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: SB 50-A

SPONSOR: Senators Clary, Alexander, and Atwater

SUBJECT: Workers' Compensation

DATE: May 19, 2003 REVISED: 05/20/03 05/23/03 _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Deffenbaugh	BI	Favorable
2.				
3.				
4.				
5.				
6.				

I. Summary:

The bill 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, increase medical reimbursement fees for physicians and surgical procedures, and increase availability and affordability of coverage.

Benefits

- Revises eligibility for permanent total disability benefits by providing that to be eligible for permanent total disability benefits, an employee must have either a catastrophic injury or be unable to uninterruptedly engage in at least sedentary employment. The definition of "catastrophic injury" is revised to eliminate the social security eligibility standard and to provide limited inclusion of certain injuries. Permanent total disability benefits are payable until the employee reaches age 75; however, if an employee is injured on or after age 70, benefits are payable for a maximum of 5 years following the determination of permanent total disability. The amount of the annual permanent total disability supplemental benefit is reduced from 5 percent to 3 percent of the employee's compensation rate and the supplemental benefit ceases at age 62.
- Increases permanent partial disability benefits from 50 percent to 75 percent of the employees' temporary total disability benefits, reduces duration of permanent partial disability benefits for employees with an impairment rating of 1-10 percent, maintains or increases duration of such benefits for employees with an impairment rating of 11 percent or more, eliminates permanent partial supplemental disability benefits; and reduces permanent partial disability by 50 percent for each week in which the employee has

earned income equal to or greater than the employee's average weekly wages. Permanent impairment benefits for permanent psychiatric impairment are limited to 1 percent.
- Provides that only the disability or medical treatment associated with a compensable injury is payable, excluding preexisting disability or medical condition.
- Increases caps on chiropractic treatments from 18 to 24 visits and the number of weeks of treatments are increased from 8 to 12 weeks.
- Increases benefits for funeral expenses from $5,000 to $7,500 and death benefits are increased for dependents from $100,000 to $150,000.

Training and Education

The bill provides that benefits for training and education authorized by the Department of Financial Services and funded by the Workers' Compensation Administration Trust Fund may include payment to attend a community college or vocational-technical school; provides that this benefit would include securing a general education diploma (GED). The bill provides that temporary total compensation benefits paid during the training and education would be included within, and not added to, the maximum 104 weeks provided for temporary total benefits.

Compensability for Injuries

Requires that an accidental compensable injury must be the major contributing cause of any resulting injury, meaning that the cause must be more than 50 percent responsible for the injury as compared to all other causes combined, as demonstrated by medical evidence only.

An injury or disease caused by toxic substance would require clear and convincing evidence establishing that exposure to the specific substance caused the injury or diseases sustained by the employee.

In cases involving occupational disease or repetitive exposure, both causation and sufficient exposure to support causation must be proven by clear and convincing evidence.

Pain or other subjective complaints alone, in the absence of objective relevant medical findings (as further described), are not compensable.

For mental and nervous injuries, there must be a physical injury requiring medical treatment which is the major contributing cause. The mental or nervous injury must be demonstrated by clear and convincing evidence. Payment of benefits for mental or nervous injuries are limited to no more than three months after the date of maximum medical improvement for the employee's physical injury, which shall be included in the 104-week period.

Safety in the Workplace

Requires the Division of Workers' Compensation to publicize on its Internet site, and encourage carriers to publicize, the availability of free safety consultation services and safety program resources. All policyholders in the Florida Workers' Compensation Joint Underwriting Association are required to participate in a safety program.

Workers' Compensation Joint Underwriting Association (Availability and Affordability of Coverage)

Revises the current subplans within the Florida Workers' Compensation Joint Underwriting Association (JUA) to address affordability and availability for small employers and charitable and nonprofit organizations. The premiums for small employers with 15 or fewer employees and an experience modification factor of 1.10 or less would be capped at 125 percent of the rate for the voluntary market manual rate, and premiums for charitable organizations meeting certain criteria with an experience modification factor of 1.10 percent or less would be capped at 110 percent of the voluntary market rate. Any deficits would be assessed against such employers.

The board of the JUA would be reduced from 13 to nine members. Currently 11 of the 13 members are chosen by insurance industry representatives. Under the bill, three members are appointed by the Financial Services Commission; two members by domestic insurers (Florida domiciled); two members by foreign insurers (non-Florida domiciled); one member by the largest property and casualty insurance agents' association; and the Insurance Consumer Advocate of the Department of Financial Services. The Financial Services Commission would designate a member of the board to serve as chairperson.

Independent Medical Examination; Dispute Resolution

An employer and employee would each be limited to one independent medical examination (IME) per accident rather than one per medical specialty; requires carrier to pay for only one; and allows injured worker to recoup costs of an IME if employee prevails in a medical dispute, as determined by a JCC, or if benefits are paid or treatment provided after employee has obtained an IME.

As an alternative, the bill authorizes the use of consensus medical examinations to resolve medical disputes, if both parties agree, that would be binding on both parties and would constitute resolution of the medical dispute. The bill also allows an employee and employer/carrier to mutually agree to enter into binding claim arbitration in lieu of any other remedy provided in ch. 440, F.S. These optional dispute resolution processes that require the consent of both parties; otherwise, disputes would be resolved through the judges of compensation claims.

Attorney's Fees

The bill continues the use of the current contingency fee schedule in awarding attorney's fees. The fee for benefits secured are limited to 20 percent of the first $5,000 of benefits secured, and 15 percent of the next $5,000 of benefits secured, 10 percent of the remaining amount of benefits secured to be provided during the first 10 years after the claim is filed, and 5 percent of the benefits secured after 10 years.

- As an alternative to a contingency fee, the JCC may approve an attorney's fee not to exceed $1,500, only once per accident, based on a maximum hourly rate of $150 per hour if the JCC determines that the fee schedule, based on benefits secured, fails to fairly compensate the attorney for a disputed medical-only claim.

- If there is a written offer to settle issues, including attorney's fees, at least 30 days prior to the hearing date for purposes of calculating the amount of attorney's fees to be taxed against the carrier or employer, the term "benefits secured" would include only that amount awarded to the claimant above the amount specified in the offer.

Medical Fee Reimbursement

Increases all physician fees to 110 percent of Medicare reimbursement schedules; increases maximum for surgical procedures to 140 percent of Medicare; continues to allow deviations from fee schedules in certain circumstances; provides that outpatient observation status cannot exceed 23 hours; includes legislative intent language to pay for increases to physicians by reductions to hospitals; and reduces outpatient reimbursement for scheduled nonemergency surgeries from 75 percent to 60 percent of charges. Reimbursements for prescription drugs are reduced from 1.2 times the average wholesale price plus a $4.18 dispensing fee to the average wholesale price plus a $4.18 dispensing fee.

Coverage Requirements and Construction Industry Exemptions

- Limits construction exemptions to three corporate officers each owning at least 10 percent stock ownership; and eliminates exemptions for sole proprietors and partners, effective January 1, 2004;
- Provides that an exemption certificate is applicable to the corporate officer named on the notice of exemption and applies only within the scope of the business or trade listed.
- Requires any employer with employees engaged in the construction industry in Florida to obtain a Florida policy or endorsement which uses Florida class codes and rates and failure to comply is a second-degree felony.

Compliance and Enforcement -- Fraud

Provides several measures designed to fight fraud and increase prosecution of fraud in the workers' compensation system, including:

- Provides that an employer that fails to pay stop-work order penalties is ineligible for an exemption from coverage.
- Requires a carrier to submit an annual report to the department detailing losses and recoveries attributable to workers' compensation fraud and authorizes the department to fine carriers for noncompliance.
- Requires an annual report by the Bureau of Workers' Compensation Fraud and the Division of Workers' Compensation of the Department of Financial Services to provide greater accountability regarding compliance and enforcement activities.
- Authorizes the Division of Unemployment Compensation to release information in certain circumstances concerning an employee's wages to determine if an injured worker is employed and receiving workers' compensation benefits.
- Requires a contractor to request proof of coverage from a subcontractor and requires the subcontractor to provide a copy of the certificate of exemption to the contractor.

- Incorporates certain violations of ch. 440, F.S., in the Offense Severity Ranking Chart which would assist in the prosecution and sentencing of workers' compensation fraud by establishing ranking for these violations.

Carrier Compliance

Authorizes the department to examine and investigate carriers, self-insured employers and their servicing agents to determine compliance with ch. 440, F.S., and increases the department's authority to examine and fine such entities that engage in patterns or practices of unreasonable delay in claims handling or patterns or practices of harassment, coercion, or intimidation of claimants.

- Authorizes the department to impose an administrative penalty in an amount not to exceed $2,500 for each pattern or practice constituting a nonwillful pattern or practice, not to exceed an aggregate amount of $10,000 for all nonwillful violation arising out of the same action. Any administrative penalty imposed under this section (s. 440.525, F.S.) for a nonwillful violation cannot duplicate an administrative penalty imposed under another provision in ch. 440, F.S., or the Insurance Code.
- Authorizes the department to impose an administrative penalty for patterns or practices constituting a willful violation in an amount not to exceed $20,000 for each willful practice or pattern. Such fines cannot exceed $100,000 for all willful pattern or practice arising out of the same action.

Horizontal Immunity

Provides immunity to a subcontractor from lawsuits by employees of another subcontractor or the contractor, if the subcontractor is providing services in conjunction with a contractor on the same project or contract work, under certain conditions. The conditions are that the subcontractor or contractor has secured workers' compensation coverage for the subcontractor's employees and the subcontractor's own gross negligence was not the major contributing cause of the injury.

Intentional Tort

Provides that the liability of an employer for compensation under s. 440.10, F.S., is exclusive and in place of all other liabilities except in cases where the employer commits an intentional tort that causes the death or injury of an employee. An employer's actions are deemed to constitute an intentional tort only when the employee proves by clear and convincing evidence that the employer deliberately intended to injure the employee or the employer engaged in conduct that the employee knew was certain to result in injury or death to the employee. The section also expands immunity from third-party civil liability for safety consultants to all employees of the employer or employees of its subcontractors on a jobsite.

This bill substantially amends the following sections of the Florida Statutes: 440.02, 440.05, 440.06, 440.077, 440.09, 440.10, 440.1025, 440.103, 440.105, 440.1051, 440.107, 440.11, 440.13, 440.134, 440.14, 440.15, 440.151, 440.16, 440.185, 440.192, 440.20, 440.25, 440.34, 440.38, 440.381, 440.42, 440.49, 440.491, 440.525, 443.1715, 626.989, 626.9891, 627.162, 627.311, 921.0022, 946.523, and 985.315.

This bill creates the following sections of the Florida Statutes: 440.093, 440.1926, and 627.285.

This bill repeals section 440.1925, Florida Statutes.

II. Present Situation:

Summary of 1993 Workers' Compensation Law and Impact of Reforms

Major reforms of the Workers' Compensation Law 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;
- Authorized a maximum credit of 10 percent for implementing managed care;[1]
- 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; and
- Reduced temporary total disability benefits to 104 weeks (previously 260 weeks).

Availability and Affordability of Workers' Compensation Insurance

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 2000, Florida had the highest premiums in the country, and in 2001, Florida was ranked second only to California. Some workers' compensation carriers have indicated that they are not issuing new policies, renewing policies, or are 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 Insurance (department) authorized a 2.7 percent increase in rates, and subsequently, in 2003, the Office of Insurance Regulation approved a 13.7 percent increase. The Florida 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.

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

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

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. 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. 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 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 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 percent), which is not the case nationwide (47.1 percent).

Administration of the Workers' Compensation System in Florida

Funding for the administration of programs and functions 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 JUA (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.[2]

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. 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.

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.

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

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

The Agency for Health Care Administration (AHCA) is responsible for authorizing carriers to offer or utilize a workers' compensation managed care arrangement, if the carrier meets the conditions of s. 440.134, F.S., and regulates workers' compensation 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.] 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. The National Guideline Clearinghouse is a comprehensive database of evidence-based clinical practice guidelines and related documents produced by the federal 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. The National Guideline Clearinghouse database has 995 guidelines.

Under s. 440.13(15), F.S., the AHCA in conjunction with the department 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.

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.

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. For 2003, this maximum rate is $608 per week.

Permanent Total Disability Benefits
Only a *catastrophic injury*, in the absence of conclusive proof of a substantial earning capacity, constitutes permanent total disability.[3] The definition of *catastrophic injury*[4] includes (in summary) the following injuries:

- spinal cord injury involving severe paralysis of an arm, a leg, or the trunk;
- amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage;
- severe brain or closed head injury;
- second degree or third-degree burns of 25 percent or more of the total body or third degree burns of 5 percent or more to the face and hands;
- total or industrial blindness; or
- any other injury that would qualify an employee to receive disability income benefits under Title II or supplemental security income benefits under Title XVI of the federal Social Security Act.

Permanent total disability is determined at the time of 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 the 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 disability benefits are paid at 66 2/3 percent of the average weekly wage and cease at 104 weeks or upon maximum medical improvement ("MMI"), whichever occurs first. This is the most common disability benefit paid, during the time that an employee is totally disabled due to an injury for a limited period of time. After reaching MMI, the employee may be completely healed and return to work, or may have a permanent impairment that may or may not affect his wages. Permanent impairment benefits, described below, are determined upon reaching MMI and the cessation of temporary total benefits.

Permanent Partial Disability Benefits
If an employee has a permanent partial disability (permanent, but less than total), the employee is entitled to a permanent partial disability benefit. The determination is made at maximum medical improvement or the expiration of temporary benefits, whichever occurs earlier.

[3] Section 440.15(1), F.S.
[4] Section 440.02(38), F.S.

The primary permanent partial disability benefit is the *impairment benefit*, which is based solely on the impairment rating. The amount of the benefit is 50 percent of the temporary total disability benefit (i.e., 50 percent of 66.6 percent of average weekly wage, or about 33.3 percent of average weekly wage). The duration of the benefit is 3 weeks for each percent of impairment. For example, if an employee who was earning $300 per week has a 10 percent permanent disability, the employee would be entitled to a total impairment benefit of $3,000, calculated as follows:

Average weekly wage = $300
Temp. Total Compensation rate = $200 ($300 x .6667)
Impairment benefit at 40% of comp rate = $100
Impairment Rating = 10%
10% x 3 = 30 weeks
30 weeks @ $100 = $3,000

Supplemental benefits, a type of wage-loss benefit, 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. Where the employee has not returned to work, the employee must demonstrate that he has made a good faith attempt to return to work. Supplemental benefits are 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
An employee who has a temporary disability but is still able to work but only at a reduced wage, may be eligible for a temporary partial disability benefit prior to reaching maximum medical improvement. 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. The payment is capped at 66 2/3 percent of the employee's average weekly wage at the time of the injury. Like temporary total benefits, this benefit ceases after 104 weeks of upon reaching maximum medical improvement, whichever is earlier.

Attorney's Fees and Litigation Expense

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.

Employer Immunity; Exception for Intentional Tort

Section 440.11, F.S., provides that the liability of an employer for workers' compensation benefits shall be exclusive and in place of all other liability of such employer to the employee or his or her dependents or to anyone otherwise entitled to recover damages. An exception is provided if an employer fails to secure payment of compensation as required by ch. 440, F.S., in which case an injured employee may elect to claim compensation under ch. 440, F.S. or maintain an action at law for damages.

The statute also provides that the same immunities from liability enjoyed by an employer extend to each employee who is acting in furtherance of the employer's business. But such fellow-employee immunities are not applicable to an employee who acts, with respect to a fellow employee, with willful and wanton disregard or unprovoked physical aggression or with gross negligence Nor are such immunities applicable to employees of the same employer who are assigned primarily to unrelated works.

Florida case law has allowed employees (or dependents in a wrongful death action) to pursue tort actions against employers who intentionally injure an employee. In 2000, the Florida Supreme Court issued an important decision determining the standard that applies in such cases. In the case of *Turner v. PCR*, (754 so.2d 683), the Court determined that the prior case law had established a standard that to prove an intentional tort for purposes of an exception to workers' compensation immunity, the employer must be shown to have either exhibited a deliberate intent to injure *or* engaged in conduct which was substantially certain to result in injury or death. The Supreme Court went on to decide that an objective standard applies in making the latter determination. That is, the employee must establish that the employer *should have known* (an objective standard; rather than *knew*, a subjective standard) that its conduct was substantially certain to result in injury or death.

In *Turner*, the personal representative of the estate of an employee killed and an employee injured in a chemical plant explosion brought a wrongful death and negligence action against the employer alleging that PCR, Inc., intentionally engaged in conduct that was substantially certain to result in death or injury by failing to protect its employees from a known danger of explosion. In response to PCR's motion for summary judgment, appellants supported their allegations of PCR's knowledge with an expert's affidavit supporting the existence of a serious danger that was known or should have been known by the employer. The circuit court granted summary judgment for the employer and the plaintiffs appealed. The District Court of Appeal affirmed and certified the question to the Supreme Court of Florida as to whether an expert's affidavit sufficient to constitute a factual dispute, thereby precluding summary judgment on the issue of workers' compensation immunity. In response the Supreme Court first made the determination of the evidence that must be shown to prove commission of an intentional tort, as described

above. Then the Court determined that there were fact issues as to whether the employer intentionally engaged in conduct (under the *should have known* standard) that was substantially certain to result in injury or death, which precluded summary judgment. The Court determined that the summary judgment was erroneously granted and remanded the case for further proceedings.

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 is either an employer or employee, and is not exempt from the coverage requirements of ch. 440, F.S.

Exemptions for sole proprietors and up to three corporate officers or partners continue to be available to persons engaged in residential construction, as well as commercial construction projects valued at less than $250,000. Such persons 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.[5] 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. 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 percent 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 o 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. 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 subplans and only one of these subplans may issue assessable polices. Subplan A includes insureds whose annual premium does

[5] Section 627.311(4), F.S.

not exceed $2,500 and who have neither incurred any lost time claims nor incurred medical-only claims exceeding 50 percent of their premium for the immediate 2 years. Subplan B includes insureds that are identified by the board as high-risk employers due solely to the nature of the operations being performed and for whom no market exits in the voluntary market, and whose experience modifications are less than 1.00. Subplan C includes all other insures. Only Subplan C may issue assessable policies, which 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;
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.

III. Effect of Proposed Changes:

Sections 1 amend s. 440.02, F.S., relating to definitions, effective October 1, 2004. The definition of *catastrophic injury* is revised to eliminate the social security eligibility standard and to provide limited inclusion of certain injuries. As amended, the term would include loss of both hands, both arms, both feet, both legs, or both eyes, or any two thereof, or paraplegia or quadriplegia. (In Section 18 of the bill, below, this term is used for purposes of qualifying for permanent total disability benefits, in addition to other criteria that may be met to so qualify.)

The bill amends the definition of *employee* and other conforming changes to delete amendments made in 2001 that eliminated exemptions for sole proprietors, independent contractors, and partners engaged in the construction industry on commercial jobsites valued at $250,000 or greater. Section 3, below, effective January 1, 2004, would revise and limit exemptions for the construction industry.

The definition of *accident* is revised to provide that an injury or disease caused by toxic substance is not an injury by accident arising out of employment unless there is clear and convincing evidence establishing that exposure to the specific substance caused the injury or diseases sustained by the employee.

Specificity is defined to mean certain required information to be provided on the petition for benefits that sufficiently puts the employer or carrier on notice of the disputed issues and benefits requested.

Section 2 amends s. 440.02, F.S., related to definitions, effective January 1, 2004. The bill amends the definition of *employee* to revise the exemptions that would be allowed for persons engaged in the constructions industry. As amended, up to three officers of a corporation or of any group of affiliated corporations may elect to be exempt; however, officers must be shareholders, each owning at least 10 percent of the stock of the corporation and listed as an officer with the Division of Corporations. Sole proprietors and partners engaged in the construction industry would not be eligible for an exemption, and would either be employers or employees. The term *employee* includes all persons who are being paid by a construction contractor as a subcontractor, unless the subcontractors has validly elected an exemption or has secured the payment of compensation. The term *employee* also include an independent contractor working or performing services in the construction industry, as well as a sole proprietor who engages in the construction industry and a partner or partner4ship that is engaged in the construction industry.

The criteria for an *independent contractor* (who is not engaged in the construction industry), which is exempt from the definition of an *employee*, is substantially revised. The bill lists six criteria, or which at least four must be met, in order for a person to be considered an independent contractor. But, even if four of the criteria are not met, an individual may still be presumed to be an independent contractor under certain specified conditions.

The bill exempts from the definition of *employee* Medicaid-enrolled clients under ch. 393 who are excluded from the definition of employment under s ch. 443, F.S., and served by Adult Day Training Services under the Home and Community-Based Medicaid Waiver program in an approved sheltered workshop setting for the purpose of training, and earning less than the federal hourly minimum wage.

The bill amends the definition of *employer* to specify that a homeowner is not considered an employer of persons hired to carry out construction on the homeowner's own premises, under certain conditions.

Section 3 amends s. 440.05, F.S., effective January 1, 2004, relating to exemptions, to provide conforming changes to eliminate exemptions in the construction industry for sole proprietors and partners and authorize exemptions for up to three corporate officers per corporation if certain conditions are met. The section also provides that an exemption certificate is applicable to the corporate officer named on the notice of exemption and applies only within the scope of business or trade listed. A person who is delinquent in paying a stop-work order and penalty assessment would be ineligible for an election of exemption.

Section 4 amends s. 440.06, F.S., relating to failure to secure compensation, to provide a specific cross-reference to s. 440.10, F.S., which requires an employer to secure compensation.

Section 5 amends s. 440.077, F.S., effective January 1, 2004, to provide conforming changes to eliminate references to exemptions in the construction industry for sole proprietors and partners.

Section 6 amends s. 440.09, F.S., relating to coverage. Under current law, if an injury arising out of employment combines with a preexisting disease or condition, the employer is required to pay compensation only to the extent that the injury arising out of the employment is the major contributing cause of the disability. The bill specifies that an "accidental compensable injury" must be the major contributing cause of any resulting injury and defines "major contributing cause" as the cause which is more than 50 percent responsible for the injury as compared to all other causes combined for which treatment or benefits are being requested. Major contributing cause must be demonstrated by medical evidence only.

In cases involving occupational disease or repetitive exposure, both causation and sufficient exposure to support causation must be proven by clear and convincing evidence.

Pain or other subjective complaints alone, in the absence of objective relevant medical findings (as further described), are not compensable.

Current law provides that compensation is not payable to an employee who knowingly or intentionally engages in any of the acts described in s. 440.105, F.S., which lists various prohibited acts related to the filing of false workers' compensation claims and related acts. The bill further provides that an employee is not entitled to compensation or benefits if the employee has knowingly or intentionally engaged in any criminal act for the purpose of securing workers' compensation benefits. The bill describes actions that would be considered "intentional", including pleas of guilty or nolo contendere in criminal matters. This would apply to all accidents, regardless of the date of accident. For injuries occurring prior to January 1, 1994, this provision would apply to acts committed after January 1, 1994. The judge of compensation claims is authorized to require any benefits payable to the employee to be deposited in an escrow account during the pendency of an appeal of a finding of insurance fraud.

The bill provides standards that must be met by an injured worker as part of rebutting any presumptions of current law regarding alcohol blood level or a positive drug test.

Section 7 creates s. 440.093, F.S., relating to mental and nervous injuries, to provide that mental or nervous injury due to stress, fright, or excitement only is not compensable. The bill requires that there be an accompanying physical injury needing medical treatment which is the major contributing cause of the mental or nervous injury. The mental or nervous injury must be demonstrated by clear and convincing evidence by a licensed psychiatrist, meeting criteria of the most recent edition of a specified publication of the American Psychiatric Association. The section limits the payment of benefits for compensable mental or nervous injuries to no more than three months after the date of maximum medical improvement for the employee's physical injury which is included in the period of 104 weeks.

Section 8 amends s. 440.10, F.S., relating to liability for compensation, to provide immunity from civil liability for subcontractors providing services in conjunction with a contractor on the same project or contract work. Such subcontractors would not be liable to employees of another subcontractor or the contractor on such contract work, provided that the subcontractor's gross negligence was not the primary cause of the workplace accident and the subcontractor had secured coverage for its employees or the contractor had secured coverage on behalf of the subcontractor and its employees.

The section also requires any employer with employees engaged in the construction industry in Florida to obtain a Florida policy or endorsement which uses Florida class codes and rates. The bill provides additional detail and conditions regarding different fact situations.

The bill also makes conforming changes relating to construction industry exemptions.

Section 9 amends s. 440.1025, F.S., relating to employer workplace safety program, to require the Division of Workers' Compensation to publicize on its Internet site, and encourage carriers to publicize, the availability of free safety consultation services and safety program resources. The section is also revised to provide that a private employer is eligible for a workplace safety discount on workers' compensation coverage if certain conditions are met.

Section 10 amends s. 440.103, F.S., to require an employer to certify to the building permit issuer that it has secured compensation for its employees.

Section 11 amends s. 440.105, F.S., relating to prohibited activities. The penalty for a violation of subsection (2), which would include discharging or refusing to hire an employee or applicant due to a filed claim and violating a stop work order, would be increased from a second degree misdemeanor to a first degree misdemeanor.

Currently, it is a first-degree misdemeanor, for an employee to knowingly fail to update application for coverage with its carrier. The bill amends this provision to require such updates within 7 days after the reporting date for any change in the required information.

Any person knowingly violating a stop work order or knowingly presenting false or fraudulent statements for the purpose of filing a claim for workers' compensation benefits would be subject to the insurance fraud penalty provisions under s. 440.105(4)(f), F.S.

Section 12 amends s. 440.1051, F.S., relating to fraud reports, to increase the penalty for a person that falsely reports workers' compensation fraud or retaliates against someone that reports workers' compensation fraud from a first-degree misdemeanor to a third-degree felony.

Section 13 amends s. 440.107, F.S., to define "securing the payment of workers' compensation" to mean obtaining coverage that meets the requirements of ch. 440, F.S., and the Insurance Code. The bill specifies the powers of the department to enforce workers' compensation coverage requirements, including authority to specify by rule the business records that employers must maintain and produce to comply with this section. Employers are required to produce such records within 5 business days after the receipt of the request from the department. The section also provides that a stop-work order takes effect when served upon the employer, or for a particular worksite, when served at that worksite and provides that the stop-work order is in effect until the employer demonstrates compliance, which may include a two-year probationary period. The department is required to assess an employer that fails to secure the payment of compensation an amount equal to 1.5 times, rather than 2 times; the amount the employer would have paid in the preceding three years or $1,000, whichever is greater.

Section 14 amends s. 440.11, F.S., relating to employer liability, to provide that the liability of an employer for compensation prescribed in s. 440.10, F.S., is exclusive and in place of all other liability, including vicarious liability, except in cases where the employer commits an intentional tort that causes the death or injury of an employee. An employer's actions are deemed to constitute an intentional tort only when the employee proves by clear and convincing evidence that the employer deliberately intended to injure the employee or the employer engaged in conduct that the employee knew was certain to result in injury or death to the employee. The section also expands immunity from third-party civil liability for safety consultants to all employees of the employer or employees of its subcontractors on a jobsite.

Section 15 amends s. 440.13, F.S., relating to medical care and reimbursement. Health care providers certified by AHCA would be required to be familiar with practice parameters and protocols of treatment. The Agency for Health Care Administration is authorized to audit health care providers to determine whether providers are adhering to practice parameters and protocols established in ch. 440, F.S. Practice parameters adopted by the U.S. Agency for Healthcare Research and Quality are adopted as the practice parameters and protocols mandated under ch. 440, F.S.

The section establishes standards of care that are required to be followed in providing medical care under the provisions of ch. 440, F.S., and provides penalty for noncompliance. Carriers are required to authorize an alternative physician within 5 days after receipt of a request for a change in physician who can't be affiliated with the previous physician. If the carrier fails to provide the change in physician, such physician is considered authorized if the treatment being provided is compensable and medically necessary and provides penalty if carrier does not timely comply with this request. All referrals are required to be made in accordance with practice parameters and protocols of treatment as provided in ch. 440, F.S.

Carriers are required to authorize specialist consultation, physical therapy, surgical operations, and other specified procedures unless such treatment or procedure is not in accordance with practice parameters or protocols of treatment or unless a JCC determines the care is not medically necessary and not in accordance with practice parameters or protocols, or otherwise not compensable under ch. 440, F.S.

The section provides that the employer and employee are limited to one independent medical examination (IME) per accident and not one per medical specialty; requires carrier to pay for only one; and allows injured worker to recoup costs of an IME if employee prevails in a medical dispute, as determined by a JCC, or if benefits are paid or treatment provided after employee has obtained an IME. As an alternative, the bill authorizes the use of consensus medical examinations to resolve medical disputes, if both parties agree, that would be binding on both parties and would constitute resolution of the medical dispute.

The section also provides that attendant care provided by a family member that is not employed or is employed and is providing such care during hours that he or she is not engaged in employment would be paid at federal minimum hourly wage. If the family member remains employed while providing attendant care, the per hour value of that care equals the per-hour value of that family member's employment, not to exceed the per-hour value of such care in the community at large.

The bill increases the maximum reimbursement for physicians to 110 percent of Medicare reimbursement schedules; increases maximum reimbursement for surgical procedures to 140 percent of Medicare; continues to allow deviations from fee schedules in certain circumstances; provides that outpatient observation status cannot exceed 23 hours; includes legislative intent language to pay for increases in fees to physicians by reductions in payments to hospitals; and reduces outpatient reimbursement for scheduled nonemergency surgeries from 75 percent to 60 percent of charges. Reimbursements for prescription drugs are reduced from 1.2 times the average wholesale price to the average wholesale price. The $4.18 dispensing fee is retained.

The bill increases caps on chiropractic treatments from 18 to 24 treatments and the number of weeks of treatments are increased from 8 to 12 weeks.

Section 16 amends s. 440.134, F.S., relating to managed care arrangements, to require the use of practice parameters, to incorporate new independent medical examiner provisions; to revise provisions relating to managed care arrangements; and to include chiropractors and podiatrists as medical care coordinators.

Section 17 amends s. 440.14, F.S., relating to the calculation of average weekly wage, to revise and clarify the computation of the average weekly wage for the purpose of determining compensation benefits. If an employee has worked for any employer during substantially the whole of 13 weeks immediately preceding the injury the average weekly wage is determined as 1/13 of the wages earned during that period. The term, "substantially the whole of 13 weeks," is defined to mean the calendar period of 13 weeks before the date of the accident, excluding the week of the accident. Currently in order for the calculation to apply, the injured worker had to work at least 90 percent of the total customary full time hours. This provision is revised to apply to those injured workers working at least 75 percent of the total customary hours.

Section 18 amends s. 440.15, F.S., relating to benefits.

Permanent Total Disability -- Under the bill, a *catastrophic injury*, shall, in the absence of conclusive proof of a substantial earning capacity, constitute permanent total disability. Catastrophic injury is re-defined in Section 1 of the bill to include loss of both hands, both arms, both feet, both legs, or both eyes, or any two thereof, or paraplegia or quadriplegia.

In all other cases, no permanent total disability compensation is payable if the employee is engaged in, or is physically capable of engaging in at least sedentary employment. (By not stating a burden of proof, the normal standard would be preponderance of the evidence.)
To be entitled to permanent total disability compensation the employee must establish that he or she is not able uninterruptedly to engage in at least sedentary employment, within a 50-mile radius of the employee's residence, due to his or her physical limitation.

Such permanent total benefits are payable until the employee reaches age 75; however, if an employee is injured on or after age 70, benefits are payable for a maximum of 5 years following the determination of permanent total. The bill reduces the annual supplemental disability benefit from 5 to 3 percent and eliminates permanent total disability supplemental benefits at age 62.

Permanent Partial Disability -- The bill would revise the *impairment benefits* for a permanent partial disability, by increasing the amount of the benefit from 50 percent to 75 percent of temporary total disability benefit, (i.e., 75 percent of 66.6 percent of average weekly wage (AWW), or about 50 percent of AWW, rather than 50 percent of 66.6 percent of AWW, or about 25 percent of AWW). But, the amount of the impairment benefit would be reduced by 50 percent (i.e., to about 25 percent of average weekly wage) if the employee is able to earn the same wage or greater after the injury. The duration of this benefit would be changed from the current 3 weeks for each percent of impairment to the following schedule:

- 2 weeks for each percent of impairment from 1 to 10 percent;
- 3 weeks for each percent of impairment from 11 to 15 percent;
- 4 weeks for each percent of impairment from 16 to 20 percent;
- 6 weeks for each percent of impairment from 21 percent and higher.

The bill eliminates the *supplemental benefits* ("wage-loss" benefits) that are currently paid only to employees who have at least a 20 percent impairment and who are unable to earn at least 80 percent of their pre-injury wage.

See Private Sector Impact, below, for further discussion of the impact of the changes to the impairment benefits and the elimination of the supplemental benefits.

Permanent impairment benefits are limited for the permanent psychiatric impairment to 1 percent permanent impairment.

The bill provides that only the disability or medical treatment associated with a compensable injury is payable, excluding preexisting disability or medical condition.

The obligation of an employer to rehire an injured employee is eliminated. If an employee leaves employment while receiving temporary partial benefits without just cause as determined by a JCC, such benefits would be payable based on the deemed earnings of the employee as if the employee had remained employed.

Section 19 amends s. 440.151, F.S., relating to occupational diseases, to require that the major contributing cause be shown by medical evidence only. Both causation and sufficient exposure to a specific harmful substance must be present in the workplace to support causation proven by clear and convincing evidence. Occupational disease is defined to mean only a disease for which there are epidemiological studies showing the exposure to the specific substance may cause the precise disease sustained by the employee.

Section 20 amends s. 440.16, F.S., relating to death benefits, to increase benefits for funeral expenses from $5,000 to $7,500 and death benefits are increased for dependents from $100,000 to $150,000.

Section 21 amends s. 440.185, F.S., relating to notice of injury or death, to increases penalties for noncompliance by an employer. The department is authorized to levy a fine of up to $1,000 (currently $500) for each failure to timely submit reports or forms required under s. 440.185, F.S. If an employer or carrier fails to timely file more than 10 percent of its notices of injury or death within one calendar year, the department is authorized to levy a fine of up to $2,000 for each

instance of noncompliance. Upon receiving notification of an injury from an employee, an employer is required to provide the employee with information concerning the services of the Employee Assistance Office in a form and manner prescribed by the department.

Section 22 amends s. 440.192, F.S., relating to procedures for dispute resolution, to specify that an employee may file a petition for benefits that meets the specificity requirements for any benefit that is ripe, due, and owing. Unless stipulated in writing, only claims which have been properly raised in a petition for benefits and have undergone mediation may be considered for adjudication by a judge of compensation claims.

Section 23 creates s. 440.1926, F.S., relating to alternative dispute resolution, to allow an employee and employer/carrier to mutually agree to enter into binding claim arbitration in lieu of any other remedy provided in ch. 440, F.S.

Section 24 amends s. 440.20, F.S., relating to payment of compensation, to require carriers to pay all medical bills properly submitted by the provider within 45 days after the carrier's receipt of the bills and establishes penalties for late payments. The department is required to impose penalties for late payments or disallowances or denials of medical bills that are below a minimum 95 percent timely performance standard. With respect to any lump-sum settlement under subsection (11), any correspondence to a clerk of the circuit court of this state regarding child support documentation would be exempt from any fees or costs ordinarily assessed by the clerk's office. Currently, the JCC is required to consider the interests of the worker and the worker's family when approving a settlement, which must consider and provide for appropriate recovery of past due support.

Section 25 amends s. 440.25, F.S., relating to procedures for mediation and hearings, to require a judge of compensation claims to notify parties regarding the scheduling of a mediation hearing within 40 days after the receipt of the petition for benefits. Mediation conferences are required to be held within 130 days, rather than 90 days, after receipt of the petition for benefits. A judge of compensation claims is required to consolidate multiple petitions into one mediation hearing. The judge of compensation is required to give parties 14 days, rather than 7 days, advance notice of the final hearing.

Section 26 amends s. 440.34, F.S., relating to attorneys' fees, to revise attorney's fees. The current contingency fee schedule is maintained, which provides that the fee for benefits secured is equal to 20 percent of the first $5,000 of benefits secured, and 15 percent of the next $5,000 of benefits secured, 10 percent of the remaining amount of benefits secured to be provided during the first 10 years after the claim is filed, and 5 percent of the benefits secured after 10 years.

As an alternative to contingency fees, the JCC may approve an attorney's fee not exceed $1,500 only once per accident, based on a maximum hourly rate of $150 per hour if the JCC determines that the fee schedule, based on benefits secured fails to fairly compensate the attorney for disputed medical-only claims. If there is a written offer to settle issues, including attorney's fees, at least 30 days prior to the hearing date for purposes of calculating the amount of attorney's fees to be taxed against the carrier or employer, the term "benefits secured" would include only that amount awarded to the claimant above the amount specified in the offer.

An attorney is not entitled to attorney's fees for representation in any issue that was ripe, due, and owing and that reasonably could have been addressed during the pendency of other issues. The JCC is prohibited from approving attorney's fee in excess of the amount provided by this section. The section also provides that the nonprevailing party is liable for taxable costs, excluding attorney's fees.

Section 27 amends s. 440.38, F.S., relating to security for compensation, to require an employer who meets compensation requirements through a policy issued outside of Florida to maintain the required coverage under a Florida endorsement that accurately reflects the work performed in Florida by his or her employees.

Section 28 amends s. 440.381, F.S., to provide that it is a second-degree felony for a person to submit an application for coverage that contains false, misleading, or incomplete information that is provided with the purpose of avoiding or reducing the amount of premiums.

The department would be required to immediately notify an employer's carrier if the department determines that the employer has materially understated or concealed payroll and the carrier is required to commence an onsite audit of the employer within 30 days after receiving notification from the department. If the carrier fails to commence the audit, the department would contract with auditing professionals to conduct the audit at the carrier's expense. The onsite audit requirement is waived if the carrier gives written notice of cancellation to the employer within 30 days after receiving notification from the department and an audit is conducted in conjunction with the cancellation.

Section 29 amends s. 440.42, F.S., relating to insurance policies, to require an insurer to provide an employer with at least 10 days prior notice of cancellation due to nonpayment of premium. Currently, a carrier is required to provide at least 30 days notice prior to cancellation for any reason.

Section 30 amends s. 440.49, F.S., to provide a conforming cross reference.

Section 31 amends s. 440.491, F.S., relating to training and education of injured workers. The bill provides that benefits for training and education, authorized by the Department of Financial Services and funded by the Workers' Compensation Administration Trust Fund may include payment to attend a community college or vocational-technical school; and provides that this benefit would include securing a general education diploma (GED). The bill provides that temporary total compensation benefits paid during the training and education would be included within, and not added to, the maximum 104 weeks provided for temporary total benefits.

Section 32 amends s. 440.525, F.S., examination of carriers, to authorize the department to audit, examine, or investigate any carrier, third-party administrator, servicing agent, or other claims-handling entity. The scope of an audit, investigation, or examination may address, but is not limited to: patterns or practices of unreasonable delay in claims handling; timeliness and accuracy of payments and reports; or patterns or practices of harassment, coercion, or intimidation of claimants.

The department is authorized impose an administrative penalty upon carriers that do not comply with the provisions of ch. 440, F.S. For each pattern or practice constituting a nonwillful pattern or practice, the department is authorized to impose an administrative penalty in an amount not to exceed $2,500 and the penalty cannot exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. Any administrative penalty imposed under this section (s. 440.525, F.S.) for a nonwillful violation cannot duplicate an administrative penalty imposed under another provision in ch. 440, F.S., or the Insurance Code.

For each willful practice or pattern constituting a willful violation, the department is authorized to impose an administrative penalty in an amount not to exceed $20,000 for each willful practice or pattern. Such fines cannot exceed $100,000 for all willful pattern or practice arising out of the same action.

Section 33 amends s. 627.162, F.S., relating to delinquent collection fees for premium installments, to increase the fee to $25 or 5 percent of the delinquent installment, whichever is greater. Currently, the fee is $10 or 5 percent of the delinquent installment, whichever is greater.

Section 34 creates s. 627.285, F.S., relating to workers' compensation rating organizations, to require the Department of Financial Services to contract for an independent actuarial peer review of the workers' compensation rating organization (presently NCCI) at least every other year. The initial report to the Legislature is due February 1, 2004.

Section 35 amends s. 627.311, relating to the JUA, to revise the current plans within the JUA to address affordability and availability for small employers and charitable and nonprofit organizations, effective July 1, 2003. The premiums in the newly created subplan D for small employers with 15 or fewer employees and an experience modification factor of 1.10 or less would be capped at 125 percent of the rate for the voluntary market manual rate, and premiums for non-profit charitable organizations with an experience modification factor of 1.10 percent or less would be capped at 110 percent of the voluntary market rate. Any deficits would be assessed against such employers.

The board of the JUA would be reduced from 13 to nine members. Currently 11 of the 13 members are chosen by insurance industry representatives. Under the bill, three members are appointed by the Financial Services Commission; two members by domestic insurers (Florida domiciled); two members by foreign insurers (non-Florida domiciled); one member by the largest property and casualty insurance agents' association; and the Insurance Consumer Advocate of the Department of Financial Services. The Financial Services Commission would designate a member of the board to serve as chairperson.

The JUA is required to provide a depopulation program to reduce the number of insureds in this newly created subplan D. An employer is no longer eligible for coverage through this subplan if an employer insured in this subplan is offered coverage from a voluntary market carrier: 1) during the first 30 days of coverage; 2) before a policy is issued under the subplan; 3) by issuance of a policy upon expiration or cancellation of the policy under the subplan; or 4) by assumption of the subplan's obligation with respect to an in-force policy.

All insured employers in the JUA would be required to participate in a safety program.

Section 36 amends s. 921.0022, F.S., relating to the Offense Severity Ranking Chart, to reflect the addition of ch. 440, F.S., workers' compensation related violations for the purpose of establishing minimum sentencing guidelines.

Section 37 requires the department to provide a report to the Legislature by January 1, 2004, regarding its ability to enforce 1) provisions relating to carrier compliance and enforcement, 2) any administrative rule, and 3) any other impediment to enforcement of ch. 440, F.S.

Sections 38 and 39 provide conforming cross references.

Section 40 creates the Joint Select Committee on Rating Reform to study and report on workers' compensation ratemaking and alternatives and to submit a report to the Legislature by December 1, 2003. The committee would be comprised of three Senators and three Representatives appointed by the Senate President and the Speaker of the House of Representatives, respectively. The Department of Financial Services would provide information and assistance as requested by the committee.

Section 41 requires the board of the JUA to submit a report to the Legislature by January 1, 2005, which would include findings and recommendations regarding the number of policies and premium of the JUA, and projections for future policy and premium growth; the effectiveness of this act in improving availability of coverage in Florida; projected deficits or surpluses and possible funding mechanisms to ensure the solvency of the plan; and recommendations to the Legislature relating to the operations of the plan.

Section 42 amends s. 443.1715, F.S., to authorize the Division of Unemployment Compensation to verify wage information in order for a carrier to determine whether an employee receiving workers' compensation benefits is also employed and receiving wages, under certain circumstances.

Section 43 amends s. 626.989, F.S., relating to the annual report on compliance and enforcement by the Department, to provide greater accountability regarding the investigation of workers' compensation fraud and compliance and enforcement activities of the department.

Section 44 amends s. 626.9891, F.S., relating to insurer anti-fraud activities, to require insurers to submit annual reports to the department regarding their efforts in implementing and maintaining anti-fraud investigative units or anti-fraud plans to address workers' compensation fraud and provides penalties for noncompliance.

Section 45 repeals s. 440.1925, F.S, relating to procedures for resolving maximum medical improvement or permanent impairment disputes.

Section 46 provides that the amendments to ss. 440.02 and 440.15, F.S., would not be construed to affect any disability determination under ss. 112.18, 112.181, or 112.19, F.S.

Section 47 provides that if any law that is amended by this act was also amended by a law enacted at the 2003 Regular Session, such laws would be construed as if they had been enacted during the same session of the Legislature, and full effect would be given to each if possible.

Section 48 provides an effective date of October 1, 2003, except as otherwise provided in the bill.

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:

None.

B. Private Sector Impact:

The NCCI estimates that the overall impact of this bill on workers' compensation premiums will result in a 12.35 percent decrease. A report, dated May 19, 2003, by an independent actuarial consulting firm, Preferred Insurance Capital Consultants (PICC) that was engaged by the Florida Senate to provide an independent peer review of NCCI has generally determined that the lack of source data and documentation of analysis made it impossible to provide conclusions with any degree of precision as to the reasonableness of NCCI's cost estimates

The cost savings generated by this bill, according to NCCI, are primarily due to benefit and compensability changes. Limitations on attorney fees are estimated to result in about a 2 percent savings. Savings in hospital costs are more than offset by increased payments to physicians, resulting in about a 1.4 percent increase in rates.

Affordability and Availability of Coverage

Employers and nonprofit and charitable organizations previously unable to obtain affordable coverage could obtain such coverage through the JUA if they met the eligibility requirements for the newly created subplan D of the JUA. The premiums would be capped at 125 percent of the voluntary market rate for employers with 15 or fewer employers that have an experience modification rating of 1.10 or less. The premiums for qualified non-profit charitable organizations with an experience modification factor of 1.10 percent or less would be capped at 110 percent of the voluntary market rate. However, any deficits would be assessed against such employers. It may take two or three years for such deficits to occur.

Persons engaged in residential construction or small construction projects (valued at less than $250,000) and previously exempted from workers' compensation coverage would now be required to obtain coverage, effective January 1, 2004, unless they were corporate officers with 10 percent ownership in the corporation.

Permanent Total Disability Benefits

The bill terminates permanent total disability benefits generally at age 75. These persons would have to rely upon other sources of income, such as Social Security benefits, if such persons are eligible. Since approximately 23 percent of the population that is age 75 or older is not fully insured (eligible for or receiving Social Security benefits) according to the U.S. Census Bureau, the costs of supporting these employees attaining age 75 that are not eligible for Social Security could be shifted to the state. The fiscal impact is unknown. The NCCI estimates that the costs of retaining permanent total disability benefits for employees age 75 or more that are not eligible for receiving Social Security benefits will be a 0.25 percent increase.

Permanent Partial Disability Benefits

For persons with a permanent partial disability, the bill revises the calculation of the *impairment benefits* and eliminates the *supplemental benefits*. The impact is as follows:

If an employee is *not* able to earn his or her pre-injury wage, the bill either maintains or increases the total dollar amount of the *impairment benefit* for all employees Such an employee with a 1 to 10 percent impairment rating would receive the same total impairment benefit as under current law. Such employees with an 11 percent impairment or greater would receive greater impairment benefits, which increase significantly for employees with a 20 percent impairment rating or greater. For example, an employee with a 12 percent impairment rating who was earning $300 per week prior to the injury, and who is not able to earn this amount after the injury (for the length of time of the duration of the benefits), would receive a total impairment benefit of $3,900, as compared to $3,600 under current law. If the same employee had a 22 percent impairment rating, he would receive a total impairment benefit of $10,050, as compared to $6,600 under current law.

However, if the employee *is* able to earn his or her pre-injury wage, then the total impairment benefit is one-half of the current impairment benefit for employees with a 1 to 10 percent impairment. The total impairment benefit is reduced by less than half, on a sliding scale, for impairment ratings of 11 percent to about 33 percent, and then begins increasing at approximately a 33 percent impairment rating and greater.

The bill eliminates the *supplemental (wage loss) benefit* that is currently paid only to workers with a 20 percent impairment, paid at 80 percent of the difference between the post-injury wage and 80 percent of the pre-injury wage. However, workers with a 20 percent impairment or greater who are unable to earn their pre-injury wage would receive substantially greater *impairment benefits* under the bill. Whether such a worker would receive greater or lesser *total* benefits for permanent partial disability depends on a combination of factors: the percentage impairment, the length of time that the wage loss continued, and the percentage of the wage loss. In general, the greater the impairment rating (particularly above 20 percent), the greater the total benefit is likely to be under the bill. But, the greater the wage loss and the length of time the wage loss continues, the greater the total benefit would likely be under current law.

Other Benefits

The bill increases death benefits for funeral expenses and compensation to dependents. For other injuries, depending on the type of injury and benefit sought, worker may not be compensated or would be provided less compensation for various injuries due to higher burdens of proof or more restrictive compensability standards.

C. Government Sector Impact:

Indeterminate. (See Permanent Total Disability Benefits discussion above in Private Sector Impact.)

VI. Technical Deficiencies:

None.

VII. Related Issues:

This analysis has been revised from the previous version (05/20/03) regarding the calculation of the impairment benefits paid for permanent partial disability in Section 18 and the related discussion of such benefits in Private Sector Impact.

VIII. Amendments:

None.