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HOUSE OF REPRESENTATIVES
COMMITTEE ON
INSURANCE
ANALYSIS

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

RELATING TO: Workers' Compensation

SPONSOR(S): 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
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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 proposed committee bill includes the following changes:

Benefits: The Social Security eligibility standard for permanent total disability benefits would be removed from the definition of "catastrophic injury"; permanent total disability would be determined upon the facts in all other cases and the existing standard for eligibility, "substantial earning capacity," would be defined and would become the reference for removal from permanent total disability through rehabilitation, as well. Permanent partial disability impairment income benefits would be doubled.

Dispute Resolution: The request for assistance would be eliminated; mediation would be required within 60 days of the petition; pretrial stipulations would be completed at the mediation; and final hearing would be required within 60 days of mediation. Benefits requested in a petition would be paid or denied by the 30th day after filing the petition, rather than the 44th day after the request for assistance.

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, for the future provision of medical benefits. Carriers would be required to pay only for the claimant's first independent medical exam; one independent medical exam, per specialty, could be introduced into evidence.

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, rather than 44 days after filing the request for assistance.

Exemptions: Extends the limit of three corporate officer exemptions per construction business to any group of affiliated construction corporations; a group of affiliated corporations together would be limited to three officer exemptions, in the aggregate. A construction exemption study would be authorized. Effective January 1, 2004, sole proprietors and partnerships in the construction industry would be required to maintain minimum premium policies.

The proposed committee bill would have an indeterminate fiscal impact on state and local government.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

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

The bill authorizes additional rulemaking authority. Please see section V. B. The proposed committee bill 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 bill, refer to the Section-By-Section Analysis)

C. EFFECT OF PROPOSED CHANGES:

The proposed committee bill 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" and determine eligibility for permanent total disability claims, in all cases other than "catastrophic injuries," on a case by case basis; the standard for eligibility, "substantial earning capacity," would be defined; the reference for removal from permanent total disability through rehabilitation would be conformed from "earning capacity" to "substantial earning capacity";
- allows injured workers receiving medical benefits outside of workers' compensation managed care to change doctors one time per accident, upon written request; 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); and
- requires judges of compensation claims to consider the costs of future medical care when approving lump-sum settlements.

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; 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 permit each party to introduce the medical opinion of one independent medical examiner per specialty into evidence;
- provides that, in the case of occupational disease or repetitive trauma, the doctor's medical opinion is only admissible if based on scientific principles generally accepted in the relevant medical specialty;
- requires that a request for medical care be filed before a "grievance" may be filed with a managed care arrangement and provide that the informal dispute resolution process is exhausted if the workers' compensation managed care arrangement does not respond to a grievance within 30 days of filing;
- requires additional specificity for petitions for benefits and authorize the Chief Judge to require additional specificity in petitions by rule;
- 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;
- 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.

Exemptions

- allows only three corporate officer exemptions, in the aggregate, to any corporation, or group of affiliated corporations;
- authorizes a study of the impact of exemptions from workers' compensation coverage requirements upon the construction industry and the workers' compensation system; the study would also examine the potential use of minimum premium policies by sole proprietors and partnerships in the construction industry; and
- requires, effective January 1, 2004, sole proprietors and partnerships in the construction industry to secure workers' compensation coverage under chapter 440.

(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 -- *This section would apply the limit of three corporate officer exemptions to a single corporation, or group of affiliated corporations. This would limit the number of corporate officer exemptions in affiliated corporations to three, in the aggregate. "Affiliated" would be defined similarly to the way it is defined in the Transportation Code related to "contract crime."*

This section would also remove the Social Security standard from the definition of "catastrophic injury." Section 4 of the bill 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. 440.09(9), F.S., to 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 minimum premium policy that would provide workers' compensation coverage if the employer retains any employees.

Section 3: 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

[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.

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.

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 4: 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 5: 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. 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.

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

EFFECT OF SECTION -- *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 50 weeks (10 percentage points times five) equaling an impairment income benefit totaling $20,000*.

In conjunction with section 1 of the proposed committee bill, 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 would be determined upon the facts of the case.

The present work standard for eligibility for permanent total disability benefits, "substantial earning capacity," would be defined. A person with a "substantial earning capacity" would be an employee who is able to work uninterruptedly, either part-time or full-time, within a reasonable radius of the employee's residence. This would include sedentary work. The reference for removing a person from permanent total disability, through rehabilitation, would be conformed from "earning capacity" to "substantial earning capacity."

Section 6: 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 7: 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 bill 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 8: 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 bill 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 bill 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 9 and 11, 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 9: Amends s. 440.20, F.S. to establish a "response to petition" and would require judges of compensation claims 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.,
- to issue compensation orders within 15 days, rather than 7 days, in lump-sum settlements, when the claimant is represented by counsel, and
- consider the possible future medical costs of the claimant when approving lump-sum settlements.

Section 10: 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 6, 7, and 9 of this bill.

[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 Bill**
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	60th day
Pretrial stipulations	-	-	60th day
Pretrial hearing	61st day	193rd day	74th day (if necessary)
Final hearing	106th day	238th day	120th day
Summary order	120th day	252nd day	134th day
Final order	unspecified	268th day	141st day
Pay award	over 134 days	282nd day	155th day

OTHER EFFECTS OF SECTION – *In the event a case is not resolved within the statutory time line, the judge of compensation claims would be required to submit a report to the Chief Judge stating the names of the judge and attorneys participating in the case and the reason for the delay. Within ten 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 60 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.*

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.

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.

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.

[5] Id.

Section 11: Amends s. 440.29, F.S., to provide that the medical reports of certain independent medical examiners may be submitted into evidence.

Section 12: 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.

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 bill 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 bill would give*

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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).

[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.

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 7 and 9 of the bill, 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 13: Amends s. 440.345, F.S., to provide for the reporting of attorney's fees paid under chapter 440 to the President of the Senate and the Speaker of the House of Representative, rather than the Workers' Compensation Oversight Board.

Section 14: 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 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 15: 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 16: Authorizes the Workers' Compensation Joint Underwriting Association to conduct a study of the effect of exemptions on the workers' compensation system, including the potential impact of requiring all sole proprietors and partnerships, actively engaged in the construction industry, to carry a minimum premium policy.

Section 17: Repeals subsection (3) of s. 440.45, F.S., to eliminate docketing review of petitions by docketing judges. In combination with section 7 of this bill, 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 18: Provides an effective date of October 1, 2001.

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 bill 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, the limitations on attorney's fees proposed by the bill may result in a 0.5 percent reduction in rates. The NCCI also estimates that the increase in permanent partial disability impairment income may result in a 6.4 percent increase in rates. The NCCI was not

requested to price the bill as a single proposal since the proposed committee bill was not completed until amended and approved by the Insurance Committee on April 4, 2001. The bill proposes a number of changes to the dispute resolution process that may reduce system costs by reducing litigation, speeding the delivery of benefits, and decreasing administration costs.

The bill would have an indeterminate effect on the expenses of state and local governments and private sector employers depending on whether the bill would result in a net increase or decrease in workers' compensation system costs. The bill would increase system costs by doubling permanent partial disability impairment income benefits. The bill 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 bill may require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. However, this bill applies equally to all persons affected, whether or not they are a public or private entity.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill 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 bill 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:

N/A

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON INSURANCE:

Prepared by:	Staff Director:
Eric Lloyd	Stephen Hogge