Workers' Compensation Legislative & Regulatory Update

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Volume 8, Issue 4
April 26, 2007

With just two weeks left in the 2007 legislative session, lawmakers are close to agreeing on several workers' compensation bills including one that would revamp the Florida Workers' Compensation Joint Underwriter Association (FWCJUA). Both the House and Senate are poised to vote on a final bill that is designed to make the residual insurer eligible for federal tax-exempt status, which would require regulators to have greater control over the residual market's operations. Following the bill is one that would make certain information collected by the FWCJUA confidential. Another bill nearing a final vote is one that would grant first responders certain benefits under the workers' compensation law. The industry is maintaining its objections to the bill based on the arguments it could open up Chapter 440 and would increase the costs to employers. Finally, lawmakers have cleared the way for a bill that would prohibit general contractors from rejecting a subcontractor's proof of coverage solely on the basis that the coverage is issued by a non-rated self-insurance fund.

The First District Court of Appeals has ruled in the case of *One Beacon Insurance v. Agency for Health Care Administration* (Case Number 1D05-5459) that fees paid to Ambulatory Surgery Centers that fall outside of the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers should be reimbursed at 70 percent of the usual and customary fees based on the average providers' fees in a given geographic area. Significantly, however, the court didn't set out any standards by which to define a "geographic area." The Florida Health Care Reimbursement Manual, which is based on Medicare, is divided into three geographic areas.

The Division of Workers' Compensation Bureau of Monitoring and Audit (BMA) is reporting that a majority of insurers are meeting the standards for paying injured workers' benefits and medical bills. After evaluating over three million medical bills from roughly 900 insurers and third-party payors, auditors found the majority of payors are meeting the statutory performance standards that are designed to increase the efficiency and accountability in the system. The audits examined both indemnity payments to injured workers and also monies owed to health care providers, dental care providers, hospitals, and claims for drugs and supplies. The figures are contained in the latest DWC annual report that covers the period from June 30, 2005 to July 1, 2006.

Workers' Comp Bills

Workers' compensation has not been a top priority of lawmakers this year. Given the rate decreases following the enactment of the 2003 reforms, the prevailing wisdom is that there should be no substantive changes to Chapter 440, Florida Statutes. As a result, lawmakers have only moved forward with a few bills while rejecting a number of others.

Here is a list of the bills that are currently awaiting a final vote by lawmakers.

- **FWCJUA** – Lawmakers are close to agreeing on a bill that is designed to make the residual market eligible for federal tax-exempt status. Since 1994, the association has paid out over $33 million in federal income tax including $16 million in 2006. The two bills, (SB 1894 by Sen. Bill Posey (R-Rockledge) and HB 1429 by Rep. Mike Grant (R-Port Charlotte), would make several major changes in the FWCJUA's operations including granting regulators the power to name board members, requiring the residual market to gain prior approval before implementing rate changes, and approving the association's plan of operation. Currently, the FWCJUA has 3,000 policies in force.

  The bill also addresses the method needed to pay for possible FWCJUA deficits. In 2003, the legislature created subplan's A, B, C, and D. The rates, however, were set lower than what was needed based on actuarial estimates. As a result, the association had a $9.9 million deficit in subplan D by the end of 2003. In 2004, lawmakers replaced the subplans with three tiers while creating two meth-

ods to fund deficits. The first would allow the FWCJUA to access monies from a $15 million contingency fund set up as part of the Workers' Compensation Administrative Trust Fund. Also, the association could levy a "below the line" assessment against all state policyholders. The current bill would make several changes to funding deficits. First it would allow the FWCJUA to use surpluses from other subplans to cover other deficits. This would allow the association to utilize $39 million in subplan C to pay off deficits in tiers one, two, and subplan D. The bill would also increase the length of time that the FWCJUA could levy assessments or access the contingency reserves, which is set to expire as of July 1. Under, the bill those deadlines would be extended to July 1, 2012.

- **FWCJUA** – SB 628, sponsored by Al Lawson (D-Tallahassee) and HB 7169 sponsored by Ron Reagan (R-Sarasota) is part of the FWCJUA package. The bill would grant public records exemptions that would shield certain information from the public. The information would include underwriting files, claims files until the termination of claims, and records obtained by internal auditors until the audit is complete. Other information kept in confidence would be medical records and the work product of attorneys retained by the FWCJUA to protect or represent the association. Pursuant to the state's Government in the Sunshine Act, the bill would require a two-thirds vote in each chamber to be implemented.
- **First Responders** – SB 746 sponsored by Sen. J.D. Alexander (R-Lake Wales) and HB 701 by Rep. Sandy Adams (R-Oveido) are each awaiting a final vote by the House and Senate. The two bills are identical after lawmakers deleted a provision that would have allowed claimant attorneys to receive in excess of the statutory fees in cases involving exposure to toxic substances or occupational diseases. Even with that change, however, the industry and the cities and counties are still opposing the bill. The National Counsel on Compensation estimated that premium costs for first responder classes would increase by 5.4 percent or roughly $11 million. That estimate, however, doesn't include the costs for the state, cities, and counties. Among the changes contained in the bill are the following:
  - An adverse reaction to a small pox vaccination would automatically be deemed a compensable injury.
  - An injury due to an exposure to a toxic substance would not be compensable except in cases where the claimant could prove the injury was incurred by a preponderance of the evidence establishing that the exposure to the substance, at the levels to which the first responder was exposed, can cause the injury.
  - First responders could receive permanent total disability benefits for life if their employers don't participate in the federal social security program.
  - For first responders claiming to suffer a mental or nervous injury, it must be manifested by clear and convincing evidence. First responders could receive medical benefits even if a mental or nervous injury is not due to a physical injury. However, the claimant could only receive indemnity payments if the mental injury is accompanied by a physical injury.
  - The bill defines occupational disease as "a disease that arises out of employment as a first responder and is due to causes and conditions that are characteristic of and peculiar to a particular trade, occupational, process, or employment and excludes all ordinary diseases of life to which the general public is exposed."
- **Insurance Contracts** – SB 1748, sponsored Sen. Dan Gaetz (R-Ft. Walton Beach) and HB 701 by Rep. Dennis Ross (R-Lakeland), are likewise in line to receive final legislative approval. The bill creates Section 627.442, Florida Statutes, and reads as follows: "A person who requires a workers' compensation policy pursuant to a construction contract may not reject a workers' compensation insurance policy issued by a self-insurance fund that is subject to Part V. of chapter 631 based upon the self-insurance fund not being rated by a nationally recognized insurance rating service." There are currently four self-insurance funds in the state. They are the following: Florida Citrus, Business, and Industry Fund, the Florida Retail Federation Self Insurers Fund, the Florida Rural Electric Self Insurers Fund, and the FRSA Self Insurers Fund. None of these funds are rated by a national rating organization.

  There is one clause in the House bill where there is some disagreement. Specifically, the provisions reads, "An insurer may require a commercial applicant to combine two or more types of coverage in one or more commercial insurance contracts to obtain commercial lines coverage, which includes, but is not limited to, commercial auto, commercial multiperil, and workers' compensation." This section does not prohibit an insurer from offering each type of commercial lines coverage separately to an applicant or combining such coverage into a single policy. The clause is designed to encourage insurers to increase the amount of commercial insurance capacity in the state. However, some insurers are objecting to the provision on the basis it could possible lead lawmakers in later years to require that commercial insurers must offer multiple coverage.
- **Deviation Bill Dies** – Lawmakers are not moving forward on SB 1204 by Sen. Mike Bennett (R-Fort Walton Beach) and HB 607 by Rep. Baxter Troutman (R-Winter Haven). The bill would have specified that an employee's injury is not compensable if the employee deviates from a job regardless of whether the injury occurred on the employer's property. The bill defines "deviation" as any action not related to the employee's work duties or to the personal benefit of the employee. The industry opposed the bill because it would reopen Chapter 440, and also because it could create a situation whereby an injury worker could sue his or her employer in a civil cause of action.

Beacon v. AHCA

At issue in the Beacon v. AHCA case is whether an ambulatory surgical center should be paid at 70 percent of its

individual usual and customary charges or whether the reimbursement amount should be based on 70 percent of the average charges of all the surgical centers in a given geographic area where the specific procedure is not listed in the reimbursement manual. The facts of the case are as follows: in August 2003, an ambulatory surgical center treated a claimant and charged the claimant's insurer (One Beacon Insurance), $6,025, based on the surgical center's customary and usual charges. The insurer objected and paid $651.51. The insurer agreed the treatment fell outside the purview of the reimbursement manual but took the position that the charges should be based on the average charges in the community. Beacon appealed the case to AHCA, which determined that Beacon should pay the surgical center based on the individual surgical center's usual and customary rate.

AHCA's decision was based on the following argument. Since the ambulatory surgical center manual had not been amended between 1992 and 2005, AHCA relied on the 1992 statute, which was the last to specifically create a standard for the payment of ambulatory surgical center charges (Chapter 440.13(4)(b), Florida Statutes (1992). The Division of Workers' Compensation subsequently promulgated a rule implementing the law stating in part that charges, "not itemized in the schedule of maximum reimbursement allowances shall be 70 percent of the ambulatory surgical center's usual and customary charge."

The court noted, however, that lawmakers in the 2003 reforms removed all references to the charges of any individual service provider. As such, the court opined that the legislative intent of the law eliminated the calculation of any fees based on the 70 percent usual and customary charges of an individual AMSC. Since the 2003 amendment created a conflict with the 1992 rule, by law the statute takes precedent. As a result, the court reversed AHCA's ruling and remanded it for further action in keeping with the court's ruling.

The case raises several questions. If the ambulatory surgical center charges fall outside of the manual, the court's ruling logically states that there should be some standard dictating that an ambulatory surgical center's reimbursement should be reimbursed at 70 percent of some set of surgical centers. However, the court is silent on that issue as is the current statute. The Florida Health Care Reimbursement Manual does have a formula for setting physicians' rates that is based on Medicare, which divides the state into three geographic areas. There is some suggestion that by rule the Division will establish the geographical areas for the ambulatory surgical center industry.

Audit Results

The BMA has a number of responsibilities including auditing carriers to determine whether they are complying with the law in terms of paying injured workers' benefits and medical bills on a timely basis. The bureau also monitors employer/carriers to make sure they are paying permanent total disability benefits and permanent total supplemental benefits on time. The bureau also participates in hearings, depositions, and mediations to resolve payment disputes while also being responsible for overseeing self-insured programs set up by government and other public entities.

To assist employer/carriers in monitoring the performance of their claims-handling entities, the DWC has established a Centralized Performance System. The system is accessed through the Internet and allows employer/carriers to communicate with the division and compare the employer/carriers performance against the industry averages. The centralized system is made up of two parts, one that monitors benefit payments to injured workers and another that monitors payments to medical providers. The audit results are as follows:

- In fiscal year, 2004-2005, the bureau audited 34 employer carriers and examined a total of over 4,635 claims files. Auditors reviewed over 10,000 indemnity payments to workers and identified 224 claims files with underpayments. As a result, injured workers collected a total of $63,277 in back payments and penalties and interest of $39,929. The audits also established that employer/carriers provided injured workers with the informational brochure within three days of receiving notice of an injury 86 percent of the time.
- The bureau audited nearly 20,000 other required forms and documentations. Auditors identified $1.4 million in underpayments of permanent total disability benefits, which yielded $500,000 in penalties and interests. They also examined the $20 million in permanent total supplemental benefits for claims with dates of accident prior to July 1, 1984.
- The bureau evaluated 46,000 first reports of injury forms through the centralized performance system. The overall filing performance was 91 percent and the payment performance 90 percent.
- Auditors examined the timely filing of 6,500 DWC claims forms that are required to be submitted as per administrative rule 69L-3, FAC. Additionally, auditors reviewed the accuracy of 5,000 medical bills that were submitted to the division. As a result, auditors found 14 instances in which claims' handling entities unwittingly failed to file medical data.
- Examining the use of the centralized performance system medical component, auditors reviewed over 3.2 million medical bills from roughly 900 claims' paying entities. The overall industry performance level was 98 percent for health care provider claims' forms, 98 percent of forms for drugs and medical supplies, 95 percent of dental claims forms, and 97 percent of hospital bills.
- Auditors completed 20 payroll audits of self-insured employers and reviewed 67,800 payroll records. As a result, auditors uncovered $8.8 million in underreported payroll dollars, which generated $1.3 million in underreported premium dollars. The bureau also calculated 335 experience modification factors for self-insured employers.