



The Florida Senate

Interim Project Report 2004-110

December 2003

Committee on Banking and Insurance

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REVIEW OF THE 2003 WORKERS' COMPENSATION ACT

SUMMARY

Major changes to the workers' compensation laws were enacted in the 2003 Special Session A in Senate Bill 50-A. Concerns were raised in the Senate regarding the legal effect of various provisions and possible unintended consequences.

A major concern is the rapidly growing deficit in the Florida Workers' Compensation Joint Underwriting Association (JUA), as a result of the premium caps established by the act, which the report recommends addressing by an appropriation, exemption from certain assessments for JUA policies, and revision of the premium structure and assessment methodology.

The report recommends legislative reconsideration of two criminal penalties enacted that may have the indirect effect of making illegal aliens ineligible for workers' compensation benefits. Another concern is the inclusion of employment agencies within the definition of employer, which may have a broader sweep than intended, and capture entities that would otherwise meet the definition of an independent contractor.

This report reviews case law in Florida and other states and concludes that there is sufficient precedent to uphold the constitutionality of the act's termination of permanent total disability benefits at age 75. The report compares Florida's limitations on compensation for mental and nervous injuries to other states and also compares Florida's limitations on attorney fees to other states.

Reviews of other issues suggest corrections related to:

- benefit eligibility for governmental volunteer workers;
- exemptions from coverage for members of a limited liability company;
- criminal penalties for fraud;
- release of wage information to carriers from the Division of Unemployment Compensation;

- the valuation of attendant care provided by a family member who remains employed;
- practice parameters that must be utilized; and
- consolidation of the laws that provide for state audit and examination of workers' compensation carriers.

Finally, the issue of creating a state workers' compensation fund is examined by reviewing the state funds created in 21 other states.

BACKGROUND

Due to growing concerns regarding the availability and affordability of workers' compensation insurance in Florida, legislation was enacted in 2003 that substantially revised many aspects of the workers' compensation law.¹ The changes provided in Senate Bill 50-A were designed to reduce costs, expedite the dispute resolution process, provide greater enforcement and compliance authority for the Division of Workers' Compensation to combat fraud, provide affordable coverage for small employers, revise certain indemnity benefits, and increase medical reimbursement fees for physicians and surgical procedures. Because of this legislation, rates for new and renewal policies that are effective on or after October 1, 2003, were reduced by 14.0 percent.

In addition to debate on major policy decisions reflected by the bill, concerns were raised in the Senate regarding the legal effect of various provisions and possible unintended consequences. Such concerns related to: 1) the extent to which unfunded deficits may be created in the Florida Workers' Compensation Joint Underwriting Association; 2) terminating permanent total disability benefits at age 75; 3) compensability standards for mental and nervous injuries; 4) criminal penalties related to employees who use a false, fraudulent, or misleading statement as

¹ Senate Bill 50-A; ch. 2003-412, L.O.F.

evidence of identity in obtaining employment; 5) the status of employment agencies as employers; and 6) how the limitations on attorney fees may affect access to legal representation. In addition, proposals were discussed in the Senate to establish a state insurance fund to write workers' compensation insurance which would compete with other insurers, which generated interest among many Senate members and the desire for more information. Finally, certain "glitches" have been identified since the law's passage. Additional background on each specific issue is provided in the Findings section below.

METHODOLOGY

For the issues identified, committee staff analyzed the case law to determine how the changes of the bill are likely to be interpreted in light of those decisions. Staff also interviewed experts in the field on such issues and obtained interpretations by the Division of Workers' Compensation (Department of Financial Services) and the Agency for Health Care Administration. Other state laws were reviewed for certain issues to compare to the Florida law. Given the October 1, 2003, effective date of the Senate Bill 50-A, there was little data or actual claims information for how the bill is actually affecting claims for injuries occurring on or after that date.

FINDINGS

Deficits in the Florida Workers' Compensation Joint Underwriting Association

Senate Bill 50-A placed caps on premiums in the Florida Workers' Compensation Joint Underwriting Association (JUA), the insurer of last resort, for eligible small employers and charitable organizations. The premiums for coverage in the JUA had risen three to four times the premiums charged in the voluntary market. As the insurance market tightened, the number of policies issued in the JUA increased from 522 at the end of 2000 to 1,179 as of February 2003, and written premiums increased from \$5 to \$26 million during this period. The bill's restrictions on exemptions in the construction industry were expected to increase the JUA volume even further, prompting the Legislature to address affordability of JUA coverage.

However, the JUA premium caps are somewhat illusory because the law provides that the policies subject to such caps are assessable, meaning that any deficit must be funded by assessing JUA policyholders additional amounts. At this time, a significant deficit

appears to be almost certain. But actually collecting the full amount of any such assessments is doubtful, given the limited financial resources of many small employers, as well as the history of largely unsuccessful attempts at collecting assessments from members of insolvent group self-insurance funds.

The bill created a new subplan "D" in the JUA, in which the premiums for small employers with 15 or fewer employees and an experience modification factor of 1.10 percent or less are capped at 125 percent of the premium for the voluntary market. Premiums for charitable organizations meeting certain criteria with an experience modification factor of 1.10 percent or less are capped at 110 percent of the voluntary market premium. However, any deficits in subplan "D" will be assessed against the employers in that subplan.²

The JUA has experienced a significant increase in the number of policies issued. During the period of July 26-November 30, 2003, 1,276 applications were bound in subplan D. In November, the JUA noted that subplan D activity accounted for approximately 85 percent of the applications bound and 44 percent of premiums.

Because of the creation of subplan D and the caps on premiums, ongoing concerns exist regarding the financial impact of subplan D on the JUA, the magnitude of the statutory deficit and policyholder assessments associated with the subplan, and any resultant solvency issues. Prior to the inception of subplan D, the JUA indicated that their premiums should be 2.57 times higher than the voluntary market premium to remain actuarially sound, as compared to the act's limits of 1.25 and 1.10 percent for small employers and certain charitable organizations, respectively.³ According to the JUA's projected annual statements, subplan D will incur a \$4.6 million deficit, as of December 31, 2003, which is only six months into the policy year.⁴

To assist the Legislature in further addressing the impact of the act on the JUA and on the availability

² Section 627.311(4)(c), F.S. (2003).

³ FWCJUA Subplan D Rate Filing to Implement Senate Bill 50A, dated June 27, 2003.

⁴ Premium growth was projected based on first four months of actual premiums and assuming a 5 percent growth in Nov. and Dec. Loss projections were based on the JUA's payout patterns for the last nine years. FWCJUA - December 31, 2003 Projected and Liquidation, Subplan D.

and affordability of coverage, the law requires the JUA to submit a report to the Legislature no later than January 1, 2005, which addresses the following issues:

- number of policies and aggregate premium of the JUA before and after the implementation of Senate Bill 50-A;
- projected surpluses or deficits and possible means of providing funds to ensure solvency of the plan;
- effectiveness of the law in improving the availability of coverage in the state; and
- legislative recommendations to improve availability of coverage in the voluntary and residual market.

The JUA's proposed 2004 business plan identifies the subplan D deficit and any resultant solvency issues that may arise as a top priority to be addressed. To achieve this goal, the JUA, with input from the Office of Insurance Regulation, will be identifying and pursuing legislation in 2004. The JUA anticipates issuing, with input from the office, a white paper by March 1, 2004, that identifies the magnitude of the deficit and resultant solvency issues and potential legislative remedies supported by actuarial, financial, and underwriting information.

Termination of Permanent and Total Disability Benefits at Age 75

Senate Bill 50-A provides that permanent total disability (PTD) benefits are payable only until an employee reaches age 75, unless the employee is ineligible to receive Social Security benefits due to the compensable injury preventing the employee from working sufficient quarters to be eligible for benefits. If the accident occurs on or after the employee reaches age 70, benefits are payable during the continuance of permanent total disability, not to exceed 5 years following the determination of permanent total disability.⁵ The provision was one of many changes intended to reduce costs and ensure the affordability of the workers' compensation system in Florida. Concerns were raised regarding whether this provision violates the equal protection clause of the Florida Constitution.⁶

There appears to be sufficient precedent for the Florida Supreme Court to rule the termination of workers' compensation PTD benefits at age 75 constitutional. A split exists among different state courts regarding

whether PTD benefits may be terminated at a particular age. The state courts that have addressed the constitutionality of similar provisions have applied a rational basis test to determine whether the statute violates the state's equal protection clause. Generally, in order for an age based classification to be valid under a state constitution, the classification must have a legitimate goal and utilize a rational means to reach that goal.

The Florida workers' compensation law was amended in 1979 to provide that wage loss benefits, as newly created by that law, be terminated at age 65.⁷ This was ruled constitutional by the Florida Supreme Court in *Sasso v. Ram Property*.⁸ The Court ruled that Florida's workers' compensation system remained a "reasonable alternative" to the right of access to courts guaranteed in the Florida Constitution,⁹ because the plaintiff received adequate benefits including medical care, temporary total disability benefits, and would have received PTD benefits if he had qualified. The court also used the rational basis standard of analysis and determined that the law did not violate the state constitutional right of equal protection. The court found three legitimate state objectives: to reduce the cost of workers' compensation premiums; to induce older workers to retire, thus aiding the advancement of younger workers; and to reduce fringe benefits with age to reflect a decline in productivity. The court rejected the additional argument that the statute avoids the duplication of benefits, stating that workers' compensation benefits have a different purpose than Social Security retirement benefits.

State courts in Tennessee, Massachusetts, and Kentucky have upheld the validity of laws terminating or reducing PTD benefits at age 65. Various rationales have been advanced by the states defending their particular statutes, including reducing the program costs of the workers' compensation system, and avoiding the duplicate payment of benefits.¹⁰ Based on *Sasso*, the Florida courts are likely to agree that reducing program costs is a legitimate rationale for placing an age limit on benefits, but probably would

⁷ Ch. 79-40, L.O.F.; s. 440.15(3)(b), Fla. Stat. (1979). The statute was amended in 1983 to eliminate the provision terminating benefits at age 65 (ch. 83-305, L.O.F.).

⁸ *Sasso v. Ram Property*, 452 So.2d 932 (Fla. 1984).

⁹ FLA. CONST. art. I, sec. 21.

¹⁰ See *McDowell v. Jackson Energy RECC*, 84 S.W.3d 71 (Ky. 2002); *Tobin's Case*, 675 S.E.2d 781 (Mass. 1997); *Vogel v. Wells Fargo Guard Services*, 937 S.W.2d 856 (Tenn. 1996).

⁵ Section 440.15(1)(b), F.S. (2003).

⁶ Art. I, sec. 2, Fla. Const.

not recognize the avoidance of a duplication of benefits as a legitimate goal.¹¹

While some state courts allowed terminating or reducing workers' compensation benefits when the beneficiary is eligible for Social Security retirement, other state courts such as Arkansas, West Virginia, and Colorado have found such laws to be unconstitutional. Each of these states ruled unconstitutional laws tying a reduction or elimination of workers' compensation benefits to Social Security retirement because the two benefits have different purposes and thus it is irrational to claim that benefits are being duplicated by the receipt of both benefits.¹² The courts state that workers' compensation benefits replace lost wages and are a substitute for the tort system, while Social Security retirement benefits are solely a retirement benefit.

There appears to be adequate legal precedent to argue that the Florida Legislature has made a reasonable classification that addresses the legitimate goal of lowering workers' compensation premiums, while still offering a reasonable alternative to the tort system.

Compensability Standards for Mental and Nervous Injuries

Prior to the enactment of Senate Bill 50-A, a mental or nervous injury due to stress, fright, or excitement only, did not qualify as an accidental injury and was not compensable.¹³ The law also required that mental or nervous injuries occurring as a manifestation of a compensable injury must be demonstrated by clear and convincing evidence.¹⁴ Florida case law determined that a mental or nervous injury, even with a physical injury or accident, was not compensable unless the physical injury was the causal factor.¹⁵ The Florida Supreme Court stated:

For a mental or nervous injury to be compensable in Florida there must have been a physical injury. Otherwise, the disability would have been caused only by a mental stimulus, and must be denied coverage

*under the statutory exclusion. A mere touching cannot suffice as a physical injury.*¹⁶

Subsequently, the Florida First District Court of Appeal held that eligibility for compensation for psychiatric injury resulting from compensable work-related physical injury required a finding by clear and convincing evidence that the mental or nervous injury was directly linked to the initial injury, not that the physical injury was the major contributing cause of the psychiatric injury.¹⁷

Senate Bill 50-A continues the mental nervous injury exclusions and the clear and convincing evidence standard noted above and codifies case law that prohibits the payment of benefits for mental or nervous injuries without an accompanying physical injury; however, the law also provides that the physical injury must require medical treatment. Before the 2003 legislative changes, case law provided that the lack of medical treatment was relevant to whether or not a sufficient injury had been sustained. The new law requires that the compensable physical injury be the major contributing cause of the mental or nervous injury.¹⁸ The act also provides that a physical injury resulting from a mental or nervous injury unaccompanied by a physical trauma requiring medical treatment is not compensable. It limits the duration of "temporary benefits" for a compensable mental or nervous injury to no more than six months after the employee reaches maximum medical improvement for the physical injury. In context, this six-month limitation is understood to apply to the temporary disability benefits payable under s. 440.15, F.S., but not to medical benefits payable under s. 440.13, F.S. If a permanent psychiatric impairment results from the accident, permanent impairment benefits are limited to one percent for the psychiatric permanent impairment.

The National Council on Compensation Insurance (NCCI) noted that the savings attributable to this particular change in compensability standards is not specified; however, the NCCI estimated that this change, together with other changes that tighten compensability standards, may reduce the number of compensability claims by one percent and produce a one percent overall savings. The NCCI stated, "there is no data...to precisely model the effect of changes in compensability standards...any additional impact will

¹¹ See *Sasso*, 452 So.2d at 934.

¹² See *Industrial Claim Appeals Office v. Romero*, 912 P.2d 62 (Col 1996); *Golden v. Westmark Community College*, 969 S.W.2d 154 (Ark. 1998); *West Virginia v. Richardson*, 482 S.E.2d 162 (W.V. 1996).

¹³ Section 440.02(1), F.S. (2002).

¹⁴ Section 440.09(1), F.S. (2002).

¹⁵ *City of Holmes Beach v. Grace*, 598 So. 2d 71 (Fla. 1989).

¹⁶ *Ibid.*

¹⁷ *Cromartie v. City of St. Petersburg*, 840 So.2d 372 (Fla. 1st DCA 2003).

¹⁸ Section 440.093, F.S. (2003).

be reflected in subsequent data...and used in future rate filings.”¹⁹

Staff reviewed mental or nervous injury compensability provisions in other states and noted that these provisions generally can be divided into three groups: physical-mental cases, mental-physical cases, and mental-mental cases. In a physical-mental claim, a precipitating physical injury or trauma causes a mental or nervous injury. In a mental-physical claim, mental stress causes a physical injury or condition. In a mental-mental claim, mental stress leads to a mental condition or disability.

There are 29 states, including New Mexico and Colorado, which provide compensability for mental or nervous injury without the occurrence of a physical injury or trauma. Colorado and New Mexico limit such benefits to 12 weeks and 100 weeks, respectively. The remaining 21 states, including Florida, provide compensation for mental stress only if a compensable physical injury occurs, as noted in the table below. Arkansas and Oklahoma allow an exception for the physical injury requirement in instances of rape or violent crime, respectively. Arkansas, Florida, and Wyoming limit the duration of psychiatric disability benefits, as indicated.

States that Compensate Mental Stress Claims Only If Physical Component Is Present		
Alabama	Kansas	Ohio
Arkansas*	Kentucky	Oklahoma**
Connecticut	Minnesota	South Dakota
Florida***	Montana	Virginia
Georgia	Nebraska	Washington
Idaho	New Hampshire	West Virginia
Indiana	North Dakota	Wyoming***
* 26 weeks of disability benefits. Physical injury limitation does not apply to victims of violent crimes. ** Physical injury limitation is not applicable in the case of rape. *** Six months after physical maximum medical improvement.		

Criminal Penalties Related to Employees Who Use False Evidence of Identity

Senate Bill 50-A contains two criminal penalties that potentially impact the issue of whether illegal alien employees are entitled to receive workers' compensation benefits if injured on the job, but it is not clear if this was intended. The first provision is the

¹⁹ NCCI Explanatory Memorandum. Florida Senate Bill 50-A Law Filing, Effective October 1, 2003.

amendment to s. 440.105(4)(b), F.S., which provides that it is a felony and insurance fraud for a person:²⁰

9. To knowingly present or cause to be presented any false, fraudulent, or misleading oral or written statement to any person as evidence of identity for the purpose of obtaining employment or filing or supporting a claim for workers' compensation benefits.

The second provision s. 440.105(3), F.S., is amended to make it a first-degree misdemeanor for an employer to commit the following act:

(b) It shall be unlawful for any employer to knowingly participate in the creation of the employment relationship in which the employee has used any false, fraudulent, or misleading oral or written statement as evidence of identity.

Illegal or unauthorized aliens are not precluded from receiving benefits for work-related injuries under Florida's workers' compensation law. Such workers come within the definition of "employee" under s. 440.02(15)(a), F.S., which specifies that an employee means "any person who receives remuneration from an employer for the performance of any work or service while engaged in any employment ... whether lawfully or unlawfully employed, and includes, but is not limited to, aliens..." As such, aliens are employees and entitled to workers' compensation benefits for a work-related injury.

Historically, Florida courts have recognized that the workers' compensation law specifically includes illegal aliens among those employees entitled to benefits. In *Gene's Harvesting v. Rodriguez*, the First District Court of Appeal found that the workers' compensation law did not exclude from coverage workers not lawfully immigrated so that an alien was entitled to workers' compensation benefits for a work-related injury even though he or she was in the country illegally.²¹

²⁰ The penalties for committing insurance fraud range from a third to a first-degree felony, depending on the monetary value of the violation.

²¹ 421 So.2d 701 (Fla. 1st DCA 1982). See also, *Cenvill Development Corp. v. Candelo*, 478 So.2d 1168 (Fla. 1st DCA 1985). In *De Ayala v. Florida Farm Bureau Casualty Insurance Co.*, 543 So.2d 204 (Fla. 1989), the Florida Supreme Court struck down a provision in the workers' compensation law which had limited death benefits for nonresident alien beneficiaries of deceased workers who are not residents of Canada to \$1,000, rather

Under current Florida law relating to terms and conditions of employment, it is a noncriminal violation for any person to knowingly employ, hire, or recruit, for private or public employment within the state, an alien who is not duly authorized to work by the immigration laws or the Attorney General of the United States.²²

At the federal level, immigration laws make it unlawful for employers to knowingly hire undocumented workers and for employees to use fraudulent documents to establish employment eligibility. The Immigration Reform and Control Act of 1986 (IRCA) establishes an extensive employment verification system to deny employment to aliens who: (a) are not lawfully present in the U.S., or (b) are not lawfully authorized to work in the U.S. Under the IRCA, employers must verify the identity and eligibility of all new hires by examining specified documents before they begin work.²³ If an employer unknowingly hires an unauthorized alien or if the alien becomes unauthorized while employed, the employer is compelled to discharge the worker upon discovery of the worker's undocumented status.

Recently, the United States Supreme Court held in a case interpreting the provisions of the IRCA (*Hoffman Plastic Compounds, Inc., v. National Labor Relations Board*), that the federal immigration policy, as expressed by Congress in the IRCA, foreclosed the National Labor Relations Board (NLRB) from awarding back pay to an undocumented alien who had never been legally authorized to work in the U.S.²⁴ In *Hoffman*, the Supreme Court held that under the IRCA regime, it is "impossible for an undocumented alien to obtain employment in the U.S. without some party directly contravening explicit congressional policies. Either the undocumented alien tenders fraudulent identification, which subverts the cornerstone of the IRCA's enforcement mechanism, or the employer

than the \$100,000 otherwise available, as violative of both the Federal and State equal protection provisions.

²² Section 448.09, F.S. The noncriminal violation is a civil fine of not more than \$500, regardless of the number of aliens with respect to whom the violation occurred. Any person previously convicted of a noncriminal violation and who thereafter violates this provision, is guilty of a misdemeanor of the second-degree (sixty days in jail and a \$500 fine).

²³ Under the Act, employers are subject to criminal and civil sanctions for violating the Act with criminal penalties providing for imprisonment of up to five years and civil penalties ranging up to \$10,000.

²⁴ 535 U.S. 137 (U.S. Supreme Ct. 2002).

knowingly hires the undocumented alien in direct contradiction of its IRCA obligations."

However, a Florida appellate court in a decision handed down on October 13, 2003, distinguished *Hoffman* by finding that as a matter of first impression, the holding in *Hoffman* did not preempt the Florida Legislature's right to enact workers' compensation benefits for illegal aliens.²⁵ The Court stated that the IRCA does "not contain express preemption language nor does it so thoroughly occupy the field as to require a reasonable inference that Congress left no room for states to act. The U.S. Supreme Court has stated that workers' compensation is an area where states have authority to regulate under their police powers."²⁶

As amended by Senate Bill 50-A, the law now provides that it is a felony and insurance fraud for a person to knowingly present any false or misleading oral or written statement as evidence of identity for the purpose of obtaining employment. Therefore, if an illegal alien obtained his employment by misrepresenting his identity in order to get a job, then that person could be found to have committed insurance fraud and thus denied benefits if injured on the job. Pursuant to s. 440.09(4), F.S., this statute provides that an employee is not entitled to compensation benefits if a judge of compensation claims determines that the employee has knowingly or intentionally committed insurance fraud or any criminal act for the purpose of securing workers' compensation benefits. It is noteworthy that the Legislature did not amend the provision in the workers' compensation law which defines an "employee" to include an illegal alien under s. 440.02(15)(a), F.S.

Representatives with the Division of Insurance Fraud within the Department of Financial Services state that the purpose of this amendment was to facilitate the arrest and prosecution of illegal aliens who have lied about their identity in order to obtain employment and then falsified their on-the-job injury. These officials state that it is often easier to prove that the illegal alien lied about his identity in order to obtain work than it is to prove the job related injury was fabricated. Many times illegal aliens are in league with unethical doctors

²⁵ *Safeharbor Employer Services I, Inc. v. Cinto Valazquez* (2003 WL 22326966 (Fla. 1st DCA 2003)).

²⁶ The Court also held that since *Hoffman* found benefits other than backpay to be applicable to illegal aliens, there is no conflict between state and federal law in this case. See also, *DeCanas v. Bica*, 424 U.S. 351 (U.S. Supreme Ct. 1976).

and lawyers who bilk the workers' compensation system, these officials claim. Proponents of the amendment also argue that undocumented workers should not be entitled to benefits because they are not legally working and are, therefore, not lawful employees.

Those who criticize the provision state that public policy would not be served to deny benefits to an illegal alien merely because of their immigration status at the time they are hired. These persons emphasize that the provision is overly broad and could encompass anyone who "misleads" a prospective employer about their identity, no matter how minor the fabrication, even though there may be no causal relationship between the misrepresentation and the injury at issue. Also, persons that are critical of this provision contend that illegal alien employees who violate this provision and are legitimately injured on the job could still sue their employer in tort for negligence. Further, this provision could provide an incentive to employers to seek out illegal aliens as employees (and deny they knew their illegal work status at the time of hire), in order to avoid paying benefits if such workers were injured, and thus obtain a competitive advantage.

Senate Bill 50-A also amended the law to make it a first-degree misdemeanor for an employer to knowingly participate in the creation of the employment relationship in which the employee has used any false, fraudulent, or misleading oral or written statement as evidence of identity. This provision penalizes employers if they have knowledge of the employee's use of a false or misleading statement as evidence of identity relating to an employment relationship. It is understood that this provision was added as a way to "balance" the provision that criminalized false identification by employees, to ensure that both the employer and the employee would be subject to criminal penalties, if the requisite knowledge or intent is established. However, the criminal penalties in the two provisions are different so that the effect is to punish the employee more so than the employer.²⁷

Concern was expressed on the floor of the Senate relative to this provision that, taken literally, the language could be interpreted to mean that the

employer must merely know that an employment relationship was created, without knowledge that the employee used any false, fraudulent, or misleading statement as evidence of identity. However, this interpretation is not likely to be embraced by the courts and it is more likely to be read in a light more favorable to the employer, to require knowledge of the employee's use of a false statement as evidence of identity. The Florida Statutes and case law provide that if a criminal statute is susceptible to more than one meaning, or the meaning is in doubt, the statute must be construed in favor the accused.²⁸

Status of Employment Agencies as Employers

Senate Bill 50-A changed the definition of "employer" for purposes of the workers' compensation law to include "employment agencies, employee leasing companies, and similar agents that supply employees to other persons."²⁹ Previously these entities were not expressly included in the definition of employer.³⁰ The term, "employment agency," is not defined in chapter 440, F.S. The workers' compensation statutes are clear that the employer must pay compensation benefits if the employee suffers an accidental compensable injury or death arising out of work performed in the course and the scope of employment.³¹ Thus any entity defined as an "employer" by the statute is required to provide workers' compensation coverage to its employees. Employee leasing companies were already required by another statute to provide coverage prior to the new act, but the specific addition of employment agencies is a new development in Florida workers' compensation law.³²

It appears that this change is unlikely to affect most temporary employment agencies, but its full impact is unclear and it could adversely impact some employment placement agencies which refer or place applicants for employment. Staff was unable to find case law on this subject, but most temporary employment agencies were considered to have met the criteria of being an "employer" under the prior law, according to sources interviewed. Most temporary employment agencies exercise sufficient control over

²⁷ Section 440.105(4)(b)9., F.S., makes it a felony (for which the punishment depends on the monetary value of the violation) for an employee to falsify his identity for purposes of obtaining employment, while s. 440.105(3)(b), F.S., makes it a first-degree misdemeanor as to the employer.

²⁸ Section 775.021(1), F.S. (2003); *State v. Byars*, 823 So.2d 702 (Fla. 2002); *Allure Shoe Corp. v. Lymberis*, 173 So.2d 702 (fla. 1965).

²⁹ Section 440.02(16)(a), F.S. (2003).

³⁰ Section 440.02(16)(a), F.S. (2002).

³¹ Sections 440.09(1) and 440.10(1)(a), F.S. (2003).

³² Sections 468.520(4) and 468.529, F.S. (2003); also see, s. 440.11(2), F.S.(2003).

the employees that they send out to client employers to be considered the employer of their workers for purposes of the workers' compensation statutes. Representatives from major national employment agencies Manpower and Kelly Services indicate that their companies provide workers' compensation insurance for the employees they send to client-employers. Representatives from the National Council on Compensation Insurance also stated that generally temporary employment agencies are the named employers on workers' compensation policies.

The Division of Workers' Compensation asserts that changing the definition of employers is helpful in remedying a troubling employment practice that was developing in the construction industry. According to representatives from the Division, an increasing number of employee leasing companies (also known as professional employer organizations or PEOs) were having difficulty securing workers' compensation coverage from insurers. PEOs are required to purchase workers' compensation coverage for the employees that they lease to their clients. When a PEO failed to provide coverage, the Division would issue a stop-work order. With PEOs having difficulty supplying workers, some temporary employment ("temp") agencies stepped into the void. According to Division representatives, some temp agencies started to take on the characteristics of PEOs, but were not licensed as such. For instance, a temp agency would go to employer X and hire X's employees as "independent contractors" who now worked for the temp agency. Then, the temp agency would send the "independent contractors" back to work for X each day. Unlike PEOs, employment agencies are not required to obtain a license from the state. The workers' compensation coverage requirements were circumvented, as neither the employment agency nor the client employer provided coverage to the workers. However, the provisions of Senate Bill 50A that eliminate the independent contractor exemptions in the construction industry may do more to address this problem than the change in the definition of employer. The Division has the authority to enforce the requirement that any "employer" provide coverage for "employees" as those terms are defined. It is unclear what the changes to the definition of "employer" add to these powers.

Nurse registries are also potentially affected by the definitional change of employer. Apparently, the issue of whether nurse registries were required to provide workers' compensation was not clear and could depend on the facts of each case. This question would have been answered by determining whether or not the

nurses were independent contractors, rather than employees, under the criteria specified in statute.³³ Note that for purposes of state licensure, "nurse registries" are defined in s. 400.462(15), F.S., as "any person that procures ...health-care-related contracts for registered nurses ..., who are compensated by fees as independent contractors ..." But at least one recent determination by the Division of Workers' Compensation was that nurse registries did not meet the independent contractor criteria.³⁴ Under the new act, a nurse registry may be deemed to be an "employment agency" or other "similar agent that supplies employees to other employers" within the definition of an employer required to provide workers' compensation coverage.

In 1997, the federal Office of Management and Budget adopted the North American Industry Classification System (NAICS) as the standard industry classifications used by statistical agencies of the United States, such as the Census Bureau. The NAICS has three distinct classifications for *employment placement agencies*, *temporary help services*, and *professional employer organizations*, respectively, with definitions and examples of each. It is noteworthy that the NAICS defines *employment placement agency* as establishments primarily engaged in listing employment vacancies and in referring or placing applicants for employment, and that the individuals referred are *not employees* of the employment agencies. Specific examples include nurse registries, model registries, maid registries, babysitting bureaus or registries, casting agencies, etc., as well as "employment agencies." In contrast, *temporary help services* are defined as establishments primarily engaged in supplying workers to clients' businesses for limited periods of time to supplement the working force of the client, and that the individuals provided *are employees* of the temporary help service establishment. Examples here include manpower pools, model supply services, office help supply services, temporary help services, etc.³⁵ These classifications indicate the various nature of employment agencies and that imposing a workers' compensation requirement on all such agencies may not be appropriate.

³³ Section 440.02(15)(d), F.S. (2003).

³⁴ Letter of October 10, 2002 from Tanner Holloman, Director, Div. of Workers' Comp., to Carol Rakoff, President, Total HealthCare Services.

³⁵ The 2002 NAICS Definitions (561310 employment placement agencies, and 56320 temporary help services) and information on the NAICS are on the U.S. Census Bureau website at www.census.gov/epcd/www/naics.html.

This potential impact of the change in the law is that if an entity is considered an “employment agency” or “similar agent who provides employees to other persons” it may no longer be relevant whether the independent contractor criteria are met. But outside of the construction industry, there did not appear to be significant problems with employment agencies. The construction industry was directly addressed in the new act by requiring independent contractors and sole proprietors in the construction industry to obtain workers' compensation.³⁶

Limitations on Attorney's Fees

In recent years, attorney involvement has been identified as a significant cost driver in Florida. When attorneys are not involved in the resolution of a claim, the difference in claim cost between Florida and the average for countrywide is minimal. If attorneys are involved in the resolution of a dispute, the average claim size in Florida and is nearly 40 percent higher than countrywide average.³⁷ The NCCI report suggests that attorney involvement might contribute to the frequency of permanent total claims and to increased medical services.

For fiscal year 2002-03, the Office of the Judges of Compensation Claims (OJCC) reported claimant attorneys' fees totaling approximately \$205 million and defense attorneys' fees totaling approximately \$220 million.³⁸ Attorneys' fees for claimants appear to have declined by approximately \$18 million from the prior year, while at the same time, defense fees were significantly higher. However, the OJCC notes that this significant increase in reported defense attorneys' fees could be attributable to a new data collection approach. The decline in attorneys' fees of claimants could be the result of underreporting or a decline in fees; however, the conclusion that fees have declined would appear to be inconsistent with the 31 percent increase in the number of petitions filed during the fiscal year. The OJCC expects data reliability issues to diminish as the same data collection process is employed consistently in future years.

Senate Bill 50-A continued the use of the prior contingency fee schedule in awarding attorney's fees, but eliminated hourly fees except for medical-only

claims. The fee for benefits secured are limited to 20 percent of the first \$5,000 of benefits secured, 15 percent of the next \$5,000 of benefits secured, 10 percent of the remaining amount of benefits secured to be provided during the first 10 years after the claim is filed, and 5 percent of the benefits secured after 10 years.

Senate Bill 50-A provides that, as an alternative to the contingency fee, the judge of compensation claims may approve an attorney's fee not to exceed \$1,500 per accident, based on a maximum hourly rate of \$150 per hour, if the judge of compensation claims determines that the contingency fee schedule, based on benefits secured, fails to fairly compensate the attorney for a disputed medical-only claim.³⁹ If there is a written offer to settle issues, including attorney's fees, at least 30 days prior to the hearing date, for purposes of calculating the amount of attorney's fees to be taxed against the carrier or employer, the term “benefits secured” includes only that amount awarded to the claimant above the amount specified in the offer.⁴⁰

Previously, if the claimant prevailed against the employer, the employer was responsible for the reasonable costs of the proceedings, except for attorney's fees. The new act requires the nonprevailing party, employee or employer, to be responsible for the reasonable costs of the proceedings. The claimant is still 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.

The NCCI estimated that the provisions relating to attorneys' fees in Senate Bill 50-A would result in a 2 percent savings in overall costs since attorneys will have less financial incentive to handle workers' compensation cases, particularly cases with less merit or lower monetary values.

The attorney fee changes provided in Senate Bill 50-A have generated concerns regarding the ability of an injured worker to obtain legal representation and access to courts. Opponents contend, particularly for medical-only claims, that the contingency fees authorized under

³⁶ Section 440.02(15)(c)-(d), F.S. (2003).

³⁷ NCCI Workers' Compensation Cost Drivers Overview, March 6, 2003.

³⁸ Office of the Judges of Compensation Claims Annual Report for Fiscal Year 2002-03.

³⁹ Section 440.34(7), F.S. (2003).

⁴⁰ Section 440.34(2), F.S. (2003).

the fee schedule or, as an alternative, the hourly fee of \$150 per hour, or up to \$1,500 per accident, will not adequately compensate them for their time, thereby discouraging them from litigating smaller claims. Proponents of the fee change contend that the \$1,500 fee is a reasonable financial incentive for litigating smaller medical-only claims and that the contingency fee schedule allows for a greater amount for larger medical-only claims (exceeding \$8,333).

Some claimant attorneys argue that by only applying the fee cap to the claimant's attorney, and not the defense attorney, it places the employee at a competitive disadvantage in litigating the claim. In justifying such limits, the courts have relied on the legitimacy of the legislature's objective of protecting the injured worker's interest and the rationality of regulating only workers' attorneys as a reasonable means of furthering this objective. The prohibition on the claimant's attorney collecting a fee, unless approved by the court, was upheld on the basis that the statute serves a legitimate state interest in affording a worker necessary minimum living funds.⁴¹

Opponents of the fee change contend that many claimant attorneys will no longer represent or will reduce their representation of employees with small claims. Since these provisions are effective October 1, 2003, the ultimate impact of these changes is unknown at this time. Claimant attorneys interviewed by staff indicated that they are still handling claims that occurred prior to October 1, 2003, so their practices have not yet been significantly impacted by the new law. However, attorneys have indicated that they will provide greater scrutiny or screening of potential claims and possibly revise practice strategies.

The average dollar value of a disputed medical-only claim is unknown. Generally, petitions for benefits address multiple issues. However, the NCCI estimates that employers reported approximately 240,000 medical-only claims for policies expiring between October 1, 1999 and September 30, 2000. The average dollar value of these reported medical-only claims was \$472. The number and dollar value of medical-only claims that are ultimately resolved through litigation are unknown. According to the Office of the Judges of Compensation Claims, 38,897 petitions for benefits were filed for fiscal year 2002-03 requesting medical benefits and no monetary benefits. This represents 25.8 percent of the total number of petitions filed for that fiscal year.

⁴¹ *Samaha v. State*, 389 So.2d 639 (Fla. 1980).

Generally, most states have established maximum fees in the range of 15 to 30 percent of benefits secured. Fifteen states award an attorney's fees on an individual case basis.⁴² Committee staff reviewed statutory provisions relating to attorneys' fees in nine other comparable size states. Except for Texas, these statutory provisions are applicable to the attorney's fees of the claimant, not the defense attorney's fee. In instances that contingency fee schedules were used, the fees generally ranged from 15 to 25 percent of the benefits secured, and allowed some discretion in awarding additional fees above the fee schedule. However, Florida and New Jersey use a contingency fee schedule with limited instances in which additional fees can be awarded. California, New York, and Ohio award fees based on an individual case basis.

California authorizes a reasonable attorney's fee based on the complexity of the case. The judge is required to reference guidelines contained in the Workers' Compensation Appeals Board Policy and Procedural Manual. The manual provides that in cases of average complexity, a reasonable fee in the range of 9 to 12 percent of the permanent disability indemnity, death benefit, or settlement is appropriate. In cases involving "above average" complexity, a fee in excess of the upper limit of 12 percent is warranted. Above average cases include cases involving new or obscure theory of law or injury; highly disputed factual issues involving detailed investigation; highly disputed medical issues; and multiple defendants. In cases of below average complexity, the fee may range downward to as low as one percent and includes cases involving uncontested death cases; undisputed 100 percent permanent disability; and other essentially undisputed cases.⁴³ The manual also notes that a \$750 or one percent fee on a \$75,000 death benefit award provides ample compensation for the time and skill involvement where counsel is required to do no more than present marriage and birth certificates. The manual justifies the \$750 fee by stating, "there is no reason for the deserving widow...or employee with a major disability to underwrite the case of an employee with a minor or questionable claim."⁴⁴

Georgia law provides that a fee cannot exceed 400 weeks of income benefits unless terminated sooner or suspended by law or at the State Board of Workers'

⁴² U.S. Department of Labor.

⁴³ *Workers' Compensation Appeals Board Policy and Procedural Manual*. 2003.

⁴⁴ *Ibid*.

Compensation discretion.⁴⁵ In cases involving death, total disability, and partial disability, Illinois law generally allows a fee of not more than 20 percent of the amount that would be due for 364 weeks of permanent total disability, unless approved by the Industrial Commission. Illinois law also provides that, with regard to any claim where the amount to be paid does not exceed the written offer made to the claimant by the employer prior to representation by an attorney, no fee would be paid to any such attorney.⁴⁶ In Michigan, a judge may approve a fee for a lump-sum settlement of no more than 15 percent on the first \$25,000, and a fee of not more than 10 percent on any amount above \$25,000.⁴⁷ In all other cases, the maximum fee for an attorney in Michigan is 30 percent of all benefits secured; however, this attorney fee cannot be based upon a rate of benefits that is higher than two-thirds of the state average weekly wage at the time of the injury. The director of the Michigan workers' compensation bureau is authorized to award fees in excess of these limits by special order. New Jersey law caps the fee at 20 percent of the judgment and provides an offer of settlement provision similar to the provision of Illinois.⁴⁸ However, when the amount of judgment, or when that part of the judgment or awarding excess of the offer is less than \$200, an attorney's fee may be allowed, not to exceed \$50.

In New York, a fee cannot be based solely on the amount of the award. Rather, the judge is required to approve a fee that is commensurate with the services rendered. The judge is also required to consider certain factors in determining the fee, including the financial status of the claimant and tactics or procedures used by the attorney.⁴⁹ Ohio awards an attorney's fee on an individual case basis. Pennsylvania authorizes a fee not to exceed 20 percent of the amount awarded; however, the hearing officer has the discretion to award fees in excess of 20 percent.⁵⁰ In Texas, an attorney's fee is generally limited to 25 percent of each weekly income benefit payment and 25 percent of the total income benefit payment.⁵¹ In awarding fees, the Texas Workers' Compensation Commission is required to consider administrative guidelines for legal services,

along with other factors, including the statutory fee limitations. Fees for defense counsel must be approved by the court and are based on the time spent and expenses incurred in defending the case, and other evidence necessary in making a determination.⁵²

Other Issues Noted in Senate Bill 50-A

Senate Bill 50-A contains certain provisions that are technically inconsistent or that might require clarification. The Legislature may want to consider addressing certain technical glitches contained in Senate Bill 50-A, particularly if such glitches are compromising the implementation of the law or are resulting in unintended consequences. These issues are addressed below.

Definition of "Employee;" Volunteers

Under both the prior law and the act, the definition of employee excludes a volunteer, except for a volunteer worker for the state other governmental entities.⁵³ As a result, state and local governments have been required to obtain coverage for volunteer employees. Although this provision was not amended by Senate Bill 50-A, the definition of "employee" was amended to mean any person *who receives remuneration* from an employer for the performance of any work or service.⁵⁴ As a result, persons volunteering to work for governmental entities may no longer be considered employees and may not be entitled to workers' compensation coverage. This statutory change could also expose a governmental entity to tort liability in the event of an injury, since workers' compensation would no longer be the exclusive remedy.

Exemptions for Limited Liability Companies

Senate Bill 50-A substantially revised and limited exemptions from coverage in the construction industry to no more than three corporate officers, each owning at least a 10 percent stock ownership. Then, in Special Session E, legislation additionally allowed exemptions in the construction industry for up to three members of a limited liability company each having at least a 10 percent ownership interest.⁵⁵ However, additional conforming changes are necessary to chapter 440, F.S., to require members of a limited liability company to meet the same coverage and exemption requirements.

⁴⁵ Ga. Code Ann., Rule 108.

⁴⁶ 820 ILCS 310/16a.

⁴⁷ Rule 408.44, Department of Consumer and Industry Services.

⁴⁸ N.J.S.A. 34:15-64.

⁴⁹ 12 NYCRR 300.17

⁵⁰ 77 P.S. 442.

⁵¹ Section 152.1, Rules of the Texas Workers' Compensation Commission.

⁵² TX Labor Section 408.222.

⁵³ Section 440.02(15)(d)6., F.S. (2003).

⁵⁴ Section 440.02(15)(a), F.S. (2003).

⁵⁵ CS/CS/SB's 14-E and 16-E; ch. 2003-422, L.O.F.

Criminal Penalties for Insurance Fraud

Senate Bill 50-A provides several other measures designed to fight fraud and increase prosecution of fraud in the workers' compensation system, as follows:

- Provides that any person who violates a stop-work order commits a first-degree misdemeanor under s. 440.105(2)(a)4., F.S.;
- Provides that any person who knowingly violates a stop-work order commits insurance fraud under s. 440.105(4)(f), F.S.;
- Authorizes the Division of Unemployment Compensation to release information in certain circumstances concerning an employee's wages to determine if an injured worker is employed and receiving workers' compensation benefits; and
- Incorporates certain violations of ch. 440, F.S., in the Offense Severity Ranking Chart which would assist in the prosecution and sentencing of workers' compensation fraud by establishing ranking for these violations.

Representatives of the Division of Insurance Fraud of the Department of Financial Services have suggested that the stop-work order violation provisions should be revised to eliminate the misdemeanor provision, since a misdemeanor would less likely be prosecuted. The felony penalty provision would remain for a *knowing* violation of a stop-work order, which is the crime that is more likely to be prosecuted.

Also, Senate Bill 50-A created additional criminal penalties for violations relating to workers' compensation fraud. However, certain violations were omitted from the Offense Severity Ranking Chart, which appears to be inadvertent. This chart is used for establishing minimum sentencing guidelines.

Access to Unemployment Compensation Records

The new act authorizes the Division of Unemployment Compensation to release information to a carrier paying workers' compensation if the carrier has the authorization of either the employee or the employer paying the wages.⁵⁶ This is for the purpose of enabling the carrier to determine if an injured worker is employed and receiving wages. However, the act omitted a related provision, included in a prior workers' compensation bill (CSCS/SB 1132), which would require that as a condition of receiving

compensation, an injured employee must execute a waiver authorizing the carrier to obtain such information from the Division of Unemployment Compensation.⁵⁷

Permanent Total Disability

In revising the eligibility requirements for permanent total disability benefits, the act deleted the definition of *catastrophic injury* previously contained in s. 440.02(37), F.S. (2002), and instead, delineated the specific injuries formerly under the definition in s. 440.15(1)(b), F.S. (2003). The term *catastrophic injury* is no longer defined but a reference to this term remains in a provision that states, "Only claimants with catastrophic injuries or claimants who are incapable of engaging in employment, as described in this paragraph, are eligible for permanent total benefits." Although the term is likely to be read to merely refer to the specified injuries listed in that paragraph, it may cause confusion.

Valuation of Attendant Care by a Family Member

The act revised the method for valuing nonprofessional attendant care provided by a family member to address the situation where the family member remains employed.⁵⁸ However, the act provides two different valuations that may be in conflict.

The prior statute addressed only two situations, neither of which are changed by the act: 1) if the family member *is not employed*, the attendant care is valued at the federal minimum wage, and 2) if the family member *is employed and elects to leave that employment to provide attendant care*, the value 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.

The new act adds two provisions regarding a family member who remains employed, but the scenarios do not appear to be mutually exclusive and may conflict. First, it provides that if a family member *is employed and is providing attendant care services during hours that he or she is not engaged in employment*, the per-hour value equals the federal minimum hourly wage. It further provides that if the family member *remains employed while providing attendant care*, the value equals the per-hour value of the family member's

⁵⁶ Section 443.1715, F.S. (2003).

⁵⁷ 2003 Regular Session.

⁵⁸ Section 440.13(2), F.S. (2003).

employment, not to exceed the per-hour value of such care available in the community at large.

Medical Practice Parameters

The bill provides that the practice parameters and protocols mandated under chapter 440, F.S., must be the practice parameters and protocols adopted by the U.S. Agency for Healthcare Research and Quality (AHRQ) in effect January 1, 2003.⁵⁹ The AHRQ is the lead Federal agency for research on health care quality, costs, outcomes, and patient safety. However, the AHRQ no longer develops and adopts practice parameters. Instead, the AHRQ and the U.S. Department of Health and Human Services, in partnership with the American Medical Association and the American Association of Health Plans, sponsors the National Guideline Clearinghouse, a public resource for evidence-based clinical practice guidelines.

Dual Roles of DFS and OIR to Audit, Examine and Investigate Carriers

Both the Department of Financial Services (DFS) and the Office of Insurance Regulation (OIR) are provided overlapping authority in chapter 440, F.S., relating to audits, examinations, and investigations of carriers. The DFS, headed by the Chief Financial Officer, is the agency primarily responsible for enforcing the workers' compensation act, while OIR, headed by the Director of Insurance Regulation, is the agency responsible for regulation of insurers. This was first addressed by legislation enacted in the 2003 Regular Session which conformed statutory authority to the reorganization of the former Department of Insurance.⁶⁰ In Special Session A, Senate Bill 50-A made further changes related to each agency's oversight of workers' compensation insurers. Additional changes may be needed to more clearly distinguish their respective powers and to delete redundant provisions.

The general intent has been to authorize the DFS to monitor workers' compensation carriers for compliance with the workers compensation act. Responsibilities of the DFS include determining if indemnity benefits and medical bills are timely and accurately paid, and imposing fines on carriers for non-compliance. It is also intended that OIR have regulatory power to conduct market conduct examinations of all insurers, including workers' compensation insurers, for

compliance with all insurance laws, and to fine carriers for violations.

The authority for DFS to monitor, audit, investigate, and penalize carriers for compliance, such as timeliness and accuracy of payments, is provided in four different provisions.⁶¹ However, these provisions are redundant and, in some cases, inconsistent. The standards and penalties for late payment of medical bills are particularly confusing, due to different provisions on this same subject. Also, references to the authority for OIR to conduct market conduct examinations under s. 624.3161, F.S., appear to be redundant to the provisions of that section.

State Workers' Compensation Funds

State insurance funds have been created in 26 states, either as the exclusive insurer of workers' compensation in the state or as an insurer that competes with private carriers. Twenty-one states have competitive funds (Arizona, California, Colorado, Hawaii, Idaho, Kentucky, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, New Mexico, New York, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, and Utah, as well as South Carolina which insures only public employers). Five states have exclusive state funds (North Dakota, Ohio, Washington, West Virginia, and Wyoming).

The history of state funds is as long as the workers' compensation system itself. Thirteen state funds were created by 1916, near the time that those states initially enacted workers' compensation laws. A recent renewal of interest in state funds led to the creation of eight funds in the 1990s. These funds are intended to provide a stable and reliable source of reasonably priced insurance coverage, in response to legislative concerns of affordability and availability of coverage and adequate service, particularly to small employers.

State funds are generally expected to be self-supporting from their premium and investment income. However, the recent funds have typically been provided initial capitalization from the state, usually in the form of a loan that must be repaid. For example, Minnesota's State Fund Mutual, created in 1983, was capitalized by \$5.7 million in surplus notes, which the fund was required to repay to the state at an 8 percent interest rate, which it has done. Similarly, Missouri Employers Mutual Insurance was provided capitalization from a

⁵⁹ Section 440.13(15), F.S. (2003).

⁶⁰ CS/CS/SB 1712; ch. 2003-261, L.O.F.

⁶¹ Sections 440.13(11)(b), 440.20(6)(b), and 440.20(8)(b), and 440.525, F.S.

\$5 million state loan in 1995, which was repaid with interest in 1999.

When the Maine Employers' Mutual Insurance Company was created in 1993, it obtained a private bank loan and letter of credit and was legally permitted to charge policyholders a capital contribution to repay the loan and to build surplus. This amounted to a 15 percent surcharge to policyholders in 1993 and 10 percent in 1994, totaling about \$47 million, and then the surcharge was terminated. Most of these amounts have since been returned to their policyholders.

The Kentucky state fund was loaned \$7 million from its second injury fund, which it was required to pay back in seven years, but was able to do so in within three years.

Those state funds that have been in existence for many decades are typically subject to the same financial and solvency requirements as private companies. However, the recently created funds have generally been capitalized by a loan that must be repaid, and an insurer would not normally be allowed to consider the amount of a loan as surplus, without special allowance by law or order of the insurance regulator. Other exceptions to financial requirements often apply for a temporary period. The Missouri state insurer has been operating under a protective order issued by the state Director of Insurance since it began operating in 1995. The order exempts the fund from certain financial requirements, such as maximum premium to surplus limitations. The protective order is scheduled to expire at the end of 2005 and according to representatives of the fund, it is on track to come into compliance at that time. The fund currently has about a \$43.5 million surplus and its premiums writings are about 3.2 times this amount, which is slightly above the 3:1 ratio limitation applied to insurers.

Similarly, the Maine state mutual was given ten years to comply with financial and solvency requirements, but was able to do so within five years. The Kentucky state fund was at first given three years to fully comply with state solvency requirements, which was later changed to seven years. However, the fund was reportedly able to meet the requirements within three years of operation.

State funds are created as non-profit entities, but their various legal organizations and relationships to the state have been characterized as an "exercise in semantic gymnastics." According to the American Association of State Compensation Insurance Funds,

nine of the funds are considered state agencies, four use the term "quasi-agency," one is an "independent unit of state government," another is a state non-profit enterprise, two others call themselves private non-profits, six are mutual insurance companies, one is a "public company" and two are "independent companies."⁶² Most of the funds created in the last 20 years have been organized as mutual insurance companies.

State funds are typically, but not always, required to provide coverage to any employer. As the insurer of last resort, state funds typically insure most of the small employers and construction industry employers in the state who are less attractive to the private market. But state funds also obtain a significant market share of large employers as well. In all but one of the 21 states, the state fund is the largest carrier in the state, as measured by premium market share. A recent study by Conning Research & Consulting⁶³ found that the 21 competitive state funds grew from 24.6 percent of the direct premiums written in 1997 to 32.2 percent in 2001. This growth was said to be precipitated by private carrier insolvencies and market withdrawals. Five of these state funds wrote more than 50 percent of the workers' compensation premium in its state. The 8 state funds created in the 1990's quickly became the leading writer in their respective states and acted to depopulate the assigned risk plans in those states.

The Conning study found that although the swings in growth tended to make the state fund results unpredictable, they remained profitable in the period 1995-2001. In total, the 21 competitive funds had a higher level of reserves to premium compared with private carriers, also resulting in relatively more invested assets and more investment income. This study further found that state fund underwriting expenses countrywide were lower, as a percentage of net written premium, than for private insurers, having an expense ratio of 18.8 percent compared to 26.2 percent for private insurers in 2001. Loss data were available for only 19 of the 21 competitive state funds. Overall, the 2001 loss ratio of the state funds was 87.2 percent, compared to 100.0 percent for the private insurers in these 19 states, but the ratios were significantly impacted by the more favorable results of

⁶² "Funds' Challenges Vary from State to State" American Assoc. of State Compensation Insurance Funds (Spring, 2001 Newsletter).

⁶³ "Workers' Compensation State Funds - What You Don't Know Might Hurt You," Conning Research & Consulting (2003).

the larger state funds such as California and New York. Only 8 of the 19 state funds had a lower loss ratio than the state's overall workers' compensation loss ratio, with two states (Pennsylvania and Maryland) having dramatically larger loss ratios. The study concluded that the combination of adequate reserves and successful investment strategies allowed the state funds to prosper in difficult times.

The Conning study cited certain advantages that state funds have compared to private insurers. State funds have geographic concentration that allows for adequate staffing of loss control and claims personnel which helps reduce losses. State funds also share information, primarily through the American Association of State Compensation Insurance Funds, to an extent not legally permitted for private insurers. The study also opined that since state funds are under the scrutiny of the legislature, they tend to be more conservative in their approaches, compared to the goal of private insurers to report positive results to their shareholders.

The National Council on Compensation Insurance ranked the 45 states for which they collect loss costs, comparing the average loss costs for manufacturers as of January 1, 2003.⁶⁴ The highest loss costs were in California (which has a competitive state fund) with Florida being the second highest (which does not). No particular pattern emerges when comparing the 21 states that have competitive state funds with the 24 states that do not have state funds. Of the ten highest cost states, five have competitive state funds (California, Texas, New York, Oklahoma, and Hawaii) and five do not (Florida, Delaware, Vermont, Connecticut, and Alaska). Similarly, at the other end of the chart, of the ten lowest cost states, five have competitive state funds (Arizona, Utah, Oregon, New Mexico, and South Carolina) and five do not (Indiana, Virginia, Arkansas, North Carolina, and Massachusetts). Of the 21 states with competitive state funds, 12 have loss costs above the median, 8 are below the median, and 1 is at the median.

⁶⁴ "Rates vs. Loss Costs and NCCI's Role in the Rating Environment (Part II)," PowerPoint presented on Nov. 6, 2003, to the Joint Select Committee on Workers' Compensation Rating Reform, available at the Senate Banking and Insurance Committee.

RECOMMENDATIONS

Deficits in the Workers' Compensation Joint Underwriting Association

The current capped rates for subplan D are not actuarially sound and will ultimately result in a deficit that must be funded to ensure the payment of claims and the solvency of the JUA. To alleviate and address the amount of the deficit in the short-term, the Legislature should consider providing a one-time budget transfer from the Workers' Compensation Administration Trust Fund and exempting the JUA from the Workers' Compensation Administration Trust Fund and the Special Disability Trust Fund assessments. To address long-term solvency issues and the overall viability of the subplan, the Legislature should consider revising the premium structure of subplan D and the assessment methodology. The JUA's white paper, that is expected to be released on March 1, 2004, is expected to provide additional financial updates and legislative recommendations to address solvency and operational associated with subplan D.

Criminal Penalties Related to Employees who use False Evidence of Identity

Alternative recommendations are made, depending on the Legislature's intent:

If it is not the intent of the Legislature to deny workers' compensation benefits to illegal aliens, then it is recommended that the amendment made to s. 440.105(4)(b)9, be deleted, which provides that it is a felony and insurance fraud for a person to present false identification as to evidence of identity for the purpose of obtaining employment; and that the amendment to s. 440.105(3)(b), F.S., also be deleted, which provides that it is a misdemeanor for an employer to knowingly hire a person who uses a false identity.

If it is the Legislature's purpose to deny workers' compensation benefits to illegal aliens, then it is recommended that this be done directly, by amending the definition of *employee* under s. 440.02(15)(a), F.S., to delete the provision stating that aliens, whether lawfully or unlawfully employed, are employees for workers' compensations purposes.

If it is the Legislature's purpose to criminalize only illegal aliens who falsify their identity in order to

obtain employment, then the language in s. 440.105(4)(b)9., F.S., should be narrowed to that purpose.

If it is the Legislature's intent to have the same penalties for similar behavior by both the employer and employee as to employment, then the two provisions noted above should have the same penalty. Further, s. 448.09, F.S., should provide for a similar penalty as well as to persons knowingly hiring illegal aliens. Section 440.105(3)(b), F.S., should be amended to clarify that the employer must know or should have known that the employee used false evidence of identity.

If it is the Legislature's purpose to retain the criminal provision pertaining to employees who knowingly present false or misleading evidence of identity, it should be limited to "material" misrepresentations.

Status of Employment Agencies as Employers

Due to its uncertain impact, the Legislature should delete the amendment to s. 440.02(16)(a), F.S., which included employment agencies and similar agents that supply employees to other persons within the definition of employer.

Compensability for Mental and Nervous Injury

Presently, Florida and 21 other states provide compensation for mental stress only if a compensable physical injury occurs; however, Arkansas and Oklahoma allow an exception for the physical injury requirement in instances of rape or violent crime, respectively. The Legislature should consider allowing a similar exception in instances of violent crime.

Other Issues Noted in Senate Bill 50-A

It is recommended that the Legislature:

- Delete the amendment to the definition of "employee" in s. 440.02(15)(a), F.S., which requires a person to "receive remuneration," or otherwise clarify that the amendment does not affect the status of volunteer workers for governmental entities as employees entitled to workers' compensation.
- Make conforming changes to the amendment that allows exemptions in the construction industry for up to three members of a limited liability company

each having at least a 10 percent ownership interest.

- Delete the provision that makes it a misdemeanor for violating a stop-work order, while retaining the felony penalty provision for a knowing violation of a stop-work order.
- Require that as a condition of receiving compensation, an injured employee must execute a waiver authorizing the carrier to obtain wage information from the Division of Unemployment Compensation.
- Delete the reference to *catastrophic injury* that remains in s. 440.15(1)(b), since that term is no longer defined.
- Resolve the apparent conflict in the two methods provided in s. 440.13(2), F.S., for the valuation of attendant care provided by a family member who remains employed.
- Change the practice parameters that must be utilized due to the fact that the U.S. Agency for Healthcare Research and Quality no longer develops and adopts such practice parameters.
- Consolidate the various statutory provisions for the audit, examination, investigation, and sanctioning of carriers by DFS related to claims practices, in order to eliminate redundancies and inconsistencies, and to delete unnecessary references to OIR's authority to conduct market conduct examinations under the Insurance Code.