Journal of the Senate

Number 7—Special Session C **Wednesday, November 10, 1993**

CALL TO ORDER

The Senate was called to order by the President at 9:15 a.m. A quorum present—39:

Mr. President	Dantzler	Hargrett	Myers
Bankhead	Diaz-Balart	Holzendorf	Scott
Beard	Dudley	Jenne	Siegel
Boczar	Dyer	Jennings	Silver
Brown-Waite	Foley	Johnson	Sullivan
Burt	Forman	Kirkpatrick	Turner
Casas	Grant	Kiser	Weinstein
Childers	Grogan	Kurth	Wexler
Crenshaw	Gutman	McKay	Williams
Crist	Harden	Meadows	

Excused: Senator Jones

PRAYER

The following prayer was offered by Father Jim Hobby, Pastor, The Church of the Advent, Tallahassee:

The Lord is King, let the people tremble. He is enthroned upon a chair and, let the earth shake. The Lord is great in Zion. He is high above all peoples. Let them confess his name which is great and awesome. He is the holy one.

Almighty King, lover of justice, you have established equity. You have executed justice and righteousness in Jacob. Proclaim the greatness of the Lord, our God, and fall down before his footstool. He is the holy one.

Pray with me. Oh God, the fountain of wisdom, whose will is good and gracious and whose law is truth. We beseech you to guide and bless our Senators and Representatives in the Legislature of this State that they may enact such laws as shall please you to the glory of your name and to the welfare of this people.

Oh Lord God, hear our prayer. Amen.

PLEDGE

Senator Turner led the Senate in the pledge of allegiance to the flag of the United States of America.

By direction of the President the following Conference Committee Report was read:

CONFERENCE COMMITTEE REPORT ON SB 12-C

The Honorable Pat Thomas
President of the Senate

The Honorable Bolley L. Johnson
Speaker, House of Representatives

Dear President Thomas and Speaker Johnson:

Your Conference Committee on the disagreeing votes of the two houses on Workers' Compensation, same being:

An act relating to Workers' Compensation

having met, and after full and free conference, do recommend to their respective houses as follows:

1. That the House of Representatives recede from House Amendment 1.
2. That the House of Representatives and Senate adopt the Conference Committee Amendment attached hereto, and by reference made a part of this report.
3. That the House of Representatives and Senate pass Senate Bill 12-C as amended by said Conference Committee Amendment.

s/W. D. Childers	*s/Fred Lippman*
Chairman	Vice Chairman
s/Rick Dantzler	*s/F. Allen Boyd, Jr.*
s/Toni Jennings	*s/Beryl D. Burke*
s/Jim Scott	*s/Paul M. Hawkes*
	s/James E. King, Jr.
	s/Joseph R. Mackey
Managers on the part of the Senate	Managers on the part of the House of Representatives

Summary of Conference Committee Action:

A. *Administration*

1. Claims Processing

Authorizes collective bargaining agreements between an individually self-insured employer or other employer upon consent of the employer's carrier and a recognized or certified exclusive bargaining representative.

Provides that a carrier may make compensation payments for a period of 120 days without affecting its right to contest compensability.

Revises the statute of limitations for filing petitions for benefits.

2. Dispute Resolution

Creates the Employee Assistance and Ombudsman Office within the Division of Workers' Compensation. Provides that injured employees who have not received benefits that they believe they are entitled to must participate in an informal dispute resolution conference before filing a petition for benefits. Authorizes the assistance office to compel the parties to attend the informal dispute resolution conference. Provides that an ombudsman may be assigned to assist the injured employee in resolving the dispute.

Provides that any settlement agreement that is reached by the parties be submitted to the Office of the Judges of Compensation Claims for approval. Provides that if the parties fail to reach an agreement, the employee may file a petition for benefits. Provides that the assistance office will aid the employee in completing and filing a petition for benefits. Provides that the Division of Workers' Compensation shall refer the petition to the Office of the Judges of Compensation Claims. Requires the Office of the Judges of Compensation Claims to schedule a mandatory mediation conference. Provides that if the parties fail to reach an agreement, a pretrial and final hearing will be scheduled.

3. Monitoring and Auditing

Requires notice of noncoverage to be posted at worksites when the employer elects not to be covered under the workers' compensation system.

Authorizes the division to enforce employer compliance with the coverage requirements of this chapter. Allows the division to examine each carrier as often as warranted to ensure that carriers are fulfilling their obligations under the law.

4. Special Disability Trust Fund

Revises the legislative intent relating to the purpose of the Special Disability Trust Fund. Limits the conditions which qualify as a permanent physical impairment and revises the requirements for employer knowledge. Establishes a preferred worker program. Provides for a $10,000 deductible which must be reached before a claim is reimbursed and revises the assessment formula.

B. *Indemnity*

Provides that compensation shall be paid if the employee suffers an accidental injury or death arising out of work performed in the course and scope of employemnt. Provides that injuries must be established by medical evidence.

Provides that the eligibility for permanent total benefits is limited to those claimants with catastrophic injuries, as enumerated in the act.

The duration of temporary total disability and temporary partial disability benefits are reduced from 260 weeks to 104 weeks with the additional requirement that once the employee reaches the maximum number of weeks allowed, temporary disability benefits shall cease and the injured worker's permanent impairment shall be determined.

Employers and carriers are not required to make any payment of benefits for temporary total disability for any period during which the employee willfully fails or refuses to report all earned income, including income from social security.

Determinations of permanent impairment are permitted to be made by physicians, osteopaths, chiropractors, podiatrists, optometrists, and dentists.

Permanent impairment benefits are paid weekly at the rate of 50 percent of the employee's average weekly temporary total benefit, for a duration of 3 weeks for each percentage point of impairment.

Supplemental benefits are paid to claimants with an impairment rating of 20 or more, who have not returned to work or have returned to work earning less than 80 percent of the employee's average weekly wage as a direct result of the employee's impairment, and have attempted to obtain employment.

Provides that employers with more than 50 employees are required to make available, within 30 days after the carrier notifies the employer of maximum medical improvement and the employee's physical limitations, work appropriate to the employee's physical limitations. Employers who are unable to make a good faith effort to find work available within a 100 mile radius of the employee's residence are subject to a fine of $250 for each $5,000 of premiums or payroll, not to exceed an aggregate fine of up to $2,000.

C. *Medical*

Provides for a voluntary system of re-employment assessments, training and education, and medical care coordination for the rehabilitation of injured workers.

Provides for medical services and supplies, penalties for violations, and limitations on chiropractic care. Provides for attendant care. Provides for certification and authorization of providers by the division. Provides filing requirements. Provides for Independent Medical Examinations chosen by the employer, carrier, or employee, and limitations thereon. Provides penalties for failure to cooperate with an IME. Provides enhanced utilization review procedures.

Provides for Expert Medical Advisors, certified by the division, to assist the division and the JCCs regarding disputes in utilization and reimbursements. Provides criteria for certifying advisors. Provides for witness fees and for audits by the division.

Provides for revised fee schedules. Provides for hospital inpatient charges to be reimbursed at 75 percent of usual and customary charges until per diem rates can be adopted. Hospital outpatient charges are reimbursed at 75 percent of usual and customary charges. Provides for uniform reimbursement rates for all other medical providers and facilities. Provides for a $10 copayment for all medical services rendered after MMI. Provides for practice parameters.

Effective January 1, 1997, provides for the delivery of all medical services and supplies solely through managed care networks. Until managed care becomes mandatory, a premium credit, not to exceed 10 percent, is provided to employers who utilize managed care arrangements.

Provides for pilot programs for a 24-hour policy.

D. *Attorney's Fees*

Modifies the provisions relating to attorney's fees to reduce by 5 percent the multipliers used in calculating attorney's fees and limits the amount of fees paid for future indemnity benefits. Attorneys may be fined for continuing any frivolous case.

Provides a code of judicial conduct for the judges of compensation claims. Requires minority representation on the statewide nominating commission. Provides for the Governor to choose a Chief Judge who is to be confirmed by the Cabinet. When the term of a judge of compensation claims expires, the Governor may choose from a list of three nominations, one of which may be the judge of compensation claims.

E. *Insurance*

Requires insurance carriers and self-insurers to provide for the security for payment of compensation. Provides penalties when certain applications for coverage are willfully misreported to the carrier.

Transfers the regulatory authority of group self-insurers to the Department of Insurance from the Department of Labor and Employment Security.

Creates a self-insurance fund guaranty association which includes commercial self-insurance funds, assessable mutual insurers, group self-insurance funds and requires their participation in the Florida Self-Insurance Fund Guaranty Association.

Provides for a self-funded joint underwriting association with three separate sub-plans. Subplan "A" includes those insureds whose annual premium does not exceed $2,500 and who have neither incurred any lost-time claims nor incurred medical-only claims exceeding 50 percent of their premium for 2 years.

Subplan "B" includes insurers that are employers identified by the Board of Governors as high-risk employers due solely to the nature of the operations being performed by those insureds and for whom no market exists in the voluntary market, and whose experience modifications are less than 1.00.

Subplan "C" includes all other insureds within the plan and provides for the option of issuing assessable policies to insureds of the subplan "C".

Includes insurers who provide coverage for workers' compensation and employer's liability insurance to abide by the provisions relating to the notice of cancellation, nonrenewal, or renewal of premiums.

Creates the Workers' Compensation Insurance Purchasing Alliance to provide clear, uniform information on each workers' compensation policy offered by workers' compensation underwriters to its members.

F. *Fraud*

Provides penalties for illegal activities ranging from a first degree misdemeanor to a third degree felony. Provides for fraud reporting. Provides a civil cause of action. Provides authority for the Department of Insurance, Division of Workers' Compensation Fraud, to enforce compliance with coverage requirements. Provides for funding of the Bureau of Fraud within the Department of Insurance. Provides for the prosecution by the state attorney or the Justice Administration Commission of criminal violations of the Workers' Compensation Law and related crimes.

G. *Safety*

Includes a safety credit which provides that a rating plan be approved for the implementation of an approved safety program.

Provides for the implementation of safety committees within certain businesses.

H. *Other*

Provides for employer immunity, clarifying legislative intent regarding exclusiveness of employer immunity, and extending the immunity enjoyed by an employer to employees of county constitutional officials.

Provides for the requirements of a drug-free workplace program, including standards necessary for employer discounts and drug test-

ing; specifying medical screening criteria and notice requirements; includes provisions for safety-sensitive positions and special-risk positions; and substitutes the Agency for Health Care Administration for the Department of Health and Rehabilitative Services as the agency for the oversight.

Requires contractors to provide proof of coverage or exemptions prior to obtaining a building permit. Provides a cause of action and penalties for a contract award obtained by a contractor who violated the provisions of this chapter.

Provides for a Workers' Compensation Oversight Board to advise the Legislature and the division on workers' compensation issues.

Provides for the act to take effect January 1, 1994, except as otherwise provided by this act.

Conference Committee Amendment 1 (with Title Amendment)—Strike everything after the enacting clause and insert:

Section 1. Section 440.015, Florida Statutes, is amended to read:

440.015 Legislative intent.—It is the intent of the Legislature that the Workers' Compensation Law be interpreted so as to assure the quick and efficient delivery of disability and medical benefits to an injured worker *and to facilitate the worker's return to gainful reemployment* at a reasonable cost to the employer. It is the specific intent of the Legislature that workers' compensation cases shall be decided on their merits. The workers' compensation system in Florida is based on a mutual renunciation of common law rights and defenses by employers and employees alike. In addition, it is the intent of the Legislature that the facts in a workers' compensation case are not to be interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Additionally, the Legislature hereby declares that disputes concerning the facts in workers' compensation cases are not to be given a broad liberal construction in favor of the employee on the one hand or of the employer on the other hand, *and the laws pertaining to workers' compensation are to be construed in accordance with the basic principles of statutory construction and not liberally in favor of either employee or employer. It is the intent of the Legislature to ensure the prompt delivery of benefits to the injured worker. Therefore, an efficient and self-executing system must be created which is not an economic or administrative burden. The Division of Workers' Compensation shall administer the Workers' Compensation Law in a manner which facilitates the self-execution of the system and the process of ensuring a prompt and cost-effective delivery of payments.*

Section 2. Subsections (1), (13), (14), (19), (21), (24), and (31) of section 440.02, Florida Statutes, are amended, and subsections (32), (33), (34), (35), and (36) are added to that section to read:

440.02 Definitions.—When used in this chapter, unless the context clearly requires otherwise, the following terms shall have the following meanings:

(1) "Accident" means only an unexpected or unusual event or result *that happens*~~, happening~~ suddenly. A mental or nervous injury due to stress, fright, or excitement only, or disability or death due to the accidental acceleration or aggravation of a venereal disease or of a disease due to the habitual use of alcohol or controlled substances or narcotic drugs, *or a disease that manifests itself in the fear of or dislike for an individual because of the individual's race, color, religion, sex, national origin, age, or handicap is* ~~shall be deemed~~ not ~~to be~~ an injury by accident arising out of the employment. *If* ~~Where~~ a preexisting disease or anomaly is accelerated or aggravated by an accident arising out of and in the course of employment, only acceleration of death or acceleration or aggravation of the preexisting condition reasonably attributable to the accident *is* ~~shall be~~ compensable, with respect to death or permanent impairment.

(13)(a) "Employee" means *any* ~~every~~ person engaged in any employment under any appointment or contract of hire or apprenticeship, express or implied, oral or written, ~~including aliens and also including minors,~~ whether lawfully or unlawfully employed, *and includes, but is not limited to, aliens and minors.*

(b) "Employee" includes any person who is an officer of a corporation and who performs services for remuneration for such corporation within this state, whether or not such services are continuous.

1. Any officer of a corporation may elect to be exempt from ~~the provisions of~~ this chapter by filing written notice of the election with the division as provided in s. 440.05.

2. As to officers of a corporation who are actively engaged in the construction industry, no more than three officers may elect to be exempt from ~~the provisions of~~ this chapter by filing written notice of the election with the division as provided in s. 440.05.

3. An officer of a corporation who elects to be exempt from ~~the provisions of~~ this chapter by filing a written notice of the election with the division as provided in s. 440.05 is not an employee.

Services *are* ~~shall be~~ presumed to have been rendered *to* the corporation *if the* ~~in cases when such~~ officer is compensated by other than dividends upon shares of stock of *the* ~~such~~ corporation *which he owns* ~~owned by him~~.

(c) "Employee" includes a sole proprietor or a partner who devotes full time to the proprietorship or partnership and, except as ~~hereinafter~~ provided *in this paragraph*, elects to be included in the definition of employee by filing notice thereof as provided in s. 440.05. Partners or sole proprietors actively engaged in the construction industry are considered employees unless they elect to be excluded from the definition of employee by filing written notice of the election with the division as provided in s. 440.05. However, no more than three partners in a partnership that is actively engaged in the construction industry may elect to be excluded. A sole proprietor or partner who is actively engaged in the construction industry and who elects to be exempt from ~~the provisions of~~ this chapter by filing a written notice of the election with the division as provided in s. 440.05 is not an employee. *For purposes of this chapter, an independent contractor is an employee unless he meets all of the conditions set forth in subparagraph (d)1.*

(d) "Employee" does not include:

1. An independent contractor, *if* ~~who is not subject to the control and direction of the employer as to his actual conduct, including~~:

a. The independent contractor maintains a separate business with his own work facility, truck, equipment, materials, or similar accommodations;

b. The independent contractor holds or has applied for a federal employer identification number, unless the independent contractor is a sole proprietor who is not required to obtain a federal employer identification number under state or federal requirements;

c. The independent contractor performs or agrees to perform specific services or work for specific amounts of money and controls the means of performing the services or work;

d. The independent contractor incurs the principal expenses related to the service or work that he performs or agrees to perform;

e. The independent contractor is responsible for the satisfactory completion of work or services that he performs or agrees to perform and is or could be held liable for a failure to complete the work or services;

f. The independent contractor receives compensation for work or services performed for a commission or on a per-job or competitive-bid basis and not on any other basis;

g. The independent contractor may realize a profit or suffer a loss in connection with performing work or services;

h. The independent contractor has continuing or recurring business liabilities or obligations; and

i. The success or failure of the independent contractor's business depends on the relationship of business receipts to expenditures.

However, the determination as to whether an individual included in the Standard Industrial Classification Manual of 1987, Industry Numbers 0711, 0721, 0722, 0751, 0761, 0762, 0781, 0782, 0783, 0811, 0831, 0851, 2411, 2421, 2435, 2436, 2448, or 2449, or a newspaper delivery person, is an independent contractor is governed not by the criteria in this paragraph but by common law principles, giving due consideration to the business activity of the individual.

~~2.a. An individual who agrees in writing to perform services for a person or corporation without supervision or control as~~ A real estate *salesperson* ~~salesman~~ or agent, if *that person agrees, in writing, to perform* ~~such service by such individual for such person or corporation is performed~~ for remuneration solely by way of commission.;

3.~~b.~~ Bands, orchestras, and musical and theatrical performers, including disk jockeys, performing in licensed premises as defined in chapter 562, *if* ~~provided~~ a written contract evidencing an independent contractor relationship is entered into *before* ~~prior to~~ the commencement of such entertainment.~~; and~~

4.~~c.~~ An owner-operator of a motor vehicle who transports property under a written contract with a motor carrier which evidences a relationship by which the owner-operator assumes the responsibility of an employer for the performance of the contract, *if* ~~provided that~~ the owner-operator is required to furnish the necessary motor vehicle equipment and all costs incidental to the performance of the contract, including, but not limited to, fuel, taxes, licenses, repairs, and hired help; and the owner-operator is paid a commission for his transportation service and is not paid by the hour or on some other time-measured basis.

5.~~2.~~ A person whose employment is both casual and not in the course of the trade, business, profession, or occupation of the employer.

6.~~3.~~ A volunteer, except a volunteer worker for the state or a county, *municipality* ~~city~~, or other governmental entity. A person who does not receive monetary remuneration for his services is presumed to be a volunteer unless there is substantial evidence that a valuable consideration was intended by both employer and employee. For purposes of this chapter, the term "volunteer" includes, but is not limited to:

a. Persons who serve in private nonprofit agencies and who receive no compensation other than expenses in an amount less than or equivalent to the standard mileage and per diem expenses provided to salaried employees in the same agency or, *if* ~~in the event that~~ such agency does not have salaried employees who receive mileage and per diem, then such volunteers who receive no compensation other than expenses in an amount less than or equivalent to the customary mileage and per diem paid to salaried workers in the community as determined by the division; and

b. Volunteers participating in federal programs established *under* ~~pursuant to~~ Pub. L. No. 93-113.

7.~~4.~~ Any officer of a corporation who elects to be exempt from ~~the provisions of~~ this chapter.

8.~~5.~~ A sole proprietor or officer of a corporation who actively engages in the construction industry, and a partner in a partnership that is actively engaged in the construction industry, who elects to be exempt from the provisions of this chapter. Such sole proprietor, officer, or partner is not an employee for any reason until the notice of revocation of election filed pursuant to s. 440.05 is effective.

9. An exercise rider who does not work for a single horse farm or breeder, and who is compensated for riding on a case-by-case basis, provided a written contract is entered into prior to the commencement of such activity which evidences that an employee/employer relationship does not exist.

10. A taxicab, limousine, or other passenger vehicle-for-hire driver who operates said vehicles pursuant to a written agreement with a company which provides any dispatch, marketing, insurance, communications, or other services under which the driver and any fees or charges paid by the driver to the company for such services are not conditioned upon, or expressed as a proportion of, fare revenues.

(14) "Employer" means the state and all political subdivisions thereof, all public and quasi-public corporations therein, every person carrying on any employment, and the legal representative of a deceased person or the receiver or trustees of any person. *If the employer is a corporation, parties in actual control of the corporation, including, but not limited to, the president, officers who exercise broad corporate powers, directors, and all shareholders who directly or indirectly own a controlling interest in the corporation, are considered the employer for the purposes of ss. 440.105 and 440.106.*

(19) "Permanent impairment" means any anatomic or functional abnormality or loss *determined as a percentage of the body as a whole*, existing after the date of maximum medical improvement, which results from the injury.

(21) "Self-insurer" means:

(a) Any employer who has secured payment of compensation pursuant to s. 440.38(1)(b) or (6) as an individual self-insurer;

(b) Any employer who has secured payment of compensation through a group *self-insurance fund under s. 624.4621* ~~self-insurer pursuant to s. 440.57~~;

(c) Any group *self-insurance fund* ~~self-insurer~~ established *under s. 624.4621* ~~pursuant to s. 440.57~~;

(d) A public utility as defined in s. 364.02 or s. 366.02 that has assumed by contract the liabilities of contractors or subcontractors pursuant to s. 440.571; or

(e) Any local government *self-insurance fund* ~~pool~~ established *under s. 624.4622* ~~pursuant to s. 440.575~~.

(24) "Wages" means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the injury and includes only the wages earned *and reported for federal income tax purposes* on the job where the employee is injured and *any other concurrent employment where he is also subject to workers' compensation coverage and benefits* ~~does not include wages from outside or concurrent employment except in the case of a volunteer firefighter~~, together with the reasonable value of housing furnished to the employee by the employer which is the permanent year-round residence of the employee, and gratuities to the extent reported to the employer in writing as taxable income received in the course of employment from others than the employer and employer contributions for health insurance for the employee or the employee's dependents. However, housing furnished to migrant workers shall be included in wages unless provided after the time of injury. In employment in which an employee receives consideration for housing, the reasonable value of such housing compensation shall be the actual cost to the employer or based upon the Fair Market Rent Survey promulgated pursuant to s. 8 of the Housing and Urban Development Act of 1974, whichever is less. However, if employer contributions for housing or health insurance are continued after the time of the injury, the contributions are not "wages" for the purpose of calculating an employee's average weekly wage.

(31) "Insolvency" or "insolvent" means:

(a) *With respect to an individual self-insurer:*

1. That all assets of the individual self-insurer, if made immediately available, would not be sufficient to meet all the individual self-insurer's liabilities;

2.~~(b)~~ That the individual self-insurer is unable to pay its debts as they become due in the usual course of business;

3.~~(c)~~ That the individual self-insurer has substantially ceased or suspended the payment of compensation to its employees as required in this chapter; or

4.~~(d)~~ That the individual self-insurer has sought protection under the United States Bankruptcy Code or has been brought under the jurisdiction of a court of bankruptcy as a debtor pursuant to the United States Bankruptcy Code.

(b) With respect to an employee claiming insolvency pursuant to s. 440.25(5), a person is insolvent who:

1. Has ceased to pay his debts in the ordinary course of business and cannot pay his debts as they become due; or

2. Has been adjudicated insolvent pursuant to the Federal Bankruptcy Law.

(32) "Arising out of" pertains to occupational causation. An accidental injury or death arises out of employment if work performed in the course and scope of employment is the major contributing cause of the injury or death.

(33) "Soft-tissue injury" means an injury that produces damage to the soft tissues, rather than to the skeletal tissues or soft organs.

(34) "Catastrophic injury" means a permanent impairment constituted by:

(a) Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk;

(b) Amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage;

(c) Severe brain or closed-head injury as evidenced by;

1. Severe sensory or motor disturbances;

2. Severe communication disturbances;

3. Severe complex integrated disturbances of cerebral function;

4. Severe episodic neurological disorders; or

5. Other severe brain and closed-head injury conditions at least as severe in nature as any condition provided in subparagraphs 1.-4.

(d) Second-degree or third-degree burns of 25 percent or more of the total body surface or third-degree burns of 5 percent or more to the face and hands;

(e) Total or industrial blindness; or

(f) Any other injury that would otherwise qualify under this chapter of a nature and severity that would qualify an employee to receive disability income benefits under Title II or supplemental security income benefits under Title XVI of the federal Social Security Act as the Social Security Act existed on July 1, 1992, without regard to any time limitations provided under that act.

(35) "Insurer" means a group self-insurers' fund authorized by s. 624.4621, an individual self-insurer authorized by s. 440.38, a commercial self-insurance fund authorized by s. 624.462, an assessable mutual insurer authorized by s. 628.6011, and an insurer licensed to write workers' compensation and employer's liability insurance in this state. The term "carrier," as used in this chapter, means an insurer as defined in this subsection.

(36) "Statement," for the purposes of ss. 440.105 and 440.106, includes, but is not limited to, any notice, representation, statement, proof of injury, bill for services, diagnosis, prescription, hospital or doctor record, X ray, test result, or other evidence of loss, injury, or expense.

Section 3. Section 440.05, Florida Statutes, is amended to read:

440.05 *Election* ~~Notice~~ of exemption*; revocation of election; notice; certification* ~~or acceptance and waiver of exemption or acceptance~~.—

(1) *Each* ~~Every~~ corporate officer who elects not to accept the provisions of this chapter or who, after electing such exemption, revokes that exemption shall mail to the division in Tallahassee notice to such effect in accordance with a form to be prescribed by the division.

(2) *Each* ~~Every~~ sole proprietor or partner who elects to be included in the definition of "employee" or who, after such election, revokes that election *must* ~~shall~~ mail to the division in Tallahassee notice to such effect, in accordance with a form to be prescribed by the division.

(3) *Each* ~~Every~~ sole proprietor, partner, or officer of a corporation who is actively engaged in the construction industry and who elects an exemption from ~~the provisions of~~ this chapter or who, after electing such exemption, revokes that exemption, *must* ~~shall~~ mail a written notice to such effect to the division on a form prescribed by the division. The notice of election to be exempt from the provisions of this chapter must be notarized and under oath. The *election* ~~form~~ must list the name, federal tax identification number, social security number, and all certified or registered licenses issued pursuant to chapter 489 held by the person seeking the exemption. The form must identify each sole proprietorship, partnership, or corporation that employs the person *electing* ~~seeking~~ the exemption and must list the social security number or federal tax identification number of each such employer. In addition, the *election* ~~exemption~~ form must provide that the sole proprietor, partner, or officer electing an exemption is not entitled to benefits under this chapter, must provide that the *election* ~~exemption~~ does not exceed exemption limits for officers and partnerships *provided in s. 440.02*, and must certify that any employees of the sole proprietor, partner, or officer electing an exemption are covered by workers' compensation insurance. Upon receipt of the notice of the election to be exempt and a determination that the notice meets the requirements of this subsection, the division shall issue a certification of the election to the sole proprietor, partner, or officer. The certificate of election must list the names of the sole proprietorship, partnership, or corporation listed in the request for exemption. A new certificate of election must be obtained each time the person is employed by a new sole proprietorship, partnership, or corporation that is not listed on the certificate of election. A copy of the certificate of election *must* ~~shall~~ be sent to each workers' compensation carrier identified in the request for exemption. The certification of the election is valid ~~for 2 years or~~ until the sole proprietor, partner, or officer revokes his election~~, whichever occurs first~~. Upon filing a notice of revocation of election, *a* ~~if the~~ sole proprietor, partner, or officer *who* is a subcontractor *must*~~, he shall~~ notify his contractor.

(4) *A* ~~No~~ notice given *under* ~~pursuant to~~ subsection (1), subsection (2), or subsection (3) is *not* effective until 30 days after the date it is mailed to the division in Tallahassee. However, if an accident or occupational disease occurs less than 30 days after the effective date of the insurance policy under which the payment of compensation is secured or the date the employer qualified as a self-insurer, such notice is effective as of 12:01 a.m. of the day following the date it is mailed to the division in Tallahassee.

(5) Any contractor responsible for compensation under s. 440.10 may register in writing with the workers' compensation carrier for any subcontractor and shall thereafter be entitled to receive written notice from the carrier of any cancellation or nonrenewal of the policy.

(6) The division may assess a fee, not to exceed $50, with each request for election or renewal of election under this section. The funds collected by the division shall be used to administer this section and to audit the businesses that pay the fee for compliance with any requirements of this chapter.

Section 4. Section 440.055, Florida Statutes, is amended to read:

440.055 *Notice requirements* ~~Annual employer affidavits~~.—*An* ~~If an~~ employer *who* employs fewer than four employees*, who is permitted by law to elect not to secure payment of compensation under this chapter, and who elects not to do so shall post clear written notice in a conspicuous location at each work site directed to all employees and other persons performing services at the work site of their lack of entitlement to benefits under this chapter.* ~~and chooses not to secure payment of compensation under this chapter, such employer shall file, on an annual basis, an affidavit with the division stating that he has not secured payment of compensation under this chapter for his employees and shall provide clear written notice to all employees of their lack of entitlement to benefits under this chapter. Such affidavit shall also contain the nature of the employer's business, the business address, and the telephone number~~.

Section 5. Section 440.09, Florida Statutes, is amended to read:

440.09 Coverage.—

(1) *The employer shall pay compensation or furnish benefits required by this chapter if the employee suffers an accidental injury or death arising out of work performed in the course and the scope of employment. The injury, its occupational cause, and any resulting manifestations or disability shall be established to a reasonable degree of medical certainty and by objective medical findings. Mental or nervous injuries occurring as a manifestation of an injury compensable under this section shall be demonstrated by clear and convincing evidence.* ~~Compensation shall be payable under this chapter in respect of disability or death of an employee if the disability or death results from an injury arising out of and in the course of employment.~~

(a) This chapter does not require any compensation or benefits for any subsequent injury the employee suffers as a result of an original injury arising out of and in the course of employment unless the original injury is the major contributing cause of the subsequent injury.

(b) If an injury arising out of and in the course of employment combines with a preexisting disease or condition to cause or prolong disability or need for treatment, the employer must pay compensation or benefits required by this chapter only to the extent that the injury arising out of and in the course of employment is and remains the major contributing cause of the disability or need for treatment.

(c) Death resulting from an operation by a surgeon furnished by the employer for the cure of hernia as required in s. 440.15(6) shall for the purpose of this chapter be considered *to be* ~~as~~ a death resulting from the accident causing the hernia.

(d) If ~~Where~~ an accident happens while the employee is employed elsewhere than in this state, which would entitle him or his dependents to compensation if it had happened in this state, the employee or his dependents *are* ~~shall be~~ entitled to compensation if the contract of employment was made in this state, or the employment was principally localized in this state. However, if an employee *receives* ~~shall receive~~

compensation or damages under the laws of any other state, *the* ~~nothing herein contained shall be construed so as to permit a~~ total compensation for the ~~same~~ injury *may not be* greater than is provided *in this chapter* ~~herein~~.

(2) *Benefits are not* ~~No compensation shall be~~ payable in respect of the disability or death of any employee covered by the Federal Employer's Liability Act, the Longshoremen's and Harbor Worker's Compensation Act, or the Jones Act.

(3) ~~No~~ Compensation *is not* ~~shall be~~ payable if the injury was occasioned primarily by the intoxication of the employee; by the influence of any drugs, barbiturates, or other stimulants not prescribed by a physician~~, which affected the employee to such an extent that the employee's normal faculties were impaired~~; or by the willful intention of the employee to injure or kill himself, herself, or another. ~~If there was at the time of the injury 0.10 percent or more by weight of alcohol in the employee's blood, or if the employee has a positive confirmation of a drug as defined in this act, it shall be presumed that the injury was occasioned primarily by the intoxication of, or by the influence of the drug upon, the employee. In the absence of a drug-free workplace program, this presumption may be rebutted by clear and convincing evidence that the intoxication or influence of the drug did not contribute to the injury. Percent by weight of alcohol in the blood shall be based upon grams of alcohol per 100 milliliters of blood. However, if, prior to the accident, the employer had actual knowledge of and expressly acquiesced in the employee's presence at the workplace while under the influence of such alcohol or drug, the presumption specified in this subsection shall not apply.~~

(4) An employee shall not be entitled to compensation or benefits under this chapter if any administrative hearing officer, court, or jury convened in this state determines that the employee has knowingly or intentionally engaged in any of the acts described in s. 440.105 for the purpose of securing workers' compensation benefits.

(5)~~(4)~~ *If* ~~Where~~ injury is caused by the knowing refusal of the employee to use a safety appliance or observe a safety rule required by statute or lawfully *adopted* ~~promulgated~~ by the division, and brought prior to the accident to *the employee's* ~~his or her~~ knowledge, or *if* ~~where~~ injury is caused by the knowing refusal of the employee to use a safety appliance provided by the employer, the compensation as provided in this chapter shall be reduced 25 percent.

~~(5) The division shall adopt rules governing the manner, means, and frequency of safety inspections and consultations by all carriers and self-insurers.~~

(6) Except as provided in this chapter, *a* ~~no~~ construction design professional who is retained to perform professional services on a construction project, *or an* ~~nor any~~ employee of a construction design professional in the performance of professional services on the site of the construction project, *is not* ~~shall be~~ liable for any injuries resulting from the employer's failure to comply with safety standards on the construction project for which compensation is recoverable under this chapter, unless responsibility for safety practices is specifically assumed by contracts. The immunity provided by this subsection to *a* ~~any~~ construction design professional *does* ~~shall~~ not apply to the negligent preparation of design plans or specifications.

(7)(a) To ensure that the workplace is a *drug-free* ~~drug and alcohol free~~ environment and to deter the use of drugs and alcohol at the workplace, if the employer has reason to suspect that the injury was occasioned primarily by the intoxication of the employee or by the use of any drug, *as defined in this chapter,* which affected the employee to the extent that the employee's normal faculties were impaired, *and the employer has not implemented a drug-free workplace pursuant to ss. 440.101 and 440.102,* the employer may require the employee to submit to a test for the presence of any or all drugs or alcohol in his system.

(b) If the employee has, at the time of the injury, a blood alcohol level equal to or greater than the level specified in s. 316.193, or if the employee has a positive confirmation of a drug as defined in this act, it is presumed that the injury was occasioned primarily by the intoxication of, or by the influence of the drug upon, the employee. In the absence of a drug-free workplace program, this presumption may be rebutted by clear and convincing evidence that the intoxication or influence of the drug did not contribute to the injury. Percent by weight of alcohol in the blood must be based upon grams of alcohol per 100 milliliters of blood. If the results are positive, the testing facility must maintain the specimen for a minimum of 90 days. Blood serum may be used for testing purposes under this chapter; however, if this test is used, the presumptions under this section do not arise unless the blood alcohol level is proved to be medically and scientifically equivalent to or greater than the comparable blood alcohol level that would have been obtained if the test was based on percent by weight of alcohol in the blood. However, if, before the accident, the employer had actual knowledge of and expressly acquiesced in the employee's presence at the workplace while under the influence of such alcohol or drug, the presumptions specified in this subsection do not apply.

(c)~~(b)~~ If the injured worker refuses to submit to a *drug* test ~~for nonprescription controlled substances or alcohol~~, it shall be presumed in the absence of clear and convincing evidence to the contrary that the injury was occasioned primarily by the influence of *drugs* ~~a nonprescription controlled substance or alcohol~~.

(d)~~(c)~~ The division shall provide by rule for the authorization and regulation of drug testing policies, procedures, and methods. Testing of injured employees shall not commence until such rules are adopted.

(8) If, by operation of s. 440.04, benefits become payable to a professional athlete under this chapter, such benefits shall be reduced or setoff in the total amount of injury benefits or wages payable during the period of disability by the employer under a collective bargaining agreement or contract for hire.

Section 6. Subsection (4) of section 440.092, Florida Statutes, is amended to read:

440.092 Special requirements for compensability; deviation from employment; subsequent intervening accidents.—

(4) TRAVELING EMPLOYEES.—An employee who is required to travel in connection with his employment who suffers an injury while in travel status shall be eligible for benefits under this chapter only if the injury arises out of and in the course of his employment while he is actively engaged in the duties of his employment. *This subsection applies to travel necessarily incident to performance of the employee's job responsibility but does not include travel to and from work as provided in subsection (2)*~~, which shall include travel necessary to and from the place where such duties are to be performed and other activities reasonably required by the travel status~~.

Section 7. Subsection (1) of section 440.10, Florida Statutes, is amended to read:

440.10 Liability for compensation.—

(1)(a) Every employer coming within the provisions of this chapter, including any brought within the chapter by waiver of exclusion or of exemption, shall be liable for, and shall secure, the payment to his employees, or any physician, surgeon, or pharmacist providing services under the provisions of s. 440.13, of the compensation payable under ss. 440.13, 440.15, and 440.16. ~~Every contractor or subcontractor, if required by rules requiring coverage according to the provisions of this chapter adopted by the Department of Labor and Employment Security, must, as a condition to receiving a building permit, show proof that he has secured compensation for his employees under this chapter as provided in s. 440.38 or, if applicable, provide a written certificate of election issued under s. 440.05. Further,~~ Any contractor or subcontractor who engages in any public or private construction in the state shall secure and maintain compensation for his employees under this chapter as provided in s. 440.38.

(b) In case a contractor sublets any part or parts of his contract work to a subcontractor or subcontractors, all of the employees of such contractor and subcontractor or subcontractors engaged on such contract work shall be deemed to be employed in one and the same business or establishment; and the contractor shall be liable for, and shall secure, the payment of compensation to all such employees, except to employees of a subcontractor who has secured such payment.

(c) A contractor may require a subcontractor to provide evidence of workers' compensation insurance or a copy of his certificate of election. A subcontractor electing to be exempt as a sole proprietor, partner, or officer of a corporation shall provide a copy of his certificate of election to his contractor.

(d)1. If a contractor becomes liable for the payment of compensation to the employees of a subcontractor who has failed to secure such pay-

ment in violation of s. 440.38, the contractor or other third-party payor shall be entitled to recover from the subcontractor all benefits paid or payable plus interest unless the contractor and subcontractor have agreed in writing that the contractor will provide coverage.

2. If a contractor or third-party payor becomes liable for the payment of compensation to the employee of a subcontractor who is actively engaged in the construction industry and has elected to be exempt from the provisions of this chapter, but whose election is invalid, the contractor or third-party payor may recover from the claimant, partnership, or corporation all benefits paid or payable plus interest, unless the contractor and the subcontractor have agreed in writing that the contractor will provide coverage.

~~(e) A subcontractor who knowingly presents or causes to be presented, any false, fraudulent, or misleading oral or written statement to any person as evidence of compliance with s. 440.38 commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.~~

(e)~~(f)~~ A subcontractor is not liable for the payment of compensation to the employees of another subcontractor on such contract work and is not protected by the exclusiveness-of-liability provisions of s. 440.11 from action at law or in admiralty on account of injury of such employee of another subcontractor.

(f) If an employer willfully fails to secure compensation as required by this chapter, the division may assess against the employer a penalty not to exceed $5,000 for each employee of that employer who is classified by the employer as an independent contractor but who is found by the division to not meet the criteria for an independent contractor that are set forth in s. 440.02.

(g) For purposes of this section, a person is conclusively presumed to be an independent contractor if:

1. The independent contractor provides the general contractor with an affidavit stating that he meets all the requirements of s. 440.02(13)(d); and

2. The independent contractor provides the general contractor with a valid certificate of workers' compensation insurance or a valid certificate of exemption issued by the division.

A sole proprietor, independent contractor, partner, or officer of a corporation who elects exemption from this chapter by filing a certificate of election under s. 440.05 may not recover benefits or compensation under this chapter.

Section 8. Section 440.101, Florida Statutes, is amended to read:

440.101 Legislative intent; drug-free workplaces.—

(1) It is the intent of the Legislature to promote drug-free workplaces in order that employers in the state be afforded the opportunity to maximize their levels of productivity, enhance their competitive positions in the marketplace, and reach their desired levels of success without experiencing the costs, delays, and tragedies associated with work-related accidents resulting from drug abuse by employees. It is further the intent of the Legislature that drug abuse be discouraged and that employees who choose to engage in drug abuse face the risk of unemployment and the forfeiture of workers' compensation benefits.

(2) If an employer implements a drug-free workplace program *in accordance with s. 440.102* which includes notice, education, and *procedural requirements for* testing for drugs and alcohol pursuant to rules developed by the division, the employer may require the employee to submit to a test for the presence of drugs or alcohol and, if a drug or alcohol is found to be present in the employee's system at a level prescribed by rule adopted pursuant to this act, the employee may be terminated and *forfeits* ~~shall forfeit~~ his eligibility for medical and indemnity benefits ~~upon exhaustion of the procedures prescribed in s. 440.102(5)~~. However, a drug-free workplace program *must* ~~shall~~ require the employer to notify all employees that it is a condition of employment *for an employee* to refrain from *reporting to work or working with the presence of* ~~taking~~ drugs *or alcohol in his or her body* ~~on or off the job~~ and, if *an* ~~the~~ injured *employee* ~~worker~~ refuses to submit to a test for drugs or alcohol, *the employee* ~~he~~ forfeits ~~his~~ eligibility for medical and indemnity benefits.

Section 9. Section 440.102, Florida Statutes, is amended to read:

440.102 Drug-free workplace program requirements.—The following *provisions* apply to a drug-free workplace program implemented pursuant to rules adopted by the division:

(1) DEFINITIONS.—Except where the context otherwise requires, as used in this act:

(a)~~(c)~~ "Chain of custody" refers to the methodology of tracking specified materials or substances for the purpose of maintaining control and accountability from initial collection to final disposition for all such materials or substances and providing for accountability at each stage in handling, testing, and storing specimens and reporting test results.

(b)~~(d)~~ "Confirmation test," "confirmed test," or "confirmed drug test" means a second analytical procedure used to identify the presence of a specific drug or metabolite in a specimen, *which.* ~~The confirmation~~ test must be different in scientific principle from that of the initial test procedure *and.* ~~This confirmation method~~ must be capable of providing requisite specificity, sensitivity, and quantitative accuracy.

(c)~~(a)~~ "Drug" means alcohol, including *a* distilled *spirit* ~~spirits~~, wine, *a* malt *beverage* ~~beverages~~, *or an* ~~and~~ intoxicating *liquor* ~~liquors~~; *an amphetamine* ~~amphetamines~~; *a cannabinoid* ~~cannabinoids~~; cocaine; phencyclidine (PCP); *a hallucinogen* ~~hallucinogens~~; methaqualone; *an opiate* ~~opiates~~; *a barbiturate* ~~barbiturates~~; *a benzodiazepine* ~~benzodiazepines~~; *a* synthetic *narcotic* ~~narcotics~~; *a* designer *drug* ~~drugs~~; or a metabolite of any of the substances listed *in this paragraph* ~~herein~~. *An employer may test an individual for any or all of such drugs.*

(d) "Drug rehabilitation program" means a service provider, established pursuant to s. 397.311(28), that provides confidential, timely, and expert identification, assessment, and resolution of employee drug abuse.

(e)~~(b)~~ "Drug test" or "test" means any chemical, biological, or physical instrumental analysis administered, *by a laboratory certified by the United States Department of Health and Human Services or licensed by the Agency for Health Care Administration,* for the purpose of determining the presence or absence of a drug or its metabolites.

(f)~~(g)~~ "Employee" means any person who works for salary, wages, or other remuneration for an employer.

(g)~~(l)~~ "Employee assistance program" means an established program *capable of providing expert assessment of employee personal concerns; confidential and timely identification services with regard to employee drug abuse; referrals of employees for appropriate diagnosis, treatment, and assistance; and followup services for employees who participate in the program or require monitoring after returning to work. If, in addition to the above activities, an employee assistance program provides diagnostic and treatment services, these services shall in all cases be provided by service providers pursuant to s. 397.311(28)* ~~for employee assessment, counseling, and possible referral to an alcohol and drug rehabilitation program~~.

(h) "Employer" means a person or entity that employs a person and that is covered by the Workers' Compensation Law.

(i)~~(e)~~ "Initial drug test" means a sensitive, rapid, and reliable procedure to identify negative and presumptive positive *specimens, using* ~~specimens. All initial tests shall use~~ an immunoassay procedure or an equivalent, or ~~shall use~~ a more accurate scientifically accepted method approved by the *United States Food and Drug Administration or the Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ as such more accurate technology becomes available in a cost-effective form.

(j)~~(f)~~ "Job applicant" means a person who has applied for a position with an employer and has been offered employment conditioned upon successfully passing a drug test, *and may have begun work pending the results of the drug test. For a public employer, "job applicant" means only a person who has applied for a special-risk or safety-sensitive position.*

(k) "Medical review officer" or "MRO" means a licensed physician, employed with or contracted with an employer, who has knowledge of substance abuse disorders, laboratory testing procedures, and chain of custody collection procedures; who verifies positive, confirmed test results; and who has the necessary medical training to interpret and evaluate an employee's positive test result in relation to the employee's medical history or any other relevant biomedical information.

(l)~~(i)~~ "Prescription or nonprescription medication" means a drug or medication obtained pursuant to a prescription as defined by s. 893.02 or a medication that is authorized pursuant to federal or state law for general distribution and use without a prescription in the treatment of human diseases, ailments, or injuries.

(m) "Public employer" means any agency within state, county, or municipal government that employs individuals for a salary, wages, or other remuneration.

(n)~~(j)~~ "*Reasonable-suspicion* ~~Reasonable suspicion~~ drug testing" means drug testing based on a belief that an employee is using or has used drugs in violation of the employer's policy drawn from specific objective and articulable facts and reasonable inferences drawn from those facts in light of experience. Among other things, such facts and inferences may be based upon:

1. Observable phenomena while at work, such as direct observation of drug use or of the physical symptoms or manifestations of being under the influence of a drug.

2. Abnormal conduct or erratic behavior while at work or a significant deterioration in work performance.

3. A report of drug use, provided by a reliable and credible source~~, which has been independently corroborated~~.

4. Evidence that an individual has tampered with a drug test during his employment with the current employer.

5. Information that an employee has caused, ~~or~~ contributed to, *or been involved in* an accident while at work.

6. Evidence that an employee has used, possessed, sold, solicited, or transferred drugs while working or while on the employer's premises or while operating the employer's vehicle, machinery, or equipment.

(o) "Safety-sensitive position" means, with respect to a public employer, a position in which a drug impairment constitutes an immediate and direct threat to public health or safety, such as a position that requires the employee to carry a firearm, perform life-threatening procedures, work with confidential information or documents pertaining to criminal investigations, or work with controlled substances; a position subject to s. 110.1127; or a position in which a momentary lapse in attention could result in injury or death to another person.

(p) "Special-risk position" means, with respect to a public employer, a position that is required to be filled by a person who is certified under chapter 633 or chapter 943.

(q)~~(k)~~ "Specimen" means tissue, hair, or *a* product of the human body capable of revealing the presence of drugs or their metabolites, *as approved by the United States Food and Drug Administration or the Agency for Health Care Administration.*

(2) DRUG TESTING.—*An employer may test an employee or job applicant for any drug described in paragraph (1)(c). In order to qualify as having established a drug-free workplace program which affords an employer the ability to qualify for the discounts provided under s. 627.0915 and deny medical and indemnity benefits, under this chapter* all drug testing conducted by employers shall be in conformity with the standards *and procedures* established in this section and all applicable rules adopted pursuant to this section. However, *an employer does* ~~employers shall~~ not have a legal duty under this section to request an employee or job applicant to undergo drug testing. *If an employer fails to maintain a drug-free workplace program in accordance with the standards and procedures established in this section and in applicable rules, the employer shall not be eligible for discounts under s. 627.0915. All employers qualifying for and receiving discounts provided under s. 627.0915 must be reported annually by the insurer to the division.*

(3) NOTICE TO EMPLOYEES AND JOB APPLICANTS.—

(a) One time only, prior to testing, *an employer shall give* all employees and job applicants for employment ~~must be given~~ a written policy statement ~~from the employer~~ which contains:

1.~~(a)~~ A general statement of the employer's policy on employee drug use, which *must* ~~shall~~ identify:

a.~~1.~~ The types of *drug* testing an employee or job applicant may be required to submit to, including *reasonable-suspicion drug testing* ~~reasonable suspicion~~ or *drug testing conducted on any* other basis.~~; and~~

b.~~2.~~ The actions the employer may take against an employee or job applicant on the basis of a positive confirmed drug test result.

2.~~(b)~~ A statement advising the employee or job applicant of the existence of this section.

3.~~(c)~~ A general statement concerning confidentiality.

4.~~(d)~~ Procedures for employees and job applicants to confidentially report *to a medical review officer* the use of prescription or nonprescription medications *to a medical review officer* both before and after being tested.

5. A list ~~Additionally, employees and job applicants shall receive notice~~ of the most common medications, by brand name or common name, as applicable, as well as by chemical name, which may alter or affect a drug test. A list of such medications as developed by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ shall be available to employers through the Division of Workers' Compensation of the Department of Labor and Employment Security.

6.~~(e)~~ The consequences of refusing to submit to a drug test.

7.~~(f)~~ *A representative sampling of* names, addresses, and telephone numbers of employee assistance programs and local ~~alcohol and~~ drug rehabilitation programs.

8.~~(g)~~ A statement that an employee or job applicant who receives a positive confirmed ~~drug~~ test result may contest or explain the result to the *medical review officer* ~~employer~~ within 5 working days after *receiving* written notification of the ~~positive~~ test result*; that*~~.~~ if an employee's or job applicant's explanation or challenge is unsatisfactory to the *medical review officer, the medical review officer shall report a positive test result back to the* employer*; and that a*~~, the~~ person may contest the drug test result pursuant to rules adopted by the Department of Labor and Employment Security.

9.~~(h)~~ A statement informing the employee or job applicant of his responsibility to notify the laboratory of any administrative or civil action brought pursuant to this section.

10.~~(i)~~ A list of all drugs for which the employer will test, described by brand *name* ~~names~~ or common *name* ~~names~~, as applicable, as well as by chemical *name* ~~names~~.

11.~~(j)~~ A statement regarding any applicable collective bargaining agreement or contract and the right to appeal to the Public Employees Relations Commission or applicable court.

12.~~(k)~~ A statement notifying employees and job applicants of their right to consult *with a medical review officer* ~~the testing laboratory~~ for technical information regarding prescription *or* ~~and~~ nonprescription medication.

(b)~~(l)~~ An employer not having a *drug-testing* ~~drug testing~~ program shall ensure that at least 60 days elapse between a general one-time notice to all employees that a *drug-testing* ~~drug testing~~ program is being implemented and the beginning of actual drug testing. An employer having a *drug-testing* ~~drug testing~~ program in place prior to *July 1, 1990,* ~~the effective date of this section~~ is not required to provide a 60-day notice period.

(c)~~(m)~~ An employer shall include notice of drug testing on vacancy announcements for ~~those~~ positions for which drug testing is required. A notice of the employer's *drug-testing* ~~drug testing~~ policy must also be posted in an appropriate and conspicuous location on the employer's premises, and copies of the policy must be made available for inspection by the *employees or job applicants of the employer* ~~general public~~ during regular business hours in the employer's personnel office or other suitable locations.

(4) TYPES OF TESTING.—

(a) An employer is required to conduct the following types of drug tests ~~in order to qualify for the discounts provided under s. 627.0915~~:

1.~~(a)~~ Job applicant *drug* testing.—An employer must require job applicants to submit to a drug test and may use a refusal to submit to a drug test or a positive confirmed drug test as a basis for *refusing* ~~refusal~~ to hire *a* ~~the~~ job applicant.

2.~~(b)~~ *Reasonable-suspicion drug testing* ~~Reasonable suspicion~~.—An employer must require an employee to submit to *reasonable-suspicion* ~~reasonable suspicion~~ drug testing.

3.~~(c)~~ Routine *fitness-for-duty drug testing* ~~fitness for duty~~.—An employer must require an employee to submit to a drug test if the test is conducted as part of a routinely scheduled employee fitness-for-duty medical examination that is part of the employer's established policy or that is scheduled routinely for all members of an employment classification or group.

4.~~(d)~~ Followup *drug* testing.—If the employee in the course of employment enters an employee assistance program for drug-related problems, or *a* ~~an alcohol and~~ drug rehabilitation program, the employer must require the employee to submit to a drug test as a followup to such program, *unless the employee voluntarily entered the program. In those cases, the employer has the option to not require followup testing. If followup testing is required, it must be conducted at least once a year for a 2-year period after completion of the program. Advance notice of a followup testing date must not be given to the employee to be tested* ~~and on a quarterly, semiannual, or annual basis for up to 2 years thereafter~~.

(b) This subsection does not preclude a private employer from conducting random testing, or any other lawful testing, of employees for drugs.

(c) Limited testing of applicants, only if it is based on a reasonable classification basis, is permissible in accordance with division rule.

(5) PROCEDURES AND EMPLOYEE PROTECTION.—All specimen collection and testing for drugs under this section shall be performed in accordance with the following procedures:

(a) A sample shall be collected with due regard to the privacy of the individual providing the sample, and in a manner reasonably calculated to prevent substitution or contamination of the sample.

(b) Specimen collection *must* ~~shall~~ be documented, and the documentation procedures shall include:

1. Labeling of specimen containers so as to reasonably preclude the likelihood of erroneous identification of test results.

2. A form for the employee or job applicant to provide any information he considers relevant to the test, including identification of currently or recently used prescription or nonprescription medication or other relevant medical information. *The* ~~Such~~ form *must* ~~shall~~ provide notice of the most common medications by brand name or common name, as applicable, as well as by chemical name, which may alter or affect a drug test. The providing of information shall not preclude the administration of the drug test, but shall be taken into account in interpreting any positive confirmed *test result* ~~results~~.

(c) Specimen collection, storage, and transportation to the testing site shall be performed in a manner *that* ~~which will~~ reasonably *precludes* ~~preclude specimen~~ contamination or adulteration *of specimens.*

(d) Each initial *drug test* and confirmation test conducted under this section, not including the taking or collecting of a specimen to be tested, shall be conducted by a licensed *or certified* laboratory as described in subsection (9).

(e) A specimen for a drug test may be taken or collected by any of the following persons:

1. A physician, a physician assistant, a registered professional nurse, a licensed practical nurse, or a nurse practitioner or a certified paramedic who is present at the scene of an accident for the purpose of rendering emergency medical service or treatment.

2. A qualified person employed by a licensed *or certified* laboratory *as described in subsection (9).*

(f) A person who collects or takes a specimen for a drug test ~~conducted pursuant to this section~~ shall collect an amount sufficient for two drug tests as determined by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~.

(g) Every specimen that produces a positive, confirmed *test* result shall be preserved by the licensed *or certified* laboratory that *conducted* ~~conducts~~ the confirmation test for a period of at least 210 days after the *result* ~~results~~ of the ~~positive confirmation~~ test *was* ~~are~~ mailed or otherwise delivered to the *medical review officer* ~~employer~~. However, if an employee or job applicant undertakes an administrative or legal challenge to the test result, the employee or job applicant shall notify the laboratory and the sample shall be retained by the laboratory until the case or administrative appeal is settled. During the 180-day period after written notification of a positive test result, the employee or job applicant who has provided the specimen shall be permitted by the employer to have a portion of the specimen retested, at the employee's or job applicant's expense, at another laboratory, licensed and approved by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~, chosen by the employee or job applicant. The second laboratory must test at equal or greater sensitivity for the drug in question as the first laboratory. The first laboratory *that* ~~which~~ performed the test for the employer *is* ~~shall be~~ responsible for the transfer of the portion of the specimen to be retested, and for the integrity of the chain of custody during such transfer.

(h) Within 5 working days after receipt of a positive confirmed test result from the *medical review officer* ~~testing laboratory~~, an employer shall inform an employee or job applicant in writing of such positive test result, the consequences of such results, and the options available to the employee or job applicant.

~~(i)~~ The employer shall provide to the employee or job applicant, upon request, a copy of the test results.

(i)~~(j)~~ Within 5 working days after receiving notice of a positive confirmed test result, *an* ~~the~~ employee or job applicant may submit information to *the* ~~an~~ employer explaining or contesting the test *result* ~~results~~, and *explaining* why the *result does* ~~results do~~ not constitute a violation of the employer's policy.

(j)~~(k)~~ ~~If~~ *The* ~~an~~ employee's or job applicant's explanation or challenge of the positive test *result* ~~results~~ is unsatisfactory to the employer, a written explanation as to why the employee's or job applicant's explanation is unsatisfactory, along with the report of positive *result* ~~results~~, shall be provided by the employer to the employee or job applicant; and all such documentation shall be kept confidential by the employer pursuant to subsection (8) and shall be retained by the employer for at least 1 year.

(k)~~(l)~~ *An* ~~No~~ employer may *not* discharge, discipline, refuse to hire, discriminate against, or request or require rehabilitation of an employee or job applicant on the sole basis of a positive test result that has not been verified by a confirmation test *and by a medical review officer.*

(l)~~(m)~~ An employer *that* ~~who~~ performs drug testing or specimen collection shall use chain-of-custody procedures ~~as~~ established by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ to ensure proper recordkeeping, handling, labeling, and identification of all specimens ~~to be~~ tested.

(m)~~(n)~~ An employer shall pay the cost of all drug tests, initial and confirmation, which *the employer* ~~he~~ requires of employees.

~~(o)~~ An employee or job applicant shall pay the costs of any additional drug tests not required by the employer.

(n)~~(p)~~ *An* ~~No~~ employer shall *not* discharge, discipline, or discriminate against an employee solely upon the employee's voluntarily seeking treatment, while under the employ of the employer, for a drug-related problem if the employee has not previously tested positive for drug use, entered an employee assistance program for drug-related problems, or entered *a* ~~an alcohol and~~ drug rehabilitation program. *Unless otherwise provided by a collective bargaining agreement, an employer may select the employee assistance program or drug rehabilitation program if the employer pays the cost of the employee's participation in the program.*

(o)~~(q)~~ If *drug* testing is conducted based on reasonable suspicion, the employer shall promptly detail in writing the circumstances which formed the basis of the determination that reasonable suspicion existed to warrant the testing. A copy of this documentation shall be given to the employee upon request and the original documentation shall be kept confidential by the employer pursuant to subsection (8) and shall be retained by the employer for at least 1 year.

(p) All authorized remedial treatment, care, and attendance provided by a health care provider to an injured employee before medical and indemnity benefits are denied under this section must be paid for by the carrier or self-insurer. However, the carrier or self-insurer must have given reasonable notice to all affected health care providers that

payment for treatment, care, and attendance provided to the employee after a future date certain will be denied. A health care provider, as defined in s. 440.13(1)(j), that refuses, without good cause, to continue treatment, care, and attendance before the provider receives notice of benefit denial commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(6) CONFIRMATION TESTING.—

(a) If an initial drug test is negative, the employer may in its sole discretion seek a confirmation test.

(b) Only licensed *or certified* laboratories as described in subsection (9) *may* ~~shall~~ conduct confirmation drug tests.

(c) All positive initial tests shall be confirmed using gas chromatography/mass spectrometry (GC/MS) or an equivalent or more accurate scientifically accepted method approved by the *Agency for Health Care Administration or the United States Food and Drug Administration* ~~Department of Health and Rehabilitative Services~~ as such technology becomes available in a cost-effective form.

(d) If an initial drug test of an employee or job applicant is confirmed as positive, the employer's medical review officer shall provide technical assistance to the employer and to the employee or job applicant for the purpose of interpreting the test result to determine whether the result could have been caused by prescription or nonprescription medication taken by the employee or job applicant.

(7) EMPLOYER PROTECTION.—

(a) *An* ~~No~~ employee or job applicant whose drug test result is confirmed as positive in accordance with ~~the provisions of~~ this section shall *not*, by virtue of the result alone, be *deemed to have a "handicap" or "disability" as defined under federal, state, or local handicap and disability discrimination laws* ~~defined as a person having a "handicap" as cited in the 1973 Rehabilitation Act~~.

(b) An employer who discharges or disciplines an employee or refuses to hire a job applicant in compliance with this section *is* ~~shall be~~ considered to have discharged, disciplined, or refused to hire for cause.

(c) No physician-patient relationship is created between an employee or job applicant and an employer or any person performing or evaluating a drug test, solely by the establishment, implementation, or administration of a *drug-testing* ~~drug testing~~ program.

(d) Nothing in this section shall be construed to prevent an employer from establishing reasonable work rules related to employee possession, use, sale, or solicitation of drugs, including convictions for drug-related offenses, and taking action based upon a violation of any of those rules.

(e) ~~Nothing in~~ This section *does not* ~~shall be construed to~~ operate retroactively, and *does not* ~~nothing in this section shall~~ abrogate the right of an employer under state law to conduct drug tests, or implement employee *drug-testing* ~~drug testing~~ programs~~, prior to October 1, 1990~~; however, only those programs that meet the criteria outlined in this section qualify for reduced rates under s. 627.0915.

(f) If an employee or job applicant refuses to submit to a drug test, the employer *is* ~~shall~~ not ~~be~~ barred from discharging or disciplining the employee or from refusing to hire the job applicant. However, ~~nothing in~~ this paragraph *does not* ~~shall~~ abrogate the rights and remedies of the employee or job applicant as otherwise provided in this section.

(g) ~~Nothing in~~ This section *does not* ~~shall be construed to~~ prohibit an employer from conducting medical screening or other tests required, *permitted, or not disallowed* by any statute, rule, or regulation for the purpose of monitoring exposure of employees to toxic or other unhealthy substances in the workplace or in the performance of job responsibilities. Such screening or *testing is* ~~tests shall be~~ limited to the specific substances expressly identified in the applicable statute, rule, or regulation, unless prior written consent of the employee is obtained for other tests. *Such screening or testing need not be in compliance with the rules adopted by the Department of Labor and Employment Security and the Agency for Health Care Administration under s. 112.0455. A public employer may, through the use of an unbiased selection procedure, conduct random drug tests of employees occupying safety-sensitive or special-risk positions if the testing is performed in accordance with drug-testing rules adopted by the Agency for Health Care Administration and the Department of Labor and Employment Security. If applicable, random drug testing must be specified in a collective bargaining agreement as negotiated by the appropriate certified bargaining agent before such testing is implemented.*

(h) No cause of action shall arise in favor of any person based upon the failure of an employer to establish a program or policy for drug testing.

(8) CONFIDENTIALITY.—The provisions of s. 119.07 to the contrary notwithstanding:

(a) All information, interviews, reports, statements, memoranda, and drug test results, written or otherwise, received by the employer through a *drug-testing* ~~drug testing~~ program are confidential communications and may not be used or received in evidence, obtained in discovery, or disclosed in any public or private proceedings, except in accordance with this section or in determining compensability under this chapter.

(b) Employers, laboratories, *medical review officers,* employee assistance programs, drug ~~and alcohol~~ rehabilitation programs, and their agents who receive or have access to information concerning drug test results shall keep all information confidential. Release of such information under any other circumstance *is authorized* ~~shall be~~ solely pursuant to a written consent form signed voluntarily by the person tested, unless such release is compelled by a hearing officer or a court of competent jurisdiction pursuant to an appeal taken under this section~~,~~ or *is* ~~unless~~ deemed appropriate by a professional or occupational licensing board in a related disciplinary proceeding. The consent form must contain, at a minimum:

1. The name of the person who is authorized to obtain the information.

2. The purpose of the disclosure.

3. The precise information to be disclosed.

4. The duration of the consent.

5. The signature of the person authorizing release of the information.

(c) Information on drug test results shall not be released or used in any criminal proceeding against the employee or job applicant. Information released contrary to this section *is* ~~shall be~~ inadmissible as evidence in any such criminal proceeding.

(d) *This subsection does not* ~~Nothing herein shall be construed to~~ prohibit *an* ~~the~~ employer, agent of *an* ~~the~~ employer, or laboratory conducting a drug test from having access to employee drug test information *or using such information* when consulting with legal counsel in connection with actions brought under or related to this section or when the information is relevant to its defense in a civil or administrative matter.

(9) *DRUG-TESTING* ~~DRUG TESTING~~ STANDARDS *FOR*~~;~~ LABORATORIES.—

(a) *A* ~~No~~ laboratory may *not* analyze initial or confirmation *test* ~~drug~~ specimens unless:

1. The laboratory is licensed and approved by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ using criteria established by the *United States Department of Health and Human Services* ~~National Institute on Drug Abuse~~ as guidelines for modeling the state drug testing program pursuant to this section *or the laboratory is certified by the United States Department of Health and Human Services.*

2. The laboratory has written procedures to ensure the chain of custody.

3. The laboratory follows proper quality control procedures, including, but not limited to:

a. The use of internal quality controls, including the use of samples of known concentrations which are used to check the performance and calibration of testing equipment, and periodic use of blind samples for overall accuracy.

b. An internal review and certification process for drug test results, conducted by a person qualified to perform that function in the testing laboratory.

c. Security measures implemented by the testing laboratory to preclude adulteration of specimens and drug test results.

d. Other necessary and proper actions taken to ensure reliable and accurate drug test results.

(b) A laboratory shall disclose to the *medical review officer* ~~employer~~ a written *positive confirmed* test result report within 7 working days after receipt of the sample. All laboratory reports of a drug test result *must* ~~shall~~, at a minimum, state:

1. The name and address of the laboratory *that* ~~which~~ performed the test and the positive identification of the person tested.

2. Positive results on confirmation tests only, or negative results, as applicable.

3. A list of the drugs for which the drug analyses were conducted.

4. The type of tests conducted for both initial *tests* and confirmation tests and the minimum cutoff levels of the tests.

5. Any correlation between medication reported by the employee or job applicant pursuant to subparagraph (5)(b)2. and a positive confirmed drug test result.

A ~~No~~ report *must not* ~~shall~~ disclose the presence or absence of any drug other than a specific drug and its metabolites listed pursuant to this section.

(c) The laboratory shall submit to the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ a monthly report with statistical information regarding the testing of employees and job applicants. The report *must* ~~shall~~ include information on the methods of *analysis* ~~analyses~~ conducted, the drugs tested for, the number of positive and negative results for both initial *tests* and confirmation tests, and any other information deemed appropriate by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~. *A* ~~No~~ monthly report *must not* ~~shall~~ identify specific employees or job applicants.

~~(d) Laboratories shall provide technical assistance to the employer, employee, or job applicant for the purpose of interpreting any positive confirmed test results which could have been caused by prescription or nonprescription medication taken by the employee or job applicant.~~

(10) RULES.—

~~(a)~~ The Department of Labor and Employment Security shall adopt rules, using *the* rules adopted by the *Agency for Health Care Administration* ~~Department of Health and Rehabilitative Services~~ pursuant to s. 112.0455 and criteria established by the *United States Department of Health and Human Services* ~~National Institute on Drug Abuse~~ as guidelines for modeling the state *drug-testing* ~~drug testing~~ program, concerning, but not limited to:

(a)~~1.~~ Standards for *licensing drug-testing laboratories* ~~drug testing laboratory licensing~~ and suspension and revocation of *such licenses* ~~a license~~.

(b)~~2.~~ Body specimens and minimum specimen amounts *that* ~~which~~ are appropriate for drug testing.

(c)~~3.~~ Methods of analysis and procedures to ensure reliable *drug-testing* ~~drug testing~~ results, including standards for initial tests and confirmation tests.

(d)~~4.~~ Minimum cutoff detection levels for *each drug* ~~drugs~~ or ~~their~~ metabolites *of such drug* for the purposes of determining a positive test result.

(e)~~5.~~ Chain-of-custody procedures to ensure proper identification, labeling, and handling of specimens ~~being~~ tested.

(f)~~6.~~ Retention, storage, and transportation procedures to ensure reliable results on confirmation tests and retests.

(11) PUBLIC EMPLOYEES IN SAFETY-SENSITIVE OR SPECIAL-RISK POSITIONS.—

(a) If an employee who is employed by a public employer in a safety-sensitive position enters an employee assistance program or drug rehabilitation program, the employer must assign the employee to a position other than a safety-sensitive position or, if such position is not available, place the employee on leave while the employee is participating in the program. However, the employee shall be permitted to use any accumulated annual leave credits before leave may be ordered without pay.

(b) An employee who is employed by a public employer in a special-risk position may be discharged or disciplined by a public employer for the first positive confirmed test result if the drug confirmed is an illicit drug under s. 893.03. A special-risk employee who is participating in an employee assistance program or drug rehabilitation program may not be allowed to continue to work in any special-risk or safety-sensitive position of the public employer, but may be assigned to a position other than a safety-sensitive position or placed on leave while the employee is participating in the program. However, the employee shall be permitted to use any accumulated annual leave credits before leave may be ordered without pay.

(12) DENIAL OF BENEFITS.—An employer shall deny an employee medical or indemnity benefits under this chapter, pursuant to this section.

(13)~~(b)~~ *COLLECTIVE BARGAINING RIGHTS.—This section does* ~~shall~~ not ~~be construed to~~ eliminate the bargainable rights as provided in the collective bargaining process if applicable.

Section 10. Section 440.103, Florida Statutes, is created to read:

440.103 Building permits.—Except as otherwise provided in this chapter, every employer shall, as a condition to receiving a building permit, show proof that it has secured compensation for its employees under this chapter as provided in ss. 440.10 and 440.38. Such proof of compensation must be evidenced by a certificate of coverage issued by the carrier, a valid exemption certificate approved by the division, or a copy of the employer's authority to self-insure. Each certificate of coverage must show, on its face, whether or not coverage is secured under the minimum premium provisions of the National Council of Compensation Insurers rules. The words "minimum premium policy" or similar language may be typed, printed, stamped, or legibly handwritten.

Section 11. Section 440.104, Florida Statutes, is created to read:

440.104 Competitive bidder; civil actions.—

(1) Any person engaged in the construction industry, as provided in s. 440.02(7), who loses a competitive bid for a contract may bring an action for damages against another person who is awarded the contract for which the bid was made, if the person making the losing bid establishes that the winning bidder knowingly violated the provisions of s. 440.10, s. 440.105 or s. 440.38 while performing the work under the contract.

(2) To recover in an action brought under this section, a party must establish a violation of s. 440.105 or s. 440.38 by a preponderance of the evidence.

(3) Upon establishing that the violation occurred, the person shall recover as liquidated damages 10 percent of the total amount bid on the contract by the person bringing the action, or $5,000, whichever is greater.

(4) In any action under this section, the prevailing party is entitled to an award of reasonable attorney's fees.

(5) An action under this section must be commenced within 2 years after the performance of activities involving any building, clearing, filling, or execution contract, or the substantial improvement in the size or use of any structure, or the appearance of any land.

(6) A person may not recover any amounts under this section if the defendant in the action establishes by a preponderance of the evidence that the plaintiff:

(a) Was in violation of s. 440.10, s. 440.105, or s. 440.38 at the time of making the bid on the contract; or

(b) Was in violation of s. 440.10, s. 440.105, or s. 440.38 with respect to any contract performed by the plaintiff within 1 year before making the bid on the contract.

(7)(a) Any person who loses a competitive bid may petition the court to join in a suit brought under this section by another person against the winning bidder on the same contract and shall be joined in such suit. If

more than one person is joined against the winning bidder and such persons prevail in the suit, the court must enter judgment dividing damages recoverable under this section between the parties equally.

(b) Any person who receives notice of a suit filed under this section and fails, within 20 days after receipt of such notice, to petition the court to join as a party to the suit is barred from bringing a cause of action under this section against the winning bidder on the contract at issue. For purposes of this subsection, publication in accordance with s. 49.10 constitutes sufficient notice.

Section 12. Section 440.105, Florida Statutes, is created to read:

440.105 Prohibited activities; penalties.—

(1)(a) Any insurance carrier, any individual self-insured, any commercial or group self-insurance fund, any professional practitioner licensed or regulated by the Department of Business and Professional Regulation, except as otherwise provided by law, any medical review committee as defined in s. 766.101, any private medical review committee, and any insurer, agent, or other person licensed under the insurance code, or any employee thereof, having knowledge or who believes that a fraudulent act or any other act or practice which, upon conviction, constitutes a felony or misdemeanor under this chapter is being or has been committed shall send to the Division of Insurance Fraud, Bureau of Workers' Compensation Fraud, a report or information pertinent to such knowledge or belief and such additional information relative thereto as the bureau may require. The bureau shall review such information or reports and select such information or reports as, in its judgment, may require further investigation. It shall then cause an independent examination of the facts surrounding such information or report to be made to determine the extent, if any, to which a fraudulent act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under this chapter is being committed. The bureau shall report any alleged violations of law which its investigations disclose to the appropriate licensing agency and state attorney or other prosecuting agency having jurisdiction with respect to any such violations of this chapter. If prosecution by the state attorney or other prosecuting agency having jurisdiction with respect to such violation is not begun within 60 days of the bureau's report, the state attorney or other prosecuting agency having jurisdiction with respect to such violation shall inform the bureau of the reasons for the lack of prosecution.

(b) In the absence of fraud or bad faith, a person is not subject to civil liability for libel, slander, or any other relevant tort by virtue of filing reports, without malice, or furnishing other information, without malice, required by this section or required by the bureau, and no civil cause of action of any nature shall arise against such person:

1. For any information relating to suspected fraudulent acts furnished to or received from law enforcement officials, their agents, or employees;

2. For any information relating to suspected fraudulent acts furnished to or received from other persons subject to the provisions of this chapter; or

3. For any such information relating to suspected fraudulent acts furnished in reports to the bureau, or the National Association of Insurance Commissioners.

(2) Whoever violates any provision of this subsection commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(a) It shall be unlawful for any employer to knowingly:

1. Coerce or attempt to coerce, as a precondition to employment or otherwise, an employee to obtain a certificate of election of exemption pursuant to s. 440.05.

2. Discharge or refuse to hire an employee or job applicant because the employee or applicant has filed a claim for benefits under this chapter.

3. Discharge, discipline, or take any other adverse personnel action against any employee for disclosing information to the division or any law enforcement agency relating to any violation or suspected violation of any of the provisions of this chapter or rules promulgated hereunder.

4. Violate a stop-work order issued by the division pursuant to s. 440.107.

(b) It shall be unlawful for any insurance entity to revoke or cancel a workers' compensation insurance policy or membership because an employer has returned an employee to work or hired an employee who has filed a workers' compensation claim.

(3) Whoever violates any provision of this subsection commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(a) It shall be unlawful for any employer to knowingly fail to update applications for coverage as required by s. 440.381(1) and Department of Insurance rules, or to post notice of coverage pursuant to s. 440.40.

(b) It shall be unlawful for any attorney or other person, in his individual capacity or in his capacity as a public or private employee, or for any firm, corporation, partnership, or association to receive any fee or other consideration or any gratuity from a person on account of services rendered for a person in connection with any proceedings arising under this chapter, unless such fee, consideration, or gratuity is approved by a judge of compensation claims or by the Chief Judge of Compensation Claims.

(4) Whoever violates any provision of this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(a) It shall be unlawful for any employer to knowingly:

1. Present or cause to be presented any false, fraudulent, or misleading oral or written statement to any person as evidence of compliance with s. 440.38.

2. Make a deduction from the pay of any employee entitled to the benefits of this chapter for the purpose of requiring the employee to pay any portion of premium paid by his employer to a carrier or to contribute to a benefit fund or department maintained by such employer for the purpose of providing compensation or medical services and supplies as required by this chapter.

3. Fail to secure payment of compensation if required to do so by this chapter.

(b) It shall be unlawful for any person:

1. To knowingly make, or cause to be made, any false, fraudulent, or misleading oral or written statement for the purpose of obtaining or denying any benefit or payment under this chapter.

2. To present or cause to be presented any written or oral statement as part of, or in support of, a claim for payment of other benefit pursuant to any provision of this chapter, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim.

3. To prepare or cause to be prepared any written or oral statement that is intended to be presented to any employer, insurance company, or self-insured program in connection with, or in support of, any claim for payment or other benefit pursuant to any provision of this chapter, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim.

4. To knowingly assist, conspire with, or urge any person to engage in activity prohibited by this section.

5. To knowingly make any false, fraudulent, or misleading oral or written statement, or to knowingly omit or conceal material information, required by s. 440.381 or s. 440.185, for the purpose of obtaining workers' compensation coverage or for the purpose of avoiding, delaying, or diminishing the amount of payment of any workers' compensation premiums.

6. To knowingly misrepresent or conceal payroll, classification of workers, or information regarding an employer's loss history which would be material to the computation and application of an experience rating modification factor for the purpose of avoiding or diminishing the amount of payment of any workers' compensation premiums.

7. To knowingly present or cause to be presented any false, fraudulent, or misleading oral or written statement to any person as evidence of compliance with s. 440.38.

(c) It shall be unlawful for any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractic physician licensed under chapter 460, podiatric physician licensed under chapter

461, optometric physician licensed under chapter 463, or any other practitioner licensed under the laws of this state to knowingly and willfully assist, conspire with, or urge any person to fraudulently violate any of the provisions of this chapter.

(d) It shall be unlawful for any person or governmental entity licensed under chapter 395 to maintain or operate a hospital in such a manner so that such person or governmental entity knowingly and willfully allows the use of the facilities of such hospital by any person, in a scheme or conspiracy to fraudulently violate any of the provisions of this chapter.

(e) It shall be unlawful for any attorney or other person, in his individual capacity or in his capacity as a public or private employee, or any firm, corporation, partnership, or association, to knowingly assist, conspire with, or urge any person to fraudulently violate any of the provisions of this chapter.

(f) It shall be unlawful for any attorney or other person, in his individual capacity or in his capacity as a public or private employee or for any firm, corporation, partnership, or association, to unlawfully solicit any business in and about city or county hospitals, courts, or any public institution or public place; in and about private hospitals or sanitariums; in and about any private institution; or upon private property of any character whatsoever for the purpose of making workers' compensation claims.

(5) This section shall not be construed to preclude the applicability of any other provision of criminal law that applies or may apply to any transaction.

(6) For the purpose of the section, the term "statement" includes, but is not limited to, any notice, representation, statement, proof of injury, bill for services, diagnosis, prescription, hospital or doctor records, x-ray, test result, or other evidence of loss, injury or expense.

(7) All claim forms as provided for in this chapter shall contain a notice that clearly states in substance the following: "Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree." Each claimant shall personally sign the claim form and attest that he has reviewed, understands, and acknowledges the foregoing notice.

Section 13. Section 440.1051, Florida Statutes, is created to read:

440.1051 Fraud reports; civil immunity; criminal penalties.—

(1) The Bureau of Workers' Compensation Insurance Fraud of the Division of Insurance Fraud of the Department of Insurance shall establish a toll-free telephone number to receive reports of workers' compensation fraud committed by an employee, employer, insurance provider, physician, attorney, or other person.

(2) Any person who reports workers' compensation fraud to the division under subsection (1) is immune from civil liability for doing so, and the person or entity alleged to have committed the fraud may not retaliate against him for providing such report, unless the person making the report knows it to be false.

(3) A person who calls and, knowingly and falsely, reports workers' compensation fraud or who, in violation of subsection (2) retaliates against a person for making such report, is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, or both.

Section 14. Section 440.106, Florida Statutes, is created to read:

440.106 Civil remedies; administrative penalties.—

(1) Whenever any circuit or special grievance committee acting under the jurisdiction of the Supreme Court finds probable cause to believe that an attorney has violated s. 440.105, such committee may forward to the appropriate state attorney a copy of the findings of probable cause and a copy of the report being filed in the matter.

(2) Whenever a physician, osteopath, chiropractor, podiatrist, or other practitioner is determined to have violated s. 440.105, the Board of Medical Examiners as set forth in chapter 458, the Board of Osteopathic Medical Examiners as set forth in chapter 459, the Board of Chiropractic as set forth in chapter 460, the Board of Podiatric Medicine as set forth in chapter 461, or other appropriate licensing authority, shall hold an administrative hearing to consider the imposition of administrative sanctions as provided by law against said physician, osteopath, chiropractor, or other practitioner.

(3) Whenever any group or individual self-insurer, carrier, rating bureau, or agent or other representative of any carrier or rating bureau is determined to have violated s. 440.105, the Department of Insurance may revoke or suspend the authority or certification of any group or individual self-insurer, carrier, agent, or broker.

(4) The division shall report any contractor determined in violation of requirements of this chapter to the appropriate state licensing board for disciplinary action.

(5) The terms "violation" or "violated" shall include having been found guilty of or having pleaded guilty or nolo contendere to a felony or misdemeanor under the law of the United States of America or any state thereof or under the law of any other country without regard to whether a judgment of conviction has been entered by the court having jurisdiction of such cases.

Section 15. Section 440.107, Florida Statutes, is created to read:

440.107 Division powers to enforce employer compliance with coverage requirements.—

(1) Whenever the division determines that an employer who is required to secure the payment to his employees of the compensation provided for by this chapter has failed to do so, such failure shall be deemed an immediate serious danger to public health, safety, or welfare sufficient to justify service by the division of a stop-work order on the employer, requiring the cessation of all business operations at the place of employment or job site. The order shall take effect upon the date of service upon the employer, unless the employer provides evidence satisfactory to the division of having secured any necessary insurance or self-insurance and pays a civil penalty to the division, to be deposited by the division into the Workers' Compensation Administration Trust Fund, in the amount of $100 per day for each day the employer was not in compliance with this chapter.

(2) The division may file a complaint in the circuit court in and for Leon County to enjoin any employer, who has failed to secure compensation as required by this chapter, from employing individuals and from conducting business until the employer presents evidence satisfactory to the division of having secured payment for compensation and pays a civil penalty to the division, to be deposited by the division into the Workers' Compensation Administration Trust Fund, in the amount of $100 per day for each day the employer was not in compliance with this chapter.

(3) In addition to any penalty, stop-work order, or injunction, the division may assess against any employer, who has failed to secure the payment of compensation as required by this chapter, a penalty in the amount of:

(a) Twice the amount the employer would have paid during periods it illegally failed to secure payment of compensation in the preceding 3-year period based on the employer's payroll during the preceding 3-year period; or

(b) One thousand dollars, whichever is greater.

Any penalty assessed under this subsection is due within 30 days after the date on which the employer is notified, except that, if the division has posted a stop-work order or obtained injunctive relief against the employer, payment is due, in addition to those conditions set forth in this section, as a condition to relief from a stop-work order or an injunction. Interest shall accrue on amounts not paid when due at the rate of 1 percent per month.

(4) The division may bring an action in circuit court to recover penalties assessed under this section, including any interest owed to the division pursuant to this section. In any action brought by the division pursuant to this section in which it prevails, the circuit court shall award costs, including the reasonable costs of investigation and a reasonable attorney's fee.

(5) Any judgment obtained by the division and any penalty due pursuant to the service of a stop-work order or otherwise due under this section shall, until collected, constitute a lien upon the entire interest of the employer, legal or equitable, in any property, real or personal, tangible or intangible; however, such lien is subordinate to claims for unpaid wages

and any prior recorded liens, and a lien created by this section is *not valid* against any person who, subsequent to such lien and in good faith and for value, purchases real or personal property from such employer or becomes the mortgagee on real or personal property of such employer, or against a subsequent attaching creditor, unless, with respect to real estate of the employer, a notice of the lien is recorded in the public records of the county where the real estate is located, and with respect to personal property of the employer, the notice is recorded with the Secretary of State.

(6) Any law enforcement agency in the state may, at the request of the division, render any assistance necessary to carry out the provisions of this section, including, but not limited to, preventing any employee or other person from remaining at a place of employment or job site after a stop-work order or injunction has taken effect.

(7) Actions by the division under this section must be contested as provided in chapter 120. All civil penalties assessed by the division must be paid into the Workers' Compensation Administration Trust Fund. The division shall return any sums previously paid, upon conclusion of an action if the division fails to prevail and if so directed by an order of court or an administrative hearing officer. The requirements of this subsection may be met by posting a bond in an amount equal to twice the penalty and in a form approved by the division.

Section 16. Subsection (1) of section 440.11, Florida Statutes, is amended to read:

440.11 Exclusiveness of liability.—

(1) The liability of an employer prescribed in s. 440.10 shall be exclusive and in place of all other liability of such employer to any third-party tortfeasor and to the employee, the legal representative thereof, husband or wife, parents, dependents, next of kin, and anyone otherwise entitled to recover damages from such employer at law or in admiralty on account of such injury or death, except that if an employer fails to secure payment of compensation as required by this chapter, an injured employee, or the legal representative thereof in case death results from the injury, may elect to claim compensation under this chapter or to maintain an action at law or in admiralty for damages on account of such injury or death. In such action the defendant may not plead as a defense that the injury was caused by negligence of a fellow employee, that the employee assumed the risk of the employment, or that the injury was due to the comparative negligence of the employee. The same immunities from liability enjoyed by an employer shall extend as well to each employee of the employer when such employee is acting in furtherance of the employer's business and the injured employee is entitled to receive benefits under this chapter. Such fellow-employee immunities shall not be applicable to an employee who acts, with respect to a fellow employee, with willful and wanton disregard or unprovoked physical aggression or with gross negligence when such acts result in injury or death or such acts proximately cause such injury or death, nor shall such immunities be applicable to employees of the same employer when each is operating in the furtherance of the employer's business but they are assigned primarily to unrelated works within private or public employment. The same immunity provisions enjoyed by an employer shall also apply to any sole proprietor, partner, corporate officer or director, supervisor, or other person who in the course and scope of his duties acts in a managerial or policymaking capacity and the conduct which caused the alleged injury arose within the course and scope of said managerial or policymaking duties and was not a violation of a law, whether or not a violation was charged, for which the maximum penalty which may be imposed does not exceed ~~exceeds~~ 60 days imprisonment as set forth in s. 775.082. *The immunity from liability provided in this subsection extends to county governments with respect to employees of county constitutional officers whose offices are funded by the board of county commissioners.*

Section 17. Section 440.13, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 440.13, F.S., for present text.)

440.13 Medical services and supplies; penalty for violations; limitations.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Alternate medical care" means a change in treatment or health care provider.

(b) "Attendant care" means care rendered by trained professional attendants which is beyond the scope of household duties. Family members may provide nonprofessional attendant care, but may not be compensated under this chapter for care that falls within the scope of household duties and other services normally and gratuitously provided by family members. "Family member" means a spouse, father, mother, brother, sister, child, grandchild, father-in-law, mother-in-law, aunt, or uncle.

(c) "Carrier" means, for purposes of this section, insurance carrier, self-insurance fund or individually self-insured employer, or assessable mutual insurer.

(d) "Catastrophic injury" means an injury as defined in s. 440.02.

(e) "Certified health care provider" means a health care provider who has been certified by the division or who has entered an agreement with a licensed managed care organization to provide treatment to injured workers under this section. Certification of such health care provider must include documentation that the health care provider has read and is familiar with the portions of the statute, impairment guides, and rules which govern the provision of remedial treatment, care, and attendance.

(f) "Compensable" means a determination by a carrier or judge of compensation claims that a condition suffered by an employee results from an injury arising out of and in the course of employment.

(g) "Emergency services and care" means services and care as defined in s. 395.002(9).

(h) "Health care facility" means any hospital licensed under chapter 395 and any health care institution licensed under chapter 400.

(i) "Health care provider" means a physician or any recognized practitioner who provides skilled services pursuant to a prescription or under the supervision or direction of a physician and who has been certified by the division as a health care provider. The term "health care provider" includes a health care facility.

(j) "Independent medical examiner" means a physician selected by either an employee or a carrier to render one or more independent medical examinations in connection with a dispute arising under this chapter.

(k) "Independent medical examination" means an objective evaluation of the injured employee's medical condition, including, but not limited to, impairment or work status, performed by a physician or an expert medical advisor at the request of a party, a judge of compensation claims, or the division to assist in the resolution of a dispute arising under this chapter.

(l) "Instance of overutilization" means a specific inappropriate service or level of service provided to an injured employee.

(m) "Medically necessary" means any medical service or medical supply which is used to identify or treat an illness or injury, is appropriate to the patient's diagnosis and status of recovery, and is consistent with the location of service, the level of care provided, and applicable practice parameters. The service should be widely accepted among practicing health care providers, based on scientific criteria, and determined to be reasonably safe. The service must not be of an experimental, investigative, or research nature, except in those instances in which prior approval of the Agency for Health Care Administration has been obtained. The Agency for Health Care Administration shall adopt rules providing for such approval on a case-by-case basis when the service or supply is shown to have significant benefits to the recovery and well-being of the patient.

(n) "Medicine" means a drug prescribed by an authorized health care provider and includes only generic drugs or single-source patented drugs for which there is no generic equivalent, unless the authorized health care provider writes or states that the brand-name drug as defined in s. 465.025 is medically necessary, or is a drug appearing on the schedule of drugs created pursuant to s. 465.025(6), or is available at a cost lower than its generic equivalent.

(o) "Palliative care" means noncurative medical services that mitigate the conditions, effects, or pain of an injury.

(p) "Pattern or practice of overutilization" means repetition of instances of overutilization within a specific medical case or multiple cases by a single health care provider.

(q) "Peer review" means an evaluation by two or more physicians licensed under the same authority and with the same or similar specialty

as the physician under review, of the appropriateness, quality, and cost of health care and health services provided to a patient, based on medically accepted standards.

(r) "Physician" or "doctor" means a medical doctor or doctor of osteopathy licensed under chapter 458, a physician licensed under chapter 458, an osteopath licensed under chapter 459, a chiropractor licensed under chapter 460, a podiatrist licensed under chapter 461, an optometrist licensed under chapter 463, or a dentist licensed under chapter 466, each of whom must be certified by the division as a health care provider.

(s) "Reimbursement dispute" means any disagreement between a health care provider or health care facility and carrier concerning payment for medical treatment.

(t) "Utilization control" means a systematic process of implementing measures that assure overall management and cost containment of services delivered.

(u) "Utilization review" means the evaluation of the appropriateness of both the level and the quality of health care and health services provided to a patient, including, but not limited to, evaluation of the appropriateness of treatment, hospitalization, or office visits based on medically accepted standards. Such evaluation must be accomplished by means of a system that identifies the utilization of medical services based on medically accepted standards as established by medical consultants with qualifications similar to those providing the care under review, and that refers patterns and practices of overutilization to the division.

(2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—

(a) Subject to the limitations specified elsewhere in this chapter, the employer shall furnish to the employee such medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require, including medicines, medical supplies, durable medical equipment, orthoses, prostheses, and other medically necessary apparatus. Remedial treatment, care, and attendance, including work-hardening programs or pain-management programs accredited by the Commission on Accreditation of Rehabilitation Facilities or Joint Commission on the Accreditation of Health Organizations or pain-management programs affiliated with medical schools, shall be considered as covered treatment only when such care is given based on a referral by a physician as defined in this chapter. Each facility shall maintain outcome data, including work status at discharges, total program charges, total number of visits, and length of stay. The department shall utilize such data and report to the President of the Senate and the Speaker of the House of Representatives regarding the efficacy and cost effectiveness of such program, no later than October 1, 1994. Medically necessary treatment, care, and attendance does not include chiropractic services in excess of 18 treatments or rendered 8 weeks beyond the date of the initial chiropractic treatment, whichever comes first, unless the carrier authorizes additional treatment or the employee is catastrophically injured.

(b) The employer shall provide appropriate professional or nonprofessional attendant care performed only at the direction and control of a physician when such care is medically necessary. The value of nonprofessional attendant care provided by a family member must be determined as follows:

1. If the family member is not employed, the per-hour value equals the federal minimum hourly wage.

2. If the family member is employed and elects to leave that employment to provide attendant or custodial care, the per-hour value of that care equals the per-hour value of the family member's former employment, not to exceed the per-hour value of such care available in the community at large. A family member or a combination of family members providing nonprofessional attendant care under this paragraph may not be compensated for more than a total of 12 hours per day.

(c) If the employer fails to provide treatment or care required by this section after request by the injured employee, the employee may obtain such treatment at the expense of the employer, if the treatment is compensable and medically necessary. There must be a specific request for the treatment, and the employer or carrier must be given a reasonable time period within which to provide the treatment or care. However, the employee is not entitled to recover any amount personally expended for the treatment or service unless he has requested the employer to furnish that treatment or service and the employer has failed, refused, or neglected to do so within a reasonable time or unless the nature of the injury requires such treatment, nursing, and services and the employer or his superintendent or foreman, having knowledge of the injury, has neglected to provide the treatment or service.

(d) The carrier has the right to transfer the care of an injured employee from the attending health care provider if an independent medical examination determines that the employee is not making appropriate progress in recuperation.

(e) Except in emergency situations and for treatment rendered by a managed care arrangement, after any initial examination and diagnosis by a physician providing remedial treatment, care, and attendance, and before a proposed course of medical treatment begins, each insurer shall review, in accordance with the requirements of this chapter, the proposed course of treatment, to determine whether such treatment would be recognized as reasonably prudent. The review must be in accordance with all applicable workers' compensation practice parameters. The insurer must accept any such proposed course of treatment unless the insurer notifies the physician of its specific objections to the proposed course of treatment by the close of the tenth business day after notification by the physician, or a supervised designee of the physician, of the proposed course of treatment.

(3) PROVIDER ELIGIBILITY; AUTHORIZATION.—

(a) As a condition to eligibility for payment under this chapter, a health care provider who renders services must be a certified health care provider and must receive authorization from the carrier before providing treatment. This paragraph does not apply to emergency care. The division shall adopt rules to implement the certification of health care providers. As a one-time prerequisite to obtaining certification, the division shall require each physician to demonstrate proof of completion of a minimum 5-hour course that covers the subject areas of cost containment, utilization control, ergonomics, and the practice parameters adopted by the division governing the physician's field of practice. The division shall coordinate with the Agency for Health Care Administration, the Florida Medical Association, the Florida Osteopathic Medical Association, the Florida Chiropractic Association, the Florida Podiatric Medical Association, the Florida Optometric Association, the Florida Dental Association, and other health professional organizations and their respective boards as deemed necessary by the Agency for Health Care Administration in complying with this subsection. No later than October 1, 1994, the division shall adopt rules regarding the criteria and procedures for approval of courses and the filing of proof of completion by the physicians.

(b) A health care provider who renders emergency care must notify the carrier by the close of the third business day after it has rendered such care. If the emergency care results in admission of the employee to a health care facility, the health care provider must notify the carrier by telephone within 24 hours after initial treatment. Emergency care is not compensable under this chapter unless the injury requiring emergency care arose as a result of a work-related accident. Pursuant to chapter 395, all licensed physicians and health care providers in this state shall be required to make their services available for emergency treatment of any employee eligible for workers' compensation benefits. To refuse to make such treatment available is cause for revocation of a license.

(c) A health care provider may not refer the employee to another health care provider, diagnostic facility, therapy center, or other facility without prior authorization from the carrier, except when emergency care is rendered. Any referral must be to a health care provider that has been certified by the division, unless the referral is for emergency treatment.

(d) A carrier must respond, by telephone or in writing, to a request for authorization by the close of the third business day after receipt of the request. A carrier who fails to respond to a written request for authorization for referral for medical treatment by the close of the third business day after receipt of the request consents to the medical necessity for such treatment. All such requests must be made to the carrier. Notice to the carrier does not include notice to the employer.

(e) Carriers shall adopt procedures for receiving, reviewing, documenting, and responding to requests for authorization. Such procedures shall be for a health care provider certified under this section.

(f) By accepting payment under this chapter for treatment rendered to an injured employee, a health care provider consents to the jurisdiction

of the division as set forth in subsection (11) and to the submission of all records and other information concerning such treatment to the division in connection with a reimbursement dispute, audit, or review as provided by this section. The health care provider must further agree to comply with any decision of the division rendered under this section.

(g) The employee is not liable for payment for medical treatment or services provided pursuant to this section except as otherwise provided in this section.

(h) The provisions of s. 455.236 are applicable to referrals among health care providers, as defined in subsection (1), treating injured workers.

(i) Notwithstanding paragraph (d), a claim for specialist consultations, surgical operations, physiotherapeutic or occupational therapy procedures, X-ray examinations, or special diagnostic laboratory tests that cost more than $1,000 and other specialty services that the division identifies by rule is not valid and reimbursable unless the services have been expressly authorized by the carrier, or unless the carrier has failed to respond within 10 days to a written request for authorization, or unless emergency care is required. The insurer shall not refuse to authorize such consultation or procedure unless the health care provider or facility is not authorized or certified or unless an expert medical advisor has determined that the consultation or procedure is not medically necessary or otherwise compensable under this chapter. Authorization of a treatment plan does not constitute express authorization for purposes of this section, except to the extent the carrier provides otherwise in its authorization procedures. This paragraph does not limit the carrier's obligation to identify and disallow overutilization or billing errors.

(j) Notwithstanding anything in this chapter to the contrary, a sick or injured employee shall be entitled, at all times, to free, full, and absolute choice in the selection of the pharmacy or pharmacist dispensing and filling prescriptions for medicines required under this chapter. It is expressly forbidden for the division, an employer or a carrier, or any agent or representative of the division, an employer, or a carrier to select the pharmacy or pharmacist which the sick or injured employee must use; condition coverage or payment on the basis of the pharmacy or pharmacist utilized; or to otherwise interfere in the selection by the sick or injured employee of a pharmacy or pharmacist.

(4) NOTICE OF TREATMENT TO CARRIER; FILING WITH DIVISION.—

(a) Any health care provider providing necessary remedial treatment, care, or attendance to any injured worker shall submit treatment reports to the carrier in a format prescribed by the division. A claim for medical or surgical treatment is not valid or enforceable against such employer or employee, unless, by the close of the third business day following the first treatment, the physician providing the treatment furnishes to the employer or carrier a preliminary notice of the injury and treatment on forms prescribed by the division and, within 15 days thereafter, furnishes to the employer or carrier a complete report, and subsequent thereto furnishes progress reports, if requested by the employer or insurance carrier, at intervals of not less than 3 weeks apart or at less frequent intervals if requested on forms prescribed by the division.

(b) Each medical report or bill obtained or received by the employer, the carrier, or the injured employee, or the attorney for the employer, carrier, or injured employee, with respect to the remedial treatment or care of the injured employee, including any report of an examination, diagnosis, or disability evaluation, must be filed with the Division of Workers' Compensation pursuant to rules adopted by the division. The health care provider shall also furnish to the injured employee or to his attorney, on demand, a copy of his office chart, records, and reports, and may charge the injured employee an amount authorized by the division for the copies. Each such health care provider shall provide to the division any additional information about the remedial treatment, care, and attendance that the division reasonably requests.

(c) It is the policy for the administration of the workers' compensation system that there be reasonable access to medical information by all parties to facilitate the self-executing features of the law. Notwithstanding the limitations in s. 455.241 and subject to the limitations in s. 381.004, upon the request of the employer, the carrier, or the attorney for either of them, the medical records of an injured employee must be furnished to those persons and the medical condition of the injured employee must be discussed with those persons, if the records and the discussions are restricted to conditions relating to the workplace injury. Any such discussions may be held before or after the filing of a claim without the knowledge, consent, or presence of any other party or his agent or representative. A health care provider who willfully refuses to provide medical records or to discuss the medical condition of the injured employee, after a reasonable request is made for such information pursuant to this subsection, shall be subject by the division to one or more of the penalties set forth in paragraph (8)(b).

(5) INDEPENDENT MEDICAL EXAMINATIONS.—

(a) In any dispute concerning overutilization, medical benefits, compensability, or disability under this chapter, the carrier or the employee may select an independent medical examiner. The examiner may be a health care provider treating or providing other care to the employee. An independent medical examiner may not render an opinion outside his area of expertise, as demonstrated by licensure and applicable practice parameters.

(b) Each party is bound by his selection of an independent medical examiner and is entitled to an alternate examiner only if:

1. The examiner is not qualified to render an opinion upon an aspect of the employee's illness or injury which is material to the claim or petition for benefits;

2. The examiner ceases to practice in the specialty relevant to the employee's condition;

3. The examiner is unavailable due to injury, death, or relocation outside a reasonably accessible geographic area; or

4. The parties agree to an alternate examiner.

Any party may request, or a judge of compensation claims may require, designation of a division medical advisor as an independent medical examiner. The opinion of the advisors acting as examiners shall not be afforded the presumption set forth in paragraph (9)(c).

(c) The carrier may, at its election, contact the claimant directly to schedule a reasonable time for an independent medical examination. The carrier must confirm the scheduling agreement in writing within 5 days and notify claimant's counsel, if any, at least 7 days before the date upon which the independent medical examination is scheduled to occur. An attorney representing a claimant is not authorized to schedule independent medical evaluations under this subsection.

(d) If the employee fails to appear for the independent medical examination without good cause and fails to advise the physician at least 24 hours before the scheduled date for the examination that he cannot appear, the employee is barred from recovering compensation for any period during which he has refused to submit to such examination. Further, the employee shall reimburse the carrier 50 percent of the physician's cancellation or no-show fee unless the carrier that schedules the examination fails to timely provide to the employee a written confirmation of the date of the examination pursuant to paragraph (c) which includes an explanation of why he failed to appear. The employee may appeal to a judge of compensation claims for reimbursement when the carrier withholds payment in excess of the authority granted by this section.

(e) No medical opinion other than the opinion of a medical advisor appointed by the judge of compensation claims or division, an independent medical examiner, or an authorized treating provider is admissible in proceedings before the judges of compensation claims.

(f) Attorney's fees incurred by an injured employee in connection with delay of or opposition to an independent medical examination, including, but not limited to, motions for protective orders, are not recoverable under this chapter.

(6) UTILIZATION REVIEW.—Carriers shall review all bills, invoices, and other claims for payment submitted by health care providers in order to identify overutilization and billing errors, and may hire peer review consultants or conduct independent medical evaluations. Such consultants, including peer review organizations, are immune from liability in the execution of their functions under this subsection to the extent provided in s. 766.101. If a carrier finds that overutilization of medical services or a billing error has occurred, it must disallow or adjust payment for such services or error without order of a judge of compensation claims or the division, if the carrier, in making its determination, has complied with this section and rules adopted by the division.

(7) UTILIZATION AND REIMBURSEMENT DISPUTES.—

(a) Any health care provider, carrier, or employer who elects to contest the disallowance or adjustment of payment by a carrier under subsection (6) must, within 30 days after receipt of notice of disallowance or adjustment of payment, petition the division to resolve the dispute. The petitioner must serve a copy of the petition on the carrier and on all affected parties by certified mail. The petition must be accompanied by all documents and records that support the allegations contained in the petition. Failure of a petitioner to submit such documentation to the division results in dismissal of the petition.

(b) The carrier must submit to the division within 10 days after receipt of the petition all documentation substantiating the carrier's disallowance or adjustment. Failure of the carrier to submit the requested documentation to the division within 10 days constitutes a waiver of all objections to the petition.

(c) Within 60 days after receipt of all documentation, the division must provide to the petitioner, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or disallowed payment. The division must be guided by standards and policies set forth in this chapter, including all applicable reimbursement schedules, in rendering its determination.

(d) If the division finds an improper disallowance or improper adjustment of payment by an insurer, the insurer shall reimburse the health care provider, facility, insurer, or employer within 30 days, subject to the penalties provided in this subsection.

(e) The division shall adopt rules to carry out this subsection. The rules may include provisions for consolidating petitions filed by a petitioner and expanding the timetable for rendering a determination upon a consolidated petition.

(f) Any carrier that engages in a pattern or practice of arbitrarily or unreasonably disallowing or reducing payments to health care providers may be subject to one or more of the following penalties imposed by the division:

1. Repayment of the appropriate amount to the health care provider.

2. An administrative fine assessed by the division in an amount not to exceed $5,000 per instance of improperly disallowing or reducing payments.

3. Award of the health care provider's costs, including a reasonable attorney's fee, for prosecuting the petition.

(8) PATTERN OR PRACTICE OF OVERUTILIZATION.—

(a) Carriers must report to the division all instances of overutilization including, but not limited to, all instances in which the carrier disallows or adjusts payment. The division shall determine whether a pattern or practice of overutilization exists.

(b) If the division determines that a health care provider has engaged in a pattern or practice of overutilization or a violation of this chapter or rules adopted by the division, it may impose one or more of the following penalties:

1. An order of the division barring the provider from payment under this chapter;

2. Deauthorization of care under review;

3. Denial of payment for care rendered in the future;

4. Decertification of a health care provider certified as an expert medical advisor under subsection (9) or of a rehabilitation provider certified under s. 440.49;

5. An administrative fine assessed by the division in an amount not to exceed $5,000 per instance of overutilization or violation; and

6. Notification of and review by the appropriate licensing authority pursuant to s. 440.106(3).

(9) EXPERT MEDICAL ADVISORS.—

(a) The division shall certify expert medical advisors in each specialty to assist the division and the judges of compensation claims within the advisor's area of expertise as provided in this section. The division shall, in a manner prescribed by rule, in certifying, recertifying, or decertifying an expert medical advisor, consider the qualifications, training, impartiality, and commitment of the health care provider to the provision of quality medical care at a reasonable cost. As a prerequisite for certification or recertification, the division shall require, at a minimum, that an expert medical advisor have specialized workers' compensation training or experience under the workers' compensation system of this state and board certification or board eligibility.

(b) The division shall contract with or employ expert medical advisors to provide peer review or medical consultation to the division or to a judge of compensation claims in connection with resolving disputes relating to reimbursement, differing opinions of health care providers, and health care and physician services rendered under this chapter. Expert medical advisors contracting with the division shall, as a term of such contract, agree to provide consultation or services in accordance with the timetables set forth in this chapter and to abide by rules adopted by the division, including, but not limited to, rules pertaining to procedures for review of the services rendered by health care providers and preparation of reports and recommendations for submission to the division.

(c) If there is disagreement in the opinions of the health care providers, if two health care providers disagree on medical evidence supporting the employee's complaints or the need for additional medical treatment, or if two health care providers disagree that the employee is able to return to work, the division may, and the judge of compensation claims shall, upon his own motion or within 15 days after receipt of a written request by either the injured employee, the employer, or the carrier, order the injured employee to be evaluated by an expert medical advisor. The opinion of the expert medical advisor is presumed to be correct unless there is clear and convincing evidence to the contrary as determined by the judge of compensation claims. The expert medical advisor appointed to conduct the evaluation shall have free and complete access to the medical records of the employee. An employee who fails to report to and cooperate with such evaluation forfeits entitlement to compensation during the period of failure to report or cooperate.

(d) The expert medical advisor must complete his evaluation and issue his report to the division or to the judge of compensation claims within 45 days after receipt of all medical records. The expert medical advisor must furnish a copy of the report to the carrier and to the employee.

(e) An expert medical advisor is not liable under any theory of recovery for evaluations performed under this section without a showing of fraud or malice. The protections of s. 766.101 apply to any officer, employee, or agent of the division and to any officer, employee, or agent of any entity with which the division has contracted under this subsection.

(f) If the division or a judge of compensation claims determines that the services of a certified expert medical advisor are required to resolve a dispute under this section, the carrier must compensate the advisor for his time in accordance with a schedule adopted by the division. The division may assess a penalty not to exceed $500 against any carrier that fails to timely compensate an advisor in accordance with this section.

(10) WITNESS FEES.—Any health care provider who gives a deposition shall be allowed a witness fee. The amount charged by the witness may not exceed $200 per hour. An expert witness who has never provided direct professional services to a party but has merely reviewed medical records and provided an expert opinion or has provided only direct professional services that were unrelated to the workers' compensation case may not be allowed a witness fee in excess of $200 per day.

(11) AUDITS BY DIVISION; JURISDICTION.—

(a) The Division of Workers' Compensation of the Department of Labor and Employment Security may investigate health care providers to determine whether providers are complying with this chapter and with rules adopted by the division, whether the providers are engaging in overutilization, and whether providers are engaging in improper billing practices. If the division finds that a health care provider has improperly billed, overutilized, or failed to comply with division rules or the requirements of this chapter it must notify the provider of its findings and may determine that the health care provider may not receive payment from the carrier or may impose penalties as set forth in subsection (8) or other sections of this chapter. If the health care provider has received payment from a carrier for services that were improperly billed or for overutilization, it must return those payments to the carrier. The division may

assess a penalty not to exceed $500 for each overpayment that is not refunded within 30 days after notification of overpayment by the division or carrier.

(b) The division shall monitor and audit carriers to determine if medical bills are paid in accordance with this section and division rules. Any employer, if self-insured, or carrier found by the division not to be within 90 percent compliance as to the payment of medical bills after July 1, 1994, must be assessed a fine not to exceed 1 percent of the prior year's assessment levied against such entity under s. 440.51 for every quarter in which the entity fails to attain 90-percent compliance. The division shall fine an employer or carrier, pursuant to rules adopted by the division, for each late payment of compensation that is below the minimum 90-percent performance standard. Any carrier that is found to be not in compliance in subsequent consecutive quarters must implement a medical-bill review program approved by the division, and the carrier is subject to disciplinary action by the Department of Insurance.

(c) The division has exclusive jurisdiction to decide any matters concerning reimbursement, to resolve any overutilization dispute under subsection (7), and to decide any question concerning overutilization under subsection (8), which question or dispute arises after January 1, 1994.

(d) The following division actions do not constitute agency action subject to review under s. 120.57 and do not constitute actions subject to s. 120.54 or s. 120.56: referral by the entity responsible for utilization review; a decision by the division to refer a matter to a peer review committee; establishment by a health care provider or entity of procedures by which a peer review committee reviews the rendering of health care services; and the review proceedings, report, and recommendation of the peer review committee.

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.—

(a) A three-member panel is created, consisting of the Insurance Commissioner, or his designee, and two members to be appointed by the Governor, subject to confirmation by the Senate, one member who, on account of present or previous vocation, employment, or affiliation, shall be classified as a representative of employers, the other member who, on account of previous vocation, employment, or affiliation, shall be classified as a representative of employees. The panel shall determine statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment. The maximum reimbursement allowances for inpatient hospital care shall be based on a schedule of per diem rates, to be approved by the three-member panel no later than March 1, 1994, to be used in conjunction with a precertification manual as determined by the division. All compensable charges for hospital outpatient care shall be reimbursed at 75 percent of usual and customary charges. Until the three-member panel approves a schedule of per diem rates for inpatient hospital care and it becomes effective, all compensable charges for hospital inpatient care must be reimbursed at 75 percent of their usual and customary charges. Annually, the three-member panel shall adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers, work-hardening programs, and pain programs. However, the maximum percentage of increase in the individual reimbursement allowance may not exceed the percentage of increase in the Consumer Price Index for the previous year. An individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program shall be reimbursed either the usual and customary charge for treatment, care, and attendance, the agreed-upon contract price, or the maximum reimbursement allowance in the appropriate schedule, whichever is less.

(b) As to reimbursement for a prescription medication, the reimbursement amount for a prescription shall be the average wholesale price times 1.2 plus $4.18 for the dispensing fee, except where the carrier has contracted for a lower amount. Fees for pharmaceutical and pharmaceutical services shall be reimbursable at the applicable fee schedule amount. Where the employer or carrier has contracted for such services and the employee elects to obtain them through a provider not a party to the contract, the carrier shall reimburse at the schedule, negotiated, or contract price, whichever is lower.

(c) Reimbursement for all fees and other charges for such treatment, care, and attendance, including treatment, care, and attendance provided by any hospital or other health care provider, ambulatory surgical center, work-hardening program, or pain program, must not exceed the amounts provided by the uniform schedule of maximum reimbursement allowances as determined by the panel or as otherwise provided in this section. This subsection also applies to independent medical examinations performed by health care providers under this chapter. Until the three-member panel approves a uniform schedule of maximum reimbursement allowances and it becomes effective, all compensable charges for treatment, care, and attendance provided by physicians, ambulatory surgical centers, work-hardening programs, or pain programs shall be reimbursed at the lowest maximum reimbursement allowance across all 1992 schedules of maximum reimbursement allowances for the services provided regardless of the place of service. In determining the uniform schedule, the panel shall first approve the data which it finds representative of prevailing charges in the state for similar treatment, care, and attendance of injured persons. Each health care provider, health care facility, ambulatory surgical center, work-hardening program, or pain program receiving workers' compensation payments shall maintain records verifying their usual charges. In establishing the uniform schedule of maximum reimbursement allowances, the panel must consider:

1. The levels of reimbursement for similar treatment, care, and attendance made by other health care programs or third-party providers;

2. The impact upon cost to employers for providing a level of reimbursement for treatment, care, and attendance which will ensure the availability of treatment, care, and attendance required by injured workers;

3. The financial impact of the reimbursement allowances upon health care providers and health care facilities, including trauma centers as defined in s. 395.401, and its effect upon their ability to make available to injured workers such medically necessary remedial treatment, care, and attendance. The uniform schedule of maximum reimbursement allowances must be reasonable, must promote health care cost containment and efficiency with respect to the workers' compensation health care delivery system, and must be sufficient to ensure availability of such medically necessary remedial treatment, care, and attendance to injured workers; and

4. The most recent average maximum allowable rate of increase for hospitals determined by the Health Care Board under chapter 408.

(13) REMOVAL OF PHYSICIANS FROM LISTS OF THOSE AUTHORIZED TO RENDER MEDICAL CARE.—The division shall remove from the list of physicians or facilities authorized to provide remedial treatment, care, and attendance under this chapter the name of any physician or facility found after reasonable investigation to have:

(a) Engaged in professional or other misconduct or incompetency in connection with medical services rendered under this chapter;

(b) Exceeded the limits of his or its professional competence in rendering medical care under this chapter, or to have made materially false statements regarding his or its qualifications in his application;

(c) Failed to transmit copies of medical reports to the employer or carrier, or failed to submit full and truthful medical reports of all his or its findings to the employer or carrier as required under this chapter;

(d) Solicited, or employed another to solicit for himself or itself or for another, professional treatment, examination, or care of an injured employee in connection with any claim under this chapter;

(e) Refused to appear before, or to answer upon request of, the division or any duly authorized officer of the state, any legal question, or to produce any relevant book or paper concerning his conduct under any authorization granted to him under this chapter;

(f) Self-referred in violation of this chapter or other laws of this state; or

(g) Engaged in a pattern of practice of overutilization or a violation of this chapter or rules adopted by the division.

(14) PAYMENT OF MEDICAL FEES.—

(a) Except for emergency care treatment, fees for medical services are payable only to a health care provider certified and authorized to render remedial treatment, care, or attendance under this chapter. A health care provider may not collect or receive a fee from an injured employee within this state, except as otherwise provided by this chapter. Such providers have recourse against the employer or carrier for payment for services rendered in accordance with this chapter.

(b) Fees charged for remedial treatment, care, and attendance may not exceed the applicable fee schedules adopted under this chapter.

(c) Notwithstanding any other provision of this chapter, following overall maximum medical improvement from an injury compensable under this chapter, the employee is obligated to pay a copayment of $10 per visit for medical services. The copayment shall not apply to emergency care provided to the employee.

(15) PRACTICE PARAMETERS.—

(a) The Agency for Health Care Administration, in conjunction with the division and appropriate health professional associations and health-related organizations shall develop and may adopt by rule scientifically sound practice parameters for medical procedures relevant to workers' compensation claimants. Practice parameters developed under this section must focus on identifying effective remedial treatments and promoting the appropriate utilization of health care resources. Priority must be given to those procedures that involve the greatest utilization of resources either because they are the most costly or because they are the most frequently performed. Practice parameters for treatment of the ten top procedures associated with workers' compensation injuries including the remedial treatment of lower-back injuries must be developed by December 31, 1994.

(b) The guidelines may be initially based on guidelines prepared by nationally recognized health care institutions and professional organizations but should be tailored to meet the workers' compensation goal of returning employees to full employment as quickly as medically possible, taking into consideration outcomes-data collected from managed care providers and any other inpatient and outpatient facilities serving workers' compensation claimants.

(c) Procedures must be instituted which provide for the periodic review and revision of practice parameters based on the latest outcomes-data, research findings, technological advancements, and clinical experiences, at least once every 3 years.

(d) Practice parameters developed under this section must be used by carriers and the division in evaluating the appropriateness and overutilization of medical services provided to injured employees.

Section 18. Section 440.134, Florida Statutes, is created to read:

440.134 Workers' Compensation Managed Care Arrangement.—

(1) As used in this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Complaint" means any dissatisfaction expressed by an injured worker concerning an insurer's workers' compensation managed care arrangement.

(c) "Emergency care" means medical services as defined in chapter 395.

(d) "Grievance" means 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.

(e) "Insurer" means an insurance carrier, self-insurance fund, assessable mutual insurer, or individually self-insured employer.

(f) "Service area" means the agency-approved geographic area within which an insurer is authorized to offer a workers' compensation managed care arrangement.

(g) "Workers' compensation managed care arrangement" means an arrangement under which a provider of health care, a health care facility, a group of providers of health care, a group of providers of health care and health care facilities, an insurer that has an exclusive provider organization approved under s. 627.6472 or a health maintenance organization licensed under part I of chapter 641 has entered into a written agreement directly or indirectly with an insurer to provide and to manage appropriate remedial treatment, care, and attendance to injured workers in accordance with this chapter.

(h) "Capitated contract" means a contract in which an insurer pays directly or indirectly a fixed amount to a health care provider in exchange for the future rendering of medical services for covered expenses.

(i) "Medical care coordinator" means a primary care provider within a provider network who is responsible for managing the medical care of an injured worker including determining other health care providers and health care facilities to which the injured employee will be referred for evaluation or treatment. A medical care coordinator shall be a physician licensed under chapter 458 or an osteopath licensed under chapter 459.

(j) "Provider network" means a comprehensive panel of health care providers and health care facilities who have contracted directly or indirectly with an insurer to provide appropriate remedial treatment, care, and attendance to injured workers in accordance with this chapter.

(k) "Primary care provider" means, except in the case of emergency treatment, the initial treating physician and, when appropriate, continuing treating physician, who may be a family practitioner, general practitioner, or internist physician licensed under chapter 458; a family practitioner, general practitioner, or internist osteopath licensed under chapter 459; a chiropractor licensed under chapter 460; a podiatrist licensed under chapter 461; an optometrist licensed under chapter 463; or a dentist licensed under chapter 466.

(2)(a) The agency shall, beginning April 1, 1994, authorize an insurer to offer or utilize a workers' compensation managed care arrangement after the insurer files a completed application along with the payment of a $1,000 application fee, and upon the agency's being satisfied that the applicant has the ability to provide quality of care consistent with the prevailing professional standards of care and the insurer and its workers' compensation managed care arrangement otherwise meets the requirements of this section. Effective April 1, 1994, no insurer may offer or utilize a managed care arrangement without such authorization. The authorization, unless sooner suspended or revoked, shall automatically expire 2 years after the date of issuance unless renewed by the insurer. The authorization shall be renewed upon application for renewal and payment of a renewal fee of $1,000, provided that the insurer is in compliance with the requirements of this section and any rules adopted hereunder. An application for renewal of the authorization shall be made 90 days prior to expiration of the authorization, on forms provided by the agency. The renewal application shall not require the resubmission of any documents previously filed with the agency if such documents have remained valid and unchanged since their original filing.

(b) Effective January 1, 1997, the employer shall, subject to the limitations specified elsewhere in this chapter, furnish to the employee solely through managed care arrangements such medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery requires.

(3) An insurer may not directly or indirectly enter into a capitated contract with any person who is not a health care provider, a health care facility, a health maintenance organization licensed under part I of chapter 641, or a health insurer that has an exclusive provider organization approved under s. 627.6472. A capitated contract must provide that the capitated amount for rendering of covered medical services be paid directly to the person who has contracted with the insurer. Such contracts excluding the capitated amount must be filed with the agency for approval prior to use.

(4) An insurer may not offer or utilize a workers' compensation managed care arrangement in this state until its managed care plan of operation has been approved by the agency and the insurer is authorized by the agency to offer or utilize a workers' compensation managed care arrangement.

(5) An insurer must file a proposed managed care plan of operation with the agency in a format prescribed by the agency. The plan of operation must contain evidence that all covered services are available and accessible, including a demonstration that:

(a) Such services can be provided with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care must reflect usual practice in the local area. Geographic availability must reflect the usual travel times within the community.

(b) Unless the agency determines that insufficient numbers of providers are available, the number of providers in the workers' compensation managed care arrangement service area are sufficient, with respect to current and expected workers to be served by the arrangement, either:

1. By delivery of all required medical services; or

2. Through the ability to make appropriate referrals within the provider network.

(c) There are written agreements with providers describing specific responsibilities.

(d) Emergency care is available 24 hours a day and 7 days a week.

(e) In the case of covered services, there are written agreements with providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any injured worker.

(6) The proposed managed care plan of operation must include:

(a) A statement or map providing a clear description of the service area.

(b) A description of the grievance procedure to be used.

(c) A description of the quality assurance program which assures that the health care services provided to workers shall be rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the medical community. The program shall include, but not be limited to:

1. A written statement of goals and objectives that stresses health and return-to-work outcomes as the principal criteria for the evaluation of the quality of care rendered to injured workers.

2. A written statement describing how methodology has been incorporated into an ongoing system for monitoring of care that is individual case oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers.

3. Written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

4. A written plan, which includes ongoing review, for providing review of physicians and other licensed medical providers.

5. Appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service.

6. Adequate methods of peer review and utilization review. The utilization review process shall include a health care facilities precertification mechanism, including, but not limited to, all elective admissions and nonemergency surgeries.

7. Provisions for resolution of disputes arising between a health care provider and an insurer regarding reimbursements and utilization review.

8. Availability of a process for aggressive medical care coordination, as well as a program involving cooperative efforts by the workers, the employer, and the workers' compensation managed care arrangement to promote early return to work for injured workers.

9. A process allowing employees to obtain one second medical opinion in the same specialty and within the provider network during the course of treatment for a work related injury.

10. A provision for the selection of a primary care provider by the employee from among primary providers in the provider network.

11. The written information proposed to be used by the insurer to comply with subparagraph 8.

(7) Written procedures to provide the insurer with timely medical records and information including, but not limited to, work status, work restrictions, date of maximum medical improvement, permanent impairment ratings, and other information as required.

(8) Evidence that appropriate health care providers and administrative staff of the insurer's workers' compensation managed care arrangement have received training and education on the provisions of chapter 440 and the administrative rules that govern the provision of remedial treatment, care, and attendance of injured workers.

(9) Written procedures and methods to prevent inappropriate or excessive treatment.

(10) Written procedures and methods for the management of an injured worker's medical care by a medical care coordinator including:

(a) The mechanism for assuring that covered employees receive all initial covered services from a primary care provider participating in the provider network, except for emergency care.

(b) The mechanism for assuring that all continuing covered services be received from the same primary care provider participating in the provider network that provided the initial covered services, except when services from another provider are authorized by the medical care coordinator pursuant to paragraph (d).

(c) The policies and procedures for allowing an employee one change to another provider within the same specialty and provider network as the authorized treating physician during the course of treatment for a work-related injury, if a request is made to the medical care coordinator by the employee; and requiring that special provision be made for more than one such referral through the arrangement's grievance procedures.

(d) The process for assuring that all referrals authorized by a medical care coordinator are made to the participating network providers, unless medically necessary treatment, care, and attendance are not available and accessible to the injured worker in the provider network.

(11) A description of the use of workers' compensation practice parameters for health care services when adopted by the agency.

(12) An insurer must file any proposed changes to the plan of operation, except for changes to the list of providers, with the agency prior to implementing the changes. The changes are considered approved by the agency after 45 days unless specifically disapproved.

(13) An updated list of providers must be filed with the agency at least semiannually.

(14) An insurer must make full and fair disclosure in writing of the provisions, restrictions, and limitations of the workers' compensation managed care arrangement to affected workers, including at least:

(a) A description, including address and phone number, of the providers, including primary care physicians, specialty physicians, hospitals, and other providers.

(b) A description of coverage for emergency and urgently needed care provided within and outside the service area.

(c) A description of limitations on referrals.

(d) A description of the grievance procedure.

(15)(a) A workers' compensation managed care arrangement must have and use procedures for hearing complaints and resolving written grievances from injured workers and health care providers. The procedures must be aimed at mutual agreement for settlement and may include arbitration procedures. Procedures provided herein are in addition to other procedures contained in chapter 440.

(b) The grievance procedure must be described in writing and provided to the affected workers and health care providers.

(c) At the time the workers' compensation managed care arrangement is implemented, the insurer must provide detailed information to workers and health care providers describing how a grievance may be registered with the insurer.

(d) Grievances must be considered in a timely manner and must be transmitted to appropriate decisionmakers who have the authority to fully investigate the issue and take corrective action.

(e) If a grievance is found to be valid, corrective action must be taken promptly.

(f) All concerned parties must be notified of the results of a grievance.

(g) The insurer must report annually, no later than March 31, to the agency regarding its grievance procedure activities for the prior calendar year. The report must be in a format prescribed by the agency and must contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.

(16) When a carrier enters into a managed care arrangement pursuant to this section the employees who are covered by the provisions of such arrangement shall be deemed to have received all the benefits to

which they are entitled pursuant to s. 440.13(2)(a) and (b). In addition, the employer shall be deemed to have complied completely with the requirements of such provisions. The provisions governing managed care arrangements shall govern exclusively unless specifically stated otherwise in this section.

(17) Notwithstanding any other provisions of this chapter, when a carrier provides medical care through a workers' compensation managed care arrangement, pursuant to this section, those workers who are subject to the arrangement must receive medical services for work-related injuries and diseases as prescribed in the contract, provided the employer and carrier have provided notice to the employees of the arrangement in a manner approved by the agency. Treatment received outside the workers' compensation managed care arrangement is not compensable unless authorized by the carrier prior to the treatment date.

(18) The agency may suspend the authority of an insurer to offer a workers' compensation managed care arrangement or order compliance within 60 days, if it finds that:

(a) The insurer is in substantial violation of its contracts;

(b) The insurer is unable to fulfill its obligations under outstanding contracts entered into with its employers;

(c) The insurer knowingly utilizes a provider who is furnishing or has furnished health care services and who does not have an existing license or other authority to practice or furnish health care services in this state;

(d) The insurer no longer meets the requirements for the authorization as originally issued; or

(e) The insurer has violated any lawful rule or order of the agency or any provision of this section.

(19) Revocation of an insurer's authorization shall be for a period of 2 years. After 2 years, the insurer may apply for a new authorization by compliance with all application requirements applicable to first-time applicants.

(20) Suspension of an insurer's authority to offer a workers' compensation managed care arrangement shall be for such period, not to exceed 1 year, as is fixed by the agency. The agency shall, in its order suspending the authority of an insurer to offer workers' compensation managed care, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the insurer prior to reinstatement of its authority. The order of suspension is subject to rescission or modification by further order of the agency prior to the expiration of the suspension period. Reinstatement shall not be made unless requested by the insurer; however, the agency shall not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.

(21) Upon expiration of the suspension period, the insurer's authorization shall automatically be reinstated unless the agency finds that the causes of the suspension have not been rectified or that the insurer is otherwise not in compliance with the requirements of this part. If not so automatically reinstated, the authorization shall be deemed to have expired as of the end of the suspension period.

(22) If the agency finds that one or more grounds exist for the revocation or suspension of an authorization issued under this section, the agency may, in lieu of such revocation or suspension, impose a fine upon the insurer. With respect to any nonwillful violation, such fine shall not exceed $2,500 per violation. In no event shall such fine exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of a lawful order or rule of the agency or a provision of this section, the agency may impose a fine upon the insurer in an amount not to exceed $20,000 for each such violation. In no event shall such fine exceed an aggregate amount of $100,000 for all knowing and willful violations arising out of the same action.

(23) The agency shall immediately notify the Department of Insurance and the Department of Labor and Employment Security whenever it issues an administrative complaint or an order or otherwise initiates legal proceedings resulting in, or which may result in, suspension or revocation of an insurer's authorization.

(24) Nothing in this part shall be deemed to authorize any entity to transact any insurance business, assume risk, or otherwise engage in any other type of insurance unless it is authorized as an insurer or a health maintenance organization under a certificate of authority issued by the Department of Insurance under the provisions of the Florida Insurance Code.

Section 19. Subsection (1) of section 440.135, Florida Statutes, is amended to read:

440.135 Pilot programs for medical and remedial care in workers' compensation.—

(1) It is the intent of the Legislature to determine whether the costs of the workers' compensation system can be effectively contained by monitoring more closely the medical, hospital, and remedial care required by s. 440.13, while providing injured workers with more prompt and effective care and earlier restoration of earning capacity without diminution of the quality of such care. *It is the further intent of the Legislature to determine whether the total cost to an employer that provides a policy or plan of health insurance and a separate policy or plan of workers' compensation and employer's liability insurance for its employees can be reduced by combining both coverages under a policy or plan that provides 24-hour health insurance coverage as set forth in this section.* Therefore, the Legislature authorizes the establishment of one or more pilot programs to be administered by the Department of Insurance after consulting with the division. Each pilot program shall terminate 2 years after the first date of operation of the program, unless extended by act of the Legislature. In order to *evaluate the feasibility of implementing* ~~implement~~ these pilot programs, the Department of Insurance shall consult with the division regarding:

~~(a) Initiating a pilot project basing reimbursement to hospitals on diagnostic related groups, if a study determines that it is cost-effective and a statistically valid method for reimbursement.~~

(a)~~(b)~~ *Establishing* ~~Establish~~ alternate delivery systems using a health maintenance organization model, which includes physician fees, competitive bidding, or capitation models.

(b)~~(c)~~ Controlling and enhancing the selection of providers of medical, hospital, and remedial care and using the peer review and utilization review procedures in s. 440.13(1) to control the utilization of care by physicians providing treatment pursuant to s. 440.13(2)(a).

(c)~~(d)~~ Establishing, by agreement, appropriate fees for medical, hospital, and remedial care pursuant to this chapter.

(d)~~(e)~~ Promoting effective and timely utilization of medical, hospital, and remedial care by injured workers.

(e)~~(f)~~ Coordinating the duration of payment of disability benefits with determination made by qualified participating providers of medical, hospital, or remedial care.

(f) Initiating one or more pilot programs under which participating employers would provide a 24-hour health insurance policy to their employees under a single insurance policy or self-insured plan. The policy or plan must provide a level of health insurance benefits which meets criteria established by the Department of Insurance but which provides medical benefits for at least occupational injuries and illnesses comparable to those required by this chapter and which may use deductibles and coinsurance provisions that require the employee to pay a portion of the actual medical care received by the employee, notwithstanding any other provisions of this chapter. The policy or plan may also provide indemnity benefits as specified in s. 440.38(1)(e). The employer shall pay the entire premium for the 24-hour health insurance policy or self-insured plan other than the portion of the premium which relates to dependent coverage.

(g) Other methods of monitoring reduced costs within the workers' compensation system while maintaining quality care.

Section 20. Section 440.15, Florida Statutes, is amended to read:

440.15 Compensation for disability.—Compensation for disability shall be paid to the employee, subject to the limits provided in s. 440.12(2), as follows:

(1) PERMANENT TOTAL DISABILITY.—

(a) In case of total disability adjudged to be permanent, 66 $^{2}/_{3}$ percent of the average weekly wages shall be paid to the employee during the continuance of such total disability.

(b) Only a catastrophic injury as defined in s. 440.02 ~~Loss of both hands, or both arms, or both feet, or both legs, or both eyes, or of any two thereof or paraplegia or quadriplegia~~ shall, in the absence of conclusive proof of a substantial earning capacity, constitute permanent total disability. *Only claimants with catastrophic injuries are eligible for permanent total benefits. In no other case may permanent total disability be awarded.* ~~In all other cases, permanent total disability shall be determined in accordance with the facts. In such other cases, no compensation shall be payable under paragraph (a) if the employee is engaged in, or is physically capable of engaging in, gainful employment; and the burden shall be upon the employee to establish that he is not able uninterruptedly to do even light work available within a 100 mile radius of the injured employee's residence due to physical limitation.~~

(c) In cases of permanent total disability resulting from injuries *that* ~~which~~ occurred prior to July 1, 1955, such payments shall not be made in excess of 700 weeks.

(d) If an employee who is being paid compensation for permanent total disability becomes rehabilitated to the extent that he establishes an earning capacity, he shall be paid, instead of the compensation provided in paragraph (a), ~~wage-loss~~ benefits pursuant to *subsection* ~~paragraph~~ (3)~~(b)~~. The division shall adopt rules to enable a permanently and totally disabled employee who may have reestablished an earning capacity to undertake a trial period of reemployment without prejudicing his return to permanent total status in the case that such employee is unable to sustain an earning capacity.

(e)1. The employer's or carrier's right to conduct vocational evaluations or testing pursuant to s. 440.491 continues even after the employee has been accepted or adjudicated as entitled to compensation under this chapter. This right includes, but is not limited to, instances in which such evaluations or tests are recommended by a treating physician or independent medical-examination physician, instances warranted by a change in the employee's medical condition, or instances in which the employee appears to be making appropriate progress in recuperation. This right may not be exercised more than once every calendar year.

2. The carrier must confirm the scheduling of the vocational evaluation or testing in writing, and must notify employee's counsel, if any, at least 7 days before the date on which vocational evaluation or testing is scheduled to occur.

3. Pursuant to an order of the judge of compensation claims, the employer or carrier may withhold payment of benefits for permanent total disability or supplements for any period during which the employee willfully fails or refuses to appear without good cause for the scheduled vocational evaluation or testing.

(f)~~(e)~~1. *If* ~~In case of~~ permanent total disability *results* ~~resulting~~ from injuries *that* ~~which~~ occurred subsequent to June 30, 1955, and for which the liability of the employer for compensation has not been discharged under ~~the provisions of~~ s. 440.20(12), the injured employee shall receive additional weekly compensation benefits equal to 5 percent of his weekly compensation rate, as established pursuant to the law in effect on the date of his injury, multiplied by the number of calendar years since the date of injury. The weekly compensation payable and the additional benefits payable *under* ~~pursuant to~~ this paragraph, when combined, *may* ~~shall~~ not exceed the maximum weekly compensation rate in effect at the time of payment as determined pursuant to s. 440.12(2). Entitlement to these supplemental payments shall cease at age 62 if the employee is eligible for social security benefits under 42 U.S.C. ss. 402 and 423, whether or not the employee has applied for such benefits. These supplemental benefits shall be paid by the division out of the Workers' Compensation Administration Trust Fund when the injury occurred subsequent to June 30, 1955, and before July 1, 1984. These supplemental benefits shall be paid by the employer when the injury occurred on or after July 1, 1984. Supplemental benefits are not payable for any period prior to October 1, 1974.

2.a. The division shall provide by rule for the periodic reporting to the division of all earnings of any nature and social security income by the injured employee entitled to or claiming additional compensation under subparagraph 1. Neither the division nor the employer or carrier shall make any payment of those additional benefits provided by subparagraph 1. for any period during which the employee willfully fails or refuses to report upon request by the division in the manner prescribed by such rules.

b. The division shall provide by rule for the periodic reporting to the employer or carrier of all earnings of any nature and social security income by the injured employee entitled to or claiming benefits for permanent total disability. The employer or carrier *is* ~~shall~~ not ~~be~~ required to make any payment of benefits for permanent total disability for any period during which the employee willfully fails or refuses to report upon request by the employer or carrier in the manner prescribed by such rules *or if any employee who is receiving permanent total disability benefits refuses to apply for or cooperate with the employer or carrier in applying for social security benefits.*

3. When an injured employee receives a full or partial lump-sum advance of the employee's permanent total disability compensation benefits, the employee's benefits under this paragraph shall be computed on the employee's weekly compensation rate as reduced by the lump-sum advance.

(2) TEMPORARY TOTAL DISABILITY.—

(a) In case of disability total in character but temporary in quality, 66 2/3 percent of the average weekly wages shall be paid to the employee during the continuance thereof, not to exceed *104* ~~260~~ weeks except as provided in *this subsection,* s. 440.12(1), *and s. 440.14(3). Once the employee reaches the maximum number of weeks allowed, or the employee reaches the date of maximum medical improvement, whichever occurs earlier, temporary disability benefits shall cease and the injured worker's permanent impairment shall be determined.*

(b) Notwithstanding the provisions of paragraph (a), an employee who has sustained the loss of an arm, leg, hand, or foot, has been rendered a paraplegic, paraparetic, quadriplegic, or quadriparetic, or has lost the sight of both eyes shall be paid temporary total disability of 80 percent of his average weekly wage. ~~In no event should~~ The increased temporary total disability compensation provided for in this paragraph *must not* extend beyond 6 months from the date of the accident. The compensation provided by this paragraph is not subject to the limits provided in s. 440.12(2), but instead is subject to a maximum weekly compensation rate of $700. If, at the conclusion of this period of increased temporary total disability compensation, the employee is still temporarily totally disabled, the employee shall continue to receive temporary total disability compensation as set forth in paragraphs (a) and (c). The period of time the employee has received this increased compensation will be counted as part of, and not in addition to, the maximum periods of time for which the employee is entitled to compensation under paragraph (a) but not paragraph (c).

(c) Temporary total disability benefits paid pursuant to this subsection shall include such period as may be reasonably necessary for training in the use of artificial members and appliances, and shall include such period as the employee may be receiving training and education under a program pursuant to s. 440.49(1). Notwithstanding s. 440.02(8), the date of maximum medical improvement for purposes of paragraph (3)(b) shall be no earlier than the last day for which such temporary disability benefits are paid.

(d) The division shall, by rule, provide for the periodic reporting to the division, employer, or carrier of all earned income, including income from Social Security, by the injured employee who is entitled to or claiming benefits for temporary total disability. The employer or carrier is not required to make any payment of benefits for temporary total disability for any period during which the employee willfully fails or refuses to report upon request by the employer or carrier in the manner prescribed by the rules. The rule must require the claimant to personally sign the claim form and attest that he has reviewed, understands, and acknowledges the foregoing.

(3) PERMANENT IMPAIRMENT AND WAGE-LOSS BENEFITS.—

(a) Impairment benefits.—

~~1. In case of permanent impairment due to amputation, loss of 80 percent or more of vision of either eye, after correction, or serious facial or head disfigurement resulting from an injury other than an injury entitling the injured worker to permanent total disability benefits pursuant to subsection (1), there shall be paid to the injured worker the following:~~

~~a. Two hundred and fifty dollars for each percent of permanent impairment of the body as a whole from 1 percent through 10 percent; and~~

~~b. Five hundred dollars for each percent of permanent impairment of the body as a whole for that portion in excess of 10 percent.~~

1.~~2.~~ Once the employee has reached the date of maximum medical improvement, impairment benefits are due and payable within 20 days after the carrier has knowledge of the impairment.

2.~~3.~~ The three-member panel, in cooperation with the division, shall establish and use a uniform *permanent impairment* ~~disability~~ rating *schedule* ~~guide by January 1, 1991~~. This *schedule must* ~~guide shall~~ be based on medically or scientifically demonstrable findings as well as the systems and criteria set forth in the American Medical Association's Guides to the Evaluation of Permanent Impairment; the Snellen Charts, published by American Medical Association Committee for Eye Injuries; and the Minnesota Department of Labor and Industry Disability Schedules. *The schedule should be based upon objective findings.* The *schedule* ~~guide~~ shall be more comprehensive than the AMA Guides to the Evaluation of Permanent Impairment and shall expand the areas already addressed and address additional areas not currently contained in the guides. On August 1, 1979, and pending the adoption, by rule, of a permanent schedule, Guides to the Evaluation of Permanent Impairment, copyright 1977, 1971, 1988, by the American Medical Association, shall be the temporary schedule and shall be used for the purposes hereof. For injuries after July 1, 1990, pending the adoption by division rule of a uniform disability rating *schedule* ~~guide~~, the Minnesota Department of Labor and Industry Disability Schedule shall be ~~temporarily~~ used unless that schedule does not address an injury. In such case, the Guides to the Evaluation of Permanent Impairment by the American Medical Association shall be used. *Determination of permanent impairment under this schedule must be made by a physician licensed under chapter 458, a doctor of osteopathy licensed under chapters 458 and 459, a chiropractor licensed under chapter 460, a podiatrist licensed under chapter 461, an optometrist licensed under chapter 463, or a dentist licensed under chapter 466, as appropriate considering the nature of the injury. No other persons are authorized to render opinions regarding the existence of or the extent of permanent impairment.*

3. All impairment income benefits shall be based on an impairment rating using the impairment schedule referred to in subparagraph 2. Impairment income benefits are paid weekly at the rate of 50 percent of the employee's average weekly temporary total disability benefit not to exceed the maximum weekly benefit under s. 440.12. An employee's entitlement to impairment income benefits begins the day after the employee reaches maximum medical improvement or the expiration of temporary benefits, whichever occurs earlier, and continues until the earlier of:

a. The expiration of a period computed at the rate of 3 weeks for each percentage point of impairment; or

b. The death of the employee.

4. After the employee has been certified by a doctor as having reached maximum medical improvement or 6 weeks before the expiration of temporary benefits, whichever occurs earlier, the certifying doctor shall evaluate the condition of the employee and assign an impairment rating, using the impairment schedule referred to in subparagraph 2. Compensation is not payable for the mental, psychological, or emotional injury arising out of depression from being out of work. If the certification and evaluation are performed by a doctor other than the employee's treating doctor, the certification and evaluation must be submitted to the treating doctor, and the treating doctor must indicate agreement or disagreement with the certification and evaluation. The certifying doctor shall issue a written report to the division, the employee, and the carrier certifying that maximum medical improvement has been reached, stating the impairment rating, and providing any other information required by the division. If the employee has not been certified as having reached maximum medical improvement before the expiration of 102 weeks after the date temporary total disability benefits begin to accrue, the carrier shall notify the treating doctor of the requirements of this section.

5. The carrier shall pay the employee impairment income benefits for a period based on the impairment rating.

(b) Supplemental benefits.—

1. All supplemental benefits must be paid in accordance with this subsection. An employee is entitled to supplemental benefits as provided in this paragraph as of the expiration of the impairment period, if:

a. The employee has an impairment rating from the compensable injury of 20 percent or more as determined pursuant to this chapter;

b. The employee has not returned to work or has returned to work earning less than 80 percent of the employee's average weekly wage as a direct result of the employee's impairment; and

c. The employee has in good faith attempted to obtain employment commensurate with the employee's ability to work.

2. If an employee is not entitled to supplemental benefits at the time of payment of the final weekly impairment income benefit because the employee is earning at least 80 percent of the employee's average weekly wage, the employee may become entitled to supplemental benefits at any time within 1 year after the impairment income benefit period ends if:

a. The employee earns wages that are less than 80 percent of the employee's average weekly wage for a period of at least 90 days;

b. The employee meets the other requirements of subparagraph 1.; and

c. The employee's decrease in earnings is a direct result of the employee's impairment from the compensable injury.

3. If an employee earns wages that are at least 80 percent of the employee's average weekly wage for a period of at least 90 days during which the employee is receiving supplemental benefits, the employee ceases to be entitled to supplemental benefits for the filing period. Supplemental benefits that have been terminated shall be reinstated when the employee satisfies the conditions enumerated in subparagraph 2. and files the statement required under subparagraph 5. Notwithstanding any other provision, if an employee is not entitled to supplemental benefits for 12 consecutive months, the employee ceases to be entitled to any additional income benefits for the compensable injury. If the employee is discharged within 12 months after losing entitlement under this subsection, benefits may be reinstated if the employee was discharged at that time with the intent to deprive the employee of supplemental benefits.

4. During the period that impairment income benefits or supplemental income benefits are being paid, the carrier has the affirmative duty to determine at least annually whether any extended unemployment or underemployment is a direct result of the employee's impairment. To accomplish this purpose, the division may require periodic reports from the employee and the carrier, and it may, at the carrier's expense, require any physical or other examinations, vocational assessments, or other tests or diagnoses necessary to verify that the carrier is performing its duty. Not more than once in each 12 calendar months, the employee and the carrier may each request that the division review the status of the employee and determine whether the carrier has performed its duty with respect to whether the employee's unemployment or underemployment is a direct result of impairment from the compensable injury.

5. After the initial determination of supplemental benefits, the employee must file a statement with the carrier stating that the employee has earned less than 80 percent of the employee's average weekly wage as a direct result of the employee's impairment, stating the amount of wages the employee earned in the filing period, and stating that the employee has in good faith sought employment commensurate with the employee's ability to work. The statement must be filed quarterly on a form and in the manner prescribed by the division. The division may modify the filing period as appropriate to an individual case. Failure to file a statement relieves the carrier of liability for supplemental benefits for the period during which a statement is not filed.

6. The carrier shall begin payment of supplemental benefits not later than the seventh day after the expiration date of the impairment income benefit period and shall continue to timely pay those benefits. The carrier may request a mediation conference for the purpose of contesting the employee's entitlement to or the amount of supplemental income benefits.

7. Supplemental benefits are calculated quarterly and paid monthly. For purposes of calculating supplemental benefits, 80 percent of the employee's average weekly wage and the average wages the employee has earned per week are compared quarterly. For purposes of this paragraph, if the employee is offered a bona fide position of employment that the employee is capable of performing, given the phys-

ical condition of the employee and the geographic accessibility of the position, the employee's weekly wages are considered equivalent to the weekly wages for the position offered to the employee.

8. Supplemental benefits are payable at the rate of 80 percent of the difference between 80 percent of the employee's average weekly wage determined pursuant to s. 440.14 and the weekly wages the employee has earned during the reporting period, not to exceed the maximum weekly income benefit under s. 440.12.

(d) Duration of temporary impairment, and supplemental income benefits.—The employee's eligibility for temporary benefits, impairment income benefits, and supplemental benefits terminates on the expiration of 401 weeks after the date of injury.

~~(b) Wage-loss benefits.—~~

~~1. Each injured worker who suffers a permanent impairment, which permanent impairment is determined pursuant to the schedule adopted in accordance with subparagraph (a)3., is not based solely on subjective complaints, and results in one or more work-related physical restrictions which are directly attributable to the injury, may be entitled to wage-loss benefits under this subsection, provided that such permanent impairment results in a work-related physical restriction which affects such employee's ability to perform the activities of his usual or other appropriate employment. Such benefits shall be based on actual wage loss and shall not be subject to the minimum compensation rate set forth in s. 440.12(2). Subject to the maximum compensation rate as set forth in s. 440.12(2), such wage-loss benefits shall be equal to 80 percent of the difference between 80 percent of the employee's average weekly wage and the salary, wages, and other remuneration the employee is able to earn after reaching maximum medical improvement, as compared weekly; however, the weekly wage-loss benefits shall not exceed an amount equal to 66 2/3 percent of the employee's average weekly wage at the time of injury. In order to simplify the comparison of the preinjury average weekly wage with the salary, wages, and other remuneration the employee is able to earn after reaching maximum medical improvement, the division may by rule provide for the modification of the weekly comparison so as to coincide as closely as possible with the injured worker's pay periods. In determining the amount the employee is able to earn in any month after injury, commissions and similar irregular payments shall be allocated first to the week in which they are received, in an amount which when added to other earnings for such week does not exceed the employee's average weekly wage, and the balance in the same manner to the subsequent weeks until fully allocated, but not to exceed 52 weeks from the week that the commission or a similar irregular payment was received.~~

~~2. The amount determined to be the salary, wages, and other remunerations the employee is able to earn after reaching the date of maximum medical improvement shall in no case be less than the sum actually being earned by the employee, including earnings from sheltered employment. In the case of an employee who has not voluntarily limited his income or who has not failed to accept employment commensurate with his abilities or who was not terminated from employment due to his own misconduct, and who has made a good faith attempt to find employment after attaining maximum medical improvement but remains unemployed, it shall be presumed that the salary, wages, and other remuneration the employee is able to earn was zero for each week that the employee made a good faith attempt to find employment within his physical and vocational capabilities. Wage-loss forms and job search reports are to be mailed to the employer, carrier, or servicing agent within 14 days after the time benefits are due. Failure of an employee to timely request benefits and file the appropriate job search forms showing that he looked for a minimum of 5 jobs in each biweekly period (unless a judge of compensation claims determines fewer job searches are justified due to the availability of suitable employment) after the employee has knowledge that a job search is required, whether he has been advised by the employer, carrier, servicing agent, or his attorney, shall result in benefits not being payable during the time that the employee fails to timely file his request for wage-loss and the job search reports. However, beginning on the 13th week after the employee has attained maximum medical improvement, if an employee does not obtain and maintain employment, the employer may show that the salary, wages, and other remuneration the employee is able to earn is greater than zero by proving the existence of actual job openings within a reasonable geographical area which the employee is physically and vocationally capable of performing, in which case the amount the employee is able to earn may be deemed to be the amount the judge of compensation claims finds that the employee could earn in such jobs. The amount deemed shall be applied against the next three biweekly payments.~~

~~3. An injured worker requesting wage-loss benefits for any period during which such injured worker was unemployed shall have a duty to make reasonable and good faith efforts to obtain suitable gainful employment on a consistent basis. "Suitable gainful employment" means employment which is reasonably attainable in light of the individual's age, education, personal aptitudes, previous vocational experience, and physical abilities. For any such period, the employer may require the injured worker's request for wage-loss benefits to include verification of the injured worker's efforts to obtain suitable gainful employment, which verification shall be made on forms prescribed by the division. In determining whether the injured worker has made reasonable and good faith efforts to obtain suitable gainful employment, the judge of compensation claims shall consider the availability of suitable employment in the area of the injured worker's residence, the injured worker's access to transportation, and the effect of the injured worker's physical and mental impairments upon his ability to conduct job search activities. Unless otherwise provided under this section, an injured worker requesting wage-loss benefits for any period during which he shall have been unemployed shall not be entitled to such benefits if the injured worker failed or refused to make reasonable and good faith efforts to obtain suitable gainful employment during such period.~~

~~4. The right to wage-loss benefits shall terminate upon the occurrence of the earliest of the following:~~

~~a. As of the end of any 2-year period commencing at any time subsequent to the month when the injured employee reaches the date of maximum medical improvement, unless during such 2-year period wage-loss benefits shall have been payable during at least 3 consecutive months. This limitations period shall not be tolled or extended by the incarceration of the employee or by virtue of the employee becoming an inmate of a penal institution.~~

~~b. For injuries occurring on or before July 1, 1980, 350 weeks after the injured employee reaches the date of maximum medical improvement.~~

~~c. For injuries occurring after July 1, 1980, but before July 1, 1990, 525 weeks after the injured employee reaches maximum medical improvement.~~

~~d. For injuries occurring after June 30, 1990, the employee's eligibility for wage-loss benefits shall be determined according to the following schedule:~~

~~(I) Twenty-six weeks of eligibility for permanent impairment ratings up to and including 3 percent;~~

~~(II) Fifty-two weeks of eligibility for permanent impairment ratings greater than 3 and up to and including 6 percent;~~

~~(III) Seventy-eight weeks of eligibility for permanent impairment ratings greater than 6 and up to and including 9 percent;~~

~~(IV) One hundred four weeks of eligibility for permanent impairment ratings greater than 9 and up to and including 12 percent; and~~

~~(V) One hundred twenty weeks of eligibility for permanent impairment ratings greater than 12 percent and up to and including 13 percent; 135 weeks of eligibility for permanent impairment ratings greater than 13 percent and up to and including 14 percent; 150 weeks of eligibility for permanent impairment ratings greater than 14 and up to and including 15 percent; 170 weeks of eligibility for permanent impairment ratings greater than 15 percent and up to and including 16 percent; 190 weeks of eligibility for permanent impairment ratings greater than 16 percent and up to and including 17 percent; 210 weeks of eligibility for permanent impairment ratings greater than 17 percent and up to and including 18 percent; 230 weeks of eligibility for permanent impairment ratings greater than 18 percent and up to and including 19 percent; 250 weeks of eligibility for permanent impairment ratings greater than 19 percent and up to and including 20 percent; 275 weeks of eligibility for permanent impairment ratings greater than 20 percent and up to and including 21 percent; 300 weeks of eligibility for permanent impairment ratings greater than 21 percent and up to and including 22 percent; 325 weeks of eligibility for permanent impairment ratings greater than 22 percent and up to and including 23 percent; 350 weeks of eligibility for permanent impairment ratings greater than 23 percent and up to and including 24 percent; 364 weeks of eligibility for permanent impairment ratings greater than 24 percent.~~

~~e. In the case of an employee whose permanent impairment from the injury is at least 1 percent but no more than 20 percent of the body as a~~

~~whole, the burden is on the employee to demonstrate that his postinjury earning capacity is less than his preinjury average weekly wage and is not the result of economic conditions or the unavailability of employment or of his own misconduct. In the case of an employee whose permanent impairment from the injury is 21 percent or more of the body as a whole, the burden is on the employer to demonstrate that the employee's postinjury earning capacity is the same or more than his preinjury wage.~~

~~5. Notwithstanding subparagraph 4., the right to wage loss benefits shall terminate if, within a 2-year period, there are three occurrences of any of the following incidents:~~

~~a. The employee voluntarily terminates his employment for reasons unrelated to his compensable injury.~~

~~b. The employee refuses an offer of suitable or reasonable employment within his restrictions and abilities.~~

~~c. The employee is terminated from employment due to his own misconduct as defined in s. 440.02(16).~~

~~d. The employee voluntarily limits his income.~~

~~Each of the three occurrences must be in a different biweekly period. Additionally, for each of the above occurrences, the employee may be disqualified from receiving wage loss benefits for 3 biweekly periods.~~

~~6. The right to wage loss benefits shall terminate if an employee is convicted of conduct punishable under s. 775.082 or s. 775.083 or is subjected to imprisonment under chapter 316 which directly affects the employee's ability to perform the activities of his usual or other appropriate employment. For purposes of this subparagraph, "convicted" means an adjudication of guilt by a court of competent jurisdiction; a plea of guilty or of nolo contendere; or a jury verdict of guilty when adjudication of guilt is withheld and the accused is placed on probation.~~

~~7. If an employee is entitled to both wage loss benefits and social security retirement benefits under 42 U.S.C. ss. 402 and 405, such social security retirement benefits shall be primary and the wage loss benefits shall be supplemental only. The sum of the two benefits shall not exceed the amount of wage loss benefits which would otherwise be payable. For the purposes of termination of wage loss benefits pursuant to sub-subparagraph 4.a., the term "payable" shall be construed to include payment of social security retirement benefits in lieu of wage loss benefits. However, the reduction of wage loss benefits under the provisions of this subparagraph is not applicable to any wage loss benefits payable to an employee for any month subsequent to the month in which the employee reaches the age of 70 years.~~

~~8. Beginning with the 25th month after maximum medical improvement and for the purpose of determining wage loss benefits, the total wages, salary, and other remuneration for the week in consideration shall be discounted as follows:~~

~~a. For those injuries occurring on or after July 1, 1979, and on or before July 1, 1980, by a factor of 3 percent and compounded annually at 3 percent thereafter; and~~

~~b. For those injuries occurring after July 1, 1980, by a factor of 5 percent and compounded annually at 5 percent thereafter.~~

~~However, with respect to any year in which the annual rate of inflation, calculated by using the national Consumer Price Index published by the United States Department of Labor, is less than the applicable discount factor, such rate shall be substituted for such discount factor for that year.~~

~~9. The division shall keep such records and conduct such investigations as are necessary to determine the feasibility of providing additional protection from inflation for workers entitled to wage loss benefits and shall report its findings to the Legislature not later than February 1, 1988.~~

(4) TEMPORARY PARTIAL DISABILITY.—

(a) In case of temporary partial disability, ~~benefits shall be based on actual wage loss and shall not be subject to the minimum compensation rate set forth in s. 440.12(2). The~~ compensation shall be equal to 80 percent of the difference between 80 percent of the employee's average weekly wage and the salary, wages, and other remuneration the employee is able to earn, as compared weekly; however, the weekly ~~wage loss~~ benefits *may* ~~shall~~ not exceed an amount equal to 66⅔ percent of the employee's average weekly wage at the time of injury. In order to simplify the comparison of the preinjury average weekly wage with the salary, wages, and other remuneration the employee is able to earn, the division may by rule provide for the modification of the weekly comparison so as to coincide as closely as possible with the injured worker's pay periods. The amount determined to be the salary, wages, and other remuneration the employee is able to earn shall in no case be less than the sum actually being earned by the employee, including earnings from sheltered employment.

~~(b) Whenever a temporary partial wage loss benefit as set forth in paragraph (a) may be payable, the burden shall be on the employee to establish that any wage loss claimed is the result of the compensable injury. It shall also be the burden of the employee to show that his inability to obtain employment or to earn as much as he earned at the time of his industrial accident is due to physical limitation related to his accident and not because of economic conditions or the unavailability of employment or his own misconduct. In the event the employee voluntarily limits his income or fails to accept employment commensurate with his abilities, or is terminated from employment due to his own misconduct, it shall be presumed, in the absence of substantial evidence to the contrary, that the salary, wages, and other remuneration that the employee was able to earn for such period that the employee voluntarily limited his income or failed to accept employment commensurate with his abilities or was terminated from employment due to his own misconduct is the amount which would have been earned if the employee had not limited his income or failed to accept appropriate employment or had not been terminated from employment due to his own misconduct. The amount deemed shall be applied against the next three biweekly payments. In the case of an employee who has not voluntarily limited his income or who has not failed to accept employment commensurate with his abilities or who was not terminated from employment due to his own misconduct, and who has made a good faith attempt to find employment but remains unemployed, it shall be presumed that the salary, wages, and other remuneration the employee is able to earn was zero for each week that the employee made a good faith attempt to find employment within his physical and vocational capabilities. However, beginning on the 13th week after the employee has received the first payment of a temporary partial wage loss benefit, if the employee does not obtain and maintain employment, the employer may show that the salary, wages, and other remuneration the employee is able to earn is greater than zero by proving the existence of actual job openings within a reasonable geographical area which the employee is physically and vocationally capable of performing, in which case the amount the employee is able to earn may be deemed to be the amount the judge of compensation claims finds that the employee could earn in such jobs. The amount deemed shall be applied against the next two biweekly payments.~~

(b)~~(c)~~ Such benefits shall be paid during the continuance of such disability, not to exceed a period of *104* ~~260~~ weeks, *as provided by this subsection and subsection (2). Once the injured employee reaches the maximum number of weeks, temporary disability benefits cease and the injured worker's permanent impairment must be determined.*

(5) SUBSEQUENT INJURY.—

(a) The fact that an employee has suffered previous disability, impairment, anomaly, or disease, or received compensation therefor, shall not preclude him from benefits for a subsequent aggravation or acceleration of the preexisting condition nor preclude benefits for death resulting therefrom, except that no benefits shall be payable if the employee, at the time of entering into the employment of the employer by whom the benefits would otherwise be payable, falsely represents himself in writing as not having previously been disabled or compensated because of such previous disability, impairment, anomaly, or disease *and the employer detrimentally relies on the misrepresentation.* Compensation for temporary disability, medical benefits, and wage-loss benefits shall not be subject to apportionment.

(b) If a compensable permanent impairment, or any portion thereof, is a result of aggravation or acceleration of a preexisting condition, or is the result of merger with a preexisting impairment, an employee eligible to receive impairment benefits under paragraph (3)(a) shall receive such benefits for the total impairment found to result, excluding the degree of impairment existing at the time of the subject accident or injury or which would have existed by the time of the impairment rating without the intervention of the compensable accident or injury. The degree of permanent impairment attributable to the accident or injury shall be compensated in accordance with paragraph (3)(a). As used in this paragraph,

"merger" means the combining of a preexisting permanent impairment with a subsequent compensable permanent impairment which, when the effects of both are considered together, result in a permanent impairment rating which is greater than the sum of the two permanent impairment ratings when each impairment is considered individually.

~~(c) If an employee receiving wage-loss benefits suffers a subsequent injury causing temporary disability, both wage-loss benefits and temporary disability benefits shall be payable during the duration of temporary disability. In calculating the amount of any wage-loss benefits due, the average weekly wage for the subsequent accident shall be deemed to be the salary, wages, and other remuneration the employee is able to earn. However, the total benefits payable shall not exceed the maximum compensation rate in effect for temporary disability at the time of the subsequent injury. Any reduction in benefits due to such limit shall be applied first to the wage-loss benefits payable as a result of the prior injury.~~

~~(d) If an employee receiving wage-loss benefits suffers a subsequent injury causing an additional compensable wage loss, benefits for each wage-loss shall be payable. In calculating the amount of any wage-loss benefits due, the average weekly wage for the subsequent accident shall be deemed to be the salary, wages, and other remuneration the employee is able to earn. However, the total wage-loss benefits payable shall not exceed the maximum compensation rate in effect for permanent disability at the time of the subsequent injury. Any reduction in wage-loss benefits due to such limitation shall be applied first to the benefits payable as a result of the prior injury.~~

(6) OBLIGATION TO REHIRE.—If the employer has not in good faith made available to the employee, within a 100-mile radius of the employee's residence, work appropriate to the employee's physical limitations within 30 days after the carrier notifies the employer of maximum medical improvement and the employee's physical limitations, the employer shall pay to the division for deposit into the Workers' Compensation Administrative Trust Fund a fine of $250 for every $5,000 of the employer's workers' compensation premium or payroll, not to exceed $2,000 per violation, as the division requires by rule. The employer is not subject to this subsection if the employee is receiving permanent total disability benefits or if the employer has 50 or fewer employees.

(7)~~(6)~~ EMPLOYEE REFUSES EMPLOYMENT.—If an injured employee refuses employment suitable to the capacity thereof, offered to or procured therefor, such employee shall not be entitled to any compensation at any time during the continuance of such refusal unless at any time in the opinion of the judge of compensation claims such refusal is justifiable.

(8)~~(7)~~ EMPLOYEE LEAVES EMPLOYMENT.—If an injured employee, when receiving compensation for temporary partial disability, leaves the employment of the employer by whom he was employed at the time of the accident for which such compensation is being paid, he shall, upon securing employment elsewhere, give to such former employer an affidavit in writing containing the name of his new employer, the place of employment, and the amount of wages being received at such new employment; and, until he gives such affidavit, the compensation for temporary partial disability will cease. The employer by whom such employee was employed at the time of the accident for which such compensation is being paid may also at any time demand of such employee an additional affidavit in writing containing the name of his employer, the place of his employment, and the amount of wages he is receiving; and if the employee, upon such demand, fails or refuses to make and furnish such affidavit, his right to compensation for temporary partial disability shall cease until such affidavit is made and furnished.

(9)~~(8)~~ EMPLOYEE BECOMES INMATE OF INSTITUTION.—In case an employee becomes an inmate of a public institution, then no compensation shall be payable unless he has dependent upon him for support a person or persons defined as dependents elsewhere in this chapter, whose dependency shall be determined as if the employee were deceased and to whom compensation would be paid in case of death; and such compensation as is due such employee shall be paid such dependents during the time he remains such inmate.

(10)~~(9)~~ EMPLOYEE ELIGIBLE FOR BENEFITS UNDER THIS CHAPTER AND FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE ACT.—

(a) Weekly compensation benefits payable under this chapter for disability resulting from injuries to an employee who becomes eligible for benefits under 42 U.S.C. s. 423 shall be reduced to an amount whereby the sum of such compensation benefits payable under this chapter and such total benefits otherwise payable for such period to the employee and his dependents, had such employee not been entitled to benefits under this chapter, under 42 U.S.C. ss. 423 and 402, does not exceed 80 percent of the employee's average weekly wage. However, this provision shall not operate to reduce an injured worker's benefits under this chapter to a greater extent than such benefits would have otherwise been reduced under 42 U.S.C. s. 424(a). This reduction of compensation benefits is not applicable to any compensation benefits payable for any week subsequent to the week in which the injured worker reaches the age of 62 years.

(b) If the provisions of 42 U.S.C. s. 424(a) are amended to provide for a reduction or increase of the percentage of average current earnings that the sum of compensation benefits payable under this chapter and the benefits payable under 42 U.S.C. ss. 423 and 402 can equal, the amount of the reduction of benefits provided in this subsection shall be reduced or increased accordingly.

(c) No disability compensation benefits payable for any week, including those benefits provided by paragraph (1)(e), shall be reduced pursuant to this subsection until the Social Security Administration determines the amount otherwise payable to the employee under 42 U.S.C. ss. 423 and 402 and the employee has begun receiving such social security benefit payments. The employee shall, upon demand by the division, the employer, or the carrier, authorize the Social Security Administration to release disability information relating to him and authorize the Division of Unemployment Compensation to release unemployment compensation information relating to him, in accordance with rules to be promulgated by the division prescribing the procedure and manner for requesting the authorization and for compliance by the employee. Neither the division nor the employer or carrier shall make any payment of benefits for total disability or those additional benefits provided by paragraph (1)(e) for any period during which the employee willfully fails or refuses to authorize the release of information in the manner and within the time prescribed by such rules. The authority for release of disability information granted by an employee under this paragraph shall be effective for a period not to exceed 12 months, such authority to be renewable as the division may prescribe by rule.

(d) If compensation benefits are reduced pursuant to this subsection, the minimum compensation provisions of s. 440.12(2) do not apply.

(11)~~(10)~~ EMPLOYEE ELIGIBLE FOR BENEFITS UNDER THIS CHAPTER WHO HAS RECEIVED OR IS ENTITLED TO RECEIVE UNEMPLOYMENT COMPENSATION.—

(a) No compensation benefits shall be payable for temporary total disability or permanent total disability under this chapter for any week in which the injured employee has received, or is receiving, unemployment compensation benefits.

(b) If an employee is entitled to ~~both wage-loss benefits pursuant to subsection (3), or~~ temporary partial benefits pursuant to subsection (4), and unemployment compensation benefits, such unemployment compensation benefits shall be primary and the ~~wage-loss benefits or~~ temporary partial benefits shall be supplemental only, the sum of the two benefits not to exceed the amount of ~~wage-loss benefits or~~ temporary partial benefits which would otherwise be payable. ~~For purposes of termination of wage-loss benefits pursuant to sub-subparagraph (3)(b)4.a., the term "payable" shall be construed to include payment of unemployment compensation benefits in lieu of income supplement benefits as provided in this subsection.~~

(12)~~(11)~~ FULL-PAY STATUS FOR CERTAIN LAW ENFORCEMENT OFFICERS.—Any law enforcement officer as defined in s. 943.10(1), (2), or (3) who, while acting within the course of employment as provided by s. 440.091, is maliciously or intentionally injured and who thereby sustains a job-connected disability compensable under this chapter shall be carried in full-pay status rather than being required to use sick, annual, or other leave. Full-pay status shall be granted only after submission to the employing agency's head of a medical report which gives a current diagnosis of the employee's recovery and ability to return to work. In no case shall the employee's salary and workers' compensation benefits exceed the amount of the employee's regular salary requirements.

(13)~~(12)~~ *REPAYMENT.—If an employee has received a sum as an indemnity benefit under any classification or category of benefit under this chapter to which he is not entitled, the employee is liable to repay*

that sum to the employer or the carrier or to have that sum deducted from future benefits, regardless of the classification of benefits, payable to the employee under this chapter; however, a partial payment of the total repayment may not exceed 20 percent of the amount of the biweekly payment. ~~EMPLOYEE ELIGIBLE FOR BENEFITS UNDER THIS CHAPTER AND PENSION DISABILITY BENEFITS PAYABLE BY A PUBLIC EMPLOYER.—Where any person receives compensation under this chapter by reason of the disability of an employee of the state or any political subdivision of the state, and such person is also entitled to receive any sum, by reason of the same disability, from any pension plan or other benefit fund with respect to which the same employer provides the majority of the current funding, nothing in this chapter shall be construed to prevent the reduction of pension benefits paid by said employer by the amount of workers' compensation payments paid by the employer. However, no such reduction may result in compensation benefits payable under this chapter and under the pension plan or other benefit fund which, in sum, total less than 100 percent of the money rate at which the service rendered by the employee was recompensed, excluding overtime, under the contract of hiring in force at the time of the employee's injury. Nothing in this subsection shall be construed to abrogate the terms of any contract of employment or the stated conditions of employment at the time of hiring.~~

Section 21. Paragraph (a) of subsection (1) of section 440.16, Florida Statutes, is amended to read:

440.16 Compensation for death.—

(1) If death results from the accident within 1 year thereafter or follows continuous disability and results from the accident within 5 years thereafter, the employer shall pay:

(a) Actual funeral expenses not to exceed *$5,000* ~~$2,500~~.

Section 22. Subsections (1), (2), (4), (7), (10), and (11) of section 440.185, Florida Statutes, are amended to read:

440.185 Notice of injury or death; reports; penalties for violations.—

(1) *An employee who suffers an injury arising out of and in the course of employment shall advise his employer of the injury within 30 days after the date of or initial manifestation of the injury. Failure to so advise the employer shall bar a petition under this chapter unless* ~~Within 30 days after the date of injury, the employee shall give notice of such injury to the employer. However, failure to give such notice shall not be a bar to any claim under this chapter unless objection to such failure is raised before the judge of compensation claims at the first hearing of a claim for compensation in respect to such injury or death, and if~~:

(a) *The employer or the employer's agent had actual knowledge of the injury* ~~The employer or the agent thereof in charge of the business in the place where the injury occurred or the carrier had knowledge of the injury, and the judge of compensation claims determines that the employer or carrier has not been prejudiced by the employee's failure to give such notice; or~~

(b) *The cause of the injury could not be identified without a medical opinion and the employee advised the employer within 30 days after obtaining a medical opinion indicating that the injury arose out of and in the course of employment;* ~~The judge of compensation claims excuses such failure on the ground that for some satisfactory reason such notice could not be given. However, when the delay in giving notice is so excused, no compensation shall be payable for aggravation of the injury caused by want of first aid or proper medical treatment during such delay, and every presumption shall be against the validity of the claim.~~

(c) The employer did not put its employees on notice of the requirements of this section by posting notice pursuant to s. 440.055; or

(d) Exceptional circumstances, outside the scope of paragraph (a) or paragraph (b) justify such failure.

In the event of death arising out of and in the course of employment, the requirements of this subsection shall be satisfied by the employee's agent or estate. Documents prepared by counsel in connection with litigation, including but not limited to notices of appearance, petitions, motions or complaints, shall not constitute notice for purposes of this section.

(2) Within 7 days *after* ~~of~~ actual knowledge of injury or death, the employer shall report such injury or death to *its* ~~the~~ carrier ~~and the employee~~, *in a format* ~~on a form~~ prescribed by the division, *and shall provide a copy of such report to the employee or the employee's estate. The report of injury shall contain* ~~providing~~ the following information:

(a) The name, address, and business of the employer;

(b) The name, social security number, street, mailing address, telephone number, and occupation of the employee;

(c) The cause and nature of the injury or death;

(d) The year, month, day, and hour when, and the particular locality where, the injury or death occurred; *and*

(e) Such other information as the division may require.~~; and~~

~~(f) On the copy of the form furnished to the employee, a clear and understandable summary statement of the rights, benefits, and obligations of injured workers under the Workers' Compensation Law, including an explanation of wage-loss benefits and the eligibility conditions for such benefits.~~

The carrier ~~or a self-insured employer~~ shall, within *14* ~~30~~ days after *the employer's* receipt of the form reporting the injury, *file* ~~mail the form containing~~ the information required by this subsection *with* ~~to~~ the division ~~at its address~~ in Tallahassee. However, the division may by rule provide for a different reporting system for those types of injuries which it determines should be reported in a different manner and for those cases which involve minor injuries requiring professional medical attention in which the employee does not lose more than 7 days of work as a result of the injury and is able to return to his job immediately after treatment and resume his regular work.

(4) Within 3 days after *the employer or the employee informs the carrier* ~~receipt of notice~~ of *an* injury ~~from the employer or any other indication of a compensable injury which will result in the employee losing more than 7 days from work,~~ the *carrier* ~~division~~ shall mail to the injured worker an informational brochure *approved* ~~as prescribed~~ by the division which sets forth in clear and understandable language *an explanation* ~~a summary statement~~ of the rights, benefits, *procedures for obtaining benefits and assistance, criminal penalties,* and obligations of injured workers and their employers under the Florida Workers' Compensation Law~~, together with an explanation of its operation~~. *Annually* ~~*Within 3 days after receipt of a notice of injury from the employer or any other indication of a compensable injury which will result in the employee losing more than 7 days from work*~~, *the* ~~a~~ carrier or *its* third-party administrator shall mail to the employer an informational brochure *approved* ~~as prescribed~~ by the division which sets forth in clear and understandable language *an explanation* ~~a summary statement~~ of the rights, benefits, *procedures for obtaining benefits and assistance, criminal penalties,* and obligations of injured workers and their employers under the Florida Workers' Compensation Law. *All such informational brochures shall contain a notice that clearly states in substance the following: "Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits a felony of the third degree."* ~~The division shall monitor the furnishing of benefits by the employer or carrier to ascertain that correct benefits are being furnished in cases accepted as compensable injuries. Upon receipt of a request for assistance by the injured worker, the employer, or carrier, or upon its own motion, the division shall be empowered to compel all parties to participate in any conferences held by the division to resolve the issues giving rise to the request for assistance. In the event of controversion or the filing of a claim, the division shall attempt to resolve the claim. If the division determines that it cannot establish the relevant facts necessary to resolve the issues in a claim, the division may curtail its investigation and promptly forward the file to the appropriate judge of compensation claims for any requested hearing on the claim. In either event, the division shall forward the file to the appropriate judge of compensation claims no later than 15 days prior to the date set for such final hearing.~~

(7) Every ~~insurance~~ carrier ~~writing workers' compensation insurance for employment covered under this chapter~~ shall file ~~written notice~~ with the division within 21 days after the issuance of a policy or contract of insurance *such policy information as the division may require*. Notice of cancellation or expiration of a policy as set out in s. 440.42(2) shall be mailed to the division in accordance with rules promulgated by the division under chapter 120.

~~(10) Any compensable wage loss shall be reported by the employee to the carrier or self-insured employer within 30 days after the termination of the month for which such loss is claimed. The division shall provide by rule for the reporting of wage loss by the injured worker, and for the reporting of wage loss and payment of wage loss benefits by the employer, to the division and may prescribe forms for such reporting. These forms must contain a provision that requires the employee to report his efforts, if any, to obtain employment, including contacts with prospective employers. The employee must sign the form and the form must include the following statement: "I declare that the facts reported herein are true to the best of my knowledge and I understand that any false or misleading statement I make could subject me to prosecution for fraud pursuant to section 440.37, Florida Statutes." The division, upon request by the employer or carrier, shall provide verification through unemployment compensation records of any claimed wage loss and shall obtain such verification from other states, if applicable. The division shall require by rule that the employer inform a worker who suffers a permanent impairment of his possible entitlement to wage loss and other benefits and of the worker's obligation to report a claimed wage loss.~~

~~(11) The division may establish by rule an alternative electronic reporting system whereby an employer or carrier may elect to report required information to the division electronically rather than by filing otherwise required forms or reports. The division may by rule establish different time requirements for reporting information to the division via the electronic reporting system than is otherwise required.~~

Section 23. Section 440.19, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 440.19, F.S., for present text.)

440.19 Time bars to filing petitions for benefits.—

(1) Except to the extent provided elsewhere in this section, all employee petitions for benefits under this chapter shall be barred unless the employee, or the employee's estate if the employee is deceased, has advised the employer of the injury or death pursuant to s. 440.185(1) and the petition is filed within 2 years after the date on which the employee knew or should have known that the injury or death arose out of work performed in the course and scope of employment.

(2) Payment of any indemnity benefit or the furnishing of remedial treatment, care, or attendance pursuant to either a notice of injury or a petition for benefits shall toll the limitations period set forth above for 1 year from the date of such payment. This tolling period does not apply to the issues of compensability, date of maximum medical improvement, or permanent impairment.

(3) The filing of a petition for benefits does not toll the limitations period set forth in this section unless the petition meets the specificity requirements set forth in s. 440.192.

(4) Notwithstanding the provisions of this section, the failure to file a petition for benefits within the periods prescribed is not a bar to the employee's claim unless the carrier advances the defense of a statute of limitations in its initial response to the petition for benefits. If a claimant contends that an employer or its carrier is estopped from raising a statute of limitations defense and the carrier demonstrates that it has provided notice to the employee in accordance with s. 440.185 and that the employer has posted notice in accordance with s. 440.055, the employee must demonstrate estoppel by clear and convincing evidence.

(5) If a person who is entitled to compensation under this chapter is mentally incompetent or a minor, the limitations period is tolled while that person has no guardian or other authorized representative, but the period shall begin to run from the date of appointment of such guardian or other representative, or in the case of a minor, if no guardian is appointed before the minor becomes of age, from the date the minor becomes of age.

(6) When recovery is denied to any person in a suit brought at law or in admiralty to recover damages for injury or death on the ground that such person was an employee, that the defendant was an employer within the meaning of this chapter, and that such employer had secured compensation of such employee under this chapter, the limitations period set forth in this section shall begin to run from the date of termination of such suit; however, in such an event, the employer is allowed a credit of his actual cost of defending such suit in an amount not to exceed $250, which amount must be deducted from any compensation allowed or awarded to the employee under this chapter.

Section 24. Section 440.191, Florida Statutes, is created to read:

440.191 Employee Assistance and Ombudsman Office.—

(1)(a) In order to effect the self-executing features of the workers' compensation law, this chapter shall be construed to permit injured employees and employers or the employer's carrier to resolve disagreements without undue expense, costly litigation, or delay in the provisions of benefits. It is the duty of all who participate in the workers' compensation system, including, but not limited to, carriers, service providers, health care providers, attorneys, employers, and employees, to attempt to resolve disagreements in good faith and to cooperate with the division's efforts to resolve disagreements between the parties.

(b) An Employee Assistance and Ombudsman Office is created within the Division of Workers' Compensation to inform and assist injured workers, employers, carriers, and health care providers in fulfilling their responsibilities under this chapter.

(c) The Employee Assistance and Ombudsman Office, Division of Workers' Compensation, shall be a resource available to all employees who participate in the workers' compensation system and shall take all steps necessary to educate and disseminate information to employees and employers.

(2)(a) An employee may not file a petition requesting any benefit under this chapter unless the employee has exhausted the procedures for informal dispute resolution under this section.

(b) If at any time the employer or its carrier fails to provide benefits to which the employee believes he is entitled, the employee shall contact the office to request assistance in resolving the dispute. The office shall investigate the dispute and shall attempt to facilitate an agreement between the employee and the employer or carrier. The employee, the employer, and the carrier shall cooperate with the office and shall timely provide the office with any documents or other information that it may require in connection with its efforts under this section.

(c) The office may compel parties to attend conferences in person or by telephone in an attempt to resolve disputes quickly and in the most efficient manner possible. Settlement agreements resulting from such conferences must be submitted to the Office of the Judges of Compensation Claims for approval.

(d) The Employee Assistance and Ombudsman Office may assign an ombudsman to assist the employee in resolving the dispute. If the dispute is not resolved within 30 days after the employee contacts the office, the ombudsman shall, at the employee's request, assist the employee in drafting a petition for benefits and explain the procedures for filing petitions. The Employee Assistance and Ombudsman Office may not represent employees before the judges of compensation claims. An employer or carrier may not pay any attorneys' fees on behalf of the employee for services rendered or costs incurred in connection with this section, unless expressly authorized elsewhere in this chapter.

Section 25. Section 440.192, Florida Statutes, is created to read:

440.192 Procedure for resolving benefit disputes.—

(1) Subject to s. 440.191, any employee who has not received a benefit to which he believes he is entitled under this chapter shall serve by certified mail upon his employer, the employer's carrier, and the division in Tallahassee a petition for benefits that meets the requirements of this section. The division shall refer the petition to the Office of the Judges of Compensation Claims.

(2) The Office of the Judges of Compensation Claims shall review each petition and shall dismiss each petition, upon its own motion or upon the motion of any party, that does not on its face specifically identify or itemize the following:

(a) Name, address, telephone number, and social security number of the employee.

(b) Name, address, and telephone number of the employer.

(c) A detailed description of the injury and cause of the injury, including the location of the occurrence.

(d) A detailed description of the employee's job, work responsibilities, and work the employee was performing when the injury occurred.

(e) The time period for which compensation was not timely provided.

(f) Date of maximum medical improvement, character of disability, and specific statement of all benefits or compensation that the employee is seeking.

(g) All travel costs to which the employee believes he is entitled, including dates of travel and purpose of travel, means of transportation, and mileage.

(h) Specific listing of all medical charges alleged unpaid, including the name and address of the medical provider, the amounts due, and the specific dates of treatment.

(i) The type or nature of treatment care or attendance sought and the justification for such treatment.

(j) Specific explanation of any other disputed issue that a judge of compensation claims will be called to rule upon.

(3) A petition for benefits may contain a claim for past benefits and continuing benefits in any benefit category, but is limited to those in default and ripe, due, and owing on the date the petition is filed. If the employer has elected to satisfy its obligation to provide medical treatment, care, and attendance through a managed care arrangement designated under this chapter, the employee must exhaust all managed care grievance procedures before filing a petition for benefits under this section.

(4) The petition must include a certification by the claimant or, if the claimant is represented by counsel, the claimant's attorney, stating that the claimant, or attorney if the claimant is represented by counsel, has made a good-faith effort to resolve the dispute and that the claimant or attorney was unable to resolve the dispute with the carrier.

(5) All motions to dismiss must state with particularity the basis for the motion. The judge of compensation claims shall enter an order upon such motions without hearing, unless good cause for hearing is shown. When any petition is dismissed for lack of specificity under this subsection, the claimant must be allowed 20 days after the date of the order of dismissal in which to file an amended petition. Any grounds for dismissal for lack of specificity under this section not asserted within 30 days after receipt of the petition for benefits are thereby waived.

(6) If the claimant is not represented by counsel, the Office of the Judges of Compensation Claims may request the Employee Assistance and Ombudsman Office to assist the claimant in filing a petition that meets the requirements of this section.

(7) Notwithstanding the provisions of s. 440.34, a judge of compensation claims may not award attorney's fees payable by the carrier for services expended or costs incurred prior to the filing of a petition that does not meet the requirements of this section.

(8) Within 14 days after receipt of a petition for benefits by certified mail, the carrier must either pay the requested benefits without prejudice to its right to deny within 120 days from receipt of the petition or file a notice of denial with the division. The carrier must list all benefits requested but not paid and explain its justification for nonpayment in the notice of denial. A carrier that does not deny compensability in accordance with s. 440.20(4) is deemed to have accepted the employee's injuries as compensable, unless it can establish material facts relevant to the issue of compensability that could not have been discovered through reasonable investigation within the 120-day period. The carrier shall provide copies of the notice to the filing party, employer, and claimant by certified mail.

Section 26. Section 440.20, Florida Statutes, is amended to read:

440.20 *Time for* payment of compensation*; penalties for late payment.*—

(1)(a) Unless it denies compensability or entitlement to benefits, the carrier shall pay compensation directly to the employee as required by ss. 440.14, 440.15, and 440.16, in accordance with the obligations set forth in such sections.

(b) Notwithstanding any other provision of this chapter, all insurance carriers, group self-insurance funds, assessable mutual insurers, and the Joint Underwriting Association authorized to write workers' compensation insurance in this state shall make available a notice in writing to the employer the fact that a state-authorized deductible plan is available. Under this plan, an employer may pay, for each injury for which an employee files a claim under this chapter as a deductible, up to the first $2,500 of the total amount payable under compensable claims related to such injury. An employer shall not be reimbursed for any amount paid under this paragraph; however, the reporting requirements of the employer, relating to injuries required under any provision under this chapter, are not altered or alleviated. The rate base of any workers' compensation insurance offered pursuant to this chapter shall include the deductible provision authorized by this paragraph. Any amounts paid by an employer pursuant to this paragraph shall not apply in any way to such employer's experience rating for injury.

(2) The carrier must pay the first installment of compensation or deny compensability no later than the 14th day after the employer receives notice of the injury or death. The carrier shall thereafter pay compensation in biweekly installments or as otherwise provided in s. 440.15, unless the judge of compensation claims determines or the parties agree that an alternate installment schedule is in the best interests of the employee.

(3) Upon making payment, or upon suspension or cessation of payment for any reason, the carrier shall immediately notify the division that it has commenced, suspended, or ceased payment of compensation. The division may require such notification in any format it deems necessary to obtain accurate and timely reporting.

(4) If the carrier is uncertain of its obligation to provide benefits or compensation, it may initiate payment without prejudice and without admitting liability. The carrier shall immediately and in good faith commence investigation of the employee's entitlement to benefits under this chapter and shall admit or deny compensability within 120 days after the initial provision of compensation or benefits. Upon commencement of payment, the carrier shall provide written notice to the employee that it has elected to pay all or part of the claim pending further investigation, and that it will advise the employee of claim acceptance or denial within 120 days. A carrier that fails to deny compensability within 120 days after the initial provision of benefits or payment of compensation waives the right to deny compensability, unless the carrier can establish material facts relevant to the issue of compensability that it could not have discovered through reasonable investigation within the 120-day period.

(5) If the employer has advanced compensation payments or benefits to the employee, the carrier shall reimburse the employer for the advanced payments if the employee is entitled to compensation and benefits pursuant to this chapter. The carrier may deduct such reimbursements from the employee's compensation installments or, if applicable, from payments to the employee ordered by a judge of compensation claims.

~~(1) Compensation under this chapter shall be paid periodically, promptly in the usual manner, and directly to the person entitled thereto, without an award, except when liability to pay compensation is controverted by the employer.~~

~~(2) The first installment of compensation for total disability or death shall become due on the 14th day after the employer has knowledge of the injury or death, on which date all compensation then due shall be paid. Thereafter, compensation shall be paid in installments biweekly, except when the judge of compensation claims determines that payments in installments should be made at some other period.~~

~~(3) Impairment benefits shall be payable in accordance with s. 440.15(3)(a)2.~~

~~(4) Benefits payable pursuant to s. 440.15(3)(b) or (4) shall be paid biweekly, subsequent to the termination of the period for which such payments are due, within 14 days of the date upon which the carrier or employer has knowledge of the compensable wage loss.~~

~~(5) Upon making payment, and upon suspension of payment for any cause, the employer shall immediately notify the division, in accordance with a form prescribed by the division, that payment of compensation has begun or has been suspended, as the case may be. The division shall monitor compensation payment practices for conformity with the provisions of this section.~~

~~(6) If the employer or carrier initially controverts the right to compensation, it shall file with the division, on or before the 21st day after it has knowledge of the alleged injury or death, a notice, on a form and~~

~~in a manner prescribed by the division, stating that the right to compensation is controverted, the name of the claimant, the name of the employer, the date of the alleged injury or death, and the grounds upon which the right to compensation is controverted, together with the reason or reasons why the claim has been controverted; and a copy of such notice shall be furnished by the carrier to the employee and employer. If the employer or carrier initially accepts the claim but subsequently controverts the claim, it shall file with the division a notice to controvert, within 10 days after the date of initial cessation of benefits on a form and in a manner prescribed by the division. The form must contain a space in which the carrier may report the reasons for the delayed controversion. A copy of such notice shall be furnished by the carrier to the employee and employer.~~

(6)~~(7)~~ If any installment of compensation for death or dependency benefits, disability, permanent impairment, or wage loss payable without an award is not paid within 7 ~~14~~ days after it becomes due, as provided in subsection (2), subsection (3), or subsection (4), there shall be added to such unpaid installment a punitive penalty of an amount equal to *20* ~~the greater of 10~~ percent of the unpaid installment or $5, which shall be paid at the same time as, but in addition to, such installment of compensation, unless notice is filed under subsection *(4)* ~~(6)~~ or unless such nonpayment results from conditions over which the employer or carrier had no control. When any installment of compensation payable without an award has not been paid within 7 ~~14~~ days after it became due and the claimant concludes the prosecution of the claim before a judge of compensation claims without having specifically claimed additional compensation in the nature of a penalty under this section, he will be deemed to have acknowledged that, owing to conditions over which the employer or carrier had no control, such installment could not be paid within the period prescribed for payment and to have waived his right to claim such penalty. However, during the course of a hearing, the judge of compensation claims shall on his own motion raise the question of whether such penalty should be awarded or excused. The division may assess without a hearing the *punitive penalty* ~~above mentioned 10 percent additional payment~~ against either the employer or the insurance carrier, depending upon who was at fault in causing the delay. The insurance policy cannot provide that this sum will be paid by the carrier if the division or the judge of compensation claims determines that the *punitive penalty* ~~10 percent additional payment~~ should be made by the employer rather than the carrier. Any additional installment of compensation paid by the carrier pursuant to this section shall be paid directly to the employee.

(7)~~(8)~~ If any compensation, payable under the terms of an award, is not paid within 7 ~~30~~ days after it becomes due, there shall be added to such unpaid compensation an amount equal to 20 percent thereof, which shall be paid at the same time as, but in addition to, such compensation, unless review of the compensation order making such award is had as provided in s. 440.25.

(8)~~(9)~~ In addition to any other penalties provided by this chapter for late payment, if any installment of compensation is not paid when it becomes due, the employer, carrier, or servicing agent shall pay interest thereon at the rate of 12 percent per year from the date the installment becomes due until it is paid, whether such installment is payable without an order or under the terms of an order. The interest payment shall be the greater of the amount of interest due or $5.

(a) Within 30 days after final payment of compensation has been made, the employer, carrier, or servicing agent shall send to the division a notice, in accordance with a form prescribed by the division, stating that such final payment has been made and stating the total amount of compensation paid, the name of the employee and of any other person to whom compensation has been paid, the date of the injury or death, and the date to which compensation has been paid.

(b) If the employer, carrier, or servicing agent fails to so notify the division within such time, the division shall assess against such employer, carrier, or servicing agent a civil penalty in an amount not over $100.

(c) *In order to ensure carrier compliance under this chapter, the division shall monitor the performance of carriers. The division shall establish by rule minimum performance standards for carriers to ensure that a minimum of 90 percent of all compensation benefits are timely paid. The division shall fine a carrier as provided in s. 440.13(11)(b) up to $50 for each late payment of compensation that is below the minimum 90 percent performance standard. This paragraph does not affect the imposition of any penalties or interest due to the claimant. If a carrier contracts with a servicing agent to fulfill its administrative responsibilities under this chapter, the payment practices of the servicing agent are deemed the payment practices of the carrier for the purpose of assessing penalties against the carrier.* ~~The division shall also assess the employer, carrier, or servicing agent a fine of $50 for every installment of compensation not paid when it becomes due. Such fines shall be deposited by the division in the fund created by s. 440.50.~~

(9)~~(10)~~ The division may upon its own initiative at any time in a case in which payments are being made without an award investigate same and shall, in any case in which the right to compensation is controverted, or in which payments of compensation have been stopped or suspended, upon receipt of notice from any person entitled to compensation or from the employer that the right to compensation is controverted or that payments of compensation have been stopped or suspended, make such investigations, cause such medical examination to be made, or hold such hearings, and take such further action as it considers will properly protect the rights of all parties.

(10)~~(11)~~ Whenever the division deems it advisable, it may require any employer to make a deposit with the Treasurer to secure the prompt and convenient payments of such compensation; and payments therefrom upon any awards shall be made upon order of the division or judge of compensation claims.

(11)~~(12)(a) It is the stated policy for the administration of the workers' compensation system that it is in the best interests of the injured worker that he receive disability or wage loss payments periodically. Lump sum payments in exchange for the employer's or carrier's release from liability for future payments of compensation, death benefits, and rehabilitation expenses other than for medical expenses shall be allowed only under special circumstances, as when the claimant can demonstrate that lump sum payments will definitely aid in his rehabilitation or are otherwise clearly in his best interests and that lump sum payments will avoid undue expense or undue hardship to any party, or that such claimant has removed himself or is about to remove himself from the state. In no case may a lump sum payment be allowed in exchange for the release of an employer's or carrier's liability for future medical expenses and training and education. In no case may a lump sum settlement be allowed until 3 months after the date of maximum medical improvement has been reached; provided that such 3 month period shall be waived with respect to nonresident aliens of the United States or Canada. However, no such alien thus exempted shall be eligible for a lump sum settlement under this exception more than one time in any 48 month period. Upon the approval of a lump sum settlement under this paragraph, the judge of compensation claims shall send a report to the Chief Judge of the amount of the settlement, the amount of the attorney's fees, the amount of the benefits payable to the injured employee upon which the attorney's fees are payable, and the statutory basis for the payment of the attorney's fees.~~

(a)~~(b)~~ *Upon joint petition of all interested parties* ~~Notwithstanding the provisions of paragraph (a)~~, a lump-sum payment in exchange for the employer's or carrier's release from liability for future medical expenses, as well as future payments of compensation ~~and rehabilitation~~ expenses *and any other benefits provided under this chapter*~~, but not training and educational expenses~~, shall be allowed at any time in any case in which the employer or carrier has ~~initially~~ filed a written notice *of denial within 120 days after the date of the injury* ~~to controvert and denied that a compensable accident or injury occurred for which compensation and medical and rehabilitation expenses are payable~~, and the judge of compensation claims at a hearing to consider the settlement proposal finds a justiciable controversy as to legal or medical compensability of the claimed injury or the alleged accident. *The employer or carrier may not pay any attorney's fees on behalf of the claimant for any settlement under this section unless expressly authorized elsewhere in this chapter.* ~~In such event, and~~ Upon the joint petition of all interested parties and after giving due consideration to the interests of all interested parties, the judge of compensation claims may enter a compensation order approving and authorizing the discharge of the liability of the employer for compensation and remedial treatment, care, and attendance, as well as rehabilitation expenses, ~~but not training and educational expenses,~~ by the payment of a lump sum. Such a compensation order so entered upon joint petition of all interested parties is not subject to modification or review under s. 440.28. If the settlement proposal together with supporting evidence is not approved by the judge of compensation claims, it shall be considered ~~null and~~ void. ~~If the employer or carrier initially accepts the case as compensable or provides any benefits to the employee or his dependents, this paragraph does not apply. Notwithstanding the provi-~~

~~sions of s. 440.34(3)(c), a claimant shall be responsible for the payment of his own attorney's fees in any case settled under this subsection.~~ Upon approval of a lump-sum settlement under this subsection, the judge of compensation claims shall send a report to the Chief Judge of the amount of the settlement and a statement of the nature of the controversy. The Chief Judge shall keep a record of all such reports filed by each judge of compensation claims and shall submit to the Legislature a summary of all such reports filed under this subsection annually by *September 15* ~~March 1~~.

~~(c) Notwithstanding the provisions of paragraph (a) or paragraph (b), a lump-sum payment in exchange for the employer's or carrier's release from liability for future payments of compensation, death benefits, rehabilitation expenses, including training and educational expenses and medical expenses shall be allowed when the claimant has reached maximum medical improvement, has been assigned a permanent impairment rating from 1 through 5 percent, and has not received any medical treatment for at least 3 months. In no case may a lump sum settlement be allowed until 3 months after the date of maximum medical improvement has been reached. The lump-sum payment shall be equal to an amount determined by multiplying the claimant's weekly compensation rate by a factor of 3, then multiplying that product by the number of permanent impairment rating points assigned. Notwithstanding the provision of s. 440.34(3)(c), a claimant shall be responsible for the payment of his own attorney's fees in any case settled under this subsection. Upon approval of a lump sum settlement under this subsection, the judge of compensation claims shall send a report to the Chief Judge of the amount of the settlement and a statement of the nature of the controversy. The Chief Judge shall keep a record of all such reports filed by each judge of compensation claims and shall submit to the Legislature a summary of all such reports filed under this subsection annually by March 1.~~

(b)~~(d)~~ *Upon joint petition of all interested parties, a lump-sum payment in exchange for the employer's or carrier's release from liability for future medical expenses, as well as future payments of compensation and rehabilitation expenses, and any other benefits provided under this chapter, may be allowed at any time in any case after the injured employee has attained maximum medical improvement. An employer or carrier may not pay any attorney's fees on behalf of the claimant for any settlement, unless expressly authorized elsewhere in this chapter.* ~~Upon the application of any party in interest or upon joint petition of all interested parties, and after giving due consideration to the interests of all interested parties, if a judge of compensation claims finds that a lump-sum payment in exchange for release from liability is proper under paragraph (a), the judge of compensation claims may enter a compensation order requiring that the liability of the employer for compensation be discharged by the payment of a lump sum equal to the present value of all future payments of compensation, computed at 8 percent true discount compounded annually, or requiring that the employer make advance payment of a part of the compensation for which the employer is liable by the payment of a lump sum equal to the present value of such part of the compensation, computed at 8 percent true discount compounded annually.~~ A compensation order so entered upon joint petition of all interested parties shall not be subject to modification or review under s. 440.28. However, ~~nothing in this subsection shall be construed to mean that~~ a judge of compensation claims is *not* required to approve any award for lump-sum payment when it is determined by the judge of compensation claims that the payment being made is in excess of the value of benefits the claimant would be entitled to under this chapter. The judge of compensation claims shall make or cause to be made such investigations as he considers necessary, in each case in which the parties have stipulated that a proposed final settlement of liability of the employer for compensation shall not be subject to modification or review under s. 440.28, to determine whether such final disposition will definitely aid the rehabilitation of the injured worker or otherwise is clearly for the best interests of the person entitled to compensation and, in his discretion, may have an investigation made by the Rehabilitation Section of the Division of Workers' Compensation. The joint petition and the report of any investigation so made will be deemed a part of the proceeding. ~~A judge of compensation claims, in his discretion, may hear testimony relating to a proposed stipulation for settlement under this subsection without having in hand the division file; however, he may in no event enter an order thereon without first having reviewed the division file.~~ An employer shall have the right to appear at any hearing pursuant to this subsection which relates to the discharge of such employer's liability and to present testimony at such hearing. The carrier shall provide reasonable notice to the employer of the time and date of any such hearing and inform him of his rights to appear and testify. When the claimant is represented by counsel or when the claimant and carrier or employer are represented by counsel, final approval of the lump-sum settlement agreement, as provided for in a joint petition and stipulation, shall be approved by entry of an order within 7 days *after* ~~of~~ the filing of such joint petition and stipulation without a hearing, unless the judge of compensation claims determines, in his discretion, that additional testimony is needed before such settlement can be approved or disapproved and so notifies the parties. The probability of the death of the injured employee or other person entitled to compensation before the expiration of the period during which such person is entitled to compensation shall, in the absence of special circumstances making such course improper, be determined in accordance with the most recent United States Life Tables published by the National Office of Vital Statistics of the United States Department of Health and Human Services. The probability of the happening of any other contingency affecting the amount or duration of the compensation, except the possibility of the remarriage of a surviving spouse, shall be disregarded. As a condition of approving a lump-sum payment to a surviving spouse, the judge of compensation claims, in the judge of compensation claims' discretion, may require security which will ensure that, in the event of the remarriage of such surviving spouse, any unaccrued future payments so paid may be recovered or recouped by the employer or carrier. Such applications shall be considered and determined in accordance with s. 440.25 ~~and the rules of procedure adopted by the Supreme Court~~.

(c) This section applies to all claims that the parties have not previously settled, regardless of the date of accident.

(12)~~(13)~~(a) Liability of an employer for future payments of compensation may not be discharged by advance payment unless prior approval of a judge of compensation claims or the division has been obtained as hereinafter provided. The approval shall not constitute an adjudication of the claimant's percentage of disability.

(b) When the claimant has reached maximum recovery and returned to his former or equivalent employment with no substantial reduction in wages, such approval of a reasonable advance payment of a part of the compensation payable to the claimant may be given informally by letter by a judge of compensation claims, by the division director, or by the administrator of claims of the division.

(c) In the event the claimant has not returned to the same or equivalent employment with no substantial reduction in wages or has suffered a substantial loss of earning capacity or a physical impairment, actual or apparent:

1. An advance payment of compensation not in excess of $2,000 may be approved informally by letter, without hearing, by any judge of compensation claims or the Chief Judge.

2. An advance payment of compensation not in excess of $2,000 may be ordered by any judge of compensation claims after giving the interested parties an opportunity for a hearing thereon pursuant to not less than 10 days' notice by mail, unless such notice is waived, and after giving due consideration to the interests of the person entitled thereto. When the parties have stipulated to an advance payment of compensation not in excess of $2,000, such advance may be approved by an order of a judge of compensation claims, with or without hearing, or informally by letter by any such judge of compensation claims, or by the division director, if such advance is found to be for the best interests of the person entitled thereto.

3. When the parties have stipulated to an advance payment in excess of $2,000, subject to the approval of the division, such payment may be approved by a judge of compensation claims by order if he finds that such advance payment is for the best interests of the person entitled thereto and is reasonable under the circumstances of the particular case. The judge of compensation claims shall make or cause to be made such investigations as he considers necessary concerning the stipulation and, in his discretion, may have an investigation of the matter made by the Rehabilitation Section of the division. The stipulation and the report of any investigation shall be deemed a part of the record of the proceedings.

(d) When an application for an advance payment in excess of $2,000 is opposed by the employer or carrier, it shall be heard by a judge of compensation claims after giving the interested parties not less than 10 days' notice of such hearing by mail, unless such notice is waived. In his discretion, the judge of compensation claims may have an investigation of the matter made by the Rehabilitation Section of the division, in which event the report and recommendation of that section will be deemed a part of the record of the proceedings. If the judge of compensation claims finds

that such advance payment is for the best interests of the person entitled to compensation, will not materially prejudice the rights of the employer and carrier, and is reasonable under the circumstances of the case, he may order the same paid. However, in no event may any such advance payment under this paragraph be granted in excess of $7,500 or 26 weeks of benefits in any 48-month period, whichever is greater, from the date of the last advance payment.

(13)~~(14)~~ If the employer has made advance payments of compensation, he shall be entitled to be reimbursed out of any unpaid installment or installments of compensation due.

(14)~~(15)~~ When an employee is injured and the employer pays his full wages or any part thereof during the period of disability, or pays medical expenses for such employee, and the case is contested by the carrier or the carrier and employer and thereafter the carrier, either voluntarily or pursuant to an award, makes a payment of compensation or medical benefits, the employer shall be entitled to reimbursement to the extent of the compensation paid or awarded, plus medical benefits, if any, out of the first proceeds paid by the carrier in compliance with such voluntary payment or award, provided the employer furnishes satisfactory proof to the judge of compensation claims of such payment of compensation and medical benefits. Any payment by the employer over and above compensation paid or awarded and medical benefits, pursuant to subsection *(13)* ~~(14)~~, shall be considered a gratuity.

(15)~~(16)~~(a) The division shall examine on an ongoing basis claims files in order to identify questionable claims-handling techniques, questionable patterns or practices of claims, or a pattern of repeated unreasonably controverted claims by employers, carriers, self-insurers, health care providers, health care facilities, training and education providers, or any others providing services to employees pursuant to this chapter and may certify its findings to the Department of Insurance. Such questionable techniques, patterns, or repeated unreasonably controverted claims as constitute a general business practice of a carrier in the judgment of the division shall be certified in its findings by the division to the Department of Insurance or such other appropriate licensing agency. Such certification by the division is exempt from the provisions of chapter 120. Upon receipt of any such certification, the Department of Insurance shall take appropriate action so as to bring such general business practices to a halt pursuant to s. 440.38(3)(a). The division may initiate investigations of questionable techniques, patterns, practices, or repeated unreasonably controverted claims.

(b) As to any examination, investigation, or hearing being conducted under this chapter, the Secretary of Labor and Employment Security or his designee:

1. May administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence; and

2. Shall have the power to subpoena witnesses, compel their attendance and testimony, and require by subpoena the production of books, papers, records, files, correspondence, documents, or other evidence which is relevant to the inquiry.

(c) If any person refuses to comply with any such subpoena or to testify as to any matter concerning which he may be lawfully interrogated, the circuit court of Leon County or of the county wherein such examination, investigation, or hearing is being conducted, or of the county wherein such person resides, may, on the application of the department, issue an order requiring such person to comply with the subpoena and to testify.

(d) Subpoenas shall be served, and proof of such service made, in the same manner as if issued by a circuit court. Witness fees, costs, and reasonable travel expenses, if claimed, shall be allowed the same as for testimony in a circuit court.

(e) The division shall publish annually a report which indicates the promptness of first payment of compensation records of each carrier or self-insurer so as to focus attention on those carriers or self-insurers with poor payment records for the preceding year. A copy of such report shall be certified to the Department of Insurance which shall take appropriate steps so as to cause such poor carrier payment practices to halt pursuant to s. 440.38(3)(a). In addition, the division shall take appropriate action so as to halt such poor payment practices of self-insurers. "Poor payment practice" means a practice of late payment sufficient to constitute a general business practice.

(f) The division shall promulgate rules providing guidelines to carriers, self-insurers, and employers to indicate behavior that may be construed as questionable claims-handling techniques, questionable patterns of claims, repeated unreasonably controverted claims, or poor payment practices.

(16)~~(17)~~ No penalty assessed under this section may be recouped by any carrier or self-insurer in the rate base, the premium, or any rate filing. In the case of carriers, the Department of Insurance shall enforce this subsection; and in the case of self-insurers, the division shall enforce this subsection.

Section 27. Section 440.207, Florida Statutes, is amended to read:

440.207 Workers' Compensation system guide.—

(1) The Division of Workers' Compensation of the Department of Labor and Employment Security shall educate all persons providing or receiving benefits pursuant to this chapter as to their rights and responsibilities under this chapter.

(2) The division shall publish *an understandable* ~~a~~ guide to the workers' compensation system which shall contain an explanation of benefits provided*; services provided by the Employee Assistance and Ombudsman Office;*~~,~~ procedures regarding *mediation, the hearing process, and civil and criminal penalties;* ~~disputes,~~ relevant rules of the division;~~,~~ and such other information *as* ~~that~~ the division believes will inform employees, employers, carriers, and those providing services pursuant to this chapter of their rights and responsibilities under this chapter and the rules of the division. *For the purposes of this subsection, a guide is understandable if the text of the guide is written at a level of readability not exceeding the 8th-grade level, as determined by a recognized readability test.*

(3) The guide *must* ~~shall~~ be updated as necessary and *must* ~~shall~~ be available at cost.

(4) The guide *does* ~~shall~~ not constitute either rules or agency action for purposes of chapter 120.

Section 28. Section 440.21, Florida Statutes, is amended to read:

440.21 Invalid agreements~~; penalty~~.—

(1) *Any* ~~No~~ agreement by an employee to pay any portion of premium paid by his employer to a carrier or to contribute to a benefit fund or department maintained by *the* ~~such~~ employer for the purpose of providing compensation or medical services and supplies as required by this chapter *is invalid* ~~shall be valid, and any employer who makes a deduction for such purpose from the pay of any employee entitled to the benefits of this chapter shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 775.083~~.

(2) *An* ~~No~~ agreement by an employee to waive his right to compensation under this chapter *is invalid* ~~shall be valid~~.

Section 29. Section 440.211, Florida Statutes, is created to read:

440.211 Authorization of collective bargaining agreement.—

(1) Subject to the limitation stated in subsection (2), a provision that is mutually agreed upon in any collective bargaining agreement filed with the division between an individually self-insured employer or other employer upon consent of the employer's carrier and a recognized or certified exclusive bargaining representative establishing any of the following shall be valid and binding:

(a) An alternative dispute resolution system to supplement, modify, or replace the provisions of this chapter which may include, but is not limited to, conciliation, mediation, and arbitration. Arbitration held pursuant to this section shall be binding on the parties.

(b) The use of an agreed-upon list of certified health care providers of medical treatment which may be the exclusive source of all medical treatment under this chapter.

(c) The use of a limited list of physicians to conduct independent medical examinations which the parties may agree shall be the exclusive source of independent medical examiners pursuant to this chapter.

(d) A light-duty, modified-job, or return-to-work program.

(e) A vocational rehabilitation or retraining program.

(2) Nothing in this section shall allow any agreement that diminishes an employee's entitlement to benefits as otherwise set forth in this chapter. Any such agreement in violation of this provision shall be null and void.

Section 30. Section 440.25, Florida Statutes, is amended to read:

440.25 *Procedures for mediation and hearings* ~~Procedure in respect to claims and hearing requests.—~~

~~(1) A claim for compensation or other benefits may be filed with the division at its office in the City of Tallahassee at any time after a notice to controvert is filed by the employer or carrier or at any time after a specific benefit becomes due and is not provided. The judge of compensation claims shall have full power and authority to hear and determine all questions presented in respect to such claims.~~

(1)~~(2)~~ *Within 21 days after a petition for benefits is filed under s. 440.192, a mediation conference concerning such petition shall be held.* Within 7 ~~10~~ days after such *petition* ~~a claim~~ is filed, the *judge of compensation claims* ~~division, in accordance with rules prescribed by it,~~ shall notify the ~~employer and any other person other than the claimant whom the division considers an~~ interested *parties that a mediation conference concerning such petition will be held. Such notice shall give the date, time, and location of the mediation conference* ~~party that a claim has been filed~~. Such notice may be served personally upon the *interested parties* ~~employer or other person~~ or may be sent to *the interested parties* ~~such employer or person~~ by mail.

(2)~~(3)(a) The division or judge of compensation claims shall make or cause to be made such investigation as is considered necessary in respect to the claim; and, upon request by any interested party, the judge of compensation claims shall order all parties to attend either a mediation conference or a hearing thereof.~~ Any party who *participates in* ~~requests~~ a mediation conference shall not be precluded from requesting a hearing following the mediation conference should both parties not agree to be bound by the results of the mediation conference. *A mediation conference is required to be held unless this requirement is waived by the Chief Judge. No later than 3 days prior to the mediation conference, all parties must submit any applicable motions, including, but not limited to, a motion to waive the mediation conference, to the judge of compensation claims.*

~~(b)1. If the request in paragraph (a) is for a mediation conference, an application for a mediation conference shall state the reasons for requesting the mediation conference and the questions in dispute so that the responding or opposing parties may be notified of the purpose of the mediation conference.~~

(3) Such mediation conference shall be conducted informally and does not require the use of formal rules of evidence or procedure. Any information from the files, reports, case summaries, mediator's notes, or other communications or materials, oral or written, relating to a mediation conference *under* ~~pursuant to~~ this section obtained by any person performing mediation duties is privileged and confidential and may not be disclosed without the written consent of all parties to the conference. Any research or evaluation effort directed at assessing the mediation program activities or performance must protect the confidentiality of such information. Each party to a mediation conference has a privilege during and after the conference to refuse to disclose and to prevent another from disclosing communications made during the conference whether or not the contested issues are successfully resolved. This paragraph shall not be construed to prevent or inhibit the discovery or admissibility of any information that is otherwise subject to discovery or that is admissible under applicable law or rule of procedure, except that any conduct or statements made during a mediation conference or in negotiations concerning the conference are inadmissible in any proceeding under this chapter. The Chief Judge shall select a ~~judge of compensation claims, a general master, or a special master to serve as the~~ mediator. The *mediator* ~~general master~~ shall be employed on a full-time basis by the Office of the *Judges of Compensation Claims* ~~Chief Judge~~. ~~The rate of compensation for a general master shall be at 60 percent of the salary of a judge of compensation claims.~~ A *mediator* ~~general master~~ must be a member of The Florida Bar *for at least 5 years and must complete a mediation training program approved by the Chief Judge* ~~and have 3 years' experience in the practice of workers' compensation law in this state~~. *Adjunct mediators may be employed by the Office of the Judges of Compensation Claims on an as-needed basis and* ~~The special master~~ shall be selected from a list prepared by the Chief Judge. *An adjunct mediator* ~~The special master~~ must be independent of all parties participating in the mediation conference. *An adjunct mediator* ~~A special master~~ must be a member of The Florida Bar *for at least 5 years and must complete a mediation training program approved by the Chief Judge* ~~and have 3 years' experience in the practice of workers' compensation law in this state. The rate of compensation for a special master shall be $250 per day plus travel and per diem expenses.~~ *An adjunct mediator* ~~The special master~~ shall have access to the office, equipment, and supplies of the judge of compensation claims in each district. In the event both parties agree, the results of the mediation conference shall be binding and neither party shall have a right to appeal the results. In the event either party refuses to agree to the results of the mediation conference, the results of the mediation conference as well as the testimony, witnesses, and evidence presented at the conference shall not be admissible at any subsequent proceeding on the claim. The mediator shall not be called in to testify or give deposition to resolve any claim for any hearing before the judge of compensation claims. ~~The fact of requesting or accepting an offer to mediate shall not be admissible as evidence of liability in any collateral or subsequent proceeding on the claim.~~ The employer may be represented by an attorney at the mediation conference if the employee is also represented by an attorney at the mediation conference. ~~Any judge who serves as a mediator shall not be permitted to preside at a hearing involving the same claim pursuant to paragraph (c). If a request for mediation is filed, the mediation conference must be held within 45 days after it is filed and the judge, general master, or special master shall give the claimant and other interested parties at least 15 days' notice of such conference, served upon the claimant and other interested parties by mail.~~

(4)(a)~~2.~~ *If, on the 10th day following commencement of mediation, the questions in dispute have not been resolved,* the judge of compensation claims shall hold a pretrial hearing ~~on a claim no earlier than 30 days after the date of filing of the request for hearing and no later than 60 days after such date~~. The judge of compensation claims shall give the ~~claimant and all other~~ interested parties at least 7 ~~15~~ days' advance notice of the *pretrial* hearing by mail. At the pretrial hearing, the judge of compensation claims shall, subject to *paragraph (b)* ~~subparagraph 3.~~, set a date for the final hearing that allows the parties at least *30* ~~90~~ days to conduct discovery unless the parties consent to an earlier hearing date.

(b)~~3.~~ The final hearing must be held and concluded within *45* ~~120~~ days after the pretrial hearing. Continuances may be granted only if the requesting party demonstrates *to the judge of compensation claims* that the reason for requesting the continuance arises from circumstances beyond the party's control.

(c) ~~If the request in paragraph (a) is for a hearing, an application for a hearing concerning a claim shall refer to the claim previously filed and state the reasons for requesting a hearing and the questions in dispute which the applicant expects the judge of compensation claims to hear and determine, so that the responding or opposing parties may be notified of the purpose of the hearing. Any application for a hearing not in compliance with this paragraph shall be subject to dismissal upon motion of any interested party. If a request for a hearing is filed,~~ The judge of compensation claims shall ~~hold a hearing within 90 days after it is filed and shall~~ give the ~~claimant and other~~ interested parties at least 7 ~~15~~ days' *advance* notice of *the final* ~~such~~ hearing, served upon the ~~claimant and other~~ interested parties by mail.

(d) The hearing shall be held in the county where the injury occurred, if the injury occurred in this state, unless otherwise agreed to between the parties and authorized by the judge of compensation claims in the county where the injury occurred. If the injury occurred without the state and is one for which compensation is payable under this chapter, then the hearing above referred to may be held in the county of the employer's residence or place of business, or in any other county of the state which will ~~at the time of forwarding the file for hearing~~, in the discretion of the Chief Judge, be the most convenient for a hearing. ~~Subsequent to the forwarding of the file to such county, the parties and the judge of compensation claims may agree to transfer such file to a county that is deemed most convenient for a hearing.~~ The hearing shall be conducted by a judge of compensation claims, who shall, within *14* ~~30~~ days after *final* ~~such~~ hearing, unless otherwise agreed by the parties, determine the dispute in a summary manner. At such hearing, the claimant and employer may each present evidence in respect of such claim and may be represented by any attorney authorized in writing for such purpose. When there is a conflict in the medical evidence submitted at the hearing, the *provisions of s. 440.13 shall apply* ~~judge of compensation claims may designate a disinterested doctor to submit a report or to testify in the proceeding, after~~

~~such doctor has reviewed the medical reports and evidence, examined the claimant, or otherwise made such investigation as appropriate~~. The report or testimony of *the expert medical advisor* ~~any doctor so designated by the judge of compensation claims~~ shall be made a part of the record of the proceeding and shall be given the same consideration by the judge of compensation claims as is accorded other medical evidence submitted in the proceeding; and all costs incurred in connection with such examination and testimony may be assessed as costs in the proceeding, subject to the provisions of s. 440.13~~(4)(a)~~. No judge of compensation claims may make a finding of a degree of permanent impairment that is greater than the greatest permanent impairment rating given the claimant by any examining or treating physician, except upon stipulation of the parties.

(e) The order making an award or rejecting the claim, referred to in this chapter as a "compensation order," shall set forth the findings of ultimate facts and the mandate; and the order need not include any other reason or justification for such mandate. The compensation order shall be filed in the office of the division at Tallahassee. A copy of such compensation order shall be sent by mail to the parties and attorneys of record at the last known address of each, with the date of mailing noted thereon.

(f) Each judge of compensation claims is required to submit a special report to the Chief Judge in each contested workers' compensation case in which the case is not determined within *14* ~~30~~ days of final hearing. Said form shall be provided by the Chief Judge and shall contain the names of the judge of compensation claims and of the attorneys involved and a brief explanation by the judge of compensation claims as to the reason for such a delay in issuing a final order. The Chief Judge shall compile these special reports into an annual public report to the Governor, the Secretary of Labor and Employment Security, the Legislature, The Florida Bar, and the appellate district judicial nominating commissions.

(g) Judges of compensation claims shall adopt and enforce uniform local rules for workers' compensation.

(h) Notwithstanding any other provision of this section, the judge of compensation claims may require the appearance of the parties and counsel before him without written notice for an emergency conference where there is a bona fide emergency involving the health, safety, or welfare of an employee. An emergency conference under this section may result in the entry of an order or the rendering of an adjudication by the judge of compensation claims.

(i) To expedite dispute resolution and to enhance the self-executing features of the Workers' Compensation Law, the Chief Judge shall make provision by rule or order for the resolution of appropriate motions by judges of compensation claims without oral hearing upon submission of brief written statements in support and opposition, and for expedited discovery and docketing.

(j) To further expedite dispute resolution and to enhance the self-executing features of the system, those petitions filed in accordance with s. 440.192 that involve a claim for benefits of $5,000 or less shall, in the absence of compelling evidence to the contrary, be presumed to be appropriate for expedited resolution under this paragraph; and any other claim filed in accordance with s. 440.192, upon the written agreement of both parties and application by either party, may similarly be resolved under this paragraph. For purposes of expedited resolution pursuant to this paragraph, the Chief Judge shall make provision by rule or order for expedited and limited discovery and expedited docketing in such cases. At least 15 days prior to hearing, the parties shall exchange and file with the judge of compensation claims a pretrial outline of all issues, defenses, and witnesses on a form promulgated by the Chief Judge; provided, in no event shall such hearing be held without 15 days' written notice to all parties. No pretrial hearing shall be held. The judge of compensation claims shall limit all argument and presentation of evidence at the hearing to a maximum of 30 minutes, and such hearings shall not exceed 30 minutes in length. Neither party shall be required to be represented by counsel. The employer or carrier may be represented by an adjuster or other qualified representative. The employer or carrier and any witness may appear at such hearing by telephone. The rules of evidence shall be liberally construed in favor of allowing introduction of evidence.

(5)~~(4)~~(a) ~~Beginning on October 1, 1979,~~ Procedures with respect to appeals from orders of judges of compensation claims shall be governed by rules adopted by the Supreme Court. Such an order shall become final 30 days after mailing of copies of such order to the parties, unless appealed pursuant to such rules.

(b) An appellant may be relieved of any necessary filing fee by filing a verified petition of indigency for approval as provided in s. 57.081(1) and may be relieved in whole or in part from the costs for preparation of the record on appeal if, within 15 days after the date notice of the estimated costs for the preparation is served, *the appellant* ~~he~~ files with the judge of compensation claims *a copy of the designation of the record on appeal, and* a verified petition to be relieved of costs. *A verified petition filed prior to the date of service of the notice of the estimated costs shall be deemed not timely filed.* The verified petition relating to record costs shall contain a ~~detailed and~~ sworn statement *that the appellant is insolvent and a complete, detailed, and sworn financial affidavit showing* ~~of~~ all the appellant's assets, liabilities, and income. *Failure to state in the affidavit all assets and income, including marital assets and income, shall be grounds for denying the petition with prejudice. The division shall promulgate rules as may be required pursuant to this subsection, including forms for use in all petitions brought under this subsection.* The appellant's attorney, or the appellant if he is not represented by an attorney, shall include as a part of the verified petition relating to record costs an affidavit or affirmation that, in his opinion, the notice of appeal was filed in good faith and that there is a probable basis for the District Court of Appeal, First District, to find reversible error, *and shall state with particularity the specific legal and factual grounds for his opinion. Failure to so affirm shall be grounds for denying the petition.* A copy of the verified petition relating to record costs shall be served upon *all interested parties, including the division and the Office of the General Counsel, Department of Labor and Employment Security* ~~the division~~ in Tallahassee ~~and upon all other interested parties~~. The judge of compensation claims shall promptly conduct a hearing on the verified petition relating to record costs, giving at least 15 days' notice to the appellant, the division, and all other interested parties, all of whom shall be parties to the proceedings. The judge of compensation claims may enter an order without such hearing if no objection is filed by ~~the division or by~~ an interested party within *20* ~~12~~ days from the *service* date *of* the verified petition relating to record costs ~~is filed~~. Such proceedings shall be conducted in accordance with the provisions of this section and with the workers' compensation rules of procedure, to the extent applicable. In the event an insolvency petition is granted, the judge of compensation claims *shall direct the division to pay* ~~may provide for payment of~~ record costs and filing fees from the Workers' Compensation Trust Fund pending final disposition of the costs of appeal. *The division may transcribe or arrange for the transcription of the record in any proceeding for which it is ordered to pay the cost of the record. In the event the insolvency petition is denied, the judge of compensation claims may enter an order requiring the petitioner to reimburse the division for costs incurred in opposing the petition, including investigation and travel expenses.*

(c) As a condition of filing a notice of appeal to the District Court of Appeal, First District, an employer who has not secured the payment of compensation under this chapter in compliance with s. 440.38 shall file with his notice of appeal a good and sufficient bond, as provided in s. 59.13, conditioned to pay the amount of the demand and any interest and costs payable under the terms of the order if the appeal is dismissed, or if the District Court of Appeal, First District, affirms the award in any amount. Upon the failure of such employer to file such bond with the judge of compensation claims or the District Court of Appeal, First District, along with his notice of appeal, the District Court of Appeal, First District, shall dismiss the notice of appeal.

(6)~~(5)~~ An award of compensation for disability may be made after the death of an injured employee.

(7)~~(6)~~ An injured employee claiming or entitled to compensation shall submit to such physical examination by a *certified expert medical advisor* ~~duly qualified physician designated or~~ approved by *the division or* the judge of compensation claims as *the division or* the judge of compensation claims may require. The place or places shall be reasonably convenient for the employee. Such physician or physicians as the employee, employer, or carrier may select and pay for may participate in an examination if the employee, employer, or carrier so requests. Proceedings shall be suspended and no compensation shall be payable for any period during which the employee may refuse to submit to examination. Any interested party shall have the right in any case of death to require an autopsy, the cost thereof to be borne by the party requesting it; and the judge of compensation claims shall have authority to order and require an autopsy and may, in his discretion, withhold his findings and award until an autopsy is held.

Section 31. Section 440.28, Florida Statutes, is amended to read:

440.28 Modification of orders.—Upon a judge of compensation claims' own initiative, or upon the application of any party in interest, on the ground of a change in condition or because of a mistake in a determination of fact, the judge of compensation claims may, at any time prior to 2 years after the date of the last payment of compensation pursuant to *the* ~~any~~ compensation order *the party seeks to modify*, or at any time prior to 2 years after the date copies of an order rejecting a claim are mailed to the parties at the last known address of each, review a compensation case in accordance with the procedure prescribed in respect of claims in s. 440.25 and, in accordance with such section, issue a new compensation order which may terminate, continue, reinstate, increase, or decrease such compensation or award compensation. Such new order shall not affect any compensation previously paid, except that an award increasing the compensation rate may be made effective from the date of the injury, and, if any part of the compensation due or to become due is unpaid, an award decreasing the compensation rate may be made effective from the date of the injury, and any payment made prior thereto in excess of such decreased rate shall be deducted from any unpaid compensation, in such manner and by such method as may be determined by the judge of compensation claims.

Section 32. Subsection (4) is added to section 440.29, Florida Statutes, to read:

440.29 Procedure before the judge of compensation claims.—

(4) All medical reports of authorized treating health care providers relating to the claimant and subject accident shall be received into evidence by the judge of compensation claims upon proper motion. However, such records must be served on the opposing party at least 30 days before the final hearing. This section does not limit any right of further discovery, including, but not limited to, depositions.

Section 33. Section 440.32, Florida Statutes, is amended to read:

440.32 Cost in proceedings brought without reasonable ground.—

(1) If the judge of compensation claims or any court having jurisdiction of proceedings in respect of any claim or compensation order determines that the proceedings in respect of such claim or order have been instituted or continued without reasonable ground, the cost of such proceedings shall be assessed against the party who has so instituted or continued *the* ~~such~~ proceedings.

(2) If the judge of compensation claims or any court having jurisdiction of proceedings in respect to any claims or defense under this section determines that the proceedings were maintained or continued frivolously, the cost of the proceedings, including reasonable attorney's fees, shall be assessed against the offending attorney. If a penalty is assessed under this subsection, a copy of the order assessing the penalty must be forwarded to the appropriate grievance committee acting under the jurisdiction of the Supreme Court. Penalties, fees, and costs awarded under this provision may not be recouped from the party.

(3) Every pleading, motion, and other paper of a party represented by an attorney shall be signed by at least one attorney of record in the attorney's individual name, whose address shall be stated. The signature of an attorney constitutes a certificate by the signer that the signer has read the pleading, motion, or other paper; that to the best of the signer's knowledge, information, and belief formed after reasonable inquiry it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation. If a pleading, motion, or other paper is not signed, it shall be stricken unless it is signed promptly after the omission is called to the attention of the pleader or movant. If a pleading, motion, or other paper is signed in violation of this section, the judge of compensation claims or any court having jurisdiction of proceedings, upon motion or upon its own initiative, shall impose upon the person who signed it, an appropriate sanction, which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleading, motion, or other paper, including a reasonable attorney's fee.

Section 34. Section 440.34, Florida Statutes, is amended to read:

440.34 Attorney's fees; costs~~; penalty for violations~~.—

(1) *A* ~~No~~ fee, gratuity, or other consideration *may not* ~~shall~~ be paid for services rendered for a claimant in connection with any proceedings arising under this chapter, unless approved as reasonable by the judge of compensation claims or court having jurisdiction over such proceedings. Except as provided by this subsection, any attorney's fee approved by a judge of compensation claims *for services rendered to a claimant must* ~~shall be~~ equal to *20* ~~25~~ percent of the first $5,000 of the amount of the benefits secured, *15* ~~20~~ percent of the next $5,000 of the amount of the benefits secured, *10* ~~and 15~~ percent of the remaining amount of the benefits secured *to be provided during the first 10 years after the date the claim is filed, and 5 percent of the benefits secured after 10 years.* However, the judge of compensation claims shall consider the following factors in each case and may increase or decrease the attorney's fee if, in his judgment, the circumstances of the particular case warrant such action:

(a) The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly.

~~(b) The likelihood, if apparent to the claimant, that the acceptance of the particular employment will preclude employment of the lawyer by others or cause antagonisms with other clients.~~

(b)~~(c)~~ The fee customarily charged in the locality for similar legal services.

(c)~~(d)~~ The amount involved in the controversy and the benefits resulting to the claimant.

(d)~~(e)~~ The time limitation imposed by the claimant or the circumstances.

~~(f) The nature and length of the professional relationship with the claimant.~~

(e)~~(g)~~ The experience, reputation, and ability of the lawyer or lawyers performing services.

(f)~~(h)~~ The contingency or certainty of a fee.

(2) In awarding a reasonable *claimant's* attorney's fee, the judge of compensation claims shall consider only those benefits to the claimant that the attorney is responsible for securing. The amount, statutory basis, and type of benefits obtained through legal representation shall be listed on all attorney's fees awarded by the judge of compensation claims. For purposes of this section, the term "benefits secured" means benefits obtained as a result of the claimant's attorney's legal services rendered in connection with the claim for benefits. However, such term does not include future medical benefits to be provided on any date more than 5 years after the date the claim is filed.

(3) If the claimant should prevail in any proceedings before a judge of compensation claims or court, there shall be taxed against the employer the reasonable costs of such proceedings, not to include the attorney's fees of the claimant. A claimant shall be responsible for the payment of his own attorney's fees, except that a claimant shall be entitled to recover a reasonable attorney's fee from a carrier or employer:

(a) Against whom he successfully asserts a claim for medical benefits only, if the claimant has not filed or is not entitled to file at such time a claim for disability, permanent impairment, wage-loss, or death benefits, arising out of the same accident; or

(b) In any case in which the employer or carrier *files a notice of denial with the division* ~~fails or refuses to pay a claim filed with the division which meets the requirements of s. 440.19(1)(c) on or before the 21st day after receiving notice of the claim,~~ and the injured person has employed an attorney in the successful prosecution of his claim; or

(c) In a proceeding in which a carrier or employer denies that an injury occurred for which compensation benefits are payable, and the claimant prevails on the issue of compensability; or

(d) In cases where the claimant successfully prevails in proceedings filed under s. 440.24 or s. 440.28.

In applying the factors set forth in subsection (1) to cases arising under paragraphs (a), (b), (c), and (d) ~~of this subsection~~, the judge of compensation claims *must* ~~shall~~ only consider *only* such benefits and the time reasonably spent in obtaining them as were secured for the claimant within the scope of paragraphs (a), (b), (c), and (d) ~~of this subsection~~.

(4) In such cases in which the claimant is responsible for the payment of his own attorney's fees, such fees *are* ~~shall be~~ a lien upon compensation payable to the claimant, notwithstanding ~~the provisions of~~ s. 440.22.

(5) If any proceedings are had for review of any claim, award, or compensation order before any court, the court may award the injured employee or dependent an attorney's fee to be paid by the employer or carrier, in its discretion, which shall be paid as the court may direct.

~~(6) Any person:~~

~~(a) Who receives any fees or other consideration or any gratuity on account of services so rendered, unless such consideration or gratuity is approved by the judge of compensation claims or the court; or~~

~~(b) Who makes it a business to solicit employment for a lawyer or for himself in respect of any claim or award for compensation,~~

~~is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.~~

(6)~~(7)~~ *A* ~~No~~ judge of compensation claims *may not* ~~shall~~ enter an order approving the contents of a retainer agreement that permits the escrowing of any portion of the employee's compensation until benefits have been secured.

Section 35. Section 440.345, Florida Statutes, is created to read:

440.345 Reporting of attorney's fees.—All fees paid to attorneys for services rendered under this chapter shall be reported to the division as the division requires by rule. The division shall annually summarize such data in a report to the Workers' Compensation Oversight Board.

Section 36. Paragraph (e) of subsection (1) and subsection (4) of section 440.38, Florida Statutes, are amended to read:

440.38 Security for compensation; insurance carriers and self-insurers.—

(1) Every employer shall secure the payment of compensation under this chapter:

(e) *In accordance with s. 440.135, an employer, other than a local government unit, may elect coverage under the Workers' Compensation Law and retain the benefit of the exclusiveness of liability provided in s. 440.11 by obtaining a 24-hour health insurance policy from an authorized property and casualty insurance carrier or an authorized life and health insurance carrier, or by participating in a fully or partially self-insured 24-hour health plan that is established or maintained by or for two or more employers, so long as the law of this state is not preempted by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, or any amendment to that law, which policy or plan must provide, for at least occupational injuries and illnesses, medical benefits that are comparable to those required by this chapter. A local government unit, as a single employer, in accordance with s. 440.135, may participate in the 24-hour health insurance coverage plan referenced in this paragraph. Disputes and remedies arising under policies issued under this section are governed by the terms and conditions of the policies and under the applicable provisions of the Florida Insurance Code and rules adopted under the insurance code and other applicable laws of this state.* ~~By obtaining a 24-hour health insurance policy which shall provide medical benefits required by this chapter and which shall meet criteria established by the Department of Insurance by rule.~~ The 24-hour health insurance policy may provide for health care by a health maintenance organization or a preferred provider organization. The premium for such 24-hour health insurance policy shall be paid entirely by the employer. The 24-hour health insurance policy may *use* ~~utilize~~ deductibles and coinsurance provisions that require the employee to pay a portion of the actual medical care received by the employee. *If* ~~In the event~~ an employer obtains a 24-hour health insurance policy *or self-insured plan* to secure payment of compensation as to medical benefits, the employer *must* ~~shall~~ also obtain an insurance policy *or policies that* ~~which shall~~ provide indemnity benefits *as follows:*

1. If indemnity benefits are provided only for occupational-related disability, such benefits must be comparable to those required by this chapter.

2. If indemnity benefits are provided for both occupational-related and nonoccupational-related disability, such benefits must be comparable to those required by this chapter, except that they must be based on 60 percent of the average weekly wages.

3. The employer shall provide for each of its employees life insurance with a death benefit of $100,000.

4. Policies providing coverage under this subsection must use prescribed and acceptable underwriting standards, forms, and policies approved by the Department of Insurance. If any insurance policy that provides coverage under this section is canceled, terminated, or nonrenewed for any reason, the cancellation, termination, or nonrenewal is ineffective until the self-insured employer or insurance carrier or carriers notify the division and the Department of Insurance of the cancellation, termination, or nonrenewal, and until the division has actually received the notification. The division must be notified of replacement coverage under a workers' compensation and employer's liability insurance policy or plan by the employer prior to the effective date of the cancellation, termination, or nonrenewal. ~~so that the total coverage afforded by both the 24-hour health insurance policy and the policy providing indemnity benefits shall provide the total compensation required by this chapter; or~~

(4)(a) *A* ~~No~~ carrier of insurance, including the parties to any mutual, reciprocal, or other association, *may not* ~~shall~~ write any compensation insurance under this chapter without a permit from the Department of Insurance. Such permit shall be given, upon application therefor, to any insurance or mutual or reciprocal insurance association upon the department's being satisfied of the solvency of such corporation or association and its ability to perform all its undertakings. The Department *of Insurance* may revoke any permit so issued for violation of any provision of this chapter.

(b) *A* ~~No~~ carrier of insurance, including the parties to any mutual, reciprocal, or other association, *may not* ~~shall~~ write any compensation insurance under this chapter unless such carrier has a claims adjuster, either in-house or under contract, situated within this state. *Self-insurers whose compensation payments are administered through a third party and carriers of insurance shall maintain a claims adjuster within this state during any period for which there are any open claims against such self-insurer or carrier arising under the compensation insurance written by the self-insurer or carrier. Individual self-insurers whose compensation payments are administered by employees of the self-insurer shall not be required to have their claims adjuster situated within this state.* Individual self insurers shall not be required to have their claims adjusters situated within this state.

~~(c) Any insurer, rating bureau, or agent or other representative or employee of any insurer or rating bureau failing to comply with, or who is guilty of a violation of, any of the provisions of this chapter or of any order or ruling of the Department of Insurance made hereunder is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.083. In addition thereto, the license of any insurer, agent, or broker who is guilty of such violation may be revoked or suspended by the department.~~

Section 37. Subsections (1), (2), (3), and (6) of section 440.381, Florida Statutes, are amended to read:

440.381 Application for coverage; reporting payroll; payroll audit procedures; penalties.—

(1) Applications by an employer to a carrier for coverage required by s. 440.38 *must* ~~shall~~ be made on a form prescribed by the Department of Insurance. The Department of Insurance shall adopt rules ~~by January 1, 1991,~~ for applications for coverage required by s. 440.38. The rules *must* ~~shall~~ provide that an application include information on the employer, the type of business, past and prospective payroll, estimated revenue, previous workers' compensation experience, employee classification, employee names, and any other information necessary to enable a carrier to accurately underwrite the applicant. The rules *must include a provision that a carrier or self-insurance fund may* ~~shall also~~ require that an employer update an application monthly to reflect any change in the required application information.

(2) The application *must* ~~or application update shall~~ contain a statement that the filing of an application ~~or application update~~ containing false, misleading, or incomplete information with the purpose of avoiding or reducing the amount of premiums for workers' compensation coverage is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The application *must* ~~shall~~ contain a sworn statement by the employer attesting to the accuracy of the information submitted and acknowledging the provisions of s. 440.37(4).

(3) The Department of Insurance and the Department of Labor and Employment Security shall establish by rule minimum requirements for audits of payroll and classifications in order to ensure that the appropriate premium is charged for workers' compensation coverage. The rules shall ensure that audits performed by both carriers and employers are adequate to provide that all sources of payments to employees, subcontractors, and independent contractors have been reviewed and that the accuracy of classification of employees has been verified. The rules shall provide that employers in all classes other than the construction class be audited not less frequently than biennially and may provide for more frequent audits of employers in specified classifications based on factors such as amount of premium, type of business, loss ratios, or other relevant factors. In no event shall employers in the construction class, generating more than the amount of premium required to be experience rated, be audited less than annually. The annual audits required for construction classes shall consist of physical onsite *audits* ~~audit for the years 1991-1993~~. Payroll verification audit rules *must* ~~shall~~ include, but *need* not be limited to, the use of state and federal reports of employee income, payroll and other accounting records, certificates of insurance maintained by subcontractors, and duties of employees.

(6) If an employer intentionally understates *or conceals* payroll, or misrepresents *or conceals* employee duties so as to avoid proper classification for premium calculations, *or misrepresents or conceals information pertinent to the computation and application of an experience rating modification factor,* the employer, *or his agent or attorney,* shall pay *to the insurance carrier a penalty of ten times the amount of the difference in premium paid and the amount the employer should have paid and reasonable attorney's fees. The penalty may be enforced in the circuit courts of this state.*~~, in addition to any additional premium due resulting from an audit, a 12 percent penalty on the amount underpaid. The penalty shall be paid to the carrier.~~

Section 38. Section 440.4416, Florida Statutes, is created to read:

440.4416 Workers' Compensation Oversight Board.—

(1) There is created within the Department of Labor and Employment Security the Workers' Compensation Oversight Board. The board shall be composed of the following members, each of whom has knowledge of, or experience with, the workers' compensation system:

(a) Six members selected by the Governor, none of whom shall be a member of the Legislature at the time of appointment, consisting of the following:

1. Two representatives of employers.

2. Four representatives of employees, one of whom must be a representative of an employee's union whose members are covered by workers' compensation pursuant to this chapter.

(b) Three members selected by the President of the Senate, none of whom shall be members of the Legislature at the time of appointment, consisting of:

1. A representative of employers who employs at least 10 employees in Florida for which workers' compensation coverage is provided pursuant to this chapter, and who is a licensed general contractor actively engaged in the construction industry in this state.

2. A representative of employers who employs fewer than 10 employees in Florida for which workers' compensation coverage is provided pursuant to this chapter.

3. A representative of employees.

(c) Three members selected by the Speaker of the House of Representatives, none of whom shall be members of the Legislature at the time of appointment, consisting of:

1. A representative of employers who employs fewer than 10 employees in Florida and who is a licensed general contractor actively engaged in the construction industry in this state for which workers' compensation coverage is provided pursuant to this chapter.

2. A representative of employers who employs at least 10 employees in Florida for which workers' compensation coverage is provided pursuant to this chapter.

3. A representative of employees.

(d) Additionally, the Insurance Commissioner and the Secretary of the Department of Labor and Employment Security shall be nonvoting ex officio members.

(e) The original appointments to the board shall be made on or before January 1, 1994. Vacancies in the membership of the board shall be filled in the same manner as the original appointments. Except as to ex officio members of the board, three appointees of the Governor, two appointees of the President of the Senate, and two appointees of the Speaker of the House of Representatives shall serve for terms of 2 years, and the remaining appointees shall serve for terms of 4 years. Thereafter, all members shall serve for terms of 4 years; except that a vacancy shall be filled by appointment for the remainder of the term. The board shall have an organizational meeting on or before March 1, 1994, the time and place of such meeting to be determined by the Governor.

(f) Each member is accountable to the Governor for proper performance of his or her duties as a member of the board. The Governor may remove from office any member for malfeasance, misfeasance, neglect of duty, drunkenness, incompetence, permanent inability to perform official duties, or for pleading guilty or nolo contendere to, or having been adjudicated guilty of, a first degree misdemeanor or a felony.

(g) A vacancy shall occur upon failure of a member to attend four consecutive meetings of the board or 50 percent of the meetings of the board during a 12-month period, unless the board by majority votes to excuse the absence of such member.

(2) POWERS AND DUTIES; ORGANIZATION.—

(a) The board shall have all the powers necessary and convenient to carry out and effectuate the purposes of this section, including, but not limited to, the power to:

1. Conduct public hearings.

2. Report to the Legislature by January 1, 1995, as to the feasibility of a return-to-work program that includes incentives for employers who encourage such a program and disincentives for employers who hinder such a program.

3. Prescribe qualifications for board employees.

4. Appear on its own behalf before other boards, commissions, or agencies of the state or Federal Government.

5. Make and execute contracts to the extent that such contracts are consistent with duties and powers set forth in this section and elsewhere in the law of this state.

(b) The board shall adopt bylaws, formulate workers' compensation legislation or amendments, review, advise, and appear before the Legislature in connection with legislation that impacts the workers' compensation system, advise the division on policy, administrative and legislative issues, and appear before other state or federal agencies in connection with matters impacting the workers' compensation system.

(c) The board shall select a chairman who shall serve for a period of 2 years and until a successor is elected and qualified. The chairman shall be the chief administrative officer of the board and shall have the authority to plan, direct, coordinate, and execute the powers and duties of the board.

(d) The board shall hold such meetings during the year as it deems necessary, except that the chairman, a quorum of the board, or the division may call meetings. The board shall maintain transcripts of each meeting. Such transcripts shall be available to any interested person in accordance with chapter 119.

(e) The board shall approve the bylaws or amendments thereto by unanimous vote. All other board actions or recommendations shall be approved by not less than a majority vote of employee representatives and majority vote of employer representatives, unless the bylaws otherwise provide.

(3) EXECUTIVE DIRECTOR; EXPENSES.—

(a) The board shall appoint an executive director to direct and supervise the administrative affairs and general management of the board who shall be subject to the provisions of part IV of chapter 110. The executive director may employ persons and obtain technical assistance as authorized by the board and shall attend all meetings of the board. Board employees shall be exempt from part II of chapter 110.

(b) In addition to per diem and travel expenses authorized by s. 112.061, board members shall receive compensation of $50 for each full day allocable to business of the board. The board shall promulgate procedures defining "business" for purposes of receiving compensation. Such procedures shall require each member to maintain time records and submit such records to the executive director on a monthly basis. Failure to timely file such monthly record shall extinguish the member's entitlement to compensation for the subject period. Travel outside this state shall be approved by the secretary of the department. Expenses associated with the administration of this section shall be appropriated and paid for from the trust fund created by s. 440.50.

Section 39. Section 440.442, Florida Statutes, is amended to read:

440.442 Code of Judicial Conduct.—The Chief Judge, and judges of compensation claims shall observe and abide by the Code of Judicial Conduct *as provided in this section.* ~~adopted by the Supreme Court of Florida as of July 1, 1978, as well as all amendments thereto that are hereafter adopted by the court, except for the provisions of subparagraph C of Canon 6.~~ Any material violation of a provision of the Code of Judicial Conduct shall constitute either malfeasance or misfeasance in office and shall be grounds for suspension and removal of such Chief Judge, or judge of compensation claims by the Governor.

(1) A JUDGE SHOULD UPHOLD THE INTEGRITY AND INDEPENDENCE OF THE JUDICIARY.—An independent and honorable judiciary is indispensable to justice in our society. A judge should participate in establishing, maintaining, and enforcing, and should himself observe, high standards of conduct so that the integrity and independence of the judiciary may be preserved. The provisions of this code should be construed and applied to further that objective.

(2) A JUDGE SHOULD AVOID IMPROPRIETY AND THE APPEARANCE OF IMPROPRIETY IN ALL HIS ACTIVITIES.—

(a) A judge should respect and comply with the law and should conduct himself at all times in a manner that promotes public confidence in the integrity and impartiality of the judiciary.

(b) A judge should not allow his personal relationships to influence his judicial conduct of judgment. A judge should not lend the prestige of the office to advance the private interest of others; nor should he convey or authorize others to convey the impression that they are in a special position to influence him. A judge should not testify voluntarily as a character witness.

(3) A JUDGE SHOULD PERFORM THE DUTIES OF HIS OFFICE IMPARTIALLY AND DILIGENTLY.—The judicial duties of a judge take precedence over all his other activities. The judicial duties include all the duties of his office prescribed by law. In the performance of these duties, the following standards with respect to adjudicative responsibilities apply:

(a) A judge should be faithful to the law and maintain professional competence in it. A judge should be unswayed by partisan interests, public clamor, or fear of criticism.

(b) A judge should maintain order and decorum in proceedings.

(c) A judge should be patient, dignified, and courteous to litigants, jurors, witnesses, lawyers, and others with whom he must deal in a official capacity, and should request similar conduct of lawyers, and of his staff, court officials, and others subject to his direction and control.

(4) A JUDGE MAY ENGAGE IN ACTIVITIES TO IMPROVE THE LAW, THE LEGAL SYSTEM, AND THE ADMINISTRATION OF JUSTICE.—A judge, subject to the proper performance of his judicial duties, may engage in the following quasi-judicial activities, if in doing so he does not cast doubt on his capacity to decide impartiality on any issue that may come before him:

(a) Speak, write, lecture, teach, and participate in other activities concerning the law, the legal system, and the administration of justice.

(b) Appear at a public hearing before an executive or legislative body or official on matters concerning the law, the legal system, and the administration of justice, and may otherwise consult with an executive or legislative body or official, but only on matters concerning the administration of justice.

(c) Serve as a member, officer, or director of an organization or governmental agency devoted to the improvement of the law, the legal system, or the administration of justice and assist such an organization in raising funds and may participate in their management and investment, but should not personally participate in public fundraising activities.

(d) Make recommendations to public and private fund-granting agencies on projects and programs concerning the law, the legal system, and the administration of justice.

(5) A JUDGE SHOULD REGULATE HIS EXTRAJUDICIAL ACTIVITIES TO MINIMIZE THE RISK OF CONFLICT WITH HIS JUDICIAL DUTIES.—

(a) Avocational activities.—A judge may write, lecture, teach, and speak on nonlegal subjects, and engage in the arts, sports, or other social and recreational activities, if such avocational activities do not detract from the dignity of the office or interfere with the performance of his judicial duties.

(b) Civil and charitable activities.—A judge may not participate in civic and charitable activities that reflect adversely upon his impartiality or interfere with the performance of his duties. A judge may serve as an officer, director, trustee, or nonlegal advisory of an educational, religious, charitable, fraternal, or civic organization not conducted for the economic or political advantage of its members, subject to the following limitations:

1. A judge should not serve if it is likely that the organization will be engaged in proceedings that would ordinarily come before him or will be regularly engaged in adversary proceedings in any court.

2. A judge should not solicit funds for any educational, religious, charitable, fraternal, or civil organization, or use or permit the use of the prestige of the office for that purpose, but may be listed as an officer, director, or trustee of such an organization. A judge should not be a speaker or a guest of honor at any organization's fundraising events, but may attend such events.

3. A judge should not give investment advice to such an organization, but may serve on its board of directors or trustees even though it has the responsibility for approving investment decisions.

(c) Financial activities.—

1. A judge should refrain from financial and business dealings that tend to reflect adversely on his impartiality, interfere with the proper performance of his judicial duties, exploit his judicial position, or involve him in frequent transactions with lawyers or persons likely to come before the court on which he serves.

2. Subject to the requirements of subsection (1), a judge in an individual or corporate capacity may hold and manage investments, including real estate, and engage in other remunerative activity, but should not serve as an officer, director, manager, advisor, or employee of any business, except a closely held family business that does not conflict with subsection (1).

3. A judge should manage his investments and other financial interests to minimize the number of cases in which he is disqualified. As soon as he can do so without serious financial detriment, he should divest himself of investments and other financial interests that might require frequent disqualifications.

4. A judge should not accept a gift, bequest, favor, or loan from anyone except as follows:

a. A judge may accept a gift incident to a public testimonial to him; books supplied by publishers on a complimentary basis for official use; or an invitation to the judge and spouse to attend a bar-related function or activity devoted to the improvement of the law, the legal system, or the administration of justice;

b. A judge may accept ordinary hospitality; a gift, bequest, favor or loan from a relative; a wedding or an engagement gift; a loan from a lending institution in its regular course of business on the same terms generally available to persons who are not judges; or a scholarship or fellowship awarded on the same terms applied to other applicants;

c. A judge may accept any other gift, bequest, favor, or loan exceeding $100 only if the donor is not a party or other person whose interests have recently come or may likely come before him in the immediate future.

5. A judge should make a reasonable effort to inform himself about the personal financial interests of members of his family residing in his household and shall report any gift, bequest, favor, or loan received thereby of which he has knowledge and which tends to reflect adversely on his impartiality, in the same manner as he reports compensation in subsection 6.

6. For the purpose this section, "member of his family residing in his household" means any relative of a judge by blood or marriage, or a person treated by a judge as a member of his family, who resides in his household.

7. A judge is not required by this section to disclose his income, debts, or investments, except as provided in subsections (3) and (6).

8. Information required by a judge in which his judicial capacity should not be used or disclosed by him in financial dealings or for any other purpose not related to his judicial duties.

(6) Fiscal matters of a judge should be conducted in a manner that will not give the appearance of influence or impropriety. A judge should regularly file public reports as required by s. 8, Art. II of the State Constitution, and should publicly report gifts.

(a) Compensation for quasi-judicial and extrajudicial services and reimbursement of expenses.—A judge may receive compensation and reimbursement of expenses for the quasi-judicial and extrajudicial activities permitted by this section, if the source of such payments does not give the appearance of influencing the judge in his judicial duties or otherwise give the impression of impropriety subject to the following restrictions:

1. Compensation: Compensation should not exceed a reasonable amount nor should it exceed what a person who is not a judge would receive for the same activity.

2. Expense reimbursement: Expense reimbursement should be limited to the actual cost of travel, food, and lodging reasonably incurred by the judge and, where appropriate to the occasion, to his spouse. Any payment in excess of such an amount is compensation.

(b) Public financial reporting.—

1. Income and assets: A judge shall file such public reports as may be required by law for all public officials to comply fully with the provisions of s. 8, Art. II of the State Constitution. The form for public financial disclosure shall be that recommended or adopted by the Florida Commission on Ethics for use by all public officials. The form shall be filed in the office of the Secretary of State on the date prescribed by law.

2. Gifts: A judge shall file a public report of all gifts which are required to be disclosed under s. 112 [Canon 5C(4)(c) of the Code of Judicial Conduct]. The report of gifts received in the preceding calendar year shall be filed in the office of the Secretary of State on or before July 1 of each year.

Section 40. Section 440.45, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 440.45, F.S., for present text.)

440.45 Office of Judges of Compensation Claims.—

(1) There is hereby created the Office of the Judges of Compensation Claims within the Department of Labor and Employment Security. The Office of the Judges of Compensation Claims shall be headed by a Chief Judge who shall serve at the pleasure of the Governor and Cabinet. The Chief Judge shall be appointed by the Governor and confirmed by the Cabinet from a list of two names submitted by each of the District Court Judicial Nominating Commissions created by Article V, Section II of the Florida Constitution and s. 43.29. The office shall be a separate budget entity and the Chief Judge shall be its agency head for all purposes. The Department of Labor and Employment Security shall provide administrative support and service to the office to the extent requested by the Chief Judge but shall not direct, supervise or control the Office of the Judges of Compensation Claims in any manner, including but not limited to personnel, purchasing, budgetary matters or property transactions. The operating budget of the Office of the Judges of Compensation Claims shall be paid out of the Workers' Compensation Administrative Trust Fund established in s. 440.50.

(2)(a) The Governor shall appoint full time judges of compensation claims to conduct proceedings as required by this chapter or other law. No person may be appointed as a judge of compensation claims unless he or she has been a member of The Florida Bar in good standing for the preceding five years and is knowledgeable in the law of workers' compensation. No judge of compensation claims shall engage in the private practice of law during a term of office.

(b) The Governor shall initially appoint a judge of compensation claims from a list of three persons nominated by a statewide nominating commission. The statewide nominating commission shall be composed of the following: five members, at least one of whom must be a member of a minority group as defined in s. 288.703(3), one of each who resides in each of the territorial jurisdictions of the district courts of appeal, appointed by the Board of Governors of The Florida Bar from among The Florida Bar members who are engaged in the practice of law; five electors, at least one of whom must be a member of a minority group as defined in s. 288.703(3), one of each who resides in each of the territorial jurisdictions of the district courts of appeal, appointed by the Governor; and five electors, at least one of whom must be a member of a minority group as defined in s. 288.703(3), one of each who resides in the territorial jurisdictions of the district courts of appeal, selected and appointed by a majority vote of the other ten members of the commission. No attorney who appears before any judge of compensation claims more than four times a year is eligible to serve on the statewide nominating commission. The meetings and determinations of the nominating commission as to the judges of compensation claims shall be open to the general public.

(c) Each judge of compensation claims shall be appointed for a term of 4 years, but during the term of office may be removed by the Governor for cause. Prior to the expiration of judge's term of office, the statewide nominating commission shall review the judge's conduct. The commission shall report its finding to the Governor no later than 6 months prior to the expiration of the judge's term of office. The report of the commission shall include a list of 3 candidates for appointment. The candidates shall include the judge whose term is expiring, if that judge desires reappointment and the judge's performance is satisfactory upon review by the commission. If a vacancy occurs during a judge's unexpired term, the commission shall issue a report to the Governor which includes a list of 3 candidates for appointment. The Governor shall review the commission's report, and may select one of the listed candidates. If no candidate is selected, the Governor shall so inform the commission, which shall within 2 months issue a report to the Governor which includes a list of three different candidates for appointment.

(3) The Chief Judge shall select from among the full time judges of the office two or more judges to rotate as docketing judges. Docketing judges shall review all claims for benefits for consistency with the requirements of this chapter and the rules of procedure, including but not limited to specificity requirements, and shall dismiss any claim that fails to comport with such rules and requirements. The docketing judge shall not dismiss any claim with prejudice without offering the parties an opportunity to appear and present argument. The Chief Judge may as he or she deems appropriate expand the duties of the docketing judges to include resolution without hearing of other types of procedural and substantive matters, including resolution of fee disputes.

(4) The Chief Judge shall have the discretion to require mediation and to designate qualified persons to act as mediators in any dispute pending before the Judges of Compensation Claims and the division. The Chief Judge shall coordinate with the Director of the Division of Workers' Compensation to establish a mandatory mediation program to facilitate early and efficient resolution of disputes arising under this chapter and to establish training and continuing education for new and sitting judges.

(5) The Office of the Judges of Compensation Claims shall promulgate rules to effect the purposes of this section. Such rules shall include procedural rules applicable to workers' compensation claim resolution and uniform criteria for measuring the performance of the office, including but not limited to the number of cases assigned and disposed, the age of pending and disposed cases, timeliness of decision making, extraordinary fee awards and other performance indicators. The Workers' Compensation Rules of Procedure approved by the Supreme Court shall apply until the rules promulgated by the Office of the Judges of Compensation Claims pursuant to this section become effective.

(6) Not later than December 1 of each year, the Office of Judges of Compensation Claims and the Division of Workers' Compensation shall jointly issue a written report to the Governor, the House of Representatives, and the Senate summarizing the amount, cost, and outcome of all

litigation resolved in the prior year, summarizing the disposition of applications and motions for mediation conferences and recommending changes or improvements to the dispute resolution elements of the workers' compensation law and regulations.

Section 41. Subsection (4) of section 440.56, Florida Statutes, is amended to read:

440.56 Safety rules and provisions; penalty.—

(4)*(a)* No later than January 1, 1990, the division shall develop a means by which it can identify both those individual employers and those groups of employers with high frequency or severity of work-related injuries. The division shall carry out safety inspections of those employers so identified in order to assist those employers in reducing the number of work-related injuries. No penalties shall be assessed by the division as the result of such inspections, except as provided by subsection (6). Copies of any report made as the result of such inspection shall be provided the employer and its carrier. Effective January 1, 1990, all employers identified by the division as having high frequency or severity of work-related injuries shall submit an employee safety training program to the division for approval. The division shall promptly review the program submitted and approve or disapprove it. Upon approval by the division, the program shall be implemented by the employer. If the program is not approved or if no program is submitted, the division may design a safety training program and provide it to the employer for implementation.

(b) A client of a help supply services company shall include employees of the help supply services company, in the client's employee safety training program. A help supply services company may, by written contract, expressly assume its client's responsibility for compliance.

Section 42. Subsection (5) is added to section 442.115, Florida Statutes, to read:

442.115 Employee education and training.—

(5) For purposes of this section, a client of a help supply services company shall include employees of the help supply services company in the client's employee safety training program. A help supply services company may, by written contract, expressly assume its client's responsibility for compliance.

Section 43. Section 440.49, Florida Statutes, is amended to read:

440.49 *Limitation of liability for subsequent injury through* ~~Rehabilitation of injured employees~~; Special Disability Trust Fund.—

~~(1) REHABILITATION OF INJURED EMPLOYEES.—~~

~~(a) When an employee has suffered an injury covered by this chapter and it appears that the injury will preclude the employee from earning wages equal to wages earned prior to the injury, the employee shall be entitled to appropriate training and education. Upon request by the employee, the employer, or the carrier, the division shall provide such injured employee with appropriate training and education for suitable gainful employment and may cooperate with federal and state agencies for training and education and with any public or private agency cooperating with such federal and state agencies in the training and education of such injured employees. Within 10 days of the request, the division shall respond by assigning a public or private evaluator to conduct an evaluation to determine if training and education are appropriate, unless the injured employee and the employer/carrier have agreed upon an evaluator to conduct the evaluation and included the evaluator's name in the request. Within 30 days of the assignment, the evaluator shall submit the results of the evaluation to the division, employer, and employee. Any contracts entered into for this purpose shall be exempt from the competitive bidding requirements of chapter 287. The division shall establish a blind rotation system for the selection of the evaluators in the appropriate geographic area, except in the community college districts served by Miami-Dade Community College, Florida Community College at Jacksonville, and Indian River Community College. Until October 1, 1991, 50 percent of the evaluations in those districts shall be assigned to the community college in the district and the other 50 percent to other evaluators in the district who are selected by a blind rotation system. Thereafter, the method of selecting the evaluator shall be consistent statewide. Based on the results of the evaluation, the division is authorized to expend moneys from the Workers' Compensation Administration Trust Fund established by s. 440.50, for the purpose of assisting such injured employees to obtain appropriate training and education, if necessary. Such expenditures shall only be made in accordance with rules promulgated by the division establishing standards for eligibility and types, duration, and direct cost of training and educational programs to be made available. All hearings arising under this subsection shall be conducted by a judge of compensation claims pursuant to s. 440.25. However, no judge of compensation claims shall assume jurisdiction to approve or disapprove training and education under this provision until the division has advised all parties as to the training and education program it may propose if such training and education program is to be funded out of the fund established by s. 440.50. The division shall be a party to all hearings involving any claims made against the fund established by s. 440.50. For purposes of this section only, "suitable gainful employment" means employment or self-employment which is reasonably attainable in light of the individual's age, education, previous occupation, and injury and which offers an opportunity to restore the individual as soon as practicable and as nearly as possible to his average weekly earnings at the time of injury. If any voluntary vocational rehabilitation services or training and education services are voluntarily provided to the employee by the employer or carrier, those services shall be reported to the division within such time as the division may prescribe by rule, so that the division may perform utilization review of such services. Neither the employer, carrier, or injured employee is required to furnish or accept voluntary vocational rehabilitation services. As used in this subsection, the term "voluntary vocational rehabilitation services" means services helpful to restore injured employees to suitable gainful employment. Voluntary vocational rehabilitation within the Workers' Compensation Act includes two major interrelated types of services, medical care coordination and vocational services coordination. "Medical care coordination" includes, but is not limited to, coordinating physician and mental restoration services, such as medical, psychiatric, or therapeutic treatment for the injured employee, providing health teaching to the employee and family, and monitoring the employee's recovery process to maximize recovery, minimize the disability, and prevent complications. The purpose of medical care coordination is to minimize the recovery period without jeopardizing medical stability, to assure that proper medical treatment and other restorative services are received in a timely and sequential manner, so as to assist in the containment of medical costs. "Vocational services coordination" includes, but is not limited to, vocational services needed by the injured employee to secure suitable gainful employment. Such services include counseling for adjustment to disability, vocational counseling, vocational and functional capacity assessments, job seeking skills training, self-employment assistance, and selective job placement, arranging other services such as education or training (vocational and on-the-job) which may be needed by the employee, and monitoring the employee's progress toward attainment of the identified vocational goal. For the purpose of this subsection, "selective job placement" means a process by which a provider directly assists the injured employee in securing suitable employment by matching the needs and abilities of the injured employee with the requirements and demands of specific jobs. These voluntary services shall be considered loss adjustment expenses of the employer or carrier and not benefits to the employee, including, but not limited to, the purposes of ratemaking.~~

~~(b)1. The Division of Workers' Compensation shall continuously study the issue of education and training and rehabilitation, both physical and vocational, and shall investigate and maintain a directory of all qualified rehabilitation facilities and agencies, both public and private. The division shall establish by rule the minimum qualifications, standards, and requirements which must be met in order to be listed in the directory of qualified training and education and rehabilitation service providers, facilities, and agencies. Such minimum qualifications, standards, and requirements shall be based on those generally accepted within the various specific fields for which the provider, facility, or agency is to be approved. A biennial application fee of $25 shall be charged for a listing in the directory, and all such fees shall be deposited in the Workers' Compensation Administration Trust Fund. The division has the authority to monitor and evaluate qualified training and education or rehabilitation service providers, facilities, and agencies to ensure their continued compliance with the minimum qualifications, standards, and requirements established pursuant to this subparagraph. The failure of a training and education or rehabilitation service provider, facility, or agency to provide the division with information requested or access necessary for it to carry out this monitoring and evaluation function shall be grounds for removing the provider, facility, or agency from the directory.~~

~~2. A training and education or rehabilitation service provider, facility, or agency shall prepare an individualized written rehabilitation plan on all compensable workers' compensation cases which require three or more counseling sessions, vocational evaluations, training, work evaluations, or placement. Prior to implementing any plan, the plan shall be signed by~~

~~the carrier or employer, if self-insured, and the employee as verification of acceptance of the plan. The plan shall be filed electronically with the division and copies furnished to all interested parties. Progress reports shall be filed electronically every 30 days with the division and within 30 days of the completion of the plan. Funding for electronic reporting equipment for the division shall be from the Workers' Compensation Administration Trust Fund established by s. 440.50.~~

~~3. A training and education or rehabilitation service provider, facility, or agency may not be authorized by any employer, carrier, or the division to provide any training and education or rehabilitation services in this state to an injured worker unless such provider, facility, or agency is listed or has been approved for listing in the directory as being qualified to provide the specific service to be authorized. However, Miami-Dade Community College, Florida Community College at Jacksonville, and Indian River Community College shall be authorized to conduct evaluations of injured employees until October 1, 1991, regardless of whether or not they are listed in the directory. Thereafter, they will have to be listed in the directory to be an authorized provider. This paragraph does not apply to training and education or rehabilitation services provided outside this state and does not apply to the services of a training and education or rehabilitation service provider, facility, or agency unless such provider, facility, or agency is included in the definition of same contained in subparagraph 4. Job placement services provided by private employment agencies under this subsection are exempt from this subparagraph if those services are limited to job placement.~~

~~4. As used in this paragraph, the term:~~

~~a. "Private employment agency" means any person, firm, or corporation which, for hire or for profit, undertakes to secure employment or help, or through the medium of a card, circular, pamphlet, or other medium whatsoever, or through the display of a sign or bulletin, or by any other holding out to the public, offers to secure employment or help or give information as to where employment or help may be secured.~~

~~b. "Qualified training and education or rehabilitation service providers, facilities, and agencies" means training and education or rehabilitation service providers, facilities, and agencies which are listed in the division directory of qualified training and education or rehabilitation service providers, facilities, and agencies.~~

~~c. "Training and education or rehabilitation service providers, facilities, and agencies" means nurses licensed pursuant to chapter 464, vocational rehabilitation counselors, and public and private agencies, companies, and corporations which provide to injured workers, pursuant to this section, training and educational or vocational rehabilitation services including vocational retraining, testing, counseling, evaluation, and job placement services. The term includes self-insured employers or carriers, their employees or wholly owned subsidiaries when they provide such services wholly in-house to the injured workers of the self-insured employer or carrier's insureds. Such in-house services shall be subject to s. 440.20(16). The term does not include the Department of Labor and Employment Security or the Department of Health and Rehabilitative Services or the employees of either department. The term does not include physicians licensed under chapter 458, osteopaths licensed under chapter 459, chiropractors licensed under chapter 460, podiatrists licensed under chapter 461, psychologists licensed under chapter 490, or hospitals.~~

~~(c) Prior to entering an order adjudicating an injured employee to be permanently and totally disabled, the judge of compensation claims shall first determine whether there is a reasonable probability that, with appropriate training or education, the injured employee may be rehabilitated to the extent that such employee can achieve suitable gainful employment and whether it is in the best interest of such individual to undertake such training or education.~~

~~(d) When it appears that training and education are necessary and desirable to restore the injured employee to suitable gainful employment, the employee shall be entitled to be paid by the employer additional compensation for temporary total disability during such period as the employee may be receiving training and education under a program pursuant to this section for a period not to exceed 26 weeks, which period may be extended for an additional period not to exceed 26 additional weeks, if such extended period is determined to be necessary and proper by the judge of compensation claims. However, no carrier or employer shall be precluded from continuing such additional temporary total disability compensation beyond such period voluntarily. If training and education require residence at or near a facility or an institution and away from the employee's customary residence, the reasonable cost of board, lodging, or travel shall be borne by the division from the Workers' Compensation Administration Trust Fund established by s. 440.50. Refusal to accept training and education as deemed necessary by the judge of compensation claims shall result in a 50-percent reduction in weekly compensation, including wage-loss benefits as determined pursuant to s. 440.15(3)(b), for each week of the period of refusal.~~

~~(e) The division, after consultation with representatives of employees, employers, carriers, training and education service providers, and rehabilitation providers, shall adopt rules governing practices and standards for training and education and rehabilitation service providers which reflect the generally accepted standards for such providers.~~

~~(2) LIMITATION OF LIABILITY FOR SUBSEQUENT INJURY THROUGH SPECIAL DISABILITY TRUST FUND.—~~

(1)~~(a)~~ LEGISLATIVE INTENT.—*Whereas it is often difficult for workers with disabilities to achieve employment or to become reemployed following an injury, and it is the desire of the Legislature to facilitate the return of these workers to the workplace,* it is the purpose of this *section* ~~subsection~~ to encourage the employment, *reemployment, and accommodation* of the physically *disabled by reducing an employer's insurance premium for reemploying an injured worker, to decrease litigation between carriers on apportionment issues, and to protect* ~~handicapped by protecting~~ employers from excess liability for compensation and medical expense when an injury to a *physically disabled* ~~handicapped~~ worker merges with, *aggravates, or accelerates* his preexisting permanent physical impairment to cause *either* a greater disability *or*~~,~~ permanent impairment, or *an increase in expenditures for temporary compensation or medical benefits* ~~wage loss~~ than would have resulted from the injury alone. The division shall inform all employers of the existence and function of the fund and shall interpret eligibility requirements liberally. However, this subsection shall not be construed to create or provide any benefits for injured employees or their dependents not otherwise provided by this chapter. The entitlement of an injured employee or his dependents to compensation under this chapter shall be determined without regard to this subsection, the provisions of which shall be considered only in determining whether an employer or carrier who has paid compensation under this chapter is entitled to reimbursement from the Special Disability Trust Fund.

(2)~~(b)~~ DEFINITIONS.—As used in this *section, the term* ~~subsection~~:

(a)~~1.~~ "Permanent physical impairment" means *and is limited to the conditions listed in paragraph (6)(a)* ~~any permanent condition due to previous accident or disease or any congenital condition which is, or is likely to be, a hindrance or obstacle to employment, but not due to the natural aging process.~~

(b) "Preferred worker" means a worker who, because of a permanent impairment resulting from a compensable injury or occupational disease, is unable to return to the worker's regular employment.

(c)~~2.~~ "Merger" describes or means that:

1.~~a.~~ *If* ~~Had~~ the permanent physical impairment *had* not existed, the subsequent accident or occupational disease would not have occurred;

2.~~b.~~ The permanent disability *or*~~,~~ permanent impairment~~, or wage loss~~ resulting from the subsequent accident or occupational disease is materially and substantially greater than that which would have resulted had the permanent physical impairment not existed, and the employer has been required to pay, and has paid, permanent total disability *or*~~,~~ permanent impairment~~, or wage loss~~ benefits for that materially and substantially greater disability; ~~or~~

3. The preexisting permanent physical impairment is aggravated or accelerated as a result of the subsequent injury or occupational disease, or the preexisting impairment has contributed, medically and circumstantially, to the need for temporary compensation, medical, or attendant care and the employer has been required to pay, and has paid, temporary compensation, medical, or attendant care benefits for the aggravated preexisting permanent impairment; or

4.~~c.~~ Death would not have been accelerated *if* ~~had~~ the permanent physical impairment *had* not existed.

(d)~~3.~~ "Excess permanent compensation" means that compensation for permanent impairment, ~~wage loss benefits,~~ or permanent total disability or death benefits, for which the employer or carrier is otherwise entitled to reimbursement from the Special Disability Trust Fund.

(3) DEDUCTIBLE.—Reimbursement may not be obtained for the first $10,000 of benefits paid which otherwise qualify for reimbursement under this section. This deductible does not apply to claims by employers for reimbursement under subparagraph (b) 3.

(4)~~(c)~~ PERMANENT IMPAIRMENT~~, wage loss,~~ OR PERMANENT TOTAL DISABILITY, *TEMPORARY BENEFITS, MEDICAL BENEFITS, OR ATTENDANT CARE* AFTER OTHER PHYSICAL IMPAIRMENT.—

(a)~~1.~~ Permanent impairment.—If an employee who has a preexisting permanent physical impairment incurs a subsequent permanent impairment from injury or occupational disease arising out of, and in the course of, his employment which merges with the preexisting permanent physical impairment to cause a permanent impairment, the employer shall, in the first instance, pay all benefits provided by this chapter; but, subject to the limitations specified in *subsection (6)* ~~paragraph (f)~~, such employer shall be reimbursed from the Special Disability Trust Fund created by *subsection (8)* ~~paragraph (h)~~ for *50* ~~60~~ percent of all impairment benefits which the employer has been required to provide pursuant to s. 440.15(3)(a) as a result of the subsequent accident or occupational disease.

~~2. Wage loss.—If an employee who has a preexisting permanent physical impairment incurs a subsequent permanent impairment from injury or occupational disease arising out of, and in the course of, his employment which merges with the preexisting permanent physical impairment to cause a wage loss, the employer shall, in the first instance, pay all benefits provided by this chapter; but, subject to the limitations specified in paragraph (f), such employer shall be reimbursed from the Special Disability Trust Fund created by paragraph (h) for 60 percent of all compensation for wage loss which the employer has been required to provide pursuant to s. 440.15(3)(b) during the first 5 years after the date of maximum medical improvement and for 75 percent of all compensation for wage loss which the employer has been required to provide after the 5-year period following the date of maximum medical improvement.~~

(b)~~3.~~ Permanent total disability.—If an employee who has a preexisting permanent physical impairment incurs a subsequent permanent impairment from injury or occupational disease arising out of, and in the course of, his employment which merges with the preexisting permanent physical impairment to cause permanent total disability, the employer shall, in the first instance, pay all benefits provided by this chapter; but, subject to the limitations specified in *subsection (6)* ~~paragraph (f)~~, such employer shall be reimbursed from the Special Disability Trust Fund created by *subsection (8)* ~~paragraph (h)~~ for *50 percent of* all compensation for permanent total disability. ~~which is in excess of the first 175 weeks of permanent total disability compensation. Upon a determination that a merger has caused permanent total disability, the employer shall be immediately reimbursed from the Special Disability Trust Fund for all excess compensation paid for temporary disability and remedial treatment subject to the limitations of paragraphs (c) and (f).~~

(c) Temporary compensation and medical benefits; aggravation or acceleration of preexisting condition or circumstantial causation.—If an employee who has a preexisting permanent physical impairment experiences an aggravation or acceleration of the preexisting permanent physical impairment as a result of an injury or occupational disease arising out of an in the course of his employment, or suffers an injury as a result of a merger as defined in s. 440.49(1)(b)2., the employer shall provide all benefits provided by this chapter, but, subject to the limitations specified in subsection (7), the employer shall be reimbursed by the Special Disability Trust Fund created by subsection (8) for 50 percent of its payments for temporary, medical, and attendant care benefits.

(5)~~(d)~~ WHEN DEATH RESULTS.—If death results from the subsequent permanent impairment contemplated in paragraph (c) within 1 year after the subsequent injury, or within 5 years after the subsequent injury when disability has been continuous since the subsequent injury, and it is determined that the death resulted from a merger, the employer shall, in the first instance, pay the funeral expenses and the death benefits prescribed by this chapter; but, subject to the limitations specified in *subsection (6)* ~~paragraph (f)~~, he shall be reimbursed from the Special Disability Trust Fund created by ~~this~~ subsection *(8)* for the last *50* ~~75~~ percent of all compensation allowable and paid for such death and for *50* ~~75~~ percent of the amount paid as funeral expenses.

~~(e) Reimbursement for compensation paid for temporary disability or medical benefits.—Subject to the limitations specified in paragraph (f), and when the preexisting permanent physical impairment has contributed to the need, either medically or circumstantially, for temporary disability and remedial treatment, care, and attendance, an employer entitled to reimbursement from the Special Disability Trust Fund for compensation paid for permanent impairment, wage loss, permanent total disability, or death shall be reimbursed from such fund for 50 percent of the first $10,000 paid as compensation for temporary disability and remedial treatment, care, and attendance pursuant to s. 440.13, for the same injury; thereafter, the employer shall be reimbursed from such fund for all sums paid by the employer as compensation for temporary disability and remedial treatment, care, and attendance pursuant to s. 440.13 which are in excess of $10,000.~~

(6)~~(f)~~ *EMPLOYER KNOWLEDGE, EFFECT ON* REIMBURSEMENT ~~limitations~~.—

(a)~~1. No~~ Reimbursement *is not* ~~shall be~~ allowed under this *section* ~~subsection~~ unless it is established that ~~the employer reached an informed conclusion prior to the occurrence of the subsequent injury or occupational disease that the preexisting physical condition is permanent and is, or is likely to be, a hindrance or obstacle to employment. However, when~~ the employer ~~establishes that he~~ knew of the preexisting permanent physical impairment prior to *the occurrence of* the subsequent *injury* ~~accident~~ or occupational disease, *and that the permanent physical impairment* ~~or the employer has reemployed an employee who subsequently suffers an injury that results in a permanent physical impairment, and the records of the employer establish that the employee had a preexisting permanent physical impairment, and such records were in the employer's possession prior to the subsequent accident, there shall be a conclusive presumption that the employer considered the condition to be permanent and to be, or likely to be, a hindrance or obstacle to employment, when the condition~~ is one of the following:

1.~~a.~~ Epilepsy.

2.~~b.~~ Diabetes.

3.~~c.~~ Cardiac disease.

~~d. Marie-Strumpell disease.~~

4.~~e.~~ Amputation of foot, leg, arm, or hand.

5.~~f.~~ Total loss of sight of one or both eyes or a partial loss of corrected vision of more than 75 percent bilaterally.

6.~~g.~~ Residual disability from poliomyelitis.

7.~~h.~~ Cerebral palsy.

8.~~i.~~ Multiple sclerosis.

9.~~j.~~ Parkinson's disease.

10. Meniscectomy.

11. Patellectomy.

12. Ruptured cruciate ligament.

~~k. Vascular disorder.~~

~~l. Psychoneurotic disability following confinement for treatment in a recognized medical or mental institution for a period in excess of 6 months.~~

13.~~m.~~ Hemophilia.

14.~~n.~~ Chronic osteomyelitis.

15.~~o.~~ *Surgical or spontaneous fusion* ~~Ankylosis~~ of a major weight-bearing joint.

16.~~p.~~ Hyperinsulinism.

17.~~q.~~ Muscular dystrophy.

18.~~r.~~ Thrombophlebitis.

19.~~s.~~ Herniated intervertebral disk.

20.~~t.~~ Surgical removal of an intervertebral disk or spinal fusion.

21. One or more back injuries or a disease process of the back resulting in disability over a total of 120 or more days, if substantiated by a doctor's opinion that there was a preexisting impairment to the claimant's back.

22.~~u.~~ Total deafness.

23.~~v.~~ Mental retardation, provided the employee's intelligence quotient is such that he falls within the lowest 2 percentile of the general population. However, it shall not be necessary for the employer to know the employee's actual intelligence quotient or actual relative ranking in relation to the intelligence quotient of the general population.

24.~~w.~~ Any permanent physical condition which, prior to the industrial accident or occupational disease, constitutes a 20-percent impairment of a member or of the body as a whole.

25.~~x.~~ Obesity, provided the employee is 30 percent or more over the average weight designated for his ~~or her~~ height and age in the Table of Average Weight of Americans by Height and Age prepared by the Society of Actuaries using data from the 1979 Build and Blood Pressure Study.

26. Any permanent physical impairment as defined in s. 440.15(3) which is a result of a prior industrial accident with the same employer or the employer's parent company, subsidiary, sister company, or affiliate located within the geographical boundaries of this state.

(b)~~2.~~ The Special Disability Trust Fund *is* ~~shall~~ not ~~be~~ liable for any costs, interest, penalties, or attorneys' fees.

(c)~~3.~~ An employer's or carrier's right to apportionment or deduction pursuant to ss. 440.02(1), 440.15(5)(b), and 440.151(1)(c) *does* ~~shall~~ not preclude reimbursement from such fund, except when the merger comes within the definition of *subparagraph (2)(b)2.* ~~sub-subparagraph (b)2.b.~~ and such apportionment or deduction relieves the employer or carrier from providing the materially and substantially greater permanent disability benefits otherwise contemplated in *those* ~~said~~ paragraphs.

~~4. For purposes of this subsection only, the costs for rehabilitation required to be provided by subsection (1) shall be considered remedial attendance and shall be reimbursed in accordance with the formula contained in paragraph (c) if it has been determined that a merger has occurred which entitles the employer or carrier to reimbursement for excess permanent compensation.~~

(7)~~(g)~~ REIMBURSEMENT OF EMPLOYER.—~~Except for reimbursement claimed pursuant to paragraph (k),~~ The right to reimbursement as provided in this *section is* ~~subsection shall be~~ barred unless written notice of claim of the right to such reimbursement is filed by the employer or carrier entitled to such reimbursement with the division at Tallahassee within 2 years after the date the employee last reached maximum medical improvement, or within 2 years after the date of the first payment of compensation for permanent total disability, wage loss, or death, whichever is later. The notice of claim *must* ~~shall~~ contain such information as the division by rule *requires* ~~may require~~; and the employer or carrier claiming reimbursement shall furnish such evidence in support of the claim as the division reasonably may require. For notice of claims on the Special Disability Trust Fund filed on or after July 1, 1978, the Special Disability Trust Fund shall, within 120 days *after* ~~of~~ receipt of notice that a carrier has paid, been required to pay, or accepted liability for excess compensation, serve notice of the acceptance of the claim for reimbursement. *For dates of accident on or before January 1, 1994, the Special Disability Trust Fund shall, within 120 days of receipt of notice that a carrier has been required to pay, and has paid over $10,000 in benefits, serve notice of the acceptance of the claim for reimbursement.* Failure of the Special Disability Trust Fund *to serve notice of acceptance shall give rise to the right to request a hearing on the claim for reimbursement. If the* ~~to serve the notice shall be deemed a denial by the Special Disability Trust Fund of the claim for reimbursement. If the~~ Special Disability Trust Fund through its representative denies or controverts the claim, the right to such reimbursement shall be barred unless an application for a hearing thereon is filed with the division at Tallahassee within 60 days after notice to the employer or carrier of such denial or controversion. When such application for a hearing is timely filed, the claim shall be heard and determined in accordance with the procedure prescribed in s. 440.25, to the extent that such procedure is applicable, and in accordance with the workers' compensation rules of procedure. In such proceeding on a claim for reimbursement, the Special Disability Trust Fund shall be made the party respondent, and no findings of fact made with respect to the claim of the injured employee or the dependents for compensation, including any finding made or order entered pursuant to s. 440.20(12), shall be res judicata. The Special Disability Trust Fund may not be joined or made a party to any controversy or dispute between an employee and the dependents and the employer or between two or more employers or carriers without the written consent of the fund. When it has been determined that an employer or carrier is entitled to reimbursement in any amount, the employer or carrier shall be reimbursed *annually* ~~periodically every 6 months~~ from the Special Disability Trust Fund for the compensation and medical benefits paid by the employer or carrier for which the employer or carrier is entitled to reimbursement, upon filing request therefor and submitting evidence of such payment in accordance with rules prescribed by the division, *which rules may include parameters for annual audits.*

(8) PREFERRED WORKER PROGRAM.—The division shall issue identity cards to preferred workers upon request by qualified employees and shall reimburse an employer, from the Special Disability Trust Fund, for the cost of workers' compensation premium related to the preferred workers payroll for up to 3 years of continuous employment upon satisfactory evidence of placement and issuance of payroll and classification records and upon the employee's certification of employment.

(9)~~(h)~~ SPECIAL DISABILITY TRUST FUND.—

(a)~~1.~~ There is established in the State Treasury a special fund to be known as the "Special Disability Trust Fund," which shall be available only for the purposes stated in this *section* ~~subsection~~; and the assets thereof may not at any time be appropriated or diverted to any other use or purpose. The Treasurer shall be the custodian of such fund, and all moneys and securities in such fund shall be held in trust by such Treasurer and shall not be the money or property of the state. The Treasurer is authorized to disburse moneys from such fund only when approved by the division and upon the order of the Comptroller. The Treasurer shall deposit any moneys paid into such fund into such depository banks as the division may designate and is authorized to invest any portion of the fund which, in the opinion of the division, is not needed for current requirements, in the same manner and subject to all the provisions of the law with respect to the deposits of state funds by such Treasurer. All interest earned by such portion of the fund as may be invested by the Treasurer shall be collected by him and placed to the credit of such fund.

(b)1.~~2.~~ The Special Disability Trust Fund shall be maintained by annual assessments upon the insurance companies writing compensation insurance in the state, *the commercial self-insurers under ss. 624.462 and 624.4621, the assessable mutuals under s. 628.601,* and the self-insurers under this chapter, which assessments shall become due and be paid quarterly at the same time and in addition to the assessments provided in s. 440.51. The division shall estimate annually in advance the amount necessary for the administration of this subsection and the maintenance of this fund and shall make such assessment in the manner hereinafter provided.

2. The annual assessment shall be calculated to produce during the ensuing fiscal year an amount which, when combined with that part of the balance in the fund on June 30 of the current fiscal year which is in excess of $100,000, is equal to *the average of:*

a. The sum of disbursements from the fund during the immediate past 3 calendar years, *and*~~.~~

b. Two times the disbursements of the most recent calendar year.

Such amount shall be prorated among the insurance companies writing compensation insurance in the state and the self-insurers.

3. The net premiums *written* ~~collected~~ by the companies *for* ~~on~~ workers' compensation ~~premiums~~ in this state and the *net premium written applicable to the self-insurers* ~~amount of premiums a self-insurer, if insured, would have to pay~~ in this state are the basis for computing the amount to be assessed as a percentage of net premiums. Such payments shall be made by each insurance company and self-insurer to the division for the Special Disability Trust Fund in accordance with such regulations as the division *prescribes* ~~may prescribe~~.

4. The Treasurer is authorized to receive and credit to such Special Disability Trust Fund any sum or sums that may at any time be contributed to the state by the United States under any Act of Congress, or otherwise, to which the state may be or become entitled by reason of any payments made out of such fund.

(10)~~(i)~~ DIVISION ADMINISTRATION OF FUND; CLAIMS; ADVISORY COMMITTEE; EXPENSES.—The division shall administer the Special Disability Trust Fund with authority to allow, deny, compromise, controvert, and litigate claims made against it and to designate an attorney to represent it in proceedings involving claims against the fund, including negotiation and consummation of settlements, hearings before judges of compensation claims, and judicial review. The division or the attorney designated by it shall be given notice of all hearings and proceedings involving the rights or obligations of such fund and shall have authority to make expenditures for such medical examinations, expert witness fees, depositions, transcripts of testimony, and the like as may be necessary to the proper defense of any claim. The division shall appoint an advisory committee composed of representatives of management, compensation insurance carriers, and self-insurers to aid it in formulating policies with respect to conservation of the fund, who shall serve without compensation for such terms as specified by it, but be reimbursed for travel expenses as provided in s. 112.061. All expenditures made in connection with conservation of the fund, including the salary of the attorney designated to represent it and necessary travel expenses, shall be allowed and paid from the Special Disability Trust Fund as provided in this *section* ~~subsection~~ upon the presentation of itemized vouchers therefor approved by the division.

(11)~~(j)~~ EFFECTIVE DATES.—~~The provisions of~~ This *section does* ~~subsection shall~~ not *apply* ~~be applicable~~ to any case in which the accident causing the subsequent injury or death or the disablement or death from a subsequent occupational disease ~~shall have~~ occurred prior to July 1, 1955~~; and the provisions of paragraphs (e) and (f) of this subsection shall not be applicable to any case in which the accident causing the subsequent injury or death or the disablement or death from a subsequent occupational disease shall have occurred prior to July 1, 1963~~.

(12)~~(k)~~ REIMBURSEMENT *FROM THE SPECIAL DISABILITY TRUST FUND* ~~to subsequent employer of permanently injured worker~~.—*The applicable law for the purposes of determining entitlement to reimbursement from the Special Disability Trust Fund is the law in effect on the date the accident occurred.* ~~If an employee incurs a permanent impairment from injury or occupational disease arising out of, and in the course of, his employment and has been unemployed as a result of his injury or disease for 2 consecutive years, the employer who then employs such an employee shall be reimbursed from the fund for 50 percent of the employee's wages, not to exceed the maximum compensation rate as provided in s. 440.12, up to a period of 6 months. Any subsequent employer seeking reimbursement under this paragraph shall file a notice of claim in conformance with the rules adopted by the division within 6 months of the date of hire by the subsequent employer.~~

Section 44. Section 440.491, Florida Statutes, is created to read:

440.491 Reemployment of injured workers; rehabilitation.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Carrier" means group self-insurance funds or individual self-insureds authorized under this chapter and commercial funds or insurance entities authorized to write workers' compensation insurance under chapter 624.

(b) "Medical care coordination" includes, but is not limited to, coordinating physical rehabilitation services such as medical, psychiatric, or therapeutic treatment for the injured employee, providing health training to the employee and family, and monitoring the employee's recovery. The purposes of medical care coordination are to minimize the disability and recovery period without jeopardizing medical stability, to assure that proper medical treatment and other restorative services are timely provided in a logical sequence, and to contain medical costs.

(c) "Qualified rehabilitation provider" means a rehabilitation nurse, rehabilitation counselor, vocational evaluator, rehabilitation facility, or agency approved by the division as qualified to provide reemployment assessments, medical care coordination, reemployment services, or vocational evaluations under this chapter.

(d) "Reemployment assessment" means a written assessment performed by a qualified rehabilitation provider which provides a comprehensive review of the medical diagnosis, treatment, and prognosis; includes conferences with the employer, physician, and claimant; and recommends a cost-effective physical and vocational rehabilitation plan to assist the employee in returning to suitable gainful employment.

(e) "Reemployment services" means services that include, but are not limited to, vocational counseling, job-seeking skills training, ergonomic job analysis, transferable skills analysis, selective job placement, labor market surveys, and arranging other services such as education or training, vocational and on-the-job, which may be needed by the employee to secure suitable gainful employment.

(f) "Reemployment status review" means a review to determine whether an injured employee is at risk of not returning to work.

(g) "Suitable gainful employment" means employment or self-employment that is reasonably attainable in light of the employee's age, education, work history, transferrable skills, previous occupation, and injury, and which offers an opportunity to restore the individual as soon as practicable and as nearly as possible to his average weekly earnings at the time of injury.

(h) "Vocational evaluation" means a review of the employee's physical and intellectual capabilities, his aptitudes and achievements, and his work-related behaviors to identify the most cost-effective means toward his return to suitable gainful employment.

(2) INTENT.—It is the intent of this section to implement a systematic review by carriers of the factors that are predictive of longer-term disability and to encourage the provision of medical care coordination and reemployment services that are necessary to assist the employee in returning to work as soon as is medically feasible.

(3) REEMPLOYMENT STATUS REVIEWS AND REPORTS.—

(a) When an employee who has suffered an injury compensable under this chapter is unemployed 60 days after the date of injury and is receiving benefits for temporary total disability, temporary partial disability, or wage loss, and has not yet been provided medical care coordination and reemployment services voluntarily by the carrier, the carrier must determine whether the employee is likely to return to work and must report its determination to the division. The carrier must thereafter determine the reemployment status of the employee at 90-day intervals as long as the employee remains unemployed, is not receiving medical care coordination or reemployment services, and is receiving the benefits specified in this subsection.

(b) If medical care coordination or reemployment services are voluntarily undertaken within 60 days of the date of injury, such services may continue to be provided as agreed by the employee and the carrier.

(4) REEMPLOYMENT ASSESSMENTS.—

(a) The carrier may require the employee to receive a reemployment assessment as it considers appropriate. However, the carrier is encouraged to obtain a reemployment assessment if:

1. The carrier determines that the employee is at risk of remaining unemployed.

2. The case involves catastrophic or serious injury.

(b) The carrier shall authorize only a qualified rehabilitation provider to provide the reemployment assessment. The rehabilitation provider shall conduct its assessment and issue a report to the carrier, the employee, and the division within 30 days after the time such assessment is complete.

(c) If the rehabilitation provider recommends that the employee receive medical care coordination or reemployment services, the carrier shall advise the employee of the recommendation and determine whether the employee wishes to receive such services. The employee shall have 15 days after the date of receipt of the recommendation in which to agree to accept such services. If the employee elects to receive services, the carrier may refer the employee to a rehabilitation provider for such coordination or services within 15 days of receipt of the assessment report or notice of the employee's election, whichever is later.

(5) MEDICAL CARE COORDINATION AND REEMPLOYMENT SERVICES.—

(a) Once the carrier has assigned a case to a qualified rehabilitation provider for medical care coordination or reemployment services, the provider shall develop a reemployment plan and submit the plan to the carrier and the employee for approval.

(b) If the rehabilitation provider concludes that training and education are necessary to return the employee to suitable gainful employment, or if the employee has not returned to suitable gainful employment within 180 days after referral for reemployment services or receives $2,500 in reemployment services, whichever comes first, the carrier must discontinue reemployment services and refer the employee to the division for a vocational evaluation. Notwithstanding any provision of chapter 289 or chapter 627, the cost of a reemployment assessment and the first $2,500 in reemployment services to an injured employee must not be treated as loss adjustment expense for workers' compensation ratemaking purposes.

(c) A carrier may voluntarily provide medical care coordination or reemployment services to the employee at intervals more frequent than those required in this section. For the purpose of monitoring reemployment, the carrier or the rehabilitation provider shall report to the division, in the manner prescribed by the division, the date of reemployment and wages of the employee. The carrier shall report its voluntary service activity to the division as required by rule. Voluntary services offered by the carrier for any of the following injuries must be considered benefits for purposes of ratemaking: traumatic brain injury; spinal cord injury; amputation, including loss of an eye or eyes; burns of 5 percent or greater of the total body surface.

(d) If medical care coordination or reemployment services have not been undertaken as prescribed in paragraph (3)(b), a qualified rehabilitation service provider, facility, or agency that performs a reemployment assessment shall not provide medical care coordination or reemployment services for the employees it assesses.

(6) TRAINING AND EDUCATION.—

(a) Upon referral of an injured employee by the carrier, or upon the request of an injured employee, the division shall conduct a training and education screening to determine whether it should refer the employee for a vocational evaluation and, if appropriate, approve training and education or other vocational services for the employee. The division may not approve formal training and education programs unless it determines, after consideration of the reemployment assessment, pertinent reemployment status reviews or reports, and such other relevant factors as it prescribes by rule, that the reemployment plan is likely to result in return to suitable gainful employment. The division is authorized to expend moneys from the Workers' Compensation Administrative Trust Fund, established by s. 440.50, to secure appropriate training and education or other vocational services when necessary to satisfy the recommendation of a vocational evaluator. The division shall establish training and education standards pertaining to employee eligibility, course curricula and duration, and associated costs.

(b) When it appears that an employee who has attained maximum medical improvement requires training and education to obtain suitable gainful employment, the employer shall pay the employee additional temporary total compensation while the employee receives such training and education for a period not to exceed 26 weeks, which period may be extended for an additional 26 weeks or less, if such extended period is determined to be necessary and proper by a judge of compensation claims. However, a carrier or employer is not precluded from voluntarily paying additional temporary total disability compensation beyond that period. If an employee requires temporary residence at or near a facility or an institution providing training and education which is located more than 50 miles away from the employee's customary residence, the reasonable cost of board, lodging, or travel must be borne by the division from the Workers' Compensation Administration Trust Fund established by s. 440.50. An employee who refuses to accept training and education that is recommended by the vocational evaluator and considered necessary by the division is subject to a 50-percent reduction in weekly compensation benefits, including wage-loss benefits, as determined under s. 440.15(3)(b).

(7) PROVIDER QUALIFICATIONS.—

(a) The division shall investigate and maintain a directory of each qualified public and private rehabilitation provider, facility, and agency, and shall establish by rule the minimum qualifications, credentials, and requirements that each rehabilitation service provider, facility, and agency must satisfy to be eligible for listing in the directory. These minimum qualifications and credentials must be based on those generally accepted within the service specialty for which the provider, facility, or agency is approved.

(b) The division shall impose a biennial application fee of $25 for each listing in the directory, and all such fees must be deposited in the Workers' Compensation Administrative Trust Fund.

(c) The division shall monitor and evaluate each rehabilitation service provider, facility, and agency qualified under this subsection to ensure its compliance with the minimum qualifications and credentials established by the division. The failure of a qualified rehabilitation service provider, facility, or agency to provide the division with information requested or access necessary for the division to satisfy its responsibilities under this subsection is grounds for disqualifying the provider, facility, or agency from further referrals.

(d) A qualified rehabilitation service provider, facility, or agency may not be authorized by an employer, a carrier, or the division to provide any services, including expert testimony, under this section in this state unless the provider, facility, or agency is listed or has been approved for listing in the directory. This restriction does not apply to services provided outside this state under this section.

(e) The division, after consultation with representatives of employees, employers, carriers, rehabilitation providers, and qualified training and education providers, shall adopt rules governing professional practices and standards.

(8) CARRIER PRACTICES.—The division shall monitor the selection of providers and the provision of services by carriers under this section for consistency with legislative intent set forth in subsection (2).

(9) PERMANENT DISABILITY.—The judge of compensation claims may not adjudicate an injured employee as permanently and totally disabled until or unless the carrier is given the opportunity to provide a reemployment assessment.

Section 45. Paragraph (a) of subsection (1) of section 440.50, Florida Statutes, is amended to read:

440.50 Workers' Compensation Administration Trust Fund.—

(1)(a) There is established in the State Treasury a special fund to be known as the "Workers' Compensation Administration Trust Fund" for the purpose of providing for the payment of all expenses in respect to the administration of this chapter, including the vocational rehabilitation of injured employees as provided in s. 440.49 and the payments due under s. 440.15(1)(e) *and the funding of the Bureau of Workers' Compensation Fraud within the Department of Insurance*. Such fund shall be administered by the division. The Treasurer shall be the custodian of such fund, and all moneys and securities in such fund shall be held in trust by such Treasurer and shall not be the money or property of the state.

Section 46. Paragraph (b) of subsection (6) of section 440.51, Florida Statutes, is amended to read:

440.51 Expenses of administration.—

(6)

(b) The *Department of Insurance* ~~division~~ may require from each self-insurer, at such time and in accordance with such regulations as the *Department of Insurance prescribes* ~~division may prescribe~~, reports in respect to wages paid, the amount of premiums such self-insurer would have to pay if insured, and all payments of compensation made by such self-insurer during each prior period, and may determine the amounts paid by each self-insurer and the amounts paid by all self-insurers during such period. For the purposes of this section, the payroll records of each self-insurer shall be open to annual inspection and audit by the *Department of Insurance* ~~division~~ or its authorized representative, during regular business hours; and if any audit of such records of a self-insurer discloses a deficiency in the amounts reported to the *Department of Insurance* ~~division~~ or in the amounts paid to the *Department of Insurance* ~~division~~ by *a* ~~such~~ self-insurer pursuant to this section, the *Department of Insurance* ~~division~~ may assess the cost of such audit against *the* ~~such~~ self-insurer.

Section 47. Section 440.515, Florida Statutes, is amended to read:

440.515 Reports from self-insurers; confidentiality.—The *Department of Insurance* ~~division~~ shall maintain the reports filed in accordance with s. 440.51(6)(b) as confidential and exempt from the provisions of s. 119.07(1), and such reports shall be released only for bona fide research or educational purposes or after receipt of consent from the employer. This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14.

Section 48. Section 440.572, Florida Statutes, is amended to read:

440.572 Authorization for individual self-insurer to provide coverage.—An individual self-insurer having a net worth of not less than $250,000,000 as authorized by *s. 440.38(1)(f)* ~~s. 440.38(1)(e)~~ may assume by contract the liabilities under this chapter of contractors and subcontractors, or each of them, employed by or on behalf of such individual self-insurer when performing work on or adjacent to property owned or used by the individual self-insurer by the division. The net worth of the individual self-insurer shall include the assets of the self-insurer's parent company and its subsidiaries, sister companies, affiliated companies, and other related entities, located within the geographic boundaries of the state.

Section 49. Section 440.59, Florida Statutes, is amended to read:

440.59 *Reporting requirements* ~~Risk management report.~~—

(1) The Department of Labor and Employment Security shall annually prepare a report of the administration of this chapter for the preceding calendar year, including a detailed statement of the receipts of and expenditures from the fund established in s. 440.50 and a statement of the causes of the accidents leading to the injuries for which the awards were made, together with such recommendations as the department considers advisable. On or before September 15 of each year, the department shall submit a copy of the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Democrat and Republican Leaders of the Senate and the House of Representatives, and the chairs of the legislative committees having jurisdiction over workers' compensation.

(2)~~(1)~~ The Division of Workers' Compensation of the Department of Labor and Employment Security shall complete on a quarterly basis an analysis of the previous quarter's injuries which resulted in workers' compensation claims. The analysis shall be broken down by risk classification, shall show for each such risk classification the frequency and severity for the various types of injury, and shall include an analysis of the causes of such injuries. The division shall distribute to each employer and self-insurer in the state covered by the Workers' Compensation Law the data relevant to its workforce. The report shall also be distributed to the insurers authorized to write workers' compensation insurance in the state.

(3)~~(2)~~ The division shall ~~also~~ annually prepare a closed claim report for all claims for which the employee lost more than 7 days from work and shall submit a copy of the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the *Democrat* ~~Majority~~ and *Republican* ~~Minority~~ Leaders of the Senate and the House of Representatives, and the chairs of the legislative committees having jurisdiction over workers' compensation on or before *September 15* ~~March 1~~ of each year. The closed claim report shall include, but not be limited to, an analysis of all claims closed during the preceding year as to the date of accident, age of the injured employee, occupation of the injured employee, type of injury, body part affected, type and duration of indemnity benefits paid, permanent impairment rating, medical benefits identified by type of health care provider, and type and cost of any rehabilitation benefits provided.

(4)~~(3)~~ The division shall ~~also~~ prepare an annual report for all claims for which the employee lost more than 7 days from work and shall submit a copy of the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the *Democrat* ~~Majority~~ and *Republican* ~~Minority~~ Leaders of the Senate and the House of Representatives, and the chairs of the legislative committees having jurisdiction over workers' compensation, on or before *September 15* ~~March 1~~ of each year. The annual report shall include a status report on all cases involving work-related injuries in the previous 10 years. The annual report shall include, but not be limited to, the number of open and closed cases, the number of cases receiving various types of benefits, the cash and medical benefits paid between the date of injury and the evaluation date, the number of litigated cases, and the amount of attorney's fees paid in each case.

(5) The Chief Judge must prepare an annual report summarizing the disposition of mediation conferences, and must submit the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Democrat and Republican Leaders of the Senate and the House of Representatives, and the chairs of the legislative committees having jurisdiction over workers' compensation, on or before September 15 of each year.

Section 50. Section 440.593, Florida Statutes, is created to read:

440.593 Electronic reporting.— The division may establish by rule an electronic reporting system whereby an employer or carrier is required to submit information electronically rather than by filing otherwise required forms or reports. The division may by rule establish different deadlines for reporting information to the division via the electronic reporting system than are otherwise required.

Section 51. Examination of carriers.—Beginning July 1, 1994, the Division of Workers' Compensation of the Department of Labor and Employment Security may examine each carrier as often as is warranted to ensure that carriers are fulfilling their obligations under the law, and shall examine each carrier not less frequently than once every 3 years. The examination must cover the preceding 3 fiscal years of the carrier's operations and must commence within 12 months after the end of the most recent fiscal year being covered by the examination. The examination may cover any period of the carrier's operations since the last previous examination.

Section 52. Section 442.001, Florida Statutes, is created to read:

442.001 Short Title.—This chapter may be cited as the "Florida Occupational Safety and Health Act."

Section 53. Section 442.002, Florida Statutes, is created to read:

442.002 Definitions.—Unless the context clearly requires otherwise, the definitions set forth in s. 440.02 apply to this chapter.

Section 54. Section 442.003, Florida Statutes, is created to read:

442.003 Legislative intent.—It is the intent of the Legislature to enhance occupational safety and health in this state through the implementation and maintenance of policies, procedures, practices, rules, and standards that reduce the incidence of employee accidents, occupational diseases, and fatalities compensable under chapter 440. The Legislature further intends that the Division of Safety of the Department of Labor and Employment Security develop a means by which it can identify individual employers with a high frequency or severity of work-related injuries; conduct safety inspections of those employers; and assist those employers in the development and implementation of employee safety and health programs. In addition, it is the intent of the Legislature that the Division of Safety of the Department of Labor and Employment Security administer the provisions of this chapter; provide assistance to employers, employees, and insurance carriers; and enforce the policies, rules, and standards set forth in this chapter.

Section 55. Present subsections (6), (7), and (8) of section 440.09, Florida Statutes, are renumbered as subsections (5), (6), and (7), respectively, and subsection (5) of that section is transferred and renumbered as section 442.004, Florida Statutes, and amended to read:

442.004 Safety inspections, consultations; rules.—

~~(5)~~ The division shall adopt rules governing the manner, means, and frequency of safety inspections and consultations by all carriers and self-insurers.

Section 56. Section 440.152, Florida Statutes, is transferred and renumbered as section 442.005, Florida Statutes, and amended to read:

442.005 ~~440.152~~ Division to make study of occupational diseases, etc.—The division shall make a continuous study of occupational diseases and the ways and means for their control and prevention *and*~~;~~ shall make and enforce necessary regulations for such control. For this purpose, the division is authorized to cooperate with employers, employees, and carriers and with the Department of Health and Rehabilitative Services.

Section 57. Subsections (2) and (3) of section 440.46, Florida Statutes, are repealed and subsection (1) of that section is renumbered as section 442.006, Florida Statutes, and amended to read:

442.006 ~~440.46~~ Investigations by the division; refusal to admit; penalty.—

(1)~~(a)~~ The division shall make studies and investigations with respect to safety provisions and the causes of injuries in employments covered by this chapter, and shall make to the Legislature and employers and carriers such recommendations as it *considers* ~~may deem~~ proper as to the best means of preventing injuries. In making such studies and investigations, the division *may* ~~is authorized~~:

(a)~~1.~~ ~~To~~ Cooperate with any agency of the United States charged with the duty of enforcing any law securing safety against injury in any employment covered by this chapter, or any agency or department of the state engaged in enforcing any laws to assure safety for employees.

(b)~~2.~~ *Allow* ~~To permit~~ any such agency or department to have access to the records of the division.

(2)~~(b)~~ The division and its authorized representatives *may* ~~shall have the power and authority to~~ enter and inspect any place of employment at any reasonable time for the purpose of investigating compliance with this chapter and making inspections for the proper enforcement of this chapter. Any employer or owner who refuses to admit any member of the division or its authorized representative to any place of employment or to *allow* ~~permit~~ investigation and inspection pursuant to this paragraph *is* ~~shall be~~ guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 58. Section 442.007, Florida Statutes, is created to read:

442.007 Safety; employer responsibilities.—Every employer as defined in s. 440.02 shall furnish employment that is safe for the employees therein, furnish and use safety devices and safeguards, adopt and use methods and processes reasonably adequate to render such an employment and place of employment safe, and do every other thing reasonably necessary to protect the life, health, and safety of such employees. As used in this section, the terms "safe" and "safety" as applied to any employment or place of employment mean such freedom from danger as is reasonably necessary for the protection of the life, health, and safety of employees, including conditions and methods of sanitation and hygiene. Safety devices and safeguards required to be furnished by the employer by this section or by the division under authority of this section shall not include personal apparel and protective devices that replace personal apparel normally worn by employees during regular working hours.

Section 59. Section 442.008, Florida Statutes, is created to read:

442.008 Division authority.—The division shall:

(1) Investigate and prescribe what safety devices, safeguards, or other means of protection must be adopted for the prevention of accidents in every employment or place of employment; determine what suitable devices, safeguards, or other means of protection for the prevention of occupational diseases must be adopted or followed in any or all such employments, or places of employment; and adopt reasonable rules for the prevention of accidents and the prevention of occupational diseases.

(2) Ascertain, fix, and order such reasonable standards and rules for the construction, repair, and maintenance of places of employment as shall render them safe. Such rules and standards must be adopted in accordance with chapter 120.

(3) Assist employers in the development and implementation of employee safety-training programs by contracting with professional safety organizations.

Section 60. Section 442.009, Florida Statutes, is created to read:

442.009 Right of entry.—The division and its authorized representatives may enter at any reasonable time any place of employment for the purpose of examining any tool, appliance, or machinery used in such employment and may make inspections for the proper enforcement of this chapter. An employer or owner may not refuse to admit any member of the division or its authorized representatives to any place of employment.

Section 61. Section 442.0105, Florida Statutes, is created to read:

442.0105 Employers whose employees have a high frequency of work-related injuries.—The division shall develop a means by which it can identify individual employers whose employees have a high frequency or severity of work-related injuries. The division shall carry out safety inspections of the facilities and operations of these employers in order to assist them in reducing the frequency and severity of work-related injuries. The division shall develop safety and health programs for those employers. Carriers shall distribute these safety and health programs to the employers so identified by the division. Those employers identified by the division as having a high frequency or severity of work-related injuries shall implement a division-developed safety and health program. The division shall carry out safety inspections of those employers so identified to ensure compliance with the safety and health program and to assist such employers in reducing the number of work-related injuries. The division may not assess penalties as the result of such inspections, except as provided by s. 442.013. Copies of any report made as the result of such an inspection must be provided to the employer and its carrier. Employers may submit their own safety and health programs to the division for approval in lieu of using the division-developed safety and health program. The division must promptly review the program submitted and approve or disapprove it. Upon approval by the division, the program must be implemented by the employer. If the program is not approved or if a program is not submitted, the employer must implement the division-developed program. The division shall adopt rules setting forth the criteria for safety and health programs.

Section 62. Section 442.011, Florida Statutes, is created to read:

442.011 Carrier consultations.—Each insurance carrier writing workers' compensation insurance in this state, each employer qualifying as an individual self-insurer under s. 440.38, each self-insurance fund under s. 624.461, and each assessable mutual insurer under s. 628.6011 must provide safety consultations to each of its policyholders who requests such consultations. Each such carrier or self-insurer must inform its policyholders of the availability of such consultations and must report annually on its safety and health programs and consultations to the division in such form and at such time as the division prescribes. The division is responsible for approving all safety and health programs. The division shall aid all insurance carriers and self-insurers in establishing their safety and health programs by setting out criteria in an appropriate format.

Section 63. Section 442.012, Florida Statutes, is created to read:

442.012 Workplace safety committees.—

(1) In order to promote health and safety in places of employment in this state:

(a) Each public or private employer of more than 10 employees shall establish and administer a workplace safety committee in accordance with rules adopted under this section.

(b) Each public or private employer of 10 or fewer employees which is identified by the division as having high frequency or severity of work-related injuries shall establish and administer a workplace safety committee in accordance with rules adopted under this section.

(2) The division shall adopt rules:

(a) Prescribing the membership of the workplace safety committees so as to ensure an equal number of employee representatives, who are volunteers or are elected by their peers, and of employee representatives, and specifying the frequency of meetings.

(b) Requiring employers to make adequate records of each meeting and to file and to maintain the records subject to inspection by the division.

(c) Prescribing the duties and functions of the workplace safety committee, which include, but are not limited to:

1. Establishing procedures for workplace safety inspections by the committee.

2. Establishing procedures investigating all workplace accidents, safety-related incidents, illnesses, and deaths.

3. Evaluating accident-prevention and illness-prevention programs.

4. Prescribing guidelines for the training of safety committee members.

(3) Employers that operate under a collective-bargaining agreement that contains provisions regulating the formation and operation of workplace safety committees that meet or exceed the minimum requirements contained in this section, or employers who otherwise have existing workplace safety committees that meet or exceed the minimum requirements established by this section are in compliance with this section.

(4) Employees must be compensated their regular hourly wage while engaged in workplace safety committee training, meetings, or other duties prescribed under this section.

Section 64. Section 442.013, Florida Statutes, is created to read:

442.013 Employer penalties.—If any employer violates or fails or refuses to comply with this chapter or with any rule adopted by the division, in accordance with chapter 120, for the prevention of injuries, accidents, or occupational diseases or with any lawful order of the division in connection with this chapter, or fails or refuses to furnish or adopt any safety device, safeguard, or other means of protection prescribed by the division under this chapter for the prevention of accidents or occupational diseases, the division may assess against the employer a civil penalty of not less than $100 nor more than $5,000 for each day the violation, omission, failure, or refusal continues after the employer has been given notice thereof in writing. The total penalty for each violation may not exceed $50,000. The division shall adopt rules requiring penalties commensurate with the frequency or severity, or both, of safety violations. A hearing must be held in the county where the violation, omission, failure, or refusal is alleged to have occurred, unless otherwise agreed to by the employer and authorized by the division.

Section 65. Section 442.014, Florida Statutes, is created to read:

442.014 Division cooperation with federal government; exemption from Division of Safety requirements.—

(1) The division shall cooperate with the federal government so that duplicate inspections will be avoided yet assure safe places of employment for the citizens of this state.

(2) Except as provided in this section, a private sector employer is not subject to the requirements of the Division of Safety if:

(a) The employer is subject to the federal regulations in 29 C.F.R. 1926 and 29 C.F.R. 1910; and

(b) The employer has adopted and implemented a written safety program that conforms to the requirements of 29 C.F.R. 1926 and 29 C.F.R. 1910; and

(c) An employer with more than ten full-time employees shall include provisions for a safety committee in the safety program. The safety committee must include employee representation and must meet at least once each calendar quarter. The employer must make adequate records of each meeting and maintain the records subject to inspections under subsection (3). The safety committee shall, if appropriate, make recommendations regarding improvements to the safety program and corrections of hazards affecting workplace safety; and

(d) The employer provides the Division of Safety with a written statement, that certifies compliance with this subsection.

(3) The Division of Safety may enter at any reasonable time any place of employment for the purposes of verifying the accuracy of the written certification. If the Division of Safety determines that the employer has not complied with the requirements of subsection (2), the employer shall be subject to the rules of the Division of Safety until the employer complies with subsection (2) and recertifies that fact to the Division of Safety.

(4) This section shall not restrict the Division of Safety from performing any duties pursuant to a written contract between the Division of Safety and the Federal Occupational Safety and Health Administration (OSHA).

Section 66. Section 442.015, Florida Statutes, is created to read:

442.015 Failure to implement a safety and health program; cancellations.—If an employer that is found by the division to have a high frequency or severity of work-related injuries fails to implement a safety and health program, the carrier or self-insurer's fund that is providing coverage for the employer may cancel the contract for insurance with the employer. In the alternative, the carrier or fund may terminate any discount or deviation granted to the employer for the remainder of the term of the policy. If the contract is canceled or the discount or deviation is terminated, the carrier must make such reports as are required by law.

Section 67. Section 442.016, Florida Statutes, is created to read:

442.016 Expenses of administration.—The total expenses of administering this chapter must be estimated annually and provided to the Division of Workers' Compensation of the Department of Labor and Employment Security for inclusion under s. 440.51. The amounts that are needed to administer this chapter shall be disbursed from the Workers' Compensation Administration Trust Fund, established under s. 440.50, in the manner provided in that section.

Section 68. Section 442.017, Florida Statutes, is created to read:

442.017 Refusal to admit; penalty.—The division and its authorized representatives may enter and inspect any place of employment at any reasonable time for the purpose of investigating compliance with this chapter and conducting inspections for the proper enforcement of this chapter. An employer or owner who refuses to admit any member of the division or its authorized representative to any place of employment or to allow investigation and inspection pursuant to this paragraph, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 69. Section 442.018, Florida Statutes, is created to read:

442.018 Employee rights and responsibilities.—

(1) Each employee of an employer covered under this chapter shall comply with rules adopted by the division and with reasonable workplace safety and health standards, rules, policies, procedures, and work practices established by the employer and the workplace safety committee. An employee who knowingly fails to comply with this subsection may be disciplined or discharged by the employer.

(2) An employer may not discharge, threaten to discharge, cause to be discharged, intimidate, coerce, otherwise discipline, or in any manner discriminate against an employee for any of the following reasons:

(a) The employee has requested information regarding safety and health, filed a complaint or suit, or instituted or caused to be instituted a proceeding under this chapter;

(b) The employee has testified or is about to testify, on his own behalf, or on behalf of others, in any proceeding instituted under this chapter;

(c) The employee has exercised any other right afforded under this chapter; or

(d) The employee is engaged in activities relating to the workplace safety committee.

(3) Neither pay, position, seniority, nor other benefit may be lost for exercising any right under, or for seeking compliance with, any requirement of this chapter.

Section 70. Section 442.019, Florida Statutes, is created to read:

442.019 Compliance.—Failure of an employer or carrier to comply with this chapter or with any rules adopted under this chapter constitutes grounds for the division to seek remedies, including injunctive relief, for compliance by making appropriate filings with the Circuit Court of Leon County.

Section 71. Section 442.020, Florida Statutes, is created to read:

442.020 False statements to carriers.—An employer who knowingly and willfully falsifies or conceals a material fact, makes a false, fictitious, or fraudulent statement or representation; or makes or uses any false document knowing the document to contain any false, fictitious, or fraudulent entry or statement to a carrier of workers' compensation insurance under this chapter is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 72. Section 442.021, Florida Statutes, is created to read:

442.021 Carrier penalties.—If any carrier violates, or fails or refuses to comply with, this chapter or with any rule adopted or order issued under this chapter, the division, after notice and hearing in accordance with chapter 120, assess against the carrier a civil penalty of not less than $100 nor more than $5,000 each day the violation, failure, or refusal continues after the carrier has been given written notice thereof. The total penalty for each violation, failure, or refusal may not exceed $50,000. The division shall adopt rules providing for penalties for noncompliance with this chapter by carriers.

Section 73. Section 442.022, Florida Statutes, is created to read:

442.022 Preemption authority.—The division has the authority to adopt rules prescribing occupational safety and health standards that preempt the standards, procedures, or practices of other state agencies or political subdivisions when the division conducts enforcement activities in any such state agency or political subdivision. The authority of the division to adopt such standards is exclusive, notwithstanding any other provisions of state law that delegate rulemaking authority for safety standards to other agencies or political subdivisions of this state.

Section 74. Section 442.023, Florida Statutes, is created to read:

442.023 Matters within jurisdiction of the Division of Safety; false, fictitious, or fraudulent acts, statements, and representations prohibited; penalty; statute of limitations.—A person may not, in any matter within the jurisdiction of the Division of Safety of the Department of Labor and Employment Security, knowingly and willfully falsify or conceal a material fact, make any false, fictitious, or fraudulent statement or representation, or make or use any false document, knowing the same to contain any false, fictitious, or fraudulent statement or entry. A person who violates this section commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. The statute of limitations for prosecution of an act committed in violation of this section is 5 years after the date the act was committed.

Section 75. Paragraph (b) of subsection (4) of section 489.115, Florida Statutes, 1992 Supplement, as amended by section 10 of chapter 93-166, Laws of Florida, is amended to read:

489.115 Certification and registration; endorsement; renewals; continuing education.—

(4)

(b) Each certificateholder or registrant shall provide proof, in a form established by rule of the board, that the certificateholder or registrant has completed at least 14 classroom hours of at least 50 minutes each of continuing education courses during each biennium since the issuance or renewal of the certificate or registration. *The board shall establish by rule that a portion of the required 14 hours must deal with the subject of workers' compensation and workplace safety.* The board shall by rule establish criteria for the approval of continuing education courses and providers and may by rule establish criteria for accepting alternative nonclassroom continuing education on an hour-for-hour basis.

Section 76. (1) The self-insurance regulatory functions relating to group self-insurance funds under section 624.4261, Florida Statutes, within the Department of Labor and Employment Security are hereby transferred by a type four transfer as defined in section 20.06(4), Florida Statutes, to the Department of Insurance effective July 1, 1994.

(2) The administrative rules of the agencies involved in this reorganization that are in effect immediately before the effective date of this act shall remain in effect until specifically changed in the manner provided by law.

(3) This act does not affect the validity of any judicial or administrative proceeding pending on the effective date of this act, and any agency to which are transferred the powers, duties, and functions relating to the pending proceeding shall be substituted as a party in interest for that proceeding.

(4) Any group self-insurer authorized under section 440.57, Florida Statutes, on July 1, 1994, shall receive a certificate of authority to operate a group self-insurance fund under section 624.4621, Florida Statutes.

Section 77. Section 624.461, Florida Statutes, is created to read:

624.461 Definition.—For the purposes of the Florida Insurance Code, "self-insurance fund" means both commercial self-insurance funds organized under s. 624.462 and group self-insurance funds organized under s. 624.4621. The term "self-insurance fund" does not include a governmental self-insurance pool created under s. 768.28(14).

Section 78. Subsection (5) of section 624.462, Florida Statutes, is amended to read:

624.462 Commercial self-insurance funds.—

(5) A commercial self-insurance fund *must* ~~shall not~~ participate in the Florida *Self-Insurance Fund* ~~Insurance~~ Guaranty Association.

Section 79. Section 440.57, Florida Statutes, is transferred and renumbered as section 624.4621, Florida Statutes, and amended to read:

624.4621 ~~440.57~~ *Group self-insurance funds* ~~Pooling liabilities~~.—

(1) The *department* ~~division~~ shall adopt rules *that allow* ~~permitting~~ two or more employers to enter into agreements to pool their liabilities under ~~this~~ chapter *440* for the purpose of qualifying as a group self-insurer's fund, which shall be classified as a self-insurer, and each employer member of such approved group shall be known as a group self-insurer's fund member and shall be classified as a self-insurer as defined in ~~this~~ chapter *440*. The agreement entered into under this section may provide that the pool will be liable for 80 percent, and the employer member will be liable for 20 percent, of the medical benefits due any employee for an injury compensable under this chapter up to the amount of $5,000. One hundred percent of the medical benefits above $5,000 due to an employee for one injury shall be paid by the pool. The agreement may also provide that each employer member will be responsible for up to the first $500 of medical benefits due each of its employees for each injury. The claim shall be paid by the pool, regardless of its size, which shall be reimbursed by the employer for any amounts required to be paid by the employer under the agreement.

(2) The *department* ~~division~~ shall adopt rules:

(a) Requiring monetary reserves to be maintained by such self-insurers to insure their financial solvency; and

(b) Governing their organization and operation to assure compliance with such requirements.

(3) The *department* ~~division~~ shall *adopt* ~~promulgate~~ rules implementing the reserve requirements in accordance with accepted actuarial techniques.

(4) Any self-insurer established under this section, except for self-insurers *that* ~~which~~ are state or local governmental entities, *is* ~~shall be~~ required to carry reinsurance in accordance with rules *adopted* ~~promulgated~~ by the *department* ~~division~~.

(5) *A* ~~No~~ dividend or premium refund of any self-insurer established under this section, otherwise earned, *may not* ~~shall~~ be made contingent upon continued membership in the fund, renewal of any policy, or the payment of renewal premiums for membership in the fund or on any policy issued by such self-insurer. *Before* ~~Prior to~~ making any dividend or premium refund, the group self-insurer shall submit to the *department* ~~division~~ the following information:

(a) An audited certified financial statement.

(b) An annual report of financial condition.

(c) A loss reserve review by a qualified actuary.

The required information listed in paragraphs (a)-(c) shall be submitted annually, no later than 7 months after the end of the group self-insurer's fund year. *A* ~~No~~ request for such dividend or premium refund may *not* be made *before* ~~prior to the filing of~~ the required information *is filed*. The request for such dividend or premium refund *must* ~~shall~~ include a resolution of the board of trustees of the group self-insurer requesting approval of a specific amount to be distributed. *A* ~~Any~~ dividend, premium refund, or premium discount or credit *must not* ~~shall in no manner~~ discriminate on the basis of continued coverage or continued membership in the group self-insurer. The *department* ~~division~~ shall review *the* ~~such~~ request and shall issue a decision within 60 days *after* ~~of~~ the filing. Failure to issue a decision within 60 days *constitutes* ~~shall constitute~~ an approval of *the* ~~such~~ request. Any dividend or premium refund approved by the *department* ~~division~~ for distribution which cannot be paid to the applicable member or policyholder or former member or policyholder of the group self-insurer because the former member or policyholder cannot be reasonably located shall become the property of the group self-insurer.

(6) The *department* ~~division~~ may impose civil penalties not to exceed $100 per occurrence for violations of the provisions of this chapter or rules adopted pursuant hereto.

(7) Premiums, contributions, and assessments received by a group self-insurer's fund are subject to ss. 624.509(1) and (2) and 624.5092, except that the tax rate shall be 1.6 percent of the gross amount of such premiums, contributions, and assessments.

(8) This section does not apply to any program, intergovernmental agreement, cooperative effort, consortium, or agency through which two or more governmental entities, without pooling their liabilities, administer the payment of workers' compensation to their respective employees.

(9) A group self-insurance fund shall participate in the Florida Self-Insurance Fund Guaranty Association.

Section 80. Section 440.575, Florida Statutes, is transferred and renumbered as section 624.4622, Florida Statutes, and amended to read:

624.4622 ~~440.575~~ Local government *self-insurance funds* ~~pools~~.—

(1) Any two or more local governmental entities may enter into interlocal agreements for the purpose of securing the payment of benefits under ~~this~~ chapter *440*, provided the local government *self-insurance fund* ~~pool~~ that is created must:

(a) Have annual normal premiums in excess of $5 million;

(b) Maintain a continuing program of excess insurance coverage and reserve evaluation to protect the financial stability of the fund in an amount and manner determined by a qualified and independent actuary;

(c) Submit annually an audited fiscal year-end financial statement by an independent certified public accountant within 6 months after the end of the fiscal year to the *department* ~~division~~; and

(d) Have a governing body which is comprised entirely of local elected officials.

(2) A local government *self-insurance fund* ~~pool~~ that meets the requirements of this section is not subject to *s. 624.4621* ~~the provisions of s. 440.57~~ and is not required to file any report with the *department under* ~~division pursuant to~~ s. 440.38(2)(b) which is uniquely required of group self-insurer funds qualified under *s. 624.4621* ~~s. 440.57~~. If any of the requirements of this section are not met, the local government *self-insurance fund* ~~pool~~ is subject to the requirements of *s. 624.4621* ~~s. 440.57~~.

Section 81. Section 440.571, Florida Statutes, is transferred and renumbered as section 624.46225, Florida Statutes, and amended to read:

624.46225 ~~440.571~~ Self-insured public utilities.—A self-insured public utility, as authorized by s. 440.38(1)*(c)* ~~(b)~~, may assume by contract the liabilities under this chapter of contractors and subcontractors, or each of them, employed by or on behalf of such public utility when performing work on or adjacent to property owned or used by the public utility.

Section 82. Section 624.463, Florida Statutes, is amended to read:

624.463 Conversion of ~~commercial~~ self-insurance fund.—

(1) A ~~commercial~~ self-insurance fund may become a domestic mutual insurer under a plan and procedure which are approved by the department.

(2) The department may not approve any plan or procedure unless:

(a) It is equitable to the ~~commercial~~ self-insurance fund members; and

(b) The requirements imposed as to the formation of domestic mutual insurers are satisfied.

Section 83. Subsection (1) of section 624.474, Florida Statutes, is amended to read:

624.474 Assessments.—

(1) The trustees of a self-insurance fund operating as a trust, or the corporate directors of a self-insurance fund operating as a corporation, may assess from time to time members of a ~~commercial~~ self-insurance fund liable therefor under the terms of their policies and pursuant to this section, or the department may assess the members in the event of liquidation of the fund.

Section 84. Section 624.4741, Florida Statutes, is created to read:

624.4741 Venue in assessment actions.—In any action brought by a self-insurance fund to collect assessments levied under this chapter, venue lies where the fund maintains its principal place of business or, if the department or the Florida Group Self-Insurers Guaranty Association is a party to such action, in the Circuit Court of Leon County.

Section 85. Subsections (1) and (3) of section 624.476, Florida Statutes, are amended to read:

624.476 Impaired ~~commercial~~ self-insurance funds.—

(1) If the assets of a ~~commercial~~ self-insurance fund are at any time insufficient to comply with the requirements of law or to discharge its liabilities, other than any liability on account of funds contributed by the trustees or others, and to meet the required conditions of financial soundness, or if a judgment against the fund has remained unsatisfied for 30 days, its trustees shall forthwith make up the deficiency or levy an assessment upon the members for the amount needed to make up the deficiency, but subject to the limitation set forth in the trust agreement or the policy.

(3) Subject to ~~the provisions of~~ this section, any rehabilitation, liquidation, conservation, or dissolution of a ~~commercial~~ self-insurance fund shall be conducted under the supervision of the department, which shall have all power with respect thereto granted to it under part I of chapter 631 governing the rehabilitation, liquidation, conservation, or dissolution of insurers.

Section 86. Subsection (1) of section 624.480, Florida Statutes, is amended to read:

624.480 Filing, approval, and disapproval of forms.—

(1) *A* ~~No~~ basic insurance policy or application form *for which* ~~where~~ written application is required and is to be a part of the policy or contract or printed rider or endorsement form *may not* ~~shall~~ be issued by a ~~commercial~~ self-insurance fund unless the form has been filed with and approved by the department.

Section 87. Subsections (1), (8), (9), and (10) of section 624.482, Florida Statutes, are amended to read:

624.482 Making and use of rates.—

(1) With respect to all classes of insurance which a ~~commercial~~ self-insurance fund *underwrites* ~~shall underwrite~~, the rates *must* ~~shall~~ not be excessive, inadequate, or unfairly discriminatory. In determining what rates, including credits and surcharges, are excessive, inadequate, or unfairly discriminatory, the department shall apply the same standards applicable to other insurers regulated by the department.

(8) A ~~commercial~~ self-insurance fund shall ~~be required to~~ file its rates, including credits and surcharge schedules, with the department for approval pursuant to the standards of this section and the procedures of s. 624.480(2).

(9) Any ~~commercial~~ self-insurance fund may subscribe to, or be a member of, a rating organization as prescribed in s. 627.231. A rating organization *may* ~~shall~~ not discriminate against a ~~commercial~~ self-insurance fund as to conditions of subscription or membership.

(10) Any ~~commercial~~ self-insurance fund *that* ~~which~~ writes workers' compensation insurance and employer's liability insurance is subject to, and shall make all rate filings for workers' compensation insurance and employer's liability insurance in accordance with, ss. 627.091, 627.101, 627.111, 627.141, 627.151, 627.171, 627.191, and 627.211.

Section 88. Section 440.58, Florida Statutes, is transferred and renumbered as section 624.483, Florida Statutes, and amended to read:

624.483 ~~440.58~~ Self-insurer members; payment of delinquent premiums and assessments.—Upon petition of the trustees of the following self-insurers groups: Printing Industry Associates, Allied Gasoline Retailers Association, Florida Plumbing and Mechanical Contractors, Florida State Retailers Association, Automotive Industries of Florida, Florida Nurserymen and Growers Association, Florida Pest Control Association, Florida Wholesalers Association, Florida Electrical Contractors, Florida Home Builders, Florida Restaurant Association, and Florida Nursing Home Association, who entered into agreements with Robert F. Coleman of Florida, Inc., as servicing agent, or any other self-insurers groups similarly situated, the *department* ~~division~~ shall enter its order requiring the employer members and former members of said groups liable therefor to pay all delinquent premiums and all necessary assessments, such payments to be paid to the *department* ~~division~~ and by it disbursed to said trustees to be used for the payment of workers' compensation claims and related compensation expenses.

Section 89. Section 624.484, Florida Statutes, is amended to read:

624.484 Registration of agent.—A ~~commercial~~ self-insurance fund shall register with and designate the Insurance Commissioner as its agent solely for the purpose of receiving service of legal documents or process.

Section 90. Section 624.486, Florida Statutes, is amended to read:

624.486 Examination.—~~Commercial~~ Self-insurance funds licensed under ss. 624.460-624.488 *are* ~~shall be~~ subject to periodic examination by the department in the same manner and subject to the same terms and conditions applicable to insurers under part II of this chapter.

Section 91. Section 440.5705, Florida Statutes, is transferred and renumbered as section 624.487, Florida Statutes, and amended to read:

624.487 ~~440.5705~~ Enforcement of specified insurance provisions; adoption of rules.—The department ~~of Labor and Employment Security~~ may enforce, with respect to group self-insurance funds established or operated *under s. 624.4621* ~~pursuant to s. 440.57~~, the provisions of s. 624.316, s. 624.424, s. 625.091, or s. 625.305 as they relate to workers' compensation insurers, and may adopt rules to implement the enforcement authority granted by this section.

Section 92. Section 624.488, Florida Statutes, is amended to read:

624.488 Applicability of related laws.—In addition to other provisions of the code cited in ss. 624.460-624.488:

(1) Sections 624.155, 624.308, 624.414, 624.415, and 624.416(4); ss. 624.418-624.4211, except s. 624.418(2)(f); and s. 624.501;

(2) Part II of chapter 625;

(3) Applicable sections of part VI of chapter 626; s. 626.9541(1)(a), (b), (c), (d), (e), (f), (h), (i), (j), (k), (l), (m), (n), (o), (q), (u), (w), and (x); and ss. 626.9561-626.9641;

(4) Sections 627.291, 627.413, 627.4132, 627.416, 627.418, 627.420, 627.421, 627.425, 627.426, 627.4265, 627.427, 627.428, 627.702, and 627.706; part XI of chapter 627; ss. 627.912, 627.913, and 627.918; and

(5) Section 628.361(2),

~~shall~~ apply to ~~commercial~~ self-insurance funds. *Only those sections* ~~No section~~ of the code *that are* ~~not~~ expressly and specifically cited in ss. 624.460-624.488 ~~shall~~ apply to ~~commercial~~ self-insurance funds.

Section 93. Subsection (9) of section 627.041, Florida Statutes, is amended to read:

627.041 Definitions.—As used in this part:

(9) "Insurer," for purposes of ss. 627.091, 627.096, 627.101, 627.111, 627.141, 627.171, 627.191, 627.211, and 627.291, includes a commercial self-insurance fund as defined in s. 624.462 *and a group self-insurance fund as defined in s. 624.4621.*

Section 94. Section 627.0915, Florida Statutes, is amended to read:

627.0915 Rate filings; workers' compensation, ~~and~~ drug-free workplace, *and safe* employers.—The Department of Insurance shall approve ~~a~~ rating *plans* ~~plan~~ for workers' compensation insurance that *give* ~~gives~~ specific identifiable consideration in the setting of rates to employers that *either* implement a drug-free workplace program pursuant to rules adopted by the Division of Workers' Compensation of the Department of Labor and Employment Security *or implement a safety program approved by the Division of Safety pursuant to rules adopted by the Division of Safety of the Department of Labor and Employment Security or implement both a drug-free workplace program and a safety program.* The *plans* ~~plan~~ must take effect January 1, *1994* ~~1992~~, must be actuarially sound, and must state the savings anticipated to result from such drug testing *and safety programs* ~~program~~.

Section 95. Premium credit; managed care arrangements.—The Department of Insurance shall approve rating plans for workers' compensation that provide for premium credits not to exceed 10 percent for employers that utilize managed care arrangements as certified by the Agency for Health Care Administration. This section expires January 1, 1997.

Section 96. Section 627.0916, Florida Statutes, is created to read:

627.0916 Agricultural horse farms.—Notwithstanding any other provision of this chapter to the contrary, any rates, rating schedules, or rating manuals for workers' compensation and employers' liability insurance filed with the Department of Insurance shall provide for the rates of an agricultural horse farm engaged in breeding or training to be separated into the following three rate classifications and shall be proportioned according to payroll: breeding activity involving stallions; breeding activity not involving stallions, including but not limited to boarding and foaling; and training.

Section 97. Section 627.212, Florida Statutes, is created to read:

627.212 Workplace safety program surcharge.—The department shall approve a rating plan for workers' compensation coverage insurance that provides for carriers voluntarily to impose a surcharge of no more than 10 percent on the premium of a policyholder or fund member if that policyholder or fund member has been identified by the Division of Safety of the Department of Labor and Employment Security as having been required to implement a safety program and having failed to establish or maintain, either in whole or in part, a safety program. The division shall adopt rules prescribing the criteria for the employee safety programs.

Section 98. Subsection (4) of section 627.311, Florida Statutes, is amended to read:

(Substantial rewording of subsection. See s. 627.311(4), F.S., for present text.)

(4)(a) Effective upon this act becoming a law, the department shall, after consultation with insurers, approve a joint underwriting plan of insurers which shall operate as a nonprofit entity. For the purposes of this subsection, the term "insurer" includes group self-insurance funds authorized by s. 624.4621, commercial self-insurance funds authorized by s. 624.462, assessable mutual insurers authorized under s. 628.6011, and insurers licensed to write workers' compensation and employer's liability insurance in this state. The purpose of the plan is to provide workers' compensation and employer's liability insurance to applicants who are required by law to maintain workers' compensation and employer's liability insurance and who are in good faith entitled to but who are unable to purchase such insurance through the voluntary market. The joint underwriting plan shall issue policies beginning January 1, 1994. The plan must have actuarially sound rates that assure that the plan is self-supporting. The operation of the plan is subject to the supervision of a 13-member board of governors. The board of governors shall be comprised of five domestic insurers, one of whom shall be the assessable mutual insurer or other domestic insurer which has the largest voluntary written premium for workers' compensation and employer's liability insurance as of December 31, 1993, one of whom shall be the commercial self-insurance fund which has the largest voluntary written premium for workers' compensation and employer's liability insurance, as of December 31, 1993, and three of whom shall be the three of the five group self-insurers' funds, authorized by s. 440.57, which have the largest voluntary written premium for workers' compensation and employer's liability insurance, as of December 31, 1993; and five of the 20 foreign insurers which are defined in s. 624.06(2) with the largest voluntary written premium in this State of Florida for workers' compensation and employer's liability insurance, for the latest year for which data are available, as selected by those 20 foreign insurers. If the assessable mutual insurer or the commercial self-insurance fund, described in this paragraph, decline to serve on, or resign from, the board of governors, such position on the board of governors shall be filled by appointment by a committee comprised of the ten assessable mutual insurers, commercial self-insurance funds, and group self-insurers' funds, authorized by s. 440.57, which have the largest voluntary written premium for workers' compensation and employer's liability insurance, as of December 31, 1993. No board member shall be an insurer which provides service to the plan or which has an affiliate which provides services to the plan or which is serviced by a service company or third-party administrator which provides services to the plan or which has an affiliate which provides services to the plan. The board of governors shall have a chairman, who shall be named by the Insurance Commissioner. The board of governors shall include one representative appointed by the largest property and casualty insurance agents' association in this state. The consumer advocate appointed under s. 627.0613 shall be a member of the board of governors. The minutes, audits, and procedures of the board of governors are subject to chapter 119.

(b) The operation of the plan shall be governed by a plan of operation that is prepared at the direction of the board of governors. The plan of operation may be changed at any time by the board of governors or upon request of the department. The plan of operation and all changes thereto are subject to the approval of the department. The plan of operation shall:

1. Authorize the board to engage in the activities necessary to implement this subsection, including, but not limited to, borrowing money.

2. Develop criteria for eligibility for coverage by the plan, including, but not limited to, documented rejection by at least two insurers which reasonably assures that insureds covered under the plan are unable to acquire coverage in the voluntary market. Any insured may voluntarily elect to accept coverage from an insurer for a premium equal to or greater than the plan premium if the insurer writing the coverage adheres to the provisions of s. 627.171.

3. Require notice from the agent to the insured at the time of the application for coverage that the application is for coverage with the plan and that coverage may be available through an insurer, group self-insurers' fund, commercial self-insurance fund, or assessable mutual insurer through another agent at a lower cost.

4. Establish programs to encourage insurers to provide coverage to applicants of the plan in the voluntary market and to insureds of the plan, including, but not limited to:

a. Establishing procedures for an insurer to use in notifying the plan of the insurer's desire to provide coverage to applicants to the plan or existing insureds of the plan and in describing the types of risks in which the insurer is interested. The description of the desired risks must be on a form developed by the plan.

b. Developing forms and procedures that provide an insurer with the information necessary to determine whether the insurer wants to write particular applicants to the plan or insureds of the plan.

c. Developing procedures for notice to the plan and the applicant to the plan or insured of the plan that an insurer will insure the applicant or the insured of the plan, and notice of the cost of the coverage offered; and developing procedures for the selection of an insuring entity by the applicant or insured of the plan.

d. Provide for a market-assistance plan to assist in the placement of employers. All applications for coverage in the plan received 45 days before the effective date for coverage shall be processed through the market-assistance plan. A market-assistance plan specifically designed to serve the needs of small good policyholders as defined by the board must be finalized by January 1, 1994.

5. Provide for policy and claims services to the insureds of the plan of the nature and quality provided for insureds in the voluntary market.

6. Provide for the review of applications for coverage with the plan for reasonableness and accuracy, using any available historic information regarding the insured.

7. Provide for procedures for auditing insureds of the plan which are based on reasonable business judgment and are designed to maximize the likelihood that the plan will collect the appropriate premiums.

8. Authorize the plan to terminate the coverage of and refuse future coverage for any insured that submits a fraudulent application to the plan or provides fraudulent or grossly erroneous records to the plan or to any service provider of the plan in conjunction with the activities of the plan.

9. Establish service standards for agents who submit business to the plan.

10. Establish criteria and procedures to prohibit any agent who does not adhere to the established service standards from placing business with the plan or receiving, directly or indirectly, any commissions for business placed with the plan.

11. Provide for the establishment of reasonable safety programs for all insureds in the plan. At the direction of the board, the Division of Safety shall provide inspection to insureds and applicants for coverage in the plan identified as high-risk insureds by the board or its designee.

12. Authorize the plan to terminate the coverage of and refuse future coverage to any insured who fails to pay premiums or surcharges when due; who, at the time of application, is delinquent in payments of workers' compensation or employer's liability insurance premiums or surcharges owed to an insurer, group self-insurers' fund, commercial self-insurance fund, or assessable mutual insurer licensed to write such coverage in this state; or who refuses to substantially comply with any safety programs recommended by the plan.

13. Authorize the board of governors to provide the services required by the plan through staff employed by the plan, through reasonably compensated service providers who contract with the plan to provide services as specified by the board of governors, or through a combination of employees and service providers.

14. Provide for service standards for service providers, methods of determining adherence to those service standards, incentives and disincentives for service, and procedures for terminating contracts for service providers that fail to adhere to service standards.

15. Provide procedures for selecting service providers and standards for qualification as a service provider that reasonably assure that any service provider selected will continue to operate as an ongoing concern and is capable of providing the specified services in the manner required.

16. Provide for reasonable accounting and data-reporting practices.

17. Provide for annual review of costs associated with the administration and servicing of the policies issued by the plan to determine alternatives by which costs can be reduced.

18. Authorize the acquisition of such excess insurance or reinsurance as is consistent with the purposes of the plan.

19. Provide for an annual report to the department on a date specified by the department and containing such information as the department reasonably requires.

20. Establish multiple rating plans for various classifications of risk which reflect risk of loss, hazard grade, actual losses, size of premium, and compliance with loss control. At least one of such plans must be a preferred-rating plan to accommodate shall-premium policyholders with good experience as defined in sub-subparagraph 22.a.

21. Establish agent commission schedules.

22. Establish three subplans as follows:

a. Subplan "A" must include those insureds whose annual premium does not exceed $2,500 and who have neither incurred any lost-time claims nor incurred medical-only claims exceeding 50 percent of their premium for the immediate 2 years.

b. Subplan "B" must include insureds that are employers identified by the board of governors as high-risk employers due solely to the nature of the operations being performed by those insureds and for whom no market exists in the voluntary market, and whose experience modifications are less than 1.00.

c. Subplan "C" must include all other insureds within the plan.

(c) The plan must be funded through actuarially sound premiums charged to insureds of the plan. The plan may issue assessable policies only to those insureds in subplan "C." Those assessable policies must be clearly identified as assessable by containing, in contrasting color and in not less than 10-point type, the following statements: "This is an assessable policy. If the plan is unable to pay its obligations, policyholders will be required to contribute on a pro-rata-earned-premium basis the money necessary to meet any assessment levied." The plan may issue assessable policies with differing terms and conditions to different groups within the plan when a reasonable basis exists for the differentiation. The plan may offer rating, dividend plans, and other plans to encourage loss prevention programs.

(d) The plan shall establish and use its rates and rating plans, and the plan may establish and use changes in rating plans at any time, but no more frequently than two times per any rating class for any calendar year. By December 1, 1993, and December 1 of each year thereafter, the board shall establish and use actuarially sound rates for use by the plan to assure that the plan is self-funding while those rates are in effect. Such rates and rating plans must be filed with the department within 30 calendar days after their effective dates, and shall be considered a "use and file" filing. Any disapproval by the department must have an effective date that is at least 60 days from the date of disapproval of the rates and rating plan and must have prospective effect only. The plan may not be subject to any order by the department to return to policyholders any portion of the rates disapproved by the department. The department may not disapprove any rates or rating plans unless it demonstrates that such rates and rating plans are excessive, inadequate, or unfairly discriminatory.

(e) No later than June 1 of each year, the plan shall obtain an independent actuarial certification of the results of the operations of the plan for prior years, and shall furnish a copy of the certification to the department. If, after the effective date of the plan, the projected ultimate incurred losses and expenses and dividends for prior years exceed collected premiums, accrued net investment income, and prior assessments for prior years, the certification is subject to review and approval by the department before it becomes final.

(f) Whenever a deficit exists, the plan shall, within 90 days, provide the department with a program to eliminate the deficit within a reason-

able time. The deficit may be funded both through increased premiums charged to insureds of the plan for subsequent years and through assessments on insureds in the plan if the plan uses assessable policies.

(g) Any premium or assessments collected by the plan in excess of the amount necessary to fund projected ultimate incurred losses and expenses of the plan and not paid to insureds of the plan in conjunction with loss prevention or dividend programs shall be retained by the plan for future use.

(h) The decisions of the board of governors do not constitute final agency action and are not subject to chapter 120.

(i) Policies for insureds shall be issued by the plan.

(j) The plan created under this subsection is liable only for payment for losses arising under policies issued by the plan with dates of accidents occurring on or after January 1, 1994.

(k) Plan losses are the sole and exclusive responsibility of the plan, and payment for such losses must be funded in accordance with this subsection and must not come, directly or indirectly, from insurers or any guaranty association for such insurers.

(l) Each joint underwriting plan or association created under this section is not a state agency, board, or commission. However, for the purposes of s. 199.183(1) only, the joint underwriting plan is a political subdivision of the state and is exempt from the corporate income tax.

(m) Each joint underwriting plan or association may elect to pay premium taxes on the premiums received on its behalf or may elect to have the member insurers to whom the premiums are allocated pay the premium taxes if the member insurer had written the policy. The joint underwriting plan or association shall notify the member insurers and the Department of Revenue by January 15 of each year of its election for the same year. As used in this paragraph, the term "premiums received" means the consideration for insurance, by whatever name called, but does not include any policy assessment or surcharge received by the joint underwriting association as a result of apportioning losses or deficits of the association pursuant to this section.

(n) Effective midnight, December 31, 1993, the Florida Workers' Compensation Insurance Plan, administered by the National Council on Compensation Insurance, shall terminate, except with respect to workers' compensation policies issued pursuant to such Florida Workers' Compensation Insurance Plan with inception dates on or before December 31, 1993.

(o) Neither the plan nor any member of the board of governors is liable for monetary damages to any person for any statement, vote, decision, or failure to act, regarding the management or policies of the plan, unless:

1. The member breached or failed to perform his duties as a member; and

2. The member's breach of, or failure to perform, duties constitutes:

a. A violation of the criminal law, unless the member had reasonable cause to believe his conduct was unlawful. A judgment or other final adjudication against a member in any criminal proceeding for violation of the criminal law estops that member from contesting the fact that his breach, or failure to perform, constitutes a violation of the criminal law; but does not estop the member from establishing that he had reasonable cause to believe that his conduct was lawful or had no reasonable cause to believe that his conduct was unlawful;

b. A transaction from which the member derived an improper personal benefit, either directly or indirectly; or

c. Recklessness or any act or omission that was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. For purposes of this sub-subparagraph, the term "recklessness" means the acting, or omission to act, in conscious disregard of a risk:

(I) Known, or so obvious that it should have been known, to the member; and

(II) Known to the member, or so obvious that it should have been known, to be so great as to make it highly probably that harm would follow from such act or omission.

(p) The provisions of this subsection shall be reviewed by the Legislature before July 1, 1996.

Section 99. Subsection (1) of section 627.4133, Florida Statutes, is amended to read:

627.4133 Notice of cancellation, nonrenewal, or renewal premium.—

(1) An insurer issuing a policy providing coverage for *workers' compensation and employer's liability insurance,* property, casualty, except mortgage guaranty, surety, or marine insurance, other than motor vehicle insurance subject to s. 627.728, shall give the named insured at least 45 days' advance written notice of nonrenewal or of the renewal premium. If the policy is not to be renewed, the written notice shall state the reason or reasons as to why the policy is not to be renewed. ~~The provisions of this section requiring 45 days' advance written notice of the renewal premium do not apply to workers' compensation and employer's liability insurance. An insurer must furnish written notice of the renewal premium to an insured covered by a policy of workers' compensation and employer's liability insurance not later than the expiration date of the policy to be renewed.~~ This requirement applies only if the insured has furnished all of the necessary information so as to enable the insurer to develop the renewal premium prior to the expiration date of the policy to be renewed.

Section 100. Subsection (1) of section 628.6013, Florida Statutes, is amended to read:

628.6013 Converted self-insurance fund; trade association; board of directors.—

(1) Any self-insurance fund regulated under the insurance code other than a commercial self-insurance fund may, with the approval of *a majority of the members of the fund and after written notice to the sponsoring association and approved by* the department, elect to convert to an assessable mutual insurer in accordance with part I.

Section 101. Part V of chapter 631, Florida Statutes, consisting of sections 631.90, 631.905, 631.91, 631.915, 631.92, 631.925, 631.93, 631.935, 631.94, 631.945, 631.95, 631.955, 631.96, 631.965, 631.97, 631.975, 631.98, 631.985, 631.99, and 631.995, Florida Statutes, is created to read:

PART V
FLORIDA SELF-INSURANCE FUND GUARANTY ASSOCIATION

631.90 Title.—This part may be cited as the "Florida Self-Insurance Fund Guaranty Association Act."

631.905 Purposes.—The purposes of this part are to:

(1) Create a Florida Self-Insurance Fund Guaranty Association which will provide a mechanism for the payment of covered claims under chapter 440 to avoid excessive delay in payment and to avoid financial loss to claimants because of the insolvency of a fund.

(2) Create a not-for-profit corporation to administer and supervise the operation of the association.

(3) Assist in the detection and prevention of fund insolvencies.

(4) Assess the cost of such protection among the funds.

(5) Provide for the prompt payment by the association of workers' compensation claims incurred by delinquent funds.

631.91 Construction.—The statutes controlling the association shall be liberally construed to achieve the purposes stated in s. 631.905. The association shall perform its functions under a plan of operation established by its board of directors and approved by the department.

631.915 Definitions.—As used in this part, the term:

(1) "Association" means the Florida Self-Insurance Fund Guaranty Association.

(2) "Commissioner" means the Commissioner of the Department of Insurance.

(3) "Covered claim" means an unpaid claim, including one of unearned premiums, which arises out of, is within the coverage of, and is not in excess of the applicable limits of, an insurance policy to which this part applies, issued by a self-insurer's fund, which claim is made on behalf of a claimant or insured who is a resident of this state at the time of the injury. The term does not include any claims resulting from dates

of accidents or losses incurred by a member self-insurance fund before January 1, 1994, or any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise. Member self-insurer's funds have no right of subrogation against the insured of any insolvent self-insurance fund.

(4) "Delinquent fund" means a self-insurer's fund against which an order of rehabilitation or liquidation has been entered by a court of competent jurisdiction, with the department appointed as receiver, even if such order has not become final by the exhaustion of appellate review.

(5) "Department" means the Department of Insurance.

(6) "Self-insurance fund" means a group self-insurance fund authorized under s. 624.4621, a commercial self-insurance fund writing workers' compensation insurance under s. 624.462, or an assessable mutual insurer authorized under s. 628.6011.

631.92 Creation of Florida Self-Insurance Fund Guaranty Association and fund.—There is created a nonprofit corporation to be known as the "Florida Self-Insurance Fund Guaranty Association Incorporated." All self-insurance funds must be members of the association as a condition of their authority to provide workers' compensation coverage to their fund members. As a further condition of such authority, a self-insurance fund is deemed to agree to reimburse the association for all funds advanced to the self-insurance fund and all claim payments the association makes on the insured's behalf if the self-insurance fund, having been placed in rehabilitation receivership, is subsequently rehabilitated. The association shall perform its functions under a plan of operation and shall exercise its powers through a board of directors. The corporation has all powers granted or allowed to not-for-profit corporations under chapter 617, as well as other powers that are granted in this section. Upon the adoption of a plan of operation for the association, there shall be created the Florida Self-Insurance Fund Account to be managed by the association.

631.925 Organizational meeting.—The department shall give at least 30 days' notice to all self-insurance funds of the time and place of the organizational meeting of the Florida Self-Insurance Fund Guaranty Association, which time and place shall be as determined by the department but not later than July 1, 1994. At the organizational meeting, each self-insurance fund is entitled to one vote, in person or by proxy. The self-insurance funds shall elect their five initial board members at the organizational meeting. If the self-insurance funds fail to elect their five board members at the organizational meeting, the commissioner shall appoint persons to the unfilled positions for a term of 1 year, after which term the positions shall be filled by persons elected by the self-insurance funds.

631.93 Board of directors.—

(1) The board of directors of the association shall consist of nine persons, four of whom are appointed by the commissioner, and five of whom are elected by the self-insurance funds. The commissioner may remove any board member for cause. Board members shall be appointed to serve for a term of 4 years; however, the terms of the initial board members may be staggered by the commissioner. A person may not serve more than one consecutive term. A vacancy on the board shall be filled for the remaining period of the term in the same manner by which the original appointment was made.

(2) Members of the board may be reimbursed from the assets of the association for actual and reasonable out-of-pocket expenses incurred by them as members of the board of directors, but a member of the board may not otherwise be compensated by the association for his services. The department may adopt rules that specify reasonable and allowable expenses, which rules are binding upon the association.

631.935 Powers and duties of the association.—

(1) The association is obligated to the extent of the full amount of the covered claims existing:

(a) Before the adjudication of insolvency and arising within 30 days after the determination of insolvency;

(b) Before the policy expiration date if less than 30 days after the determination; or

(c) Before the insured replaces the policy or causes its cancellation, if he does so within 30 days after the determination.

The association is not obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent self-insurer's funds under the policy from which the claim arises.

(2) The association is considered to be the insurer to the extent of its obligation on the covered claims, and, to such extent, has all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent. The association is not liable for any penalties or interest.

(3) The association may:

(a) Employ or retain such persons as are necessary to handle claims and perform other duties of the association.

(b) Borrow funds necessary to effect the purposes of this part in accord with the plan of operation.

(c) Sue or be sued. Service of process in such legal actions must be made upon the person registered with the department as agent for the receipt of service of process.

(d) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this part.

(4) State funds may not be allocated or paid to the association.

(5) Any necessary and proper expenses incurred by a self-insurance fund in the investigation, adjustment, compromise, settlement, denial, or handling of claims assigned to it shall, upon proper verification under the rules of the association, entitle the self-insurance fund to reimbursement. Any self-insurance fund that has an employee serving on the staff of the association may set off from its assessment, upon proper verification under the rules of the association, any necessary and proper expenses incurred by the self-insurance fund resulting from service of its employee on the association staff. A self-insurance fund that ceases to engage in business has no right to a refund of any assessment previously remitted.

631.94 Assessments.—

(1) For the purpose of providing the funds necessary to carry out the obligations, duties, and powers of the association, the board of directors shall assess all self-insurance funds in accordance with the plan of operation. Assessments are due not less than 30 days after written notice to the self-insurance fund. In any 1 year, a self-insurance fund's assessment may not exceed 1 percent of the self-insurance fund's net direct written premium in the calendar year immediately preceding. The board of directors may impose more than one assessment in any one year, subject to the aggregate annual dollar limit on the assessment. The plan of operation shall provide for assessments in the proportion that each self-insurance fund's net direct written premiums bears to the total of such net direct written premiums received in the year. Assessment shall be remitted to and administered by the board of directors in the manner specified by the approved plan of operation. Until January 1, 1998, self-insurance funds shall receive a credit for any assessments paid to the association pursuant to this act against the assessment paid to the division pursuant to s. 440.51.

(2) The department may temporarily defer, in whole or in part, the assessment of a self-insurance fund if, in the opinion of the department, payment of the assessment would endanger the ability of the self-insurance fund to fulfill its contractual obligations. The trustees of the fund determined to be endangered must immediately levy an assessment upon the members of that self-insurance fund in an amount sufficient to pay the assessment to the association.

(3) The association may bring suit in the circuit courts of this state to collect any assessment that has not been deferred by the department.

(4) Failure for any reason by any self-insurance fund to pay, when due, an assessment that has not been deferred by the department constitutes grounds for the department to bring action to suspend, revoke, or fine the self-insurance fund.

(5) If any self-insurance fund refuses or is unable to pay its assessment, the association has standing and authority, by means including bringing a civil action, to collect the assessment against that self-insurance fund directly from the members of the self-insurance fund. Any person or entity that is a member of that self-insurance fund at the date of the assessment, or was a member of that self-insurance fund at any time in the 3 years next preceding the notice of assessment, is liable for the assessment in the proportion that premiums paid by that person or entity to that self-insurance fund bears to premiums paid to that self-insurance fund by all its members in that same period.

(6) The association shall assess the persons or entities who were members of the delinquent fund for the assessment that would have been levied against the delinquent fund for its share of the assessment as if the assessment had not been caused by it, and each such person or entity is liable in the proportion that premiums paid by that person or entity to that self-insurance fund bears to premiums paid to that self-insurance fund by all its members in that same period. The association may bring suit in the courts of this state to collect such assessments.

(7) Assessments must be included as an appropriate factor in the making of rates.

(8) If provided for in the plan of operation, assessments may be made in advance of actual need therefor, to the extent the board can predict the need with reasonable accuracy, and may be made for the administrative expense of maintaining a ready condition and association staff and facilities, even though no claims on the association are on hand or foreseen at the time of the assessment.

631.945 Plan of operation.—The board of directors shall prepare and submit to the department a proposed plan of operation and any amendments thereto which are necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The proposed plan of operation and any amendments thereto shall become effective upon approval in writing from the department. If the association fails to submit a plan of operation within 90 days after the appointment of the board, the department must implement an interim plan of operation which will be effective until the board submits a plan of operation acceptable to the department. The plan of operation is subject to periodic review as required by the department. All self-insurer's funds shall comply with he approved plan of operation. The plan of operation must, in addition to the requirements enumerated elsewhere in this part:

(1) Establish procedures for handling the assets of the association.

(2) Establish regular places and times for meetings of the board of directors.

(3) Establish procedures for keeping records of all financial transactions of the association, its agents, and the board of directors.

(4) Establish procedures for levying and collecting assessments.

(5) Establish criteria and procedures under which funds may be advanced by the association to a delinquent fund in rehabilitation, to assist in its rehabilitation, and subject to repayment by the delinquent fund.

(6) Establish additional provisions necessary or proper for executing the powers and duties of the association.

631.95 Prevention of insolvencies.—To aid in the detection and prevention of self-insurance fund insolvencies or impairments:

(1) The board of directors may make reports and recommendations to the department upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member self-insurance fund.

(2) The board of directors shall notify the department of any information indicating that a member self-insurance fund may be insolvent or financially impaired.

(3) The board of directors may make recommendations to the department for the detection and prevention of self-insurance fund insolvencies.

631.955 Records of the association.—Except as otherwise provided by law, all records and meetings of the association or its representative in connection with the carrying out of its powers and duties under this section shall be subject to the provisions of ss. 119.07(1) and 286.011.

631.96 Immunity.—There is no liability on the part of, and a cause of action may not arise against, the association, its agents or employees, or members of its board of directors, or the department or its agents or employees, for any action taken by them in the performance of their powers and duties under this section, unless such action was in bad faith or undertaken with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

631.965 Prohibited advertisement of solicitation.—A person may not make, publish, disseminate, advertise, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any print, television, or broadcast media, or in any circular, letter, pamphlet, or publication or any kind, a statement or announcement that uses the existence of the Florida Self-Insurer's Fund Guaranty Association to induce an employer to purchase membership in or insurance from a self-insurance fund.

631.97 Department powers.—The department shall examine the books and records, and supervise the operations, of the association. By March 1 of each year, the board of directors shall cause a report to be filed with the department regarding the immediately preceding calendar year, detailing operations of the association over the prior year, and providing such financial and other informations as the department by rule requires.

631.975 Liability of members of an impaired self-insurance fund for unpaid claims.—This part may not be construed to reduce the liability of a member of an impaired self-insurer's fund for the member's liability under s. 624.4621 or s. 624.476.

631.98 Effect of paid claims.—

(1) Any person who recovers under this part is considered to have assigned his rights under the policy to the association to the extent of his recovery from the association. Every insured or claimant seeking the protection of this part shall cooperate with the association to the same extent as the insured or claimant would have been required to cooperate with the insolvent self-insurance fund. The association has no cause of action against the insured of the insolvent self-insurance fund for any sums it has paid out except such causes of action as the insolvent self-insurance fund would have had if the sums had been paid by the insolvent self-insurance fund.

(2) The receiver, liquidator, or statutory successor of an insolvent insurer is bound by settlements of covered claims by the association. The court having jurisdiction shall grant such claims priority equal to that to which the claimant would have been entitled, in the absence of this part, against the assets of the insolvent insurer. The expenses of the association or similar organization in handling claims must be accorded the same priority as the liquidator's expenses.

(3) The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association, which shall preserve the rights of the association against the assets of the insolvent self-insurance fund.

(4) Any release of the association and its insured must clearly state whether or not any claim filed with the receiver in excess of the liability of the association under s. 631.57 is waived.

631.985 Stay of proceedings; reopening of default judgments.—All proceedings in which the insolvent self-insurance fund is a party or is obligated to defend a party in any court or before any quasi-judicial body or administrative board in this state must be stayed for 6 months, or such additional period from the date the insolvency is adjudicated, by a court of competent jurisdiction to allow proper defense by the association of all pending causes of action as to any covered claims. The stay may be extended for a period of time greater than 6 months upon proper application to a court of competent jurisdiction. The association, either on its own behalf or on behalf of the insured, may apply to have any judgment, order, decision, verdict, or finding based on the default of the insolvent self-insurance fund or its failure to defend an insured set aside by the same court or administrator that made the judgment, order, decision, verdict, or finding and may defend against the claim on the merits. If the association so requests, the stay of proceedings may be shortened or waived.

631.99 Attorney's fees.—The provisions of s. 627.428 providing for an attorney's fee are inapplicable to any claim presented to the association under this part, unless the association denies, by affirmative action other than delay, a covered claim or a portion thereof.

631.995 Assumption of liability.—Notwithstanding s. 631.935, the association shall assume the liability for the payment of the workers' compensation indemnity and medical benefits that are due to claimants covered by the Certified Pulpwood Dealers Self-Insurers Fund. The association shall assess the former members of the Certified Pulpwood Dealers pursuant to the provisions of this part.

Section 102. Part XXII of chapter 627, Florida Statutes, consisting of sections 627.990, 627.991, and 627.992, Florida Statutes, is created to read:

PART XXII
WORKERS' COMPENSATION INSURANCE
PURCHASING ALLIANCE

627.990 Workers' Compensation Insurance Purchasing Alliance.—The Workers' Compensation Insurance Purchasing Alliance is created within the Department of Insurance to act as a broker between small employers, as defined in s. 627.6699, and insurance underwriters who specialize in workers' compensation. The alliance shall be operated as a state-chartered non-profit organization pursuant to chapter 617.

627.991 Powers, duties, and responsibilities.—The alliance has the following powers, duties, and responsibilities:

(1) Establish the conditions of alliance membership.

(2) Provide to alliance members clear, uniform information on each workers' compensation policy offered by workers' compensation underwriters.

(3) Request proposals for standard workers' compensation policies from workers' compensation underwriters. Such requests for proposals may be in a format specified by the alliance and may request any information necessary to provide alliance members with valid comparisons of the costs of policies available.

(4) Develop a marketing plan to publicize the alliance to potential members and develop a plan to inform the public about the alliance and its services.

(5) Establish administrative and accounting procedures for the operation of the alliance and member services and prepare an alliance budget which shall be funded from annual appropriations from the Workers' Compensation Administrative Trust Fund pursuant to chapter 216.

627.992 Alliance board.—The board of the alliance shall be composed of seven members who must be representative of alliance members and workers' compensation insurance underwriters. Board members shall be appointed by January 1, 1994, by the Insurance Commissioner, the President of the Senate, and the Speaker of the House of Representatives, as follows:

(1) Two representatives of small employers, including a member of the construction industry and one member of the workers' compensation insurance industry who is an individual self-insured, appointed by the Insurance Commissioner.

(2) One representative of small employers and one member of the workers' compensation insurance industry representing a group self-insurance fund or an assessable mutual insurance company offering workers' compensation policies, appointed by the President of the Senate.

(3) One representative of small employers and one member of the workers' compensation insurance industry representing a commercial carrier offering workers' compensation policies, appointed by the Speaker of the House of Representatives.

(4) Each appointment is for a 2-year term.

Section 103. The First District Court of Appeal shall use the state video teleconferencing network established by the Department of Management Services to facilitate access to courts for purposes of workers' compensation actions.

Section 104. Paragraph (a) of subsection (1) of section 772.102, Florida Statutes, is amended to read:

772.102 Definitions.—As used in this chapter, the term:

(1) "Criminal activity" means to commit, to attempt to commit, to conspire to commit, or to solicit, coerce, or intimidate another person to commit:

(a) Any crime which is chargeable by indictment or information under the following provisions:

1. Section 210.18, relating to evasion of payment of cigarette taxes.

2. Section 409.325, relating to public assistance fraud.

3. Sections 440.105 or 440.106, relating to workers' compensation.

4.~~3.~~ Chapter 517, relating to securities transactions.

5.~~4.~~ Section 550.235, s. 550.3551, or s. 550.3605, relating to dogracing and horseracing.

6.~~5.~~ Chapter 550, relating to jai alai frontons.

7.~~6.~~ Chapter 552, relating to the manufacture, distribution, and use of explosives.

8.~~7.~~ Chapter 562, relating to beverage law enforcement.

9.~~8.~~ Chapter 687, relating to interest and usurious practices.

10.~~9.~~ Section 721.08, s. 721.09, or s. 721.13, relating to real estate time-share plans.

11.~~10.~~ Chapter 782, relating to homicide.

12.~~11.~~ Chapter 784, relating to assault and battery.

13.~~12.~~ Chapter 787, relating to kidnapping.

14.~~13.~~ Chapter 790, relating to weapons and firearms.

15.~~14.~~ Section 796.01, s. 796.03, s. 796.04, s. 796.05, or s. 796.07, relating to prostitution.

16.~~15.~~ Chapter 806, relating to arson.

17.~~16.~~ Chapter 812, relating to theft, robbery, and related crimes.

18.~~17.~~ Chapter 815, relating to computer-related crimes.

19.~~18.~~ Chapter 817, relating to fraudulent practices, false pretenses, fraud generally, and credit card crimes.

20.~~19.~~ Section 827.071, relating to commercial sexual exploitation of children.

21.~~20.~~ Chapter 831, relating to forgery and counterfeiting.

22.~~21.~~ Chapter 832, relating to issuance of worthless checks and drafts.

23.~~22.~~ Section 836.05, relating to extortion.

24.~~23.~~ Chapter 837, relating to perjury.

25.~~24.~~ Chapter 838, relating to bribery and misuse of public office.

26.~~25.~~ Chapter 843, relating to obstruction of justice.

27.~~26.~~ Section 847.011, s. 847.012, s. 847.013, s. 847.06, or s. 847.07, relating to obscene literature and profanity.

28.~~27.~~ Section 849.09, s. 849.14, s. 849.15, s. 849.23, or s. 849.25, relating to gambling.

29 ~~28.~~ Chapter 893, relating to drug abuse prevention and control.

30.~~29.~~ Section 914.22 or s. 914.23, relating to witnesses, victims, or informants.

31.~~30.~~ Section 918.12 or s. 918.13, relating to tampering with jurors and evidence.

Section 105. Subsection (4) is added to section 27.34, Florida Statutes, to read:

27.34 Salaries and other related costs of state attorneys' offices; limitations.—

(4) Notwithstanding s. 27.25, the Insurance Commissioner may contract with the state attorney of any judicial circuit of the state or the Justice Administration Commission for the prosecution of criminal violations of the Workers' Compensation Law and related crimes and may contribute funds for such purposes. Such contracts may provide for the training, salary, and expenses of one or more assistant state attorneys used in the prosecution of such crimes.

Section 106. Paragraph (a) of subsection (1) of section 895.02, Florida Statutes, is amended to read:

895.02 Definitions.—As used in ss. 895.01-895.08, the term:

(1) "Racketeering activity" means to commit, to attempt to commit, to conspire to commit, or to solicit, coerce, or intimidate another person to commit:

(a) Any crime which is chargeable by indictment or information under the following provisions of the Florida Statutes:

1. Section 210.18, relating to evasion of payment of cigarette taxes.

2. Section 403.727(3)(b), relating to environmental control.

3. Section 409.325, relating to public assistance fraud.

4. Section 409.920, relating to Medicaid provider fraud.

5. Sections 440.105 or 440.106, relating to workers' compensation.

6.~~5.~~ Chapter 517, relating to sale of securities and investor protection.

7.~~6.~~ Section 550.235, s. 550.3551, or s. 550.3605, relating to dogracing and horseracing.

8.~~7.~~ Chapter 550, relating to jai alai frontons.

9.~~8.~~ Chapter 552, relating to the manufacture, distribution, and use of explosives.

10.~~9.~~ Chapter 562, relating to beverage law enforcement.

11.~~10.~~ Section 655.50, relating to reports of currency transactions, when such violation is punishable as a felony.

12.~~11.~~ Chapter 687, relating to interest and usurious practices.

13.~~12.~~ Section 721.08, s. 721.09, or s. 721.13, relating to real estate time-share plans.

14.~~13.~~ Chapter 782, relating to homicide.

15.~~14.~~ Chapter 784, relating to assault and battery.

16.~~15.~~ Chapter 787, relating to kidnapping.

17.~~16.~~ Chapter 790, relating to weapons and firearms.

18.~~17.~~ Section 796.01, s. 796.03, s. 796.04, s. 796.05, or s. 796.07, relating to prostitution.

19.~~18.~~ Chapter 806, relating to arson.

20.~~19.~~ Chapter 812, relating to theft, robbery, and related crimes.

21.~~20.~~ Chapter 815, relating to computer-related crimes.

22.~~21.~~ Chapter 817, relating to fraudulent practices, false pretenses, fraud generally, and credit card crimes.

23.~~22.~~ Section 827.071, relating to commercial sexual exploitation of children.

24.~~23.~~ Chapter 831, relating to forgery and counterfeiting.

25.~~24.~~ Chapter 832, relating to issuance of worthless checks and drafts.

26.~~25.~~ Section 836.05, relating to extortion.

27.~~26.~~ Chapter 837, relating to perjury.

28.~~27.~~ Chapter 838, relating to bribery and misuse of public office.

29.~~28.~~ Chapter 843, relating to obstruction of justice.

30.~~29.~~ Section 847.011, s. 847.012, s. 847.013, s. 847.06, or s. 847.07, relating to obscene literature and profanity.

31.~~30.~~ Section 849.09, s. 849.14, s. 849.15, s. 849.23, or s. 849.25, relating to gambling.

32.~~31.~~ Chapter 893, relating to drug abuse prevention and control.

33.~~32.~~ Chapter 896, relating to offenses related to financial transactions.

34.~~33.~~ Sections 914.22 and 914.23, relating to tampering with a witness, victim, or informant, and retaliation against a witness, victim, or informant.

35.~~34.~~ Sections 918.12 and 918.13, relating to tampering with jurors and evidence.

Section 107. Subsection (6) is added to section 628.161, Florida Statutes, to read:

628.161 Initial qualifications; mutuals.—

(6) A self-insured fund organized under s. 440.57 and holding a certificate of authority as a self-insurer's fund on December 31, 1993, may become a mutual insurer under part I of chapter 628, pursuant to a plan of reorganization approved by the department. A plan of reorganization must be approved by the department if:

(a) The self-insurer's fund has sufficient financial resources to satisfy all of its obligations under all policies and coverages afforded by the fund before the reorganization and has sufficient financial resources to satisfy all of its other liabilities;

(b) The self-insurer's fund has minimum of $5 million of surplus;

(c) The self-insurer's fund submits a plan that demonstrates its ability to satisfy the requirements of chapter 628 pertaining to mutual insurers on an ongoing basis; and

(d) The mutual insurer resulting from the reorganization of the self-insurer's fund retains ownership of all of the assets of the self-insurer's fund, retains all of the liabilities of the self-insurer's fund, and agrees to hold all fund members harmless from any assessment for liabilities of the self-insurer's fund before the date of reorganization.

Upon approval of the plan by the department, any contingent liability of the members or former members of the self-insurer's fund for assessment for losses of the self-insurer's fund is considered satisfied, and all liability for any such contingent assessment is extinguished as of the date the self-insurer's fund becomes an authorized mutual insurer and retains all of the assets and liabilities of the self-insurer's fund.

Section 108. Procedure for resolving maximum medical improvement or permanent impairment disputes.—

(1) Notwithstanding the limitations on carrier independent medical examinations in section 440.13, Florida Statutes, an employee or carrier who wishes to obtain an opinion other than the opinion of the treating physician or a division advisor on the issue of permanent impairment may obtain one independent medical examination, except that the employee or carrier who selects the treating physician is not entitled to obtain an alternate opinion on the issue of permanent impairment, unless the parties otherwise agree. This section and section 440.13(2), Florida Statutes, do not permit an employee or a carrier to obtain an additional medical opinion on the issue of permanent impairment by requesting an alternate treating physician pursuant to section 440.13, Florida Statutes.

(2) A dispute as to the date of maximum medical improvement or degree of permanent impairment which is not subject to dispute resolution according to rules promulgated pursuant to section 440.134, Florida Statutes, shall be resolved according to the procedure set out in this section.

(3) Disputes shall be resolved under this section when:

(a) A carrier that is entitled to obtain a determination of an employee's date of maximum medical improvement or permanent impairment has done so;

(b) The independent medical examiner's opinion on the date of the employee's maximum medical improvement and degree or permanent impairment differs from the opinion of the employee's treating physician on either of those issues, or from the opinion of the expert medical advisor appointed by the division on the degree of permanent impairment; or

(c) The carrier denies any portion of an employee's claim petition for benefits due to disputed maximum medical improvement or permanent impairment issues.

(4) Only opinions of the employee's treating physician, a division medical advisor, or an independent medical examiner are admissible in proceedings before a judge of compensation claims to resolve maximum medical improvement or impairment disputes.

(5) The judge of compensation claims shall first resolve any dispute concerning the date on which the employee reached maximum medical improvement. The judge shall then determine the degree of the employee's permanent impairment, which shall be either the highest or lowest estimate of permanent impairment which is in evidence before the judge of compensation claims.

Section 109. Sections 440.37, 440.43, 440.48, and 440.56, Florida Statutes, are repealed.

Section 110. The following are hereby appropriated for fiscal year 1993-1994 from the Workers' Compensation Administration Trust Fund:

(1) To the Department of Insurance, 20 FTE positions and $756,953 in salaries, benefits, expenses, and operating capital outlay.

(2) To the Department of Labor and Employment Security, 149 FTE positions and $6,014,956 in salaries, benefits, expenses, and operating capital outlay.

(3) To the Agency for Health Care Administration, 7 FTE positions and $436,663 in salaries and benefits, expenses, and operating capital outlay.

Section 111. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared severable.

Section 112. This act shall take effect January 1, 1994, except as otherwise provided in this act.

And the title is amended as follows:

In title, strike everything before the enacting clause and insert: A bill to be entitled An act relating to workers' compensation; amending s. 440.015, F.S.; revising the legislative intent; amending s. 440.02, F.S.; amending definitions; amending s. 440.05, F.S.; providing for election and revocation of election of an exemption; amending s. 440.055, F.S.; requiring notice of noncoverage at worksites under certain circumstances; amending s. 440.09, F.S.; providing for extent of workers' compensation coverage; requiring that injuries be established by medical evidence; clarifying compensation for subsequent injuries related to preexisting conditions; providing presumptions that intoxication or drug use caused certain injuries; amending s. 440.092, F.S.; excluding from certain travel benefits certain travel to and from work; amending s. 440.10, F.S.; deleting a requirement that contractors or subcontractors show proof of workers' compensation coverage before receiving a building permit; providing a penalty for employers who fail to secure required compensation; deleting a penalty; providing circumstances under which a person is presumed to be an independent contractor; amending s. 440.101, F.S.; revising legislative intent with regard to drug-free workplaces; amending s. 440.102, F.S.; revising provisions related to the drug-free workplace program; revising definitions; providing certain employers are ineligible for certain discounts; providing additional requirements for followup testing; providing for payment of medical treatments; providing a penalty; providing that certain screening and testing need not comply with certain rules; providing additional employer protection provisions; revising provisions relating to confidentiality of drug-test results; adding provisions relating to public employees in safety-sensitive or special-risk positions; prohibiting an employer from refusing to deny certain benefits; creating s. 440.103, F.S.; requiring proof of secured compensation as a condition to receiving a building permit; creating s. 440.104, F.S.; providing for actions for damages by losers of competitive biddings against certain winners of such biddings; specifying recovery of damages; providing for attorney's fees; providing exceptions; providing for joinder in such actions; barring certain actions under certain circumstances; creating s. 440.105, F.S.; requiring reports of suspected fraudulent acts to the Bureau of Workers' Compensation Fraud; limiting liability; prohibiting certain activities; providing penalties; creating s. 440.1051, F.S.; requiring that the Bureau of Workers' Compensation Insurance Fraud of the Division of Insurance Fraud of the Department of Insurance establish a toll-free telephone number to receive reports of workers' compensation fraud; providing civil immunity for persons who make such a report; providing criminal penalties; creating s. 440.106, F.S.; providing for civil remedies, stop-work orders, and liens under certain circumstances; authorizing the division to bring certain actions; creating s. 440.107, F.S.; providing powers of the division to enforce certain employer compliance; authorizing the division to bring certain actions in circuit court; providing penalties; providing that certain judgments constitute liens under certain circumstances; providing for application of the Administrative Procedures Act; providing for disposition of penalties; authorizing law enforcement agencies to assist the division; amending s. 440.11, F.S., expanding provisions with respect to exclusiveness of liability; amending s. 440.13, F.S.; providing definitions; requiring employers to provide certain medical services and supplies; providing for eligibility of providers; requiring notice of treatment to carriers; providing for independent medical examinations; providing for utilization review; providing for resolving utilization and reimbursement disputes; providing for certification of expert medical advisors; providing for witness fees; providing for audits by the division; providing for creation of a three-member panel; providing duties; providing for managed care; providing for a community health purchasing alliance; providing for removal of physicians from lists of those authorized to render medical care under certain conditions; providing for payment of medical fees and employee copayment; providing practice parameters for outpatient services; creating s. 440.134, F.S.; authorizing an insurer to offer or use a workers' compensation managed care arrangement; providing for the expiration of such authorization; providing for renewal of such authorization; prohibiting an insurer from entering into a contract in which the insurer pays a fixed amount to a health care provider in exchange for the future rendering of medical services for covered expenses; specifying requirements for the managed care plan of operations; providing for revocation or suspension of such authorization; providing for administrative fines; amending s. 440.135, F.S.; amending provisions relating to pilot programs for medical and remedial care; allowing such programs to combine other health insurance and workers' compensation insurance into 24-hour health insurance coverage; amending s. 440.15, F.S.; revising provisions that provide for compensation for disability; providing for repayment of indemnity benefits for which there was no entitlement; amending s. 440.16, F.S.; increasing required amount for funeral expenses; amending s. 440.185, F.S.; revising certain provisions relating to notice of injury or death; deleting a requirement that the division forward certain files to a judge of compensation claims; amending s. 440.19, F.S.; revising provisions relating to filing petitions for benefits; specifying limitations; creating s. 440.191, F.S.; creating the Employee Assistance and Ombudsman Office; providing procedures, duties, and responsibilities of the office; creating s. 440.192, F.S.; providing procedures for resolving benefit disputes; amending s. 440.20, F.S.; revising provisions specifying the timely payment of compensation benefits; providing penalties; requiring the Division of Workers' Compensation of the Department of Labor and Employment Security to monitor the payment of compensation benefits; revising provisions relating to lump-sum payments as settlement to a claim; amending s. 440.207, F.S.; amending requirements for workers' compensation system guide; amending s. 440.21, F.S.; deleting a penalty related to invalid employer-employee agreements; creating s. 440.211, F.S.; authorizing certain collective bargaining agreements; providing criteria; amending s. 440.25, F.S.; revising provisions requiring a pretrial hearing and a final hearing under certain circumstances; providing for mediation; revising procedures for resolution of claims and requests; providing for uniform local rules for workers' compensation; amending s. 440.28, F.S.; providing for modification of orders; amending s. 440.29, F.S.; requiring receipt into evidence by a judge of compensation claims of certain medical reports; amending s. 440.32, F.S.; providing for assessing costs and attorney's fees against an attorney who frivolously brings or maintains proceedings; requiring that pleadings, motions, and other papers of a party represented by an attorney be signed by an attorney of record; providing for the effect of the attorney's signature; providing sanctions for violations; amending s. 440.34, F.S.; revising provisions for attorney's fees; prohibiting carriers from recouping attorney's fees by specified means; deleting a penalty; creating s. 440.345, F.S.; requiring reporting of attorney's fees to the division; amending s. 440.38, F.S.; revising provisions requiring security for payments of compensation; providing additional options for employer coverage; revising provisions for indemnity benefits; requiring specified life insurance benefits; requiring carriers to maintain claims adjusters in this state; deleting a penalty for failure to comply; amending s. 440.381, F.S.; revising a penalty for understating payroll or misrepresenting employee duties; creating s. 440.4416, F.S.; creating a Workers' Compensation Oversight Board; providing for duties, membership, employees, meetings, and per diem and travel expenses; amending s. 440.442, F.S.; providing a code of judicial conduct for judges of compensation claims; amending s. 440.45, F.S.; providing for minority representation on the statewide nominating commission; amending ss. 440.56, 442.115, F.S.; requiring a client of a help supply services company to include certain employees of that company in the client's employee safety training program; amending s. 440.49, F.S.; revising provisions relating to reemployment of injured workers and rehabilitation; focusing on limiting the liability for subsequent injury through the Special Disability Trust Fund; providing definitions; providing legislative intent; amending definitions; providing a deductible; providing for temporary compensation and medical benefits, and allowing partial reimbursement to the employer from the trust fund; providing for the effect that the employer's knowledge of a preexisting condition has upon his reimbursement; revising the list of compensable injuries; revising the criteria by which claims for reimbursement are accepted; providing for assessments to maintain the trust fund;

providing for a preferred workers' program for permanently impaired workers who are unable to return to work; providing for the applicable law for purposes of determining entitlement to reimbursement; creating s. 440.491, F.S.; providing for reemployment status reviews and reports; providing for reemployment assessments; providing for medical care coordination and reemployment services; providing for training and education; specifying provider qualifications; requiring the division to monitor selection of providers, provision of services, and carrier practices; restricting adjudications of permanent and total disability; amending s. 440.50, F.S.; providing for the funding of the Bureau of Workers' Compensation Fraud within the Department of Insurance from the Workers' Compensation Administration Trust Fund; amending ss. 440.51, 440.515, F.S.; providing for the Department of Insurance to assume certain administrative functions, including auditing self-insurers and maintaining confidential reports; amending s. 440.572, F.S.; correcting a cross-reference; amending s. 440.59, F.S.; requiring the Department of Labor and Employment Security to make an annual report on the administration of ch. 440, F.S., to specified officials; requiring the chief judge to prepare an annual report; creating s. 440.593, F.S.; providing for the division to establish an electronic reporting system; providing for the division to periodically examine each carrier; creating the "Florida Occupational Safety and Health Act"; creating s. 442.001, F.S.; providing a short title; creating s. 442.002, F.S.; providing definitions; creating s. 442.003, F.S.; providing legislative intent; transferring, amending, and renumbering s. 440.09(5), F.S., as s. 442.004, F.S.; providing for rulemaking governing safety inspections and consultations; transferring, amending, and renumbering s. 440.152, F.S., as s. 442.005, F.S.; providing for the division to make a continuous study of occupational diseases; repealing s. 440.46(2), (3), F.S., and transferring, amending, and renumbering s. 440.46(1), F.S., as s. 442.006, F.S.; authorizing the division to enter and inspect places of employment for purposes of compliance; providing a penalty for refusing to allow an inspection; creating s. 442.007, F.S.; providing employers' responsibilities for employees' safety; creating s. 442.008, F.S.; providing the division with the authority to investigate safety at places of employment and to prescribe means of preventing accidents and occupational diseases; creating s. 442.009, F.S.; providing the division and its representatives with a right of entry to make inspections; creating s. 442.0105, F.S.; requiring employers whose employees have a high frequency or severity of work-related injuries to implement a safety and health program, for division approval; providing for rulemaking; creating s. 442.011, F.S.; requiring carriers to provide safety consultations to their policyholders on request; requiring a report to the division; requiring the division to set out criteria for, and to approve, safety programs; creating s. 442.012, F.S.; requiring employers to establish workplace safety committees; requiring the division to adopt certain rules relating to committee membership and duties and to employer recordkeeping; requiring employees to receive their regular wages while engaged in committee activities; creating s. 442.013, F.S.; providing for employer penalties; creating s. 442.014, F.S.; providing for cooperation between the division and the Federal Government for specified purposes; creating s. 442.015, F.S.; providing penalties for certain employers who fail to implement a safety and health program; creating s. 442.016, F.S.; providing for paying the expenses of administering ch. 442, F.S.; creating s. 442.017, F.S.; providing a criminal penalty for an employer or owner that refuses to allow entry and inspections by division representatives; creating s. 442.018, F.S.; providing employees' rights and responsibilities; creating s. 442.019, F.S.; providing for compliance; creating s. 442.020, F.S.; prohibiting making false statements to carriers; providing a penalty; creating s. 442.021, F.S.; providing civil penalties for carriers under certain circumstances; creating s. 442.022, F.S.; providing preemptive authority to the division to adopt certain rules; creating s. 442.023, F.S.; prohibiting certain acts; providing penalties; providing a statute of limitations; amending s. 489.115, F.S.; prescribing for contractors' continuing education curricula to contain information on workers' compensation and workplace safety; transferring the self-insurance regulatory functions of the Department of Labor and Employment Security to the Department of Insurance; preserving current administrative rules; providing that the validity of current legal actions is not affected by the transfer; authorizing group self-insurers who have certificates of authority under current law to receive certificates of authority under this act; creating s. 624.461, F.S.; defining the term "self-insurance fund"; amending s. 624.462, F.S.; prohibiting a commercial self-insurance fund from participating in the Florida Self-Insurance Fund Guaranty Association; transferring, amending, and renumbering s. 440.57, F.S., as s. 624.4621, F.S.; providing for group self-insurance funds; transferring administrative responsibilities from the division to the Department of Insurance; requiring participation in the Florida Self-Insurance Fund Guaranty Association; transferring, amending, and renumbering s. 440.575, F.S., as s. 624.4622, F.S.; providing for local government self-insurance funds; conforming cross-references; transferring, amending, and renumbering s. 440.571, F.S., as s. 624.46225, F.S.; conforming a cross-reference; amending ss. 624.463, 624.474, 624.476, 624.480, 624.482, 624.484, 624.486, 624.488, F.S.; replacing the term "commercial self-insurance fund" with the term "self-insurance fund" in provisions relating to the conversion of such a fund into a domestic mutual insurer, relating to such a fund's payment of dividends or refunds to its members, relating to allowing assessments to be made upon such funds for deficiencies, relating to impaired funds, relating to filing, approval, and disapproval of forms, relating to the making and use of rates, relating to the registration of the funds, relating to filing, approval, and disapproval of forms, relating to the registration of the fund's agent, relating to periodic examinations of the fund, and relating to the applicability of related laws to the funds; creating s. 624.4741, F.S.; providing venue in assessment actions brought by a self-insurance fund; transferring, amending, and renumbering s. 440.58, F.S., as s. 624.483, F.S.; reassigning, from the division to the Department of Insurance, certain duties relating to self-insurers' payments of delinquent premiums and assessments; transferring, amending, and renumbering s. 440.5705, F.S., as s. 624.487, F.S.; conforming cross-references; reassigning, from the Department of Labor and Employment Security to the Department of Insurance, duties relating to enforcing specified insurance provisions and rulemaking; amending s. 627.041, F.S.; amending the definition of the term "insurer" to include group self-insurance funds; amending s. 627.0915, F.S.; requiring the Department of Insurance to provide for giving consideration in setting rates to certain employers who implement certain safety programs; providing for premium credits for employers that utilize managed care arrangements; amending s. 627.0916, F.S.; providing rate classifications for certain agricultural horse farms; creating s. 627.212, F.S.; providing for carriers voluntarily to impose a workplace safety program surcharge on certain policyholders or fund members; providing for rulemaking; amending s. 627.311, F.S.; providing for joint underwriters and joint reinsurers; providing purposes and requirements; providing for supervision of the joint underwriting plan by a board of governors; providing board members' qualifications and terms of office; requiring a plan of operation and prescribing contents of the plan; providing for funding the plan; providing qualifications necessary for insurance under the plan; requiring an independent actuarial certification; providing procedures in case of deficits; allowing the plan to retain excess premiums and assessments; providing liability for losses arising after a specified date; providing that plan losses are not to come from insurers; providing that the joint underwriting plan is not a state agency, except as specified; providing alternatives for paying premium taxes; amending s. 627.4133, F.S.; providing that workers' compensation and employer's liability insurance is subject to certain notice provisions; amending s. 628.6013, F.S.; revising requirements for conversion of a self-insurance fund to an assessable mutual insurer; creating part V of ch. 631, F.S., the "Florida Self-Insurance Fund Guaranty Association Act," consisting of ss. 631.90, 631.905, 631.91, 631.915, 631.92, 631.925, 631.93, 631.935, 631.94, 631.945, 631.95, 631.955, 631.96, 631.965, 631.97, 631.975, 631.98, 631.985, 631.99, 631.995, F.S.; providing a title; providing purposes; providing for liberal construction; providing definitions; creating the association and fund; providing for an organizational meeting and a board of directors; providing powers and duties of the association; providing for assessments; requiring a plan of operation to be submitted to the department; specifying plan contents; providing for the prevention of insolvencies; providing for open association records and open meetings; providing immunity to the association and to the Department of Insurance; prohibiting certain advertisements or solicitations; providing powers of the Department of Insurance; providing liability of members of an impaired self-insurance fund for unpaid claims; providing for certain effects of paid claims; providing for a stay of proceedings and for reopening of default judgments; prohibiting an award of attorney's fees, except as specified; providing for assumption of liability relating to claimants covered by the Certified Pulpwood Dealers Self-Insurers Fund; requiring the district court of appeal to use the state video teleconferencing network to facilitate access to courts; creating part XXII of ch. 627, F.S., the "Workers' Compensation Insurance Purchasing Alliance"; amending ss. 772.102, 895.02, F.S., to include violations of ss. 440.105, 440.106, F.S., as a criminal activity; amending s. 27.34, F.S.; authorizing the Insurance Commissioner to contract with state attorneys to prosecute certain criminal violations and to contribute funds to pay salaries and expenses of assistant state attorneys; amending s. 628.161, F.S.; providing that certain self-insurer's funds may become mutual insurers, by meeting specified requirements and submitting a plan of reorganization to the Department of Insurance for its approval; providing that certain contingent liability of the self-insurer's

fund members or former members is extinguished, as specified; prescribing procedures for resolving maximum medical improvement or permanent impairment disputes; repealing ss. 440.37, 440.43, 440.48, 440.56, F.S., relating to misrepresentation and fraudulent activity for the purpose of obtaining or denying workers' compensation benefits, relating to a penalty for failure to secure payment of compensation, relating to an annual report of the administration of ch. 440, F.S., and relating to workplace safety rules and provisions; providing appropriations; providing for severability; providing an effective date.

WHEREAS, the Legislature finds that there is a financial crisis in the workers' compensation insurance industry, causing severe economic problems for Florida's business community and adversely impacting Florida's ability to attract new business development to the state, and

WHEREAS, over the past several years, businesses have experienced dramatic increases in the cost of workers' compensation insurance coverage despite recent legislative reforms, and

WHEREAS, it is the sense of the Legislature that if the present crisis is not abated, many businesses will cease operating which, in the current recessionary climate, could cripple the employment market in the state, and

WHEREAS, workers' compensation health care costs are escalating at a far greater rate than the present rate of inflation, and

WHEREAS, Florida employers are currently paying the second highest overall rates for workers' compensation coverage in the country, and

WHEREAS, despite initial system cost reductions occurring as a result of 1990 reforms to the compensation system, current system costs exceed cost levels prior to the 1990 legislation and workers' compensation insurance premium rates are 6 percent above the prereform level of 1990, and

WHEREAS, the Legislature finds that the current wage loss formula for permanent partial disability benefits causes a disincentive to return to work for those employees able to return to the same or similar employment, and

WHEREAS, the Legislature finds that the wage loss formula is partly to blame for an increase in eligibility for permanent partial disability benefits and for an increase in total payments for permanent partial disabilities, and

WHEREAS, permanent total disability benefits are awarded in Florida at levels more than five times the national average, and

WHEREAS, high costs for workers' compensation coverage inhibit economic growth and restrict funds available to provide employment and raise workers' wages, and

WHEREAS, an overriding public purpose is the necessity to lower compensation rates while retaining the ability of employers to purchase compensation coverage, and

WHEREAS, the Legislature finds that additional changes to the compensation system are necessary to lower rates while discouraging fraud and promoting workplace safety that will promote economic growth and stability for employers and employees, and

WHEREAS, the Legislature finds that there is an overpowering public necessity for reform of the current workers' compensation system in order to reduce the cost of workers' compensation insurance while protecting the rights of employees to benefits for on-the-job injuries, and

WHEREAS, the Legislature finds that the reforms contained in this act are the only alternative available that will meet the public necessity of maintaining a workers' compensation system that provides adequate coverage to injured employees at a cost that is affordable to employers, and

WHEREAS, the magnitude of these compelling economic problems demands immediate, dramatic, and comprehensive legislative action, NOW, THEREFORE,

SENATOR DYER PRESIDING

THE PRESIDENT PRESIDING

The Conference Committee Report was read and on motion by Senator Childers was adopted. **SB 12-C** passed as recommended and the action of the Senate was certified to the House. The vote on passage was:

Yeas—39 Nays—None

MOTIONS RELATING TO COMMITTEE REFERENCE

On motions by Senator Kirkpatrick, by two-thirds vote **Senate Bills 56-C, 58-C, 60-C, 62-C** and **64-C** were withdrawn from the Committee on Commerce and by two-thirds vote placed on the Special Order Calendar.

SPECIAL ORDER

On motions by Senator Childers, by two-thirds vote—

SB 56-C—A bill to be entitled An act relating to public records; providing an exemption from public records requirements for an injured employee's medical records and reports and identifying information in medical bills provided to the Division of Workers' Compensation; providing for future review and repeal; providing a finding of public necessity; providing a contingent effective date.

—was read the second time by title and by two-thirds vote read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—39 Nays—None

On motions by Senator Childers, by two-thirds vote—

SB 58-C—A bill to be entitled An act relating to public records; providing an exemption from public records requirements for information held by the Department of Labor and Employment Security identifying an employee who has exercised any right under the Florida Occupational Safety and Health Act; providing for future review and repeal; providing a finding of public necessity; providing a contingent effective date.

—was read the second time by title and by two-thirds vote read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—39 Nays—None

On motions by Senator Childers, by two-thirds vote—

SB 60-C—A bill to be entitled An act relating to public records and meetings; providing exemptions from public records requirements for certain reports and recommendations made by the Board of Directors of the Florida Self-Insurance Fund Guaranty Association to the Department of Insurance and for certain documents relating to negotiations between the association and a self-insurance fund; providing an exemption from public meetings requirements for such negotiations; providing for future review and repeal; providing findings of public necessity; providing a contingent effective date.

—was read the second time by title and by two-thirds vote read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—39 Nays—None

On motions by Senator Childers, by two-thirds vote—

SB 62-C—A bill to be entitled An act relating to public records; providing an exemption from public records requirements for certain investigatory records of the Department of Insurance relating to workers' compensation, and related examination records; providing for future review and repeal; providing a finding of public necessity; providing a contingent effective date.

—was read the second time by title and by two-thirds vote read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—39 Nays—None

On motions by Senator Childers, by two-thirds vote—

SB 64-C—A bill to be entitled An act relating to trust funds; creating the Florida Group Self-Insurance Fund Account, to be managed by the Florida Group Self-Insurance Fund Guaranty Association; providing a contingent effective date.

—was read the second time by title and by two-thirds vote read the third time by title, passed by the required constitutional three-fifths vote of the membership and certified to the House. The vote on passage was:

Yeas—39 Nays—None

RECESS

On motion by Senator Kirkpatrick, the Senate recessed at 10:33 a.m. to reconvene at 11:00 a.m.

CALL TO ORDER

The Senate was called to order by the President at 11:12 a.m. A quorum present—36:

Mr. President	Dantzler	Harden	McKay
Bankhead	Diaz-Balart	Hargrett	Meadows
Boczar	Dudley	Holzendorf	Myers
Brown-Waite	Dyer	Jenne	Scott
Burt	Foley	Jennings	Silver
Casas	Forman	Johnson	Sullivan
Childers	Grant	Kirkpatrick	Turner
Crenshaw	Grogan	Kiser	Weinstein
Crist	Gutman	Kurth	Williams

CONSIDERATION OF BILL OUT OF ORDER

On motion by Senator Kirkpatrick, by unanimous consent—

HB 137-C—A bill to be entitled An act relating to public records; providing an exemption from public records requirements for certain investigatory records of the Agency for Health Care Administration relating to workers' compensation, and related examination records; providing for future review and repeal; providing a finding of public necessity; providing a contingent effective date.

—was taken up out of order. On motions by Senator Kirkpatrick, by two-thirds vote **HB 137-C** was read the second time by title, and by two-thirds vote read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—36 Nays—None

INTRODUCTION AND REFERENCE OF BILLS

FIRST READING

By Senators Jennings and Childers—

SB 56-C—A bill to be entitled An act relating to public records; providing an exemption from public records requirements for an injured employee's medical records and reports and identifying information in medical bills provided to the Division of Workers' Compensation; providing for future review and repeal; providing a finding of public necessity; providing a contingent effective date.

—was referred to the Committee on Commerce.

By Senators Jennings and Childers—

SB 58-C—A bill to be entitled An act relating to public records; providing an exemption from public records requirements for information held by the Department of Labor and Employment Security identifying an employee who has exercised any right under the Florida Occupational Safety and Health Act; providing for future review and repeal; providing a finding of public necessity; providing a contingent effective date.

—was referred to the Committee on Commerce.

By Senators Jennings and Childers—

SB 60-C—A bill to be entitled An act relating to public records and meetings; providing exemptions from public records requirements for certain reports and recommendations made by the Board of Directors of the Florida Self-Insurance Fund Guaranty Association to the Department of Insurance and for certain documents relating to negotiations between the association and a self-insurance fund; providing an exemption from public meetings requirements for such negotiations; providing for future review and repeal; providing findings of public necessity; providing a contingent effective date.

—was referred to the Committee on Commerce.

By Senators Jennings and Childers—

SB 62-C—A bill to be entitled An act relating to public records; providing an exemption from public records requirements for certain investigatory records of the Department of Insurance relating to workers' compensation, and related examination records; providing for future review and repeal; providing a finding of public necessity; providing a contingent effective date.

—was referred to the Committee on Commerce.

By Senators Jennings and Childers—

SB 64-C—A bill to be entitled An act relating to trust funds; creating the Florida Group Self-Insurance Fund Account, to be managed by the Florida Group Self-Insurance Fund Guaranty Association; providing a contingent effective date.

—was referred to the Committee on Commerce.

MESSAGES FROM THE HOUSE OF REPRESENTATIVES

FIRST READING

The Honorable Pat Thomas, President

I am directed to inform the Senate that the House of Representatives has passed as amended HB 137-C and requests the concurrence of the Senate.

John B. Phelps, Clerk

By Representative Boyd and others—

HB 137-C—A bill to be entitled An act relating to public records; providing an exemption from public records requirements for certain investigatory records of the Agency for Health Care Administration relating to workers' compensation, and related examination records; providing for future review and repeal; providing a finding of public necessity; providing a contingent effective date.

(Taken up out of order and passed this day.)

RETURNING MESSAGES—FINAL ACTION

The Honorable Pat Thomas, President

I am directed to inform the Senate that the House of Representatives has passed SB 56-C, SB 58-C, SB 60-C; and has passed SB 64-C by the required constitutional three-fifths vote of the membership of the House.

John B. Phelps, Clerk

The bills contained in the foregoing message were ordered enrolled.

The Honorable Pat Thomas, President

I am directed to inform the Senate that the House of Representatives has accepted the Conference Committee Report as an entirety and passed SB 12-C as amended by the Conference Committee Report.

John B. Phelps, Clerk

The bill contained in the foregoing message was ordered engrossed and then enrolled.

ROLL CALLS ON SENATE BILLS

SB 12-C
Conference Committee Report

Yeas—39

Mr. President	Dantzler	Hargrett	Myers
Bankhead	Diaz-Balart	Holzendorf	Scott
Beard	Dudley	Jenne	Siegel
Boczar	Dyer	Jennings	Silver
Brown-Waite	Foley	Johnson	Sullivan
Burt	Forman	Kirkpatrick	Turner
Casas	Grant	Kiser	Weinstein
Childers	Grogan	Kurth	Wexler
Crenshaw	Gutman	McKay	Williams
Crist	Harden	Meadows	

Nays—None

SB 56-C

Yeas—39

Mr. President	Dantzler	Hargrett	Myers
Bankhead	Diaz-Balart	Holzendorf	Scott
Beard	Dudley	Jenne	Siegel
Boczar	Dyer	Jennings	Silver
Brown-Waite	Foley	Johnson	Sullivan
Burt	Forman	Kirkpatrick	Turner
Casas	Grant	Kiser	Weinstein
Childers	Grogan	Kurth	Wexler
Crenshaw	Gutman	McKay	Williams
Crist	Harden	Meadows	

Nays—None

SB 58-C

Yeas—39

Mr. President	Dantzler	Hargrett	Myers
Bankhead	Diaz-Balart	Holzendorf	Scott
Beard	Dudley	Jenne	Siegel
Boczar	Dyer	Jennings	Silver
Brown-Waite	Foley	Johnson	Sullivan
Burt	Forman	Kirkpatrick	Turner
Casas	Grant	Kiser	Weinstein
Childers	Grogan	Kurth	Wexler
Crenshaw	Gutman	McKay	Williams
Crist	Harden	Meadows	

Nays—None

SB 60-C

Yeas—39

Mr. President	Burt	Dantzler	Forman
Bankhead	Casas	Diaz-Balart	Grant
Beard	Childers	Dudley	Grogan
Boczar	Crenshaw	Dyer	Gutman
Brown-Waite	Crist	Foley	Harden
Hargrett	Kirkpatrick	Myers	Turner
Holzendorf	Kiser	Scott	Weinstein
Jenne	Kurth	Siegel	Wexler
Jennings	McKay	Silver	Williams
Johnson	Meadows	Sullivan	

Nays—None

SB 62-C

Yeas—39

Mr. President	Dantzler	Hargrett	Myers
Bankhead	Diaz-Balart	Holzendorf	Scott
Beard	Dudley	Jenne	Siegel
Boczar	Dyer	Jennings	Silver
Brown-Waite	Foley	Johnson	Sullivan
Burt	Forman	Kirkpatrick	Turner
Casas	Grant	Kiser	Weinstein
Childers	Grogan	Kurth	Wexler
Crenshaw	Gutman	McKay	Williams
Crist	Harden	Meadows	

Nays—None

SB 64-C

Yeas—39

Mr. President	Dantzler	Hargrett	Myers
Bankhead	Diaz-Balart	Holzendorf	Scott
Beard	Dudley	Jenne	Siegel
Boczar	Dyer	Jennings	Silver
Brown-Waite	Foley	Johnson	Sullivan
Burt	Forman	Kirkpatrick	Turner
Casas	Grant	Kiser	Weinstein
Childers	Grogan	Kurth	Wexler
Crenshaw	Gutman	McKay	Williams
Crist	Harden	Meadows	

Nays—None

ROLL CALLS ON HOUSE BILLS

HB 137-C

Yeas—36

Mr. President	Crist	Gutman	Kurth
Bankhead	Dantzler	Harden	McKay
Beard	Diaz-Balart	Hargrett	Myers
Boczar	Dudley	Holzendorf	Scott
Brown-Waite	Dyer	Jenne	Silver
Burt	Foley	Jennings	Sullivan
Casas	Forman	Johnson	Turner
Childers	Grant	Kirkpatrick	Weinstein
Crenshaw	Grogan	Kiser	Williams

Nays—None

ENROLLING REPORTS

Senate Bills 30-C and 54-C have been enrolled, signed by the required Constitutional Officers and presented to the Governor on November 10, 1993.

Joe Brown, Secretary

CORRECTION AND APPROVAL OF JOURNAL

The Journal of November 9 was corrected and approved.

CO-SPONSORS

Senators Foley, Siegel—SB 10-C

VOTE RECORDED

Senator Siegel requested that he be recorded as voting yea on **HB 137-C.**

ADJOURNMENT

On motion by Senator Kirkpatrick, the Senate in Special Session adjourned sine die at 11:29 a.m.