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HOUSE OF REPRESENTATIVES
AS REVISED BY THE
COUNCIL FOR COMPETITIVE COMMERCE
ANALYSIS

BILL #: CS/HB 1927 (PCB IN 01-04)

RELATING TO: Workers' Compensation

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

TIED BILL(S): None

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

(1) INSURANCE YEAS 14 NAYS 0
(2) COUNCIL ON COMPETITIVE COMMERCE YEAS 13 NAYS 0
(3)
(4)
(5)

I. SUMMARY:

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

Benefits: The Social Security eligibility standard for permanent total disability benefits would be removed; eligibility would be limited to persons with a "catastrophic injury" who are able show an inability to work based upon specified criteria; permanent partial disability impairment income benefits would be doubled; compensation for psychiatric impairments would be prohibited.

Dispute Resolution: The request for assistance would be eliminated; mediation would be required within 90 days of the petition; pretrial stipulations would be completed at the mediation; and final hearing would be required within 90 days of mediation or a maximum of 210 days from the date of petition. Benefits requested in a petition would be paid or denied by the 30th day after filing the petition, rather than the 44th day.

Procedure: Use of workers' compensation managed care arrangements would be permissive not mandatory. Employers and carriers would be permitted to negotiate fee contracts, in excess of the uniform reimbursement schedule. Carriers would be required to pay only for the claimant's first independent medical exam; one independent medical exam, per specialty, would be admissible.

Attorney's fees: Attorney's fees would be paid according to the statutory contingency fee schedule only; however, in medical-only cases an additional attorney's fee of up to $1,000 could be awarded. Attorney's fees would attach 30 days after filing the petition.

Exemptions: Only certain corporate officers in construction corporations would be permitted to elect to be exempt from workers' compensation coverage requirements. Effective January 1, 2004, sole proprietors and partnerships in the construction industry would be required to maintain minimum premium policies.

The council substitute would take effect January 1, 2001. The council substitute would have an indeterminate fiscal impact on state and local government.

On April 18, 2001, the Council for Competitive Commerce adopted one "remove everything" amendment and reported the bill as a council substitute. See section VI. for an explanation.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

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

The council substitute authorizes additional rulemaking authority. Please see section V. B. The council substitute would reduce government by eliminating mandatory use of workers' compensation managed care arrangements.

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

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

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

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

B. PRESENT SITUATION:

Basis for Workers' Compensation

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

Legislative Intent

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

Agency Jurisdiction

Department of Labor and Employment Security

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

- enforcing employer compliance with workers' compensation coverage requirements;
- overseeing reemployment of injured employees;
- monitoring and auditing the delivery of benefits;

- operating the Employee Assistance Office; and
- administering the Special Disability Trust Fund.

The Office of the Judges of Compensation Claims, within the Department of Labor and Employment Security, oversees 31 judges of compensation claims located throughout the state. These judges of compensation claims preside over the formal dispute resolution process.

Agency for Health Care Administration

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

Department of Insurance

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

Securing Worker's Compensation Coverage

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

1993 Reforms

In 1993, the Legislature found that 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.

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

Dispute Resolution

Despite the Legislature's intent, the workers' compensation system is not always self-executing and does not always deliver benefits in a quick and efficient manner. Disputes frequently arise between employees and employers or carriers. The workers' compensation system has several

mechanisms designed to deal with disputes, including an informal process through the Division's Employee Assistance Office, managed care grievance procedures, and a formal dispute resolution process before a judge of compensation claims. Florida law sets out specific time frames for resolving disputes through these mechanisms.

Committee on Insurance Staff Report -- "Resolving Workers' Compensation Disputes According to Statutory Time Lines: Policy Options for Consideration"

In October of 1999, the staff of the Committee on Insurance released a report, entitled "Resolving Workers' Compensation Disputes According to Statutory Time Lines: Policy Options for Consideration."[1] This report examines the workers' compensation dispute resolution system to determine the extent to which statutory time frames for workers' compensation cases were being met and raises various policy options for Members to consider. In this report, staff found:

- from beginning to end, dispute resolution took an average of 268 days -- more than twice the 120 days allowed in statute;
- presiding judges of compensation claims did not even receive petitions for benefits until 25 days after the petition was filed (which is 4 days after the statutory time for holding mediation);
- mediation occurred, on average, 138 days after the filing of the petition for benefits (117 days longer than the statute contemplates);
- approximately 85 percent of employees exited the dispute resolution process within 163 days by settling their cases prior to or during state mediation;
- the number of employees filing petitions for benefits remained stable, yet the number of petitions for benefits filed annually more than doubled from 1993; and
- numerous statutory requirements relevant to the dispute resolution process were not met or implemented as presumably intended by the Legislature.

The Task Force on Workers' Compensation Administration

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

Insurance Committee staff identified over fifty recommendations in the task force report. The task force summarized its recommendations as follows:

- continue to fund the system through assessments on premium;
- eliminate the Workers' Compensation Oversight Board;
- transfer the Division to the Department of Insurance;
- transfer the judges of compensation claims to the Department of Management Services, Division of Administrative Hearings;

[1] This staff report is available on Online Sunshine, the Florida Legislature's web site (www.leg.state.fl.us).

- eliminate the requirement of placing Division reserves with the State Treasury for investment purposes;
- conduct a complete audit of the Division's budget;
- eliminate construction exemptions and require all persons in the construction industry to be covered by workers' compensation insurance;
- eliminate the request for assistance;
- repeal mandatory managed care;
- allow only one independent medical exam per accident;
- eliminate the judge of compensation claims' discretion to award attorney's fees that exceed the statutory contingency fee schedule;
- prohibit attorney's fees for average weekly wage and medical mileage disputes;
- allow partial dismissal of petitions for benefits;
- require documentation to be submitted with petitions; and
- eliminate the judges of compensation claims' jurisdiction over medical bill disputes.

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

C. EFFECT OF PROPOSED CHANGES:

The council substitute would effect the following changes to the workers' compensation law:

Benefits

- removes the Social Security standard for eligibility for permanent total disability benefits from the definition of "catastrophic injury"; persons with a "catastrophic injury," as amended by the council substitute, who are unable to perform their prior job, a job available in substantial numbers in the national economy, or any gainful employment within a 100 mile radius of their home would be permanently totally disabled; the burden would be on the injured employee to show permanent total disability;
- allows injured workers receiving medical benefits outside of workers' compensation managed care to change doctors one time per accident, upon written request;
- prohibits the payment of compensation for psychiatric impairments, whether or not the psychiatric condition is preexisting;
- revises the calculation of the 13 week period that determines the employee's compensation rate;
- provides that persons who reach permanent total disability prior to the age of 62 would no longer receive supplemental income benefits after age 62; persons who reach permanent total disability after age 62 would continue to be eligible for permanent total disability benefits; and
- increases permanent partial disability impairment income benefits from half the compensation rate to the full compensation rate (66 2/3 of the employee's average weekly wage); requires impairment income to be paid biweekly, rather than weekly.

Dispute resolution

- eliminates the request for assistance;

- specifically authorizes the Division to contact the injured worker directly upon receipt of the notice of injury;
- authorizes the partial dismissal of petitions for benefits, without prejudice;
- replaces the "notice of denial" with a "response to petition" for purposes of granting or denying benefits requested by petition;
- revises the statutory dispute resolution time line;
- specifically authorizes the use of private mediation, upon agreement of the parties, prior to the date of mandatory mediation; allows the judge to require private mediation if a public mediator is not available to mediate the case within 60 days of the filing of the petition, and directs the judge to select a mediator, if the parties cannot agree on a mediator; repeals public mediation, effective January 1, 2003;
- requires the judge of compensation claims to report multiple continuances of the final hearing
- allows the entry of an abbreviated final order in cases where compensability is not denied;
- permits parties to request separate findings of fact and conclusions of law; requires the judge to issue requested findings of fact and conclusions of law within 14 days of request; and
- resolves medical-only claims less than $5,000 and medical mileage disputes through expedited dispute resolution.

Procedure

- allows employers and carriers to deliver medical benefits either through a workers' compensation managed care arrangement or outside of a workers' compensation managed care arrangement;
- allows employers and carriers who deliver medical benefits outside of workers' compensation managed arrangements to negotiate medical fees in excess of the uniform reimbursement schedule;
- provides that family members who provide non-professional attendant care will be paid at the rate of their regular employment, not to exceed the value of that care in the community;
- requires the carrier to pay for the claimant's first independent medical examination per accident, but permits each party to introduce the medical opinion of one independent medical examiner per specialty into evidence;
- revises the evidentiary standard for "occupational disease," repetitive trauma, and toxic injuries;
- further specifies the effect of the limitation of liability provided to employers who provide coverage for work-related injuries under chapter 440, F.S.;
- provides that when a third party may be liable for damages arising from a work-related injury, the carrier has no duty to preserve evidence;
- specifies that when a carrier is providing compensation when uncertain of its obligation to pay compensation, the carrier must comply with other provisions of statute that require payment of compensation within 14 days of receiving notice of the injury;
- requires that a request for medical care be filed before a "grievance" may be filed with a managed care arrangement and provides that the informal dispute resolution process is exhausted if the workers' compensation managed care arrangement does not respond to a grievance within 15 days of filing; permits 30 days for the "grievance" process;
- requires additional specificity for petitions for benefits and authorizes the Chief Judge to require additional specificity in petitions by rule;

- removes requirement that judge of compensation claims must approve lump-sum settlement agreements when the claimant is represented by an attorney; continues to require the judge of compensation claims to approve the attorney's fees when the claimant is represented by an attorney; requires judges of compensation claims to review all settlement proposals, stipulations, and agreements between the claimant and their attorney for compliance the provisions regulating attorney's fees;
- requires employers to report information on the injured workers' wages as part of the notice of injury;
- provides that continuance orders must set the rescheduled date by order; requires the judge of compensation claims to report multiple continuances of final hearings;
- prohibits the award of interest on unpaid medical bills;
- allows the medical reports of certain independent medical examiners into evidence;
- provides that safety programs implemented pursuant to an approved rating plan qualify for workers' compensation premium discounts; and
- restructures the Workers' Compensation Oversight Board.

Attorney's fees

- limits attorney's fees to the statutory fee schedule, but allows the judge of compensation claims to approve an additional attorney's fee in medical-only cases, up to a maximum of $1,000;
- prohibits the attachment of attorney's fees until 30 days after the employer or carrier receives the petition for benefits; and
- requires the reporting of attorney's fees to the Governor, the President of the Senate, and the Speaker of the House.

Exemptions

- allows construction corporate officers to elect an exemption from the coverage requirements of chapter 440, F.S, only if they are the corporate president, vice president, secretary, or treasurer and they own at least 10 percent of the corporation; and
- requires, effective January 1, 2004, sole proprietors and partnerships in the construction industry to secure workers' compensation coverage under chapter 440; construction sole proprietors and partners would continue to be able to elect to be excluded from the coverage requirements of chapter 440, F.S, but would have to carry coverage for any employees they may have or may hire.

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

The provisions of the council substitute would take effect January 1, 2002.

(Please refer to the section-by-section portion of this analysis for further detail.)

D. SECTION-BY-SECTION ANALYSIS:

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

PRESENT SITUATION – Certain "employees" may qualify for and elect an "exemption" under the workers' compensation law. In construction corporations, up to three corporate officers may elect an exemption from workers' compensation coverage. In a construction sole proprietorship, the sole proprietor may elect to be exempt from workers' compensation coverage. In construction

partnerships, up to three partners may elect an exemption from workers' compensation coverage. And in non-construction businesses, without limit, any corporate officer may elect to be exempt from workers' compensation coverage.

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

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

Persons with a "catastrophic injury" are presumed to be permanently and totally disabled. Workers' compensation pays less than 100 percent of an injured worker's prior average weekly wage for a limited number of weeks so that injured workers are encouraged to return to work. However, permanent total disabilities receive benefits until reemployment or death.

According to the NCCI's Annual Statistical Bulletin, 2000 Edition, Florida ranks near the top of forty-two states and Washington, D.C., in losses associated with permanent total disability.

- 2nd in rate of permanent total disabilities per 100,000 workers
- 2nd in percentage of overall costs that are permanent total disability
- 3rd in percentage of indemnity losses that are permanent total disability
- 3rd in percentage of medical losses that are permanent total disability

EFFECT OF SECTION – *The definition of "accident" would be amended to provide that an injury caused by a toxic substance would have to be proven by "clear and convincing" evidence, rather than to a "reasonable degree of medical certainty," in order to qualify for workers' compensation benefits. "Clear and convincing" evidence is a standard somewhere between the standard in civil court (i.e., "by a preponderance of the evidence") and the standard in criminal court (i.e., "beyond a reasonable doubt"). "Clear and convincing" evidence indicates that something is highly probable. "Reasonable degree of medical certainty" is established if a medical expert, perhaps the treating physician or an independent medical examiner, testifies that their medical opinion is to a reasonable degree of medical certainty.*

This section would amend the definition of "employee" to provide to allow only the president, vice president, secretary, or treasurer of a construction corporation who owns at least 10 percent of the business to elect an exemption from workers' compensation coverage requirements.

This section would also remove the Social Security standard from the definition of "catastrophic injury." Section 7 of the council substitute would provide for determination of permanent total disability in cases other than "catastrophic injury." This section does not affect the amount of benefits that permanently totally disabled workers receive; rather, it addresses how eligibility for permanent total disability is determined.

Section 2: Amends s. 440.06, F.S, to further specify the obligation of an employer to provide workers' compensation coverage in order to enjoy immunity from suit.

Section 3: Amends s. 440.09, F.S., to specify that causation in cases involving occupational disease and repetitive trauma must be established by clear and convincing evidence; rather than the current "reasonable degree of medical certainty" standard. "Clear and convincing" evidence is a

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

Current statute prohibits compensation for depression related to the loss of employment because of a work-related injury. This section would generally prohibit payment of compensation for psychiatric impairment.

This section would require all sole proprietors and partnerships actively engaged in the construction industry to secure workers' compensation coverage. Since sole proprietors and up to three partners in businesses actively engaged in the construction industry may elect to be excluded from workers' compensation coverage requirements, this requirement could be satisfied by securing a minimum premium policy that would provide workers' compensation coverage if the employer retains any employees.

Section 4: Amends s. 440.10(1)(a), F.S., to further specify that employers must secure workers' compensation coverage as provided by s. 440.38, F.S.

Section 5: Amends s. 440.11(1), F.S., to further specify the limits of the employer's immunity from lawsuit and responsibility to provide workers' compensation coverage.

Statute provides a limited exception to the employer's general immunity from tort liability. The employer's general immunity does not include injuries sustained as a result of the actions of a co-worker who is engaged in work unrelated to the injured employee. The "unrelated works" exception would be eliminated. In theses cases, the employer's liability would be limited to workers' compensation benefits.

The employer would be liable to the employee, in excess of the coverage requirements of workers' compensation, if the employer acts with intent to cause harm; "intent" would be defined for this purpose. If the employee recovers damages, either through award or settlement, against the employer, the employer would receive an offset for workers' compensation benefits provided to the employee. This section would also provide that the employer is not vicariously liable for the intentional acts of employees.

Section 6: Amends s. 440.13, F.S.

PRESENT SITUATION:

Attendant care. The workers' compensation law requires employers to provide "medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require. . . ." Family members may perform and be compensated for providing non-professional attendant care for the injured worker. Reimbursement for non-professional attendant care is made pursuant to statutory limits.

A family member who is unemployed prior to providing attendant care to the injured worker is paid the federal minimum hourly wage. A family member who quits a job to provide attendant care to the injured worker earns the rate of pay of the job they left, not to exceed the value of that attendant care in the community. Non-professional attendant care is capped at 12 hours per day. This system attempts to lower costs by encouraging the use of lower cost alternatives to professional attendant care.

The statute does not contemplate the rate of pay for a family member who maintains outside employment and provides attendant care to the injured worker. The First District Court of Appeal[2] has authorized family members who continue to work to be paid the full value of the care available in the community without regard to their regular rate of pay. Consequently, if two persons providing non-professional attendant care are working at the same rate of pay (outside the home) and one quits a job and the other does not; the one who continues to work may be paid a higher rate than the person who gave up their job.

Independent medical examinations. Injured workers are permitted one independent medical exam (i.e., a second opinion) per medical specialty. For example, an injured worker might receive an independent medical exam from an orthopedist, a neurologist, a psychiatrist, a podiatrist, a chiropractor, and so on. Only the medical opinions of independent medical examiners, a Division or judge appointed expert medical examiner, or the authorized treating provider are admissible before a judge of compensation claims. The carrier bears the cost of all independent medical examinations. The number of independent medical exams litigated in petitions for benefits increased almost seven fold between 1995 and 1999.[3]

Expert medical advisors. Chapter 440 provides for division certification of expert medical advisors. Expert medical advisors are used to aid the Division and the judges of compensation claims to fulfill their duties under the chapter. The Division is required to use expert medical advisors in peer review and medical consultations. A judge of compensation claims is required to utilize an expert medical advisor to resolve conflicts and disagreements between the opinions of health care providers, at the carrier's expense. The standard for admissibility of a medical opinion is a reasonable degree of medical certainty.

Managed care. Since 1997, all workers' compensation medical benefits have been required to be delivered through managed care arrangements. The vast majority of medical benefits are delivered in this manner; however, some employers reportedly continue to provide medical benefits outside of managed care arrangements. Under managed care, employees have the right, under statute, to change their treating physician once during the treatment of a work-related injury. Employees receiving medical benefits outside of a managed care arrangement do not have this right.

Medical fee payment. Generally, fees for medical benefits under workers' compensation are limited to the uniform reimbursement schedule adopted by the three-member panel. All fees for medical services are limited to the uniform reimbursement schedule except under workers' compensation managed care arrangements. Workers' compensation managed care arrangements are permitted to negotiate capitated contracts for the provision of future medical services.

EFFECT OF SECTION -- *Family members who maintain their present employment and provide attendant care would be compensated at the rate of their present employment, not to exceed the value of attendant care in the community.*

Parties would bear the costs of independent medical exams themselves; however, the carrier would pay the claimant's first independent medical examination. Each party would still be permitted to submit into evidence the medical opinion of one independent medical examiner per specialty. Also, the judges of compensation claims would be given the discretion over whether or not to order evaluations by expert medical advisors when resolving discrepancies between medical opinions. In the case of an occupational disease or repetitive trauma, a medical opinion would only be admissible if based on scientific principles generally accepted in the relevant medical specialty.

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[2] Office Depot, Inc. v. Sweikata, 737 So.2d 1189 (Fla. 1st DCA 1999)
[3] 2000 Dispute Resolution Report, Florida Department of Labor and Employment Security, Division of Workers' Compensation.

Upon written request, an injured worker receiving medical benefits outside of a workers' compensation managed care arrangement would be permitted to change the treating physician once from among three or more carrier-authorized physicians who are not professionally affiliated. Also, employers and carriers would be permitted to negotiate fee reimbursements in excess of the uniform reimbursement schedule.

Section 7: Amends s. 440.134, F.S.

PRESENT SITUATION -- Section 440.134, F.S., is the workers' compensation managed care statute. Since January 1, 1997, the use of workers' compensation managed care arrangements has been mandatory. The Agency for Health Care Administration approves all workers' compensation managed care arrangements. A workers' compensation managed care arrangement is a contractual arrangement between an insurer and a health care provider designed to provide medical care to injured employees under workers' compensation.

For the Agency for Health Care Administration to approve an insurer's workers' compensation managed care arrangement, the insurer must file a plan of operation that includes a description of the grievance procedures to be used. The term "grievance" is defined as "dissatisfaction with the medical care provided by an insurer's workers' compensation managed care arrangement health care providers, expressed in writing by an injured worker." See s. 440.134(1)(d), F.S.

Statute requires claimants to exhaust all managed care grievance procedures before filing a petition for benefits. There are no time frames in statute limiting the amount of time permitted to resolve grievances before filing a petition. There is, however, an Agency for Health Care Administration administrative rule that limits grievances to 60 days. Rule 59A-23.006, F.A.C., see also s. 440.192(3), F.S.

In the report, "Resolving Workers' Compensation Disputes According to Statutory Time Lines: Policy Options for Consideration," Insurance committee staff found many grievances were being filed with the managed care arrangement regarding medical care that had never been requested of the insurer. In other words, the first time an insurer became aware that an injured worker desired a particular provider or treatment was in a filed grievance.

EFFECT OF SECTION – *This section would permit employers and carriers to deliver medical benefits either through workers' compensation managed care arrangements or outside of workers' compensation managed care arrangements.*

This section revises the definition of "grievance" to provide that an injured worker must first request medical care from the insurer prior to filing a grievance.

This section also requires insurers and managed care providers to respond to injured workers' requests for medical care within 15 days of the date of the request. Then, if the request for medical care is denied, the injured worker may initiate the grievance process, which is presumed to be exhausted if the insurer does not notify the injured worker of the outcome of the grievance within 15 days from the date the grievance is filed.

Section 8: Amends s. 440.14(1)(a), F.S., to revise the method for calculating the employee's average weekly wage. The definition of "substantially the whole of 13 weeks" would be revised to mean the actual 13 weeks prior to, but not including, the date of accident; rather than a constructive 13 week period of 91 days preceding the accident.

Section 9: Amends s. 440.15, F.S.

PRESENT SITUATION -- Employees with permanent partial disabilities are eligible to receive either impairment income benefits or supplemental income benefits. Persons with some remaining impairment after they reach maximum medical improvement and are able to work after their injury have a permanent partial disability. Those persons with less than 20 percent impairment after maximum medical improvement receive half of their temporary disability benefits (one-third of their average weekly wage) for a period of three weeks per percentage of impairment; paid on a weekly basis. For example someone who averaged $600 per week prior to the injury and has a10 percent impairment would receive $200 a week (1/3 of $600) for 30 weeks (10 percentage points times three weeks) equaling an impairment income benefit totaling $6,000.

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

Please see section 1 of the section-by-section analysis for a discussion of "catastrophic injuries" and permanent total disability.

EFFECT OF SECTION – *This section would make permanent impairment benefits payable biweekly, rather than weekly. Also, permanent partial disability impairment income benefits would be increased to the full compensation rate (2/3 of the employee's average weekly wage). To follow the example above, someone who averaged $600 per week prior to the injury and has a 10 percent impairment would receive $400 a week (2/3 of $600) for 30 weeks (10 percentage points times three) equaling an impairment income benefit totaling $12,000*.

In conjunction with section 1 of the council substitute, this section would remove the Social Security eligibility standard from determinations of permanent total disability. If the employee does not suffer from an injury listed under the definition of "catastrophic injury," permanent total disability benefits would not be payable.

A person would be eligible for permanent total disability benefits if they are unable to perform their prior job or any job that is generally available in the national economy. If someone is capable of any gainful employment, they would not be eligible for permanent total disability benefits. The burden would be on the claimant to prove that they are unable to perform part-time sedentary employment, if that type of employment is available within a 100 mile radius of their home.

This section would overrule the First District's decision in the Burger King decision and codify their decision in the Wilkins case. Persons who reach permanent total disability would have their benefits cease at age 62, rather than 65, and persons who reach permanent total disability after age 62 would continue to receive supplemental benefits; s. 440.15(1)(f)1., F.S., would continue to be inapplicable to those persons. Please see section V. of this analysis.

This section would also specify that, in addition to the current prohibition on compensation for depression related to being out of work, compensation for preexisting psychological, mental, or emotional conditions would be prohibited.

Section 10: Amends s. 440.151(1) and (2), F.S, to provide that, as to injury or death related to tuberculosis among workers with a preexisting tuberculosis condition working at a state tuberculosis hospital, causation would have to be proven by clear and convincing evidence. As to occupational disease generally, epidemiological studies would be required to support causation.

Section 11: Amends s. 440.185, F.S., to provide that employers must submit the employee's earnings for the 13 weeks prior to the injury with the notice of injury.

Section 12: Amends s. 440.191, F.S.

PRESENT SITUATION – Statute requires injured workers to exhaust the informal dispute resolution process before filing a petition for benefits. The informal dispute resolution process includes the managed care grievance process and the request for assistance. The Employee Assistance Office within the Division oversees the request for assistance process. An injured worker files a request for assistance with the Employee Assistance Office which then has 30 days to help resolve the dispute. The Employee Assistance Office has the authority to investigate requests, facilitate agreements, and compel parties to attend conferences. No attorney's fees may be awarded for the 30 days allowed for the request for assistance process. According to the Division's *2000 Dispute Resolution Report*, less than 5 percent of issues presented by requests for assistance in 1999 were resolved. Also, the report also indicates that attorneys filed over 95 percent of the requests for assistance in 1999.

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

Section 13: Amends s. 440.192, F.S.

PRESENT SITUATION -- Employees must file petitions with the Division, which records certain information. The Division then sends the petition to a docketing judge, where it is reviewed before being forwarded to the judge of compensation claims presiding over the dispute. There is no standard petition form. According to the October 1999 Committee on Insurance staff report, "Resolving Workers' Compensation Disputes According to Statutory Time Lines: Policy Options for Consideration," this process took an average of 25 days -- 4 days longer than the statutory time for holding mediation.

Section 440.192(2), F.S., sets forth the specific information that must be contained in a petition for it to be considered. This section requires the Office of the Judges of Compensation Claims to dismiss any petition that does not contain all of the required information.

Section 440.192(5), F.S., relating to motions to dismiss, requires all motions to state with particularity the basis for the motion. This section, however, does not specifically permit judges of compensation claims to dismiss discrete portions of a petition.

Under current law, an employer or carrier answers the claimant's petition for benefits with a "notice of denial" within 14 days of receipt (at least 44 days from the request for assistance). However, the employer or carrier does not necessarily deny all of the benefits requested in the petition.

EFFECT OF SECTION -- *The council substitute would require claimants to file the petition for benefits directly with the Office of the Judges of Compensation Claims, instead of the Division. The judge of compensation claims would be permitted to partially dismiss petitions for benefits. Dismissals would be without prejudice and would not require a hearing.*

The council substitute would require petitions to contain the following additional specificity:

- *the date or dates of accident;*
- *the specific classification of the benefit denied;*
- *the date of request for mileage and a copy of the request;*
- *the doctor's request, authorization, or recommendation for treatment, if the claimant is under a doctor's care.*

The Chief Judge would also be given the authority to require additional specificity by rule.

In combination with portions of sections 14 and 15, the "notice of denial" would be renamed "response to petition" in those instances where a petition has been filed. The "notice of denial" would remain in use to address requests for benefits prior to the filing of a petition. Carriers would be required to pay or deny benefits within 30 days of receipt of the petition. Considering the elimination of the request for assistance procedure, the claimants would receive payment or a response to petition two weeks earlier than under current law.

Section 14: Amends s. 440.20, F.S. to establish a "response to petition" and would:

- specify that when the carrier is uncertain of an obligation to pay compensation, the carrier must comply with the portions of statute that requires the carrier to pay compensation within 14 days of receipt of the notice of injury;
- remove lump-sum settlement agreements, when the claimant is represented by an attorney, from the jurisdiction of the judge of compensation claims, except the judge would still approve the attorney's fees;
- require judges to approve only settlement proposals, stipulations, and agreements between claimants and their attorney that comply with the attorney's fees provisions contained in s. 440.34, F.S.; and
- require judges to consider whether the settlement allocation by the claimant provides for recovery of child support arrearages.

Section 15: Amends s. 440.25, F.S.

The following table illustrates the current statutory dispute resolution time line, the actual time line as identified by the October 1999 staff report,[4] and the statutory time line that would be created by sections 11, 12, and 14 of this council substitute.

[4] "Resolving Workers' Compensation Disputes According to Statutory Time Lines: Policy Options for Consideration," October 1999, prepared by the staff of the Florida House of Representatives Committee on Insurance.

Dispute Resolution Time Lines			
Events	**PRESENT SITUATION**		**EFFECT OF SECTION**
	Statute	**Actual[5]**	**Proposed by the council substitute**
Request for assistance	1st day	1st day	-
Petition for benefits	30th day	25th day	1st day
Pay or deny benefits	44th day	39th day	30th day
Response to petition	-	-	30th day
Attorney's fees attach	44th day	39th day	30th day
Mediation	51st day	163rd day	90th day
Pretrial stipulations	-	-	90th day
Pretrial hearing	61st day	193rd day	104th day (if necessary)
Final hearing	106th day	238th day	180th day; 210th day, max
Summary order	120th day	252nd day	eliminated
Final order	unspecified	268th day	210th day; 240th day, max
Pay award	over 134 days	282nd day	224th day; 254th day, max

OTHER EFFECTS OF SECTION – *Within 40 days of being assigned a petition, the judge of compensation claims would be required to establish, by order, a date by which a mandatory mediation must be held. If the parties agree, or if a public mediator is not available to mediate the case within 90 days of the filing of the petition, the judge would be authorized to order private mediation, at the carrier's expense. If the parties are unable to agree upon a mediator within 10 days of the order setting the date by which mediation shall occur, the claimant would be required to notify the judge; the judge would then appoint a mediator within 7 days. This section would also repeal public mediation on January 1, 2003; thereafter all mediation would be done privately, at carrier expense.*

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

Any party would be permitted to request, and the judge would have 14 days to issue, separate findings of fact and conclusions of law. The judge would be permitted to issue an abbreviated final order in cases where compensability is not denied.

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

[5] Id.

The provision of statute authorizing judges of compensation claims to adopt local rules of procedure would be repealed. The judge of compensation would be authorized to dismiss a petition, without prejudice, if there has been no petitions, responses, motions, orders, requests for a hearing, or notice of deposition for a period of 12 months. The judge would be prohibited from awarding interest on unpaid medical bills. Attachment of attorney's fees would only be permitted 30 days after the carrier receives the petition.

Section 16: Amends s. 440.29, F.S., to provide that the medical reports of certain independent medical examiners may be submitted into evidence.

Section 17: Amends s. 440.34, F.S.

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

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

However, the Judge of Compensation Claims or court may increase or decrease the fee and award claimant attorney fees on an hourly basis[6] based on the following statutory criteria:

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

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

A prevailing claimant may collect attorney fees from the employer or carrier if they do not pay the benefits within 14 days of the receipt of the petition[7]. The statute provides for this in four instances:

- in medical-only claims,
- where the employer/carrier has filed a notice of denial,
- where the employer/carrier denies that a compensable injury occurred, or
- where the claimant prevails in an enforcement or modification proceeding.

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[6] According to the Division of Workers' Compensation's *Performance Indicators for Judges of Compensation Claims,* August 2000, average attorney fees continue to surpass the statutory guideline.

[7] In *Allen v. Tyrone Square 6 AMC Theaters*, the First District Court of Appeal held that, even though the carrier approved the benefit within fourteen days of the filing of a petition for benefits, given the delay from the initial request for medical care, the approval was not given within a reasonable period of time and the claimant was entitled attorney's fees pursuant to s. 440.34(3)(a), F.S. (1997).

If a claimant is responsible for his or her own attorney fees, the attorney fee represents a lien upon the compensation. Attorney fees are reported to and summarized by the Division.[8]

EFFECT OF SECTION – *The council substitute would limit attorney's fees to the contingency fee schedule for awards under a final order, a joint stipulation, or paid under an agreement between the claimant and their attorney, or any other agreement. However, in medical-only petitions, the council substitute would give the judge of compensation claims the discretion to award an additional amount at a reasonable hourly rate, up to a maximum of $1,000. Attorney's fees would attach after the 30th day, instead of the 44th day. Specifically, attorney's fees would attach 30 days after the carrier receives the petition.*

This section, along with sections 12 and 14 of the council substitute, would provide for a "response to petition." The "response to petition" would be filed with the Office of the Judges of Compensation Claims, instead of the Division.

Section 18: Amends s. 440.345, F.S., to provide for the reporting of attorney's fees paid under chapter 440 to the Governor, the President of the Senate, and the Speaker of the House of Representative, rather than the Workers' Compensation Oversight Board.

Section 19: Creates s. 440.39(8), F.S., to provide that, as to cooperating with an injured worker when a third party is liable for the injury, the carrier would have no duty to preserve relevant evidence for the injured worker.

Section 20: Amends s. 440.4416, F.S.

PRESENT SITUATION - The Workers' Compensation Oversight Board is currently constituted of 12 members; 6 employer representatives and 6 employee representatives. Statute establishes a voting system where each side (i.e., the employees and the employers) effectively receives one vote. There is no statutory provision for the resolution of ties.

EFFECT OF SECTION – *The membership of the Workers' Compensation Oversight Board would be made up of nine members as follows:*

- *The Governor would appoint –*
  - *one insurer representative,*
  - *one health care provider representative,*
  - *one claimant's attorney representative,*
  - *one defense attorney representative, and*
  - *one employer or employee.*
- *The President of the Senate would appoint –*
  - *one small employer representative, and*
  - *one employee of a large employer.*
- *The Speaker of the House of Representatives would appoint –*
  - *one large employer representative, and*
  - *one employee of a small employer.*

The term of the present members of the board would expire on December 31, 2001, and new appointments would be made by January 1, 2002. Five members would serve an initial term of 2 years and four would serve a 4-year term. Thereafter, all members would serve 4-year terms. The

[8] Although, attorney fees in lump-sum settlements have not typically been reported, the Division has recently begun tracking this information. Additionally, the proposed Uniform Practices and Procedures of the Office of Judges of Compensation Claims include a provision to require the reporting of attorney fees.

Governor would select one of the members to serve as chair for two years. All votes would be decided by a majority of the board members present.

The board would be required to hold at least one meeting per quarter. The board would also be required to hold two meetings a year outside of Leon County. All board reports would be required to be submitted to the Division 30 days prior to release; any response by the Division would become part of the report.

Section 21: Amends s. 627.0915, F.S.

PRESENT SITUATION – The state no longer mandates safety committees and safety programs. Under the federal Occupational Safety and Health Act, the state is generally without the authority to regulate safety at private workplaces. However, statute allows the Insurance Commissioner to approve rating plans that provide workers' compensation premium discounts for the implementation of safety programs. Current statute references safety programs approved by the now defunct Division of Safety. There is no provision of law that provides guidance as to which safety programs qualify for workers' compensation premium discounts.

EFFECT OF SECTION – *This section would provide for workers' compensation premium discounts for safety programs implemented under the provisions of the rating plan.*

Section 22: Repeals subsection (3) of s. 440.45, F.S., to eliminate docketing review of petitions by docketing judges. In combination with section 12 of this council substitute, this section would require each judge of compensation claims to review their assigned petitions and dismiss those portions of the petition that are insufficient under s. 440.192, F.S.

Section 23: Provides for the severance of any portion of the council substitute if any portion of it is found to be invalid; the remaining portions of the council substitute would continue to be effective.

Section 24: Provides an effective date of January 1, 2002.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

Please see fiscal comments, below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

Please see fiscal comments, below.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Please see fiscal comments, below.

D. FISCAL COMMENTS:

It is difficult to predict what impact this council substitute will have on workers' compensation rates. No independent actuarial analysis has been done. According to the National Council on Compensation Insurance, Inc., the insurance rating organization retained by workers' compensation insurers to file a single rate application in Florida, has estimated the overall impact of the council substitute at between –4.7 percent to +1.4 percent on workers' compensation rates.

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

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

A. APPLICABILITY OF THE MANDATES PROVISION:

This council substitute may require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. However, this council substitute applies equally to all persons affected, whether or not they are a public or private entity.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

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

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

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

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

The Chief Judge of Compensation Claims has rule-making authority to adopt relating to uniform practices and procedures and expedited dispute resolution procedures. Section 440.192, F.S., requires petitions for benefits to contain certain specific information, subject to dismissal. The Chief Judge would receive the authority to require additional specificity by rule. Section 440.25(4)(g),

F.S., authorizing judges of compensation claims to adopt local rules of procedure, would be repealed.

C. OTHER COMMENTS:

The Burger King decision would be overruled because the court had refused to read the word "and" as an "or"; the council substitute would replace the word "and" with the word "or." The Wilkins case would be codified because, while the court was willing to read the word "and" as an "or," the court found that s. 440.15(1)(f)1., F.S., was inapplicable to persons who reach permanent total disability after the age of 62. That subparagraph of statute states that supplemental benefits "shall cease at age 62." If benefits cease at 62, they must have been received prior to 62. Since a person who reaches permanent total disability after age 62 was not receiving the benefits prior to age 62, the statute could not have operated against them. Since the council substitute, and current statute, does not preclude supplemental benefits to persons who reach permanent total disability after the age of 62, the proposed amendment implicitly codifies the decision in Wilkins.

Section 20 of the council substitute terminates the current term of the members of the Workers' Compensation Oversight Board on December 31, 2001. This section also requires the Governor to appoint new members on or before January 1, 2002. These provisions may be inoperable since the effective date of the council substitute is January 1, 2002. Either this section may require a separate effective date or the effective date of the council substitute may need to be changed.

Legislation is pending that would transfer the Division of Workers Compensation from the Department of Labor and Employment Security to the Department of Insurance. The Workers' Compensation Oversight Board would be transferred also. The majority of the members of the Workers' Compensation Oversight Board are appointed by the Governor. The Department of Labor and Employment Security is within the executive authority of the Governor, while the Department of Insurance is within the executive authority of the Treasurer. The Governor and the Treasurer are co-equal members of the Florida Cabinet.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On April 18, 2001, the Council for Competitive Commerce adopted one "remove everything" amendment and unanimously reported the bill favorably as a council substitute. The council substitute differs from the original bill in that the council substitute would propose changes in the following areas:

Benefits: replace the proposed "substantial earning capacity" standard for eligibility with a standard providing that anyone who cannot perform their prior job, a job that is available in substantial numbers in the national economy, or any gainful employment within 100 miles of their home is permanently totally disabled; the burden of proof would be on the employee to prove their eligibility; no compensation for psychiatric impairments would be allowed.

Attorney's fees: a technical correction would be made to the language proposed by the bill.

Dispute resolution time lines: provide an additional 30 days each, over the proposed time line, for mediation orders, mediation conferences, and final hearings; require final hearings within 210 days of the petition, maximum; and require the final order to be issued within 30 days of the final hearing or close of the record, rather than 21 days as proposed; repeal use of public mediators, effective January 1, 2003

Procedure: prohibit mediation solely on attorney's fees; allow abbreviated final orders if compensability is not denied; allow separate findings of fact and conclusions of law; allow continuances only when caused by circumstances beyond the party's control; and report multiple continuances to the Chief Judge; eliminate the award of interest on unpaid medical bills; no longer require approval of lump-sum

settlements if the claimant is represented by an attorney; and revise the calculation of the 13 week period, for purposes of average weekly wage determination.

Exemptions: limit construction corporate officer exemptions to certain officers; remove the proposed language requiring a study of workers' compensation exemptions and minimum premium policies; and remove the proposed language limiting construction exemptions among affiliated corporations.

Tort liability: revise statute to make certain that employers providing workers' compensation coverage are immune from tort liability.

The effective date of the bill would be changed from October 1, 2001 to January 1, 2002.

VII. SIGNATURES:

COMMITTEE ON INSURANCE:

Prepared by:	Staff Director:
Eric Lloyd	Stephen Hogge

AS REVISED BY THE COUNCIL FOR COMPETITIVE COMMERCE:

Prepared by:	Staff Director:
David M. Greenbaum	Hubert "Bo" Bohannon