HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	CS/HB 613	**FINAL HOUSE FLOOR ACTION:**	
SPONSOR(S):	Regulatory Affairs Committee; Sullivan	115 **Y's**	2 **N's**
COMPANION BILLS:	CS/SB 986	**GOVERNOR'S ACTION:**	Approved

SUMMARY ANALYSIS

CS/HB 613 passed the House on March 3, 2016, and subsequently passed the Senate on March 3, 2016.

The workers' compensation law requires an employer to obtain coverage for their "employees" that provides for lost income and all medically necessary remedial treatment, attendance, and care resulting from work related injuries and occupational diseases. The Division of Workers' Compensation within the Department of Financial Services (DFS) provides regulatory oversight of the system. The DFS' responsibilities include enforcing employer compliance with coverage requirements, administration of the workers' compensation health care delivery system, collecting system data, and assisting injured workers regarding their benefits and rights.

The bill contains a variety of changes to the workers' compensation law. The changes include:

- Providing for a 25 percent penalty credit for certain employers;
- Establishing a deadline for employers to file certain documentation to receive a penalty reduction;
- Reducing the imputed payroll multiplier related to penalty calculations from 2 times to 1.5 times the statewide average weekly wage;
- Requiring employers to simply notify their insurers of their employee's coverage exemption, rather than requiring that a copy of the exemption be provided;
- Eliminating a 3-day response requirement applicable to employer held exemption information;
- Removing the requirement that construction employers maintain written exemption acknowledgements;
- Deleting a requirement that exemption revocations be filed by mail only;
- Removing unnecessary information from the exemption application;
- Relieving employers of the obligation to notify the DFS by telephone or telegraph within 24 hours of any work related death and relying instead on other existing reporting requirements;
- Removing insurers and employers from the medical reimbursement dispute provision since they meet their adjustment, disallowance and provider violation reporting duties through other provisions of law;
- Eliminating fees collected by the DFS related to new insurer registrations and Special Disability Trust Fund notices of claim and proofs of claim;
- Revising the method for selecting an expert medical examiner; and
- Eliminating the Preferred Worker Program, which has not been used in over ten years.

The bill is expected to have a significant negative fiscal impact on state revenues deposited into the Workers' Compensation Administration Trust Fund (WCATF) of approximately $2.0 million due to the elimination of certain fees, a change in the imputed payroll multiplier from 2 to 1.5 times the statewide average weekly wage, and a 25 percent penalty credit provided to employers meeting requirements set forth in the bill. However, the DFS estimates that the fiscal year-end balance of the WCATF (including the impact of HB 613) will maintain a positive surplus cash balance of: $161.1 million in FY 2016-17, $162.4 million in FY 2017-18, and $163.7 million in FY 2018-19. It has no impact on state expenditures and no impact on local governments. It has an indeterminate positive impact on the private sector.

The bill was approved by the Governor on March 10, 2016, ch. 2016-56, L.O.F., and will become effective on October 1, 2016.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Background – Workers' Compensation

The workers' compensation law[1] requires employers[2] to obtain coverage for work related injuries and occupational diseases. The required coverage must provide injured "employees"[3] all medically necessary remedial treatment, attendance, and care; including medicines, medical supplies, durable medical equipment, and prosthetics.[4] Employers must also provide compensation for lost income when the injury causes the employee to miss more than seven days of work.[5] The Division of Workers' Compensation within the Department of Financial Services (DFS) provides regulatory oversight of the system. The DFS' responsibilities include enforcing employer compliance with coverage requirements,[6] administration of the workers' compensation health care delivery system,[7] collecting system data,[8] and assisting injured workers[9] with accessing benefits and understanding their rights.[10]

Current Situation – Employer Failure to Comply with Coverage Requirements

Whether an employer is required to have workers' compensation insurance depends upon the employer's industry (i.e., construction, non-construction, or agricultural) and the number of employees. The coverage thresholds are as follows:

- Construction – one or more "employees;"
- Non-construction – four or more "employees;" and
- Agricultural - six or more regular employees and/or 12 or more seasonal employees who work for more than 30 days.

Employers may obtain coverage by: purchasing a workers' compensation insurance policy from an insurer; purchasing coverage from the Workers' Compensation Joint Underwriting Association (for employers that are unable to purchase a workers' compensation insurance policy from an authorized insurance company); or, qualifying as a self-insurer.[11]

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[1] ch. 440, F.S.

[2] "Employer" means the state and all political subdivisions thereof, all public and quasi-public corporations therein, every person carrying on any employment, and the legal representative of a deceased person or the receiver or trustees of any person. "Employer" also includes employment agencies, employee leasing companies, and similar agents who provide employees to other persons. s. 440.02(16), F.S. The most common exception to this is non-construction industry employers with fewer than four employees. There are a number of other exceptions, exclusions, and exemptions that affect whether an employer must provide workers' compensation coverage generally or to a particular individual. See s. 440.02(15)–(17), F.S.

[3] s. 440.02(15), F.S. Generally, the term "employee" means any person who receives remuneration from an employer for the performance of any work or service while engaged in any employment under any appointment or contract for hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed, and includes, but is not limited to, aliens and minors. s. 440.02(15)(a), F.S. However, there are numerous statutory inclusions and exclusions that determine whether a particular individual is an "employee" for purposes of the workers' compensation law.

[4] s. 440.13(2)(a), F.S.

[5] s. 440.12(1), F.S.

[6] s. 440.107(3), F.S.

[7] s. 440.13, F.S.

[8] Many information filing and reporting requirements occur throughout ch. 440, F.S. The primary employee, employer, and insurer reporting requirements are located in s. 440.185, F.S. The DFS may collect information electronically. s. 440.593, F.S.

[9] The terms "injured employee" and "injured worker" are used interchangeably throughout ch. 440, F.S., in relation to individuals claiming or receiving workers' compensation benefits. However, neither term is expressly defined in the workers' compensation law. Since the term "injured employee" implies a continuing employment relationship that may not in fact exist following an injury, this analysis will use the term "injured worker" exclusively, but it is intended to mean both "injured employee" and "injured worker" wherever it is used, unless the context or law requires otherwise. The term "injured employee" is not same as "employee." The former denotes one who is claiming benefits following an injury, while the latter denotes one who may be subject to the coverage requirements of the workers' compensation law, depending upon the circumstances of their employment and nature of their employer.

[10] s. 440.191, F.S.

[11] ss. 440.38, F.S. and 627.311(5)(a), F.S.

Stop-Work Orders and Business Records Requests/Responses

If an employer fails to comply with coverage requirements, the DFS must issue a stop-work order (SWO) within 72 hours of the DFS determining employer non-compliance.[12] Non-compliance includes the failure of an employer to answer a written business records request within ten days of the request; however, requests for documentation of a coverage exemption must be answered within three days.[13] SWOs require the employer to cease business operations. The SWO remains in effect until the DFS issues an order releasing the stop-work order. Additionally, employers are assessed penalties equal to two times what the employer would have paid in workers' compensation premiums for all periods of non-compliance during the preceding two-year period or $1,000, whichever is greater.[14] SWOs are issued for the following violations:

- Failure to obtain workers' compensation insurance;
- Materially understating or concealing payroll;
- Materially misrepresenting or concealing employee duties to avoid paying the proper premium;
- Materially concealing information pertinent to the calculation of an experience modification factor;[15] and
- Failure to produce business records in a timely manner.

In fiscal year 2014-2015, the DFS issued 2,727 SWOs with approximately $52.4 million in penalties to employers that violated the coverage requirements.[16]

Avoiding Work Stoppage and Minimizing Penalties

There are several ways for a non-compliant employer to mitigate the impact of a DFS finding of non-compliance on their business operations. First, if the employer comes into compliance after initiation of an investigation, but before they are ordered to stop work, an SWO is not issued. Instead, if penalties are required by law, the DFS will only levy penalties. In that case, the penalties are levied via an Order of Penalty Assessment (OPA).[17] This permits the employer to avoid the work stoppage due to an SWO, while also achieving compliance. This also provides the employer an opportunity to reduce their potential penalty. If the employer has never received an SWO before, the employer may receive a credit against the penalty equal to the amount of the initial payment of workers' compensation premium resulting from them achieving compliance following the initiation of the DFS investigation.[18]

Imputation of Payroll for Penalty Purposes

Sometimes, an employer will either lack required payroll information or will ignore the DFS' business records request. In that instance, the DFS will issue an SWO; however, DFS will lack sufficient documentation to calculate the penalty. Subsection 440.107(7), F.S., provides a means for the DFS to impute the employer's payroll for penalty purposes.

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[12] s. 440.107(7)(a), F.S.
[13] s. 440.05(11), F.S.
[14] s. 440.107(7)(d), F.S.
[15] An experience modification factor is a multiplier that the insurer applies to the premium calculation. It increases or decreases the employer's premium based upon their claims history. If the employer has a positive claims history (i.e., fewer claims or claim costs than statistically expected) they will receive a discount when the experience modification factor is applied to their standard premium. If they have a negative claims history (i.e., more claims or claim costs than statistically expected) they will receive a higher premium when the factor is applied.
[16] Florida Department of Financial Services, *Division of Workers' Compensation 2015 Results & Accomplishments Report*, at 2, *available at* http://www.myfloridacfo.com/Division/WC/PublicationsFormsManualsReports/Reports/AnnualReportWC2015.pdf. The DFS reports that they are able to collect between 25 percent and 35 percent of the penalties they assess. Florida Department of Financial Services, Agency Analysis of 2016 House Bill 613, p. 6 (Dec. 8, 2015).
[17] In fiscal year 2014-2015, the DFS issued 256 OPAs levying about $3.1 million in penalties when an employer came into compliance with the coverage requirements prior to the issuance of an SWO. Id, at 4.
[18] s. 440.107(7)(d)1., F.S.

The imputed payroll under the law is twice the statewide average weekly wage (SAWW)[19] for each individual that the employer failed to cover. Depending on the circumstances of a particular case, the DFS may have to impute payroll for all of the employees for the entire two-year period or the DFS may only have to impute payroll for one or more employees for a small portion of the two-year period. It depends upon the quality and availability of the employer's records.

When the DFS power to impute payroll was added to the law in 2003, it was set at one and one-half times the SAWW. It was increased to twice the SAWW in 2014. The DFS suggests that this can lead to "exorbitant penalty amounts that do not correlate with the violation committed by the employer."[20] The DFS imputed payroll against the employer in 1,584 cases in fiscal year 2014-2015.[21]

Effect of the Bill

The bill removes the three day response requirement applicable to exemption information held by the employer since the DFS maintains these records online. Also, the bill reduces the imputed payroll multiplier from twice the SAWW and returns it to the pre-2014 level of one and one-half times the SAWW.

The bill adds two new eligibility requirements to the existing penalty credit for achieving compliance after the initiation of an investigation and adds a second penalty credit. The bill requires non-compliant employers to document their purchase of coverage to the DFS within 28 days of the SWO or OPA to qualify for the reduction in penalty and requires that the employer has never before received an SWO or OPA, rather than just an SWO. The bill creates another penalty credit for non-compliant employers who have never previously received an SWO or OPA. If they maintain business records consistent with the requirements of s. 440.107(5), F.S.,[22] and timely respond to the written DFS business records requests (a 10-day response requirement), the DFS is required to reduce the penalty by 25 percent.

Current Situation – Medical Reimbursement Disputes

The DFS is responsible for resolving medical reimbursement disputes between health care providers and insurers[23] or employers.[24] Health care providers, insurers, and employers have 45 days from receipt of notice of disallowance or adjustment of payment from an insurer to file a reimbursement dispute petition with the DFS. Insurers have 30 days from receipt of the provider's petition to submit all documentation substantiating the insurer's disallowance or adjustment to the DFS; otherwise they waive all objections to the petition. The DFS has 120 days from receipt of all documentation to issue a written determination. The DFS's determination is subject to the hearing provisions of the Administrative Procedures Act.[25]

Insurers are required to report all instances of health care provider overutilization to the DFS.[26] The DFS has implemented rules formalizing the procedure for reporting alleged provider violations.[27] Any interested person can report an alleged provider violation through this procedure, too. Additionally, the DFS collects adjustment information for all reported workers' compensation medical bills. When the

[19] The statewide average weekly wage is determined by the DFS pursuant to s. 440.12(2), F.S.
[20] Email from Andrew Sabolic, Assistant Director of the Division of Workers' Compensation, Department of Financial Services, Re: data requests for system admin bill (Jan. 6, 2016).
[21] *Id.*
[22] Section 440.107(5), F.S., requires the DFS to adopt rules specifying the business records that the employer must maintain. Rule 69L-6.015, F.A.C., contains these requirements.
[23] The terms "carrier" and "insurer" are commonly used interchangeably within the context of the workers' compensation law. In fact, the definition of "insurer" expressly includes the term "carrier." s. 440.02(38), F.S. "Carrier" means any person or fund authorized under s. 440.38, F.S., to insure under this chapter and includes a self-insurer, and a commercial self-insurance fund authorized under s. 624.462. s. 440.02(4), F.S. While this analysis uses the term "insurer" in this instance to maintain internal consistency, the portion of the bill described strikes the term "carrier" from statute.
[24] s. 440.13(7), F.S.
[25] ch. 120, F.S.
[26] s. 440.13(6), F.S.
[27] Chapter 69L-34, F.A.C.

insurer properly codes and reports their adjustments and reimbursement decisions, the DFS can use their electronic database to identify alleged overutilization. Insurer compliance with electronic bill reporting requirements satisfies their statutory obligation to report all instances of overutilization.[28] The inclusion of insurers and employers in the medical reimbursement dispute provision can lead to confusion over the correct method for insurer or employer reporting of alleged provider violations and insurer reporting of medical overutilization issues.

Effect of the Bill

The bill removes insurers and employers from the provision allowing the filing of a medical reimbursement dispute over the disallowance or adjustment of a medical payment. Accordingly, only health care providers will be permitted to file petitions for resolution of medical billing disputes. Insurers and employers will continue to meet their statutory reporting obligations through required data filing and elective violation reports, as described above.

Current Situation – Expert Medical Advisors and the Judges of Compensation Claims

The Office of the Judges of Compensation Claims is responsible for resolving workers' compensation benefit disputes.[29] A Judge of Compensation Claims (JCC) receives medical evidence and testimony in the course of administering their assigned cases. Whenever there is a conflict in medical evidence or medical opinion, the JCC must appoint an Expert Medical Advisor (EMA) to address the conflict.[30] EMAs are certified by the DFS.[31]

Certification as an EMA requires specialized workers' compensation training or experience and medical board certification or eligibility. The DFS is also required to "consider the qualifications, training, impartiality, and commitment of the health care provider to the provision of quality medical care at a reasonable cost."[32] Currently, there are 153 EMAs certified by the DFS.[33] The procedures that an EMA must abide by and the party responsible for the cost of the EMA's services are established by statute.[34]

The JCCs often have difficulty finding an eligible EMA to assist them with a case. This often occurs because there are too few EMAs in a particular specialty or the EMAs present in the local area of the injured worker have a conflict in participating in the matter because they have previously treated the injured worker or consulted in their care. When this occurs, the JCC identifies a willing provider with the appropriate qualifications and submits their information to the DFS for certification. Since the JCC has already considered the prospective EMA's qualifications, there is little benefit in going through the additional burden and delay of submitting the prospective EMA to the DFS for certification.

Effect of the bill

The bill allows the injured worker and a self-insured employer or insurer to jointly select a health care provider to participate in their case as an EMA. Since there are no particular qualification requirements specified for a jointly selected EMA, the parties have maximum freedom in choosing a mutually agreed upon provider.[35] This includes the ability to choose providers who are not currently eligible to serve as an expert medical advisor. If they are unable to agree on a provider, the JCC may designate an EMA of

[28] Rule 69L-34.002, F.A.C.
[29] s. 440.192, F.S.
[30] s. 440.25(4)(d), F.S.
[31] s. 440.13(9)(a), F.S.
[32] *Id.*
[33] FLORIDA DEPARTMENT OF FINANCIAL SERVICES, *Florida Division of Workers' Compensation Expert Medical Advisor List*, https://apps.fldfs.com/provider/ (last visited Jan. 15, 2016).
[34] s. 440.13(9), F.S.
[35] A "health care provider" is a physician or any recognized practitioner licensed to provide skilled services pursuant to a prescription or under the supervision or direction of a physician. s. 440.13(g), F.S. A "recognized practitioner" means a non-physician health care provider licensed by the Department of Health who works under the protocol of a physician or who, upon referral from a physician, can render direct billable services that are within the scope of the recognized practitioner's license, independent of the supervision of a Physician. Rule 69L-7.710(1)(tt), F.A.C.

the JCC's choosing. In both circumstances, the selected EMA is not required to be certified by the DFS. EMAs, whether certified by the DFS or designated by the parties or the JCC, will continue to be subject to the existing procedural requirements of statute.

Current Situation – Preferred Worker Program

In 1994, the Legislature created the Preferred Worker Program.[36] The program encourages the employment of certain disabled individuals by reimbursing an employer for the workers' compensation premium related to a "preferred worker." Under the program, a "preferred worker" is one that cannot return to their prior job due to a permanent impairment resulting from a workers' compensation injury or occupational disease. The preferred worker documents their status to the employer by applying for and receiving an identity card from the Department of Education. Subsequent to hiring a preferred worker, an employer can claim reimbursement for three years of workers' compensation premium associated with the preferred worker from the DFS via the Special Disability Trust Fund.[37]

The program has experienced a small number of claims and has not made any program reimbursements in over a decade. The DFS reports that the program paid seven claims totaling $15,915.33 since the beginning of the program. The DFS last issued a reimbursement under the program in 2002.[38]

Effect of the Bill

The bill eliminates the Preferred Worker Program. This should have no impact on workers or employers given the lack of program activity.

Miscellaneous

The bill also makes the following changes:

- Deletes a requirement that exemption holders revoke their exemptions by mail. This will allow electronic revocations.[39] Since the DFS maintains an online exemption application and record review system, the DFS could add online revocation requests to their system.
- Removes the requirement that exemption applicants provide their Federal Tax Identification Number when filing an electronic application for exemption with the DFS.[40] The Internal Revenue Service does not issue Federal Tax Identification Numbers to individuals; rather, they are issued to businesses. The Federal Tax Identification Number of the applicant's employer will still be collected.
- Changes a requirement that employers provide their insurer with copies of their employee's certificate of exemption, instead the employer will notify the insurer of the exemptions.[41] Since the DFS maintains online exemption information, the insurer can still verify the exemption without needing a copy of the certificate of exemption.

[36] s. 440.49(8), F.S., and Chapter 69L-11, F.A.C.
[37] s. 440.49, F.S. The Special Disability Trust Fund (SDTF) is Florida's "Second Injury Fund." The SDTF reimburses self-insured employers and insurers for the excess workers' compensation benefits associated with an injured worker that was injured on the job and then had a second injury or re-injury. For a variety of reasons, in 1997, the SDTF was "cut-off" and limited to claims for second injuries occurring before Jan. 1, 1998. The SDTF continues to reimburse qualifying claims. In fiscal year 2014-2015, the SDTF disbursed reimbursements of about $63.7 million and received 1,228 reimbursement requests. Florida Department of Financial Services, *Division of Workers' Compensation 2015 Results & Accomplishments Report*, at 33, *available at* http://www.myfloridacfo.com/Division/WC/PublicationsFormsManualsReports/Reports/AnnualReportWC2015.pdf.
[38] Florida Department of Financial Services, Agency Analysis of 2016 House Bill 613, p. 2 (Dec. 8, 2015).
[39] s. 440.05(1), (2), and (5), F.S. DFS reports that 2,314 exemption holders filed voluntary revocations in fiscal year 2014-2015. Email from Andrew Sabolic, Assistant Director of the Division of Workers' Compensation, Department of Financial Services, Re: data requests for system admin bill (Jan. 6, 2016).
[40] s. 440.05(3), F.S.
[41] *Id.*

- Removes a requirement that construction employers maintain written exemption acknowledgements by their corporate officers that hold an exemption certificate.[42]
- Removes a requirement that employers notify the DFS by telephone or telegraph within 24 hours of any work related death.[43] This relates to a defunct process whereby the DFS had a role in workplace safety investigations. However, the DFS' former workplace safety role is preempted to the federal government and implemented by the Occupational Safety and Health Administration. The DFS will continue to receive reports of death through an existing employer reporting requirement.[44]
- Eliminates the following fees collected by the DFS:
    - New insurer registration fee – the law requires the DFS to collect $100 from every new workers' compensation insurer that registers with the DFS.[45] New insurers will continue to register with the DFS as a workers' compensation insurer, except without the fee. The DFS reports that four new registrations were received in fiscal year 2014-2015.[46]
    - Special Disability Trust Fund (SDTF):
        - Notice of Claim Fee – every claim against the SDTF must be initiated with a notice of claim. The notice must include a $250 fee.[47]
        - Proof of Claim Fee – an insurer that files a claim against the SDTF must file certain documents to perfect their claim. If the required documents are not filed in concert with their notice of claim, they must file a proof of claim, which must include a $500 fee.[48]

      Insurers will continue to be allowed to file notices of claim and proofs of claim. The SDTF received no notices of claim or proofs of claim in fiscal year 2013-2014 and one notice of claim in fiscal year 2014-2015.[49]
- Revises multiple cross-references to conform to changes made by the bill.
- Makes edits to statute unrelated to the substantive provisions of the bill consistent with House Bill Drafting protocols.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The DFS estimates a $2,000,000 loss of revenue to the Workers' Compensation Administration Trust Fund (WCATF) due to the availability of the proposed 25 percent penalty credit and the change in the imputed payroll multiplier from 2 to 1.5 times the statewide average weekly wage. This estimate considers the worst case scenario of potentially collected penalty revenue. The DFS indicates that this may represent an approximate two percent reduction in WCATF revenue based upon experienced penalty collection rates.[50] The revenue projections also include a corresponding reduction in the Service Charge to General Revenue of approximately $160,000 annually.

[42] s. 440.05(10), F.S.
[43] s. 440.185(3), F.S.
[44] s. 440.185(2), F.S.
[45] s. 440.52(1), F.S.
[46] Email from Andrew Sabolic, Assistant Director of the Division of Workers' Compensation, Department of Financial Services, Re: data requests for system admin bill (Jan. 5, 2016).
[47] s. 440.49(7) and (8), F.S.
[48] *Id.*
[49] AMI Risk Consultants, Inc., *State of Florida Special Disability Trust Fund Actuarial Review as of June 30, 2015*, at 5, *available at* http://www.myfloridacfo.com/Division/WC/pdf/State-of-Florida-Disability-Trust-Fund_2015_FINAL_09-10-15.pdf.
[50] Email correspondence with The Department of Financial Services (Jan. 20, 2016) on file with the Government Operations Appropriations Subcommittee.

Workers' Compensation Administration Trust Fund			
	FY 2016-17	**FY 2017-18**	**FY 2018-19**
Beginning Balance	159,901,026	161,138,843	162,390,343
Estimated Revenue	88,995,769	89,011,969	89,028,332
Impact of HB 613	(2,000,000)	(2,000,000)	(2,000,000)
TOTAL Revenue	246,896,795	248,150,812	249,418,675
Estimated Expenditures	(85,757,952)	(85,760,469)	(85,763,032)
Estimated Year-end Balance	**161,138,843**	**162,390,343**	**163,655,643**

In addition, the DFS estimates a loss of combined trust fund revenue to the Special Disability Trust Fund (SDTF) and the WCATF of approximately $1,500 due to the elimination of fees as provided in the bill. The DFS reports for fiscal year 2014-15, the collection of $400 in new insurer registration fees, which are deposited into the WCATF. [51] The June 30, 2015 actuarial review of the SDTF indicated one filing for a notice or proof of claim relating to the Preferred Worker Program, with $0.00 revenue collections for filing fees as of June 30, 2015.[52] The DFS indicates that the fees eliminated by the bill are likely to have an insignificant impact on state trust fund revenues.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill is likely to have a positive impact on the private sector since it eliminates a number of burdensome requirements and facilitates use of online resources maintained by the DFS. It also provides opportunities to non-compliant employers to reduce penalties while incentivizing compliance with the law.

D. FISCAL COMMENTS:

None.

[51] Email from Andrew Sabolic, Assistant Director of the Division of Workers' Compensation, Department of Financial Services, Re: data requests for system admin bill (Jan. 5, 2016).
[52] State of Florida Special Disability Trust Fund Actuarial Review can be found here: http://www.myfloridacfo.com/division/wc/pdf/State-of-Florida-Disability-Trust-Fund_2015_FINAL_09-10-15.pdf (Last visited Jan. 19, 2016).