SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 1132

SPONSOR: Banking and Insurance Committee and Senators Clary and Atwater

SUBJECT: Workers' Compensation

DATE: April 16, 2003 REVISED: ____ ____ ____ ____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Deffenbaugh	BI	Favorable/CS
2.			AGG	
3.			AP	
4.			RC	
5.				
6.				

I. Summary:

The committee substitute provides changes to the workers' compensation system that are designed to expedite the dispute resolution process, provide greater compliance and enforcement authority for the Division of Workers' Compensation to combat fraud, revise certain indemnity benefits for injured workers, and increase availability and affordability of coverage.

Benefits

- Increases temporary total and temporary partial disability benefits from 104 to 260 weeks.
- Increases the limitation on chiropractic services from 10 to 36 treatments and 8 to 16 weeks.
- Revises definition of catastrophic injury to eliminate social security eligibility as a catastrophic injury and provides that in order for an injury listed in s. 440.02(38), F.S., to qualify as a catastrophic injury (i.e., spinal or brain injury) the employee must be unable to engage in any gainful or sheltered employment. If these criteria are met, the employee would be eligible for permanent total disability benefits.
- Reduces permanent total supplemental benefits from 5 percent to 4 percent per year, eliminates such benefits at age 62, and ceases permanent total disability benefits at age 75.
- Reduces duration of permanent partial disability benefits for employees with an impairment rating of 1-11 percent, maintains or increases duration of such benefits for employees with an impairment rating of 12 percent or more, increases permanent partial disability benefits from 50 to 75 percent of the employees' temporary total disability benefits, and eliminates permanent partial supplemental disability benefits.

- Increases the amount of temporary partial disability benefits from 80 percent to 85 percent of difference between 80 percent of the pre-injury wages and post-injury wages. Eligibility for temporary benefits ceases 401 weeks after the date of injury.
- Increases benefits for funeral expenses from $5,000 to $7,500 and death benefits are increased for dependents from $100,000 to $200,000.

Medical Care and Treatment

An employee would be entitled to an evaluation by a principal treating physician selected by the carrier. The carrier is authorized to transfer care from the principal treating physician if a peer review panel, based on a request from the carrier, determines that the employee is not making appropriate progress. Upon the written request of the employee, the employee is entitled to a one-time per accident change to a different provider from a list provided by the carrier. The principal treating physician is authorized to request a consultation with an authorized specialist for clarification of issues. The principal treating physician may alternatively recommend to the carrier the transfer of care entirely or some portion of care to an authorized specialist for evaluation.

If the employee disagrees with the principal treating physician regarding the diagnosis or care, the employee is entitled to a discretionary confirmatory consultation with a provider of his or her choice within the same specialty as the provider with whom the employee disagrees. The carrier is also limited to one discretionary confirmatory consultation for each accident. The employee and carrier are each entitled to a confirmatory consultation if certain conditions are met.

Dispute Resolution Process

An employee that is involved in a dispute with a carrier would be required to file a petition for benefits with the newly created Claims Bureau rather than the Office of the Judges of Compensation Claims in Tallahassee. The Claims Bureau, within the Department of Financial Services, would be authorized to 1) review and resolve petitions through an administrative determination within 45 days based upon evidence submitted, in accordance with rules established by the bureau; 2) refer a claim to the Office of the Judges of Compensation Claims for adjudication; or 3) refer a claim to a medical peer review panel for adjudication of a medical dispute.

The adjudication of medical disputes is substantially revised by using peer review panels to resolve medical disputes. The Department of Financial Services would contract with a peer review organization for the performance of peer reviews of medical disputes. The costs of peer review panels would be incurred by the carrier. Medical issues would be decided in a summary manner by the panel from records and pleadings submitted by the claimant and the employer/carrier with their response to the petition for benefits. If the peer review panel finds that a determination of facts by a judge of compensation claims is necessary, the panel would certify the question of fact to the judges of compensation claims.

Any party may appeal the decision and or findings of the Claims Bureau, the final adjudication of the peer review panel, or the order of a judge of compensation claims to the Workers' Compensation Tribunal. Once the Claims Bureau issues a determination and recommendation on

administrative issues, the bureau may assign issues to the judges of compensation claims for the purpose of taking evidence and holding a hearing and determining entitlement to disputed benefits. The Office of the Judges of Compensation Claims and the Workers' Compensation Appellate Tribunal is created. The tribunal would hear appeals of orders from the judges of compensation claims, the claims bureau, and peer review panel. Reviews of the orders from the tribunal would be heard by the First District Court of Appeals. The Office of the Judges of Compensation would be assigned to this office. The 31 state mediators' positions within the Office of the Judges of Compensation Claims are eliminated.

Attorneys Fees

Attorney's fees are revised to provide that fees would be equal to 20 percent of the first $10,000 in benefits, rather than the first $5,000 in benefits secured and fees would be equal to 15 percent of the remaining benefits secured and specifies that certain additional fees could be awarded in the following circumstances: of $5,000 for medical only, $5,000 in cases in which the carrier denies benefits and the employee prevails, and the greater of the fee schedule or $20,000 in cases in which the carrier denied compensability and the employee prevailed.

Medical Fees

The bill provides that it is the intent of the Legislature to increase the schedule of maximum reimbursement allowances for neurologists, orthopedic physicians, and primary care physicians through reductions in payments to hospitals. These payment revisions must not result in any increase in the aggregate medical payments and must be cost neutral to the carriers. The maximum reimbursement allowances for these selected physicians are 125 percent of the Medicare fee schedule. Payments for outpatient physical, occupational, and speech therapy provided by hospitals would be reduced to the fee schedule which applies to nonhospital providers. Payments for scheduled nonemergency radiological and clinical lab services that are not provided in conjunction with a surgical procedure would be reduced to the fee schedule applicable to nonhospital providers.

Exemptions from Coverage - Construction Industry

Exemptions in the construction industry for sole proprietors and partners are completely eliminated; however, corporate officers that secure certain limited medical and disability policies and meet other criteria would be eligible for an exemption from coverage.

Availability and Affordability of Coverage

Three tiers of plans are established in the Florida Workers' Compensation Joint Underwriting Association to address affordability and availability. Tier One would provide coverage to employers whose manual premium does not exceed $20,000 and who have neither incurred any lost-time claims nor incurred medical-only claims exceeding 50 percent of the premium in the preceding three years. Tier Two would include those employers who are unable to secure compensation in the voluntary market, but have an experience modification factor of 1.05 or less, and charitable and nonprofit organizations. Lastly, Tier Three would include all other employers and may include multiple rating plans for various classifications of employers. The rates for

Tiers One and Two are capped at 125 percent of the rate for the voluntary market manual rate. The rates of Tier Three must be actuarially sound to assure that Tier Three is self-supporting. Any deficits in these tiers would be collected as an assessment by insurers and paid by workers' compensation policyholders as a line item charge.

Compliance and Enforcement -- Fraud

Additional administrative penalties are established or increased and documentation and record keeping requirements are provided to assist the Division of Workers' Compensation in determining compliance and enforcing coverage requirements. An employer who has employees engaged in Florida is required to obtain a Florida policy or endorsement that meets certain requirements of ch. 440 and the Florida Insurance Code. A contractor is required to request proof of coverage from a subcontractor and the subcontractor is required to provide a copy of the certificate of exemption to the contractor.

Other Provisions

Each workers' compensation carrier or its rating organization is required to make a rate filing on or before August 15, 2003, reflecting the anticipated savings of this act which would be effective for policies issued on or after January 1, 2004, subject to the approval of the Office of Insurance Regulation.

The bill provides that it is the intent of the Legislature to create a state mutual insurance fund for workers' compensation, effective January 1, 2005, if rates do not decrease by 20 percent on or before that date.

This bill substantially amends the following sections of the Florida Statutes: 20.13, 20.201, 27.34, 112.181, 440.015, 440.02, 440.05, 440.06, 440.077, 440.09, 440.10, 440.1025, 440.103, 440.104, 440.105, 440.1051, 440.107, 440.11, 440.12, 440.125, 440.13, 440.132, 440.14, 440.15, 440.151, 440.16, 440.17, 440.185, 440.191, 440.192, 440.1925, 440.20, 440.24, 440.25, 440.271, 440.2715, 440.28, 440.30, 440.32, 440.34, 440.38, 440.381, 440.385, 440.386, 440.40, 440.42, 440.44, 440.442, 440.45, 440.49, 440.50, 440.501, 440.51, 440.515, 440.52, 440.59, 440.591, 440.593, 443.036, 443.171, 443.1715, 626.062, 626.989, 626.9891, 627.311, and, 921.0022.

The bill creates the following sections of the Florida Statutes: 440.152, 440.2725, and 440.465.

The bill repeals the following sections of the Florida Statutes: 440.134, 440.135, and 440.29.

II. Present Situation:

Summary of 1993 Workers' Compensation Law and Impact of Reforms

Major reforms of the Workers' Compensation Law that were enacted in 1994 and in prior years attempted to address high premium rates and low benefits. The 1993 legislation (ch. 93-415, L.O.F.) substantially revised many aspects of the workers' compensation law in an attempt to significantly reduce costs. The 1993 reforms included the following changes:

- Reduced attorney's fee schedule from 25/20/15 to 20/15/10 percent of benefits secured;[1]
- Authorized a maximum credit of 10 percent for implementing managed care;[2]
- Limited increases in the medical fees schedule to the prior year's increase in the Consumer Price Index;
- Revised the definition of catastrophic injury to specify which injuries constitute permanent total disability and to include any injury eligible for federal income disability or security income benefits;
- Reduced temporary total disability benefits to 104 weeks (previously 260 weeks);
- Authorized safety and drug-free workplace credits; and
- Revised chiropractic services to 18 treatments or 8 weeks from the initial treatment, whichever occurred first.

Availability and Affordability of Workers' Compensation Insurance

In recent years, some workers' compensation carriers are not issuing new policies, renewing policies, or tightening their underwriting requirements in response to a downturn in the economy and uncertainties in the market place. Reinsurers are restricting the types of coverage they will write and have increased rates which has adversely impacted the carriers. For 2002, the Department of Financial Services authorized a 2.7 percent increase in rates, and subsequently, in 2003, a 13.7 percent increase was approved. The Workers' Compensation Joint Underwriting Association (JUA), the insurer of last resort, has experienced a significant increase in the number of policies issued in recent years. The number of policies issued in the JUA increased from 522 in 2000 to 1,179 as of February 2003. For the same period, the volume of written premium increased from $5 to $26 million.

In recent years, many stakeholders in the workers' compensation system have contended that Florida has the highest premium rates for workers' compensation insurance in the country, while its statutory benefits are among the lowest. In recent years, Florida has been recognized by independent studies as having the highest or second highest rates (2001) countrywide.

Cost Drivers in Florida

In 2001, the Workers' Compensation Research Institute (WCRI) released a report entitled *Benchmarking Florida's Workers' Compensation Medical Fee Schedules* (September 2001), that compared Florida's fee schedule to other large states and southern states, the Medicare fee schedule in Florida, and the Florida fee schedule implemented September 30, 2001. The report also benchmarked hospital reimbursements in Florida with other states. Florida's medical fees were compared with California, Connecticut, Georgia, Louisiana, Massachusetts, Minnesota, Mississippi, New York, North Carolina, Pennsylvania, South Carolina, and Texas. The following major findings were noted by WCRI:

[1] As a result of the 1993 reforms, the fees must equal 20 percent of the first $5,000 of the benefits secured, 15 percent of the next $5,000 of the amount of benefits secured, 10 percent of the remaining amount of the benefits secured and to be provided during the first 10 years, and 5 percent of the benefits secured after 10 years. [s. 440.34, F.S.]

[2] This credit was eliminated when managed care was mandated, effective January 1, 1997.

1. The Florida fee schedule that was in effect prior to September 30, 2001, was significantly lower than neighboring states and large states evaluated. The fee schedule amounts (overall and for each major medical service group) are either the lowest or among the lowest in the United States.
2. The new fee schedule, effective September 30, 2001, lowered fees overall by 2 percent on average. Florida had the second lowest fee schedule among the eight larger states (California, Connecticut, Massachusetts, Minnesota, New York, Pennsylvania, and Texas) evaluated. Massachusetts had the lowest fee schedule of the eight states primarily due to the relatively low surgery reimbursement rates.
3. On average, Florida's fee schedule is equal to those prescribed by the Medicare fee schedule (2000 edition). The report noted that Florida reimbursements for certain categories, such as evaluation and management (-37 percent) and radiology (-19 percent) are significantly lower than the Medicare fee schedule. In contrast, surgery fees were 14 percent above the Medicare fee schedule.
4. The average payments per service paid to Florida hospitals were generally the highest of the eight large states and as much as five times higher than the Florida fee schedule amounts authorized for non-hospital providers for similar services. The average fees paid to hospitals also increased by 13 percent per year for injuries incurred during the period of 1996-98.

In 2003, the National Council on Compensation Insurance (NCCI) identified the following major cost drivers in the workers' compensation system in Florida:

- High frequency of permanent total disability (PTD) claims—five times higher than the national average;
- High medical costs for permanent partial disability (PPD) claims—nearly two times higher than the national average;
- High medical costs for temporary total disability (TTD) claims—80 percent higher than the national average; and
- Relatively high hospital costs.

The NCCI also noted that while Florida's physician reimbursement fee schedule is low, there may be high utilization of physician services or an expensive mix of services being provided. Florida does not have unusual types of injuries that would explain higher costs. Attorney involvement is significant in Florida and helps explain the major cost drivers. When attorneys are not involved, the difference in claim costs between Florida and the national average is minimal. When attorneys are involved, Florida's claim size is nearly 40 percent higher than the national average. Medical costs constitute the majority of total losses in Florida (63.6%), which is not the case nationwide (47.1%).

Administration of the Workers' Compensation System in Florida

Pursuant to s. 440.015, F.S., the Division of Workers' Compensation, within the Department of Financial Services, is charged with administering the Workers' Compensation Law in a manner that facilitates the self-execution of the system and the process of ensuring a prompt and cost-effective delivery of payments.

Funding for the division is provided through the Workers' Compensation Administration Trust Fund and the Special Disability Trust Fund. Funding is generated through annual assessments on individually self-insured employers, self-insurance funds, carriers, and the Workers' Compensation Joint Underwriting Association (on behalf of their insured employers) based on "net premiums collected" and "net premiums written" respectively. The Workers' Compensation Administration Trust Fund assessment is capped at 2.75 percent and the current calendar year rate is 1.75 percent. Entities are also subject to a 4.52 percent assessment that is used to finance the Special Disability Trust Fund.[3]

The Formal Dispute Resolution Process—Office of the Judges of Compensation Claims

The Office of the Judges of Compensation Claims is responsible for hearing and resolving disputed workers' compensation issues under the authority of ch. 440, F.S. In 2001 legislation was enacted that transferred the workers' compensation hearings function, as a separate budget entity, from the Department of Labor and Employment Security to the Division of Administrative Hearings within the Department of Management Services, effective October 1, 2001 (ch. 2001-91, L.O.F.). This transfer was initiated as a result of concerns regarding the level of accountability and independence of the office within the division.

Once an employee has exhausted the informal dispute resolution process, the employee may file a petition for benefits with the Office of the Judges of Compensation Claims in Tallahassee, the employer and the employer's carrier. [s. 440.192, F.S.] If the petition is not dismissed, it is referred to the appropriate district office. Presently, there are 17 district offices. Section 440.25, F.S., requires the mediation conference to be held within 90 days of the receipt of the petition. If state mediators are unavailable within the statutory time period to conduct the conference, the parties are required to hold mediation at the carrier's expense. If the parties fail to agree upon written submission of pretrial stipulations, the judge of compensation claims (JCC) is required to order a pretrial hearing within 14 days of the date of mediation. The final hearing is required to be held and concluded within 90 days after the date the mediation conference is held, unless the JCC grants a continuance. The final hearing is required to be held within 210 days after the receipt of the petition for benefits.

Some states, including Georgia and Minnesota, use or have used alternative dispute resolution procedures for resolving certain types of issues. The state of Georgia initiated a formal Alternate Dispute Resolution Unit (ADR) in 1994. The State Board of Workers' Compensation may direct parties to participate in mediation. Currently the ADR Unit handles requests for legal action without the necessity of an evidentiary hearing. The ADR Unit issues rulings on motions and requests for change of physicians or medical treatment, as well as conducting mediation conference on issues such as the payment of medical expenses, attorney's fees, average weekly wage disputes, light duty work issues, and overall settlement of a workers' compensation claim. The ADR Unit has been very effective in reducing litigation and expediting the dispute resolution process. In the last few years, the number of claims that would generally be heard by the Trial Unit has decreased due to the use of mediation. If there is a dispute regarding medical care, the claim may go to mediation first. If mediation is unsuccessful, the claim would automatically be referred to the Trial Unit for an evidentiary hearing. An employer, insurer, or

[3] Sections 440.49 and 440.51, F.S.

physician is required to file a request for a peer review by an organization that is authorized by the State Board of Workers' Compensation to resolve medical disputes.

In 1983, the State of Minnesota revised their dispute resolution process by transferring the jurisdiction of review medical health care and vocational issues from the compensation judges of the Office of Administrative Hearings to the commissioner of the Department of Labor and Industry and all other issues went to the compensation judges. Once the commissioner made a determination regarding a medical or vocational issue, an employee could appeal to the medical services review board or the vocational review board, respectively, and to the workers' compensation court of appeals. In the late 1980's this system was repealed because all parties agreed that the system for resolving disputes had become too complicated and lengthy and therefore, the dispute resolution process was streamlined by the elimination of the triple-track system. The compensation judges were given authority over all benefit issues and the system retained the administrative conference procedure in the Department of Labor and Industry which provides for the informal resolution of less complex rehabilitation and medical issues.

Appeals Process

Currently, all appeals are heard by the First District Court of Appeal. During the last 10 years, the number of filings at the First District Court of Appeals has decreased substantially and has remained relatively constant in the last few years. In 1993, 797 filings were made. In contrast, 419 were made in 2000, 434 in 2001, and 460 in 2002. The disposition for petitions and notices of appeals for 2002 indicates that 56 percent of petitions filed by the claimant were affirmed and 52 percent of the petitions filed by the employer were affirmed.

Medical Fees, Practice Parameters, and the Regulation of Managed Care Arrangements

The Agency for Health Care Administration is responsible for authorizing carriers to offer or utilize a worker's compensation managed care arrangement, if the carrier meets the conditions of s. 440.134, F.S., and regulates workers' compensation managed care arrangements. As part of the 1993 Act, workers' compensation managed care arrangements were authorized for the delivery of medical benefits, and mandated in 1997. However, employers are allowed to "opt-out" from the delivery of medical services through a managed care arrangement, effective October 1, 2001.[4] The "opt-out" provision was driven by concerns regarding additional administrative costs, litigation expense, and delays in providing care that were attributed to delivering medical care through managed care arrangements.

The three-member panel, consisting of the Chief Financial Officer or his designee, and two members appointed by the Governor, is charged with the responsibility of determining statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians and hospitals. The maximum percentage of increase in the individual reimbursement schedule is capped at the percentage of increase in the Consumer Price Index for the prior year. Reimbursements for all fees and other charges for medical treatment cannot exceed the amounts provided by the maximum reimbursement allowance approved by the three-member panel and developed and adopted by rule by the department. [s. 440.13 (12), F.S.]

[4] Ch. 2001-91, L.O.F

Individual physicians are required to be reimbursed at the usual and customary charge, the agreed-upon contractual amount, or the maximum reimbursement allowance, whichever is less. Inpatient hospital care is reimbursed on a per diem basis and outpatient hospital care is reimbursed at 75 percent of the usual and customary rate.

Practice parameters are guidelines developed to assist health care practitioners with patient care decisions about appropriate diagnostic, therapeutic, or other clinical procedures for specific clinical circumstances. Typically, guidelines or parameters are developed by government agencies at any level, institutions, organizations such as professional societies or governing boards, or by the convening of expert panels. They can provide a foundation for assessing and evaluating the quality and effectiveness of health care in terms of measuring improved health, reduction of variation in services or procedures performed, and reduction of variation in outcomes of health care delivered.

Prior to 1993, there were relatively few practice parameters available; however, since 1993, many medical specialty organizations have developed their own practice guidelines. In addition, the federal government has funded and developed practice guidelines via the Agency for Healthcare Research and Quality part of the U.S. Department of Health and Human Services. Due to the lack of available guidelines in the past, insurance companies, private individuals, and attorneys were supportive of development and implementation of medical practice guidelines. However, in recent years, with the ease of access to various national evidence-based guidelines that are regularly updated based on new information and knowledge, state government-developed practice parameters have become less relied upon.

Under s. 440.13(15), F.S., the Agency for Health Care Administration in conjunction with the Department of Financial Services and appropriate health professional associations and health-related organizations must develop and may adopt by rule scientifically sound practice parameters for medical procedures relevant to workers' compensation claimants. Such parameters must focus on identifying effective remedial treatments and promoting the appropriate utilization of health care resources. Procedures must be instituted which provide for the periodic review and revision of practice parameters based on the latest outcomes data, research findings, technological advancements, and clinical experiences, at least once every 3 years. Under s. 440.134, F.S., one of the elements of workers' compensation managed care arrangements is a description of the use of worker's compensation practice parameters for health care services when adopted by the Agency for Health Care Administration.

The National Guideline Clearinghouse is a comprehensive database of evidence-based clinical practice guidelines and related documents produced by the Agency for Healthcare Research and Quality in partnership with the American Medical Association and the American Association of Health Plans. The mission of the National Guideline Clearinghouse is to provide physicians, nurses, other health professionals, health care providers, health plans, integrated delivery systems, purchasers, and others an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines and to further their dissemination, implementation, and use. Development of guidelines requires extensive funds and frequent reviews. It requires retaining experts in the field of study adding to the cost. The National Guideline Clearinghouse database has 995 guidelines.

General Overview of Workers' Compensation Benefits in Florida

Chapter 440, F.S., generally requires that employers/carriers provide benefits (medical and indemnity) to a worker who is injured due to an accident arising out of and during the course of employment. The types of injury include: first aid, medical only, lost time, and death. Medical-only injuries require medical treatment only and the loss of time from work is less than 7 days. Lost time cases are the result of an employee missing 7 or more days of work. The delivery of medical benefits can be provided to employees through a managed care or non-managed care system, at the option of the employer/carrier. Both delivery systems allow for one change in physicians. [ss. 440.13(2) and 440.134(10), F.S.]

Indemnity Benefits

Florida provides the following types of indemnity benefits: permanent total, temporary total, temporary partial, impairment income benefits, and death benefits. Benefits are contingent upon the date of the accident, the employee's wages for the previous 13 weeks (which determines the average weekly wage), and the compensation rate (which is calculated at 66 2/3 percent of the average weekly wage and subject to a maximum rate of 100 percent of the statewide average weekly wage).

Permanent Total Disability Benefits

Only a catastrophic injury, in the absence of conclusive proof of a substantial earning capacity, constitutes permanent total disability.[5] The definition of "catastrophic injury" includes injuries that are considered to be a permanent impairment. This definition includes any other injury that would qualify an employee for social security disability. Permanent total disability is determined at maximum medical improvement, based upon reasonable medical probability that no further medical improvement can reasonably be anticipated. It is a lifetime benefit calculated at 66 2/3 percent of the average weekly wage, subject to a maximum compensation rate. In addition, a person will receive an annual supplemental income benefit equal to 5 percent per year of the disability payment.

Temporary Total Disability Benefits

Temporary total benefits are paid at 66 2/3 percent of the average weekly wage and cease at 104 weeks or upon maximum medical improvement, whichever occurs first. Permanent impairment benefits are determined upon the cessation of temporary total benefits.

Permanent Partial Disability Benefits

Permanent partial disability benefits occur at maximum medical improvement or the expiration of temporary benefits, whichever occurs earlier and continues until the earlier of the expiration of a period computed at a rate of 3 percent for each percentage point of impairment or the death of the employee. Determination of permanent impairment is based on a physician's objective findings and is paid at 50 percent of the compensation rate. Supplemental benefits provide a second tier of benefits for employees with impairment ratings in excess of 20 percent who have not returned to work or are earning less than 80 percent of the employee's pre-injury average weekly wage as a result of the employee's impairment, and where the employee has not returned to work, the employee has in good faith attempted to return to work. Supplemental benefits are

[5] Section 440.15(1), F.S.

payable at the rate of 80 percent of the difference between 80 percent of the employee's pre-injury average weekly wages and the weekly wages the employee has earned during the specified reporting period. [s. 440.15(3), F.S.] Temporary impairment and supplemental income benefits cease 401 weeks after the date of injury.

Temporary Partial Disability Benefits
Temporary partial compensation is equal to 80 percent of the difference between 80 percent of the average weekly wage and the salary or wages an employee is able to earn; however, the payment is capped at 66 2/3 percent of the employee's average weekly wage at the time of the injury. Benefits cease after 104 weeks.

Attorney's Fees and Litigation Expense

In Florida, the judges of compensation claims use a three-tier fee schedule to award attorney's fees based upon the amount of benefits secured. Generally, the fees must equal 20 percent of the first $5,000 of the benefits secured, 15 percent of the next $5,000 of the amount of benefits secured, 10 percent of the remaining amount of the benefits secured and to be provided during the first 10 years, and 5 percent of the benefits secured after 10 years.

However, judges of compensation claims do have the discretion to increase or decrease the attorney's fees without any dollar limitation, based on the following factors: 1) time and labor involved; 2) fee customarily charged in the locality for similar services; 3) amount involved in controversy and the benefits resulting; 4) time limitation imposed by claimant or circumstances; 5) experience, reputation, and the ability of the lawyer; and 6) contingency or certainty of a fee. Generally, a claimant is responsible for the payment of his or her attorney's fees, except in the following situations: 1) claimant successfully asserts a claim for medical only; 2) claimant's attorney successfully prosecutes a claim previously denied by the employer/carrier; 3) claimant prevails on the issue of compensability previously denied by the employer/carrier; and 4) claimant successfully prevails in proceedings related to the enforcement of an order or modification of an order.

Election of Exemption from Workers' Compensation Coverage

Employers are generally required to provide workers' compensation coverage, unless they obtain an exemption from coverage. Employers secure workers' compensation coverage by purchasing insurance or meeting the requirements to self-insure. [s. 440.38, F.S.] In 2002, the Legislature revised exemption criteria for businesses primarily engaged in the construction industry by eliminating exemptions for persons engaged in commercial construction. For any commercial construction job site estimated to be valued at $250,000 or greater, a person who is actively engaged in the construction industry and is not considered an independent contractor, would be either an employer or employee, and is not exempt from the coverage requirements of ch.440, F.S. Exemptions continue to be available to persons engaged in residential construction.

Corporate officers, partners, and sole proprietors actively engaged in the residential construction industry and commercial construction projects valued at less than $250,000 may elect to be exempt from the workers' compensation system by filing a notice of election to be exempt and providing certain information to the Division of Workers Compensation along with a $50 filing

fee. No more than three corporate officers of a corporation and three partners in a partnership actively engaged in the residential construction industry or small commercial construction project may elect to be exempt.

Workers' Compensation Joint Underwriting Association

In 1993 the Legislature established a joint underwriting association (JUA) or insurer of last resort for workers' compensation insurance. The plan must have actuarially sound rates that assure that it is self-supporting.[6] The purpose of the plan is to provide policies to employers who are unable to purchase a policy through the voluntary market. Due to market conditions in recent years, more employers are being forced to obtain coverage through the JUA. The number of policies issued in the JUA increased from 522 in 2000 to 1,179 as of February 2003. For the same period, the volume of written premiums increased from $5 to $26 million. Premiums in the JUA are significantly higher than the voluntary market and policyholders are required to pay a substantial premium deposit.[7] As of April 1, 2003, the JUA rates were 42.9 percent higher than the manual rates (excludes surcharges) in the voluntary market. Presently, the plan has three sub plans and only one these sub plans may issue assessable polices. Assessable policies are subject to assessments if a deficit occurs in the JUA.

The Governor's Commission on Workers' Compensation Reform (2002)

In May 2002, the Governor created the Governor's Commission on Workers' Compensation Reform (commission) to evaluate Florida's workers' compensation system and make policy recommendations relating to affordability and availability, dispute resolution process, major cost drivers, and benefits for injured workers. The recommendations of the commission included:

1. Authorize the Workers' Compensation JUA to create sub plans for small employers with pricing differentials according to risk and subsidize the underwriting of those plans using proceeds of administrative fines levied by the Department of Financial Services:
2. Increase reimbursement to providers from current levels to 150 percent of Medicare and decrease reimbursement for inpatient hospitalization;
3. Revise the definition of permanent total disability by eliminating social security eligibility as a criteria;
4. Increase the percentage of lost wages that are paid for temporary partial disability benefits if the employee returns to work within the employee's restrictions prior to maximum medical improvement; and
5. Establish a peer review panel to address medical disputes.

[6] Section 627.311(4)

[7] A deposit premium is required from any insured whose total estimated annual premium is less than or equal to $7,000. If applicable, the deposit is equal to 50% of the total estimated annual premium, and is a condition to securing or renewing coverage in the JUA At final audit, the deposit will be applied to any earned premium due or to the renewal premium (not to the renewal deposit). A similar deposit is required at renewal. The amount of deposit premium is dependent upon the total estimated annual premium.

III. Effect of Proposed Changes:

Benefits

- Revises the definition of "catastrophic injury" to eliminate social security eligibility as a catastrophic injury and provides that in order for an injury listed in s. 440.02(38), F.S., to qualify as a catastrophic injury (i.e., spinal or brain injury) the employee must be unable to engage in any gainful or sheltered employment. If these criteria are met, the employee would be eligible for permanent total disability benefits.
- Increases benefits for temporary total and temporary partial disability benefits from 104 weeks to 260 weeks.
- Reduces permanent total supplemental benefits from 5 percent to 4 percent per year and eliminates such benefits at age 62.
- Ceases permanent total disability benefits at age 75.
- Reduces duration of permanent partial disability benefits for employees with an impairment rating of 1-11 percent, and maintains or increases duration of such benefits for employees with an impairment rating of 12 percent or more. Presently the majority of employees have an impairment rating of 11 percent or less.
- Increases permanent partial disability benefits for employee from 50 to 75 percent of the employees' temporary total disability benefits.
- Eliminates permanent partial supplemental disability benefits. Supplemental benefits provide a second tier of benefits for employees with impairment ratings in excess of 20 percent who have not returned to work or are earning less than 80 percent of the employee's pre-injury average weekly wage as a result of the employee's impairment, and where the employee has not returned to work, the employee has in good faith attempted to return to work. Eligibility for supplemental benefits ceases 401 weeks after the date of injury.
- Increases the amount of temporary partial disability benefits from 80 percent to 85 percent of difference between 80 percent of the pre-injury wages and post-injury wages. Eligibility for temporary benefits ceases 401 weeks after the date of injury.
- Increases benefits for funeral expenses from $5,000 to $7,500 and death benefits are increased for dependents from $100,000 to $200,000.
- Tightens compensability requirements for occupational diseases by requiring clear and convincing evidence to prove compensability.

Medical Care and Treatment

If an employer fails to provide medical treatment after a request by the employee or recommendation by the principal treating physician, the employee is authorized to file a petition for benefits for such care. Such treatment is considered compensable and medically necessary unless a peer review panel determines that it is not compensable. A carrier has five days to respond to the request for medical treatment.

Upon the allegation of an accident or injury, the employee would be entitled to an evaluation by a principal treating physician selected by the carrier. The carrier is authorized to transfer care from the principal treating physician if a peer review panel, based on a request from the carrier,

determines that the employee is not making appropriate progress. Upon the written request of the employee, the employee is entitled to a one-time per accident change to a different provider from a list provided by the carrier.

The principal treating physician is authorized to request a consultation with an authorized specialist for clarification of issues. The principal treating physician may alternatively recommend to the carrier the transfer of care entirely or some portion of care to an authorized specialist for evaluation.

If the employee disagrees with the principal treating physician regarding the diagnosis or care, the employee is entitled to a discretionary confirmatory consultation with a provider of his or her choice within the same specialty as the provider with whom the employee disagrees. The carrier is also limited to one discretionary confirmatory consultation for each accident. The employee is entitled to a confirmatory consultation if certain conditions are met. The carrier is also entitled to a confirmatory consultation if certain conditions are met.

The committee substitute retains the authorization for one change in physician. Presently, there is no limitation in the number of physicians; however, medical care must be medically necessary and there is no entitlement to any certain number of physicians. Currently, second opinion by a physician could be obtained, one or more independent medical examination could be obtained relating to injuries, and the services of an expert medical advisor might be requested, if two or physicians disagree on the treatment or ability of the employee to return to work.

Medical Fees

The maximum reimbursement allowance for physicians is increased and these increases are funded through a reduction in payments to hospitals. The maximum reimbursement allowances for neurologist, orthopedic physicians, and primary care physicians are increased to 125 percent of the Medicare fee schedule.

Payments for outpatient physical, occupational, and speech therapy provided by hospitals would be reduced to the fee schedule which applies to nonhospital providers. Payments for scheduled nonemergency radiological and clinical lab services that are not provided in conjunction with a surgical procedure would be reduced to the fee schedule applicable to nonhospital providers.

Technical and conforming changes are provided to reflect the intent to transfer the certification of health care providers, adoption of the medical fee schedules, and medical payment and overutilization disputes from the Agency for Health Care Administration to the Department of Financial Services. It appears that the regulation of managed care arrangements is specifically eliminated.

The Health Care Oversight Board is established within the Department of Financial Services to monitor and audit peer review organizations and develop and update practice parameters. Presently, the Agency for Health Care Administration is responsible for developing practice parameters.

Attorneys Fees and Taxable Costs

The bill revises attorney's fees to provide that fees would be equal to 20 percent of the first $10,000 in benefits, rather than the first $5,000 in benefits secured and fees would be equal to 15 percent of the remaining benefits secured and specifies certain additional fees that could be awarded in the following circumstances: $5,000 for medical only, $5,000 in cases in which the carrier denies benefits and the employee prevails, and the greater of the fee schedule or $20,000 in cases in which the carrier denied compensability and the employee prevailed. Currently, the fees must equal 20 percent of the first $5,000 of the benefits secured, 15 percent of the next $5,000 of the amount of benefits secured, 10 percent of the remaining amount of the benefits secured and to be provided during the first 10 years, and 5 percent of the benefits secured after 10 years. Presently there are no limitations on awarding additional attorney's fees. [s. 440.34, F.S.]

Resolution of Formal Disputes - Administration and Adjudication

Procedures relating to the resolution of medical and compensability issues are substantially revised. An employee would be required to request such benefits from the carrier. Such a request would be required to meet specificity requirements. The carrier would be required to pay the benefits or provide a written denial of the benefits within 14 days of receipt. It is unclear whether this request would be required to be in writing and if the employee would be required to submit a standardized form adopted by the department. Otherwise, some requests by employees, particularly unrepresented employees, might not meet the specificity requirements of s. 440.192(1)(a), F.S.

An employee that is involved in a dispute with a carrier would be required to file a petition for benefits with the newly created Claims Bureau of the Department of Financial Services, the carrier, and the employer. Presently, petitions for benefits are filed with the Office of the Judges of Compensation Claims in Tallahassee and referred to the appropriate district for adjudication.

Within 21 days, rather than 14 days, after notification by the Claims Bureau, the carrier would be required to pay without prejudice to its right to deny within 120 days after receipt of the petition or file a response to the Claims Bureau, filing party, employer, and claimant which would include documentation and justification for nonpayment. If a carrier does not deny compensability, as provided in s. 440.20(4), F.S., the carrier is deemed to accept the injury as compensable, unless the carrier could establish relevant facts to the issue that could not have been discovered within the 120-day period.

The Claims Bureau would be authorized to 1) review and resolve petitions through an administrative determination within 45 days based upon evidence submitted, in accordance with rules established by the bureau; 2) refer a claim to the office of the judges of compensation claims for adjudication; or 3) refer a claim to a medical peer review panel for adjudication of a medical dispute.

Office of the Judges of Compensation Claims --The jurisdiction of the office is revised to exclude medical disputes which would be heard by the peer review panel. Mandatory mediation

is eliminated and any mediation costs would be an expense of the parties. Presently, carriers incur the costs of private mediators.

Medical Disputes --Peer review panel are established for the resolution of medical disputes. The department would contract with a peer review organization for the performance of peer reviews of medical disputes. The costs of peer review panels would be incurred by the carrier. Medical issues would be decided in a summary manner by the panel from records and pleadings submitted by the claimant and the employer/carrier with their response to the petition for benefits. If the peer review panel finds that a determination of facts by a judge of compensation claims is necessary, the panel would certify the question of fact to the judges of compensation claims.

The peer review panel would issue a written report to the Claims Bureau that would include a statement of the issues, the documents reviewed, and findings of fact regarding the medical issue, and the determination and adjudication of the issue by the panel. The report and findings of the panel would upheld unless found clearly erroneous.

Any party would be entitled to a reconsideration of any initial adjudication by a peer review panel within 21 days of the issuance of the decision. At reconsideration, any party may conduct discovery including medical records request, depositions of medical providers, confirmatory consultation provider or factual witnesses. However, peer review panel members are not subject to discovery, except as provided. The peer review panel may not examine the claimant or otherwise gather additional information for the reconsideration.

Once the Claims Bureau issues a determination and recommendation on administrative issues, the bureau may assign issues to the judges of compensation claims for the purpose of taking evidence and holding a hearing and determining entitlement to disputed benefits. Any party may appeal the decision of the Claims Bureau, the final adjudication of the peer review panel, or the order of a judge of compensation claims to the Workers' Compensation Appellate Tribunal. The Office of the Judges of Compensation Claims and the Workers' Compensation Appellate Tribunal are created. Reviews of the orders from the tribunal would be heard by the First District Court of Appeals. The Office of the Judges of Compensation would be assigned to this office. The 31 state mediators' positions within the Office of the Judges of Compensation Claims are eliminated.

Affordability and Availability of Coverage

Three tiers of plans are established in the Florida Workers' Compensation Joint Underwriting Association to address affordability and availability. Tier one would provide coverage to employers whose manual premium does not exceed $20,000 and who have neither incurred any lost-time claims nor incurred medical-only claims exceeding 50 percent of the premium in the preceding three years. Tier Two would include those employers who are unable to secure compensation in the voluntary market, but have an experience modification factor of 1.05 or less, and charitable and nonprofit organizations. Lastly, Tier Three would include all other employers and may include multiple rating plans for various classifications of employers. The rates for Tiers One and Two are capped at 125 percent of the rate for the voluntary market manual rate. The rates of Tier Three must be actuarially sound to assure that Tier Three is self-supporting.

Any deficits in these tiers would be collected as an assessment by insurers and paid by workers' compensation policyholders as a line item charge. The assessment is capped at two percent of premiums on an annual basis for as long as the assessment is necessary to eliminate the deficit.

Construction Industry Exemptions

Eliminates exemptions for sole proprietors and partners in the construction industry and allows up to three corporate officers holding 10 percent interest each in a corporation to obtain an exemption from coverage if each officer obtains a limited medical and disability policy that provides benefits of at least $100,000.

Compliance and Enforcement -- Fraud

Additional administrative penalties are established or increased and documentation and record keeping requirements are provided to assist the Division of Workers' Compensation in determining compliance and enforcing coverage requirements.

If an employer materially understates or conceals payroll, or materially misrepresents or conceals employee duties so as to avoid proper classification, such employer would be deemed to have failed to secure payment of coverage. A stop-work order issued due to this failure of an employer to secure payment of coverage would not have any effect upon an employer's duty to provide benefits under ch. 440, F.S. The section also requires an employer to provide business records, upon request of the department, within five business days, rather than "a reasonable time."

The department is authorized to assess a penalty of $1,000 per day against an employer for each day that the employer conducts business operations in this state which are in violation of a stop-work order. The additional penalty provision is revised by requiring the department to assess a penalty against an employer that fails to secure the payment of compensation in an amount equal to five times, rather than two times; the amount the employer would have paid in the preceding three years or $1,000, whichever is greater. Any subsequent violation within five years after the most recent violation would, in addition, to any other penalty in subsection (8) is deemed a knowing act within the meaning of s. 440.105, F.S.

An employer who has employees engaged in Florida is required to obtain a Florida policy or endorsement that meets certain requirements of ch. 440 and the Florida Insurance Code. The department is authorized to adopt rules with regard to the activities that constitute being "engaged in work" in Florida. A contractor is required to request proof of coverage from a subcontractor and the subcontractor is required to provide a copy of the certificate of exemption to the contractor.

A carrier would be required to audit an employer that has materially misstated payroll or other information so as to avoid proper classification for premium calculations. The carrier is required to commence the audit within 30 days after receiving notification from the department regarding an administrative action against such an employer.

Section 440.105, F.S., relating to prohibited acts, is revised to specify that is unlawful for an employer to knowingly fail to update applications for coverage within 5 days after the end of the quarter in which the change occurred. Currently, the section does not provide period to provide such an update on coverage. Workers' compensation payment checks issued by carriers pursuant to any claim under this chapter to contain the fraud statement provided in s. 440.105(8), F.S. Many states have implemented this requirement as a means to fight fraud.

Prior to issuing a building permit, a local government would be required to verify that a proof of coverage is valid by verifying such proof by accessing the department's proof of coverage database. Each certificate of insurance would be required to disclose the states for which coverage applies.

A contractor would register with the department, rather than the carrier, to receive notification of cancellation or nonrenewal of a policy for any subcontractor and the department would be required to immediately notify the contractor of the cancellation or nonrenewal. Carriers would be required to provide additional information concerning their anti-fraud efforts relating to workers' compensation and penalties are provided for noncompliance. Section 921.0022, F.S., is amended to include workers' compensation fraud on the offense severity ranking chart which would assist prosecutors in imposing greater criminal penalties for workers' compensation fraud.

The annual report produced by the Office of Workers' Compensation Insurance Fraud and the Division of Workers' Compensation would be revised to provide greater accountability regarding compliance and enforcement activities. Employee leasing companies would be required to provide the department with client lists twice a year that are presently submitted to the Division of Unemployment Compensation. Employee leasing companies would also be required to notify the department within 30 days after the initiation or termination with any client company.

An employee is required, as a condition of receiving compensation, to execute a waiver which authorizes the carrier to verify or determine through the Division of Unemployment Compensation whether the employee was employed while concurrently receiving compensation benefits.

Three assistant state attorneys (one in each circuit) are established for the prosecution of workers' compensation insurance fraud in Broward, Dade, and Palm Beach Counties and one senior attorney position within the Department of Legal Affairs is created to prosecute workers' compensation insurance fraud. The Bureau of Workers' Compensation Insurance Fraud is transferred from the Department of Financial Services to the Department of Law Enforcement as a Type-II transfer.

Administrative/Organizational Changes

The Workers' Compensation Appellate Tribunal is created. The tribunal would hear appeals of orders from the judges of compensation claims, the claims bureau, and peer review panel. The Office of the Judges of Compensation would also be assigned to this office. Reviews of the orders from the tribunal would be heard by the First District Court of Appeals.

The Claims Bureau is created within the Division of Workers' Compensation. Eighteen positions of the Office of the Judges of Compensation that presently receive and refer petitions and provide budgeting and purchasing support to the Office of the Judges of Compensation Claims are transferred to the Claims Bureau. The 31 state mediators' positions within the Office of the Judges of Compensation Claims are eliminated.

The duties and responsibilities of the Department of Financial Services relating to the Florida Self-Insurers Guaranty Association, Inc., are revised. The bill clarifies the methodology to be used for calculating assessments payable for the Workers' Compensation Administration Trust Fund and the Special Disability Trust Fun.

Health Care Oversight Board

The Health Care Oversight Board is created to monitor and audit peer review organizations and establish practice parameters. Workers' compensation related duties of the Agency for Health Care Administration to the Department of Financial Services. Specific regulatory authority for workers' compensation managed care arrangements is eliminated.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

The bill exempts the Workers' Compensation Joint Underwriting Association (JUA) from the insurance premium tax and assessments for the Workers' Compensation Administration Trust Fund and the Special Disability Trust Fund. In 2002, the JUA paid $1,000 in premium taxes, $576,763 for the Workers' Compensation Administration Trust assessment and $1,146,239 for the Special Disability Trust assessment.

In the event a deficit occurs in Tier One or Tier Two of the JUA, the board of the JUA is authorized to levy an assessment of not more than two percent of premium annually on all carriers which is to be paid by Florida workers' compensation policyholders as a line item in addition to the calculated premium.

B. Private Sector Impact:

The National Council on Compensation Insurers has not released a final analysis of the estimated impact of this committee substitute on workers' compensation rates.

Affordability and Availability of Coverage

Persons and nonprofit and charitable organizations previously unable to obtain affordable coverage could obtain such coverage through the JUA. The rates would be capped at 125 percent of the voluntary market rate.

Persons engaged in residential construction or small construction projects and previously exempted from workers' compensation coverage would now be required to obtain coverage, unless they were corporate officers with 10 percent ownership and secured a limited medical and disability policy. Since the limited medical and disability policy is not a guaranteed issue policy and could be medically underwritten, the availability and affordability of such coverage might make such coverage unattainable for certain persons.

Dispute Resolution Process

Employees could resolve medical only disputes in a more timely manner since peer review panels would be required to resolve medical disputes within 153 days of receipt. Presently, the average time period to resolve a petition for benefits for medical and indemnity issues is approximately 300 days. Carriers would incur the costs for the peer review panels. By contacting an injured worker soon after an injury has occurred, the Early Intervention Office could expedite the resolution of certain types of disputes, thereby providing benefits to workers in a more timely matter without the delays and costs associated with the litigation of a claim.

The elimination of mandatory mediation may have some adverse impact on the resolution of certain types of cases. For fiscal year 2001-02, there were 27,290 state mediations held. Slightly more than half of these mediations resulted in settlements of all disputed issues. According to the *Workers' Compensation Litigation Report, Fiscal Year 2001-2002,* prepared by the Office of the Judges of Compensation Claims, "mediation has been both a success story and a source of delay" since the number of cases is too large to allow for the conferences to be held within the statutory time period.

Since the costs of the peer review panels and mediations would be incurred by carriers, this would be an increased expense for the carriers which could be reflected as a benefit cost or loss adjustment expense.

Regulation of Carriers

It appears that workers' compensation carriers would be subject to market conduct exams by the Department of Financial Services and the Office of Insurance Regulation. Legislation enacted in 2002 specifically transferred the authority for market conduct

exams to the Office of Insurance Regulation.[8] Section 440.20(15)(a), F.S., authorizes the department to examine on an ongoing basis claims in accordance s. 624.3161, F.S.; however, s. 440.20(8)(c), F.S., also authorizes the Office of Insurance Regulation to monitor, audit, and investigate carriers in accordance with s. 624.3161, F.S.

C. Government Sector Impact:

Office of the Judges of Compensation Claims and the Workers' Compensation Appeals Tribunal

The bill establishes the Office of Judges of Compensation Claims and Workers' Compensation Appellate Tribunal. It appears that it is the intent to create this office within the Department of Management Services. The tribunal would consist of a chief appellate judge and four other appellate judges. The fiscal impact on the Workers' Compensation Trust Fund of creating and funding the tribunal is based on staffing ratios and other information obtained from the First District Court of Appeals. However, the fiscal impact is incomplete at this time and needs further review.

Presently, the District Court of Appeals allocates one Judicial Assistant, two law clerks, and one deputy clerk for each judge. The following is an estimate of costs if one judicial assistant, one law clerk, and one deputy clerk were allocated to each appellate judge and expenses, other capital overhead, library needs, computer case management development and support, and rent.

	Salaries & Benefits	Expenses	Other Capital Outlay
5 Judges	$915,000	$155,465 ($31,093 per judicial suite)	$190,000 ($38,000 per judicial suite)
5 Judicial Assistants	269,245		
5 Law Clerks	346,345		
1 Clerk of the Court	130,000	15,000	25,000
5 Deputy Clerks	212,500		
Computer Support Staff	45,000	2,500	9,600
Rent		100,000	
Library (electronic/books)		150,000	
Computer/Case Management development & maintenance, electronic file system			232,000 or more (an indeterminate amount would be recurring.
Totals Nonrecurring Recurring	$1,918,090	$422,965	232,000 224,600

[8] Section 20.121(3)(a), F.S.

As noted in the table above, some of these costs would be nonrecurring (start-up costs) and ongoing costs associated with a case management system ($200,000 or more) and an electronic library ($150,000 per year) and/or books ($100,000 per year).

Claims Bureau

The bill creates a Claims Bureau within the Division of Workers' Compensation. Presently, all petitions for benefits are received by the Office of the Judges of Compensation Claims (JCCs) in Tallahassee and forwarded electronically to the appropriate judge of compensation claims. The bill would transfer the receipt, referral, and docketing of petitions to the Claims Bureau. The Claims Bureau would review the petitions for benefits and determine whether a particular issue is within the jurisdiction of the peer review panel, the Claims Bureau, or the JCCs, and forward it accordingly. For fiscal year 2001-02, the JCCs received 115,367 petitions for benefits which represented an 18 percent increase from the prior year. The Department of Financial Services provided the following fiscal note regarding the establishment of this bureau:

	Salaries & Benefits	Expenses	Other Capital Outlay
New Positions Bureau Chief	$91,500	$129,173	$55,500
Administrative Assistant	33,735		
3 Clerical Specialists	63,889		
12 Risk Management Specialists	503,104		
3 Senior Attorneys	219,600		
6 Paralegal Specialists	292,800		
8 Senior Management Analysts II	435,296		
2 Senior Management Analyst I	83,851		
Other Personal Services for software development		1,500,000	
Computer Hardware Development			1,000,000
Transfer 37 positions from Early Intervention Office (EIO)	1,640,062		
Additional Salary & Benefits for 37 positions transferred from EIO	83,713		
Transfer 18 positions from the Division of Administrative Hearings/Office of Judges of Compensation	706,571	97,488	
Totals Nonrecurring Recurring	 4,154,121	 1,500,000 226,661	 1,055,500

As noted above, 37 existing positions would be transferred from the Employee Assistance Office (EAO) to the Claims Bureau and 18 positions from the Office of the Judges of Compensation Clams within the Division of Administration Hearings would be transferred to the newly created Claims Bureau within the Division of Workers' Compensation by a Type-II transfer. One position in the Employee Assistance Office is eliminated. However, the fiscal impact is incomplete at this time and needs further review.

Office of Judges of Compensation Claims

The bill eliminates 31 state mediators and eliminates mandatory mediation. Instead parties may use a mediator at their own expense. Presently, there are 31 state mediators and their annual budget is $3,952,543.

Eighteen positions from the Division of Administrative Hearings that presently receive, docket, and refer petitions and provide budgeting and purchasing support to the Office of the Judges of Compensation are transferred to the Claims Bureau within the Division of Workers' Compensation . The Office of the Judges of Compensation Claims and the Workers' Compensation Appellate Tribunal would not have administrative staffing for the financial management, accounting, and budgeting functions of the office or processing petitions. It is unclear how these responsibilities would be administered or whether the office would create additional positions.

According to the Division of Administrative Hearings (DOAH), if the Clerk's Office of the Office of the Judges of Compensation Claims is moved from their current location, the bill implementing the transfer should include language authorizing the DOAH to cancel its lease for office space in the Mag Building. Otherwise, if the Office of the Judges of Compensation Claims staff is moved from the Mag Building to a state-owned building, DOAH would be liable for the Mag Building lease for six months, totaling $35,464. If staff is instead moved to a non-state-owned building, DOAH would be liable for the Mag building lease through November 2006, totaling $327,369.

Early Intervention Office

The bill provides that the Early Intervention Office shall, rather than may, contact injured workers. This would create the need for significant additional staffing. In order for this office to maximize its resources, flexibility is necessary to allow them to focus their resources on disputes or issues that are more likely to lead to informal resolution.

Health Care Oversight Board
The department estimates that the newly created board would meet 10 times per year at an annual cost of $150,000.

Compliance and Enforcement -- Fraud
The bill establishes three positions (assistant state attorney positions) in Judicial Circuits 11, 15, and 17 for the prosecution of workers' compensation insurance fraud. The bill also establishes a Senior Attorney in the Office of the Statewide Prosecutor for the prosecution of workers' compensation insurance fraud. The positions and funding, totaling $290,923 would be appropriated from the Workers' Compensation Administrative Trust Fund. Forty two full-time positions from the Bureau of Workers' Compensation Fraud would be transferred to the Department of Law Enforcement by a Type-II transfer.

VI. Technical Deficiencies:

The bill contains various technical and drafting errors.

VII. Related Issues:

Section 32 of the bill requires an employee to submit a request to an employer for the provision of benefits from the carrier. Such a request would be required to meet specificity requirements. It is unclear whether the employee would be required to submit a standardized form adopted by the department. Otherwise, some requests by employees, particularly unrepresented employees, might not meet the specificity requirements of s. 440.192(1)(a), F.S.

Duties and responsibilities relating to workers' compensation within the Agency for Health Care Administration are transferred to the Department of Financial Services. However, the nineteen full-time positions are not specifically transferred to the department.

VIII. Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.