

# How Does the Workers' Compensation System in Florida Compare to Other States?

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*Report Number 2002-117*

November 2001

*Prepared for*  
The Florida Senate

*Prepared by*  
Committee on Banking and Insurance



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## Background

In recent years, many stakeholders in the workers' compensation system have contended that Florida has the highest premiums rates for workers' compensation insurance in the country, while its benefits are among the lowest. In the last 2 years, Florida has been recognized by independent studies as having the highest or second highest rates (2001) countrywide. Florida was noted as having the highest workers' compensation premium rates of all 50 states in the Oregon Workers' Compensation Premium Rate Ranking Calendar Year 2000 published by the State of Oregon Department of Consumer and Business Services.

In 2001, the Workers Compensation Research Institute's *Compscope Benchmarks: Multistate Comparisons, 1994-1999*, ranked Florida second highest (Alaska was ranked highest, at \$679) in cost per worker, based on benefit costs per claim and frequency of claims per 100,000 workers for policy year 1996, based upon data obtained from the National Council on Compensation Insurance (NCCI) Annual Statistical Bulletin, 2000 Edition. However, the Workers Compensation Research Institute (WCRI) noted that this type of comparison can be misleading, since this data is not adjusted for interstate differences in wages levels, injury and industry mix which are not related to system performance. Florida's average cost per worker per all paid claims was \$617. New York (\$538), California (\$520), Texas (\$369), and Georgia (\$299) experienced lower average cost.

## Summary of 1993 Workers Compensation Law and Impact of Reforms

Major reforms of the Workers' Compensation Law that were enacted in 1994 and in prior years attempted to address high premium rates and low benefits. In 1992 and 1993, premiums were steadily increasing at significant rate--21.2 percent and 7.2 percent, respectively. The 1993 legislation (ch. 93-415, L.O.F.) substantially revised many aspects of the workers' compensation law in an attempt to significantly reduce costs. The 1993 reforms included the following changes:

1. Reduced attorney's fee schedule from 25/20/15 to 20/15/10 percent of benefits secured;<sup>1</sup>
2. Authorized a maximum credit of 10 percent for implementing managed care;<sup>2</sup>

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<sup>1</sup> As a result of the 1993 reforms, the fees must equal 20 percent of the first \$5,000 of the benefits secured, 15 percent of the next \$5,000 of the amount of benefits secured, 10 percent of the remaining amount of the benefits secured and to be provided during the first 10 years, and 5 percent of the benefits secured after 10 years. [s. 440.34, F.S.]

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3. Limited increases in the medical fees schedule to the prior year's increase in the Consumer Price Index;
4. Revised the definition of catastrophic injury to specify which injuries constitute permanent total disability and to include any injury eligible for federal income disability or security income benefits;
5. Reduced temporary total disability benefits to 104 weeks (previously 260 weeks);
6. Authorized safety and drug-free workplace credits; and
7. Revised chiropractic services to 18 treatments or 8 weeks from the initial treatment, whichever occurred first.

The following table lists the annual overall premium rate changes (from the prior year) for workers' compensation insurance approved by the department since 1992, effective January 1 of each year:

'92	'93	'94	'95	'96	'97	'98	'99	2000	'01	2002
21.2%	7.2%	-10.6	0	0	-11.3%	-1.7%	1.6%	2.5%	0	7.9% (proposed)

## **Administration of the Workers' Compensation System In Florida**

### **Division of Workers' Compensation**

Pursuant to s. 440.015, F.S., the Division of Workers' Compensation, within the Department of Labor and Employment Security, is charged with administering the Workers' Compensation Law in a manner that facilitates the self-execution of the system and the process of ensuring a prompt and cost-effective delivery of payments.

The Bureau of Employee Assistance and Ombudsman Office (EAO) is charged with the responsibility of informing and assisting employers/carriers, injured workers, and health care providers in fulfilling their respective responsibilities under ch. 440, F.S., the Workers' Compensation Law.

The Bureau of Compliance is charged with the responsibility of ensuring that employers, subject to the Workers' Compensation Law, maintain workers' compensation coverage for their employees and maintain records relating to proof of coverage and exemption from coverage. The Bureau of Rehabilitation and Medical Services certifies and decertifies health care providers, resolves

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<sup>2</sup> This credit was eliminated when managed care was mandated, effective January 1, 1997.

reimbursement disputes, develops medical fee schedules, monitors carriers' compliance with reimbursement policies, monitors utilization and billing practices of providers, and provides reemployment services and training.

### **The Formal Dispute Resolution Process—Office of the Judges of Compensation Claims**

The Office of the Judges of Compensation Claims is responsible for hearing and resolving disputed workers' compensation issues under the authority of ch. 440, F.S. In 2001, legislation was enacted that transferred the workers' compensation hearings function, as a separate budget entity, from the Department of Labor and Employment Security to the Division of Administrative Hearings within the Department of Management Services, effective October 1, 2001 (ch. 2001-91, L.O.F.).

Once an employee has exhausted the informal dispute resolution process, the employee may file a petition for benefits with the Office of the Judges of Compensation Claims in Tallahassee, the employer and the employer's carrier. [s. 440.192, F.S.] If the petition is not dismissed, it is referred to the appropriate district office. Presently, there are 17 district offices.

Section 440.25, F.S., requires a mediation conference to be held within 21 days after a petition for benefits is filed with the division. If the issues are not resolved within 10 days following the commencement of the mediation, the judge is required to hold a pretrial hearing.

At the pretrial hearing the judge sets a date for the final hearing that allows the parties at least 30 days to conduct discovery, unless the parties consent to an earlier hearing date. The final hearing is required to be held and concluded within 45 days after the pretrial, unless the judge of compensation claims grants a continuance. According to the Office of the Judges of Compensation Claims, the average number of days from the date of receipt of the petition by the division to the final disposition (final merit, settlement, or stipulation) is 222 days.

### **Medical Fee Schedules**

The three-member panel, consisting of the Insurance Commissioner or his designee, and two members appointed by the Governor is charged with the responsibility for determining statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians and hospitals. The maximum percentage of increase in the individual reimbursement schedule is capped at the percentage of increase in the Consumer Price Index for the prior year. Reimbursements for all fees and other charges for

medical treatment cannot exceed the amounts provided by the maximum reimbursement allowance approved by the three-member panel and developed and adopted by rule by the Division of Workers' Compensation. [s. 440.13 (12), F.S.] Individual physicians are required to be reimbursed at the usual and customary charge, the agreed-upon contractual amount, or the maximum reimbursement allowance, whichever is less. Inpatient hospital care is reimbursed on a per diem basis and outpatient hospital care is reimbursed at 75 percent of the usual and customary rate.

Section 440.134, F.S., which authorizes the delivery of medical services through a managed care arrangement, does not specifically address reimbursement to such providers. The Division of Workers' Compensation has opined that the fee schedule does not apply to medical services delivered through a managed care arrangement, since 440.13(12), F.S., "does not require an insurer to negotiate any health care provider payment based on the schedules approved by the panel for medical services provided through an insurer's WCMCA (workers' compensation managed care arrangement)."<sup>3</sup>

## **Regulation of Managed Care Arrangements**

The Agency for Health Care Administration is responsible for authorizing carriers to offer or utilize a worker's compensation managed care arrangement, if the carrier meets the conditions of s. 440.134, F.S., and regulating workers' compensation managed care arrangements. As part of the 1993 Act, workers' compensation managed care arrangements were authorized for the delivery of medical benefits, and mandated in 1997. However, employers are allowed to "opt-out" from managed care, effective October 1, 2001.

In 2000, the Agency for Health Care Administration surveyed workers' compensation provider networks regarding the use of the current fee schedule. Approximately 61 percent of the networks responded, which represented 58 percent of the 861 workers' compensation managed care arrangements. Although the majority of the respondents (79 percent) indicated that they were experiencing difficulty in recruiting and retaining providers because their reimbursement was based on the present fee schedule; 89 percent of the respondents agreed that a fee schedule was necessary and all of the respondents reported that they were using the fee schedule as a basis for reimbursing providers. The survey solicited suggestions for revising the fee schedule. Suggestions included: 1) using Medicare (or a percentage above Medicare) as a baseline for the fee schedule; 2) increasing the initial and follow-up visits reimbursement rate; and 3) maintaining the current system but increasing the fees.

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<sup>3</sup> Division of Workers' Compensation Bulletin Number 214. January 25, 2000.

Committee staff recently conducted an informal telephone survey of carriers to determine how the current fee schedule was being used. One carrier indicated that their network providers were being reimbursed at a rate comparable to Medicare reimbursements or approximately 200 percent of the fee schedule. In outlying, rural areas, some network providers were being compensated at 400 percent of the fee schedule. Blue Cross Blue Shield has indicated that they will increase reimbursement fees (a certain percentage above Medicare fee schedule) to physicians in their panel that complete certain continuing medical education training approved by the Florida Medical Association. In response to how non-network providers were being compensated, some carriers indicated that providers were paid at the lesser of the charge or the fee schedule amount, some were paid at the fee schedule amount, and some paid a negotiated amount.

## **General Overview of Workers' Compensation Benefits in Florida**

Chapter 440, F.S., generally requires that employers/carriers provide benefits (medical and indemnity) to a worker who is injured due to an accident arising out of and during the course of employment.<sup>4</sup> The types of injury include: first aid, medical only, lost time, and death. Medical-only injuries require medical treatment only and the loss of time from work is less than 7 days. Lost time cases are the result of an employee missing 7 or more days of work.

### **Medical Benefits**

The delivery of medical benefits can be provided to employees through a managed care or non-managed care system, at the option of the employer, effective October 1, 2001.<sup>5</sup> Both delivery systems allow for one change in physician. [ss. 440.13(2) and 440.134(10), F.S.] The Agency for Health Care Administration recently determined that the "opt-out" provision "...effected a prospective only substantive amendment" to the law.<sup>6</sup> The agency also stated that the determination of whether the "opt-out" provision for employers is a substantive change in law that applies only to dates of accident after October 1, 2001, or procedural change which would apply to all persons, regardless of the date of injury, would be determined by a judge of compensation claims by evaluating the insurance policy/contract in effect at the time of the injury. The agency also stated, "If the policy/contract in effect at the time of injury specifies that managed care shall be used...then...the JCC must

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<sup>4</sup> Section 440.02(17), F.S.

<sup>5</sup> Section 440.134(2), F.S.

<sup>6</sup> Memorandum from Mari H. McCully, Assistant General Counsel, Agency for Health Care Administration, October 15, 2001.



so hold true.”<sup>7</sup> Therefore, employers may not be allowed to “opt-out” of managed care for employees injured prior to October 1, 2001, which may require employers to maintain two different methods for the delivery of medical benefits.

## **Indemnity Benefits**

Florida provides the following types of indemnity benefits: permanent total, temporary total, temporary partial, impairment income benefits, temporary partial, and death benefits. Benefits are contingent upon the date of the accident, the employee’s wages for the previous 13 weeks (which determines the average weekly wage), and the compensation rate (which is calculated at 66 2/3 percent of the average weekly wage and subject to a maximum rate of 100 percent of the statewide average weekly wage).

### ***Permanent Total Disability***

Only a catastrophic injury,<sup>8</sup> in the absence of conclusive proof of a substantial earning capacity, constitutes permanent total disability.<sup>9</sup> Permanent total disability is determined at maximum medical improvement, based upon reasonable medical probability that no further medical improvement can reasonably be anticipated. It is a lifetime benefit calculated at 66 2/3 percent of the average weekly wage, subject to a maximum compensation rate. In addition, a person will receive an annual supplemental income benefit equal to 5 percent per year of the disability payment.

Temporary total benefits are paid at 66 2/3 percent of the average weekly wage and cease at 104 weeks or upon maximum medical improvement, whichever occurs first. Permanent impairment benefits are determined upon the cessation of temporary total benefits.

Impairment income benefits occur at maximum medical improvement or the expiration of temporary benefits, whichever occurs earlier and continues until the earlier of the expiration of a period computed at a rate of 3 percent for each

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<sup>7</sup> Ibid.

<sup>8</sup> Section 440.02, F.S., defines a catastrophic injury to include 1) spinal cord injury resulting in paralysis of an arm, a leg, or the trunk, 2) amputation of an arm, a hand, a foot, or a leg, 3) severe brain or closed-head injury, 4) second-degree or third degree burns of 25 percent or more or third-degree burns of 5 percent or more of the hands or face, 5) total or industrial blindness, and 6) any other injury that would otherwise qualify under this chapter of a nature and severity that would qualify an employee to receive social security disability or supplemental income benefits.

<sup>9</sup> Section 440.15(1), F.S.

percentage point of impairment or the death of the employee. Determination of permanent impairment is based on a physician's objective findings and is paid at 50 percent of the compensation rate (or approximately 33 percent of the average weekly wage). Supplemental benefits provide a second tier of benefits for employees with impairment ratings in excess of 20 percent who have not returned to work or are earning less than 80 percent of the employee's pre-injury average weekly wage as a result of the employee's impairment, and where the employee has not returned to work, the employee has in good faith attempted to return to work. Supplemental benefits are payable at the rate of 80 percent of the difference between 80 percent of the employee's pre-injury average weekly wages and the weekly wages the employee has earned during the specified reporting period. [s. 440.15(3), F.S.]

Temporary partial compensation is equal to 80 percent of the difference between 80 percent of the average weekly wage and the salary or wages the employee is able to earn; however, the payment is capped at 66 2/3 percent of the employee's average weekly wage at the time of the injury. Benefits cease after 104 weeks.

## **Attorney's Fees and Litigation Expense**

In Florida, the judges of compensation claims use a three-tier fee schedule to award attorney's fees based upon the amount of benefits secured. Generally, the fees must equal 20 percent of the first \$5,000 of the benefits secured, 15 percent of the next \$5,000 of the amount of benefits secured, 10 percent of the remaining amount of the benefits secured and to be provided during the first 10 years, and 5 percent of the benefits secured after 10 years.<sup>10</sup>

However, the judge of compensation claims does have the discretion to increase or decrease the attorney's fees, without any dollar limitation, based on the following factors: 1) time and labor involved; 2) fee customarily charged in the locality for similar services; 3) amount involved in controversy and the benefits resulting; 4) time limitation imposed by claimant or circumstances; 5) experience, reputation, and the ability of the lawyer; and 6) contingency or certainty of a fee. Generally, a claimant is responsible for the payment of his or her attorney's fees, except in the following situations: 1) claimant successfully asserts a claim for medical only; 2) claimant's attorney successfully prosecutes a claim previously denied by the employer/carrier; 3) claimant prevails on the issue of compensability previously denied by the employer/carrier; and 4) claimant successfully prevails in proceedings related to the enforcement of an order or modification of an order.

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<sup>10</sup> Section 440.34, F.S.

## **Election of Exemption from Workers' Compensation Coverage**

Employers are required to provide workers' compensation coverage, unless they obtain an exemption from coverage.<sup>11</sup> Employers secure workers' compensation coverage by purchasing insurance or meeting the requirements to self-insure.

Each sole proprietor or partner engaged in a non-construction industry is automatically exempt from workers' compensation, unless the person elects to be included in the definition of employee and notifies the division of such an election for coverage. Corporate officers engaged in a non-construction industry who elect to be exempt from coverage must notify the division of such an election.

Corporate officers, partners, and sole proprietors actively engaged in the construction industry may elect to be exempt from the workers compensation system by filing a notice of election to be exempt and providing certain information to the Division of Workers Compensation along with a \$50 filing fee. No more than three corporate officers of a corporation and three partners in a partnership actively engaged in the construction industry may elect to be exempt. For each sole proprietor, corporate officer, or sole proprietor seeking an exemption, the division requires that certain information be submitted, including: (1) all certified or registered licenses issued pursuant to ch. 489, F.S., (2) a copy of documentation as to employment status filed with the Internal Revenue Service, (3) a copy of the occupational license; and (4) the registration number of the corporation or partnership filed with the Division of Corporations of the Department of State, if applicable.

Upon determining that the requirements for exemption are met, the Division of Workers Compensation issues a certificate of election of exemption that is valid for a 2-year period. For the prior 3 fiscal years, the division has received, on average, 97,383 exemption applications per year. As of September 11, 2001, the division had issued approximately 134,000 construction exemptions. Approximately 56 percent of these exemptions were issued to sole proprietorships, 5 percent to partnerships, and the remaining 39 percent to corporations. However, the Division of Workers Compensation has the authority to revoke the exemption if the applicant does not meet the requirements for an exemption or if the information is invalid. For fiscal years 1998-99 and 1999-00, the division revoked on average, 1,700 construction exemptions per year.

In 1997, a report issued by the Fourteenth Statewide Grand Jury entitled, *Report on Workers' Compensation Fraud*, prompted the Legislature to address workers' compensation fraud and noncompliance. The Grand Jury report attributed much of

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<sup>11</sup> Section 440.38, F.S.

the workers' compensation fraud problem to the abuse of exemptions from the workers' compensation system. The report also criticized the lack of enforcement action by the Division of Workers' Compensation. The report made numerous recommendations that were enacted by the Legislature in 1998, including:

1. Requiring local government authorities to confirm compliance with workers' compensation coverage requirements as a condition for issuing each building permit;
2. Requiring construction industry exemptions to be renewed every 2 years and authorizing the Division of Workers' Compensation to deny or revoke such exemptions if the person does not meet the requirements for an exemption or if the information is invalid; (Non-construction exemptions would be valid until revoked by the certificate holder or the division and would not be subject to renewal requirements.)
3. Increasing the criminal penalties associated with workers' compensation fraud based on the amount of the claim or the premium involved in the fraud; (These criminal penalties mirror the penalties contained in the general theft provisions of ch. 812, F.S.)

## **Rate Regulation in Florida**

Workers' compensation premium rates are regulated by the Department of Insurance pursuant to authority granted under part I of ch. 627, F.S. Section 627.091, F.S., of the Insurance Code provides that workers' compensation insurance rates "...shall not be excessive, inadequate, or unfairly discriminatory." Currently, insurers that write workers' compensation insurance in Florida must have their rates approved by the Department of Insurance (department) prior to use, but an insurer may satisfy this requirement by being a member or subscriber to a licensed rating organization that makes such filings on its behalf.<sup>12</sup> All workers' compensation insurers in Florida are currently members or subscribers to a rating organization, National Council on Compensation Insurance (NCCI), and use its rate filings, as approved by the department. Individual insurers do not file any portion of the rate. Presently, NCCI is the only licensed rating organization in Florida.

Self-insurance funds that write workers' compensation in Florida are subject to the same rate filing requirements and all of the existing self-insurance funds belong to the rating organization and uses their approved rates. Individual self-insured employers, however, are not subject to rate filing and approval requirements. Rates are determined by the size of the payroll, job classification, and the claim experience of the employer. Variation of the approved rate can

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<sup>12</sup> Sections 627.091 and 627.101, F.S.

occur through the insurer's use of deviations, fixed credits, volume discounts, retrospective rating plans, and dividends.

## **Methodology**

Data on workers' compensation costs and benefits was obtained from the Workers' Compensation Research Institute (WCRI), National Council on Compensation Insurance (NCCI), National Association of Insurance Commissioners, Division of Workers' Compensation, insurance carriers, and other sources. Comparable information for other states was also obtained. The workers' compensation laws of other states were compared to Florida's laws. Data related to current exemptions from coverage was obtained from the Division of Workers' Compensation.

### **Caveats On Comparing Adequacy of Benefits and Costs of Benefits Across States**

According to the report entitled, *Workers' Compensation: Benefits, Coverage, and Costs, 1999 New Estimates and 1996-98 Revisions* (May 2001), published by the National Academy of Social Insurance, numerous factors influence differences in benefits paid by states: As a result, the report cautions that comparisons between states do not necessarily reflect the relative adequacy of benefits that an injured employee may actually receive in various states. The report states that an evaluation of the adequacy of benefits would need to include an evaluation of the amount of benefits an injured worker receives and how the benefits compare to the actual wages that the injured worker lost due to their work-related injury. This type of data is not available on a consistent basis across states.

## **Findings**

### **Where Does the Premium Dollar Go?**

Recently, NCCI provided the following information<sup>13</sup> to the Department of Insurance concerning the composition of the 2001 premium dollar (adjusting for premium discounts and the expense constant<sup>14</sup>) and the 2002 proposed rate filing:

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<sup>13</sup>Exhibit II-F of the Workers' Compensation Rates and Rating Values - Florida Voluntary Market, Effective January 1, 2002.

<sup>14</sup> Fixed expenses which are common to all policies, regardless of size (issuing, recording, and auditing) are addressed through this adjustment and are updated annually to reflect inflationary changes.

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Component	2001	2002
Production Expense Commissions, costs of preparing policy, billing and collecting premium, etc.	10.3%	10.9%
General Expense General administration, audit, boards and bureaus, and inspection	4.9%	4.9%
Taxes Workers' Compensation Administration Trust Fund, Workers' Compensation, Guaranty Association, Special Disability Trust Fund	9.3%	9.4%
Profits & Contingencies Underwriting profit/loss allowance	-4.1%	-3.0%
Benefit & Loss Adjustment Costs medical and indemnity, expenses associated with handling claims (loss adjustment expense of 19%)	79.6%	77.8%
Totals	100.0%	100.0%

### **Cost Drivers in Florida**

In response to staff inquiries, NCCI and WCRI have recently released reports addressing cost drivers in the Florida's workers' compensation system. The WCRI issued two reports, one comparing the Florida medical fee schedule with other states and another report comparing Florida's permanent impairment benefits with other states. In addition, WCRI has released several multistate comparisons and Florida specific studies in the last few years.

In September 2001, NCCI issued a report entitled, *Florida Workers' Compensation- Cost Drivers Overview*. One of the striking features of the current Florida system is the fact that medical costs, constitute 64.9 percent of the total losses in Florida (indemnity costs represents the remaining 35.1 percent). In contrast, medical costs constitute only 55.8 percent of the countrywide average costs and indemnity represents the remaining 44.2 percent.

The NCCI report identified three significant cost drivers: 1) high frequency of permanent total claims 27 per 100,000 workers - three times higher than countrywide, which results in the total costs for Florida's permanent total claims being more than 2.5 times the countrywide average; 2) high medical costs for permanent partial claims - two times higher than countrywide and increasing at an annual rate of 6.5 percent, and, 3) high medical costs for temporary total claims - 60 percent higher than countrywide and increasing at an annual rate of 11.2 percent. In addition, the report noted the following cost drivers:

1. **Hospital costs.** Hospital costs are relatively high in Florida according to WCRI studies. Hospital costs represent almost 50 percent of medical expenditures and "...this is a significant reason for high medical costs."
2. **Physician costs.** Although the fee schedule in Florida is relatively low in comparison to other states, NCCI suggested that a high utilization of physician services was occurring or a relatively expensive mix of procedures were being provided. According to NCCI, "Florida does not have unusual types of injuries that would explain the higher costs."
3. **Attorney involvement.** If attorneys are not involved, the difference in claim costs between Florida and countrywide was minimal; however, if attorneys are involved, the difference in claim size in Florida and countrywide is nearly 40 percent. The report suggested that attorneys might contribute to the frequency of permanent total claims and to the increased medical services.

The WCRI also noted similar and additional findings related to cost drivers in Florida. The remaining sections of the findings provide greater details regarding findings made by NCCI and WCRI regarding cost drivers in Florida.

## **Trends in Claim Costs**

According to a recent WCRI report entitled, *Compscope Benchmarks: Florida, 1994-99*, the average total cost per paid claim rose from 1995 through 1998 at a rate of 10 percent per year. In contrast, average total cost per paid claim increased only 3.4 percent during the period of 1994 - 1995. The average total cost per paid claim was \$1,964 in accident year 1994 and \$2,301 in accident year 1995.<sup>15</sup> However, the average total cost per claim increased to \$2,726 by 1998. What factors triggered this increase in costs? According to the study, the following cost drivers were identified:

1. **Rapid growth in benefit-delivery expenses was a key cost driver.** Benefit delivery expenses per indemnity claim increased significantly: 18 percent (or \$964 per claim) for accident years 1996 - 1997, and 39 percent (\$1,577 per claim) from 1997 - 1998. The significant growth in benefit delivery expenses was triggered by the mandated delivery of medical benefits through managed care arrangements. For the period of 1996 to 1998, the increase in medical delivery expenses added \$427 to the average cost per indemnity claim.
2. **Increase in the amount of indemnity and medical benefits paid.** Average indemnity benefits per indemnity claim increased 15 percent during the period of 1996-1998 (from \$3,661 to \$4,208). This increase was attributed to the significant increase in claims with permanent

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<sup>15</sup> Claims were evaluated at 12-month intervals with claims experience through mid-1999.

impairment benefits and lump sum settlements. The study noted that the average benefits paid for temporary total benefits increased 10 percent annually from 1996 - 1998 from \$2,454 to \$2,958. Medical payments per claim for lost-time cases were high, particularly in permanent partial disability cases. Average medical benefits in claims increased at a rate of 5.4 percent per year between the years 1994 -1998.

3. **Indemnity Benefits were paid more frequently.** Indemnity benefits were paid on approximately 20 percent of all claims in 1998, versus 18 percent in 1996.

## **Medical Fees and Cost Containment**

Recently, the Agency for Health Care Administration published a document entitled, *Managed Care Opt-Out Frequently Asked Questions*. The document indicated that reimbursement levels for managed care arrangements could be negotiated at either above or below the fee schedule. Under a non-managed care arrangement, provider reimbursement is limited to the fee schedule, as provided in s. 440.13(14), F.S. According to the agency, carriers that provide reimbursement to non-managed care providers above the fee schedule are subject to administrative action and penalties.

Although the Division of Workers' Compensation and, subsequently, the Agency for Health Care Administration, through an memorandum of understanding, is charged with the responsibility of determining whether workers' compensation providers are engaged in practice of overutilization and is charged with the responsibility of monitoring billing practices, the division has not been aggressive in taking action against many providers in recent years. The division has the authority to fine, require reimbursement, and even decertify providers, if a provider is engaged in a pattern or practice of overutilization or a violation of ch. 440, F.S. [s. 440.13, F.S.] The division has indicated that it is the carrier's primary responsibility to conduct utilization reviews, particularly with the implementation of managed care in 1997. Prior to 1997, the division assessed penalties against providers; however, no provider has been decertified since 1997. During the period of 1989 -1997, 180 overutilization cases involving 114 providers were reviewed, resulting in \$62,421 in penalties being assessed against providers. Approximately 43 percent of the cases resulted in the assessment of a penalty. Carriers requested \$301,449 in repayments from providers. In the majority of the cases, the provider elected to make payments to the division and/or the carrier in monthly installments. No cases are noted after June 9, 1997.

Recently, the Workers' Compensation Research Institute released a report entitled, *Benchmarking Florida's Workers' Compensation Medical Fee Schedules* (September 2001) that compared Florida's fee schedule to other large states and southern states, the Medicare fee schedule in Florida, and the Florida fee schedule



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implemented September 30, 2001. The report also benchmarked hospital reimbursements in Florida with other states. Florida's medical fees were compared with California, Connecticut, Georgia, Louisiana, Massachusetts, Minnesota, Mississippi, New York, North Carolina, Pennsylvania, South Carolina, and Texas. The following major findings were noted by WCRI:

1. The Florida fee schedule that was in effect prior to September 30, 2001 was significantly lower than neighboring states and large states evaluated. The fee schedule amounts (overall and for each major medical service group) are either the lowest or among the lowest in the United States.
2. The new fee schedule, which became effective September 30, 2001, will lower fees overall by 2 percent on average. Florida had the second lowest fee schedule among the eight larger states (California, Connecticut, Massachusetts, Minnesota, New York, Pennsylvania, and Texas) evaluated. Massachusetts had the lowest fee schedule of the eight states primarily due to the relatively low surgery reimbursement rates.
3. On average, Florida's fee schedule is equal to those prescribed by the Medicare fee schedule (2000 edition). The report noted that Florida reimbursements for certain categories, such as evaluation and management (-37 percent) and radiology (-19 percent) are significantly lower than the Medicare fee schedule. In contrast, surgery fees were 14 percent above the Medicare fee schedule.
4. The average payments per service paid to Florida hospitals were generally the highest of the eight large states and as much as five times higher than the Florida fee schedule amounts authorized for non-hospital providers for similar services. The average fees paid to hospitals also increased by 13 percent per year for injuries incurred during the period of 1996-98.

As mentioned previously, the Florida Legislature recently enacted legislation (2001-91, L.O.F.) that allows employers to opt-out of managed care arrangements for the delivery of medical care and services. The legislation also allowed injured workers one change in physician during the course of treatment for one accident. The "opt-out" provision was driven by concerns regarding additional administrative costs, litigation expense, and delays in providing care that were attributed to delivering medical care through managed care arrangements. During the 2001 Legislative Session, NCCI provided the estimated impact from eliminating mandatory managed care

"Since this proposal is aimed to maintain an optional managed care program, NCCI believes managed care programs will still be used by many employers and insurers and therefore no significant impact would be expected immediately. Over time, if there is a general movement away from managed care, some increases in costs would be expected and higher medical trends could result. Employers are not likely to knowingly do this, if they recognize

that administrative expense savings could be more than offset by medical and indemnity cost increases.”

According to the *Survey of Workers' Compensation Laws*, published by the Alliance of American Insurers, the majority of the states (41) have adopted some type of medical fee schedule to address cost containment of medical services. The types of fee schedules include: Medicare, Medicaid, maximum fees, RBRVS, relative value, DRG, and usual and customary charge. Nine states have not adopted medical fee schedules.

The Resource-Based-Relative-Value-Scale (RBRVS) is a Medicare payment system determined by three categories of resources (physician work, practice expense, and professional liability insurance) that are necessary to provide a particular service. These combined costs of providing a particular service are multiplied by a conversion factor (determined by the U.S. Health Care Financing Administration) and are adjusted for geographical differences in resource costs. The transition to resource based relative value units for the practice expense is anticipated to be fully implemented by 2002 and to have a significant impact on reimbursement for providers, since providers who furnish more office-based services are expected to experience increases in payments, while those who provide primarily facility based services are expected to experience a decrease in payments. Although the RBRVS was initially developed for establishing reimbursement rates for Medicare, “over 60 percent of non-Medicare payers use Medicare RBRVS to establish fees or maximum allowables for physician services.”<sup>16</sup> However, the private sector’s use of RBRVS may differ from the Medicare reimbursement methodology. “Key differences involve the application of the GPCI (geographic practice cost indices), facility and non-facility practice expense RVUs (relative value units), and the conversion factor.”<sup>17</sup>

Relative values, for physicians, assigns unit values for physician services. According to the *2001 Relative Values for Physicians*, the relative value for a particular service or procedure is based on five criteria: 1) time, 2) skill, 3) severity of illness, 4) risk to patient, and risk to physician (medico-legal). Fees are ultimately determined by multiplying the relative value unit by a conversion factor. The conversion factor is determined by evaluating current fees, prevailing area rates, and overhead costs.

The diagnosis related group (DRG) is a payment system for classifying inpatient, hospital discharges. The U.S. Health Care Financing Agency assigns for each DRG, a weighting factor that reflects the relative cost of hospital resources used with respect to discharges classified within a particular group compared to

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<sup>16</sup> *2001 RBRVS - A Comprehensive Listing of RBRVS Values for All CPT and HCPCS Codes*. 2001. Ingenix Publishing Group. p. 15.

<sup>17</sup> *Ibid.* Preface.

discharges within other groups.<sup>18</sup> The DRG system reimburses hospitals at a fixed fee based on the particular patient's age, sex, principal diagnosis and the treatment provided. This type of payment system is used for "...Medicare, Medicaid, and an increasing number of private sector payers."<sup>19</sup>

The Survey of Workers' Compensation Laws also noted that many states had implemented other medical cost containment strategies, such as limiting the initial provider choice (26 states), limiting provider change (44 states), or mandating utilization review (25 states). Eleven of the 44 states limiting provider change (Arkansas, Connecticut, Hawaii, Illinois, Kentucky, Maine, Michigan, Mississippi, Nevada, Utah, and Wisconsin) allow an unrestricted one-time change, after the initial treatment, in the medical provider; however, subsequent changes are restricted. Subsequent to the publication of this survey, the Florida legislature enacted legislation (2001-91, L.O.F.) requiring carriers to provide an employee the opportunity for one change of physician during the course of treatment for any one accident [s. 440.13(2), F.S.] The employee is allowed to select the physician from among not fewer than three non-affiliated physicians authorized by the carrier. [s. 440.13(2), F.S.]

Recently, WCRI completed a study, entitled, *The Anatomy of Workers' Compensation Medical Costs and Utilization* (draft) which compared Florida with seven other states (California, Connecticut, Georgia, Massachusetts, Pennsylvania, Texas, and Wisconsin.) The study evaluated medical benefits or costs per claim, not worker, for lost time cases. Texas was cited as having the highest average medical cost per claim and Massachusetts had the lowest average medical cost per claim. Florida was third highest in average medical cost per claim. Although the average payment per service in Texas was typical of the states studied, the study noted that Texas had significantly higher utilization. According to the study, the average medical costs per claim in Florida increased during the period of 1996 - 1998, at a rate of 5.4 percent per year, as "...a result of an increase in the number of services per claim, rather than payment per service..." In contrast, Florida had one of second lowest average medical cost per claim for claims with less than 7 days.

The study stated, "The fact that services per visits have increases while accompanied by a decline in payment per service may mean that providers are changing billing practices (unbundling)." The average medical payment per service overall in Florida was determined to be slightly above the states evaluated, although the maximum reimbursement allowed pursuant to the fee schedule was among the lowest of the states with fee schedules. WCRI concluded that this

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<sup>18</sup> 42 CFR 412.60

<sup>19</sup> *2001 RBRVS - A Comprehensive Listing of RBRVS Values for All CPT and HCPCS Codes*. 2001. Ingenix Publishing Group. p. 19.

higher than anticipated average payment per service was driven by the higher than average hospital prices. For example, hospitals in Florida that provide physical therapy services are reimbursed at a rate, on average, that is five times higher than the payment authorized for the same services in a non-hospital setting.

Many stakeholders in the workers' compensation system contend that the low fee schedule has resulted in overutilization, upcoding of services and decreasing provider participation and recommend that the fee schedule be increased to address these concerns. Since data is not available to assess utilization and provider participation, staff was unable to independently verify these assertions. Some observers contend that overutilization and upcoding would continue due to the financial incentive provided by the increased fees.

## **Indemnity Benefits**

According to WCRI's report entitled, *Compscope Benchmarks: Multistate Comparisons, 1994-1999*, Florida has higher claims costs for lost-time cases than in most states studied in an eight state review. Florida's average claim cost, at 12-months' maturity, was \$21,235 and the eight state average was \$17,775. The study attributed the higher costs to the higher percentage of permanent partial disability claims (46 percent of lost-time cases) in Florida and frequent litigation. The study also noted that average benefit delivery expenses are higher in Florida than in the other states because of medical cost containment expenses and frequent defense attorney involvement and higher than average defense attorney payments. The report suggested that the higher medical cost containment expenses in Florida could be attributed to mandated managed care. The study concluded that the higher indemnity costs "...was fueled in particular by a growing number of PPD claims and claims with lump-sum settlements as well as growing duration of disability."

## **Permanent Total Eligibility**

A review of several states indicates that the definition of permanent total varies significantly. For example, in New York, the loss of hands, arms, feet, legs, or both eyes or of any two thereof constitutes permanent total disability, in the absence of conclusive proof to the contrary.<sup>20</sup> Illinois uses a similar definition and also provides that these specific types of injuries of total and permanent disability do not exclude other cases.<sup>21</sup>

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<sup>20</sup> Art. 2, Section 15, New York Code

<sup>21</sup> 820 ILCS 305

Georgia defines catastrophic injury to include similar losses as well as spinal cord injury involving severe paralysis of an arm, a leg, or the trunk, severe brain or closed head injury, other conditions as severe in nature, second or third degree burns over 25 percent of the body, total or industrial blindness. Georgia statutes also provide that catastrophic injury includes:

“Any other injury of a nature and severity that prevents the employee from performing his or her prior work and work available in substantial numbers within the national economy for which such employee is otherwise qualified. A decision granting or denying disability income benefits or supplemental security income benefits of the Social Security Act is admissible in evidence...”<sup>22</sup>

During the 2001 Legislative Session, legislation was considered (CS/SB 1188) that would have eliminated the Social Security eligibility standard for permanent total disability benefits and removed it from the definition of catastrophic injury. At the request of committee staff, NCCI provided the following estimated impact of removing the Social Security eligibility standard:

“PT frequency is likely to drop significantly if the social security language is deleted from the definition of “catastrophic injury.” Assuming that 70 percent of the PT cases will become major PP (permanent partial), which would bring Florida in line with countrywide PT rates, PT costs will decrease by 70 percent and major PP will increase by about 20 percent. The estimated impact on total indemnity costs is -4.5 percent. Since indemnity costs represent 40.2 percent of total benefits, the overall impact is -4.5 percent X 40.2 percent = -1.8 percent.”

“However, if a few of the cases that currently qualify under the social security provision, may also qualify under the proposed provision, as amended in s. 440.15(1)(b). If we assume that 60 percent, rather than 70 percent as assumed above, of PT cases will become major PP, the overall impact is -1.5 percent.”

## **Temporary Total Benefits**

The *Survey of Workers Compensation Laws*, published by the Alliance of American Insurers, notes that the duration of temporary total benefits in Florida is lower than 13 states and the majority of the states (29) do not specify a time limitation; rather, they allow benefits to continue for the duration of the disability. Six states, including Florida, limit benefits to 104 weeks. Ten states provide benefits based on 70 percent or more of the employee’s wages. The majority of

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<sup>22</sup> 34-9-200.1 Georgia Code

the states (including Florida) provide benefits based on 66 2/3 percent of the average wages. Recently, the *Compscope Benchmarks: Florida, 1994-1999*, by WCRI, noted the duration of temporary total benefits has been increasing, particularly since 1994 when the Legislature reduced the maximum number of weeks and allowed settlements for future medical benefits.

## **Permanent Partial Benefits**

Recently, the Workers' Compensation Research Institute released a report entitled, *Benchmarking Florida's Permanent Impairment Benefits* (September 2001), that compared Florida's benefits with nine other states (Colorado, Connecticut, Georgia, Illinois, Indiana, New Jersey, North Carolina, Texas, and Washington). The study noted the following significant findings:

1. *Statutory* benefits in Florida are less than the other large states studied. Florida sets the rate of compensation at 50 percent of the weekly benefit for temporary total disability; many states set the rate of compensation at 100 percent of the weekly benefit. Florida also has the lowest maximum weekly benefit of the large states. Florida sets the 300 weeks of benefits for the whole body, which is at the lower end of states evaluated.
2. *Actual* average permanent impairment payments per claim were not unusually higher or lower than five of large states. The report noted that Florida payments were comparable to Connecticut, 26-35 percent higher than Texas, 13-20 percent higher than Wisconsin, 25-38 percent lower than Georgia, and 12-23 percent lower than California.

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<b>WCRI Statutory Maximum Weekly Impairment Benefit and Number of Weeks for the "Whole Body" (as of January 1, 2001)</b>		
<b>State</b>	<b>Maximum Weekly Impairment Benefit</b>	<b>Weeks for Whole Body Impairment</b>
New Jersey	591	600
Illinois	516	500
Indiana	See notes	See notes
Colorado	See notes	400
Connecticut	663	374
Florida	286	300
Georgia	375	300
North Carolina	620	300
Texas	373	300
Washington	See notes	See notes

*Notes:* The maximum weekly benefit in Colorado for back injuries is \$594. For limb injuries, a flat weekly amount (\$186) is paid, independent of the worker's wage. Washington lists a fixed dollar amount, rather than a weekly rate, for total-body impairment. When benefits are paid, the worker receives an initial payment equal to three times the state's average weekly wage; the balance is paid at the worker's TTD rate (\$822 maximum weekly amount). Indiana assigns a fixed value by statute that is independent of the workers wage. For Indiana, the values are stated in degrees (100 maximum). Weekly benefits are paid at the worker's TTD rate (\$762 maximum weekly amount).

<b>WCRI Actual Average PPD Payment in PPD Claims, 1996 and 1997 Injuries</b>				
<b>State</b>	<b>Actual Average PPD Payment in 1997 PPD Claims (Experience to 6/99)</b>	<b>Florida's Actual PPD Payment as A Percent of the State Shown (1997)</b>	<b>Actual Average PPD Payment in 1996 PPD Claims (Experience to 6/99)</b>	<b>Florida's Actual PPD Payment as A Percent of the State Shown (1996)</b>
California	\$8,028	88%	\$11,075	77%
Connecticut	\$7,094	100%	\$9,327	92%
Florida	\$7,091	100%	\$8,553	100%
Georgia	\$11,370	62%	\$11,418	75%
Texas	\$5,627	126%	\$6,314	135%
Wisconsin	\$6,262	113%	\$7,121	120%

*Note:* PPD benefits in Florida, Connecticut, Georgia and Texas are based on impairment. PPD benefits in Wisconsin are based on both impairment and loss of earning capacity. In California, they are based on loss of earning capacity.<sup>23</sup> Both 1997 and 1996 injuries evaluated with experience as of June 30, 1999

<sup>23</sup> Barth, P. and M. Niss. 1999. *Permanent Partial Disability Benefits: Interstate Differences*. Cambridge, MA: Workers Compensation Research Institute. p. 82.

The WCRI study concluded that the difference between the actual payments and statutory benefits per claim may differ due to the implementation of the statutory benefits: judicial behavior in making awards, impairment rating behavior of the medical providers; and settlement behavior of the parties. WCRI stated that the higher payments in Florida for impairment benefits "...may actually include an implicit payment for settling a permanent total disability claim."

Why is the actual payment higher than the statutory benefit? According to an earlier study by WCRI entitled, *Permanent Partial Disability Benefits: Interstate Differences* (1999), "...in instances where the worker seems likely to become a claimant for permanent total disability, the settlement value of the PPD (permanent partial disability) claim is influenced by the value of a PTD (permanent total disability) claim and the likelihood of the worker's being rated for permanent total disability. Because the probability of receiving a PTD award appears to be higher in Florida than in many states, in practice many PPD cases appear to settle for more than they would were they based strictly on impairment."

As previously noted, NCCI reported that Florida has a usually high frequency of permanent total claims—three times higher than countrywide. Some persons attribute the higher frequency in permanent total disability determinations in Florida due to the inclusion of eligibility for social security disability income as part of the criteria for meeting the definition of catastrophic injury and eligibility for permanent total disability benefits.

During the 2001 Legislative Session, legislation was considered (CS/SB 1188) that would have increased permanent partial disability impairment benefits from 50 percent of the average temporary total disability benefit rate to 66 2/3 percent of the average weekly wage. At the request of committee staff, NCCI provided the following estimated impact of increasing the permanent partial benefits:

"This proposal would effectively double impairment payments (since currently temporary total is paid at 66 2/3% and PP is paid at 50% of this amount). Impairment benefits represent approximately 30% of permanent partial indemnity costs (with healing period, supplemental and rehabilitation costs making up the rest). The impact on PP indemnity costs is therefore  $+100\% \times 30\% = +30\%$ . Since PP indemnity costs represent 21.6% of total benefits, the overall impact is  $+30\% \times 21.6\% = +6.5\%$ ."

## **Litigation Expense and Attorney Involvement**

Although attorney fees were reduced in 1993, Florida has seen a significant growth in litigation rates. Defense attorney involvement in Florida has almost doubled during the period of 1994 - 1998, according to WCRI's *Multistate Comparisons, 1994-1999*. In recent years, the Division of Workers'



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Compensation has noted that attorneys are involved in filing over 95 percent of the request for assistance (informal dispute resolution process). In the WCRI comparison with eight other states, Florida had the highest litigation rates, measured by the percent of claims with defense attorney involvement of the eight states and had defense attorney involvement rate of 30 percent, versus 19 percent or less in the other eight states.

According to NCCI, attorney involvement in Florida has a more significant fiscal impact in Florida than countrywide. In cases where no attorney is involved, the average cost per case for indemnity/medical combined in Florida (\$10,424) was comparable to countrywide (\$9,753). However, if an attorney was involved in such a case the average cost per case was \$41,584 in Florida and \$30,227 countrywide. The costs for medical and indemnity benefits are impacted. The higher than expected medical costs in Florida could be attributed to the attorney involvement in Florida. In the WCRI *Multistate Comparison, 1994-1999*, the average defense attorney payment in Florida, at \$3,313, was the highest of the eight states per 1996 claims, at 36 months' maturity.

Why has attorney involvement increased significantly in Florida? Some stakeholders contend that litigation costs can be driven by claimants being uninformed of rights, their dissatisfaction with their medical care, and the nonreceipt or late payment of benefits. The WCRI *Multistate Comparison, 1994-1999*, suggested that the increase might be attributable to: 1) changes in 1993 law which allowed a worker to receive permanent impairment benefits and return to work; and 2) settlements allowing the washout or closure of future medical benefits. Current data maintained by the division does not provide sufficient data to adequately address or determine the specific cost drivers relating to attorney's fees and litigation expense. In recent years, litigation expense data has been grouped with attorney's fees data, which prevents a comparison of actual fees to the statutory fee schedule or trends regarding actual fees.

The WCRI report entitled, *Permanent Partial Disability Benefits: Interstate Differences* commented, "Because PPD benefits tend to be the most litigated benefits, attorney involvement and fees are subjects of particular interest to policymakers." In addition, the report WCRI noted that 20 states, including Florida, use a tiered fee schedule for the payment of claimants' attorneys' fees. Other states generally set the fee as percentage of the settlement, ranging from 5 - 10 percent in Maine to 33.33 percent in Iowa, Nebraska, Nevada, Ohio, and South Carolina. In New Mexico, fees are capped at \$12,500 for both claimant and defense attorneys. California allows attorney's fee of up to 15 percent. Sixteen states use a dollar amount or percentage cap on attorney's fees and 21 states provide a mechanism for attorneys to appeal their fees.

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In 39 states, the injured worker generally is responsible for the payment of his or her attorney's fees. In 18 of these 39 states, it was noted that there were no circumstances in which the liability for the payment of the claimant's attorney's fees shifted. The Illinois Workers Compensation Act provides that in the event the amount of the claim to be paid for compensation does not exceed the written offer made to the claimant by the employer/carrier prior to representation by an attorney, no fees are due to any such attorney.<sup>24</sup>

Generally, Illinois prohibits attorney's fees in excess of 20 percent of the compensation recovered and paid, unless approved by the Industrial Commission. Texas establishes a schedule of billable hours for certain types of services provided by attorneys and limits attorney's fees for claimants to 25 percent of the worker's benefits. Defense attorney's fees are limited to \$150 per hour for attorneys and \$50 per hour for legal assistant time. New York does not limit attorney's fees for lump-sum settlements or other awards.

During the 2001 Legislative Session, legislation was considered which was aimed at reducing attorney involvement and litigation expense associated with disputed claims. These proposals and the associated impact estimated by NCCI are provided below:

- CS/SB 1188 increases the attorney's fee schedule from the current contingency basis 20/25/10/5 to a fee basis of 25/20/15/10, or approximately 25 percent. Attorney's fees, including fees involving settlements would be subject to the fee schedule. The Judge of Compensation Claims would be authorized to approve an attorney's fee up to \$2,500, based on an hourly rate, if the contingency fee was determined to be inadequate. According to NCCI, since attorney's fees now comprise about 1.5% of benefit costs, the fee schedule change would directly increase system costs by 0.4%. However, current practice suggests that claimants' attorneys are paid according to hourly rates rather than the statutory fees schedule. Since the hourly rate is restricted, this would mitigate the increase and most likely result in some savings. Besides a reduction in attorney's fees, this proposal would also be expected to reduce the use of attorneys, as was the intent of the original law change.
- Attorney's fees would attach after 30 days after the carrier receives the petition, rather than 44 days after filing the request for assistance. According to NCCI, since the current law does not require the carrier to receive a copy of the request for assistance, this proposal will allow the carrier to resolve more disputes before the carrier becomes liable for

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<sup>24</sup> 820 ILCS 305/16a

payment of attorney's fees. The behavior of the parties would likely change and information would be available sooner. While difficult to quantify, this should help reduce attorney involvement and costs and may offset any incentive for increased involvement created by the higher attorney fee schedule.

Recently, the Division of Workers' Compensation reviewed attorney's fees for 2,583 settlements received in April 2001. The results of the analysis were compiled by the Division of Workers' Compensation in the 2001 Dispute Resolution Report (Draft). Approximately 75 percent of these settlements reported attorneys' fees in excess of the statutory formula. The division noted that actual fees averaged approximately 33 percent above the statutory formula. The division determined that excess fees totaled approximately \$2 million for the sample.

## **Exemptions from Coverage**

According to study recently released by the Construction Education Concepts, entitled, *A Study On the Magnitude of Loss of Workers' Compensation Premiums in 1997 Due to Employer Fraud and Exemptions in the Construction Industry* (2001), an estimated \$1.2 - \$2.8 billion in workers' compensation premiums is lost, on annual basis, due to employer premium fraud and exemptions in the construction industry. (The report noted that a conservative estimate of the lost premiums was \$1.3 billion.) In 1999, Florida had an estimated written workers' compensation premium of \$2.5 billion. The report noted that in 1997 construction industry premiums collected totaled \$912,244,160, which was less than the estimated premiums lost attributable to employer fraud and exemptions. In response to a request by committee staff, NCCI evaluated the study and provided the following comments:

1. The study appears to assume that all construction work is insured through commercial insurance. According to the Division of Workers' Compensation, self-insured employers represented approximately 30 percent of the Florida workers' compensation market in 1997. The \$1.3 billion estimate should be reduced to reflect insurance premiums, which were not required to be paid by self-insured employers. (It is unclear whether the self-insured employers comprise 30 percent of the construction industry.)
2. NCCI collects limited fraud data is therefore unable to empirically verify Dr. Coble's estimate through any sort of practical check. NCCI suggests that further independent research is needed to test his theories and assumptions.

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According to NCCI, the reporting format does provide a data field for fraud reporting, and NCCI's Statistical Plan does provide coding on an optional basis. However, the data is not used due to inconsistent fraud reporting methodology. NCCI indicated that it would be making a filing with the Department of Insurance soon to provide further definition of this fraud-reporting field for claim fraud. A methodology has not been developed for premium fraud or other types of insurance-related fraud.

As mentioned earlier, the Legislature in recent years has provided the Division of Workers' Compensation and the Division of Insurance Fraud with additional enforcement and compliance tools to fight workers' compensation fraud. In 1994 and again in 1997, the Legislature provided the Division of Workers' Compensation, in particular, with new and broader authority to effect compliance with chapter 440, F.S.

As previously noted by the Statewide Grand Jury Report, some of these provisions of ch. 440, F.S., have not been fully implemented by the Division of Workers' Compensation. Although s. 440.107, F.S., authorizes the Division of Workers' Compensation to assess against any employer who fails to obtain coverage the greater of twice the evaded premium for the preceding 3-year period (based on the preceding 3-year period payroll) or \$1,000, the division has stated that the provision does not provide guidance for the division on when to issue such penalties. The division has suggested that specific legislative intent regarding the application of this provision would assist them in the application of this penalty. Presently, the division assesses twice the evaded premium penalty provision on construction and non-construction employers who are repeat violators, rather than all violators. Although the section provides discretionary authority for the division to assess, the division does appear to have the discretionary authority to assess any employer (first instance or subsequent instances of noncompliance), if certain conditions are met (failure to secure coverage).

The Statewide Grand Jury also recommended that the Department of Labor stop considering employers to be in compliance with the law when they purchase coverage clearly insufficient for their employees. In regards to this practice by the Division of Workers' Compensation, the Statewide Grand Jury stated, "We do not believe the Legislature ever intended that an employer who engages in premium fraud should ever be considered by any state agency to be in compliance with Chapter 440 in any way, shape, or form." In response to a recent staff inquiry regarding the implementation of the Grand Jury's recommendations, the division provided the following response as to why this recommendation had not been implemented:

- "The Division considers an employer in compliance with the Workers' Compensation Law if the employer has any type of workers'

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compensation insurance policy or does not exceed the threshold number of employees. An employee who has any valid workers' compensation insurance policy is in civil compliance with ch. 440, F.S., but may be in criminal violation pursuant to s. 440.105(4)(b), F.S. An employer found by the division to be in violation of this section is referred to the Department of Insurance, Division of Insurance Fraud for prosecution. In addition, the employer is required to provide proof of an insurance policy to the division."

- "If the policy is a minimum premium policy, the division also requests that the employer provide a statement from the carrier, saying that the carrier is satisfied with the premium on the policy and the number of employees covered. The division also submits a report to the carrier including the number of employees found on the employer job site, so that the carrier can make informed business decisions based on the practices of that employer."

Section 440.10(1)(f), F.S., authorizes the Division of Workers' Compensation to assess against an employer who willfully fails to secure coverage a penalty not to exceed \$5,000 for each employee of that employer who is classified by the employer as an independent contract but who is found by the division as not meeting the criteria for an independent contractor that is set forth in s. 440.02, F.S. The division has indicated that they consider this provision unenforceable for the following reasons: 1) the section confers discretion on the division to assess a penalty (not to exceed \$5,000) but does not contain a grant of rulemaking authority for the division to establish the exact amount of the penalty; 2) the section requires the division to prove intent of the employer to willfully misclassify an employee; 3) the section conflicts with s. 440.02(14)(d), F.S., which establishes criteria for an independent contractor to not be considered an employee, but does not establish criteria status as an independent contractor as implied by s. 440.10(1)(f), F.S.

According to the division, intent should not be an element of civil infraction. Intent is an element of fraud, and prosecution of fraud under ch. 440, F.S., is within the jurisdiction of the Division of Insurance Fraud of the Department of Insurance, and only could be enforced by Division of Insurance Fraud. The Division of Workers' Compensation suggests that the term, "willful" should be removed, if it is the intent of the Legislature for the division to enforce the provision as a civil infraction. Presently, s. 440.591, F.S., grants the division authority to adopt rules to implement the provisions of ch. 440, F.S., conferring duties upon it. Therefore, it is unclear why the division would need additional rulemaking authority to adopt rules for implementing the penalty provision.

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Many observers of the Florida workers' compensation system contend that exemptions have become increasingly expensive to administer and burdensome on the public, particularly small businesses. In recent years, the Division of Workers' Compensation has suggested eliminating the exemptions or significantly streamlining the exemption process by making the exemption from coverage and waiver of such exemption automatic by operation of the law. The Division of Workers' Compensation has proposed eliminating all exemptions as its primary recommendation. This would allow the division to have complete jurisdiction over employers without coverage and allow the division to immediately shut down such businesses until coverage is obtained. The elimination of the exemption would also remove the division from litigation between employers, carriers, and claimants when the issue of whether a claimant is exempt or entitled to benefits as an employee of an employer. As an alternative, the division is suggesting the elimination of the exemption administrative process by providing that the exemption of all classes of persons eligible for exemption is automatic by operation of the law, and by making rejection of the right to such exemption automatic by the purchase of coverage by or on behalf of an otherwise exempt individual.

The current exemption process requires 20 (including 5 field support) positions and 15 temporary positions to administer the program. Currently, construction industry exemptions are issued for a 2-year period. Presently, the compliance unit has 42 full-time positions (44 are authorized). An additional 14 positions are responsible for administrative-related duties including microfilming. Five positions presently provide customer service.

Each year, the Department of Labor and Employment Security and the Department of Insurance, the Division of Workers' Compensation are required to submit a joint report to the President of the Senate and Speaker of the House of Representatives summarizing their compliance and enforcement activities for the preceding fiscal year. The following statistics regarding their efforts were included in the FY 1999-2000 report:

1. The Division of Workers' Compensation made 1,136 referrals to the Department of Insurance of suspected fraudulent employer activities. These numbers represent an increase of 150 percent in referrals over the prior fiscal year (418).
2. The Division of Workers' Compensation issued 1,264 Stop Work Orders to employers found to be in violation of chapter 440, F.S. The Division of Workers' Compensation also brought 3,106 employers into compliance and caused 13,174 employees previously not covered to become covered. The division estimates that these actions resulted in an additional \$22.8 million in premiums to be paid by employers.

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3. During fiscal year 1999-2000, the Division of Insurance Fraud opened 358 cases relating to workers' compensation and arrested 132 individuals for all types of workers' compensation fraud.

As a result of the compliance efforts of the 42 positions in the Division of Workers' Compensation, an average of \$19.4 million in new workers' compensation premiums has been generated on an annual basis during the prior 3 fiscal years. The division generated a total of \$58.2 million in new premiums for fiscal years 1997 through 2000. Based on the results of the division's efforts, given the limited staffing, the extent of noncompliance could be significant.

Investigation and enforcement of compliance with the workers' compensation coverage requirements is reported to be very difficult, especially in the construction industry where an employer's workforce can change daily depending on the size of a job. Moreover, preventing abuses in the exemption process likewise is equally challenging since the status of a person as an independent contractor or employee can change depending on the type of work being done.

The Department of Business and Professional Regulation is responsible for licensing persons engaged in certain construction related occupations, including: general contractors, electrical contractors, building contractors, and roofers. As a condition for receiving an initial license and as a condition for renewing a license, a person must show proof of workers' compensation coverage or an exemption from coverage. In the event the Department of Business and Professional Regulation determines that a licensee does not have workers' compensation coverage, the department is authorized to impose a \$100 citation for failure to maintain coverage. [Rule 61G4-19.001, F.A.C.]

According to the U.S. Department of Labor, 38 states do not authorize any numerical exemptions from workers' compensation coverage based on the number of employees. In New York, sole proprietors with no employees, partnerships with no employees, and corporations owned by one or two persons with no employees are exempt from coverage. The remaining states allow exemptions from coverage for employers with 3-5 employees.

According to a 1997 study conducted by the National Association of Homebuilders, the costs of workers' compensation coverage adds 8.1 percent to the total labor bill for the construction of a new home. This represented approximately \$4,776 of the total costs of a new home.

## **Regulation of Florida's Workers' Compensation Insurance Rates**

During calendar year 2000, the written premium for workers' compensation insurance companies and self-insurance funds combined was \$2.7 billion. Presently, 396 insurers are authorized in Florida, however, only 257 companies reported written premium in 2000.

According to the *Annual Statistical Bulletin (2001 Edition)*, issued by NCCI, presently, 35 states have adopted some type of market-based system or competitive rating law. In states that use competitive rating, an insurer may file its own expense and profit component or full rate; the rate approval requirements are less restrictive; and rate variation methods are used.

According to the *Survey of Workers' Compensation Laws*, ten states (including Florida) presently use administered pricing methods in which a rating organization files one uniform full rate filing for all companies which is approved by the insurance regulator. In states that use loss costs, insurance companies will generally develop their own rates as the loss costs (adjusted claims data) multiplied by a particular company's loss cost multiplier ( e.g., expenses, profits, and trends). The full rate or manual rate represents the rate an insurer must charge to recoup the entire cost of writing workers' compensation insurance (loss costs plus expenses, taxes, and profits and contingencies). The remaining five states provide workers' compensation insurance through an exclusive state fund.

In 1996, the actuarial firm of Wakely and Associates, engaged by the department, released a report entitled, *Review of Competitive Pricing Mechanisms in Workers' Compensation Insurance*, that concluded that Florida's workers' compensation rate system was among the least competitive in the country and recommended that Florida adopt a system that provides for a more competitive workers' compensation rating. However, the report stated that "...existing studies do not provide clear indications of the long-term impact of a market based approach to rate regulation on employers aggregate workers' compensation costs." Wakely and Associates also stated that "any substantial decrease in rate levels or changes in market share raise potential concerns regarding the viability and solvency..." In summary, the study noted the following potential advantages and disadvantages regarding market-based rate regulation:

### **Potential Advantages:**

1. Provides greater choice of methods in determining and financing premiums and easier integration with other programs (e.g., health insurance, operations in other states) for employers; and



2. Provides greater flexibility for insurers to develop and market products and to integrate programs in other states.

**Potential Disadvantages:**

1. Places small employers or employers in specific classes that lack market power at a competitive disadvantage in obtaining coverage on favorable terms;
2. Results in greater fluctuation in workers' compensation prices without the same level of regulatory control; and
3. Places small domestic carriers at a competitive disadvantage.

## **Conclusions and Recommendations**

The workers' compensation system in Florida was intended to create “. . . an efficient and self-executing system . . . which is not an economic or administrative burden.” [s.440.015, F.S.] However, in recent years, Florida has experienced substantial growth in premium costs, medical costs, indemnity costs, and litigation expenses since 1994. Premiums are among the highest countrywide. The frequency of permanent total disabilities cases is three times higher than countrywide. Attorney involvement is unusually high in Florida, and if an attorney is involved the difference in claim size is 40 percent higher in Florida versus countrywide. Although Florida has one of the lowest fee schedules for providers, medical costs represent 65 percent of the costs in Florida, versus 56 percent countrywide. However, permanent impairment benefits in Florida are among the lowest in many states reviewed. An estimated \$1.3 billion in premiums is lost annually due to fraud related to the employer premium fraud and exemptions in the construction industry. Therefore, it is recommended that the Legislature consider the following:

1. Amending s. 440.10(1)(f), F.S. which authorizes the Division of Workers' Compensation to assess against an employer who willfully fails to secure coverage a penalty not to exceed \$5,000 for each employee who is classified by the employer as an independent contractor, but who is not, by eliminating the term, “willfully,” thereby eliminating the need to prove intent.
2. Revising the current exemption requirements by eliminating exemptions below the subcontractor level. All persons contracting with a subcontractor would be required to obtain coverage. Any changes in the exemption requirements should be implemented over several years to ensure that employers understand provisions under the new law.
3. Clarifying s. 440.38, F.S., to provide that an employer purchasing inadequate insurance coverage is not in compliance with the coverage requirements of the Workers' Compensation Law.

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4. Revising the penalty provisions for contractors licensed under the provisions of chapter 489, F.S., to parallel the Division of Workers' Compensation provisions.
5. Revising the standard for permanent total disability by revising the definition of catastrophic injury to exclude the reference to injuries that would otherwise qualify an individual for social security disability or supplemental income, as provided in CS/SB 1188 during the 2001 Session. Presently, an employee can be awarded permanent total disability whether or not the employee has applied for or has been granted or denied social security benefits.
6. Increasing the permanent impairment benefits from 33 percent to 66 2/3 percent of the temporary total benefits, as provided in CS/SB 1188 during the 2001 Session.
7. Revising attorney's fee provisions to only allow fees to attach 30 days after the receipt of the petition by the carrier/employer, rather (than 44 days after filing the request for assistance) as provided in CS/SB 1188 during the 2001 Session.
8. Establishing a per accident cap on the discretionary hourly attorney's fee award rate, as provided in CS/SB 1188.
9. Discouraging frivolous claims by providing that no attorney's fees are due if the compensation awarded does not exceed the written offer to the claimant by the employer/carrier prior to representation by an attorney.
10. Clarifying that the managed care opt-out is to be applied retroactively, regardless of the date of injury. The opt-out provision was intended to provide employers with greater flexibility and potential savings by allowing the employer to determine what type of health care delivery system would best meet their needs.
11. Adopting a fee schedule for hospitals to address the increasing costs. A majority of the states have adopted fees schedules to contain medical costs.
12. Revising data collection requirements for providers and hospitals or require an annual independent study for the determination of whether the current method for reimbursement is reasonable, promotes cost containment, efficiency in the delivery of health care in the workers' compensation system, and that the reimbursement is sufficient to ensure availability of such medically necessary remedial treatment, care and attendance to injured workers. [Section 440.13(12), F.S.]
13. Revising the utilization and billing oversight process to ensure that the division takes a more proactive role in detecting overutilization and improper billing by providers. Although it is the carrier's primary responsibility, the division has an integral role in actively ensuring that providers comply with provisions of ch. 440.

