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HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
JUDICIARY
ANALYSIS

BILL #: HB 1767 (PCB IN 99-02)

RELATING TO: Workers' Compensation

SPONSOR(S): Committee on Insurance, Rep. Bainter and others

COMPANION BILL(S): SB 2252(s), HB 1679(c), and SB 1662(c)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) INSURANCE YEAS 11 NAYS 0
(2) JUDICIARY
(3)
(4)
(5)

I. SUMMARY:

In 1993, the Legislature significantly reformed Florida's workers' compensation act. The stated goals of the reforms were to reduce system costs, primarily medical costs, and to create a system which was efficient and self-executing. In the six years since the 1993 reform, few changes have been made to the workers' compensation system.

This bill would make changes to the workers' compensation system relating to medical care, permanent total disability (PTD) benefit eligibility, and program administration and procedures. Medical care issues would include authorizing individual self-insured employers to "opt-out" of managed care requirements, modifying medical bill reporting requirements, and granting rehabilitation providers access to medical records.

PTD benefit eligibility issues would include requiring the Social Security Administration to determine Social Security (SS) disability for purposes of qualifying for "catastrophic injury." The bill would also address an interpretive issue relating to the current requirement that PTD supplemental benefits only cease at age 62 if the employee is eligible for SS disability "and" SS retirement. This condition cannot occur since an employee cannot be eligible to receive both SS disability and SS retirement at the same time.

Lastly, the bill would make a variety of program administration and procedural changes including: modifying the 120 day requirement for lump sum settlements; eliminating docketing review; authorizing electronic transfer of benefit payments; authorizing the Division of Workers' Compensation (Division) to contract with a private entity to perform its data collection function; allowing initial drug testing to be conducted on an employer's premises by trained personnel instead of by a licensed of certified laboratory for drug-free workplace programs; changing the name of the "notice of denial" to a "response to petition"; redefining "wages" to exclude wages the employee continues to earn at concurrent employment; setting a time frame within which pretrial hearings shall be held; requiring certain contractors performing state construction work to implement drug-free workplaces; precluding workers' compensation for employees covered by the federal Defense Base Act; increasing the time for carrier payment after an award by judge of compensation claims; clarifying that managed care grievance procedures must be exhausted; requiring the First District Court of Appeal to hear all workers' compensation cases in a specialized division; defining the Workers' Compensation Administration Trust Fund and Special Disability Trust Fund assessment base to include premiums ceded to reinsurers; requiring premiums reported to the Division for assessments be reported as full policy premium value before application of deductible discounts; and authorizing the Workers' Compensation Joint Underwriting Association to use policyholder surplus from any year to eliminate deficits.

This bill has a fiscal impact on state government of an indeterminate amount.

The bill has an effective date of October 1, 1999 except as otherwise provided therein.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Basis for Workers' Compensation

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

Legislative Intent

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

Agency Jurisdiction

Department of Labor and Employment Security, Division of Workers' Compensation

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

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

Agency for Health Care Administration

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

Department of Insurance

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

Securing Worker's Compensation Coverage

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

Funding of Administration of Workers' Compensation System

Florida's workers' compensation system is funded though an assessment on workers' compensation insurers based on "net premiums collected" by the insurer. See s. 440.51(1)(b), F.S. Assessments are paid into the Workers' Compensation Administration Trust Fund.

Benefit Structure

There are two basic types of benefits provided under the workers' compensation act -- medical benefits and indemnity benefits.

Medical Benefits

Workers' compensation medical benefits consist of medically necessary remedial treatment, care, and attendance for as long as the employee's recovery process requires. Employees are entitled to medical benefits from the time of the injury through the recovery process.

Indemnity Benefits

There are several categories of indemnity benefits provided under the workers' compensation act for different types of disability. Indemnity benefits are not payable for the first seven days of a disability. Therefore, a disability must last for more than seven days for indemnity benefits to become payable. However, if the disability lasts for more than 21 days, indemnity benefits are allowed from the date of the disability. Disability types include:

- temporary partial disability,
- temporary total disability,
- permanent partial disability (permanent impairment and supplemental benefits),
- permanent total disability, and
- death.

Generally, employees receive *temporary* indemnity benefits during the recovery period of an injury. Temporary benefits are meant to replace a portion of the employee's pre-injury wage until the employee recovers -- i.e., until the employee reaches maximum medical improvement (MMI). *Permanent* indemnity benefits are paid to the employee after the recovery period when there are permanent residual effects from the injury.

Permanent Total Disability Benefits (PTD)

PTD benefits are paid to employees who have sustained a catastrophic injury and who are unable to return to work. "Catastrophic injuries" are defined in Florida law as permanent impairments constituted by:

- spinal cord injury, involving severe paralysis of an arm, a leg, or the trunk;
- amputation of an arm, hand, foot, or leg involving the effective loss of that appendage;
- severe brain or closed-head injury;
- second degree or third degree burns of 25 percent or more of the 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 otherwise qualify under this chapter of a nature and severity that would qualify an employee to receive federal social security disability benefits.

PTD benefits are calculated at 66 2/3 percent of the employee's pre-injury AWW and are paid for the life of the employee.

PTD Supplemental Benefits

Employees receiving PTD benefits may also receive supplemental benefits in the amount of 5 percent of the PTD benefit amount per year. See s. 440.15(1)(f), F.S. Although there is no specific legislative intent with respect to these supplemental benefits, courts have interpreted them to be annual cost of living adjustments.

1993 Reforms

In 1993, the Legislature found that employers were experiencing dramatic increases in their worker's compensation costs and that the cost of workers' compensation medical care was rising at a greater rate than the rate of inflation. As a result, the Legislature found that there was a "financial crisis in the workers' compensation industry, causing severe economic problems for Florida's business community and adversely impacting Florida's ability to attract new business development to the state." In order to address these issues, the Legislature significantly reformed Florida's workers' compensation act in order to create a more efficient and self-executing act, "which is not an economic or administrative burden." Chapter 93-415, Section 2.

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

B. EFFECT OF PROPOSED CHANGES:

This bill proposes a variety of changes to the workers' compensation act. Specifically:

- wages earned at concurrent employment would be excluded from the average weekly wage calculation;
- for purposes of qualifying as a "catastrophic injury," Social Security disability eligibility would have to be made by the Social Security Administration and not Judges of Compensation Claims;
- instead of filing petitions for benefits (PFBs) with the Division, employees would be permitted to file PFBs directly with the local Office of the Judges of Compensation Claims and provide copies to the Division;
- pretrial hearings would have to be held within 45 days from the date of the PFB;
- individual self-insured employers would be allowed the choice of providing medical care through a managed care arrangement or without a managed care arrangement;
- PTD supplemental benefits would cease upon the age of 62 if an employee is eligible to receive Social Security disability or Social Security retirement benefits;
- contractors with 3 or more employees working on state contracts would be required to implement a drug-free workplace program;
- under drug-free workplace programs, initial drug tests would be allowed to be conducted on the employer's premises;
- as when compensation is provided under other federal compensation acts such as the Federal Employer's Liability Act, the Longshoreman's and Harbor Workers' Act, and the Jones Act, this bill would exclude employees covered by the federal Defense Base Act from coverage under Florida's workers' compensation act;
- the Division of Workers' Compensation would be authorized to contract with a private entity to perform its data collection function;
- the 120 day notice requirement for lump sum settlements would begin when the employer receives notice of the injury, rather than when the injury occurs;
- docketing judges and the docketing review process would be eliminated;
- insurers would be authorized, if the employee consents, to transfer workers' compensation benefit payments electronically to the employee's bank account or to a bank account set up for the employee;
- rehabilitation providers would be granted access to employee medical records;
- reporting of medical information to the Division of Workers' Compensation would be required only upon the request of the Division;
- the time for carrier payment after final orders of judges of compensation claims would be increased from 7 to 15 days;
- the requirement that managed care grievance procedures be exhausted before a petition for benefits can be filed would be clarified;

- the WCJUA could use policyholder surplus from any year to eliminate deficits;
- the premium base for assessments would be defined as expressly including premiums ceded to reinsurers and the full policy premium value of large-deductible policies;
- an inadvertent omission relating to the liability of WCJUA board members would be corrected; and
- the First District Court of Appeal would be required to establish a specialized division to hear all appeals from judges of compensation claims, either exclusively or along with other appeals.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

N/A

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

Yes. The bill authorizes the Division of Workers' Compensation to contract with a private entity to perform its data collection function.

The bill permits employees to file PFBs directly with the appropriate local Office of the Judges of Compensation Claims. As a result, the Division of Workers' Compensation would no longer send PFBs received to the judges of compensation claims.

The bill requires contractors, regulated in Parts I and II of chapter 489, with more than three employees performing construction work on a state contract in excess of $10,000 to implement a drug-free workplace program.

The bill requires the First District Court of Appeal (DCA) to establish a specialized division to hear all appeals from judges of compensation claims. According to the bill, this specialized division need not hear appeals from judges of compensation claims exclusively -- this specialized division could hear other administrative appeals as well. Since the First DCA discontinued its practice of hearing appeals from judges of compensation claims within an administrative division, this bill would result in the First DCA recreating this division or one similar to it.

Lastly, the bill eliminates the docketing review process before a petition for benefits reaches the presiding judge of compensation claims. This would free up the judges of compensation claims who were performing docketing review and enable them to preside over cases.

(3) any entitlement to a government service or benefit?

Yes. Employees whose injuries are covered by the federal Defense Base Act would not be eligible to receive benefits under Florida's workers' compensation act.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

This bill authorizes the Division of Workers' Compensation to contract with a private entity to perform its data collection functions. The data collection includes collecting information on employers' proof of insurance coverage and information relating to policy cancellation and expiration. Presently, this function is already performed in the private sector by statistical agents and rating organizations.

(2) what is the cost of such responsibility at the new level/agency?

Not estimated.

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

The bill restates the assessment premium base for the Workers' Compensation Administration Trust Fund and the Special Disability Trust Fund in response to the recent interpretation by some carriers that premiums ceded (or transferred) to a reinsurer are not assessable. This bill also requires carriers to report premiums as the full policy premium value before the application of any deductible discounts. According to the Division, these changes will result in an increase in the total industry-wide assessment premium base, and also in a reduction in the WCATF assessment percentage from the current 2.75 percent to approximately 2.05 to 2.2 percent. Whether these changes result in an increase in the assessments paid by a carrier depends on the practice of that individual carrier.

For example, carriers no longer reporting ceded premiums to the Division could experience an increase in their assessment. Assume that carrier "A" reported $20 million in premium in 1996, which included $10 million of ceded premium. Then, based on a recent insurance company interpretation of the assessment base, carrier "A" reports only $10 million in premium in years thereafter ($20 million less the $10 million in ceded premium). The effect of this bill would be to require carrier "A" to include the ceded premium and report the full $20 million as it did in 1996. Therefore, assuming the assessment percentage was the same as in 1996, carrier "A"'s assessment would increase to the level it paid in 1996. To the extent the assessment percentage has increased since 1996 to account for the reduced assessment base, carrier "A" would pay more than it did in 1996.

However, carriers who do not cede premiums to a reinsurer, or who continue to include ceded premiums in reports to the Division, could experience a decrease in their assessment. For example, assume that carrier "B" has reported $20 million in premiums to the Division since 1996 and did not alter its reporting based on the interpretation that ceded premiums are unassessable. Also assume that:

- the total industry-wide premium base has increased due to other carriers re-including ceded premiums in their reports to the Division; and
- the assessment percentage has decreased as a result of the increased premium base.[1]

Under this scenario, carrier "B"'s assessment would decrease because although the reported premium has not changed, the assessment percentage has decreased.

[1] The Division of Workers' Compensation's annual assessment percentage is developed annually based on the amount of the expenses of administration for the preceding year and the total amount of premiums available for assessment. If the assessment premium base is increased, the assessment percentage would not have to be as high in order to generate the same amount of funds.

In addition, this bill could increase the assessment for carriers who write large-deductible policies. When a carrier writes a policy for an employer with a large-deductible, the premium the employer would normally pay is discounted because of the amount of risk the employer is willing to take per claim. Currently, the carrier reports for assessment purposes the premium paid by the employer after applying the deductible discount. Since the bill requires carriers to report the full policy premium value prior to application of deductible discounts, carriers who write large-deductible policies will have to report more premium for purposes of assessments. Therefore, assuming the assessment percentage remains the same, the carrier would pay a higher assessment.

However, this bill could decrease the assessment for carriers who do not write large-deductible policies. Assume carrier "C" did not write large deductible policies and reported to the Division $20 million in premiums in 1998. As in the above example, also assume that the total industry-wide assessment premium base increases as a result of carriers reporting more premium and that the assessment percentage decreases. Under this scenario, carrier "C" would pay a lower assessment next year, even though it reported the same amount of premiums. .

b. Does the bill require or authorize an increase in any fees?

See s. C.2.a, *supra*.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

Yes. Employees whose injuries are covered under the federal Defense Base Act would not be eligible to receive benefits under Florida's workers' compensation act.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

No.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/ associations to conduct their own affairs?

Yes. The bill permits employers with drug-free workplace programs, pursuant to rules developed by the Agency for Health Care Administration, to conduct initial drug tests on the employer's premises instead of having to use a laboratory.

The bill also permits individually self-insured employers to provide workers' compensation medical benefits either through managed care arrangements or without managed care arrangements. In effect, this enables individually self-insured employers to manage the care of their injured employees without having to comply with s. 440.134, F.S., and without supervision from the Agency for Health Care Administration.

Finally, the bill permits carriers, with the employee's authorization, to electronically transmit benefit payments to the employee's bank account or to a bank account set up by the carrier for the employee.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

Yes. The bill requires contractors, regulated in Parts I and II of chapter 489, with more than three employees performing construction work on a state contract in excess of $10,000 to implement a drug-free workplace program. As a result, these contractors may no longer perform work on state construction contracts without implementing a drug-free workplace program.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

The bill does not purport to provide services to families or children.

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

No.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

The bill does not create or change a program providing services to families or children.

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

This bill amends ss. 440.02, 440.09, 440.102, 440.12, 440.13, 440.134, 440.14, 440.15, 440.185, 440.192, 440.20, 440.25, 440.271, 440.34, 440.45, 440.49, 440.51, and 627.311, F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1: Amends s. 440.02, F.S., relating to definitions under chapter 440.

Concurrent Employment

Currently, the term "wages" is defined in the workers' compensation law to include wages earned on the job where the employee is injured and wages earned on any concurrent employment where the employee is also subject to workers' compensation coverage.

Workers' compensation indemnity benefits are calculated based on the employee's "average weekly wage" (AWW) which is governed by s. 440.14(1), F.S. The AWW is an average of the wages earned by the employee over the 13 week period preceding the injury. Since the term "wages" includes all wages from both employment where the injury occurred and wages earned at any concurrent employment, the carrier for the employer where the injury occurred may be paying indemnity benefits to the employee based on wages that the employee is still earning at the concurrent employment.

This section, along with section 7 of the bill, would modify the definition of the term "wages" to exclude any wages the employee continues to earn at the concurrent employment. Section 7 would provide that if lost wages from concurrent employment are to be used in the AWW calculation, the employee must provide evidence of the loss of earnings to the employer or carrier within 45 days of the injury, and failure to provide such information will result in the exclusion of the loss of earnings from the AWW calculation.

"Catastrophic Injury"

Section 440.02(37), F.S., currently defines the term "catastrophic injury" which serves as the primary basis for determining whether an employee is eligible to receive permanent total disability benefits. According to this definition, a "catastrophic injury" is a permanent impairments constituted by:

- spinal cord injury, involving severe paralysis of an arm, a leg, or the trunk;
- amputation of an arm, hand, foot, or leg involving the effective loss of that appendage;
- severe brain or closed-head injury;
- second degree or third degree burns of 25 percent or more of the 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 otherwise qualify under this chapter of a nature and severity that would qualify an employee to receive federal social security disability benefits.*

Based on this definition, some judges of compensation claims are themselves applying the federal Social Security disability criteria to claimants in order to determine whether a claimant (who has not yet been determined eligible by the Social Security Administration) would otherwise qualify for Social Security disability benefits.

According to the Social Security Administration, the average length of time from the initial application for Social Security disability to a determination by an administrative law judge is approximately 18 months.

The Office of the Judges of Compensation Claims could not estimate the average period of time from the filing of a petition for benefits to a disability determination in a workers' compensation permanent total disability case. However, based on staff conversations with the Office of the Judges of Compensation Claims, the average length of time from the *receipt* of a petition for benefits by a judge of compensation claims to a final hearing in all workers' compensation cases is 8 to 9 months. This estimation does not include the period of time from the filing of the petition for benefits with the Division to the time when the presiding judge of compensation claims first receives the case, which

according to the Office of the Judges of Compensation Claims can take up to a month. Moreover, this estimation does not take into consideration cases in the Miami district, which due to a backlog in mediation, are taking an average of 6 months longer to reach final hearing.

This section would also modify the final category of eligibility for "catastrophic injury" so that an injury is not deemed "catastrophic" unless the Social Security Administration, not judges of compensation claims, determines an employee eligible for Social Security disability benefits. The section also would require the injury which serves as the basis for eligibility for Social Security disability benefits to have a causal connection with the compensable workers' compensation injury.

Section 2: Amends s. 440.09, F.S. Under current law, employees whose workplace injuries are covered by federal compensation acts such as the Longshoremen's and Harbor Worker's Act, the Jones Act, or the Federal Employer's Liability Act are precluded from recovering benefits under Florida's workers' compensation act.

This section would add the federal Defense Base Act to this list of federal compensation acts which, if applicable, preclude an employee's recovery under Florida's workers' compensation act. Employees who are covered by the Defense Base Act include employees of military installations.

Section 3: Amends s. 440.102, F.S., relating to drug-free workplace programs. Employers are not required to implement a "drug-free workplace" program in their place of business. However, the Legislature promotes the implementation of "drug-free workplace" programs in order to increase employers' productivity and discourage the use of drugs. Employers who implement a "drug-free workplace" program, are granted a 5 percent credit on their workers' compensation premiums. The employer must:

(1) provide written notice to all employees and job applicants containing information relating to the employer's policy on drug use, the types of drug testing an employee or job applicant may be required to submit to, the consequences of positive drug tests, common medications which may alter a drug test, and confidentiality; and

(2) conduct drug testing in certain circumstances including first-time job applicants, upon reasonable suspicion, and as a part of routine fitness-for-duty examinations.

Section 440.102, F.S., contains detailed procedures and employee protections for collecting specimens and conducting drug tests. These procedures currently require both the initial and confirmation drug test be conducted by a licensed or certified laboratory.

This section would authorize employers to have the initial drug test conducted on the employers' premises instead of by a licensed or certified laboratory as long as the employer utilizes trained persons to collect specimens and conduct drug tests and follows statutory requirements and Agency for Health Care Administration rules and guidelines such as those relating to handling, chain of custody, and recordkeeping. This section would also require all drug tests producing positive results be confirmed at a licensed or certified laboratory before the employer could take any action against the employee or job applicant.

In addition, this section would require all contractors, as defined and regulated in Chapter 489, F.S., with more than three employees who perform construction work under a state contract in excess of $10,000, which is let pursuant to Chapter 235 (educational facilities), 255 (public property and publicly owned buildings), or 944 (state correctional system), F.S., to implement a drug-free workplace program in accordance with s. 440.102, F.S.[2]

Section 4: Amends s. 440.12, F.S. Currently, Florida law requires carriers to pay workers' compensation benefits to employees by check, which is then mailed to the employee or the employee's attorney, if the employee is represented by counsel. This process can result in delayed

[2] Parts I and II of Chapter 489, F.S., regulate construction contracting and electrical and alarm system contracting, respectively. Statutory authority to contract with the state for construction work exists in Chapters 235 (educational facilities), 255 (public property and publicly owned buildings) and 944 (state correctional system).

payments to employees as a result of incorrect mailing addresses and in the assessment of penalties against carriers for late payments.

In recent years, it has become common for many types of bank transactions and payments to be made electronically. For example, many employers, including the State of Florida, electronically deposit paychecks into employees' bank accounts. This not only reduces administrative costs associated with writing checks, it gives employees access to their money more quickly.

This section, along with a portion of section 11 of the bill, would authorize carriers, with the consent of the employee, to electronically transfer workers' compensation benefit payments to employees' bank accounts or to bank accounts set up for the employees.

Section 5: Amends s. 440.13, F.S. Currently, under s. 440.13(4)(b), F.S., all medical bills or reports obtained or received by the employer, carrier, or employee, relating to the remedial treatment or care of the injured employee, including any report of an examination, diagnosis, or disability evaluation, are required to be filed with the Division of Workers' Compensation. By rule, the Division requires this information to be sent to the Division within 30 days after each medical bill is paid. See Rule 38F-7.602(3)(b), Florida Administrative Code. This information is compiled by the Division into a report which is then sent to the Three-Member Panel for purposes of establishing reimbursement schedules.

Section 440.13(4)(c), F.S., also currently provides that it is the policy of the administration of the workers' compensation system that there be reasonable access to all medical information by all parties to facilitate the self-executing features of the workers' compensation law. Section 440.13(4)(c), F.S., specifically lists the persons who are to have access to the employee's medical information, including the employer, the carrier, and the attorney for either of them.

This section would modify the medical bill reporting requirement so that medical information would be provided only upon the request of the Division.

This section would also add rehabilitation providers to the list of persons who would have access to an employee's medical information.

Section 6: Amends s. 440.134, F.S. Section 440.134, F.S., is the workers' compensation managed care statute. Since January 1, 1997, all employers have been required to provide workers' compensation medical treatment to their injured employees through a workers' compensation managed care arrangement (MCA) approved by the Agency for Health Care Administration (AHCA). The purpose behind workers' compensation managed care was to control the escalating cost of medical expenses in the workers' compensation system. An MCA is a contractual arrangement between an insurer and a health care provider designed to provide medical care to injured employees under workers' compensation. In order for AHCA to approve an insurer's MCA, the insurer must file a plan of operation which meet the requirements of s. 440.134(5) and (6), F.S. These sections require the plan of operation to contain evidence that:

- Medical services can be provided with reasonable promptness with respect to geographic location, hours of operation, and after-hour care.
- The number of providers in the MCA service area are sufficient;
- There are written agreements with providers describing specific responsibilities.
- Emergency care is available 24 hours a day and 7 days a week.
- There are written agreements with providers prohibiting such providers from billing or otherwise seeking reimbursement from any injured worker.

The plan of operation must also include:

- A statement or map providing a clear description of the service area.
- A description of the grievance procedure to be used.
- A description of the "quality assurance program" which assures that health care providers render quality care;
- Written procedures to provide the insurer with timely medical records and information.
- Written procedures and methods to prevent inappropriate or excessive treatment.
- Written procedures and methods for the management of care by a medical care coordinator.

- Evidence that appropriate health care providers and administrative staff of the insurer's MCA have received training and education regarding workers' compensation;
- A description of the use of workers' compensation practice parameters for health care services when adopted by the agency.

Section 440.134(15)(g), F.S., also requires insurers to report to AHCA regarding its grievance procedure activities for the year.

AHCA may suspend the authority of an insurer to offer an MCA, if it finds: the insurer is in substantial violation of its contracts; the insurer knowingly utilizes a provider who does not have an existing license or other authority to furnish health care services; the insurer no longer meets the requirements for the authorization as originally issued; or the insurer has violated any lawful AHCA rule or order or statute.

Florida law presently allows individual employers, who can demonstrate the financial ability, to insure themselves for workers' compensation coverage. These employers are typically very large employers. Individually self-insured employers, unlike employers who are covered by an insurance company, pay medical and indemnity benefits to employees directly from their own funds. As such, individually self-insured employers may have more of an incentive than insured employers to closely manage workers' compensation medical costs.

This section would allow self-insured employers to furnish workers' compensation medical care either through managed care arrangements or without managed care arrangements. This section, in effect, would permit individually self-insured employers to "opt out" of the managed care requirements.

Section 7: Amends s. 440.14, F.S. See section 1 of the section-by-section analysis.

Section 8: Amends s. 440.15, F.S., relating to the payment of compensation for disability. Currently, injured employees who receive PTD benefits are also entitled to receive PTD supplemental benefits. PTD supplemental benefits give injured employees a 5 percent increase on their benefits each year in order to combat inflation and ensure that the benefits retain the same level of purchasing power. Section 440.15 (1), F.S., provides that supplemental benefits will cease at age 62, if the employee is eligible for social security benefits under 42 U.S.C. ss. 402 and 423, whether or not the employee has applied for such benefits.

In Burger King Corporation/CIGNA Insurance Company v. Moreno, 689 So.2d 288 (Fla. 1997) the First District Court of Appeal held that the provision that supplemental benefits cease at age 62 if the claimant is eligible for social security retirement benefits and social security benefits, did not preclude award of permanent total disability supplemental benefits to a 69 year-old claimant who was receiving social security retirement benefits, but not social security disability benefits. Social security disability benefits are not payable to any individual who has attained retirement age (65 years of age). Accordingly, the claimant was not eligible for social security disability benefits at the time she became permanently and totally disabled and would never be eligible for such benefits. After the Burger King decision, supplemental benefits would cease only for persons between the ages 62 and 65--because only they could ever qualify for both social security disability and social security retirement benefits.

However, based on staff conversations with the Social Security Administration, an employee cannot be eligible to receive both Social Security disability and Social Security retirement benefits at the same time -- rather Social Security disability benefits convert into Social Security retirement benefits at retirement age. Therefore, the literal interpretation of the current statute appears to base the termination of PTD supplemental benefits on a condition which cannot occur.

Workers injured prior to July 1, 1984, and determined to be PTD receive supplemental benefits from the Division of Workers' Compensation. Workers injured after July 1, 1984 receive supplemental benefits from their employers. The Division of Workers' Compensation is currently making such payments to approximately 3400 persons.

*This section would require termination of supplemental benefits at age 62 if the employee is eligible for either social security disability benefits **or** social security retirement benefits, rather than be eligible to receive both.*

Section 9: Amends s. 440.185, F.S. Presently, s. 440.185(7), F.S., requires carriers to file policy information (sometimes referred to as "proof of coverage" data) with the Division of Workers' Compensation. Pursuant to ss. 440.185(7) and 440.42(2), F.S., carriers are also required to file all notices of cancellation and expiration of policies with the Division. These statutory requirements are currently met by carriers by making a paper filing of this information with the Division. In addition to this paper filing, however, carriers also report this same information to rating organizations, such as the National Council on Compensation Insurance and Insurance Data Resources, for ratemaking purposes. Due to the more advanced technology of the rating organizations, this latter filing is usually made electronically.

This section would authorize the Division of Workers' Compensation to contract with a private entity to collect the policy information and receive the notices of cancellation and expiration.

Sections 10: Amends s. 440.192, F.S. This section currently directs employees to file petition for benefits (PFB) with the Division of Workers' Compensation, who then sends the PFB on to a docketing judge, where it is reviewed before being forwarded to the judge of compensation claims who will preside over the dispute.

Current law also requires employees who have disputes over medical issues, and who are under a managed care arrangement, to exhaust all managed care grievance procedures prior to filing a PFB. Despite this requirement, some judges of compensation claims are not dismissing PFBs even though managed care grievance procedures have not been exhausted.

After a PFB has been filed by an employee, current law gives the carrier 14 days to either pay the benefits, without prejudice to its right to deny the claim within 120 days, or file a "notice of denial." Many carriers file "notices of denial" and also pay benefits while they investigate the claim. When this happens, the employee will receive benefits, but also will receive a copy of a "notice of denial." According to some carriers, this is confusing to the employee.

This section of the bill modifies the process for filing a PFB so that the employee would file the PFB directly with the appropriate local Office of the Judges of Compensation Claims and provide copies to the employer, carrier, and Division of Workers' Compensation. This section requires the Division to inform employees of the locations of the appropriate local Offices of the Judges of Compensation Claims. This section also clarifies the requirement that managed care grievance procedures be exhausted before the filing of a PFB by requiring the employee or the employee's attorney to certify on the PFB that all managed care grievance procedures were exhausted. This section also provides that any PFBs lacking this certification shall be dismissed without prejudice. Lastly, this section, a portion of section 11, and section 14 of the bill, change the phrase "notice of denial" to a "response to petition" in order to avoid the confusion that occurs when a carrier responds to a PFB but pays benefits.

Section 11: Amends s. 440.20, F.S., relating to time for payment of compensation.

See section 4 of the section-by-section analysis for a discussion of the electronic transfer of benefit payments.

Current law states that if carriers do not pay benefits awarded by a judge of compensation claims within 7 days of the order, then they must pay a 20 percent penalty. Section 440.20(7), F.S. Some carriers suggest this is an insufficient amount of time within which to make payment to the employee.

Under current law, carriers are authorized to settle the entire case with an injured employee, which includes all future medical and indemnity payments owed to the employee. These are referred to as lump sum settlements. Section 440.20(11)(a), F.S., states that a lump sum settlement is not allowed unless the employer files a notice of denial within 120 days of the date of injury. Section 440.20(11)(a), F.S., also requires the judge of compensation claims to hold a hearing to determine whether there is a justiciable controversy and to approve the lump sum settlement.

This section of the bill would extend to 15 days, the time period for a carrier to make payment after a judge of compensation claims order. This section would also changes the 120 day requirement for lump sum settlements so that the 120 day period begins to run when the employer receives notice of the injury, rather than from the date of the injury. Finally, this section would remove the requirement that there be a hearing on lump sum settlements under 440.20(11)(a), F.S., where the claimant is represented by an attorney and where all parties agree to forego a hearing.

See section 10 of the section-by-section analysis for a discussion of the changing of the phrase "notice of denial" to "response to petition."

Section 12: Amends s. 440.25, F.S. Currently, the worker's compensation law sets forth a statutory timeline which determines when events in the litigation process are to take place. For example, current law requires a mediation conference to be held within 21 days of the filing of the petition for benefits. In addition, the law requires that the judge of compensation claims hold a final hearing within 45 days of the pretrial hearing. However, there is no statutory requirement relating to when the pretrial hearing must be held.

This section would require the judge of compensation claims to hold a pretrial hearing within 45 days of the filing of the petition for benefits.

Section 13: Amends s. 440.271, F.S. Under current law, orders of judges of compensation claims are appealable to the First District Court of Appeal (DCA). In recent years, the First DCA, by local rule approved by the Supreme Court, heard cases in three divisions. One of these divisions was an administrative division, which heard all administrative appeals, including workers' compensation cases. Beginning in January, 1999, the First DCA discontinued the practice of hearing cases in divisions. As a result, workers' compensation cases may be heard by any of 15 different judges.

This section would require the First DCA to establish a specialized division which would hear all appeals from orders of judges of compensation claims. This section would authorize the First DCA to structure this division to hear either workers' compensation cases exclusively or in addition to other appeals.

Section 14: Amends s. 440.34, F.S. See section 10 of the section-by-section analysis for a discussion of the changing of the phrase "notice of denial" to "response to petition."

Sections 15 and 16: Amends s. 440.49 and 440.51, F.S.

The Division of Workers' Compensation is responsible for the administration of Florida's workers' compensation system. The Division's funding comes from the Workers' Compensation Administration Trust Fund (WCATF). The money in the WCATF comes from an annual assessment on all workers' compensation carriers (which includes insurers, group self-insurance funds, and individual self-insured employers).

The Special Disability Trust Fund (SDTF), also called the "second injury" fund, was created in 1955 as an incentive for employers to hire employees with pre-existing physical impairments. If an

employee with a pre-existing injury was injured on the job, employers could make a claim to the SDTF to have a portion of the workers' compensation claim reimbursed by the SDTF. The funding for the SDTF also comes from assessments on workers' compensation carriers (including insurers, group self-insurance funds, and individual self-insured employers).

The assessment for the WCATF is currently based on the "net premiums collected" by carriers. The assessment for the SDTF is based on "net premiums written" by carriers. Historically, carriers have reported all premiums to the Division for these two assessments, including premiums ceded to reinsurers. However, recently some carriers have interpreted the phrase "net premiums collected" to exclude premiums ceded to reinsurers. As a result of this interpretation, some carriers are reporting less premium for purposes of assessment and are requesting refunds of past assessments. According to the Division, approximately $26 million in refunds covering the current year and past years have been requested. Due to the assessment percentage cap for both the WCATF and SDTF assessments, the Division estimates that the reduced premium base may cause the Division to have a shortfall in funding for the administration of the workers' compensation system and may lengthen the amount of time necessary to pay off SDTF claims.

Additionally, in recent years many large individually self-insured employers have discontinued their self-insured status and purchased large-deductible insurance policies from an insurer. According to the Division, the number of individually self-insured employers has shrunk from approximately 670 in 1996 to approximately 460 in 1998. Also, according to the Division, the market share of individually self-insured employers has also dropped from 39.7 percent in 1996 to 28 percent in 1998. The impetus for the switch to a large-deductible policy is the manner in which assessments for the SDTF and WCATF are calculated. Each of these assessments are based on premium -- either the direct gross premium written by an insurer (for insurance companies) or the premium a self-insurer would pay if insured (for individually self-insured employers). Switching to a large-deductible policy from self-insured status eliminates the assessment for the previously self-insured employer. Instead, the assessment is paid by the employer's new insurer based on the direct premium written, which is much smaller than the normal premium calculated for the individually self-insured employer because of the size of the deductible. According to the Division, the premium base, which serves as the basis for SDTF and WCATF assessments, has been reduced as a result of self-insured employers moving to large-deductible policies.

Since there have been some recent interpretative differences, these sections would define the phrases "net premiums collected" and "net premiums written" to include premiums ceded to reinsurers. In addition, these sections would also require that carriers, when reporting premium for purposes of these assessments, report the full premium value of the policy before applying any deductible discounts.

Section 17: Amends s. 627.311, F.S. The Florida Workers' Compensation Joint Underwriting Association (FWCJUA) is the residual market for workers' compensation insurance. The FWCJUA provides insurance coverage to those employers who cannot find coverage in the voluntary workers' compensation insurance market. Employers in the FWCJUA are typically higher risk employers -- i.e., very small employers and employers who have a high incidence of workplace injuries. The FWCJUA is funded by policyholder premiums and policyholder assessments and does not assess insurers to eliminate its deficits.

This section permits the FWCJUA to eliminate deficits through the use of policyholder surplus attributable to any year.

Under current law, board members of the FWCJUA are insulated from liability for monetary damages for any vote, decision, or failure to act regarding the management or policies of the plan, unless the member's breach or failure to perform constitutes a violation of criminal law. The law goes further to provide that even where a board member's breach or failure to perform constitutes a violation of criminal law, the board member is not liable for monetary damages if the member "had reasonable cause to believe her or his conduct **was** unlawful." As a result, current law appears to grant civil immunity to a FWCJUA board member if the board member reasonably believed he or she was committing a crime.

This section would correct this inadvertent error by inserting the word "not" before the word "unlawful." As a result, under this section a board member of the FWCJUA would receive immunity from civil liability only where the board member reasonably believed his or her conduct was ***not criminal****.*

Section 18: Amends s. 440.45, F.S. Under current law, petitions for benefits are filed with the Division of Workers' Compensation, which then sends the petitions for benefits to docketing judges, who review them before they are sent to the judges of compensation claims. According to s. 440.45(3), F.S., docketing judges review the petitions for benefits to determine whether they contain all of the necessary statutory elements and whether they comport with procedural rules. Docketing judges can dismiss petitions that do not meet the requirements of law or procedure, however, dismissals are without prejudice unless the docketing judge offers the parties an opportunity to appear and present argument.

This section would repeal subsection (3) of s. 440.45, F.S., and as a result delete docketing judges from the statute. This section would also result in the judges of compensation claims receiving the petitions for benefits directly from the employee, as prescribed in section 10 of this bill.

Section 19: Provides an effective date of October 1, 1999, except as otherwise provided in the bill.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

N/A

2. Recurring Effects:

The fiscal impact of the bill is indeterminate.

The bill eliminates the docketing review process, thereby freeing up at least two judges of compensation claims who performed docketing review to assume different responsibilities. The ability of these judges of compensation claims to take on new responsibilities may result in an increase in the number of cases which could be heard by the Office of Judges of Compensation Claims. This change would not produce a cost savings unless the elimination of docketing review justified a reduction in the number of judges of compensation claims.

The bill also authorizes the Division to contract with a private entity for the collection of policy information and receipt of notices of cancellation and expiration. A private entity may be able to perform these functions at a lower cost. However, the amount of savings produced by this change is indeterminate since it is not known how much a private entity would charge to perform these functions.

This bill defines the Division's assessment base for the WCATF and SDTF assessments so that premiums reported to the Division would include the premiums ceded to reinsurers. The bill also requires premiums for the WCATF and SDTF assessments to be reported as full policy premium value before the application of deductible discounts. According to the Division, these changes will result in an increase in the amount of premiums reported for assessment purposes from an estimated $2.714 billion in the 1999 fiscal year to approximately $3.2 to $3.4 billion the following year. According to the Division, this increase in premium will translate into a reduction in the WCATF assessment percentage from 2.75 percent to approximately 2.02 to 2.2 percent.

Absent the bill, the Division would probably be able to raise enough funds to administer the workers' compensation system by simply raising the assessment percentage (which is currently at 2.75 percent) for the next couple of years. However, the Division estimates the premium base would eventually shrink to the point where, given the current statutory assessment cap of 4 percent, the Division would not be able to raise enough money to administer the workers' compensation system. The changes made in the bill enable the Division to generate the assessments necessary to administer the workers' compensation system without reaching the 4 percent cap.

3. Long Run Effects Other Than Normal Growth:

   N/A

4. Total Revenues and Expenditures:

   N/A

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

   N/A

2. Recurring Effects:

   N/A

3. Long Run Effects Other Than Normal Growth:

   N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   This bill defines the Division's assessment base for WCATF and SDTF assessments so that premiums reported will not be reduced by the amount of premiums ceded to reinsurers. The bill also requires premiums for the WCATF and SDTF assessments to be reported as full policy premium value before the application of deductible discounts. These changes could result in an increase in assessments for carriers who currently do not report premiums ceded to a reinsurer and who write large-deductible policies. However, those carriers not ceding premiums to a reinsurer and those carriers currently reporting premiums ceded to a reinsurer could receive lower assessments as a result of this bill.

   The bill also requires contractors, regulated in Parts I and II of chapter 489, with more than three employees performing construction work on a state contract in excess of $10,000 to implement a drug-free workplace program. As a result, these contractors will be required to expend resources in order to implement a drug-free workplace program. However, the funds expended by these contractors may be offset, at least in part, by the 5 percent premium credit received on workers' compensation insurance for implementing a drug-free workplace program.

2. Direct Private Sector Benefits:

   The bill permits employers with drug-free workplace programs, pursuant to rules developed by the Agency for Health Care Administration, to conduct initial drug tests on the employer's premises using trained personnel instead of having to use a licensed or certified laboratory. If the cost of conducting the initial drug test on site is less costly than paying a laboratory to conduct the initial drug test, this may result in a cost savings for employers.

   The bill also authorizes carriers, with the consent of the employee, to pay benefits electronically. This could result in a cost savings for carriers because it may (1) eliminate the need to produce and mail a check to the employee, and (2) reduce the potential for penalties for late payments.

The bill permits individually self-insured employers to "opt-out" of the requirement of providing medical benefits through managed care arrangements. This may result in a cost savings for individually self-insured employers since they will no longer have to comply with the filing and approval requirements of s. 440.134, F.S.

In addition, since the bill is expected to increase the assessment premium base for the SDTF, the Division estimates that the gross revenue generated for the SDTF would be increased from the current $122 million to between $150 and $155 million. As a result of this revenue increase, the SDTF may be able to pay the existing claims in a shorter period of time.

3. Effects on Competition, Private Enterprise and Employment Markets:

N/A

D. FISCAL COMMENTS:

This bill defines the Division's assessment base for WCATF and SDTF assessments so that premiums reported will not be reduced by the amount of premiums ceded to reinsurers. The bill also requires premiums for the WCATF and SDTF assessments to be reported as full policy premium value before the application of deductible discounts. As a result, the bill may have an effect on carriers' assessments, depending on the individual carrier's practice. For a discussion of the bill's potential impact on carrier assessments, see section II. C. 2. a. of the analysis.

This bill would increase the assessment premium base, but it will not have a fiscal impact on the Division with respect to funds generated for the WCATF. This bill ensures that the Division's assessment base will not be lowered to the point where the statutory assessment caps would cause the Division to have a shortfall in funding. Currently, the WCATF assessment is 2.75 percent, which is below the statutory assessment cap of 4 percent. As such, this bill will not increase the amount of money raised by the Division for purposes of administration of the system -- rather it would change the distribution of the money collected from among the carriers.

Also, the Division has received audited refund requests for over $26 million from 5 insurance companies and self-insurance funds. The basic argument advanced by these companies is that they overpaid past assessments because they included premium ceded to a reinsurer when reporting their assessable premium. The bill's impact on these refund requests is indeterminate. If the bill enables the Division to successfully defend the current refund requests, the impact would be a savings of the $26 million. However, this would not take into account the money saved on future refund requests from all other carriers.

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

A. APPLICABILITY OF THE MANDATES PROVISION:

The bill does not require a city or county to spend funds or to take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the revenue raising authority of a city or county.

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

The bill does not affect the amount of state tax shared with cities and counties.

V. COMMENTS:

Judiciary Committee staff contacted the Office of State Court Administrator regarding the provision for divisions in the First District Court of Appeal. The Office of State Court Administrator did not take a position on the provision, but offered to take further review of the bill and prepare a fiscal note.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON INSURANCE:

Prepared by:	Staff Director:
Robert E. Wolfe, Jr.	Stephen Hogge

AS REVISED BY THE COMMITTEE ON JUDICIARY:

Prepared by:	Staff Director:
Michael W. Carlson	Don Rubottom