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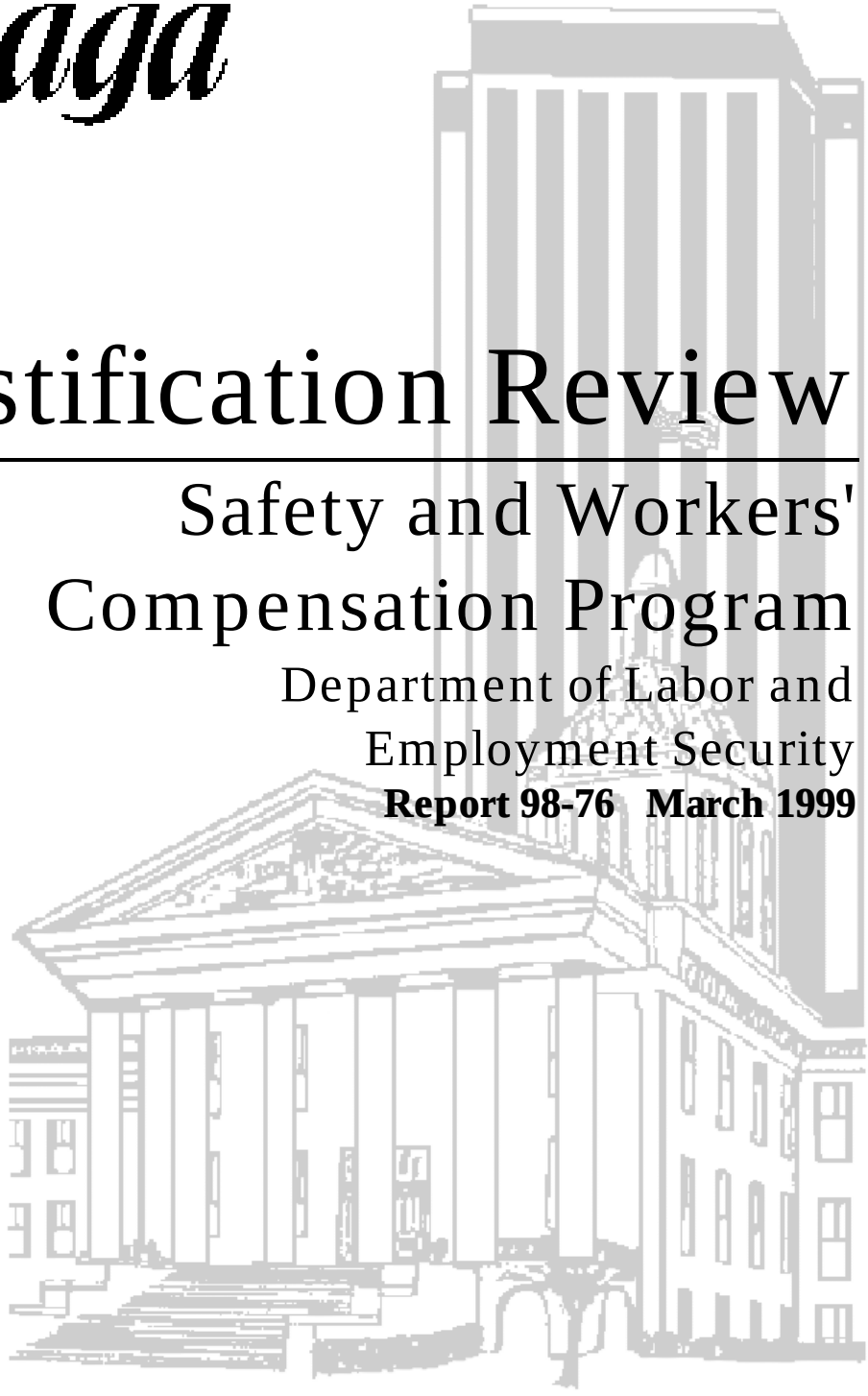

Justification Review

Safety and Workers' Compensation Program

Department of Labor and Employment Security

Report 98-76 March 1999

Office of Program Policy Analysis and Government Accountability

an office of the Florida Legislature

The Florida Legislature

OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY

John W. Turcotte, Director

March 1999

The President of the Senate,
the Speaker of the House of Representatives,
and the Joint Legislative Auditing Committee

I have directed that a program evaluation and justification review be made of the Safety and Workers' Compensation Program administered by the Department of Labor and Employment Security. The results of this review are presented to you in this report. This review was made as a part of a series of justification reviews to be conducted by OPPAGA under the Government Performance and Accountability Act of 1994. This review was conducted by Kathryn Bishop, Kira Honse, Sandra Lipner, and Don Wolf under the supervision of Debbie Gilreath.

We wish to express our appreciation to the staff of the Department of Labor and Employment Security for their assistance.

Sincerely

John W. Turcotte
Director

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Executive Summary

Justification Review of the Safety and Workers' Compensation Program

Purpose

This is the second of two reports presenting the results of the Office of Program Policy Analysis and Government Accountability's program evaluation and justification review of the Department of Labor and Employment Security's Safety and Workers' Compensation Program. State law directs our office to complete a justification review of each state agency program that is operating under a performance-based program budget. Our office is to review each program's performance and identify alternatives for improving services and reducing costs.

Background

The Safety and Workers' Compensation Program has two major components – administering Florida's workers' compensation system and providing workplace safety services. Workers' compensation systems are designed to benefit both employees and employers. Employers are able to avoid costly litigation because workers' compensation claims are handled through an administrative rather than judicial process. Employees benefit by receiving immediate medical treatment for work-related injuries or illnesses and some financial compensation for lost income. Employers furnish workers' medical benefits and indemnity benefits (lost wages) by purchasing workers' compensation insurance from an insurance carrier or by self-insuring. States have exclusive authority to regulate the workplace safety of their own employees and of employees of the state's political subdivisions.

Although other governmental entities carry out activities related to the workers' compensation system, for purposes of performance-based program budgeting, the Department of Labor and Employment Security established a single Safety and Workers' Compensation Program.

However, program functions are carried out by two divisions. The Division of Safety has primary responsibility for activities intended to prevent workplace injuries. The Division of Worker's Compensation enforces the mandatory purchase of insurance by employers; regulates insurance carriers, self-insurers, and benefit providers; and assists the participants in the system through dispute resolution and education.

The Safety and Workers' Compensation program is funded by the Workers' Compensation Administration Trust Fund. The fund's revenues are generated from an assessment on workers' compensation insurance premiums. In Fiscal Year 1997-98, the performance-based budgeting program expended $49.7 million from the trust fund to perform its functions and assigned 776 FTE positions to program operations.

General Conclusions

Although the Safety and Workers' Compensation Program has primary administrative responsibility for the workers' compensation system, many activities are carried out by other governmental entities. Given this division of responsibility, strong system oversight is needed to ensure the effective and efficient execution of the system's various functional and regulatory activities. However, several policy and programmatic issues have prevented the program from providing effective system oversight.

- Program staff question their authority to make certain administrative decisions that are essential to the cost-effective and efficient operation of the system and in many instances require clarification or elimination of roles and responsibilities. (See page 8.)
- The program focuses its efforts on handling individual processes rather than identifying and solving systemic problems. The program also continues to perform a number of activities that are no longer needed or are duplicative. (See page 9.)
- The program continues to collect data for which the need is questionable, as it is not used for a specific purpose. The program's methods of collecting data are also costly and many of the program's various organizational units separately collect and maintain data but cannot share information across databases. (See pages 9-10.)

Recommendations

To ensure that the workers' compensation system operates in the most efficient and cost-effective manner, we recommend that the program take a leadership role in identifying and solving problems within the state's workers' compensation system. As part of this role, the program should introduce policy and, when necessary, recommend legislative changes

that will enable the system to further the goal of achieving a more cost-effective, less burdensome system. To ensure the implementation of this recommendation, we also recommend that the Legislature clarify its intent regarding the program's authority to ensure the efficient and effective administration of the workers' compensation law.

To prevent duplicative or ineffective efforts in executing its various functional and regulatory activities, we recommend that the program focus on providing effective management of internal program functions and coordinating activities across system entities.

To ensure that program information is collected and maintained in the least burdensome, most cost-effective manner, we recommend that the program revise its reporting requirements to include only information that is needed and implement less resource-intensive methods for collecting data. To facilitate the integration and sharing of information, we also recommend that the program integrate its separate functional databases.

In addition to the policy-level issues discussed above, we identified concerns specific to the program's four functional areas. Recommendations associated with these issues identify an estimated $10 million in cost savings to the Workers' Compensation Administration Trust Fund. Any savings realized could be reflected in a reduction in trust fund assessments.

Prevention of Workplace Injuries

In response to a recommendation by the Office of Program Policy Analysis and Government Accountability, the 1998 Legislature eliminated funding for separate 100% state-funded consultative services that duplicate services the program provides under a contract with the Occupational Safety and Health Administration. However, the state's requirement for workplace safety standards and programs in the private sector was not eliminated. The Legislature may wish to consider eliminating this requirement from Chapter 442, Florida Statutes.

To provide a more effective use of program resources and means of ensuring workplace safety in the public sector, we recommend that the program discontinue its voluntary consultative services and actively exercise its statutory inspection and penalty authority. The program should modify its information system to allow it to monitor the incidence rate of local government employers and focus its efforts on inspecting worksites that expose employees to high risk of injury. *Estimated Annual Cost Savings to Trust Fund: $3.1 million*

Further, to improve the operational efficiency of the program's process for ensuring safety in the public workplace and eliminate duplicate administrative expenses, we recommend that the Legislature organizationally realign the safety component (i.e., contracts with the Occupational Safety and Health Administration and the federal Bureau of Labor Statistics, inspections of local government high hazard workplaces, investigations of occupational fatalities, and library services) with the

workers' compensation component by combining the two divisions that currently make up the performance-based budgeting program. *Estimated Annual Cost Savings to Trust Fund: $0.5 million*

Regulation of Employers

The program has not taken effective enforcement action when it detects employers who do not comply with workers ’compensation insurance requirements. We recommend that the program fully utilize its statutorily authorized enforcement activities by developing penalty policies that encourage compliance by all employers. To better utilize state resources and improve the identification of cases of suspected fraud and their referral to the Department of Insurance fraud unit for further investigation, we recommend that the Legislature consider transferring the program's employer compliance functions to the Department of Insurance.

Regulation of Insurers

To improve the cost-effectiveness and efficiency of the program ’s monitoring of insurers, we recommend that the program develop a comprehensive plan of action to encourage insurance carriers to submit information electronically. We also recommend that the program modify its information system to allow it to identify carriers that do not comply with all reporting requirements. In addition, we recommend that the program integrate the information produced by its various monitoring activities to allow it to assess how well carriers are delivering workers' compensation benefits overall. *Estimated Annual Cost Savings to Trust Fund: Up to $2 million*

To maximize the efficient use of insurer audit resources, we recommend that the Legislature consider privatizing this function to reduce audit costs. To improve the program's ability to assess audit coverage, we recommend that the program obtain information as to the carriers covered in its audits of third party administrators. To improve the deterrent effects of the audit function, we recommend that the program eliminate its practice of waiving penalties.

To improve the efficiency and cost-effectiveness of the program ’s regulation of medical benefits, we recommend that the Legislature clarify the program ’s oversight responsibilities. In addition, we recommend that the program, in conjunction with other stakeholders, identify the data that should be maintained under a managed care system. To further improve the efficiency and cost-effectiveness of its medical benefits regulatory processes, we recommend that the program coordinate its responsibilities and functions with those of the Agency for Health Care Administration to eliminate duplicative or overlapping activities and ensure the exchange of data and information. *Estimated Annual Cost Savings to Trust Fund: Approximately $1 million*

To improve the efficiency and cost-effectiveness of the program ’s regulation of self-insurers, we recommend that the program cease its review and monitoring activities of self-insurers' financial stability. The

program should rely upon the efforts of the Florida Self-Insurer Guaranty Association, Inc., to determine the initial stability of applicants and to monitor the continued financial stability of self-insured employers. *Estimated Annual Cost Savings to Trust Fund: Approximately $130,000*

To ensure that all employers deliver benefits to their employees through a managed care plan of operation that has been approved by the Agency for Health Care Administration, we recommend that the Legislature clarify the program's responsibility to enforce the requirement that self-insurers obtain authorization from the agency to offer or use a managed care arrangement.

Assistance to Employees

To eliminate the inefficiencies and cost of the informal dispute resolution process, we recommend that the Legislature rescind the statutory requirement that injured workers attempt to resolve any dispute through the program's Employee Assistance Office prior to filing a Petition for Benefits. If the Legislature eliminates the need to provide informal dispute resolution, the program should eliminate some positions and redirect others to increase its proactive efforts to reduce the incidence of disputes and assess whether these efforts contribute to improving the effectiveness and self-executing nature of workers' compensation. *Estimated Annual Cost Savings to Trust Fund: at Least $3.6 million*

To increase the cost-effectiveness and efficiency of reemployment services, we recommend that the Legislature consider incorporating these services into the state's workers' compensation managed care system to provide for continuity of services to injured workers and more cost-effective service provision. If the Legislature decides not to pursue this option, we recommend that the program redesign its service delivery mechanism for reemployment services. The program should evaluate the cost-effectiveness of contracting with private providers for case management, vocational evaluation, and other reemployment services.

Agency Response

The Secretary of the Florida Department of Labor and Employment Security and the Commissioner of the Department of Insurance provided written responses to our preliminary and tentative findings and recommendations. (See Appendix C, page 52, for their responses.)

Chapter 1

Introduction

Purpose

This is the second of two reports presenting the results of OPPAGA's program evaluation and justification review of the Department of Labor and Employment Security's Safety and Workers' Compensation Program. State law directs OPPAGA to complete a justification review of each state agency program that is operating under a performance-based program budget. OPPAGA is to review each program's performance and identify alternatives for improving services and reducing costs.

This report analyzes the services provided by the Safety and Workers' Compensation Program and identifies alternatives to improve and reduce the cost of these services.[1] Appendix A summarizes our conclusions regarding each of nine issue areas the law directs OPPAGA to consider in a program evaluation and justification review.

Background

The Safety and Workers' Compensation Program has two major components—administering Florida's workers' compensation system and providing workplace safety services. Workers' compensation systems are designed to benefit both employees and employers. Employers are able to avoid costly litigation because workers' compensation claims are handled through an administrative rather than judicial process. Employees benefit by receiving immediate medical treatment for work-related injuries or illnesses and some financial compensation for lost income. Employers furnish workers' medical benefits and indemnity benefits (lost wages) by purchasing workers' compensation insurance from an insurance carrier or by self-insuring. States statutorily set the level of benefits injured employees may receive. States enforce the mandatory purchase of insurance by employers; regulate insurance carriers, self-insurers, and benefit providers; and assist the participants in the system through dispute resolution and education.

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[1] Our first report, *PB² Performance Report on the Safety and Workers' Compensation Program*, OPPAGA Report No. 98-48, February 1999, addressed the program's performance based on its performance-based program budgeting measures and standards and made recommendations for improving these measures and standards. Together, these two reports include the areas the law requires to be addressed in a justification review.

To limit the costs of workers' compensation insurance and to protect employees, private and public employers have an incentive to provide a safe work environment. In order to have uniform safety standards, the federal government regulates workplace safety for private entities through the Occupational Safety and Health Administration Compliance Assistance Authorization Act of 1998. The federal government also contracts with Florida and other states to provide assistance to small businesses and to collect statistical information on workplace injuries, illnesses, and fatalities. The states have exclusive authority to regulate the workplace safety of their own employees and of employees of the state's political subdivisions.

For purposes of performance-based program budgeting (PB ²), the Department of Labor and Employment Security (DLES) established a single PB ²program to administer Florida ’s Safety and Workers ’ Compensation Program, although program functions are carried out by two divisions. The Division of Safety has primary responsibility for activities intended to prevent workplace injuries. The Division of Workers' Compensation regulates employers and insurers and provides various employee assistance activities.[2]

Exhibit 1 shows the major activities of the four main functions of the Safety and Workers ’Compensation PB ²Program.

[2] Administration of the Special Disability Trust Fund (SDTF) is a separate component of the PB ² program. The SDTF unit is responsible for determining reimbursement eligibility and making the reimbursements from the trust fund. Since the Special Disability Trust Fund has no PB ²measures and is currently under review by the Special Disability Trust Fund Privatization Commission, it was not included in the scope of this review. The SDTF no longer accepts claims with accident dates on or after January 1, 1998.

Exhibit 1
The Safety and Workers 'Compensation PB ²Program Performs Four Main Functions

Program Function	Major Activities
Prevention of Injuries	Conduct safety consultations under contract with the Federal Office of Safety and Health Administration (OSHA 7C1 program) for small private companies in hazardous industries
	Provide safety consultations to state and local government entities
	Conduct safety statistical research
Regulation of Employers	Investigate employers 'compliance with requirements to provide workers' compensation insurance coverage to employees
Regulation of Insurers	Monitor and audit insurers 'timeliness and accuracy in paying indemnity benefits
	Monitor and audit timely and appropriate delivery of medical benefits
	Provide fiscal impact analysis for the Three Member Panel that establishes reimbursement schedules for program medical services
	Regulate self-insurers
Employee Assistance	Educate workers' compensation participants
	Conduct informal dispute resolution for employees
	Provide reemployment training services as needed

Source: Compiled by OPPAGA

In addition to these four main functions, the program also manages trust funds, publishes workers' compensation statistical information, makes supplemental benefits payments, and manages program information.

While the PB ²program has primary responsibility related to safety and workers' compensation, numerous other governmental entities carry out activities related to the workers' compensation system (see Appendix B for an organizational chart of the workers' compensation system). The PB ² program's functions are highly interrelated with these activities. The activities and the entities responsible for them are outlined in Exhibit 2 below.

Exhibit 2
Other Entities Are Responsible for Activities Related to the Workers 'Compensation System

Entity	Activities
Department of Insurance	Reviews and approves workers' compensation insurance rates Licenses and monitors insurers 'financial solvency (other than self-insurers) Investigates workers' compensation insurance fraud Facilitates safety efforts in state agencies by providing training and technical information to agency safety coordinators
Agency for Health Care Administration	Authorizes insurers to use a workers' compensation managed care arrangement Approves insurers 'managed care plans of operation Regulates workers' compensation managed care arrangements

Entity	Activities
Office of Judges of Compensation Claims *Administratively housed within DLES*	Conducts mediation to settle benefit disputes Holds pre-hearing conferences and formal hearings to settle benefit disputes
Workers' Compensation Oversight Board *Administratively housed within DLES*	Advises the program on policy, administrative, and legislative issues Appears before the Legislature and other state and federal agencies on matters impacting the workers' compensation system
Three-Member Panel *Composed of the Insurance Commissioner and two appointees of the Governor confirmed by the Senate*	Establishes schedules of statewide maximum reimbursement allowances for fee-for-service medical services
Florida Self-Insurers Guaranty Association, Inc. *Non-profit corporation under the oversight of DLES*	Makes recommendations to the program to approve applications for self-insurance Monitors the solvency of self-insurers Pays claims in the event the self-insurer becomes insolvent

Source: Compiled by OPPAGA

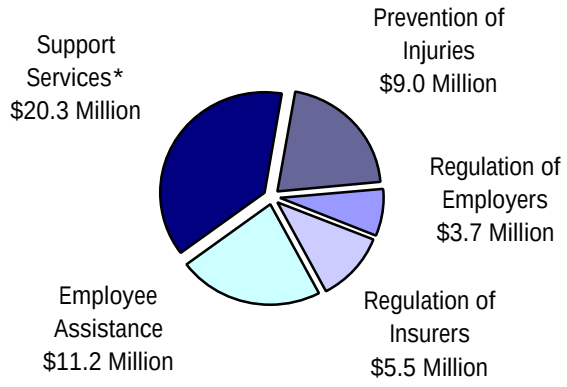
Program Resources

The Safety and Workers' Compensation program is funded by the Workers' Compensation Administration Trust Fund. The fund's revenues are generated from an assessment on workers' compensation insurance premiums. The annual assessment rate is based on the program's costs in the prior year, and may not exceed 4% of net premiums collected by insurers and the amount self-insurers would have paid in premiums if they did not self-insure. In Fiscal Year 1997-98, the assessment rate was 2.4%, and the program collected $77.8 million from insurance carriers, self-insurance funds, and self-insurers. In addition to the annual assessments, any fines or penalties collected by the program are deposited in the trust fund and used for program activities.

In Fiscal Year 1997-98, trust fund expenditures totaled an estimated $90.6 million. The PB [2]program expended $49.7 million from the trust fund in performing its functions (Exhibit 3 provides the amount of funds expended by each function). In addition to the $49.7 million in program expenditures, the program transferred $17.9 million from the Workers' Compensation Administration Trust Fund to the Department of Insurance, the Agency for Health Care Administration, and the Judges of Compensation Claims to fund the workers' compensation activities performed by those entities. The program also transferred an additional $1.7 million to the Department of Labor and Employment Security for

indirect costs, some of which is used to fund the Workers' Compensation Oversight Board. Additionally, the program paid $21.3 million in supplemental benefits to injured workers.

Exhibit 3
The Program Expended $49.7 Million in Performing Its Functions

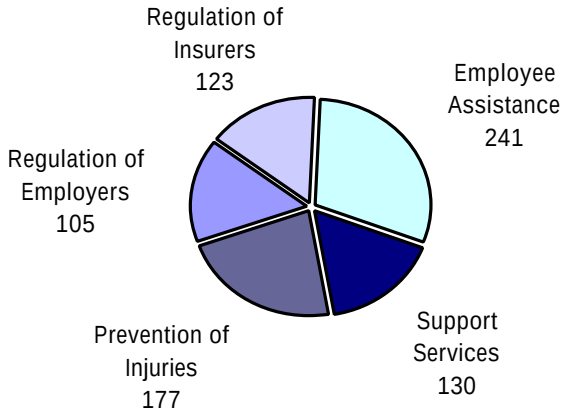


*The support function includes those activities performed by the Director's Office, the Bureau of Operations Support, the Bureau of Research and Education, and the Bureau of Information Management within the Division of Workers' Compensation and similarly identified activities within the Division of Safety.

Source: OPPAGA estimates based on budget information provided by the program and FLAIR reports

In Fiscal Year 1997-98, the program assigned 776 FTE positions to program operations. Exhibit 4 shows how the FTEs were allocated within the program.

Exhibit 4
776 FTE Positions Were Allocated to Program Functions



Source: Compiled by OPPAGA from program data

Chapter 2

General Conclusions and Recommendations

Introduction

The Department of Labor and Employment Security established its Safety and Workers' Compensation Program under performance-based program budgeting in Fiscal Year 1997-98. The program administers and oversees Florida's workers' compensation system and is charged with ensuring that the system operates efficiently and effectively.

Program Need

State law requires most employers to provide workers 'compensation coverage for their employees. Workers' compensation reduces costs the public would otherwise pay for uncompensated medical care and income replacement for workers injured on the job. The public also benefits from employers 'reduced litigation costs, which would otherwise be passed on to consumers in the form of higher prices for goods and services.

State-level oversight helps ensure that employers provide workers ' compensation coverage, as required by law, and that they implement safety and loss prevention programs to reduce the incidence of workplace injuries. State oversight also helps ensure that insurance industry practices result in the timely and appropriate delivery of medical services and of indemnity benefits for workers who lose time from work as a result of a workplace injury.

The program is beneficial and should be continued

Although it is not an essential state function, administrative oversight of the workers' compensation system is an appropriate government activity. All states provide such oversight and most states place this function within a single governmental entity similar to Florida's Department of Labor and Employment Security.

Eliminating state oversight would likely result in the erosion of employee and employer protections. In the absence of oversight and regulatory mechanisms, the number of employees covered by workers' compensation would likely decrease. Lack of system oversight could also

result in less safe workplaces and more injured employees, delays in the payment of employee benefits, and a higher number of litigated cases.

Performance Measurement

Although the program is responsible for administering and overseeing the Florida's workers' compensation system, it has not established measures to evaluate the impact of the system as a whole. For example, one of the purposes of the system is to reduce the cost of workers' compensation claims in Florida. Although such costs are not directly controlled by the program, a measure of the average cost of workers' compensation claims to insurers would provide an indicator of industry costs. Similarly, a measure of the reduction in the occupational injury and total case incidence rate would provide an indicator of the condition of the entire private sector, not just employers provided safety services by the program.

Although outcomes associated with such "macro-level" measures extend beyond the program's direct control, reporting measures that allow system-level evaluation would help the Legislature and other policymakers identify ways to improve the workers' compensation system overall.

The Program Needs to Establish a More Comprehensive and Valid Set of PB ²Performance Measures

The program's Fiscal Year 1997-98 PB ²measures do not provide a comprehensive assessment of program performance. Due to problems with data validity and reliability, the program's measures cannot be used to assess performance for two of its four major functions: prevention of injuries and assistance to employees. Our assessment of the program's performance measure in these two areas indicates that despite increased efforts by program staff, program effectiveness declined for Fiscal Year 1997-98. Measures for the other two functions, regulation of employers and regulation of insurers, provide limited information about program performance.

The program needs to develop a comprehensive set of measures that can be used to assess all of its major functions. The program also needs to develop measures that link functional activities to provide information about how the program is operating as a whole. For example, the program could adopt a measure that integrates the results of all insurer regulatory activities, such as the percentage of carriers that handle the

entire claims process appropriately. Additionally, the program needs to initiate stronger quality assurance and internal controls to improve the validity and reliability of its data. A detailed assessment of the program's performance based on its Fiscal Year 1997-98 measures is provided in OPPAGA's *PB²Performance Report on the Safety and Workers' Compensation Program*.[3]

Justification Review Conclusions

Our study concluded that although the Safety and Workers' Compensation Program has primary administrative responsibility for the workers' compensation system, many activities are carried out by other governmental entities. The many entities involved in the workers' compensation system require the system's program provide strong oversight to ensure the effective and efficient execution of the various functional and regulatory activities. However, several policy and programmatic issues have prevented the program from providing effective system oversight.

The Program Is Not Identifying and Solving System Problems

In several areas, the program has failed to make administrative decisions that could improve the workers' compensation system as a whole. Such decisions are essential to the system's cost-effective and efficient operation and in many instances require clarification or elimination of roles and responsibilities. For example, the program has not sought legislative clarification as to whether the program or the Agency for Health Care Administration should enforce the requirement that no insurer may offer or use a managed care arrangement without the agency's authorization. Consequently, 80 of 280 private self-insurers do not have the required authorization to use or provide managed care. As part of its role, the program should also be introducing policy and, when necessary, recommending legislative changes that could enable the system to further the goal of achieving a more cost-effective, less burdensome system Although it appears to be the intent of the Legislature that the program take a leadership role in identifying and solving problems within the state's workers' compensation system, program staff question their authority in this area. Thus, it may be necessary for the Legislature to clarify its intent regarding the program's authority to ensure the efficient and effective administration of the workers' compensation law.

[3] *PB²Performance Report on the Safety and Workers' Compensation Program*, OPPAGA Report No. 98-48, February 1999

The Program Is Neither Providing Effective Program Management nor Effectively Coordinating Activities Across the Workers' Compensation System

The program focuses its efforts on handling individual processes rather than identifying and solving systemic problems. For example, the program's monitoring efforts focus on how individual claims are handled rather than on determining whether individual carriers or the overall insurance industry have effective claims handling practices. As a result, problems that should be investigated, such as a pattern of claims denials, may go undetected for a period of time.

The program also continues to perform a number of activities that are no longer needed or are duplicative. For example, the program continues to perform activities required under a fee-for-service system that are no longer needed in Florida's new managed care environment. Functional activities continue to be duplicated by system entities, such as the review of the financial stability of self-insurers by both the program and the Florida Self-Insurer Guaranty Association, Inc.

Rather than focusing its efforts on individual activities and processes, the program needs to provide effective overall program management and coordination of activities across system entities to prevent duplicative or ineffective efforts.

The Program Is Not Collecting and Maintaining Data in the Least Burdensome, Most Cost-Effective Manner

The program continues to collect data for which the need is questionable, as it is not used for a specific purpose. Collection of data that the program does not intend to use is unnecessarily burdensome to insurers. For example, although carriers are required to report if an employee is unlikely to return to work, the program does not use this information to identify individuals needing reemployment assistance. The program needs to reduce the industry's reporting burden to employers by identifying and collecting only required data.

The program's methods of collecting data are costly to both the program and carriers. The program does not require that information be reported electronically, which increases the time it spends handling and storing paper and manually inputting reported information. Carriers' administrative costs are also burdensome and are ultimately passed on to

employers who are required to purchase workers' compensation insurance. The program needs to implement a less resource-intensive mechanism for collecting data, such as the use of electronic data submission.

Many of the program's organizational units separately collect and maintain data but cannot share information across databases. For example, the program cannot integrate information on payment of indemnity benefits with data on medical services to establish a profile of carrier performance in claims handling. Although the program has plans to integrate its various databases, it has not identified the data it needs to ensure more effective system operation and to provide for system-level oversight.

Potential for Privatization

As an entity charged with governmental oversight and regulation, the Safety and Workers' Compensation Program has limited opportunities to privatize its functions and activities. Workers' compensation is primarily a private sector enterprise designed to operate with little government intervention. Employers purchase workers' compensation insurance through private sector insurers, and insurers pay indemnity benefits directly to the employee. Other system activities, such as insurance rate approval, authorization for carriers to provide managed care, and formal dispute resolution, are carried out by government entities external to the program.

Although opportunities to privatize functions and activities are limited, we identified instances in which it may prove more cost-effective for the program to purchase services from private sector providers. The program should explore the potential to achieve cost saving by out-sourcing the audit of insurance carriers (see Chapter 5) and the delivery of reemployment services (see Chapter 6).

Recommendations

To ensure that the workers' compensation system operates in the most efficient and cost-effective manner, we recommend that the program take a leadership role in identifying and solving problems within the state's workers' compensation system. As part of this role, the program should introduce policy and, when necessary, recommend legislative changes that will enable the system to further the goal of achieving a more cost-effective, less burdensome system. To ensure the implementation of this recommendation, we also recommend that the Legislature clarify its

intent regarding the program's authority to ensure the efficient and effective administration of the workers' compensation law.

To prevent duplicative or ineffective efforts in executing its various functional and regulatory activities, we recommend that the program focus on providing effective management of internal program functions and coordinating activities across system entities and functions.

To ensure that program information is collected and maintained in the least burdensome, most cost-effective manner, we recommend that the program revise its reporting requirements to include only information that is needed and implement less resource-intensive methods for collecting data. To facilitate the integration and sharing of information, we also recommend that the program integrate its separate functional databases.

In addition to the policy-level issues discussed above, we identified concerns specific to the program's four functional areas. These issues and recommendations for improving the Safety and Workers' Compensation Program are discussed in detail in Chapters 3 through 6 of this report and are summarized in Exhibit 5. These recommendations identify an estimated $10 million in cost savings to the Workers' Compensation Administration Trust Fund. Any savings realized could be reflected in a reduction in trust fund assessments.

Exhibit 5
Summary of Conclusions and Recommendations

Functional Area	Recommendation
Prevention of Workplace Injuries	The program's contract with OSHA in the private sector benefits the state because it targets small employers in hazardous industries and is largely funded by OSHA. In response to a recommendation by OPPAGA, the 1998 Legislature eliminated funding for separate 100% state funded consultative services that duplicate those provided by the program under the OSHA contract.[4] However, the state's requirement for workplace safety standards and programs in the private sector was not eliminated. The Legislature may wish to consider eliminating this requirement from Ch. 442, F.S. To provide a more effective use of program resources and means of ensuring public sector safety, we recommend that the program discontinue its voluntary consultative services and actively exercise its statutory inspection and penalty authority. The program should modify its information system to allow it to monitor the incidence rate of local government employers and and focus its efforts on inspecting worksites that expose employees to high risk of injury. ***Estimated Annual Cost Savings to Trust Fund: $3.1 million***

[4] *Review of the Division of Safety, Department of Labor and Employment Security*, OPPAGA Report No. 97-25, December 1997

Functional Area	Recommendation
	Further, to improve the operational efficiency of the program's process for ensuring safety in the public workplace and eliminate duplicate administrative expenses, we recommend that the Legislature organizationally realign the remaining activities of the safety component (i.e., contracts with OSHA and the federal Bureau of Labor Statistics, inspections of local government high hazard workplaces, investigations of occupational fatalities, and library services) with the workers' compensation component, by combining the two divisions that currently make up the PB ²program. ***Estimated Annual Cost Savings to Trust Fund: $0.5 million***
Regulation of Employers	To improve the effectiveness of the employer regulatory process, we recommend that the program fully utilize its statutorily authorized enforcement activities by developing penalty policies that encourage compliance by all employers. To better utilize state resources and improve the identification of cases of suspected fraud and their referral to the Department of Insurance fraud unit for further investigation, we recommend that the Legislature consider transferring the program's employer compliance functions to the Department of Insurance. ***Estimated Annual Cost Savings to Trust Fund: Unidentified, but derived through a more cost-effective regulatory process***
Regulation of Insurers	To improve the cost-effectiveness and efficiency of the insurer monitoring process, we recommend that the program develop a comprehensive plan of action to encourage carriers to submit information electronically. We also recommend that the program modify its information system to allow it to identify carriers that do not comply with all reporting requirements. In addition, we recommend that the program integrate the information produced by its various monitoring activities to allow it to assess of how well carriers are delivering workers' compensation benefits overall. ***Estimated Annual Cost Savings to Trust Fund: Up to $2 million*** To maximize the efficient use of insurer audit resources, we recommend that the Legislature consider privatizing this function to reduce audit costs. To improve the program's ability to assess audit coverage, we recommend that the program obtain information as to the carriers covered in its audits of third party administrators. To improve the deterrent effects of the audit function, we recommend that the program eliminate its practice of waiving penalties.
	To improve the efficiency and cost-effectiveness of the program's medical benefits regulatory processes, we recommend that the Legislature clarify the program ŝ statutory responsibilities for oversight and regulation of medical benefits. In addition, we recommend that the program, in conjunction with other stakeholders, identify the data that should be maintained under a managed care system. To further improve the efficiency and cost-effectiveness of its medical benefits regulatory processes, we recommend that the program coordinate its responsibilities and functions with those of the Agency for Health Care Administration to eliminate duplicative or overlapping activities and ensure the exchange of data and information. ***Estimated Annual Cost Savings to Trust Fund: Approximately $1 million***
	To improve the efficiency and cost-effectiveness of the self-insurer regulatory process, we recommend that the program cease its review and monitoring activities of self-insurers' financial stability and rely upon the efforts of the Florida Self-Insurer Guaranty Association, Inc., to determine the initial stability of applicants and to monitor the continued financial stability of self-insured employers. ***Estimated Annual Cost Savings to Trust Fund: Approximately $130,000***

Functional Area	Recommendation
	To ensure that all employers deliver benefits to their employees through a managed care plan of operation that has been approved by the Agency for Health Care Administration, we recommend that the Legislature clarify the program's responsibility to enforce the requirement that self-insurers obtain authorization from the agency to offer or use a managed care arrangement.
Assistance to Employees	To eliminate the inefficiencies and cost of the informal dispute resolution process, the Legislature should amend the law to rescind the statutory requirement that injured workers attempt to resolve any dispute through the program's EAO prior to filing a *Petition for Benefits*. If the Legislature eliminates the need to provide informal dispute resolution, the program should eliminate some positions and redirect others to increase its proactive efforts to reduce the incidence of disputes and assess whether these efforts contribute to improving the effectiveness and self-executing nature of workers' compensation. ***Estimated Annual Cost Savings to Trust Fund: At least $3.6 million***
	To increase the cost-effectiveness and efficiency of reemployment services, we recommend that the Legislature consider incorporating these services into the state's workers' compensation managed care system to provide for continuity of services to injured workers and more cost-effective service provision. If the Legislature decides not to pursue this option, we recommend that the program redesign its service delivery mechanism for reemployment services. The program should evaluate the cost-effectiveness of contracting with private providers for case management, vocational evaluation, and other reemployment services. ***Estimated Annual Cost Savings to Trust Fund: Unidentified, but derived through greater efficiency and ability to contract at market rate***

Chapter 3

Prevention of Workplace Injuries

Introduction

The Legislature created the program's safety component to reduce the incidence of employee injuries, occupational illnesses, and fatalities compensable under workers' compensation laws. The program provides safety consultations at no cost to all public entities and some private employers in high hazard industries. Safety consultations include an assessment of the entity's safety and occupational health program; identification and prevention of workplace hazards; training and education, and injury trend analysis.

The program's responsibilities for workplace safety oversight are limited to areas not addressed by the federal government. Under federal law, the Occupational Safety and Health Administration (OSHA) is generally responsible for private sector workplace safety. However, OSHA may contract with states to conduct some private sector safety inspections, and states may establish safety standards for private sector employers in areas where no federal standards exist. Because federal law exempts public sector employers from OSHA's jurisdiction, Florida's Safety and Workers' Compensation Program has provided workplace safety services for state and local government employers.

- **Private Sector.** The program conducts most of its private sector efforts under a 90% reimbursable contract with OSHA. Under this contract, the program inspects private sector employers for compliance with OSHA safety standards. During Fiscal Year 1997-98, program staff conducted inspections of 1,700 private sector worksites. The program reports any violations that are not corrected to OSHA for federal enforcement action against the employer. Florida law also gives the program statutory responsibility for enforcing additional workplace safety standards in the private sector.

  Prior to Fiscal Year 1998-99, the program provided voluntary state-funded safety consultations to private sector providers in addition to the inspections it conducts under the OSHA contract. OPPAGA examined the program's private-sector activities in 1998 and concluded that the program's contract with OSHA benefited the state because it targets small employers in hazardous industries and is largely funded by OSHA.[5] However, we concluded that the provision

[5] *Review of the Division of Safety, Department of Labor and Employment Security*, OPPAGA Report No. 97-25, December 1997

of voluntary state safety consultations independent of OSHA duplicated services provided under the OSHA contract as well as services required of insurance carriers. The 1998 Legislature subsequently eliminated funding and staffing for the program's non-OSHA private sector consultative services.

- **Public Sector.** The program provides voluntary safety consultations for public sector employers throughout Florida, including state, county, and municipal governments and their political subdivisions. These consultations are funded through an assessment on workers' compensation insurance policies. During Fiscal Year 1997-98, program staff conducted safety consultations at approximately 3,000 public sector worksites.

  In addition to its consultative services, the program provides technical assistance to employers, responds to complaints of unsafe workplace conditions, investigates occupational fatalities, and maintains a library of safety materials. These activities are also funded through assessments on workers' compensation insurance policies.

The program also participates in two federal/state surveys to collect data on occupational safety and health, under contract with the federal Bureau of Labor Statistics. The Occupational Safety and Health Survey of Injuries and Illnesses provides information on the number and incidence rate of occupational injuries and illnesses. The Census of Fatal Occupational Injuries reports on the number of Florida workers who are fatally injured on the job and related statistics.

The program's safety component received nearly $10.1 million in Fiscal Year 1998-99, and was allocated 144 FTE**.** Exhibit 6 provides the distribution of these funds and positions. Safety field services for both the private and public sector are provided through the safety component's five district and 10 satellite offices.

Exhibit 6
The Safety Component Received $10.1 Million in Fiscal Year 1998-99

Activity	Federal Funds (in millions)	State Funds (in millions)	Total Funding (in millions)	FTE
OSHA Private Sector Activities	$1.3	$0.1	$ 1.4	24
Statistical and Survey Activities	0.2	0.2	0.4	7
Other Safety Activities *		6.8	6.8	93
Administration and Support		1.5	1.5	20
Total	$1.5	$8.6	$10.1	144

*Other Safety Activities include public sector safety consultations and occupational fatality investigations, response to complaints of unsafe workplace conditions, public and private employer technical assistance, and library services.

Source: Department of Labor and Employment Security, Division of Safety estimates

Program Performance

In OPPAGA's *PB ²Performance Report on the Safety and Workers' Compensation Program*, we determined that the program's output measures indicate that it has increased the number of private and public sector employees directly receiving services. However, it currently has no outcome measures that indicate whether its services are effective in reducing workplace injuries. For example, the disabling compensable claims rate for employers served could be compared over time to determine if the program services are having any impact. The program has proposed several outcome measures in its Fiscal Year 1999-2000 Legislative Budget Request that are appropriate for this purpose. However, no historical data exists to allow an assessment of the effectiveness of its services over time.

Given our recent review of the private sector, this review focused on the program's public sector efforts. We determined that the program should refocus its efforts from providing voluntary consultative services in the public sector to identifying and inspecting high hazard local government workplaces.

The Program's Voluntary Consultative Services Limit Its Ability to Ensure Safety in the Public Sector and Are Not Necessary

Program's focus on providing voluntary services limits its impact

The major activity performed by the program ¾s public sector safety component is conducting voluntary safety consultations for public sector employers throughout Florida. The program is authorized by law to conduct inspections of public sector employers and impose penalties for noncompliance. However, the program has opted to assume an education and assistance role by offering voluntary safety consultations on workplace safety issues. In this activity, staff visit state and local government workplaces and offer a broad range of services to help employers identify and resolve safety issues. During Fiscal Year 1997-98, program staff conducted safety consultations at approximately 3,000 public sector worksites. [6] This represents less than 4% of the estimated 80,000 public sector worksites. Focusing its efforts on providing a broad range of voluntary consultative services to a small segment of the employer population limits the program's impact on ensuring public safety in the public sector, as the program does not target its efforts at those worksites that pose the highest risk of injury, nor is it able to identify such worksites.

[6] The program defines a worksite as a separate physical location for each employer. The program is unable to identify the number of employers being served.

Safety consultations duplicate activities of other entities

The programs voluntary consultative services also duplicate safety consultations that insurance carriers are required to provide free of charge to their clients as well as services provided by state and local government risk management programs. State law requires insurance carriers, self-insurers, and self-insurance funds, to provide safety consultations to the entities that they insure. At the state level, the Department of Insurance administers Florida's workers' compensation insurance program, trains and coordinates state government safety efforts through safety coordinators within each state agency. Individual safety coordinators are responsible for carrying out agency-wide safety programs, including implementing loss prevention programs, inspecting facilities and equipment, and investigating accidents. Similarly, most large cities, counties, and school districts have internal safety programs and staff.

While the risk management program within the Department of Insurance serves as a control to ensure workplace safety in state government, there are no mechanisms in place to ensure that local governments are meeting the intent of the law. Rather than providing voluntary consultative services, a more effective means of ensuring workplace safety for local government employees would be for the program to focus its efforts on identifying worksites that expose employees to a high risk of injury and actively exercise its statutory inspection and penalty authority to eliminate risks of high hazards. This will require the program to develop monitoring tools that allow it to target inspections of local government employers that have experienced a high incidence of workplace injury. However, the program's information system does not allow it to identify worksites that may expose employees to high risk of injury, requiring that it modify its information system to collect the needed data. If local government employers refuse to correct identified safety risks, the program should exercise its statutory authority to impose penalties.

The program can reduce costs by approximately $3.1 million

There is little apparent need for the program to continue to provide its board range of voluntary consultative services. The incidence of workplace injuries for public employers in Florida has declined by 30% over the past 10 years. According to the most recent available data, approximately 1 public employee in 100 sustains an injury or illness that causes more than seven days of lost work time. Although some stakeholders have voiced concerns that eliminating state consultative services would burden smaller public employers, this concern is unwarranted as insurance carriers are required by law to provide safety consultations to the entities that they insure. Discontinuing the program's consultative services in the public sector and refocusing its efforts on identifying and inspecting local government high hazard workplaces should require half the number of staff currently dedicated to providing safety consultations to local government employers, which would eliminate 42 FTE positions and an estimated $3.1 million in annual expenditures from the Workers' Compensation Administration Trust Fund.

The Program's Safety Component Needs to Be Organizationally Realigned

Organizational realignment would reduce costs by an additional $0.5 million

Organizationally, the program's safety component is a separate division from that responsible for workers' compensation. Although both divisions are funded through an assessment on workers' compensation insurance policies, the separation of program functions is not the most cost-effective use of these funds, particularly if the Legislature implements our recommendation to downsize the program's public sector activities. Combining the two components organizationally (as the agency has done for performance-based program budgeting purposes) would eliminate duplicative administrative services, such as the cost of the division director's office. Combining the two components would also ensure a more collaborative effort in maintaining and sharing statistical information that is needed by the program. Organizational realignment would eliminate an additional seven FTE positions and an estimated $0.5 million in annual expenditures from the Workers' Compensation Administration Trust Fund

Recommendations

The program's contract with OSHA in the private sector benefits the state because it targets small employers in hazardous industries and is largely funded by OSHA. In response to a recommendation by OPPAGA, the 1998 Legislature eliminated funding for separate 100% state funded consultative services that duplicate those provided by the program under the OSHA contract.[7] However, the state's requirement for workplace safety standards and programs in the private sector was not eliminated. The Legislature may wish to consider eliminating this requirement from Ch. 442, F.S.

To provide a more effective use of program resources and means of ensuring public safety, we recommend that the program discontinue its voluntary consultative services and actively exercise its statutory inspection and penalty authority. The program should modify its information system to allow it to monitor the incidence rate of local government employers and and focus its efforts on inspecting worksites that expose employees to high risk of injury.

Further, to improve the operational efficiency of the program's process for ensuring safety in the public workplace and eliminate duplicate administrative expenses, we recommend that the Legislature realign

[7] *Review of the Division of Safety, Department of Labor and Employment Security*, OPPAGA Report No. 97-25, December 1997

organizationally the remaining activities of the safety component (i.e., contracts with OSHA and the federal Bureau of Labor Statistics, inspections of local government high hazard workplaces, investigations of occupational fatalities, and library services) with the workers' compensation component, by combining the two divisions that currently make up the PB ²program.

Chapter 4

Regulation of Employers

Introduction

State law requires employers to provide workers 'compensation coverage for their employees. Florida law generally requires employers with four or more employees to have coverage for each employee; except for the construction industry, which is required to carry coverage for one or more employees.[8] Employers who fail to provide the required coverage are subject to both civil and criminal penalties. The Department of Labor investigates civil violations of this requirement, while the Department of Insurance Workers 'Compensation Fraud Unit investigates criminal violations.

Department of Labor staff identify employers who may not be operating in accordance with the law, through telephone calls to the program's hotline from the public, notification from insurance carriers of employers who have dropped coverage, and random stops at construction sites and new business establishments. Staff then conduct on-site investigations to determine if these employers have coverage. When program investigators find employers operating without proper coverage, the law authorizes staff to issue stop work orders and fine non-compliant employers. The program may also seek injunctions in court to prevent employers from employing individuals until they obtain insurance coverage. If staff suspect that employers knowingly have not obtained the required coverage, the program must refer the case to the Department of Insurance, which is responsible for conducting criminal investigations involving insurance fraud.

Civil and criminal non-compliance contributes to the overall cost of workers 'compensation insurance. Types of workers' compensation insurance fraud include employers that fail to purchase any insurance, purchase inadequate insurance coverage, or falsely claim an exemption from the law. Employers that do not purchase coverage cause employers with coverage to pay higher insurance costs, as premium rates are based on the total projected workforce. Further, the burden of a worker's medical and subsistence expenses that are not covered by workers ' compensation may fall upon the state through public assistance

[8] Employers may file requests to exempt certain employees from workers 'compensation coverage, such as officers of corporations, sole proprietorships, or partnerships.

programs, if the worker has no other medical benefits or means of support.

Statewide Grand Jury cites program for insufficient enforcement efforts

The Statewide Grand Jury found that workers 'compensation fraud is a problem in Florida.[9] The grand jury's review also found that the program was not effectively using its civil authority to penalize non-compliant employers, nor was the program referring cases of suspected fraud to the Department of Insurance for criminal investigation.

The program expended $3,669,228 in Fiscal Year 1997-98 and assigned 105 FTE positions to carry out various compliance activities. These staff included 37 civil investigators that visit employer job sites.

Program Performance

As noted in OPPAGA's *PB ²Performance Report on the Safety and Workers' Compensation Program*, the program ŝ performance in ensuring employer compliance declined from Fiscal Year 1996-97 to 1997-98. During this period, the program conducted fewer investigations than in the prior year. The number of workers newly protected by workers ' compensation coverage decreased during this time by 18% (from 15,948 to 13,143). The number of employers brought into compliance through investigations declined by 13% (from 3,565 to 3,087).

In this report, we determined that although the program has increased its regulatory efforts since the Statewide Grand Jury review, its enforcement policies still need improvement. Further, the program is not ensuring that incidents of suspected fraud are referred to the Department of Insurance for investigation of criminal intent.

The Program Is Not Adequately Enforcing Employer Non-Compliance

The Statewide Grand Jury reviewed the program ŝ policies and procedures for ensuring adequate employer coverage. The grand jury concluded that program staff were under utilizing their authority to shut down businesses that were not in compliance and in some cases were not imposing fines or were imposing minimum penalties regardless of the amount prescribed by formula in law.

[9] The Fourteenth Statewide Grand Jury, July Term 1997, issued a report on workers' compensation fraud after investigating insurance fraud in Florida.

Enforcement policies continue to need improvement

We determined that after the grand jury concluded its investigation, the program increased the number of stop work orders issued and targeted its investigations in high-risk industries, such as the construction industry. However, the program continues to make limited use of its penalty authority. Since the Statewide Grand Jury report was issued in January 1998, penalty assessments have declined from $1,272,162 in Fiscal Year 1996-97 to $902,526 in Fiscal Year 1997-98. In Fiscal Year 1997-98, the program collected an average penalty of $290 per non-compliant employer. The law stipulates a minimum penalty of $100 a day for each day the employer was not in compliance, in addition to other monetary penalties.[10]

Staff indicated that low penalty assessments are due to the program's policy to assess a penalty of no more than $100 on first time violators that are non-construction employers. Another factor cited is the failure of employers to maintain adequate employee records and prior coverage records to allow investigators to assess an appropriate penalty. While the program may not wish to impose the maximum penalty allowed by law for first time offenders, program management needs to develop a penalty policy that will encourage compliance with the law regardless of whether the employer is in the construction industry or not.

The Program Continues to Refer Few Cases of Suspected Fraud to the Department of Insurance

Although the Statewide Grand Jury recommended that the program report to the Department of Insurance cases of suspected fraud, program efforts have resulted in few referrals. In Fiscal Year 1997-98, the program investigated over 24,042 employers and identified 3,087 employers operating without any insurance at all. They also identified cases where coverage appears to be insufficient and referred some of these to the Department of Insurance. However, the program referred less than 100 cases to the Department of Insurance between December 1997 and January 1999. Employers commit fraud when they knowingly fail to carry workers 'compensation insurance or carry inadequate insurance for their employees. Thus, the program should refer most of the employers they identify without coverage to the Department of Insurance for criminal investigation as well as those they suspect of having inadequate coverage. However, staff lack the benefit of guidance from program management as to the type of cases that should be referred to DOI and the necessary information that should be included in the referral.

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[10] Section 440.107, F.S., provides for an additional penalty of $1,000, or twice the amount of premium (up to three years), whichever is greater.

Relocation would improve effectiveness

An option to improve the ability of program staff to effectively refer employers that may be committing workers 'compensation fraud for criminal investigation is to transfer the program's civil enforcement resources to the Department of Insurance. Locating both the civil and criminal investigation functions in one agency would eliminate the fragmentation and lack of coordination that currently exists from having enforcement responsibilities in two agencies.

Placing these activities in the same department would also facilitate the development of policies for appropriate enforcement actions and penalties and of protocols for when a civil case should be referred for criminal investigation. In order to preserve the distinction between civil and criminal investigations, the Department of Insurance should place these distinct responsibilities in two separate organizational units. The Department of Insurance already has this type of structure in place for the administrative and criminal investigations of insurance companies and agents.

Recommendations

To improve the effectiveness of the employer regulatory process, we recommend that the program fully utilize its statutorily authorized enforcement activities by developing penalty policies that encourage compliance by all employers.

To better utilize state resources and improve the identification of cases of suspected fraud and their referral to the Department of Insurance's fraud unit for further investigation, we recommend that the Legislature consider transferring the program's employer compliance functions to the Department of Insurance.

Chapter 5

Regulation of Insurers

According to Florida law, the intent of the Legislature is to ensure the prompt delivery of benefits to the injured worker and create an efficient and self-executing system that is not an economic or administrative burden. The law further states that the Division of Workers' Compensation is to administer the law in a manner which facilities self-execution of the system and a prompt and cost effective delivery of payments. To accomplish this mission, the program

- oversees and monitors the delivery of indemnity benefits to injured workers;
- oversees and monitors the delivery of medical benefits to injured workers; and
- authorizes businesses that meet certain requirements to provide workers' compensation coverage through self-insurance.

We identified problems in the program's administration of each of these functions.

Provision of Indemnity Payments

Introduction

It is important that insurance carriers make prompt and accurate indemnity payments to cover the loss of income of workers who are absent for more than seven days due to work-related injuries or illnesses.[11] To detect late and inaccurate indemnity payments, the program uses two mechanisms. First, it monitors indemnity payment information submitted to the program by insurance carriers. Second, it conducts periodic on-site audits of carrier records.

The program expended $3,141,209 to monitor and audit carriers ' indemnity payment activities in Fiscal Year 1997-98. The program allocated 51 FTE positions to its monitoring function and 22 FTE positions to its auditing function.

[11] Insurance carriers are required by Ch. 440, F.S., to pay claimants their indemnity benefits 14 days after the employer receives notice of the injury and to file initial payment information with the program 14 days after the employer ŝ receipt of the notice of injury. The program reviews first payment information as part of its regulatory activities to ensure that carriers process benefits expeditiously.

Program Performance

As noted in OPPAGA's *PB ²Performance Report on the Safety and Workers' Compensation Program*, the program's performance in the monitoring and auditing of insurers ' indemnity payments declined slightly from Fiscal Year 1996-97 to 1997-98. Specifically, the program detected a slightly smaller percentage of timely initial indemnity benefit payments through its monitoring activities and conducted fewer audits of carriers.

In this review, we determined that the program is not effectively managing the insurer regulatory process. This limits the efficiency and usefulness of the monitoring process in identifying and deterring non-compliant behavior. It also limits the efficiency and effectiveness of the auditing process as an enforcement tool.

The Insurance Monitoring System Is Ineffective and Inefficient

The program has not developed an efficient and effective system for receiving indemnity payment and other claim information. To enable the program to ensure the provision of timely indemnity benefits to injured workers, carriers must report information as to the payment date of the first indemnity payment and the amounts of indemnity and medical payments that are made for each claim.[12] The program receives, manually inputs, and monitors this information. In Fiscal Year 1997-98, the program received 313,957 forms reporting indemnity and other claim information.

The program does not effectively collect monitoring information

However, the program does not receive all indemnity payment information from carriers. An independent review identified over 26,000 cases established from 1993 to 1997 in which carriers failed to file required information with the program. This review noted that the program s information system does not automatically identify insurers that do not submit the required reports. The absence of these reports and the program s lack of a mechanism to ensure that it receives them adversely affects the accuracy of state workers' compensation statistics.

Furthermore, the program s practice of manually entering indemnity information into its computer system is inefficient and results in further data inaccuracies. In Fiscal Year 1997-98, program staff manually entered

[12] The law requires carriers to report indemnity benefit amounts and costs of medical care information on each claim six months after it is initially opened and every year thereafter. It also requires carrier to report any change in case status and all denials of claims.

data from 248,022 forms into its information system. Manually entering this amount of data is time-consuming. It also creates the potential for data entry errors. Data system reviews found that program staff erroneously entered nearly $2 billion in indemnity payment amounts into the program's database during Fiscal Years 1994-95 through 1997-98.

Increased use of electronic data interchange will improve accuracy and reduce program costs by up to $2 million

The program could obtain indemnity payment information more efficiently and accurately if it encouraged more carriers to submit this information by electronic data interchange. Electronic data interchange eliminates the need for manual data entry by allowing carriers' data to be automatically transferred into the program's database. Eliminating manual data entry would allow the program to improve data accuracy and reduce data entry staff. If the program received all indemnity information by electronic data interchange, it would save an estimated $2 million a year in salaries and benefits. Other states require that insurance carriers report workers compensation claims information using EDI and have found it to be a cost-effective means of obtaining information.

Electronic data interchange can also reduce carriers' reporting costs. Some carriers currently use electronic data interchange to report indemnity payment information to the program; in Fiscal Year 1997-98, these carriers submitted 65,935 forms electronically. According to these carriers, use of electronic data interchange has reduced the amount of time their claims handlers spend processing paperwork. These carriers reported time savings ranging from 3% to 25%. The program's use of electronic data interchange is limited by the ability of its computer system to receive data electronically. The computer system can currently only receive two of the many forms carriers must use to submit data to the program. The program needs to develop the capability to receive all of the information it needs electronically. It also needs to encourage carriers to submit information through electronic data interchange. Adapting the computer system and the continued need for some program staff to remain to perform system monitoring after the transition may off set the estimated annual savings of $2 million in salaries and benefits.

The program does not effectively use monitoring information to identify systemic problems

The program also does not effectively use monitoring information to evaluate carrier claims handling practices and identify carriers that persistently make untimely or inaccurate indemnity payments. Instead, the monitoring function focuses on individual cases and certain elements of compliance such as timeliness of first indemnity payment. The program's monitoring activities are organizationally fragmented; one unit collects information on timeliness of the first payment, another collects information on the payment of medical benefits, and a third collects information on the number of denied claims. The program does not combine and analyze this information to effectively assess carriers' overall performance in delivering workers' compensation benefits. Consequently, the program has limited information on which to make

determinations concerning individual carriers 'and the industry 's claims handling practices.

The Audit Function Is Inefficient and Has Limited Effectiveness

Auditing can be a useful regulatory tool. By auditing carrier files, the program evaluates how well carriers comply with the law in delivering benefits to injured workers. Auditors review selected case files and determine how well the carrier complied with timeliness of first payment, timeliness of subsequent payments, and other requirements. In Fiscal Year 1997-98, auditors found 50% of carriers reviewed did not meet acceptable thresholds in handling their workers 'compensation claims.[13]

Contracting out the audit function could improve efficiencies

However, the program's audit function is inefficient and costly. In Fiscal Year 1997-98, the program had 22 FTE allocated to the audit section and spent $900,000 to conduct 95 audits. The program 's auditors are located in Tallahassee while most carriers and third party administrators are located throughout Florida. Auditors must travel to other cities to conduct their audits, thus incurring travel time and expenditures.

One way to improve the efficiency of the audit function is through privatization. Having local auditing firms perform audits reduces travel time and other overhead associated with keeping centrally-located staff. Other state agencies, such as the Department of Insurance, have contracted out their audit function and report a projected savings of 35%. A Senate Banking and Finance interim report also concludes that the program 's audit function should be privatized to increase efficiency and cost savings.

The program lacks data needed to analyze audit coverage

In addition, the program needs to collect better information to ensure that it is getting sufficient audit coverage and complying with state law. The law requires the program to review the records of all carriers with active claim cases on a three-year basis. Program staff estimate that approximately 1,200 carriers have licenses to provide workers ' compensation insurance in Florida. However, the program did not have information about the number of carriers it audits per year at the time of our review. Although staff conducted 95 audits in Fiscal Year 1997-98, they visit both individual carriers and third party administrators that may handle the claims of several carriers. Historically, when staff audit third party administrators, they have not identified the names and number of carriers served by that administrator. Thus, the program has not

[13] Some of these audits include the review of third party administrators rather than individual carriers.

monitored how many insurance carriers its audits cover or whether it is auditing all carriers on a three-year cycle.

The program also needs to re-design its enforcement policy to increase the effectiveness of the program's auditing function in deterring future violations. According to statute, if the results of an audit scores below 90%, the program may fine the carrier. However, the program's standard practice has been to waive any assessed penalties until program staff re-audit in the following year. In Fiscal Year 1997-98, the program originally assessed penalties amounting to $166,003. However program staff reported waiving $43,193 or 26% of the original amount.[14] This practice results in a lenient regulatory posture and weakens the deterrent effect of the auditing function.

Recommendations

The program's enforcement practices weaken auditing as a deterrent

To improve the cost-effectiveness and efficiency of the insurer monitoring process, we recommend that the program develop a comprehensive plan of action to encourage carriers to submit information electronically, thus eliminating the need for the manual review and entry of data. We also recommend that the program modify its information system to allow it to identify carriers that do not comply with all reporting requirements. In addition, we recommend that the program integrate the information produced by the various monitoring activities to allow an assessment of how well carriers are delivering workers' compensation benefits overall.

To maximize the efficient use of audit resources, we recommend that the Legislature privatize this function to reduce audit costs. To improve the program's ability to assess audit coverage, we recommend that the program change the design of audits to obtain information about the carriers included in audits of third party administrators. To improve the deterrent effects of the audit function, we recommend that the program eliminate its practice of waiving penalties.

Provision of Medical Benefits

Introduction

Florida's Workers' Compensation Law requires employers to provide medically necessary treatment and care to workers with job-related injuries or illnesses. The cost of this medical care is covered by the

[14] Although program staff provided OPPAGA with this figure, they reported a higher amount waived to the Senate Banking and Finance Committee staff of $98,999 or 60% of original assessments.

employer's workers' compensation insurance. Prior to implementation of mandatory managed care on January 1, 1997, insurers purchased medical services for injured employees on a fee-for-service basis from health care providers certified by the program to provide workers' compensation medical services. Under Florida's new mandatory managed care system, insurers must provide medical services through a managed care service delivery system.

Two entities share responsibility for administering workers' compensation medical benefits. As part of its overall administrative charge, the Safety and Workers' Compensation Program is responsible for ensuring that injured workers receive timely and appropriate medical treatment. The Agency for Health Care Administration (AHCA) administers the workers' compensation managed care system. The agency is responsible for authorizing insurers to offer or use a managed care arrangement provided either directly by the insurer or through a contracted entity. AHCA also approves the insurer's proposed managed care plan of operation.

Under managed care, insurers contract for the provision of medical services with networks of health care providers and facilities, including health maintenance organizations and preferred provider organizations. Although the law permits insurers to establish capitated contracts, insurers presently contract to reimburse the provider network for each service rendered at a percentage of the state's maximum reimbursement allowance for workers' compensation medical services. [15]

The Agency for Health Care Administration is responsible for conducting an on-site survey of each insurer's managed care services within the first year of operation, and every two years thereafter to evaluate the insurer's compliance with statutory provisions governing workers' compensation medical services. The law authorizes AHCA to suspend or revoke an insurer's authority to offer a workers' compensation managed care arrangement.

In Fiscal Year 1997-98, the Safety and Workers' Compensation Program assigned 42 FTE positions and expended over $1.9 million from the Workers' Compensation Administration Trust Fund for its medical services regulatory functions. The program transferred an additional $645,000 in trust funds to AHCA to fund AHCA's administrative and regulatory activities. AHCA also deposited into the agency's Health Care Trust Fund $144,000 in fees from insurers applying for authority to use a workers' compensation managed care arrangement.

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[15] Capitated contracts are ones in which the insurer pays the health care provider a fixed dollar amount per covered individual in exchange for providing medical services, as needed in the future.

Program Performance

As noted in OPPAGA's *PB²Performance Report on the Safety and Workers' Compensation Program*, although the program is responsible for overseeing the provision of workers' compensation medical benefits, it has not established measures to evaluate performance in this area. Medical service measures, such as timeliness of first service, customer satisfaction, or costs, would assist the program in evaluating and improving service delivery and in measuring the effect of managed care on employers' insurance costs and employee return-to-work rates. Although outcomes associated with such "macro-level" measures extend beyond the program's direct control, system-level evaluation would help the Legislature and other policymakers to identify ways to improve both managed care and the workers' compensation system as a whole.

In this report, we found the program continues to perform functions that are no longer needed or that should be modified.

The Program's Efforts to Regulate Medical Services Are Duplicative and No Longer Needed

Since implementation of mandatory managed care in 1997, the program has not modified how it regulates the provision of medical benefits. Under the former fee-for-service system, the program's regulatory efforts centered on identifying and controlling overutilization of medical services and inappropriate billing and reimbursement practices. The program's administrative activities thus focused on regulating medical services at the individual claims level. This type of regulatory activity is no longer necessary under a mandatory managed care system.

Managed care systems are designed to be self-regulating through ongoing quality assurance processes and internal mechanisms for identifying and correcting improper activity. State regulation thus focuses on the appropriate functioning of these internal control processes. The Legislature placed responsibility for administering and regulating workers' compensation managed care within the Agency for Health Care Administration, thus reducing the need for the Safety and Workers' Compensation Program to directly regulate the provision of medical services.

State law currently directs the program to carry out regulatory activities that, with the implementation of managed care, are no longer needed or that should be modified. These activities include health provider

certification, provider dispute resolution, and medical services monitoring and auditing.

The program does not need to certify health care providers

The program's certification activities duplicate those carried out through the insurer's managed care plan of operation and should be discontinued. State law provides that only certified health care providers and facilities can provide workers' compensation medical services. Certification is intended to ensure that health care professionals receive training in workers' compensation insurance requirements.

With implementation of managed care, the insurer, through its managed care plan of operation is now required to ensure that health care providers and administrative staff receive training and education on workers' compensation requirements. Further, a provider who contracts with a workers' compensation managed care arrangement is automatically designated as a certified health care provider under provisions of state law. Nevertheless, the law still requires the program to certify health care providers, and the program continues to certify and maintain listings of certified providers. [16]

The program should avoid duplicative dispute resolution activities

The program needs to streamline its dispute resolution process to eliminate duplicative activities. The Workers' Compensation Law gives the program responsibility for resolving reimbursement and utilization disputes between providers and insurers. However, the law also requires that insurers resolve these disputes through the internal dispute resolution process set forth in the managed care plan of operation. To eliminate duplication of effort, the program should intervene only after the internal dispute resolution process has failed to resolve the dispute.

The medical services monitoring and auditing functions are unnecessary

State law directs the program to monitor and audit carriers to determine if they are paying medical bills in accordance with statute and rule. State law also requires insurers to send the program all medical reports and bills for each injured employee. The program monitors these medical cost reports for accuracy and timeliness of report submission. The program previously audited paid medical claims to determine whether carriers were appropriately applying the state's schedules of maximum reimbursement allowances for workers' compensation medical services. During our review, the program temporarily suspended its medical audits to redefine the intent of the audit function.

With implementation of managed care, the program no longer needs to receive medical reports and bills and directly monitor or audit insurers' payment practices. Under workers' compensation managed care,

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[16] The program also approves and maintains a registry of qualified rehabilitation providers. If the Legislature adopts OPPAGA's recommendation to place responsibility for reemployment services within the insurer's managed care arrangement (see Chapter 6), the program could also discontinue activities associated with approving, monitoring, and evaluating rehabilitation service providers, facilities, and agencies.

payment for medical services is a contractual matter between the provider and the insurer and is regulated by the internal control mechanisms established in the managed care plan of operation. Similarly, the internal control mechanisms are designed to identify and correct the overutilization of medical services.

The program no longer needs to develop reimbursement schedules for workers 'compensation medical services. Under the fee-for-service system, the program used these schedules to constrain the cost of medical services. Managed care systems constrain costs by limiting utilization through medical care coordination and by allowing market factors to constrain costs. Program managers agreed that under the state's mandatory managed care system, the program may no longer need to develop the fee-for-service reimbursement schedules. [17] This would eliminate the need for the program to collect detailed cost information.

The Program Could Reduce Costs by Modifying Its Role in Overseeing the Provision of Medical Benefits

Reimbursement schedules are no longer needed

The program could save at least an estimated $1 million annually in personnel costs and reduce staff by a minimum of 30 FTE positions by limiting its involvement in dispute resolution and by eliminating the following regulatory activities:

- monitoring and auditing of insurers 'payment practices;
- certifying workers 'compensation health care providers;
- collecting medical services data, including cost data and reemployment services data; and
- developing schedules of maximum reimbursement allowances for workers' compensation medical services.

Recommendations

While the Legislature gave the Safety and Workers' Compensation Program oversight responsibility for the provision of medical benefits, it placed responsibility for administering and regulating workers' compensation managed care within the Agency for Health Care

[17] Section 440.13, F.S., requires a three-member panel to annually adopt statewide schedules of maximum reimbursement allowances for workers' compensation medical services. The panel is comprised of the Insurance Commissioner or a designee and two representatives appointed by the Governor, one representing employers and one representing employees. Program staff provide the panel with analyses of medical cost information.

Administration. Although better coordination is needed between the two entities, this separation of responsibilities appears to be an efficient and cost-effective way to provide medical care for injured workers.

To improve the program's efficiency and cost-effectiveness, we recommend that the Legislature reduce or eliminate the program's certification responsibilities and clarify responsibilities related to provider dispute resolution. We also recommend the Legislature modify current requirements for medical cost reporting and monitoring. In addition, we recommend that the program, in conjunction with the Agency for Health Care Administration, insurers, and other affected parties, identify the data necessary to oversee, regulate and monitor medical services provided under workers' compensation managed care.

To further improve the efficiency and cost-effectiveness of its regulatory processes, we recommend that the program coordinate its responsibilities and functions with those of the Agency for Health Care Administration to eliminate duplicative or overlapping activities and ensure the exchange of data and information.

Regulation of Self-Insurers

Introduction

In Florida, employers may obtain workers' compensation insurance in one of three ways: they can purchase workers' compensation insurance from a commercial carrier, join a group self-insurance fund, or self-insure. Employers that choose to self-insure directly fund medical and indemnity benefits. The law authorizes the program to approve companies to self-insure if the companies have the ability to pay indemnity and medical benefits, have a mechanism to deliver the benefits, carry reinsurance and provide a security deposit. After the program grants companies the authority to self-insure, it continues to monitor their financial stability.

The Florida Self-Insurer Guaranty Association, Inc., is a nonprofit corporation created by the Legislature to pay claims for self-insured members if they become insolvent. The association also reviews the financial solvency of potential self-insurers and financial stability of authorized self-insurers. All private self-insurers must be members of the association. [18]

[18] Public employers who self-insure do not have to meet the requirements of s. 440.38, F.S.

In Fiscal Year 1997-98, the program expended $320,000 and assigned eight FTE positions to review and approve employer applications to self-insure and to monitor existing self-insurers.

Program Performance

In OPPAGA's *PB²Performance Report on the Safety and Workers' Compensation Program*, we determined there should be no PB² performance measures in the state budget for this area of the program because this activity is too minor to contribute to the comprehensive evaluation of the program. Only 8 of 780 FTE perform this activity. However, the measures do show the program's outputs for activities associated with self-insurer regulation generally declined from the prior year. Specifically, the number of individual self-insured applications reviewed declined from 17 in Fiscal Year 1996-97 to 12 in Fiscal Year 1997-98 and the number of applications approved declined from 16 to 11 during this period. The decline occurred due to commercial carriers offering better options, so fewer employers are choosing to self-insure.

In this review, we determined that the program's regulatory activities for ensuring the financial stability of self-insurers are duplicative. In addition, the program is not enforcing the requirement that self-insurers receive authorization from the Agency for Health Care Administration to offer or utilize a workers' compensation managed care arrangement.

The Program's Review of Self-Insurers' Financial Stability Duplicate Efforts by the Florida Self-Insurers Guaranty Association, Inc.

Pursuant to Florida law, the program is authorized to approve employers' applications to self-insure. The program is also authorized to set the dollar amount self-insurers must set aside for security deposits. Both the program and the Florida Self-Insurers Guaranty Association, Inc., review applicants' financial condition and monitor the continued financial stability of authorized self-insurers. Although the association does not have final authority to approve self-insurers or set the amount of security deposits, it makes recommendations to the program. After a company is authorized to self-insure, both the program and the association monitor the company for continued financial stability.

The need for program staff to continue performing the activity of reviewing the financial condition of self-insurers is questionable. The association is responsible for paying claims for self-insured members if they become insolvent and therefore has a vested interest in ensuring their financial stability. The association screens companies that seek

approval to self-insure and scrutinizes the continued financial stability of those that receive approval. It also applies more stringent financial requirements than the program. The program should use the recommendations of the association in regards to financial stability and deny applicants or increase security deposits accordingly.

The program needs to maintain the final authority to approve applicants to ensure that applicants meet all requirements to self-insure. In addition to financial stability, the requirements include having the framework for delivery of benefits and authorization from the Agency for Health Care Administration to offer or use a workers' compensation managed care arrangement.

The program could reduce costs by approximately $130,000

Duplication of effort increases the cost of regulation and increases costs for carriers and self-insurers. If the program based its approval on the association's recommendations and relied on the association to monitor self-insurers' continued financial stability, it could reduce its staff by four positions. This would reduce the program's expenditures by an estimated $131,000 annually and eliminate unnecessary duplication of activities.

The Program Has Not Ensured That Self-Insurers Are Authorized to Use a Workers' Compensation Managed Care Arrangement

The program is not enforcing the requirement that self-insurers receive authorization from the Agency for Health Care Administration to offer or use a workers' compensation managed care arrangement to deliver medical benefits. Chapter 440, F.S., requires that all employers deliver medical benefits to their employees through a workers' compensation managed care arrangement. Most employers purchase insurance from commercial carriers which are already authorized to offer a workers' compensation managed care arrangement. Self-insurers must also receive authorization to use a managed care arrangement. The Agency for Health Care Administration estimates that 80 out of 280 private sector self-insurers have not applied for authorization. Thus, AHCA has not reviewed these self-insurers' plans of operations to ensure the plans comply with state requirements for the provision of workers' compensation managed care. Program managers believe that Chapter 440, F.S., does not give them the authority to enforce self-insurers to apply for authorization to use a workers' compensation managed care arrangement. As a result, no action has been taken to address this problem.

Recommendations

To improve the efficiency and cost-effectiveness of the self-insurer regulatory process, we recommend that the program cease its review and monitoring activities of self-insurers' financial stability and rely upon the efforts of the Florida Self-Insurer Guaranty Association, Inc., to determine the initial stability of applicants and to monitor the continued financial stability of self-insured employers.

To ensure that all insurers, including the self-insured, have received the appropriate authorization and approval to provide workers' compensation managed care, we recommend that the Legislature clarify the program's enforcement responsibility when a self-insurer fails to obtain AHCA authorization.

Chapter 6

Assistance to Employees

The program provides direct services to injured employees in two areas: dispute prevention and resolution and reemployment assistance. The program's dispute prevention and resolution services offer injured employees a way to resolve disagreements with insurers, such as benefits due, without costly litigation. Reemployment services assists injured workers who need help in becoming reemployed.

Dispute Prevention and Resolution

Introduction

The Legislature created the Employee Assistance Office (EAO) as a means for injured employees and employers or their carriers to resolve disagreements without undue expense, costly litigation, or delay in the provision of benefits. The EAO provides education and assistance to inform all participants (employees, employers, insurance carriers, and benefit providers) of their rights and obligations in the workers' compensation system. The office operates a hotline that individuals are able to call to receive answers to questions.

The EAO also provides informal dispute resolution assistance for employees. The law requires employees to try to resolve any type of dispute through the EAO's informal dispute process. To facilitate the informal dispute resolution process, injured employees submit a Request for Assistance form to the EAO. The law provides that the EAO has 30 days to attempt to resolve a dispute before a Petition for Benefits may be filed. During this time, the law prohibits carriers or employers from paying employees' attorney fees, although employees may seek legal representation. EAO staff then attempt to resolve the matter, if it is within their jurisdiction. For example, EAO staff may contact the insurance adjuster to determine if a benefit was denied or paid incorrectly. If after the EAO has intervened the dispute is not resolved the injured employee may file a formal Petition for Benefits with the Judges of Compensation Claims, which leads to formal mediation and possibly a hearing.

The program assigned 142 FTE positions to the EAO in Fiscal Year 1997-98 and expended $5.5 million. EAO staff are located in each of the program's seven district offices and six field offices.

Program Performance

The EAO measures its performance by how timely it handles requests for assistance and how successful it is at handling those requests. In OPPAGA's *PB ²Performance Report on the Safety and Workers' Compensation Program*, we found that the performance information was not useable because the data used to assess the measures was unreliable or the measures as stated were misleading. The program has taken steps to correct these deficiencies and has proposed changes to its Fiscal Year 1999-00 measures to better reflect its performance.

In this review, we determined that the program's informal dispute resolution process has not been effective. If the Legislature eliminated the mandatory use of the EAO and allowed the EAO to re-deploy its employees to use a more pro-active approach of providing education and assistance to employees, the program may be more successful at reducing the need for litigation.

The Program's Informal Dispute Resolution Process Has Not Proven to Be Effective

Although the program created the request for assistance process to fulfill the Legislature's intent of reducing litigation costs, the process has not been successful for three reasons.

- It has not reduced attorney involvement. Although the EAO was established to encourage employees and employers (or the employer's carrier) to resolve disagreements among themselves, attorneys file most Requests for Assistance. Since the creation of the EAO and the requirement to request informal dispute resolution assistance, attorneys have submitted 93% of all Requests for Assistance.
- It has not demonstrated an ability to resolve disputes. The EAO was only able to successfully resolve 11.5% of the issues presented to it in Fiscal Year 1997-98.
- It has not been successful in diverting cases from the formal Petition for Benefits claims process. At best, it has had a limited and declining rate of success in preventing formal petitions for claims.[19] As seen in

[19] A case is a single injury or illness for which a claim has or should have been filed on the behalf of an employee. Each case presented to the EAO could address any number of issues and result in several Requests for Assistance or Petitions for Benefits being filed. For example, in Fiscal Year 1997-98, an average of 2.38 *Requests for Assistance* and 2.48 *Petitions for Benefits* were filed for the 44,430 cases.

Exhibit 7 in Fiscal Year 1997-98, in 80% of the cases filed with the EAO, claimants later filed formal Petitions for Benefits.

Exhibit 7
The Informal Dispute Resolution Process Has Not Reduced the Filing of Petitions for Benefits

	1995-96	1996-97	1997-98
Cases Submitting Requests for Assistance	49,376	43,696	44,430
Cases Submitting Petition for Benefits	36,679	33,093	35,389
Percentage of Cases that Continue with Petition for Benefits	74%	76%	80%

Source: 1998 Dispute Resolution Report and the Division of Workers 'Compensation

Two factors undermine the mandatory use of the informal dispute resolution process and contribute to its ineffectiveness.

- Insurance carriers and attorneys representing injured workers have little incentive to cooperate with the EAO ŝ efforts. The resolution at the EAO level is non-binding; thus, the same issues can be brought before the judges of compensation claims even if the EAO concluded an issue was resolved. Claimants' attorneys have a disincentive to cooperate, because they are unable to collect attorney fees from the carriers/employers for benefits obtained during the time the disagreement is under the EAO ŝ jurisdiction.
- The EAO is unable to address many disagreements because the issues presented on the Request for Assistance are outside the EAO ŝ jurisdiction or there is nothing to dispute. For example, the EAO does not have jurisdiction over certain matters such as awarding attorney fees. An example of when there would be no dispute includes when a benefit has already been provided by the carrier but is still included on the Request for Assistance. Since attorneys may advise their clients to pursue these issues, they may still result in Petitions for Benefits even though they have no substance.

Due to the Workload of the Informal Dispute Process, the Program Has Been Unable to Take a Proactive Approach in Educating Injured Employees

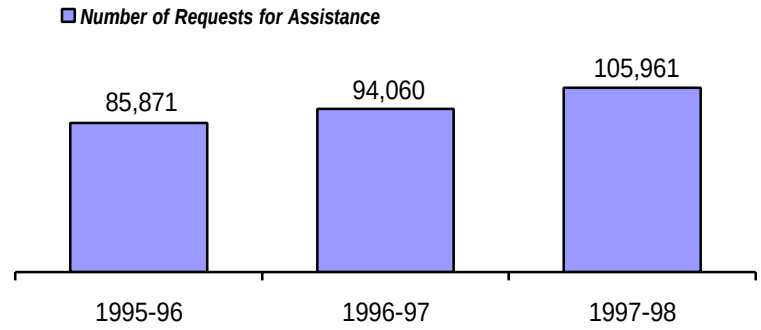
The program has not been proactive in educating employees about their workers' compensation rights. The program ŝ efforts to provide information to employees have been limited to answering questions presented by individuals calling the hotline. Answering questions can be effective in preventing disputes. However, this approach does not

proactively educate employees to prevent questions and concerns from arising that would cause them to get legal counsel prior to calling the EAO for dispute resolution assistance. As of July 1998, the EAO implemented a pilot program to contact employees immediately after the report of an injury to inform them about the services of the office. At this time it is too early to determine the effectiveness of this program. However, early indications are that the program is successful.

The program could reduce costs by at least $3.6 million

If the use of the EAO were to become optional, the number of FTE positions required by the program for the EAO could be reduced while enabling the program to be more successful. We estimate a total of 75 positions associated with the Request for Assistance process could be eliminated. The total savings would be an estimated $3.6 million annually. Additional savings could be realized by eliminating the need to increase staff to meet the demands of a growing workload (see Exhibit 8). However, in the event the pilot program is found to be effective, position reductions would be dependent upon the decision to expand the pilot outreach program, which could result in less savings.

Exhibit 8
The Number of Requests for Assistance Has Been Increasing



Source: 1998 Dispute Resolution Report

Recommendations

To eliminate the inefficiencies and cost of the informal dispute resolution process, the Legislature should amend the law to rescind the statutory requirement that injured workers attempt to resolve any dispute through the program's EAO prior to filing a Petition for Benefits.

If the Legislature eliminates the need to provide informal dispute resolution, the program should eliminate some positions and redirect others to increase its proactive efforts to reduce the incidence of disputes and assess whether these efforts contribute to improving the effectiveness and self-executing nature of workers' compensation.

Reemployment Services

Introduction

Workers' compensation reemployment services are intended to provide direct assistance to injured workers who need help in becoming reemployed. Although insurers may voluntarily provide reemployment assistance, services are generally provided through the Safety and Workers 'Compensation Program. The program provides reemployment services through its district offices where staff offer orientation sessions for interested individuals, screen applicants for eligibility to receive services, and conduct vocational assessments and testing. District staff assist eligible clients in becoming reemployed through activities such as job services, on-the-job training, and payment for training and education programs. [20]

Program staff generally refer clients with more difficult or complicated needs to private providers for vocational evaluation. Staff also refer clients to the department ŝ Division of Vocational Rehabilitation for services not covered under workers' compensation and to the Division of Jobs and Benefits for job services assistance.

In Fiscal Year 1997-98, the program allocated 99 FTE positions and expended over $5.7 million for its reemployment services.

Program Performance

As noted in OPPAGA's *PB ²Performance Report on the Safety and Workers' Compensation Program*, the department changed its data collection method for its outcome measure for reemployment services in Fiscal Year 1997-98. Thus, performance results for that year cannot be compared with results achieved in prior years or with the department ŝ standard for the outcome measure.

In this review, we determined that no single entity has statutory authority or responsibility to offer or coordinate reemployment assistance. Further, the program ŝ service delivery system is costly and inefficient and could be improved by changes in how the system delivers reemployment services.

[20] Job services include skills training in job-seeking, interviewing, and resume writing; job placement assistance; and job analysis and counseling.

The Program Is Collecting Information on Individuals Needing Reemployment Assistance That Is Not Used

Although state law requires insurers to submit periodic reports to the program on the employment status of each worker, program managers reported that the program has neither the statutory authority nor responsibility to offer assistance to workers who remain unemployed. State law also requires insurers to report the employment status of injured workers, to identify individuals who are at risk of not returning to work, and to report on individuals they have referred to the program for reemployment assistance. [21] However, the program neither uses the reported information to identify and offer assistance to individuals who remain unemployed nor follows-up on referrals to determine if the referred individuals have applied for program services. Collection of data that the program does not intend to use is unnecessarily burdensome to insurers. The program needs to identify its reporting needs in this area and require only necessary data to be reported by the industry.

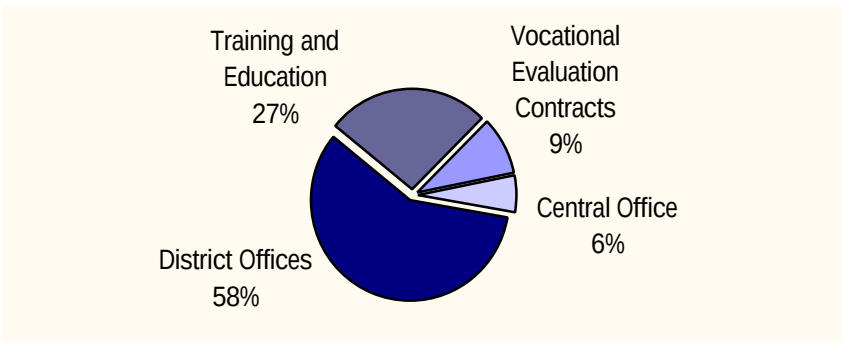
The Program's Use of District-Based Service Delivery Is Costly and Inefficient

58% of the program's budget was spent on district operations

The program spends a large portion of its budget to support district operations. As shown in Exhibit 9, of the $5.7 million the program expended for reemployment services in Fiscal Year 1997-98, over $3.3 million (58%) was spent for staff and operating costs in the program's district offices. The program reported that in Fiscal Year 1997-98, reemployment services staff closed 2,264 cases statewide, for an average overall cost of approximately $2,520 per case.

[21] Insurers are required to refer workers to the program's services after expending $2,500 in reemployment services or the employee's failure to gain suitable employment within 180 days of the insurer's referral for reemployment services, whichever occurs first.

Exhibit 9
Over 58% of Reemployment Services Expenditures Were for District Operations in Fiscal Year 1997-98



Source: Information provided by the Bureau of Rehabilitation and Medical Services, Division of Workers 'Compensation, Florida Department of Labor and Employment Security

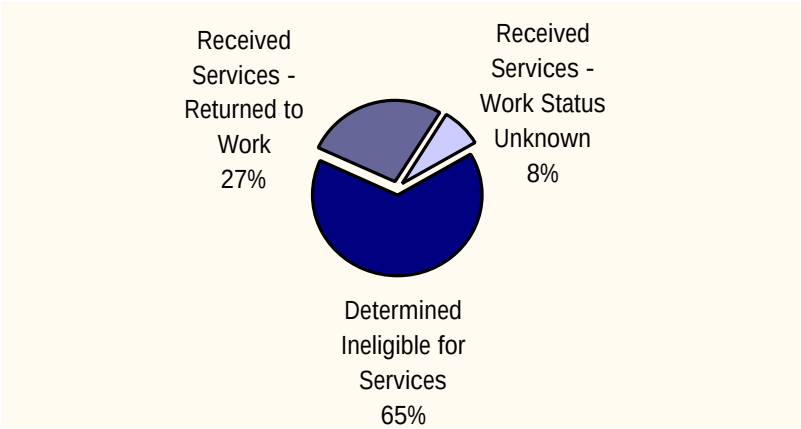
The program's district-based delivery system is designed to provide statewide accessibility to the program's reemployment services. In over two-thirds of the cases program staff closed in Fiscal Year 1997-98, the clients did not receive any services other than orientation and screening. Statewide, 788 individuals (35%) received additional, more extensive reemployment services, such as vocational evaluation, job services, or training and education assistance.

Only 27% of clients returned to work

The program's service delivery system results in relatively high service costs given the number of injured workers who receive substantive services such as vocational evaluation or job placement assistance. As shown in Exhibit 10, program staff closed 1,476 cases (65%) because the individuals were not medically ready to return to work, or were otherwise ineligible for reemployment services.[22] Of the closed cases, 614 individuals (27%) became reemployed, while 174 individuals (8%) either did not return to work or failed to report their employment status. The program thus spent over $5.7 million to achieve the reemployment of 614 individuals. These costs represented an average investment of $9,291 per successful reemployment outcome.

[22] For example, the program does not provide reemployment services to individuals who have a pending claim for permanent total disability benefits in which the person's medical condition or vocational capabilities are in dispute. After the Office of the Judges of Compensation Claims has adjudicated the claim, the employee may ask the program to reconsider the application for reemployment services.

Exhibit 10
27% of Reemployment Services Clients Returned to Work in Fiscal Year 1997-98



Source: Information provided by the Bureau of Rehabilitation and Medical Services, Division of Workers 'Compensation, Florida Department of Labor and Employment Security

The program maintains reemployment services staff at each of its seven district and eight satellite offices. Because the total case intake is relatively low statewide, staff provide services to few individuals in any one office. For example, in Fiscal Year 1997-98, the number of closed cases, including clients who received only orientation and screening, ranged from 154 in the Miami district office (19 per FTE) to 480 in the Tampa district office (22 per FTE). In comparison, the caseload in the Department's Division of Vocational Rehabilitation averages around 130 clients per counselor. The number of successful reemployment outcomes (individuals returned to work) ranged from 3 cases per FTE in the Tallahassee district office to 11 cases per FTE in the Fort Lauderdale district office.

Privatizing Reemployment Services Would Reduce Costs

Option 1: provide services through the managed care system

One option for minimizing the cost of reemployment services is for the Legislature to give more responsibility for reemployment services to insurers and to direct insurers to provide services through the managed care delivery system. The role of workers 'compensation managed care is not to provide group health care but to treat injured employees to facilitate their return to work. The state's workers' compensation managed care system could thus be designed to coordinate workers ' medical treatment with reemployment assistance. Under managed care, insurers currently provide medical services by contract with health care providers and could also provide reemployment services by contract with

job retraining and assistance providers. Responsibility for approving a reemployment service component within insurers 'managed care plans of operation, and for monitoring reemployment services provided through workers' compensation managed care delivery systems, could be incorporated into the Agency for Health Care Administration's existing duties or could be retained by the program. A limited number of FTE positions would need to be retained to approve and monitor insurers' plans of operations. However, this option would provide the program with the opportunity to significantly reduce the number of field staff, which would result in a savings to the Workers' Compensation Administration Trust Fund. Overall savings to the system should be derived through the more efficient delivery of services and from the insurer's ability to contract for managed care services at market rates.

Option 2: contract for service delivery

Another option for reducing the cost of services is for the program to contract for service delivery with local providers. Contracting would permit the program to reduce costs of low productivity by targeting resources and services to individual clients rather than maintaining full-time staff in field offices regardless of workload demands. The amount of cost savings would depend on the cost and level of services provided by contract. The program would need to retain a limited number of staff to carry out activities such as eligibility determination, approval of treatment plans, and monitoring contractor compliance and performance. However, this option would provide the program with the opportunity to significantly reduce staffing, which would release trust funds for reallocation to contracted services. [23] Additional savings to the system would be derived through more efficient service delivery.

Recommendations

To increase the cost-effectiveness and efficiency of reemployment services, we recommend that the Legislature consider incorporating reemployment services into the state's workers 'compensation managed care system to provide for continuity of services to injured workers and more cost-effective service provision.

If the Legislature decides not to pursue this option, we recommend that the program redesign its service delivery mechanism. The program should evaluate the cost-effectiveness of contracting with private providers for case management, vocational evaluation, and other reemployment services.

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[23] For example, if the program retained 2 FTE positions per district to carry out eligibility determinations and monitor contract compliance, field staff would be reduced by 78 FTE. Based on the average cost of district personnel, this would release $2.7 million in trust funds for reallocation to contracted services.

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Appendix A

Statutory Requirements for Program Evaluation and Justification Review

Section 11.513(3), F.S., provides that OPPAGA Program Evaluation and Justification Reviews shall address nine issue areas. Our conclusions on these issues as they relate to the Safety and Workers' Compensation Program are summarized in Table A-1.

Table A-1
Summary of the Program Evaluation and Justification Review of the Safety and Workers' Compensation Program

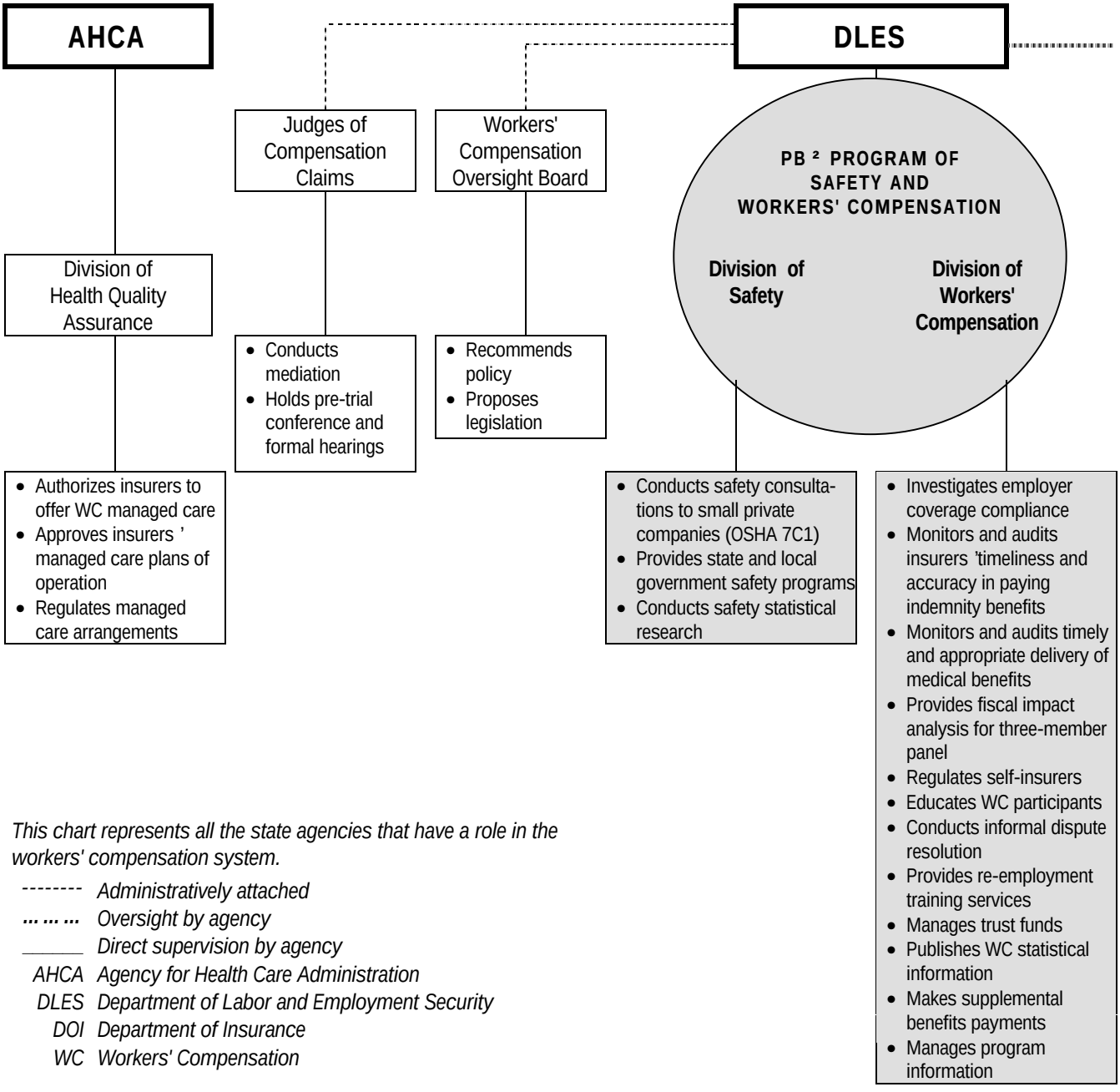
Issue	OPPAGA Conclusions
The identifiable cost of the program	In Fiscal Year 1997-98, the Safety and Workers' Compensation Program expended $49.7 million from the Workers' Compensation Administration Trust Fund. An additional $19.6 million was expended by other agencies for functions related to the program. The other agencies included the Department of Insurance, the Agency for Health Care Administration, the Office of Judges of Compensation Claims, and the Department of Labor and Employment Security.
The specific purpose of the program, as well as the specific public benefit derived therefrom	State law requires most employers to provide workers' compensation coverage for their employees. Workers 'compensation reduces costs the public would otherwise pay for uncompensated medical care and income replacement for workers' injured on the job. State-level oversight helps ensure that employers provide workers' compensation coverage, as required by law, and implement safety and loss prevention programs to reduce the incidence of workplace injuries. State oversight also helps ensure that insurance industry practices result in the timely and appropriate delivery of medical services and provision of indemnity benefits to workers who lose time from work as a result of a workplace injury. The Safety and Workers' Compensation Program provides such state-level oversight in Florida.
Progress towards achieving the outputs and outcomes associated with the program	The Safety and Workers' Compensation Program's Fiscal Year 1997-98 performance measures do not provide a comprehensive assessment of program performance due to problems with measure validity and reliability of reported data. The limited number of measures that can be used to assess the program's performance generally showed increased program workload and lower program effectiveness from the prior year.
An explanation of circumstances contributing to the state agency's ability to achieve, not achieve, or exceed its projected outputs and outcomes, as defined in s. 216.011, F.S., associated with the program	For those outcome and output measures that can be used to measure performance, the program was able to achieve the standards because the standards were set lower than the previous year s performance. For the one outcome measure that was not met, the amount of the measured activity decreased. For the one output measure that was not met, a change in policy contributed to a change in the focus of activities.
Alternative courses of action that would result in administering the program more efficiently and effectively	To ensure that the workers' compensation system is operated in the most efficient and cost-effective manner, we recommend that the program take a leadership role in identifying and solving problems within the state s workers' compensation system. As part of this role, the program should introduce policy and, when necessary, recommend legislative changes that will enable the system to further the goal of achieving a more cost-effective, less burdensome system. To ensure the implementation of this recommendation, we also recommend that the Legislature clarify its intent regarding the program's authority to ensure the efficient and effective administration of the workers' compensation law. To prevent duplicative or ineffective efforts in executing its various functional and regulatory activities, we recommend that the program focus on providing effective management of internal program functions and on coordinating activities across system entities.

Issue	OPPAGA Conclusions
	To ensure that program information is collected and maintained in the least burdensome, most cost-effective manner, we recommend that the program revise its reporting requirements to include only information that is needed and implement less resource-intensive methods for collecting data. To facilitate the integration and sharing of information, we also recommend that the program integrate its separate functional databases.
	The program s contract with OSHA in the private sector benefits the state because it targets small employers in hazardous industries and is largely funded by OSHA. In response to a recommendation by OPPAGA, the 1998 Legislature eliminated funding for separate 100% state-funded consultative services that duplicate those provided by the program under the OSHA contract. However, the state's requirement for workplace safety standards and programs in the private sector was not eliminated. The Legislature may wish to consider eliminating this requirement from Ch. 442, F.S.
	To provide a more effective use of program resources and means of ensuring public sector workplace safety, we recommend that the program discontinue its voluntary consultative services and actively exercise its statutory inspection and penalty authority. The program should modify its information system to allow it to monitor the incidence rate of local government employers and focus its efforts on inspecting worksites that expose employees to high risk of injury.
	Further, to improve the operational efficiency of the program's process for ensuring safety in the public workplace and eliminate duplicate administrative expenses, we recommend that the Legislature organizationally realign the remaining activities of the safety component (i.e., contracts with OSHA and the federal Bureau of Labor Statistics, inspections of local government high hazard workplaces, investigations of occupational fatalities, and library services) with the workers' compensation component, by combining the two divisions that currently make up the PB ²program.
	To improve the effectiveness of the employer regulatory process, we recommend that the program fully utilize its statutorily authorized enforcement activities by developing penalty policies that encourage compliance by all employers.
	To better utilize state resources and improve the identification of cases of suspected fraud and their referral to the Department of Insurance fraud unit for further investigation, we recommend that the Legislature consider transferring the program's employer compliance functions to the Department of Insurance.
	To improve the cost-effectiveness and efficiency of the insurer monitoring process, we recommend that the program develop a comprehensive plan of action to encourage carriers to submit information electronically. We also recommend that the program modify its information system to allow it to identify carriers that do not comply with all reporting requirements. In addition, we recommend that the program integrate the information produced by the various monitoring activities to allow it to assess how well carriers are delivering workers' compensation benefits overall.
	To maximize the efficient use of insurer audit resources, we recommend that the Legislature consider privatizing this function to reduce audit costs. To improve the program's ability to assess audit coverage, we recommend that the program obtain information as to the carriers covered in its audits of third party administrators. To improve the deterrent effects of the audit function, we recommend that the program eliminate its practice of waiving penalties.
	To improve the efficiency and cost-effectiveness of the program's medical benefits regulatory processes, we recommend that the Legislature clarify the program s statutory responsibilities for oversight and regulation of medical benefits. In addition, we recommend that the program, in conjunction with other stakeholders, identify the data that should be maintained under a managed care system.
	To further improve the efficiency and cost-effectiveness of its medical benefits regulatory processes, we recommend that the program coordinate its responsibilities and functions with those of the Agency for Health Care Administration to eliminate duplicative or overlapping activities and ensure the exchange of data and information.
	To improve the efficiency and cost-effectiveness of the self-insurer regulatory process, we recommend that the program cease its review and monitoring activities of self-insurers' financial stability and rely upon the efforts of the Florida Self-Insurer Guaranty Association, Inc., to determine the initial stability of applicants and to monitor the continued financial stability of self-insured employers.

Issue	OPPAGA Conclusions
	To ensure that all employers deliver benefits to their employees through a managed care plan of operation that has been approved by the Agency for Health Care Administration, we recommend that the Legislature clarify the program's responsibility to enforce the requirement that self-insurers obtain authorization from the agency to offer or use a managed care arrangement.
	To eliminate the inefficiencies and cost of the informal dispute resolution process, the Legislature should amend the law to rescind the statutory requirement that injured workers attempt to resolve any dispute through the program's EAO prior to filing a Petition for Benefits. If the Legislature eliminates the need to provide informal dispute resolution, the program should eliminate some positions and redirect others to increase its proactive efforts to reduce the incidence of disputes and assess whether these efforts contribute to improving the effectiveness and self-executing nature of workers' compensation.
	To increase the cost-effectiveness and efficiency of reemployment services, we recommend that the Legislature consider incorporating these services into the state's workers' compensation managed care system to provide for continuity of services to injured workers and more cost-effective service provision. If the Legislature decides not to pursue this option, we recommend that the program redesign its service delivery mechanism for reemployment services. The program should evaluate the cost-effectiveness of contracting with private providers for case management, vocational evaluation, and other reemployment services.
The consequences of discontinuing the program	Eliminating state oversight of safety and workers' compensation insurance coverage would likely result in the erosion of employee and employer protections. In the absence of oversight and regulatory mechanisms, the number of employees covered by workers' compensation would likely decrease. Lack of system oversight could also result in less safe workplaces and more injured employees, delays in the payment of employee benefits, and a higher number of litigated cases.
Determination as to public policy; which may include recommendations as to whether it would be sound public policy to continue or discontinue funding the program, either in whole or in part	The Safety and Workers' Compensation Program is funded by an assessment on the providers of insurance rather than general revenue. The need for the program, as outlined above, indicates that it is sound public policy to continue funding the program in part. This review identifies several alternatives for improving the operations and eliminating duplicate or unnecessary activities of the program that would reduce the overall costs.
Whether the information reported pursuant to s. 216.03(5), F.S., has relevance and utility for the evaluation of the program	As stated previously, the Safety and Workers' Compensation Program performance measures do not provide a comprehensive assessment of program performance due to problems with measure validity and reliability of reported data. The program performance accountability system needs improvement to more completely report program performance to the Legislature and public. Measures need to represent major program activities. One activity is over-represented relative to its resources.
Whether state agency management has established control systems sufficient to ensure that performance data are maintained and supported by state agency records and accurately presented in state agency performance reports	State agency management has not established sufficient control systems to ensure performance data are accurate. Our review identified that this insufficiency negatively impacts the reliability and accuracy of the measures. Five of the Fiscal Year 1997-98 outcome and output measures could not be used because data was unreliable. The unreliability is due to measuring activities that vary significantly, and lack of adequate documentation and accurate data.

Appendix B

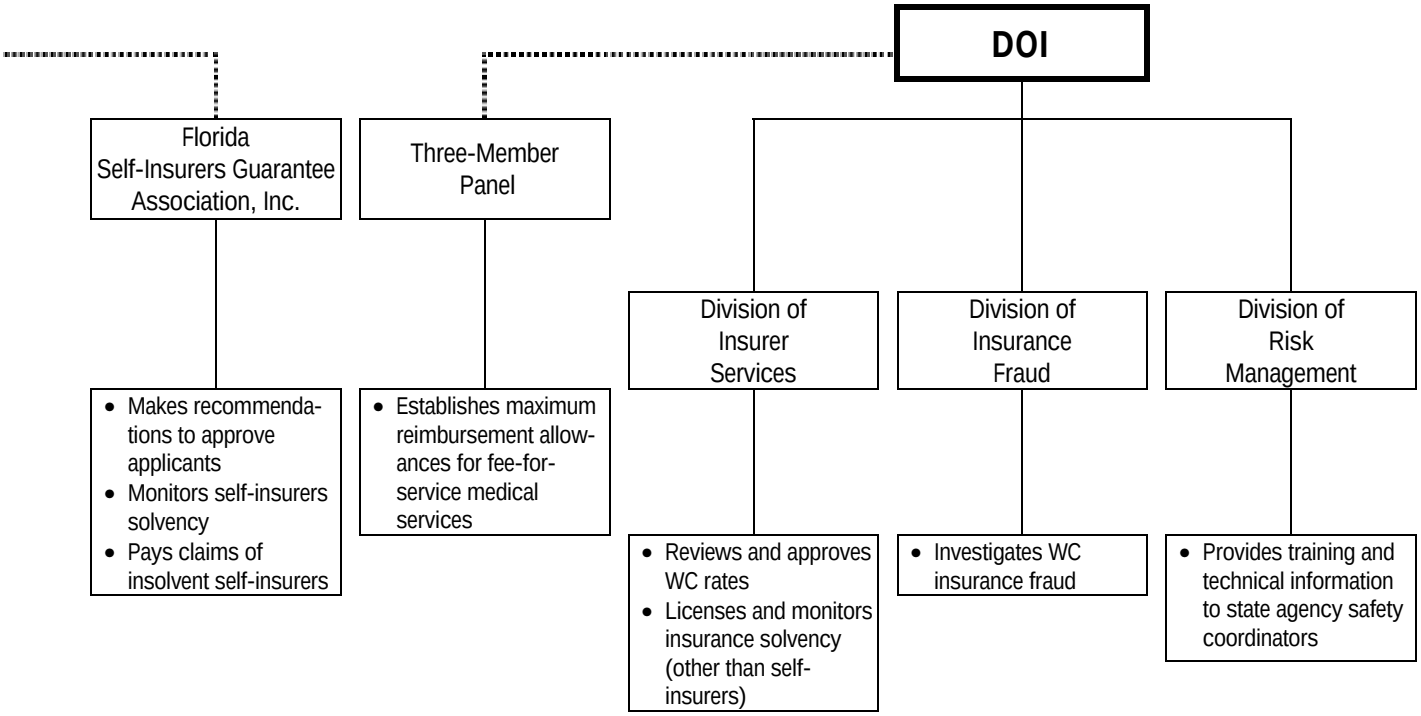
Organizational Chart of the Workers' Compensation System



This chart represents all the state agencies that have a role in the workers' compensation system.

-------- *Administratively attached*
... ... *Oversight by agency*
_____ *Direct supervision by agency*
AHCA Agency for Health Care Administration
DLES Department of Labor and Employment Security
DOI Department of Insurance
WC Workers' Compensation

Source: Compiled by OPPAGA


DOI
Florida Self-Insurers Guarantee Association, Inc.
Three-Member Panel
Division of Insurer Services
Division of Insurance Fraud
Division of Risk Management
• Makes recommendations to approve applicants
• Monitors self-insurers solvency
• Pays claims of insolvent self-insurers
• Establishes maximum reimbursement allowances for fee-for-service medical services
• Reviews and approves WC rates
• Licenses and monitors insurance solvency (other than self-insurers)
• Investigates WC insurance fraud
• Provides training and technical information to state agency safety coordinators

Appendix C

Responses From the Department of Labor and Employment Security and the Department of Insurance

In accordance with the provisions of s. 11.45(7)(d), F.S., a draft of our report was submitted to the Secretary of the Department of Labor and Employment Security. As a courtesy we also provided copies to the Commissioner of the Department of Insurance and the Executive Director of the Agency for Health Care Administration for their review.

We received written responses from the Department of Labor and Employment Security and the Department of Insurance, which are reprinted herein beginning on page 53.

Florida Department of Labor and Employment Security
Office of the Secretary

Jeb Bush
Governor

Mary B. Hooks
Secretary

March 4, 1999

Mr. John W. Turcotte, Director
Office of Program Policy Analysis and
Government Accountability (OPPAGA)
Room 312, Claude Pepper Building
111 West Madison Street
Tallahassee, Florida 32301

Dear Mr. Turcotte:

As required by Section 11.45(7)(d), Florida Statutes, the Department of Labor and Employment Security is submitting the enclosed response to OPPAGA's preliminary findings and recommendations in the Program Evaluation and Justification Review report for the Safety and Workers' Compensation Program which is administered by the department.

We appreciate the opportunity to comment on this report. The department has found the OPPAGA justification review process important in assisting program management to focus on areas for improvement and change. In many cases, the recommendations made in the OPPAGA report are consistent with department initiatives and goals.

Although the department is in agreement with many report findings and recommendations, we have attempted to explain and support those areas where we differ from the interpretations included in the preliminary report. There are some areas in which the department may differ with OPPAGA's interpretation of the law, or where statutory change must occur prior to any changes in program administrative practices. In addition, the department differs with the cost savings estimates included in several OPPAGA recommendations, and offers support for alternative savings figures.

We would also like to suggest that in the future, OPPAGA consider additional opportunities for consultation with the agencies prior to completion and distribution of the draft report. In this case, the draft report contained some inaccurate or incomplete information which was only corrected after it had been distributed.

The Hartman Building, Suite 303 • 2012 Capital Circle S.E. • Tallahassee, Florida 32399-2152 • Phone 850/922-7021

OPPAGA Comment

OPPAGA met with program staff and management throughout our review to discuss and solicit feedback on our findings and potential recommendations. Information and supporting documentation were also requested both verbally from program staff and formally in writing from program managers during our fieldwork. In most instances, changes to our draft report resulted from OPPAGA receiving information or documentation from program managers that they had revised, updated, or previously failed to furnish, after they had reviewed the draft report.

The department views OPPAGA as a valuable partner in making program improvements to enhance our effectiveness. If you have any questions regarding our response, please contact Mr. Charles Williams, Director of the Division of Workers' Compensation at 488-2514, or Mr. Lee Weaver, Acting Director of the Division of Safety at 488-3044.

Sincerely,

/s/ Mary B. Hooks

MBH/cmj

Enclosure

cc: Ms. Debbie Gilreath
Mr. James F. Mathews
Mr. Charles Williams
Mr. Lee Weaver

THE DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY'S RESPONSE TO THE OPPAGA PROGRAM EVALUATION AND JUSTIFICATION REVIEW OF THE SAFETY AND WORKERS' COMPENSATION PROGRAM

Introduction

The Department has found the OPPAGA justification review valuable in assisting programs in focusing their process improvement efforts. In many cases, the recommendations made in the OPPAGA report are congruent with current program plans for continuous improvement in our processes. There are, however, some areas in which the program must take exception to OPPAGA's interpretation of the law, clarify when recommendations require statutory change before any changes in administrative practices can be initiated, and articulate when our estimates of cost savings differ significantly from OPPAGA's.

Chapter 2: General Conclusions and Recommendations

Response to General Conclusions: Program management is committed to working proactively with the Legislature to ensure members are aware of system challenges that need to be addressed through legislation. We perceive our role as advisors and sources of information to assist legislators in making appropriate public policy decisions. An annual workers' compensation report to the Legislature is published precisely for that purpose. The ultimate decision on Legislative changes is theirs; our role is the implementation of the law they pass.

OPPAGA Comment

Section 440.015, F.S., provides that it is the intent of the Legislature to ensure the quick and efficient delivery of benefits to injured workers through a self-executing system that is not an economic or administrative burden and that ensures the prompt and cost-effective delivery of payments. Further, s. 440.44, F.S., provides that it is the intent of the Legislature that the program assume an active and forceful role in its administration of the Workers' Compensation Law, so as to ensure that the system operates efficiently and with maximum benefit to both employers and employees. OPPAGA recognizes that the ultimate decision to change the law rests with the Legislature. However, we believe that, given the complexity of the workers' compensation system, program management should advise the Legislature as to statutory changes needed to ensure that the system operates as the Legislature intends. If program managers do not believe it is their role to make recommendations to the Legislature as to policy options or changes in law, the Legislature might wish to direct another entity to carry out these oversight responsibilities.

Chapter 3: Prevention of Workplace Injuries

We support OPPAGA's recommendation to continue the Division of Safety's public sector program but disagree with several other findings in the report. OPPAGA's assessment that *"eliminating state oversight would likely result in the erosion of*

employee and employer protections [and] could result in less safe workplaces and more injured employees" is, we strongly believe, correct. In view of this and OPPAGA's criticism of the Division of Safety's four percent penetration of all public sector worksites in 1997-98, we cannot find the logic in recommending that oversight and compliance in the public sector be limited to "high hazard local government workplaces" and staffing be reduced by 50 percent. We should not reduce our vigilance on workplace safety at a time when state agencies alone had almost $85,000,000 in workers' compensation costs this year. In the report, OPPAGA again asserts that program services duplicate those provided by insurance carriers, as well as state and local governments. While the statutes assign some safety and health responsibilities to all these entities, the Division of Safety is the single entity with overall oversight responsibility for the state.

Also, the program has improved its capability to assess the effectiveness of services. As the report points out, appropriate FY 1999-2000 outcome measures have been proposed. While we agree that historical data will aid future effectiveness assessments, since July 1998 many suggested information system improvements have been made. We now have the ability to report on the proposed outcome measures and can set performance standards.

OPPAGA Recommendation: To provide a more effective use of program resources and means of ensuring public safety, we recommend that the program discontinue its voluntary consultative services and actively exercise its statutory inspection and penalty authority. The program should modify its information system to allow it to monitor the incidence rate of local government employers and focus its efforts on inspecting worksites that expose employees to high risk of injury.

Response: The program currently investigates all fatalities and employee complaints in the public sector, and we agree that the program needs to reemphasize compliance through onsite inspections. A renewed emphasis on compliance would assist in ensuring a reduction of injury/illness incidence rates at worksites experiencing high workers' compensation costs. However, there remains a role for voluntary consultations, and they should not be discontinued. Emphasizing consultations supports and complements enforcement; the two components are not mutually exclusive. Even OSHA recognizes that consultations have enforcement value and uses this approach with the 7(c)(1) grant program.

In addition, contrary to OPPAGA's insistence that the program's consultation services duplicate those provided by insurance carriers, as well as state and local governments, our experiences prove otherwise. We have found that personnel in these organizations have loss control and risk management priorities that preclude providing onsite occupational safety expertise. For example, we believe that a majority of employers do not receive onsite safety and health consultations from their carriers. Many carriers refer employers to the Division of Safety. We also find that employers often don't seek advice from their carrier. The Department of Insurance (DOI) has a small staff that provides guidance to state agency safety coordinators through the Interagency Advisory Council on Loss Prevention, a body

that meets on a quarterly basis. Since state agencies alone were assessed almost $85,000,000 in workers' compensation costs this year, this approach does not appear to provide a level of effort that would sufficiently impact injury/illness reductions. Typically, safety personnel in local governments and school systems have other priorities, with safety comprising a 5-10 percent portion of overall job duties. These part-time responsibilities don't result in onsite consultation services that are duplicative.

In summary, it is our position that safety and health consultation services which include education and training, complement enforcement and are not duplicative, are a cost effective means to reduce accidents and injuries and ultimately workers' compensation costs.

We agree that improving data quality and relevance is essential to maintaining a cost effective and high value organization. We need to be able to identify worksites with high workers' compensation costs and target the program's resources to those workplaces. Since July 1998, improvements have been made in collecting employer data that allow better identification of specific worksites with severe and/or high cost injury experience. Program associates are utilizing operational policies and procedures to conduct onsite visits at worksites with high workers' compensation costs.

OPPAGA Comment

The costs of the program's voluntary safety consultations are currently funded through an assessment on all insurance carriers, not those directly receiving this benefit. Section 442.011, F.S., requires insurance carriers and self-insurers to inform their policyholders of the availability of safety consultations and provide consultations to policyholders upon request. This approach minimizes the cost to the overall system of providing safety consultations and appropriately places safety decisions with the carrier providing the consultation and its policyholder. Section 442.004, F.S., directs the program to adopt rules governing the manner, means, and frequency of safety consultations by all carriers and self-insurers. However, rather than monitoring, strengthening, and enforcing carriers' offerings of appropriate consultative services to their policyholders, the program opted to provide these services itself at a cost to the Workers 'Compensation Administration Trust Fund. We believe that these services are bettered provided by the carriers and self-insurers, as provided by law, which would produce a cost savings to the trust fund.

The program should continue to serve as an independent source for local government employees to report unsafe working conditions and conduct limited investigations of serious or fatal occupational injury or illness.

<u>OPPAGA Recommendation</u>: Further, to improve the operational efficiency of the program's process for ensuring safety in the public workplace and eliminate duplicate administrative expenses, we recommend that the Legislature realign organizationally the remaining activities of the safety component with the workers' compensation component, by combining the two divisions that currently make up the PB2 program.

Response: The Divisions of Safety (DOS) and Workers' Compensation (DWC) share a historical relationship, parallel work processes and joint participation in the PB2 program. As a result, combining these divisions could improve program coordination and provide administrative efficiencies. This option will be evaluated by the Department as part of a current overall review of Department organizational structure.

Chapter 4: Regulation of Employers

OPPAGA Recommendation: To improve the effectiveness of the employer regulatory process, we recommend that the program fully utilize its statutory authorized enforcement activities by ensuring that all employers carry adequate workers' compensation coverage and developing penalty policies that encourage compliance by all employers.

Response: The program disagrees that it holds statutory authority for this function. The Department of Insurance (DOI) is charged with investigation and referral to the State Attorney for criminal prosecution based on fraudulent evasion by an employer of its duty to provide workers' compensation benefits pursuant to Chapter 440, Florida Statutes. Fraud by an employer under Chapter 440, Florida Statutes can be committed a number of ways. For example, fraud may be committed by evading the purchase of workers' compensation insurance altogether; by misrepresenting the class of the employer's employees to a carrier, thereby lowering the employer's premium; or by under-reporting the size of the employer's payroll, which also results in wrongfully lower premiums to the employer.

The Department of Labor and Employment Security, Division of Workers' Compensation has no jurisdiction under the current laws of the State of Florida to sanction an employer for the crime of fraud. The Division of Workers' Compensation has the authority to, and the responsibility to, investigate and sanction employers for non-compliance with Chapter 440, Florida Statutes. Non-compliance is a civil violation, and does not require any proof of intent by an employer to commit. An employer that is statutorily required to provide workers' compensation benefits to its employees and fails to do so, is out of compliance with the statute, and subject to sanctions by the Division of Workers' Compensation without regard to the motives of the employer.

Compliance investigators do not, generally, verify the adequacy of insurance coverage once coverage is found because the adequacy of coverage is a matter of CRIMINAL FRAUD and not a matter of COMPLIANCE. The entire scheme of Chapter 440, Florida Statutes, draws a distinction between fraud and non-compliance, and with good reason. To combine the two notions, one would have to assume that every employer out of compliance was deliberately, fraudulently, and criminally out of compliance. To apply a criminal standard to every investigation of a non-compliant employer would substantially reduce the number of employers who could be investigated and sanctioned for non-compliance. The

resources allocated to the Division of Workers' Compensation are based upon what is adequate to investigate civil compliance with Chapter 440, Florida Statutes.

Stop Work Orders (SWOs) are the first enforcement action described in Section 440.107, Florida Statutes, but that section offers no clear guidance to the program as to which of several enforcement tools should be used in a given situation. Following the passage of the 1993 reforms to Chapter 440, Florida Statutes, the program assumed that SWOs were the most drastic of the enforcement tools it had been given by the Legislature, and so used SWOs as a last resort. The Division of Workers' Compensation was soundly criticized for that interpretation by a grand jury, and as a result, has changed its procedures so that SWOs are now the division's first line enforcement tool. Every employer determined to be illegally operating without workers' compensation insurance coverage in the state of Florida is now issued a SWO and ordered to shut down. The division aggressively enforces its SWO until the employer comes into compliance, and pays any and all penalties which have been levied against it by the Division of Workers' Compensation through the Bureau of Compliance.

Every SWO carries with it a fine of $100/day for every day the employer is found to be out of compliance. That dollar amount is set by statute. The division has no authority to alter it. Once an employer is shut down (i.e., forced to cease all business operations), he/she is no longer out of compliance. Therefore, the amount of a fine attendant to a SWO is generally $100 unless the employer continues to operate illegally by ignoring a SWO. The $100/day fine then accumulates until the employer ceases operations.

Additionally, all construction industry employers, and all non construction industry employers who are repeat violators of Chapter 440, Florida Statutes, are assessed a penalty of twice the evaded premium for any period of non-compliance or $1,000 whichever is greater.

No SWO will be lifted until all outstanding penalties are paid by the sanctioned employer. No installment agreements will be allowed for the payment of any penalty assessed. No settlement agreement will be accepted that reduces the amount of a penalty assessed by the division.

OPPAGA Comment

OPPAGA is not recommending that the program conduct criminal fraud investigations or to sanction an employer for the crime of fraud. OPPAGA recommends that the program identify and refer cases of suspected fraud to the Department of Insurance for further investigation. Section 440.107, F.S., authorizes program staff to enter and inspect any place of business for the purpose of investigating compliance with workers' compensation coverage requirements and allows program staff access to business records for the purpose of conducting such an investigation. Further, s. 440.108, F.S., provides that the program can conduct investigations that it believes with reasonable, good faith may lead to the filing of administrative, civil, or criminal proceedings. Program records indicate that some staff use this authority to document cases against

employers they suspect of having inadequate coverage. However, this practice is not consistently followed by all program staff.

The program narrowly defines its statutory authority to assess monetary penalties. Section 440.107, F.S., provides that with the issuance of a stop work order the program may assess a penalty in the amount of $100 per day for each day the employer was not in compliance with the workers' compensation law. The law further states that in addition to any penalty, stop-work order, or injunction, the program may assess against any employer a penalty in the amount of $1,000 or twice what the employer would have paid during periods it illegally failed to secure payment of compensation in the preceding three-year period, whichever is greater.

OPPAGA Recommendation: To better utilize state resources and improve the identification of employer fraud, we recommend that the Legislature consider transferring the program's employer compliance functions to the Department of Insurance.

Response: The program feels that responsibility for workers' compensation compliance activities should remain with the program. If we are to become more proactive in a leadership role for efforts to improve the workers' compensation system as a whole, as recommended in this report, removal of this programmatic area would take away a crucial piece to those efforts. Also, this action was not recommended in the Grand Jury report. The program will continue efforts to work with the DOI to more closely link these processes.

OPPAGA Comment

The Statewide Grand Jury report recommended that the Legislature consider privatizing the program's compliance activities. Although OPPAGA considered the option of privatization, we believe that transferring these activities to the Department of Insurance is a more appropriate remedy, as did the Senate Committee on Banking and Insurance in its interim report.

Chapter 5: Regulation of Insurers

Provision of Indemnity Payments

OPPAGA Recommendation: To improve the cost-effectiveness and efficiency of the insurer monitoring process, we recommend that the program develop a comprehensive plan of action to encourage carriers to submit information electronically, thus eliminating the need for a manual review and entry of data. We also recommend that the program modify its information system to allow it to identify carriers that do not comply with all reporting requirements. In addition, we recommend that the program integrate the information produced by the various monitoring activities to allow an assessment of how well carriers are delivering workers' compensation benefits overall.

Response: The program will continue to expand its use of the Electronic Data Interchange (EDI) that is used by carriers to submit information as is laid out in a Five Year Plan. It is conceivable that the time period necessary to implement these expansions could be reduced with allocation of additional resources. The expansion of this process would continue to reduce the small percentage of cases that are received with incomplete information and improve data accuracy.

On a national level, insurance carriers are aggressively supporting a movement toward total EDI. However, Year 2000 conversion has taken precedence and the industry has asked all states to postpone implementation of EDI, as well as other major reporting changes, until Year 2000 is past. Although we agree with this recommendation, the timing of such a requirement is critical to its success. After Year 2000, a more accurate calculation of cost savings can be made as well as the number of staff required for support. These issues currently preclude a determination of the timing and amount of any resulting savings.

The program also concurs with the last two sections of this recommendation. We will soon have a linked data structure that will facilitate identifying carriers with reporting exceptions. The program's Integrated System is scheduled to go on line July 1, 1999. That system will enable us to assess carriers in a variety of ways, including the delivery of benefits.

OPPAGA Comment

Chapter 93-415, Laws of Florida, gave the program authority to establish an electronic reporting system five years ago, which it is still attempting to implement. At present Texas, South Carolina, Kentucky, and New Mexico require EDI reporting from their worker's compensation carriers. Iowa, California, and Nebraska will require the use of EDI, effective July 1, 1999.

OPPAGA Recommendation: To maximize the efficient use of audit resources, we recommend that the Legislature privatize this function to reduce audit costs. To improve the program's ability to assess audit coverage, we recommend that the program change the design of audits to obtain information about the carriers included in the audits of third party administrators. To improve the deterrent effects of the audit function, we recommend that the program eliminate its practice of waiving penalties.

Response: The program does not concur with the recommendation to privatize audits as a cost saving measure. It is unlikely that this function could be duplicated in the private sector at the same low administrative cost.

We do concur with the two subsequent recommendations. Data collected as a result of reviews of third party administrators now include information on individual carriers. This practice began in October, 1998. Also, it is no longer standard practice for the program to waive assessed penalties. A total of $290,152 was waived in FY 96-97, $53,946 in FY 97-98, and for FY 98-99 only $7,900 has been waived. This represents a significant decrease; Rule 38F-24.021, Florida

Administrative Code, appears to include broader language than Section 440.20, Florida Statutes, regarding granting of waivers. Based on this finding, the program will take steps to modify the rule to more closely mirror the language and intent of the statute.

Provision of Medical Benefits

OPPAGA Recommendation: To improve the program's efficiency and cost-effectiveness, we recommend that the Legislature reduce or eliminate the program's certification responsibilities and clarify responsibilities related to provider dispute resolution. We also recommend the Legislature modify current requirements for medical cost reporting and monitoring. In addition, we recommend that the program, in conjunction with the Agency for Health Care Administration, insurers, and other affected parties, identify the data necessary to oversee, regulate and monitor medical services provided under workers' compensation managed care.

Response: The program concurs with the recommendation to eliminate the 5 hour certification course required of physicians. We think that "certification", or designation of Expert Medical Advisors by the program remains a valuable function that should be retained. Those physicians perform services that go beyond the delivery of medical treatment and often extend to the courtroom. We also concur that the process of resolving provider disputes should be clarified. In maintaining oversight of carrier provision of appropriate and timely benefits and services, the division must continue to address provider disputes that impact the outcome of medical care and are not related to quality of care and medical necessity handled through the WCMCA grievance process. Based on elimination of those statutory responsibilities impacted by the managed care requirements, the program estimates that approximately ten positions and $300,000 are associated with those duties.

We also concur with the recommendations concerning the reporting of medical data and how those data relate to managed care.

OPPAGA Recommendation: To further improve the efficiency and cost-effectiveness of its regulatory processes, we recommend that the program coordinate its responsibilities and functions with those of the Agency for Health Care Administration to eliminate duplicative or overlapping activities and ensure the exchange of data and information.

Response: The program concurs with this recommendation. The Division of Workers' Compensation and Agency for Health Care Administration (AHCA) have agreed about the delineation of the responsibilities of each agency in overseeing the delivery of medical care in the workers' compensation system. The Division of Workers' Compensation is no longer responsible for overseeing the direct provision of medical care under WCMCA. The first line oversight of issues relating to quality of care and standards of medical necessity is the purview of AHCA. The division is now one step removed from case-by-case details of utilization review and procedure code reimbursement in order to focus on system outcomes rather than process

details such as timeliness of first service. For that reason, the medical audit function was temporarily suspended in 1998, and the program has redesigned its approach based on a cross functional team's recommendations. This redesign, which dovetails the expertise of two bureaus, not only monitors insurer compliance with statutory and rule requirements (currently in revision), but focuses on proper handling of all aspects of the claim from compensability determinations to closure.

The Division of Workers' Compensation remains the data collection mechanism in this area, as AHCA maintains no data related to medical treatment of cases within WCMCAs.

Chapter 6: Assistance to Employees

Dispute Prevention and Resolution

OPPAGA Recommendation: To eliminate the inefficiencies and cost of the informal dispute resolution process, the Legislature should amend the law to rescind the statutory requirement that injured workers attempt to resolve any dispute through the program's Employee Assistance Office (EAO) prior to filing a Petition for Benefits (PFBs).

Response: The program concurs with this recommendation.

OPPAGA Recommendation: If the Legislature eliminates the need to provide informal dispute resolution, the program should eliminate some positions and redirect others to increase its proactive efforts to reduce the incidence of disputes and assess whether these efforts contribute to improving the effectiveness and self-executing nature of workers' compensation.

Response: The recommendation to reduce the total FTE positions in Employee Assistance Office (EAO) from 142 to 67 would result in fewer FTE positions than at the time of the Reform Act of 1993. We would recommend retaining the 74 FTE positions in place at the time of the reforms, 10 FTE positions that were transferred into the program after that time and 3 FTE positions that are now dedicated to data quality and PB2 measures for a total of 87 FTE's. Retention of these positions would enable the program to provide more in-depth investigations, dispute preventions, education and coding of information on PFBs. Adjusted budget for the 87 positions would be as follows: Current Budget: $6,166,541, budget for 87 positions is $4,275,453 which results in a projected cost savings of $1,891,088. Final amount of cost savings would be impacted by the success of the EAO pilot and decisions to expand that pilot statewide.

Reemployment Services

The report cites that the program is collecting information on individuals needing reemployment assistance that is not used. The program agrees that we are not yet effectively using data provided by insurance carriers about injured workers' ability to

return to work. These data will be used in an automated fashion for this purpose by June 2000 as part of a developing initiative to offer reemployment services.

OPPAGA Recommendation: To increase the cost effectiveness and efficiency of reemployment services, we recommend that the Legislature consider incorporating reemployment services into the state's workers' compensation managed care system to provide for continuity of services to injured workers and more cost-effective service provision.

Response: Folding vocational services into medical services may hold promise for improving return-to-work outcomes for injured workers. The program intends to explore the rehabilitation model in workers' compensation managed care to determine if these outcomes are improved. However, managed care arrangements are inexperienced in dealing with vocational issues at this point in time.

OPPAGA Recommendation: If the Legislature decides not to pursue this option, we recommend that the program redesign its service delivery mechanism. The program should evaluate the cost-effectiveness of contracting with private providers for case management, vocational evaluation, and other reemployment services.

Response: The two alternate models discussed in the report are not models the program feels are appropriate to consider; however, we do intend to explore models tying rehabilitation and return-to-work more closely to managed care. Any new model being considered must maintain program control over determining injured worker eligibility for services and evaluating return-to-work outcomes for services provided. To support redesign of service delivery, the report cites that 58% of the program's budget was spent on district operations. However, these expenditures include the direct services of rehabilitation counseling and vocational evaluations provided by district staff. The report also notes that only 27% of clients return to work, but this calculation includes injured employees who apply but do not qualify for reemployment services, based on statutory definitions of qualifications. For actual eligible injured workers, the reemployment services component achieved a 78% return to-work-rate.

OPPAGA Comment

The program's caseload does not justify a district-based service delivery system. We applaud the program for its success in returning 614 individuals to work (referred to in its 78% return-to-work rate). However, we do not believe that the 788 individuals who were determined eligible for program services justify a service delivery system that resulted in district field staff being assigned an average annual caseload of only nine cases.

THE TREASURER OF THE STATE OF FLORIDA

BILL NELSON

March 9, 1999

Mr. John W. Turcotte, Director
Office of Program Policy Analysis and
Government Accountability
111 West Madison Street, Room 312
Tallahassee, FL 32301

Dear Director Turcotte:

Thank you for the opportunity to respond to the preliminary findings and recommendations of the Safety and Workers' Compensation Program Justification Review. Chapter 3 of the preliminary findings states that although the safety program is authorized by law to conduct inspections of public sector employers and impose penalties for noncompliance, it has opted to provide safety consultations. The report also mentions the role of the state risk management program, and indicates that it serves as a "control to ensure workplace safety in state government".

We do not disagree with these statements, but to avoid misleading inferences, we would add that the state risk management program has no enforcement authority (that would allow for inspections of state agency work sites and imposition of penalties). However, the program does have a formally structured safety program mandated by law that imposes an obligation on state agencies to develop and implement safety programs.

Thank you for the opportunity to respond. If any further information is necessary, please contact Phil Arnold, Inspector General, at 922-5508.

Sincerely,

/s/ Bill Nelson

BN/jhs

TREASURER • INSURANCE COMMISSIONER • FIRE MARSHAL
The Capitol, Tallahassee, FIorida 32399-0301 • (904) 922-3100 • Telecopier (904) 488-6581

Glossary of Terms

Capitated Contract	A contract in which the insurer pays the health care provider a fixed dollar amount per covered individual in exchange for providing medical services, as needed in the future.
Disabling Compensable Injury	The Division of Safety's term for an occupation-related injury which results in the loss of more than seven workdays and the allocation of medical benefits and/or indemnity compensation by the workers' compensation system. Compare to Lost Time Injury.
Fee-for-Service	Payment to providers of medical services according to the services performed. The fee for each procedure or treatment is individually billed by the provider and paid in full by the patient, insurer, or other health benefit plan sponsor.
Indemnity Benefits	Cash benefits paid to an injured worker to replace part of wages lost as a result of work injury.
Lost Time Injury	The Division of Workers' Compensation term for an injury that results in seven or more lost work days which allows an injured worker to be eligible for indemnity benefits.
Managed Care	Organizations that rely on a network of contracts with health care providers and capitation fees or other cost controls. Cost control methods include utilization review, contracts with selected health care providers, financial incentives or disincentives for using specified providers or services, prospective payment schedules, case management, and payers' efforts to identify treatment alternatives for high-cost care.
Maximum Medical Improvement (MMI)	The date after which further recovery from, or lasting improvement to, an injury or disease can no longer reasonably be anticipated, based upon reasonable medical probability.
Permanent Impairment Rating	A determination of an injured workers' condition, stated as a percentage of the body as a whole, as to the extent a work-related injury has permanently impaired the injured employee. This percentage rating is attached to the injured worker's condition, and is numerically determined using a uniform guide called the Impairment Rating Guide. Impairment ratings are often assigned to an injured worker's condition for loss of a body part such as a finger or arm, or the loss of mobility such as a permanent loss of spinal flexibility.

Permanent Total Disability	An inability to perform any important occupational duties, preventing the injured worker from doing any kind of work for the remainder of his or her life. Such a disability can result from the loss, or loss of use, of both eyes, one eye and a limb, or two limbs.
Petition for Benefits	The form that is used by the injured worker to request benefits that have not been provided to the injured worker either by the employer or the employer's carrier.
Reimbursement Schedules	Also known as fee schedules. A list of medical and surgical procedures and related services with corresponding maximum fees or benefits payable to hospitals, physicians, and other health care providers by health insurers or other sponsors of a health benefit plan
Replacement Wages	Compensation for an employee's income lost due to a work-related illness or injury. The amount is a portion of the worker's pre-injury wages prescribed by statute. Also known as indemnity benefits.
Request for Assistance (RFA)	Form created by the Employee Assistance Office used to initiate the informal dispute resolution process.
Risk Management	The procedures used to identify, assess, control and finance accidental loss; management of the pure risks to which an organization might be subject; the application of resources to reduce and finance identified loss exposures.
Safety and Workers' Compensation Program	For the purposes of this review, this is the performance-based program budgeting program of the Division of Safety and the Division of Workers' Compensation.
Self-Insurance	The planned assumption of risk instead of purchasing insurance. An organization develops a program for identifying, evaluating, and funding its losses. It is often used for workers' compensation, where losses are fairly predictable. Smaller losses that occur frequently are a better subject for self-insurance than large infrequent losses. Self-insurance programs are frequently structured to retain losses up to a specific limit, and insurance is purchased above that level. Most states regulate self-insurance as they do insurance, requiring certificates of self-insurance for compulsory coverages such as auto liability and workers' compensation.
Stop Work Order	An order issued by the Division of Workers' Compensation requiring the cessation of all business operations at the place of employment or job site if the division determines an employer does not have workers' compensation insurance.

Supplemental Benefits	Additional indemnity benefits for which an injured worker may qualify if they meet requirements in statute and rule. For accidents after June 30, 1995, and before July 1, 1984, the Division of Workers' Compensation may pay the benefit.
Third Party Administrator	Also known as a servicing company. A claims administrator or insurance company that processes claims on behalf of a self-insured organization or multiple employer welfare arrangement or manages workers' compensation claims for an employer. The administrator is a third party because it is neither the self-insurer nor an insured (claimant or payee). Services may include processing claims (including audits, adjusting, and negotiating settlements), record keeping, self-insurance certification, and notification of excess insurers.
Workers' Compensation Managed Care Arrangement	Workers' compensation managed care arrangement means an arrangement under which a provider of health care, a health care facility, a group of providers of health care, a group of providers of health care and health care facilities, an insurer that has an exclusive provider organization approved under s. 627.6472, F.S., or a health maintenance organization licensed under Part I of Ch. 641, F.S., has entered into a written agreement directly or indirectly with an insurer to provide and to manage appropriate remedial treatment, care, and attendance to injured workers in accordance with this chapter.
Workers' Compensation System	For the purpose of this review, this is the structure that provides safety administration and regulation and workers' compensation insurance administration and regulation.
Worksite	A separate physical location for each employer.