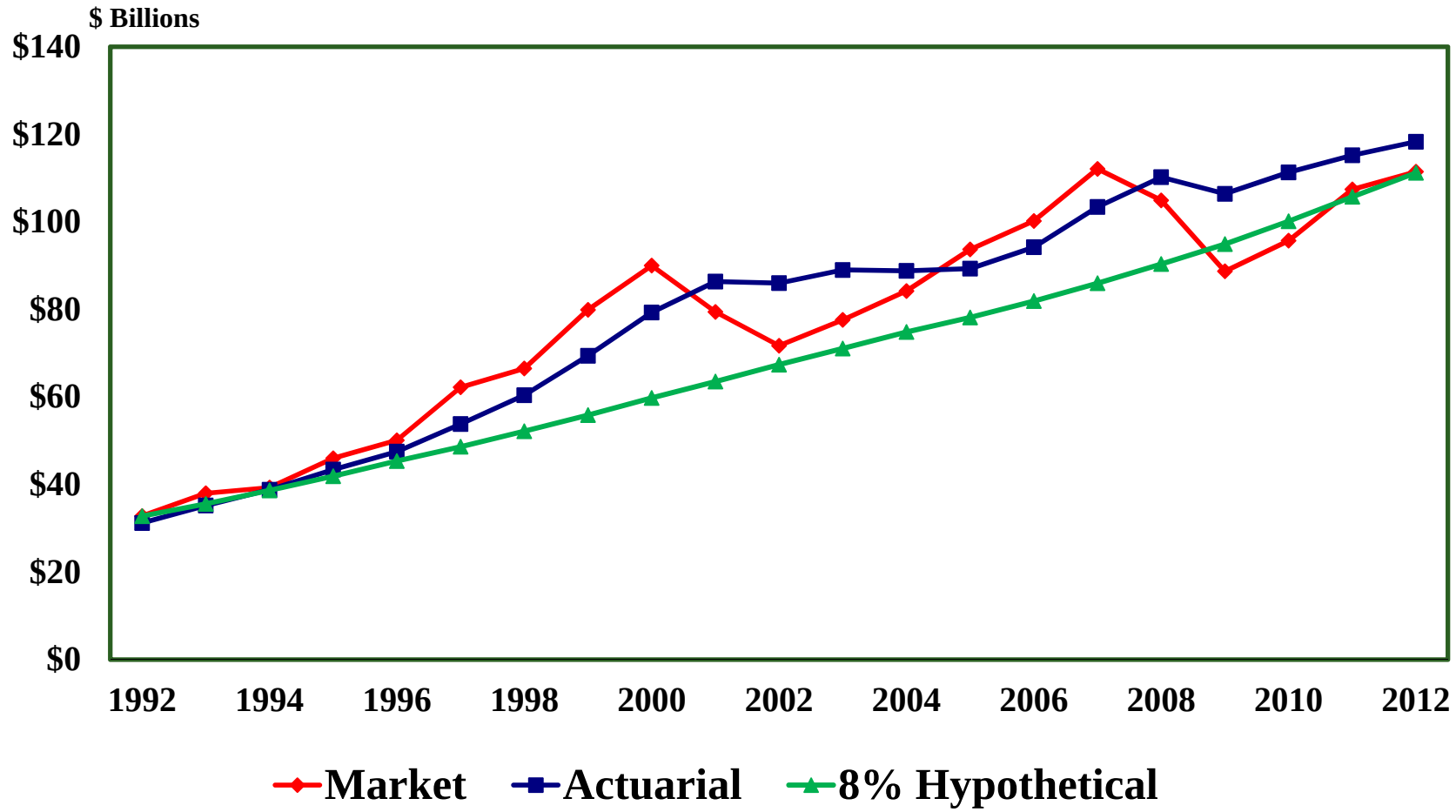
- Funding period continues to be "Never"

Actuarial Valuation

- Normal cost remains 10.6% of pay. With a total contribution rate of 12.8% (state & member each at 6.4%), the 2.2% difference helps pay down the unfunded liability of the plan.
- Total deferred net investment gains (losses)
  - at August 31, 2009 = $(23.1) billion
  - at August 31, 2010 = $(15.6) billion
  - at August 31, 2011 = $(7.8) billion
  - at August 31, 2012 = $(6.9) billion
- TRS actuarial valuations mitigate short-term fluctuations in rates of return through a process called “smoothing.” This allows the impact of annual gains and losses to be recognized over a five-year period.
- If there are no offsetting actuarial gains, TRS’s funded ratio of 81.9% should decrease over the next four years.

TRS TEACHER

Market and Actuarial Values of Assets



8% Hypothetical assumes 8% had been earned on market every year since 1992, all cash flows unchanged

TRS TEACHER

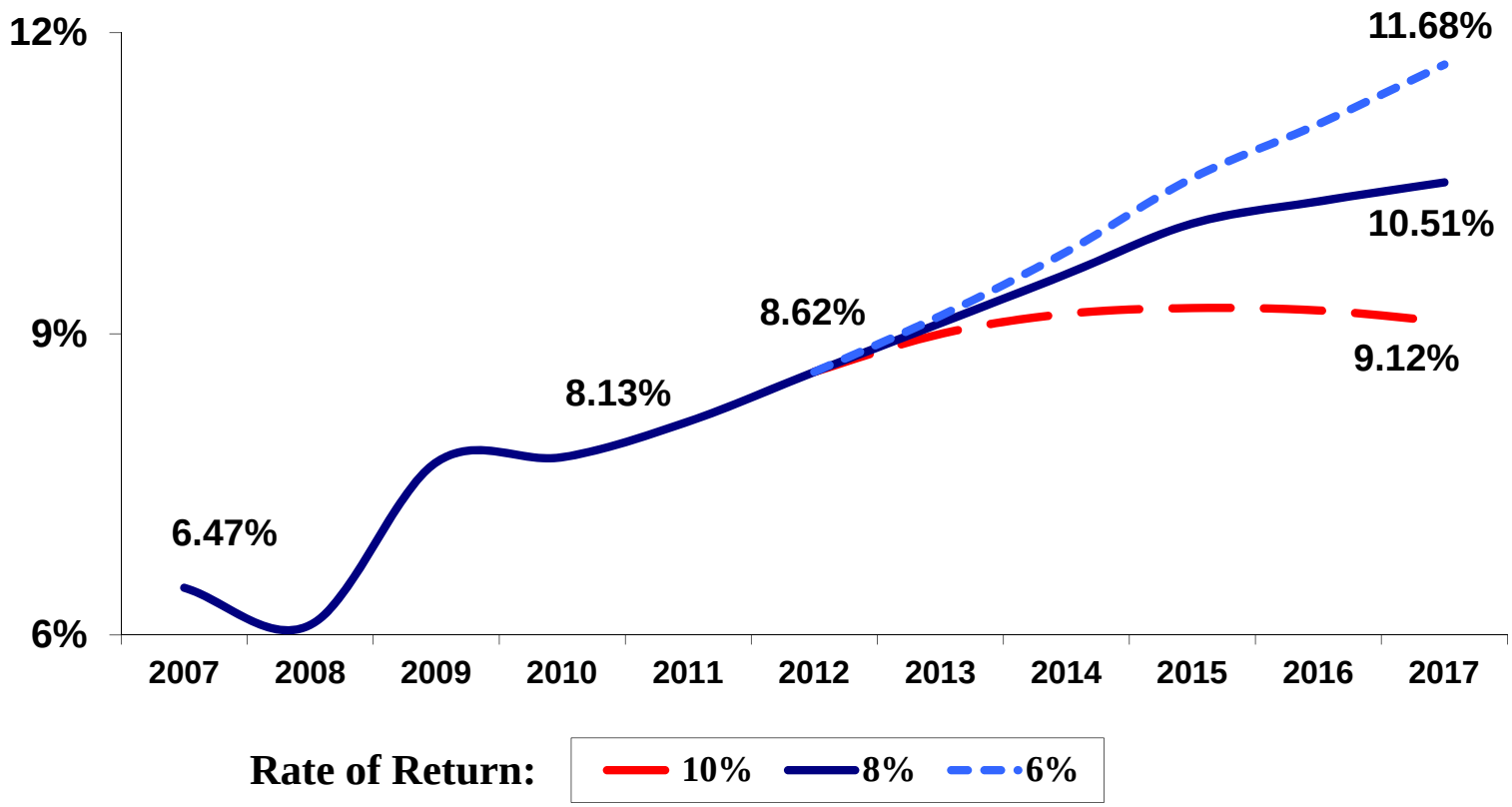
Next Year Projections

	Market Return for 12-month period ending August 31, 2013						
	16%	12%	8%	4%	0%	-4%	-8%
UAAL	$27.1	$28.3	$29.7	$30.6	$30.5	$32.3	$33.2
Funded Ratio	82.1%	81.3%	80.4%	79.8%	79.2%	78.6%	78.1%
Funding Period based on 6.40%/6.40% rate	Never	Never	Never	Never	Never	Never	Never
30-Year employer ARC	8.68%	8.88%	9.11%	9.25%	9.40%	9.54%	9.68%

The TRS Actuary recommends the Legislature begin making moderate increases in the contribution rates (state, member, or both).

TRS TEACHER

Estimated Changes in ARC Rates Over Next Five Years



- Expected ARC at each valuation date based on stated return during each year
- Assumes continuation of 6.4% State contribution rate
- Constitutional Maximum = 10.00% State contribution rate

TRS TEACHER

Pension Benefit Design Study

The pension benefit design study charge directed TRS to examine the actuarial and fiscal impacts of:

- Changing the benefit factors of the current plan, which includes changes in retirement eligibility and the final average salary and benefit multiplier provisions of the current plan; and
- Moving to an alternative plan design, such as a cash balance plan or defined benefit-defined contribution hybrid plan.

Pension Benefit Design Study

Significant Factors

- TRS contribution rates are among the lowest in the nation.
- Two significant periods are 1980-1995, during which the state contribution rate ranged from 7.1% to 8.5%, and 1996-2007, during which the state contributed the constitutional minimum of 6.0%.
- Over the past 25 years, the TRS pension plan has earned a return of approximately 8.6% despite a decade of highly volatile markets. TRS assumed return rate is 8.0%.
- The Texas Constitution requires that the state and members regularly contribute to TRS, and neither have taken a “funding holiday.”

Pension Benefit Design Study

Features to Control Plan Liabilities	
Present	▪ TRS has never enacted an automatic cost-of-living adjustment (COLA). No permanent COLA since 2001.
2011	▪ Purchase of most types of service credit requires payment of actuarial cost
2005, 2011	▪ Controlling salary "spiking"
2005	▪ Retirement age: For members joining after 8-31-07, member must be at least age 60 and meet the rule of 80 to retire without actuarial reductions.
2005	▪ Final average salary (FAS): For most members, retirement benefits now are calculated using a 5 year FAS instead of a 3 year FAS.
2005	▪ Service credit purchases: Members may no longer purchase up to 3 years of service credit ("air time") to reach retirement eligibility earlier or increase benefit amount.
2005	▪ Eligibility for a partial lump sum increased to a Rule of 90.
2005	▪ Enacted the nation's toughest laws regarding return-to-work after retirement. Public education employers who hire retirees must pay TRS pension and health care surcharges.

TRS TEACHER

Pension Benefit Design Study

Finding 1: While the TRS Pension Fund can pay benefits through 2065, the state needs to begin addressing the unfunded liability. Delays will only increase costs.

- The current funded ratio (ratio of assets to liabilities) exceeds 80% but will trend downward over time without a change in contribution rates, investment returns, or benefit levels.
- Current funding policy of a 6.4% state contribution and 6.4% member contribution is insufficient to amortize the current $26.1 billion unfunded actuarially accrued liability (UAAL).
- Changing benefits only for new hires does not have an immediate impact on the current UAAL (may have a long-term impact). Adjusting benefits for active members does have immediate impact.

Pension Benefit Design Study

Defined Benefit Representative Changes for Current Active Members
(updated since release of study to reflect latest valuation)

Provision	Representative Change	Unfunded Liability	State Contribution Rate for Actuarial Soundness*
Current Provisions as of August 31, 2012		$26.1B	8.62%
Retirement Eligibility For Current Members Not Yet Eligible to Retire	From Rule 80 & Minimum Age 60 to Rule of 80 & Minimum Age 62	$13.9B	6.35%
Salary Averaging Period	From 5 Years to 7 Years	$23.0B	7.77%
Accrual Multiplier	From 2.3% Per Year to 2.0% Per Year	$24.5B	7.26%
Member Contribution Rate	From 6.4% Per Year to 7.4% Per Year	$25.4B	7.80%

* State contribution rate for actuarial soundness is based on smoothed assets and is the rate necessary to pay for new benefit accruals and amortize the unfunded liability of $26.1 billion over a period that is less than 31 years.

TRS TEACHER

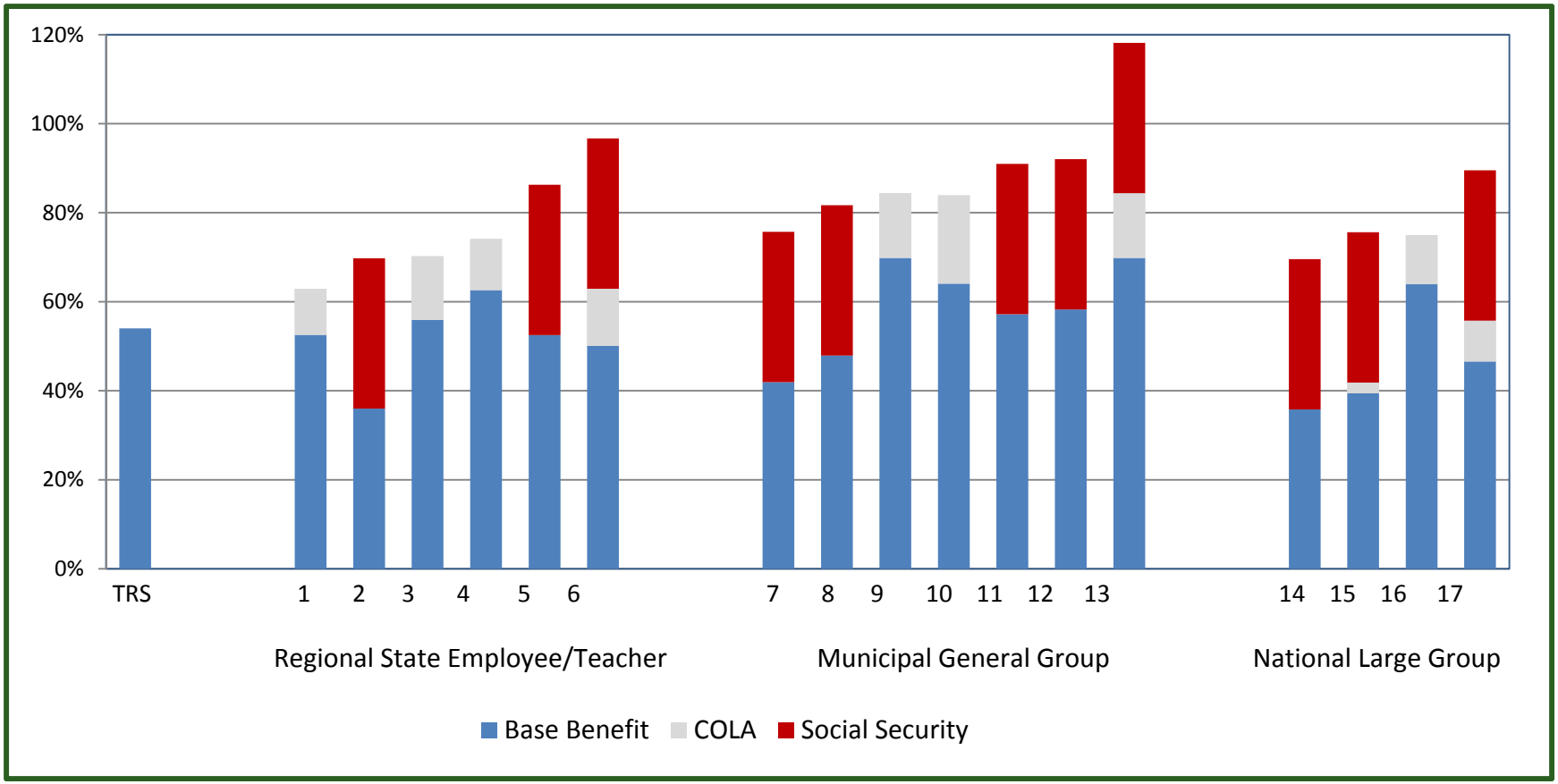
Pension Benefit Design Study

Finding 2: The value of the TRS retirement benefit is 36% less than the average benefits of members of peer systems.

- A prototypical TRS career employee (retires at age 62 with 32 years of service credit) receives a lifetime benefit that equates to 52% of pre-retirement income (after losing purchasing power).
- The average peer plan benefit TRS studied was 82% of pre-retirement income.
- The main reason: TRS retirees do not have Social Security or COLAs.

Pension Benefit Design Study

TRS Benefit Relative to Peers



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Pension Benefit Design Study

Alternative Plans Overview

Structure	Features	Risk	Unfunded Liability
Cash Balance Plan	Member receives pay and investment credits into a "virtual account." Contributions invested through TRS trust fund. At retirement account balance can be annuitized.	Shared between member and state	$24.1 B
Side by Side Hybrid	Members and State contribute to both a small defined benefit plan and a small defined contribution plan with the idea that both plans, together, provide the targeted level of benefits. Defined benefit contributions are invested through TRS trust fund. The defined benefit is annuitized. Defined contribution investments are self-directed and are taken as lump sum at retirement.	Shared between member and state	$24.1 B
Capped Hybrid	Similar to Side by Side Hybrid, but the State contribution is capped. All contributions from the members and the State go first towards paying the actuarially required contribution (ARC). Any remaining contributions after ARC is paid go toward defined contribution plan. Members are responsible for paying any portion of the ARC above the State's capped contribution.	Shared between member and state	$24.1 B
Pooled Defined Contribution	Like a traditional defined contribution plan but contributions are pooled and invested by TRS. Lump sum distribution is taken at retirement.	Member	$35.8 B
Traditional Defined Contribution	Investments are self-directed and member must manage account for duration of retirement.	Member	$35.8 B

Note: Modeling on this page is based on 2011 TRS Actuarial Valuation

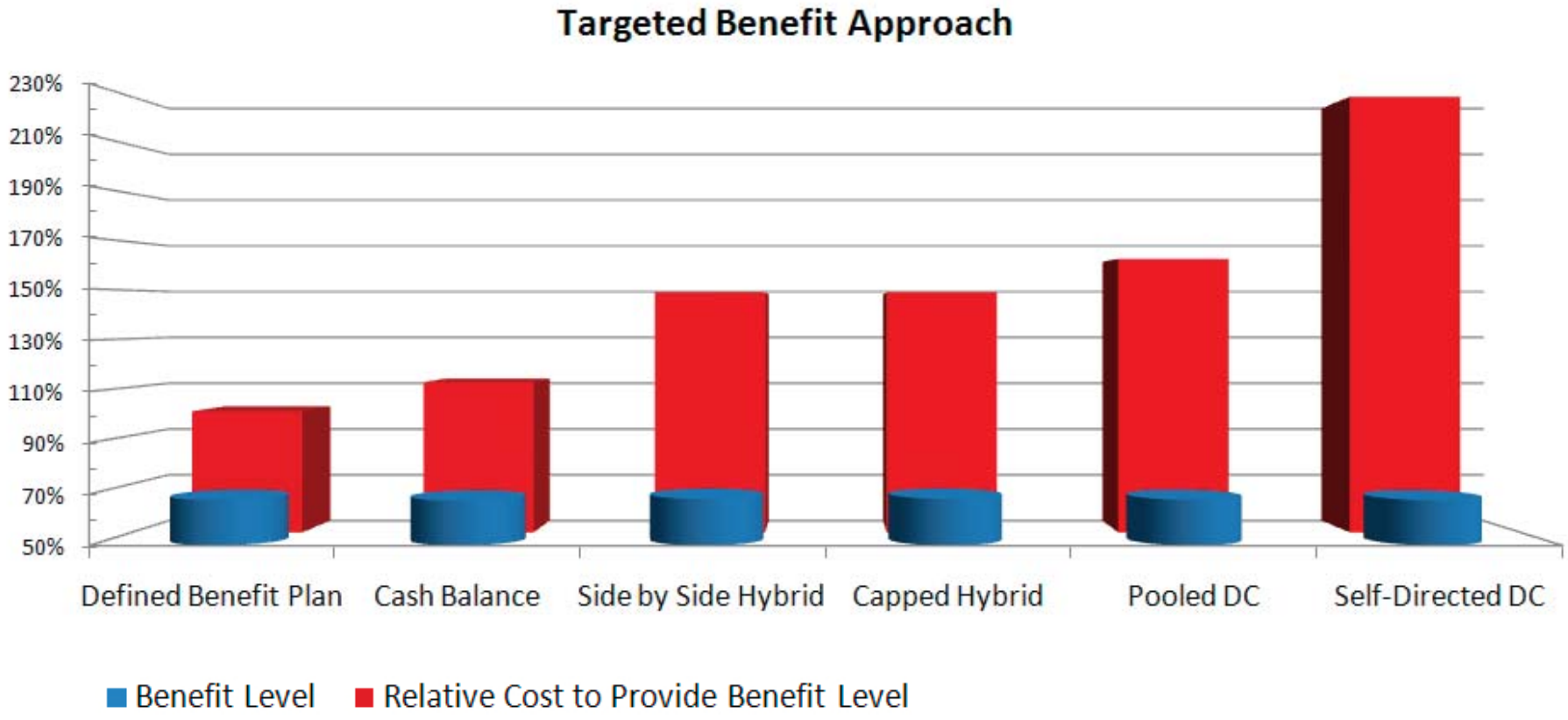
TRS TEACHER

Pension Benefit Design Study

Finding 3: The TRS defined benefit plan provides current benefits at a lower cost than alternative plans.

- The current defined benefit replaces roughly 68% of a career employee's pre-retirement income before loss of purchasing power.
- Other alternative plan structures are from 12% to 138% more expensive than the current plan (not including the cost to pay off any unfunded liability) to provide the same level of benefits.
- TRS determined that when the alternative plans were modeled to cost the same as the current plan, they replaced 27.7% to 59.7% of pre-retirement income for a career employee retiring at age 62.

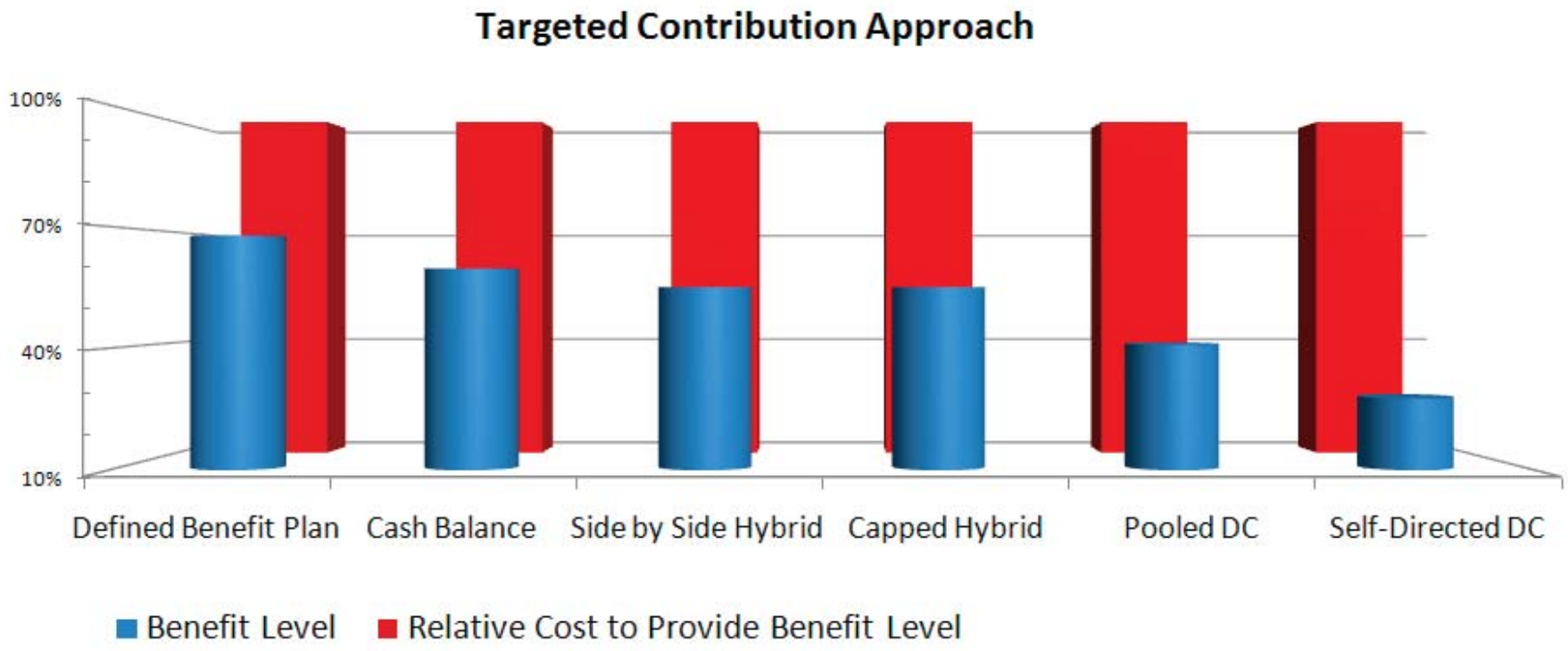
Pension Benefit Design Study



Source: Teacher Retirement System of Texas and Gabriel, Roeder, Smith & Company

TRS TEACHER

Pension Benefit Design Study



Source: Teacher Retirement System of Texas and Gabriel, Roeder, Smith & Company

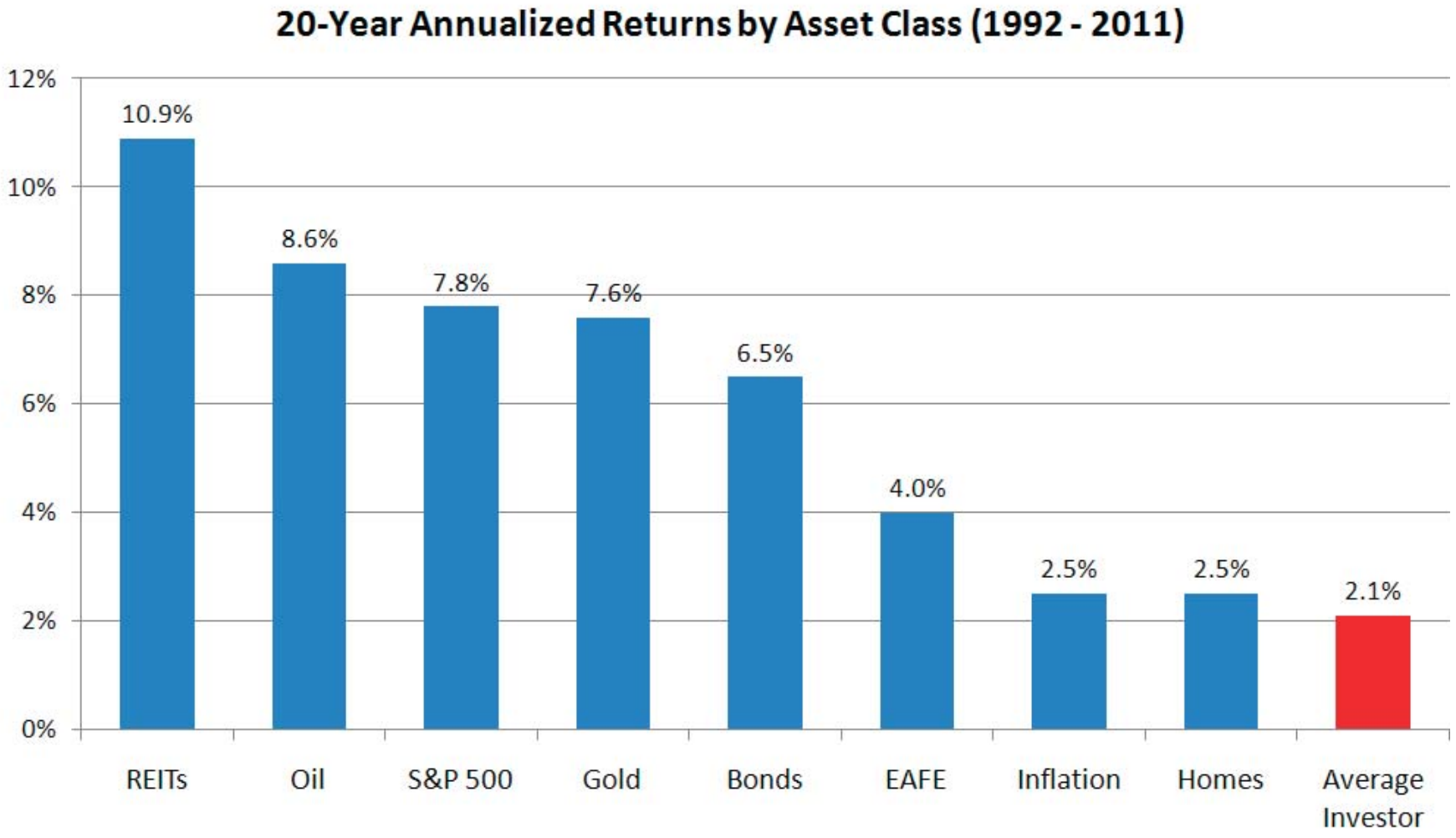
TRS TEACHER

Pension Benefit Design Study

Finding 4: The majority of TRS members will do significantly worse investing on their own in a plan with a defined contribution component.

- Based on modeling, for members in a plan with a defined contribution component, the spread of returns would likely be very wide.
- An estimated 2/3's of the members would earn returns below 60% of the current defined benefit, while over 90% would accrue less than their estimated current annuity.
- Only about 8% of the members would accrue an annuity that exceeds the current defined benefit plan.
- The estimated underperformance is due to lower investment returns from a shorter investment period, access to fewer classes, less disciplined investment approaches, and potentially higher fees.

Pension Benefit Design Study



Source: J.P. Morgan Guide to the Markets, Q3 2012.

TRS TEACHER

Pension Benefit Design Study

- In a defined contribution plan, poor investment choices or not enough savings will likely cause the employee to have to continue working past normal retirement age.
- Market timing is important – in which economic cycle are the investment returns adequate.
- Members who retire with inadequate retirement savings in a defined contribution plan could have difficulty with retirement self-sufficiency and have to rely on public services.
- These potential outcomes shift some of the longevity and poverty risk back to the employer and taxpayers.

Pension Benefit Design Study

Finding 5: Alternative plan structures carry differing levels of risk for the state and TRS members.

- While alternative plan structures, as modeled, are more expensive than the current plan to provide a comparable level of benefit, they can shift risk away from the state and to the members who become responsible for managing their own investments for the remainder of their lives.
- Other risks are how to manage the unfunded liability of the old defined benefit plan, the regular transition of workers into retirement at a manageable pace, and diminished retirement income could increase use of social services.

Pension Benefit Design Study

Finding 6: Other states changing structures have lowered benefits to realize savings.

- TRS identified six systems that moved to an alternative plan.
  - Georgia Employees Retirement System, Kansas Public Employees Retirement System, Louisiana State Employees Retirement System, Michigan Public School Employees Retirement System, Rhode Island Employees Retirement System, and Utah Retirement System.
- TRS measured the systems' benefit levels before and after the changes and determined that benefits were reduced by an average of 30% as part of moving to an alternative plan.

Pension Benefit Design Study

Finding 7: Moving new hires to an alternative plan will not eliminate existing plan liabilities.

- TRS' unfunded liability represents benefits earned by current participants; therefore, the state cannot eliminate the unfunded liability by closing the plan to new hires. Regardless of plan structure, the unfunded liability will have to be addressed eventually by paying it off or a reduction of benefits.
- If the state were to close the current plan to new hires, then the plan's liquidity needs will increase as the plan matures, and the liability is expected to grow by an estimated **$11.7 billion** due to lower investment returns from a less effective asset allocation.

Pension Benefit Design Study

Finding 8: Approximately 95% of TRS public school members do not participate in Social Security, leaving the TRS benefit as their only lifetime annuity.

- Non-participation in Social Security saves Texas public school employers an estimated $1.5 billion annually.
- The level of benefit offered governs mandatory Social Security participation. Therefore, if benefits were reduced enough, the state could find itself in a situation where it must contribute to a pension plan, as required by the Texas Constitution, and the school districts and members must each contribute 6.2% to Social Security.

Pension Benefit Design Study

Other issues

- While the Texas Constitution, Article XVI, Section 67, does not mandate that TRS operate as a defined benefit plan, the Constitution does provide operational and funding requirements such as the 10% state maximum contribution rate and requiring the TRS board to invest the funds in accordance with its fiduciary duty.
- New accounting standards from Governmental Accounting Standards Board (GASB) will impact how the state reports TRS' unfunded liability.

Budget Update

FY 2014-15 Legislative Appropriations Request:

- For the pension trust fund, the base request assumes a state contribution rate of 6.4% each year and assumes payroll growth of 0% per year for public education and 2% per year for higher education.
- An exceptional item requests that the contribution rate be increased to 6.9% for FY 2014 and 7.4% for FY 2015 and is consistent with recommendations made by the TRS actuary in the past three biennia. Each 1.0% increase costs approximately $250 million per year in general revenue.
- For retiree health insurance (TRS-Care), the base request assumes a state contribution rate of 1.0% for FY 2014 and 0.5% for FY 2015 with the same payroll growth assumptions as noted above.

Budget Update

FY 2014-15 Legislative Appropriations Request (cont'd):

- An exceptional items request increases the state contribution by 0.5% in 2015, consistent with the statutory contribution rate of 1.0%. The cost is approximately $125 million more than the base request.
- Because of recent policy changes, the TRS-Care Fund should remain solvent through the FY 2014-15 biennium. However, there will be significant funding issues for FY 2016 and beyond.
- The administrative budget for TRS is funded entirely from the Pension Trust Fund and no General Revenue is being requested. The FY 2014-15 request does include 13 additional FTEs for workload-related issues and a request for $25 million as the second increment in a three biennia plan to replace legacy computer systems for the benefits administration and financial systems.

APPENDIX TO CHARGE 8

CIVIL PRACTICE AND REMEDIES CODE

TITLE 4. LIABILITY IN TORT

CHAPTER 79. LIABILITY OF PERSONS ASSISTING IN HAZARDOUS OR DANGEROUS SITUATIONS

Sec. 79.001. DEFINITIONS. In this chapter:

(1) "Hazardous material" means:

(A) a substance classified as a hazardous material under state or federal law or under a rule adopted pursuant to state or federal law; or

(B) a chemical, petroleum product, gas, or other substance that, if discharged or released, is likely to create an imminent danger to individuals, property, or the environment.

(2) "Man-made or natural disaster" means among other types of disasters, a fire, chemical spill or flood.

(2) "Person" means an individual, association, corporation, or other private legal entity.

Acts 1985, 69th Leg., ch. 959, Sec. 1, eff. Sept. 1, 1985.

Sec. 79.002. HAZARDOUS MATERIALS. (a) Except in a case of reckless conduct or intentional, wilful, or wanton misconduct, a person is immune from civil liability for an act or omission that occurs in giving care, assistance, or advice with respect to the management of an incident that:

(1) has already occurred;

(2) is related to the storage or transportation of a hazardous material; and

(3) endangers or threatens to endanger individuals, property, or the environment as a result of the spillage, seepage, or other release of a hazardous material or as a result of fire or explosion involving a hazardous material.

(b) This section does not apply to a person giving care, assistance, or advice for or in expectation of compensation from or on behalf of the recipient of the care, assistance, or advice in excess of reimbursement for expenses incurred.

Acts 1985, 69th Leg., ch. 959, Sec. 1, eff. Sept. 1, 1985. Amended by Acts 2003, 78th Leg., ch. 58, Sec. 3, eff. Sept. 1, 2003.

Sec. 79.003. DISASTER ASSISTANCE. (a) Except in a case of reckless conduct or intentional, wilful, or wanton misconduct, a person is immune from civil liability for an act or omission that occurs in giving care, assistance, or advice with respect to ~~the~~ **an** ~~management of an~~ incident:

(1) that is **either** a man-made or natural disaster that endangers or threatens to endanger individuals, property, or the environment; and

(2) ~~in which the~~ **where such** care, assistance, or advice is provided at the request of an authorized representative of a local, state, or federal agency, including a fire department, police department, an emergency management agency, and a disaster response agency.

(b) This section does not apply to a person giving care, assistance, or advice for or in expectation of compensation from or on behalf of the recipient of the care, assistance, or advice in excess of reimbursement for expenses incurred.

Added by Acts 2003, 78th Leg., ch. 58, Sec. 1, eff. Sept. 1, 2003.