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HOUSE OF REPRESENTATIVES

COUNCIL FOR COMPETITIVE COMMERCE
ANALYSIS

BILL #: CS/HB 1947 (PCB IN 02-02A)

RELATING TO: Workers' Compensation

SPONSOR(S): Council for Competitive Commerce, Committee on Insurance, Rep. Waters & others

TIED BILL(S): None

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) INSURANCE YEAS 14 NAYS 1
(2) COUNCIL FOR COMPETITIVE COMMERCE YEAS 10 NAYS 2
(3)
(4)
(5)

I. SUMMARY:

In 1993, the Legislature approved numerous reforms to the workers' compensation act. The stated goals were to reduce system costs and to create an efficient and self-executing system. Few revisions have been approved since 1993. HB 1947 includes the following changes, effective January 1, 2003:

Benefits: Revises eligibility for permanent total disability benefits and provides that the benefit ends at age 72; doubles permanent partial disability impairment income benefits; and limits eligibility and term of benefits for permanent total disability supplemental benefits.

Dispute Resolution: Increases the statutory dispute resolution time line to 224 days (currently 150 days in statute and 268 days in actual practice); requires use of private mediation whenever public mediators are unavailable within 90 days of petition filing; requires appellate mediation.

Procedure: Requires the carrier to pay for the claimant's first independent medical exam; provides for admissibility of one independent medical exam per specialty; defines the term "major contributing cause;" revises evidentiary standards applicable to "occupational disease," "repetitive trauma," and "toxic exposure;" limits employer's civil tort liability to cases of actual intent to cause death or harm by the employer and cases where there is a failure to secure compensation; allows employers and carriers to negotiate fee contracts in excess of the uniform reimbursement schedule.

Attorney's fees: Increases contingency fees and limits attorney's fees to the statutory contingency fee schedule only.

Exemptions: Limits applicability of construction exemption by prohibiting exempt sole proprietors, partners, and corporate officers from doing construction work on certain commercial buildings unless the prime contract is less than $250,000 in value or the project is a residential building conversion; also requires the Department of Insurance to study the coverage needs of the construction industry and report to the Legislature.

The bill has an indeterminate fiscal impact on state and local government.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1. Less Government Yes [] No [x] N/A []

The bill would prohibit certain individuals and entities exempt from providing workers' compensation coverage from doing construction work on certain commercial construction projects.

The bill creates additional rulemaking authority. Please see Section V.B.

The bill would require state and local governments to provide workers' compensation benefits to firefighters, emergency medical technicians, and paramedics injured in accidents that are not currently compensable.

The bill would require private employers to provide workers' compensation benefits to emergency medical technicians and paramedics injured in accidents that are not currently compensable.

2. Lower Taxes Yes [] No [] N/A [x]

3. Individual Freedom Yes [] No [] N/A [x]

4. Personal Responsibility Yes [] No [] N/A [x]

5. Family Empowerment Yes [] No [] N/A [x]

B. PRESENT SITUATION:

Basis for Workers' Compensation

Workers' compensation statutes represent a basic compromise between labor and management. Under this compromise, employees injured on the job receive medical care and a portion of their lost wages (called indemnity or disability benefits) regardless of who was at fault for their injury. In exchange for these no-fault benefits, employees give up the right to sue their employers in tort and, as a result, give up the right to be compensated for pain and suffering associated with the workplace injury. In the United States, workers' compensation statutes date back to the beginnings of the Industrial Revolution -- a period when both the frequency and severity of injuries were expected to increase because of increased mechanization in the workplace.

Legislative Intent

It is the stated intent of Florida's workers' compensation act "to ensure the prompt delivery of benefits to injured workers" and "facilitate the employee's return to gainful employment at a reasonable cost to the employer." It is also the intent of the Legislature that the workers' compensation system be an efficient and self-executing system that is not an administrative or economic burden.

Agency Jurisdiction

Department of Labor and Employment Security

The Department of Labor and Employment Security, Division of Workers' Compensation (Division) is responsible for the administration of Florida's workers' compensation system. Its functions include:

- enforcing employer compliance with workers' compensation coverage requirements;
- overseeing reemployment of injured employees;
- monitoring and auditing the delivery of benefits;
- operating the Employee Assistance Office; and
- administering the Special Disability Trust Fund.

Department of Management Services

The Office of the Judges of Compensation Claims, within the Division of Administrative Hearings of the Department of Management Services, oversees 31 judges of compensation claims and 31 public mediators located throughout the state. These judges of compensation claims preside over the formal dispute resolution process, while the public mediators conduct required mediations.

Agency for Health Care Administration

The Agency for Health Care Administration is responsible for regulation concerning workers' compensation managed care arrangements. Since January 1, 1997, all workers' compensation medical benefits have been required to be provided through workers' compensation managed care arrangements.

Department of Insurance

The Department of Insurance has regulatory authority over insurance companies and group self-insurance funds. The Department of Insurance regulates insurance rates for workers' compensation insurers and the Workers' Compensation Joint Underwriting Association. The Department of Insurance also investigates (and refers for prosecution) criminal insurance fraud, including workers' compensation fraud.

Securing Worker's Compensation Coverage

Florida's workers' compensation act requires employers to secure the payment of medical and indemnity benefits to injured employees either by purchasing insurance or by meeting the requirements of self-insurance. Self-insurance can take two basic forms: individual self-insurance and group self-insurance funds. Individually self-insured employers typically are very large employers with substantial financial resources. Self-insurance funds are associations of employers that pool their money together in order to pay workers' compensation claims.

1993 Reforms

In 1993, the Legislature found that there was a "financial crisis in the workers' compensation industry, causing severe economic problems for Florida's business community and adversely impacting Florida's ability to attract new business development to the state." In order to address these issues, the Legislature enacted a comprehensive reform of Florida's workers' compensation

act to create a more efficient and self-executing act, "which is not an economic or administrative burden."[1]

To respond to this financial crisis, the Legislature enacted numerous reforms, including establishing managed care as a means for providing medical care, creating the Employee Assistance and Ombudsman Office, tightening the eligibility standards for permanent total disability benefits, and creating a self-funded joint underwriting association.

2001 Reforms

In 2001, the Legislature passed a “non-controversial” workers’ compensation bill by the Committee on Insurance, CS/HB 1803, 3rd ENG (Ch. 2001-158, L.O.F.). The bill made a number of "housekeeping" type changes to chapter 440, F.S., in the areas of system administration, procedure, and dispute resolution. Some of the specific changes made by the bill include:

- transferring the Office of the Judges of Compensation Claims to the Division of Administrative Hearings.
- allowing employers to choose whether or not to utilize managed care to deliver workers’ compensation medical benefits.
- eliminating docketing review and authorizing partial dismissal of petitions by judges of compensation claims.
- revising or repealing various reporting requirements.
- providing for recovery of child support arrearages.
- granting “qualified rehabilitation providers” access to claimant medical records.
- revising procedures for lump sum settlements.
- excluding wages from concurrent employment until wage information is provided to carrier.

Dispute Resolution

Despite the Legislature’s intent, the workers’ compensation system is not always self-executing and does not always deliver benefits in a quick and efficient manner. Disputes frequently arise between employees and employers or carriers. The workers’ compensation system has several mechanisms designed to deal with disputes, including an informal process through the Division’s Employee Assistance Office, managed care grievance procedures, and a formal dispute resolution process before a judge of compensation claims. Florida law sets out specific time frames for resolving disputes through these mechanisms.

In October of 1999, the staff of the Committee on Insurance released a report, entitled "Resolving Workers’ Compensation Disputes According to Statutory Time Lines: Policy Options for Consideration."[2] This report examined the workers’ compensation dispute resolution system to determine the extent to which statutory time frames for workers’ compensation cases were being met. In this report, staff found:

- from beginning to end, dispute resolution took an average of 268 days -- more than twice the 120 days allowed in statute;
- presiding judges of compensation claims did not even receive petitions for benefits until 25 days after the petition was filed (which is 4 days after the statutory time for holding mediation);
- mediation occurred, on average, 138 days after the filing of the petition for benefits (117 days longer than the statute contemplates);

[1] S. 2, Ch. 93-415, L.O.F.
[2] Committee on Insurance Staff Report -- "Resolving Workers’ Compensation Disputes According to Statutory Time Lines: Policy Options for Consideration," October 22, 1999.

- approximately 85 percent of employees exited the dispute resolution process within 163 days by settling their cases prior to or during state mediation;
- the number of employees filing petitions for benefits remained stable, yet the number of petitions for benefits filed annually more than doubled from 1993; and
- numerous statutory requirements relevant to the dispute resolution process were not met or implemented as presumably intended by the Legislature.

The Task Force on Workers' Compensation Administration

During the 2000 Session, the Legislature enacted legislation creating the Task Force on Workers' Compensation Administration "for the purpose of examining the way in which the workers' compensation system is funded and administered." (Chapter 2000-150, L.O.F.) To this end, the Legislature directed the task force to submit recommendations concerning the source of system funding, the cost-effective use of funds, services and functions meriting funding, services and functions housed within the Division of Workers' Compensation (Division or DWC), potential cost savings in system administration, and organizational changes to make the administration of the system more efficient.

Among the recommendations of the Task Force were the following:

- eliminate construction exemptions and require all persons in the construction industry to be covered by workers' compensation insurance;
- allow only one independent medical exam per accident;
- eliminate the judge of compensation claims' discretion to award attorney's fees that exceed the statutory contingency fee schedule;
- prohibit attorney's fees for average weekly wage and medical mileage disputes;
- allow partial dismissal of petitions for benefits;
- require documentation to be submitted with petitions; and
- eliminate the judges of compensation claims' jurisdiction over medical bill disputes.

(For the Present Situation relating to the specific changes proposed in the bill, refer to the Section-By-Section Analysis)

C. EFFECT OF PROPOSED CHANGES:

Changes made by the bill would include:

Benefits: Eligibility for permanent total disability benefits would be revised; permanent partial disability impairment income benefits would be doubled; permanent total disability benefits would cease for claimants when reaching age 72, subject to a 7 year minimum term for receipt of benefits; and permanent total supplemental benefits (i.e., cost-of-living increases) would cease at age 62 and would not be payable to those claimants reaching permanent total disability status at or after age 62.

Dispute Resolution: The statutory dispute resolution time line would be changed from 150 days (268 days, actual) to 224 days; use of private mediation would be required whenever public mediators are unavailable within 90 days of petition filing; appellate mediation would be required.

Procedure: Carriers would be required to pay for the claimant's first independent medical exam; one independent medical exam, per specialty, would be admissible; "major contributing cause" would be defined; evidentiary standards applicable to "occupational disease," "repetitive trauma," and "toxic exposure" would be revised; employer exposure to civil tort liability would be limited to cases of actual intent to cause death or harm by the employer or where there is a failure to secure

compensation; and employers and carriers would be authorized to contract with medical providers for reimbursement amounts other than the uniform reimbursement schedule.

Attorney's fees: Contingency fees would be increased and attorney's fees would be limited to the statutory contingency fee schedule only.

Exemptions: Exempt sole proprietors, partners, and corporate officers would be prohibited from doing construction work on certain "commercial buildings," unless the prime contract is less than $250,000 in value or the project is a "residential building" conversion. The Department of Insurance, in consultation with the Workers' Compensation Joint Underwriting Association, would be required to study of the coverage needs of the construction industry and report to the Legislature by February 1, 2003.

In the event any portion of this bill is held to be invalid, the remaining portions would be severable and continue to be in effect.

The provisions of the bill would take effect January 1, 2003, except as otherwise provided.

(Please refer to Section II.D., Section-by-Section Analysis, for further detail.)

D. SECTION-BY-SECTION ANALYSIS:

Section 1: Amends s. 440.02, F.S., the definitions section of chapter 440.

EFFECT OF SECTION – The definition of "accident" would be amended to provide that an injury caused by a toxic substance would have to be proven by "clear and convincing" evidence, rather than to a "reasonable degree of medical certainty," to qualify for workers' compensation benefits.

PRESENT SITUATION -- "Clear and convincing" evidence is a standard somewhere in between the standard in civil court (i.e., "by a preponderance of the evidence") and the standard in criminal court (i.e., "beyond a reasonable doubt"). "Clear and convincing" evidence indicates the truth of the facts asserted is highly probable. "Reasonable degree of medical certainty" is established if a medical expert, perhaps the treating physician or an independent medical examiner, testifies that their medical opinion is to a reasonable degree of medical certainty.

This section also would remove the Social Security standard from the definition of "catastrophic injury." Another section of the bill would provide for determination of permanent total disability in cases other than "catastrophic injury." This section does not affect the amount of benefits that permanently totally disabled workers receive; rather, it addresses how eligibility for permanent total disability is determined.

PRESENT SITUATION -- Since 1994, permanent total disability benefits have been awarded only to claimants who suffer a "catastrophic injury." "Catastrophic injuries" encompass:

- *Spinal cord injuries;*
- *Amputation of appendages;*
- *Severe brain or closed head injuries;*
- *Severe burns of the face, hands, or body;*
- *Blindness; or*
- *Injuries that would qualify for disability benefits or supplemental security income under the Social Security Act in effect on July 1, 1992.*

Persons with a "catastrophic injury" are presumed to be permanently and totally disabled and receive benefits until reemployment or death. The receive less than 100 percent of their prior

average weekly wage for a limited number of weeks so that injured workers are encouraged to return to work.

According to the National Council on Compensation Insurance Annual Statistical Bulletin, 2000 Edition, Florida ranks near the top of forty-two states and Washington, D.C., in losses associated with permanent total disability.

- *2nd in the rate of permanent total disabilities per 100,000 workers.*
- *2nd in the percentage of overall benefit costs due to permanent total disability cases.*
- *3rd in percentage of indemnity losses that are permanent total disability.*
- *3rd in percentage of medical losses that are permanent total disability.*

According to a fifty-state survey of laws examining workers' compensation issues by committee staff, eligibility for permanent total disability benefits generally requires claimants to meet both an injury standard and employability standard.

Qualifying injuries generally are of two types: "scheduled" injuries and "non-scheduled" injuries. "Scheduled" injuries typically are dismembering, blinding, or paralyzing injuries specifically identified in statute (e.g., loss of both arms, blindness in one eye). Non-scheduled (i.e., "other") injuries generally are unspecified injuries of a nature and severity that the injury permanently and totally disables the claimant. Only six states restrict eligibility exclusively to claimants with "scheduled" injuries.

Florida is one of forty-five states allowing claimants to meet the injury standard based on non-scheduled injuries. Only two states, Florida and Georgia, define a non-scheduled injury in relation to eligibility for certain Social Security benefits. In Florida, a judge of compensation determines if a claimant would be eligible for certain Social Security benefits, while Georgia expressly allows the state regulator to consider and defer to a federal determination of Social Security eligibility.

Thirty-nine states require claimants to meet an employability standard. These states use either one of two standards, with two States using both. Either the claimant must lack an earning capacity (the requirement in twenty-six states, including Florida) or have an incapacity for work (fifteen states). Five states do not have an employability standard, regardless of the type of injury. These five States base eligibility solely on the existence of a qualifying injury. Staff could not identify an employability standard in six states. For claimants with a "scheduled" injury, thirty-six States create a presumption of eligibility in their favor. In twenty-two of these States, the presumption is "conclusive"; that is, the injury itself establishes their eligibility. In the other States allowing a presumption in favor of the claimant, the presumption is rebuttable by the employer or carrier.

Unlike Florida, forty-two States do not grant a presumption of eligibility to claimants with non-scheduled injuries. The burden is on the claimants with these injuries to establish their eligibility. Florida is one of only two states that place the burden on the employer or carrier to prove that the claimant is not permanently and totally disabled.

Persons finding work through a licensed nurse registry would not be considered employees of the nurse registry for workers' compensation purposes. These persons are registered nurses and licensed practical nurses licensed under Ch. 464, F.S., and certified nurses assistants, home health aides, companions, and homemakers, as they are defined by s. 400.462, F.S.

The definition of "employee" would be revised to limit the ability of corporate officers, sole proprietors, and partners to elect to be exempt. In general, the revised definitions would prohibit any

person from claiming an exemption with respect to a commercial construction job site valued at $250,000 or greater.

This section also would create a definition for "specificity" for the purposes dismissing petitions that fail to meet the requirements of statute.

PRESENT SITUATION – Section 440.192, F.S., requires a petition for benefits to contain certain specific details regarding the benefits sought. Judges of compensation claims may dismiss petitions for lack of specificity upon their own motion or upon the motion of a party.

The bill would define the terms "commercial building" and "residential building." These terms would appear in language proposed by section 2 of this bill. A "commercial building" would be one intended for commercial or industrial use or a multi-family dwelling with over four units. A "residential building" would be one intended for residential use containing four dwelling units or less. Each of these would include any accessory structures built at the same time as the primary structure.

Section 2: Amends s. 440.05, F.S., to require corporations and partnerships conducting business in this state to maintain certain records. Exempt sole proprietors and partners would be required to maintain and produce, upon request by the Division of Workers' Compensation, federal income tax records for the prior three years.

Records corporations and partnerships would be required to maintain would include a written statement by exempt officers and partners affirmatively acknowledging their exempt status. The Division would be required to issue a stop-work order to an employer failing to produce required federal tax records. In the case of sole proprietors or partners with a new business and lacking tax documentation required by current statute, they would be required to produce their most recent federal income tax form 1040. To accommodate the issuance of exemptions to these persons, the Division would be required to adopt rules for to determine whether or not a new business is bona fide

PRESENT SITUATION – Exemption applicants must supply federal tax documents as proof of employment status in order to be eligible for the exemption.[3] However, Department rules provided an exception applicable to new businesses.[4] Effective September 2001, the Department repealed the exception.[5] Following the rule repeal, an applicant is only eligible for an exemption after the applicable federal tax filing has been made. Subsequently, a new construction business with no "employees" other than the sole proprietor and partner has to purchase workers' compensation coverage until the applicable tax filing is made and the exemption(s) is approved.

Section 3: Amends s. 440.06, F.S, to create a cross-reference.

Section 4: Creates s. 440.078, F.S., to prohibit persons working in the construction industry without workers' compensation coverage from contracting with other persons who lack a policy, and provide penalties for violations.

An insured contractor or subcontractor could hire either an insured subcontractor or an uninsured subcontractor. However, an uninsured contractor or subcontractor would only be able to hire an

[3] S. 440.05(3), F.S.
[4] 38F-6.012, F.A.C.
[5] *Florida Administrative Weekly*, Volume 27, Number 27, page 3117, July 6, 2001.

insured subcontractor. This would apply to sole proprietors, partners, corporations, and independent contractors contracting for construction services.

Section 5: Amends s. 440.09, F.S., to require that causation in cases involving occupational disease and repetitive trauma be established by a "preponderance of the evidence" standard, rather than the current "reasonable degree of medical certainty" standard. "Preponderance of the evidence" is the standard in civil court. "Preponderance of the evidence" indicates that something is more probable than not. "Reasonable degree of medical certainty" is established if a medical expert, perhaps the treating physician or an independent medical examiner, testifies that their medical opinion is to a reasonable degree of medical certainty.

This section also would overrule the First District Court of Appeals' decision in Closet Maid v. Sykes, 763 So2d 377, 25 Fla.L.Weekly D459 (Fla.App. 1st Dist. 2000), interpreting the term "major contributing cause" for the purposes of awarding benefits in the case of a subsequent injury or a preexisting condition. The Court interpreted the term "major contributing cause" to mean a cause that is greater than any other cause (e.g., a work related injury that is 30 percent of the cause of the disability or need for treatment, and greater than any other cause would be compensable). This section would require the work related injury to be greater than all the other causes, combined (i.e., the work related injury would have to be more than 50 percent of the cause of the disability or need for treatment), to be compensable.

PRESENT SITUATION -- Current statute requires workers' compensation coverage of subsequent injuries (i.e., there has been a prior compensable injury) or a compensable injury that combines with a preexisting disease or condition if the work related injury is, and remains, the "major contributing cause" of disability or need for treatment. Ch. 440, F.S, does not define "major contributing cause."

Section 6: Amends s. 440.091, F.S., to provide firefighters, emergency medical technicians, and paramedics essentially the same protection that ensures workers' compensation benefits to off-duty law enforcement officers who are injured while protecting the health, safety and welfare of the public.

Accidental injuries to firefighters that occur while off-duty would be compensable if the firefighter is protecting life and property in this state while fighting a fire in an emergency. Accidental injuries to certified emergency medical technicians and paramedics would be compensable if the injury occurs while they are administering basic or advanced life support services but are outside of their employer's jurisdiction or area of responsibility. These injuries would not be compensable if the firefighter, emergency medical technician, or paramedic is injured while working for pay at a second job.

The amendment would provide a statement of important state interest to support the proposed extension of workers' compensation benefits.

The amendment also would consolidate the several exceptions applicable to certain law enforcement officers within a single section.

Section 7: Amends s. 440.092, F.S., to relocate the exception to the "going or coming" rule applicable to certain law enforcement to s. 440.091, F.S.

Section 8: Provides a statement of important state interest to support the extension of workers' compensation coverage to firefighters, emergency medical technicians, and paramedics proposed in section 6.

Section 9: Amends s. 440.10(1), F.S., to create a cross-reference and require, rather than permit, contractors to seek proof of workers' compensation coverage from their subcontractors.

Section 10: Amends s. 440.103, F.S., to require that the certificate of insurance used for the purpose of securing a building permit indicate the states in which the coverage applies.

Section 11: Amends s. 440. 107, F.S., to authorize the Division of Workers' Compensation to adopt rules implementing current statutory penalties against employers failing to provide required coverage and would authorize additional sanctions.

In addition to other Division enforcement powers proposed by the bill, the Division would be required to issue stop-work orders within 72 hours of a determination that the employer has failed to secure required coverage or intentionally misrepresented the size or classification of the employer's payroll to a carrier. The penalty for evasion of premium would be revised to require the Division to impose a penalty ranging from an amount equal to the amount evaded to twice the amount evaded, instead of allowing the Division to penalize an employer twice the amount evaded.

Section 12: Amends s. 440.11(1), F.S., to create a cross-reference and further specify the limits of an employer's immunity from lawsuit and responsibility to provide workers' compensation coverage.

"Intent," for the purposes of abrogating the employer's enjoyment of workers' compensation as the exclusive remedy for work-related accidents and allowing the injured worker to pursue civil tort damages, would be defined as actual intent by the employer proven by "deliberate and knowing intent to harm" the employee. If the employee recovers civil tort damages against the employer, either through award or settlement, the employer would receive an offset for workers' compensation benefits provided to the employee. This section would also provide that the employer is not vicariously liable for the intentional acts of employees. In conjunction with other sections of the bill, this section would eliminate a judicially created, subjective standard of intent that allows a claimant to pursue civil tort liability claims against the employer despite statutory exclusive liability of workers' compensation.

PRESENT SITUATION -- Employers are liable for civil tort damages if they act with intent to cause the death or injury of an employee. In Turner v. PCR, Inc., 754 So.2d 683, 25 Fla.L.Weekly S174 (Fla. 2000), the Florida Supreme Court interpreted the intent standard to include the judicially created theory that the employer engaged in activities that were "substantially certain" to result in the death or harm to the employee.

Section 13: Amends s. 440.13, F.S.

EFFECT OF SECTION -- The carrier would pay the claimant's first independent medical examination; otherwise, each party would bear the costs of independent medical exams and the deposition of the independent medical examiner themselves. Each party would still be permitted to submit into evidence the medical opinion of one independent medical examiner per specialty. The costs of independent medical examinations, and depositions, expressly relied upon by the judge of compensation claims would be taxable (i.e., awarded).

In the case of an occupational disease or repetitive trauma, a medical opinion would only be admissible if based on "scientific principles generally accepted in the relevant medical specialty." Since independent medical examinations would be freely available at a party's own cost, this section also would revise the current prohibition on attorney's fees for delay or opposition to an independent medical examination to prohibit any attorney's fees in connection with independent medical examinations.

PRESENT SITUATION -- Injured workers are permitted one independent medical exam (i.e., a second opinion) per medical specialty. For example, an injured worker might receive an independent medical exam from an orthopedist, a neurologist, a psychiatrist, a podiatrist, a chiropractor, and others. But, only the medical opinions of independent medical examiners, a Division or judge appointed expert medical examiner, or the authorized treating provider are admissible before a judge of compensation claims. According to Division statistics, the number of independent medical exams litigated in petitions for benefits increased almost seven-fold between 1995 and 1999.

Employers and carriers would be permitted to negotiate fee reimbursements in excess of the uniform reimbursement schedule.

PRESENT SITUATION -- Generally, fees for medical benefits under workers' compensation are limited to the uniform reimbursement schedule adopted by the three-member panel, except under workers' compensation managed care arrangements. Workers' compensation managed care arrangements are permitted to negotiate capitated contracts for the provision of future medical services. With the repeal of mandatory managed care effective October 1, 2001, employers and carriers may begin choosing other methods of delivering medical benefits. However, this will occur under s. 440.13, F.S., rather than s. 440.134, F.S., which regulates workers' compensation managed care arrangements and allows the capitated contracting. There is no similar provision in s. 440.13, F.S., so employers and carriers would no longer be permitted to exercise this option.

Section 14: Amends s. 440.134(2), F.S.

EFFECT OF SECTION – This section would relieve an employer and carrier from possibly having to maintain two methods of delivering medical benefits. Employers and carriers would be specifically authorized to choose a method of delivery other than the previously required workers' compensation managed care arrangements, regardless of the date of accident (i.e., the change would effectively be made procedural).

PRESENT SITUATION -- Beginning in 1997, all workers' compensation medical benefits were required to be delivered through workers' compensation managed care arrangements. Effective October 1, 2001, employer use of workers' compensation managed care arrangements is no longer mandatory. The Legislature received an opinion of the Agency for Health Care Administration stated that the 2001 change may be "substantive;" that is, the method of medical care delivery may itself be a benefit and, therefore, not subject to a retroactive change. If the change is procedural in nature, it may be applied retroactively. In a revised opinion dated October 15, 2001, the Agency appears to have refused to assert a position and has deferred to a case-by-case court resolution of the question.

Section 15: Amends s. 440.14(1), F.S., to revise the method for calculating the employee's average weekly wage. The definition of "substantially the whole of 13 weeks" would be revised to mean the actual 13 weeks prior to, but not including, the date of accident; rather than a constructive 13-week period of 91 days preceding the accident. Also, the method for including intervening pay increases would be specified.

Section 16: Amends s. 440.15, F.S.

EFFECT OF SECTION – This section would make permanent partial disability impairment income benefits payable biweekly, rather than weekly. Also, permanent partial disability impairment income benefits would be increased to the full compensation rate (2/3 of the employee's average weekly wage). For example, someone who averaged $600 per week prior to the injury and has a 10

percent impairment would receive $400 a week (2/3 of $600) for 30 weeks (10 percentage points times three) equaling an impairment income benefit totaling $12,000, or twice the current benefit amount.

PRESENT SITUATION -- Claimants with some remaining impairment after they reach maximum medical improvement,[6] but able to work after suffering an injury, may qualify for permanent partial disability impairment income benefits or supplemental income benefits. Those with less than 20 percent impairment after reaching maximum medical improvement receive half of their temporary disability benefits (one-third of their average weekly wage) for a period of three weeks per percentage of impairment, paid on a weekly basis. For example, a claimant who averaged $600 per week prior to the injury and has 10 percent impairment would receive $200 a week (1/3 of $600) for 30 weeks (10 percentage points times three weeks) equaling an impairment income benefit totaling $6,000.

In conjunction with another section of the bill, this section would remove the Social Security eligibility standard from determinations of permanent total disability.

A person would be eligible for permanent total disability benefits if they are unable to perform sedentary work. If someone is capable of sedentary work, they would not be eligible for permanent total disability benefits. The burden would be on the claimant to prove that they are unable to perform sedentary work, if part-time work is available within a 50-mile radius of their home. The judge of compensation claims would be able to apply a greater reasonable distance depending upon the facts of the case.

This section would limit payment of permanent total disability benefits until an employee reaches age 72, in addition to the current limitation on receipt until death or return to work. If the accident occurred after the employee turned 65, then the employee could receive benefits for the duration of the permanent total disability, not to exceed 7 years.

This section also would end permanent total disability supplemental benefits (i.e., cost of living increases) at age 62. These benefits would not be payable to a claimant who becomes permanently and totally disabled at the age of 62 or older.

PRESENT SITUATION - Section 440.15(1)(f)1., F.S., provides that permanent total disability supplemental income benefits cease at age 62 for persons eligible for Social Security disability benefits and supplemental security income. The District Court of Appeal, First District, held in Burger King v. Moreno, 689 So.2d 288 (Fla.App. 1 Dist. 1997) that permanent total disability supplemental benefits cease only between the ages of 62 and 65 years of age because a person could only be eligible for both Social Security disability benefits and supplemental security income for that span of years. The First District has since modified the Burger King decision in Wilkins v. Broward County School Board, 754 So.2d 50 (Fla.App. 1 Dist. 2000), 766 So.2d 224 (Fla. 2000) rev.den. In Wilkins, the First District held that s. 440.15(1)(f)1., F.S., applied to persons who reach permanent total disability status prior to the age of 62 years old; in such a case, the person's supplemental benefits would cease at age 65. However, the First District also held that, as to persons who reached permanent total disability after age 62, their benefits would not cease or be prohibited because the statute is only applicable to permanent total disability cases involving a person under age 62.

[6] "Maximum medical improvement" is the point at which an injured worker can no longer reasonably expect an improvement in or resolution of their disability or condition and a temporary disability becomes a permanent disability for the purposes workers' compensation benefits. At this point an impairment rating is assigned as a measure of the level of disability.

The exception to compensation limits providing full-pay status to certain law enforcement officers with compensable injuries would be relocated to s. 440.091, F.S.

Section 17: Amends s. 440.191, F.S.

EFFECT OF SECTION -- The bill would eliminate the request for assistance. The Employee Assistance Office would have the ability to review petitions and attempt to resolve disputes during the 30 days after the petition is filed. The Employee Assistance Office would be expressly permitted to contact employees upon receipt of the notice of injury and inform the employee of their rights and responsibilities and the services of the Employee Assistance Office.

PRESENT SITUATION – Injured workers must exhaust the informal dispute resolution process before filing a petition for benefits. The informal dispute resolution process includes the managed care grievance process and the request for assistance process. The Employee Assistance Office within the Division oversees the request for assistance process. An injured worker files a request for assistance with the Employee Assistance Office, which then has 30 days to help resolve the dispute. The Employee Assistance Office has the authority to investigate requests, facilitate agreements, and compel parties to attend conferences. According to the Division's 2000 Dispute Resolution Report, less than 5 percent of the issues presented in requests for assistance in 1999 were resolved. Also, the report indicates that attorneys filed over 95 percent of the requests for assistance in 1999.

Section 18: Amends s. 440.192, F.S.

EFFECT OF SECTION – This section would repeal one remaining provision that requires docketing review by the Office of the Judges of Compensation Claims, but was not included in the repeal of docketing review by 2001 HB 1803, 3rd ENG (Ch. 2001-158, L.O.F.). The Office and individual judges would retain the ability to dismiss petitions, or portions of petitions, which lack the required specificity.

PRESENT SITUATION -- Employees must file petitions with the Office of the Judges of Compensation Claims, where it is reviewed before being forwarded to the judge of compensation claims presiding over the dispute. Section 440.192(2), F.S., sets forth the specific information that must be contained in a petition for it to be considered. This section requires the Office of the Judges of Compensation Claims to dismiss any petition that does not contain all of the required information.

The bill would require petitions to contain the doctor's request, authorization, or recommendation for treatment, if the claimant is under a doctor's care. The Chief Judge would also be given the authority to require additional specificity by rule.

Grounds for dismissal for lack of specificity would have to be moved within 60 days, rather than 30 days, or they would be waived.

Carriers would be required to pay or deny benefits within 30 days of receipt of the petition. Considering the elimination of the request for assistance procedure, the claimants would receive payment or a response to petition two weeks earlier than under current law.

Also, claims would be required to have been raised by a petition and mediated, to be adjudicated by a judge of compensation claims, unless the parties stipulate otherwise in writing.

Section 19: Amends s. 440.20, F.S. to require judges to approve only settlement proposals, stipulations, and agreements between claimants and their attorney that comply with the attorney's fees provisions contained in s. 440.34, F.S.

Section 20: Amends s. 440.25, F.S.

The following table illustrates the current statutory dispute resolution time line, the actual time line as identified by the October 1999 Insurance Committee staff report, and the statutory time line that would be created by this and other sections of this bill.

Dispute resolution time line.	Current Statute	Actual	Proposed
Request for assistance	1st day	1st day	Eliminated; DWC retains authority to facilitate resolutions.
Petition for benefits	30th day	25th day	1st day
Pay or deny benefits	44th day	39th day	30th day
Response to petition	44th day	39th day	30th day
Attorney's fees attach	44th day (or reasonable time after request for medical benefit, per Allen v. Tyrone Sq. 6 AMC Theatres)	39th day	30th day
JCC sets mediation by order	37th day	-	40th day
Mediation	51st day	163rd day	90th day
Pretrial stipulations	No provision. In practice, at or before pretrial hearing.	n/a	90th day
Pretrial hearing	61st day	193rd day	104th day (if necessary) (60 days, rather than 30 days, required for discovery)
Final hearing	106th day	238th day	180th day (210th day maximum)
Final order	136th day	268th day	210th day (240th day maximum) (current statute re: number of days from final hearing)
Pay award	150th day	282nd day	224th day (244th day maximum) (current statute re: number of days to pay award)

OTHER EFFECTS OF SECTION – Within 40 days of being assigned a petition, the judge of compensation claims would be required to establish, by order, the date by which a mandatory mediation must be held. If the parties agree, or if a public mediator is not available to mediate the case within 90 days of the filing of the petition, the judge would be authorized to order private mediation at the carrier's expense. If the parties are unable to agree upon a mediator within 10 days of the order setting the date by which mediation must occur, the claimant would be required to notify the judge. The judge would be required to appoint a mediator within 7 days.

If the judge of compensation claims orders the continuance of a mediation or final hearing, then the judge of compensation claims would be required to set the new date in the continuance order. Just as with a continuance of the final hearing, the party moving for a continuance of the mediation would be required to show that the need for the continuance results from circumstances beyond the party's control. If a final hearing is continued more than once at the request of a particular party, the judge would be required to report the continuance to the Chief Judge. This section would prohibit the use of mediation solely to resolve attorney's fees disputes.

Disputes over the determination of an employee's "average weekly wage" would be required to be resolved through expedited dispute resolution without a hearing. The judge of compensation claims would have the discretion to order an expedited hearing, if necessary. Disputes over medical-only claims of $5,000, or less, and medical mileage would be resolved through an expedited dispute resolution hearing, unless the judge ordered otherwise.

Any benefits that are due, but not raised at the final hearing, would be waived. The judge of compensation claims would be authorized to dismiss a petition, without prejudice, if there have been no petitions, responses, motions, orders, requests for a hearing, or notices of deposition for a period of 12 months. Attorney's fees would only attach 30 days after the carrier receives the petition.

Section 21: Amends s. 440.271, F.S., to require mediation within 60 days of the filing of a notice of appeal of a judge of compensation claims' final order.

Section 22: Amends s. 440.29, F.S., to provide that the medical reports of certain independent medical examiners may be submitted into evidence.

Section 23: Amends s. 440.34, F.S.

EFFECT OF SECTION – The bill would limit attorney's fees to the contingency fee schedule for awards under a final order, a joint stipulation, or paid under an agreement between the claimant and their attorney, or any other agreement. The bill would remove the discretion of the judge of compensation claims to approve an additional amount. The bill would increase contingency fees to 25% of the first $10,000, 20% of the next $10,000, and 15% of the remaining amount.

PRESENT SITUATION -- A judge of compensation claims or a court must approve as reasonable all fees paid under the law. Attorneys are permitted to receive fees pursuant to a statutory contingency fee schedule. The fee schedule is as follows:

- *20% of the first $5,000 in benefits secured;*
- *15% of the next $5,000 in benefits secured;*
- *10% of the remaining benefit amount to be provided during the first 10 years; and*
- *5% of the benefits secured for after 10 years from the date the claim is filed.*

However, the Judge of Compensation Claims or court may increase or decrease the fee and award claimant attorney fees on an hourly basis in consideration of the following statutory criteria:

- *the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;*
- *the fee customarily charged in the locality for similar legal services;*
- *the amount involved in the controversy and the benefits resulting to the claimant;*
- *the time limitation imposed by the claimant or the circumstances;*
- *the experience, reputation, and ability of the lawyer or lawyers performing services; and,*

- *the contingency or certainty of a fee.*

The attorney may only receive a fee for the benefits secured as a result of the representation. That is, the increase in benefits secured must be as a result of the legal services rendered in the pursuit of the claim. However, this does not include medical benefits provided more than five years after the claim is filed.

A prevailing claimant may collect attorney fees from the employer or carrier if they do not pay the benefits within 14 days of the receipt of the petition. The statute provides for this in four instances:

- *in medical-only claims;*
- *where the employer/carrier has filed a response denying the petition and the claimant employs an attorney in pursuit of the claim;*
- *where the employer/carrier denies that a compensable injury occurred; or*
- *where the claimant prevails in an enforcement or modification proceeding.*

If a claimant is responsible for his or her own attorney fees, then the attorney's fee represents a lien upon the compensation. Attorney's fees are reported to and summarized by the Division.

According to a September 2001 study prepared by the National Council on Compensation Insurance, Inc., for the Florida Senate Banking and Insurance Committee, average indemnity and medical costs in cases with attorney involvement are over one-third higher in Florida when compared with the countrywide average. However, the study found a minimal difference in average cost when attorneys were not involved.

According to a fifty-state survey of laws examining workers' compensation issues by committee staff, forty-one States, including Florida, place numerical restrictions on attorney compensation. The most common numerical limits are percentage-based. These States limit fees to a flat percentage, regardless of the total amount of benefits awarded or secured. Some states use a variation of this approach. They apply different percentages in calculating the amount of fees depending on the value of the benefits awarded or secured, or the stage of the proceedings. Other states use similar approaches, but rely on specific dollar limits rather than percentage limits. Use of a combination of these approaches also is not unusual.

Three States expressly and exclusively rely on a "reasonable" fee standard. Presumably, at least some States with express numerical limits on attorney compensation inject a reasonableness standard in awarding fees below the statutory maximum. However, the extent to which this occurs is not fully apparent from a reading of the statutes. Staff was unable to identify an express limitation on attorney compensation in nine states.

About a third of the states, including Florida, expressly permit departures.

Several States make separate provision for attorney's fees based on the type of dispute; e.g., medical-only claims or denials of compensability. For example:

- *Colorado - the retainer agreement in medical-only cases may provide for a reasonable hourly fee.*
- *Illinois - prohibits attorney's fees for "undisputed" medical benefits.*
- *Michigan - if the attorney's fee would be less than $500, the claimant and attorney may enter into an agreement for an attorney's fee of up to $500.*
- *Minnesota - allows an attorney's fee of $500 for the recovery of medical or rehabilitation benefits where the monetary value of the benefits is not reasonably ascertainable. Also, a penalty is assessed against employers and carriers, payable to the claimant, in an amount*

equal to 30 percent of the attorney's fees over $250, if the claimant prevails in a denial of compensability dispute.

- *North Dakota - does not limit attorney's fees when compensability is denied.*
- *Ohio - sets a $2,500 attorney's fee if the commission or administrator contests the right of the claimant to receive benefits from the State Fund and the claimant prevails on the appeal.*
- *Oregon - permits a $1,000 attorney's fee if the claimant prevails in a denial of responsibility (i.e., compensability) case.*
- *Pennsylvania - allows the attorney's fee to be set by contract in cases without a monetary award (e.g., a change of doctor or second opinion).*
- *Wyoming - if the employer prevails on the issue of compensability, a "reasonable" employer's attorney's fee is awarded from the State Fund.*

At a certain level, Florida operates similarly to other States. Florida is one of the forty-one states placing express numerical limits on attorney compensation. Florida and six other States change the applicable percentage of allowed attorney's fees depending on the amount of benefits awarded or secured (i.e., contingency fee schedule). In five other states, the change in percentage allowed is tied to the stage of the proceedings. Florida is among the fourteen states permitting a departure from the limit. Forty-seven States, including Florida, make some provision for awarding attorney's fees against the employer or carrier. However, Florida is the only State that permits a departure from a contingency fee schedule.

Section 24: Amends s. 440.345, F.S., to specify the rulemaking authority of the Division of Administrative Hearings and delete a required report to the Workers' Compensation Oversight Board.

Section 25: Amends s. 440.381, F.S., to require the application for coverage to include a sworn statement by the agent attesting that the agent explained to the employer or officer the classification codes that are used for premium calculations. The bill would also provide penalties for carriers for noncompliance with auditing requirements and require the employer or officer and auditor to sign the audit document. The bill provides penalties for any employer who understates or conceals payroll or makes certain misrepresentations that affect premium calculations (removing the intent requirement).

Section 26: Amends s. 440.40, F.S., to require employers to post notices of the anti-fraud reward program.

Section 27: Amends s. 440.45, F.S., to specify the duties of the Director of the Division of Administrative Hearings with respect to rulemaking and the making of agency policies and procedures.

Sections 28 and 29: Amends ss. 489.114 and 489.510, F.S., to allow the Division of Workers' Compensation to report findings of noncompliance by contractors to the Department of Business and Professional Regulation and to specify a $500 administrative fine for noncompliance.

Section 30: Amends s. 626.9892, relating to the anti-fraud reward program, to allow rewards to be paid with respect to specified violations, regardless of whether or not the offenses are considered to be "complex or organized" crimes.

Section 31: Provides that the required appellate mediation proposed by Section 21 would become effective and apply to all workers' compensation appeals filed on or after July 1, 2002.

Section 32: This section would require the Department of Insurance, in consultation with the Workers' Compensation Joint Underwriting Association, to conduct a study of the coverage needs

of the construction industry and report to the Legislature by February 1, 2003. The study would be required to address scope of coverage, cost, and availability.

Section 33: This section would make certain that changes proposed to the standards for granting workers' compensation benefits would not alter the way disability benefits are granted to law enforcement officers, fire fighters, and emergency medical technicians under separate provisions of statute. Certain statutes regarding public officers and employees provide certain special provisions governing coverage of disability, illness, and death of law enforcement officers, fire fighters, and emergency medical technicians. Certain provisions of the Workers' Compensation Law may be formally or informally used in relation to these special provisions.

Section 34: Provides for the severance of any portion of the bill if any portion of it is found to be invalid; the remaining portions of the bill would continue to be effective.

Section 35: Provides an effective date of January 1, 2003, except as otherwise provided.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

Please see fiscal comments, below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

Indeterminate. The number of additional claims and resulting increase in premiums is indeterminate. The actual incidence of these types of accidental injuries to firefighters, emergency medical technicians, and paramedics is unknown. Similarly, any offset to increased workers' compensation costs due to decreased utilization of health insurance benefits is indeterminate.

Please see fiscal comments, below.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Private employers of emergency medical technicians and paramedics may see an indeterminate increase in workers' compensation premiums to the extent that they experience increased claims as a result of the proposed extension of workers' compensation coverage. They also may see a decrease in health insurance premiums to the extent that claims are reduced as a result of the proposed extension of workers' compensation coverage.

Please see fiscal comments, below.

D. FISCAL COMMENTS:

It is difficult to predict what impact this bill will have on workers' compensation rates. No independent actuarial analysis has been done.

The bill would have an indeterminate effect on the expenses of state and local governments and private sector employers depending on whether the bill would result in a net increase or decrease in workers' compensation system costs. The bill would increase system costs by doubling permanent partial disability impairment income benefits. The bill would potentially decrease system costs by reforming the dispute resolution process, revising eligibility for permanent total disability benefits, and limiting attorney's fees to the statutory fee schedule. The net effect on workers' compensation costs is unclear.

The bill would require the Workers' Compensation Joint Underwriting Association to conduct a study of the insurance market's response to the coverage needs of the construction industry.

According to the Department of Insurance, the bill would have no fiscal impact on state government since the firefighters employed by the state have statewide jurisdiction and therefore would be acting within the course and scope of their employment whenever they are accidentally injured while fighting a fire in an emergency within the state.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill may require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. However, this bill applies equally to all persons affected, whether or not they are a public or private entity. Because the bill applies to all similarly-situated employees in governmental units other than cities and counties, if the Legislature determines an important state interest, the bill would meet the exception to the mandates provisions of Article VII, Section 18 of the Florida Constitution. The bill contains a statement of important state interest for this purpose.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

Section 440.192, F.S., requires petitions for benefits to contain certain specific information, subject to dismissal. The Chief Judge would receive the authority to require additional specificity by rule.

The Division would receive the authority to establish in rule the industrial classification codes meeting the definition of "construction industry" as revised by this bill.

The Division would be required to establish rules for authenticating the veracity of a new business that otherwise would prevent persons from qualifying for an exemption.

C. OTHER COMMENTS:

Legislation has been filed to transfer the Division of Workers Compensation from the Department of Labor and Employment Security to the Department of Insurance. The Workers' Compensation Oversight Board would be transferred also. The Governor appoints the majority of the members of the Workers' Compensation Oversight Board. The Department of Labor and Employment Security is within the executive authority of the Governor, while the Department of Insurance is within the executive authority of the Treasurer.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

The Council Substitute incorporates amendments revising the construction exemption, increasing the contingency fee schedule, removing discretion to award attorney's fees except as provided in the schedule, specifying duties of the Division of Administrative Hearings, providing for a study to be conducted by the Department of Insurance rather than the Workers Compensation Joint Underwriting Association, and adding several anti-fraud provisions.

VII. SIGNATURES:

COMMITTEE ON INSURANCE:

Prepared by:	Staff Director:
Eric Lloyd	Stephen Hogge

AS REVISED BY THE COUNCIL FOR COMPETITIVE COMMERCE:

Prepared by:	Council Director:
Leonard Schulte	Matthew M. Carter II