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News & 440 Report

The Wait Is Over...

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News & 440 Report

The NEWS AND FOUR-FORTY REPORT

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The Florida Supreme Court

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In This Issue

Section Calendar

2017

JANUARY 27, 2017
Executive Council Meeting
Joe's Stone Crab, Miami, Florida

FEBRUARY 26 - MARCH 3, 2017
33rd Annual Winter Retreat
Snowmass Village, CO

MAY 18 - 21, 2017
Long Range Planning Meeting & Retreat
Charleston, SC

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Message from the Chair

By Alan D. Kalinoski, Orlando

It is an honor and a privilege to have the opportunity to serve as Chair of the Workers' Compensation Section of the Florida Bar for 2016 to 2017. I have been a member of the Executive Council for quite some time, and I have enjoyed my association with those many leaders and individuals who have done so much for the Workers' Compensation Section for many years. I will attempt to fill the large shoes of immediate past Chair Mike Winer who has done a stellar job at the helm of the Section over the last year, as have those who preceded him. I have acquired increased respect for Mike and the others that I have worked with over the years, and I appreciate the confidence and support that members of the Executive Council have demonstrated by allowing me to serve this brief season as Section Chair. I commit that I will do my best to continue the good work that has been done by so many others, and to expand on it to the extent that I am able.

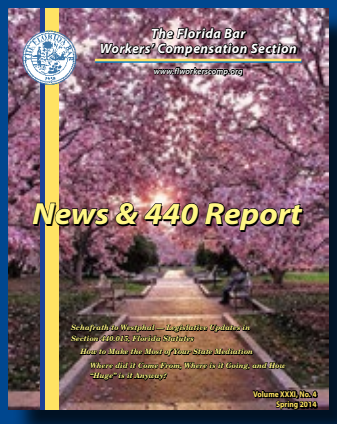
My primary objectives are to increase professionalism amongst the members of the Section, and to address the issues that will confront the stakeholders in the Workers' Compensation system regarding the recent cases that have been handed down by our First District Court of Appeal and Florida Supreme Court. See Westphal v. City of St. Petersburg, SC13-1930 & SC13-1976 (Fla. Supreme Court 2016); Castellanos v. Next Door Co., SC13-2082 (Fla. Supreme Court 2016); and Miles v. City of Edgewater, 190 So. 3d 171 (Fla. 1st DCA 2016)

What a great time to be involved in Workers' Compensation practice! This next year will surely be an exciting one as we navigate through the recent rulings from our courts that have had significant impact on virtually every aspect of the workers' compensation industry, and as we await the reaction by the legislature and other stakeholders who have varying interests.

Our Section continues to offer informative Lunch and Learn webinars through the efforts of our CLE chair, Dawn Traverso. We also continue to produce The Workers' Compensation Forum in collaboration with WCCP. This has become the premier workers' compensation educational conference which continues to grow in attendance and excellence. We have some ideas to expand upon the strong foundation that has been established by our Forum Committee Chair Leo Garcia, and Stacy Hosman of WCCP. We will continue our publication of the News & 440 Report, which is undoubtedly the best publication put out by any Section of the Florida Bar.

I appreciate the continued efforts of Joanne Prescott as Section secretary and Philip Augustine as Section treasure. I will be working closely with Chair-Elect Paul Anderson, and we have already met to discuss the future direction of the Workers Compensation section. While we cannot predict what the courts or the legislature will do, I am confident that the future of Workers' Compensation is in good hands with some of the brightest legal minds involved in the State of Florida. Join us for the ride. It is sure to be a good one!

Respectfully,
Alan D. Kalinoski, Chair



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***We need your cover photos!* This is a great opportunity to be published in full color!**

Submit a (large format) cover photo of workers' comp related scenes, local courts or Florida landscapes. Send it to our Editor, Jeff Appel at jappel@appelharden.com, or Program Administrator, Willie Mae Shepherd at wshep@flabar.org.

Editor's Comments

Is the Sky Really Falling?

By Jeff Appel, Lakeland, FL

The Supreme Court has finally spoken on long awaited cases. Some workers' compensation players are rejoicing. Others are licking their wounds and planning a legislative retort. It seems appropriate that with the winds of change, after five years, I am passing the torch as Editor-In-Chief of The News & 440 Report. The renowned Geoff Bichler is serving as Guest Editor for this edition. I understand considerable arm twisting is in progress encouraging him take on the position as Editor-In-Chief. Geoff is an excellent lawyer, well connected and wicked smart. I hope he agrees.

During the past five years, I have written articles, written editorials and enjoyed reading the contributions from my colleagues and the judiciary. I've watched judicial interpretation of the law inch toward the precipice from which it has now fallen, causing the pendulum of power in our practice to swing back toward injured workers. I cannot fathom what the next year will bring but it is an exciting and fascinating time to practice workers' compensation.

Despite NCCI's possibly voodoo-based doom and gloom prophecy for increased claims costs, I will go out on a limb, promoting a contrasting opinion that the sky is not falling. Time will tell, of course, but it appears to me that cases will be easier to settle, move along more quickly and legitimately owed benefits will flow more freely under the new paradigm. Seems like the result should bring the injured back to work more expeditiously and facilitate the removal of questionable claims from the system. Shouldn't this decrease costs? Those who have actually read Chapter 440 might find these concepts vaguely familiar. I've read some legislative analyses from time to time in the past but I can't recall one which actually addressed how the proposed law impacts the intent of the Chapter rather than some interest or another. Personally, I urge all involved in our practice to take a deep breath, let the new paradigm function and measure real results rather than making knee jerk reactions which do not consider the intent of the Act.

Inevitably, if employers and carriers resist change, these entities will put themselves in a bad spot just as did the many workers' compensation attorneys who failed to change with the times during the era of fee caps. Those embracing change, or at least altering practices to account for the loss of some power in the system, will be just fine.

The sky is not falling but if the legislature reacts like the workers' compensation world is on fire, then the statements made by Judge Lewis in his concurring opinion in *Westphal* – that the system is broken – will be bolstered. And if the workers' compensation law is determined to be universally unconstitutional, then the sky will fall, for all of us – employers, carriers, attorneys and injured workers.

One can only hope our law makers will act thoughtfully instead of reacting emotionally or under the pressure of industry to regain the perceived loss of power in the system at any cost, despite the Supreme Court's warnings. Otherwise, we all should be signing up for CEUs about writing wills and handling divorces.

Personally, I'd prefer to avoid such unpleasantries.

I any event, I owe many thanks to the contributors who have shared their opinions, wit and insight into the workers' compensation practice with The News & 440 Report over the past five years. I am grateful for the helpful staff in Tallahassee and significantly Willie Mae Smith for helping to put together each edition.

On my way out, I'll refrain from commenting or giving specific opinions on these recent historical cases since there will no doubt be detailed analyses published herein in the future as the practice adapts to the results. Regardless, I believe Justice Pariente already made my opinion on the fee cap widely known by quoting me in the *Castellanos* opinion as stating it created "an absurd result." Words cannot express how "pleased" I was to see myself quoted as the defense expert and how I imagined this would significantly improve the defense side of my multifaceted worker's compensation and civil practice. Thanks Justice Pareinte! In my defense, I was under oath when I made that statement.

Not surprisingly, the sky didn't fall on me after the opinion was released and now there is *Westphal* to take the place of *Castellanos* as the "hot topic" case. I doubt anyone will read all the way to the end to see that I co-authored an *amicus* brief in favor of Westphal in the case and hold that against me. In any event, I'm honored to have been a small part of the change which has taken place in recent months and, in my humble opinion, we all owe thanks to everyone who participated in bringing these matters to the highest tribunal. The pendulum needed to swing back to infuse integrity back into the bargain made long before our time. Although some clearly suffered, the sky

• *Editor's Comments – continued*

did not fall on injured workers during the time when the pendulum swung against them. The sky is not falling now that it has moved back toward equilibrium.

Finally, as I depart as editor, it strikes me as important to leave you all with a question which perplexes me. What is proper grammar to use in the numerous workers' compensation pleadings being filed regarding attorneys' fees. Below are some of the ways I have seen reference to fees in various pleadings and case law:

A. Attorneys fees
B. Attorney fees
C. Attorney's fees
D. Attorneys' fees

Since I'm in a firm with more than one attorney and my partner and I often work on cases together, I think attorneys' fees is appropriate for most of the pleadings I file in which I'm seeking a fee (or fees…?). I frequently use "attorney fees" to refer to a general class of benefits, but I'm not sure that's right. Microsoft's grammar check often does not like the choices I make. I'm not sure why I tend to lean towards using attorneys' fees instead of attorneys' fee. Perhaps it is because I hope to earn more than one fee in my claimant cases? Maybe it's stylistic?

In any event, I consulted Black's Law Dictionary. Black's Law Dictionary defines the word 'fee' generally as 'A recompense for an official or professional service or a charge or emolument or compensation for a particular act or service. A fixed charge or perquisite charged as recompense for labor; reward, compensation, or wage given to a person for performance of services or something done or to be done.' (Black's Law Dict. (6th ed. 1990) p. 614.) It goes on to define the phrase 'attorney fees' as a 'Charge to client for services performed (e.g. hourly fee, flat fee, contingency fee).' (Ibid.) Similarly, Webster's defines the word 'fee' as 'compensation often in the form of a fixed charge for professional service or for special and requested exercise of talent or of skill.' (Webster's New Internat. Dict., supra, p. 833; see also 5 Oxford English Dict. (2d ed. 1989) p. 797 ['fee' denotes 'a payment,' such as the 'remuneration paid or due to a lawyer, a physician, or (in recent use) any professional man, a director of a public company, etc. for an occasional service'].)

So it seems that I'm wrong to use the word 'fees' when the fee relates only to one set of services. For instance for obtaining TPD benefits, I'd be entitled to a fee. But an hourly charge would be best referred to as 'attorney fees.' That makes sense now. When the fee was capped to a guideline on benefits obtained, it was a 'fee.' But now, when the fee can be hourly, the correct reference is 'fees.' If one attorney works on the matter it is an attorney fee or attorney fees. But if more than one attorney works on the case it should be attorneys fee or attorneys fees. But if I obtain multiple benefits on a guideline basis, then I'm entitled to multiple 'attorney fees' which is the same as if it was an hourly fee per the above cited authorities on the matter.

Now I'm confused. What else is new?

I have no idea how to address this sticky issue and I anticipate the legislature will be equally clueless in light of the judicial tongue lashing it's received.

But, I have no time to contemplate the matter further as I have fee motions to write and to answer. At least I'm getting paid more than $1.53 per hour (except for the time I've spent writing this which is invaluable (i.e., I'm not paid to do this).

Thank you for allowing me to help produce this publication over the years. Again, I appreciate all who have contributed and I look forward to serving our section in other capacities in the future.

Jeffrey E. Appel, Esquire
Editor-In-Chief
The News & 440 Report

Message from the Outgoing Chair

By Michael J. Winer, Tampa

I can hardly believe that my term as Chair of the Section has come to an end. The year has flown by, with so many eventful happenings. Things got started with a rush of activity as the Section was called into action to take immediate response to the Florida Bar's inquiry on the reciprocity issue. The Executive Council voted to oppose that measure. Within a few weeks of that, the Executive Council convened for another emergency meeting to weigh in on the Daubert issue in response to the Bar's request. We also voted unanimously to oppose the adoption of the Daubert standard by the Florida Supreme Court.

I thought at that point that the rest of my tenure would be quiet. Boy was I wrong. Within weeks, the bombs started dropping from the courts. First, the First DCA rendered its landmark decision in Miles v. City of Edgewater, 190 So. 3d 171 (Fla. 1st DCA 2016) declaring that the restrictions in sections 440.105 and 440.34, when applied to a claimant's ability to retain counsel under a contract that calls for the payment of a reasonable fee by a claimant (or someone on his or her behalf), are unconstitutional violations of a claimant's rights to free speech, free association, and petition — and are not permissible time, place, or manner restrictions on those rights. The court concluded that the statutory restrictions are unconstitutional, and that the proper remedy is to allow an injured worker and an attorney to enter into a fee agreement approved by the JCC, notwithstanding the statutory restrictions. That case, in and of itself, had the potential to dramatically alter the landscape of attorneys' fees paid by claimants and settlements, changing the way things have been done for years in our practice.

Just as we were all catching our collective breath and digesting the impact of Miles, the second bomb dropped, this time by the Florida Supreme Court, and this time, it was nuclear. In Castellanos v. Next Door Co., No. SC13-2082, slip op. at 1-2 (Fla. Apr. 28, 2016), the Florida Supreme Court addressed the aspect of reasonable E/C paid fees which it labeled a "critical feature" of the workers' compensation law. The court concluded that the mandatory fee schedule in section 440.34, which creates an irrebuttable presumption that precludes any consideration of whether the fee award is reasonable to compensate the attorney, is unconstitutional under both the Florida and United States Constitutions as a violation of due process. See art. I, § 9, Fla. Const.; U.S. Const. amend. XIV, § 1. The Court ruled that the ruling revives the statute's immediate predecessor, which is the statute addressed by the Court in Murray, where the court construed the statute to provide for a "reasonable" award of attorney's fees.

The Court clarified that a JCC must allow for a claimant to present evidence to show that application of the statutory fee schedule will result in an unreasonable fee. The fee schedule remains the starting point, **and that the revival of the predecessor statute does not mean that claimants' attorneys will receive a windfal**l. Only where the claimant can demonstrate, based on the standard this Court articulated long ago in Lee Engineering, that the fee schedule results in an unreasonable fee—such as in a case like this—will the claimant's attorney be entitled to a fee that deviates from the fee schedule.

The last bomb was dropped with the release of the decision in Westphal v. City of St. Petersburg, Nos. SC13-1930, SC13-1976 (Fla. Supreme Court 2016). There, the Court considered section 440.15(2)(a), Florida Statutes (2009), which cuts off disability benefits after 104 weeks to a worker who is totally disabled and incapable of working but who has not yet reached maximum medical improvement. The Court concluded that this portion of the workers' compensation statute is unconstitutional under article I, section 21, of the Florida Constitution, as a denial of the right of access to courts, because it deprives an injured worker of disability benefits under these circumstances for an indefinite amount of time—thereby creating a system of redress that no longer functions as a reasonable alternative to tort litigation.

Justice Lewis made some cogent observations and accusations in a brilliant and sharp concurring opinion, he noted that, "As I see it, such a system is fundamentally unconstitutional and in need of legislative—not judicial—reform." He further urged that, "**It is time that both business interests and workers receive a valid, balanced program that can operate as Florida moves into its economic future."** Indeed, few could argue with the need for all sides to convene to meet this worthy objective.

Predictably, the Westphal and Castellanos case were immediately met with cries from industry that there will be a rate crisis and that greedy plaintiff lawyers will bilk the system with exorbitant fees. However a sober, objective, examination of the opinion reveals there is no legitimate reason either for legislative alarm bells to go off or for workers compensation premiums to go up. With regard to fees, Carriers or employers only have to pay injured workers' reasonable attorney's fees when they

• *Outgoing Chair – continued*

wrongfully deny needed healthcare benefits to injured workers. Should a dispute over benefits arise between a workers compensation carrier and an injured worker or his/her healthcare providers, the carrier has the option of resolving the dispute before it gets to the point where workers comp. attorneys need to get involved and fee awards become necessary. Section 440.34 allows the E/C a full 30 days to investigate the need for benefits before any fee exposure accrues. It is only when carriers turn a deaf ear to the healthcare needs of the claimant, or dig their heels in and refuse to compromise, that reasonable attorney's fees get assessed. In other words, having to pay a claimant's reasonable attorney's fees is almost always a completely avoidable outcome. Further, the irrebuttable presumption created fees that were unreasonably high, such as when the E/C accepted PTD on the 31st day. The Castellanos decision paves the way to avoid this unjust result for carriers and allows a Judge of Compensation Claims - appointed by the Governor - to review the reasonableness of those fees on a case by case basis when a carrier decides to fight a denial of benefits and loses. This is not a "crisis" or an "emergency;" it is just fair- and it is fair for both sides.

It remains to be seen whether NCCI's request for a 19.6% rate hike request will be granted, denied or granted only in part. However, the past few months and the upcoming year promises to keep Workers' Compensation in the headlines, turning our sleepy little practice into the front page headlines of newspapers and being part of the discussion in every major business publication. I've been doing this for 20 years now and I can say with absolute certainty that this is the best time ever to be a Workers' Compensation lawyer. Certainly, whether claimant or defense, we are all seeing a reinvigoration of our practices and optimism for the future.

The past 5+ years have indeed been lean for both sides. I have seen Claimant attorneys driven from the practice. I have seen large defense firms shrink and many fine lawyers lose their jobs. Oftentimes when I visited certain JCC offices, it seemed like I was the only person there other than the JCCs, mediators and their staff. Back in 2010, when I served as the Editor of this fine publication, I mentioned that the eradication of reasonable fees by the legislature on 2009 following the Murray decision resulted in my inability to represent many deserving and needy injured workers. I told my readers that I was headed to practice law in other areas. I greatly regret each injured worker that I could not help over the past years, still to this very day. Nonetheless, I had a business to run and family to support so I was compelled to chose cases which allowed me to obtain reasonable compensation for my efforts so I could make ends meet. "In the long run, as John Maynard Keynes once observed, we are all dead. In the short run, lawyers have offices to run, mortgages to pay, and children to educate." United States Department of Labor v. Triplett, 494 U.S. 715, 724-725 (1990). As this passage points out, the private practice of law is still a business. A lawyer who offers his time and the benefit of his experience should be able to receive reasonable compensation for his efforts.

The upshot to the financial adversity that plagued so many workers' compensation attorneys for so long is that many of us expanded our horizons and embarked on other areas of practice. I used the hardships of the workers' compensation law as an opportunity to develop a vibrant practice doing personal injury, appellate law

• *Outgoing Chair – continued*

and business litigation cases. The experience expanded my horizons and allowed me to become a better lawyer. However, Workers' Compensation is where my roots are, and I am eager about the prospects of continuing to practice in this field. My experience in other areas taught me that ours is an area of law that is as complex and challenging as any other, perhaps even more so. There is dignity in our profession and a higher degree of professionalism that typically exists here than what I experienced elsewhere. In essence, I am proud to be a "comp lawyer" and I hope to finish my career doing this.

As for my tenure as your Chair, it has been a pleasure and an honor to do my best to represent your collective interests, both on the Claimant and Defense sides. We started a program by which we have attracted new sponsors to the Section, who are predominately displayed via banner ads on our web site. Please visit our site and save it as one of your "favorites." http://www.flworkerscomp.org/ If you know of other interested sponsors, please let us know. I am pleased that our sponsorship efforts, with a special thanks to Lisette Francisco and Geoff Bichler, will leave the Section in a better place financially. I am also hoping to bring the 1st DCA to the Workers' Compensation Spring Forum this year for Oral Arguments. For those who have not attended, this is the premier workers' compensation educational conference in the State of Florida- The 2017 Florida Bar Workers' Compensation Forum will held at the Omni Orlando Resort @ ChampionsGate from 4/6/2017 to 4/7/2017. With the addition of live Oral Arguments from the 1st DCA, this is an opportunity not to be missed. We had attendance of over 500 last year. Check the section web site and make arrangements to be there.

Lastly, my goal as outgoing Chair to use this positive inertia from the recent cases to increase our section numbers. A larger, stronger Section has a much better chance of influencing legislators to listen to our concerns and our section's legislative agenda. When your fellow Section leaders and I sit in the offices of legislators this coming session in an effort to strike a mutually beneficial legislative bargain, one that is consistent with the message of Justice Lewis (*supra*), we want to be able to proudly state that we represent over 1,500 members, united and strong. Please help me achieve this goal. On the back page of this edition, you will find a membership application. If reading electronically, you can also click the following link to our membership application: http://www.floridabar.org/TFB/TFBResources.nsf/Attachments/9E5DD25B2BE8F69385257411 006074D8/$FILE/WCmembership.pdf?OpenElement Please print a copy of the application and give it to every member in your firm with your encouragement that they join. Also, circulate this among your colleagues and friends. Take a copy to your next mediation and recruit your opposing counsel to join as well.

In closing, I wish to recognize the outstanding work of our program coordinator Willie Mae Shepherd, without whom I would be lost. I thank our News & 440 editor Jeff Appel, as this is his last edition. I did his job for 5 years and can tell you that the publication of a newsletter of this content and quality is an extraordinarily large time consuming endeavor. To Bill Rogner, my predecessor, thanks for your help and guidance and for always answering my dumb questions.

You are in very capable hands with our incoming Chair, Alan Kalinoski. I could not ask for a better replacement or friend. He will capably guide the Section into the future to *reach even greater heights*. So with apologies to George Strait, I say, "Goodbye, farewell, so long, Vaya con Dios, Good luck, wish you well....."

Best Regards,
Mike

Guest Editorial

By Geoff Bichler

In January, during the Executive Council meeting on South Beach, I volunteered to act as Guest Editor for this edition of the News & 440 Report. I knew then that there was a significant possibility that this Issue would have to address ground breaking court decisions. After all, our Chair, Mike Winer, had just done a masterful job arguing the case of ***Miles v. City of Edgewater***, to a seemingly receptive traveling panel of the 1st DCA, and both ***Castellanos*** and ***Westphal*** remained pending in the Florida Supreme Court. Feeling almost certain that the constitutional issues framed in these cases would be addressed by the time this publication went to press, and having personal involvement in all three cases, I took on the appointed task and began the work of getting commitments for articles.

As Winter turned to Spring earlier this year the anticipation built until, in rapid succession, the Courts issued their stunning decisions in ***Miles***, ***Castellanos***, and finally ***Westphal***. ***Miles*** unmasked the absurdity of one-sided fee restrictions in the harsh light of the First Amendment and constitutionally guaranteed "right to contract." ***Castellanos***, roughly a week later, finally established that the right to recover "reasonable fees" in a wrongfully denied workers' compensation case is a constitutionally protected right under a due process analysis. ***Westphal*** completed the constitutional trifecta by rightfully finding that incessant race to eliminate benefits came with a constitutional cost: at some point the reduction of benefits must be weighed against the rights the injured worker is sacrificing. One of the most instructive parts of the ***Westphal*** decision is the discussion of ***Kluger v. White*** since it has been misinterpreted for years as allowing for endless reductions in benefits so long as "some" mechanism for recovery and quantum of benefits remained. I have more to say about this in my article which also appears in this publication although it was unfortunately submitted for publication just prior to the ***Westphal*** decision. Fittingly, the ***Westphal*** case was decided the day before the Florida Professional Firefighters convened their annual convention in Jacksonville, and Mr. Westphal received a much deserved hero's welcome as he walked the halls with members of our firm there to discuss problems in workers' compensation related to fire service. The Police Benevolent Association and Fraternal Order of Police had meetings in the following week and all three cases were hot topics for attendees. The timing could not have been scripted any better and unions representing "First Responders" are now well informed about the failings of the Act as related to many in their ranks. If history is any indication these unions will be fully engaged in the coming legislative battle since they have seen far too often how the law comes up short.

The excitement generated by this series of decisions would be hard to overstate: it is seen in all corners of "comp world" and in every facet of the practice of law; people knowing little or nothing about workers' compensation are suddenly interested and paying attention to this critical component of the economy. Beyond the excitement, however, there is no denying that the impact of these cases is simply monumental, and not just in Florida. The decisions have fundamentally altered the nature of the dialog so that Industry, Labor, and workers' compensation professionals all over the Country are re-evaluating what is required to maintain the constitutional viability in a so-called "Grand Bargain." Truly, the question has now become: what is required in terms of sufficiency and/or adequacy in order to withstand constitutional scrutiny? This implicates concerns from both a substantive and procedural perspective which are not easily answered or swept away with quick legislative fixes (e.g. remove "reasonable" from Chapter 440). While our Legislature will be forced to deal with this thorny question in the next session the debate is raging everywhere, and it is being led by academic experts like Professor John Burton who have carefully analyzed the institutional failings of our current models. We will all benefit, and our system will be improved, if we can convince policy makers to implement constructive change based on such thoughtful and extensive scholarship instead of the usual hyperbolic rhetoric and talking points. In this regard I would highly recommend a close reading of Professor Burton's article contained below.

As heartening as these cases are, it is still staggering in retrospect that it took as long as it did to get to get here. The 104 week limitation on temporary total disability benefits, highlighted in ***Westphal***, was a small part of the 2003 Act which implemented massive "reform" with little regard for the plight of injured workers or their families. This unbalanced approach successfully reduced insurance premiums through draconian cuts in benefits, but ignored the admonitions of thoughtful stakeholders that without certain minimum standards the entire statutory scheme could be in peril. Thirteen years later the Courts have simply affirmed what many of us have known for ages: our system has serious constitutional problems which must be remedied. Who among us really thought that the Act could legally restrict an injured worker and/or her union from using their own funds to pay for legal representation? Who really believed that one-sided fee restrictions arbitrarily penalizing attorneys representing

• *Guest Editorial – continued*

injured workers in the most contentious cases was just? And who could say, with a straight face, that a severely injured firefighter two years into recovery from a horrific accident should have monetary compensation suspended simply because an arbitrary deadline had been reached? The fight will continue with regard to numerous other provisions in Chapter 440 since the Court has exhibited no appetite to throw out the entire Act, but these decisions, and ***Westphal*** in particular, should give policy makers grave concerns about the potential for continued piece meal dismantling.

Early in my career I had the honor and privilege of working with Richard Sicking who rightfully played such a prominent role in framing the arguments in these cases and who argued both Castellanos and Westphal in the Florida Supreme Court. As a young lawyer just beginning to learn about workers' compensation I marveled at Richard's brilliance, encyclopedic knowledge, and perfect recall. He spoke of the "Grand Bargain" in sweeping historic terms, and helped me to understand the larger issues implicated in the smaller problems related to the provision of benefits for injured workers; the delicate balance between an adequate and/or sufficient system and an unconstitutional one. ***Miles***, ***Castellanos***, and especially ***Westphal***, harken back to these early lessons about why each case matters, and how the law requires the attorney (representing either side) to establish fairness, or the lack thereof, in order to expose constitutional problems. The simplistic beauty of this message has been a blessing to me throughout my career and helps give meaning to the practice for all who toil away in the trenches of workers' compensation litigation. It is truly poetic justice that Richard can enjoy the fruits of these victories after such a long and illustrious career and I think it can safely be said that anyone practicing workers' compensation law today owes him an extreme debt of gratitude.

In Florida many questions remain about how to deal with the constitutional infirmities identified by the Courts and others that we all know exist. For now, it is enough to acknowledge that something remarkable has occurred which will change the practice and inform the debate for years to come. I truly hope that you will enjoy this edition of the News & 440 Report and ask yourself what role you might play in the coming policy debate.

Friends of 440 Scholarship Fund, Inc. Welcomes You!

The Friends of 440 Scholarship Fund, Inc. is a 501(c)(3) charitable organization whose membership is comprised of attorneys, doctors, insurance adjusters, Judges of Compensation Claims, claims administrators, rehabilitation providers and others whose primary employment is connected within Florida's Workers' Compensation system. Throughout the year we put our differences aside and raise scholarship funds to aid students who lack the economic ability to continue their education beyond high school or to further their college education.

The Friends of 440 Scholarship Fund, Inc. has been in existence since 1991 and over the course of the past 18 years has raised almost $1 million which has been used to assist over 518 qualified college students achieve their educational goals.

During the 2009-2010 selection scholarship process, The Friends of 440 Scholarship Fund, Inc. proudly announced the award of over $73,000.00 in scholarship funds to 43 applicants throughout the State of Florida.

The number of scholarships awarded each year is directly related to the amount of funds available. Therefore, fund-raising is an important activity for this non-profit corporation. Various fund raising projects are undertaken each year throughout the state of Florida. Corporate and individual donations are welcomed, and are tax-deductible.

Our Mission Statement

To aid dependents or descendants of workers who are injured in the course and scope of their employment and receive benefits under the Florida Workers' Compensation Law and who reside or whose accident occurred in the State of Florida. Applicants must not be related directly or indirectly to any member of the Board of Directors. Furthermore, dependents or descendants of individuals who primarily engage in the operation and/or administration of the Florida Workers' Compensation Law are eligible to receive the scholarship on a statewide basis. This scholarship is intended to aid students who lack the economic ability to continue education beyond high school or to further their college education. Applications must be submitted prior to February 28th, of the year the scholarship is to be awarded.

Mail Us Your Donations or Feedback

We welcome your donations and your feedback! The location of our headquarters is: The Friends of 440 Scholarship Fund, Inc., 9350 South Dixie Highway, 10th Floor, Miami, FL 33156-2900, telephone (305) 423-8710.

For more information and updates visit us at:
www.440scholarship.org

National Developments in Workers' Compensation Relevant for Florida

A Presentation in Orlando at the
71st Annual Workers' Compensation Educational Conference

August 23, 2016 (Revised Version)

John F. Burton Jr. Professor Emeritus
Rutgers University and Cornell University

I. Introduction

Thank you for the opportunity to make a presentation to the 71st Annual Workers' Compensation Educational Conference. I am not here to serve as an expert on the Florida workers' compensation program. Rather my role is to discuss both the origins of workers' compensation and recent national developments and their relevance for the future of workers' compensation in Florida and the nation.

II. Origins of Workers' Compensation in the U.S.

Workers' compensation is the oldest social insurance program in the United States. Many of the program's current features reflect its historical origins. These features include the incorporation of the workers' compensation principle in all workers' compensation statutes and the dominant role of the states in determining the provision of the benefits provided to injured workers.

Prior to the enactment of workers' compensation statutes, a worker had to bring a negligence suit against the employer in order receive payment for a work-related injury. A negligence suit is a form of tort or civil remedy, for which the legal doctrines developed over time in decisions made by judges under common law. Injured workers were often unsuccessful in tort suits, not only because the worker had to prove that the employer was negligent, but because the courts had established several legal defenses – known as the "unholy trinity" -- that a negligent employer could use to avoid liability. One such defense was the fellow servant rule, which preluded an injured worker from suing the employer when the worker was injured by the negligence of another worker. In contrast, an employer was liable for damage to a stranger (such as a customer) caused by the negligence of an employee.[1]

In many jurisdictions, the first effort to deal with the deficiencies of the common-law approach to workplace injuries was the enactment of statutes - known as employer liability acts – which removed or limited the employers' use of the defenses such as contributory negligence. However, the employee's success in a suit still required the demonstration that the injury resulted from the employer's negligence, which often was impossible. A study cited by Somers and Somers (1954, 24), indicated that in 32.5 percent of 604 cases the survivors or workers who died in workplace accidents before 1911 received no compensation under employers' liability laws in New York, Pennsylvania, and Minnesota. In another 47.8 percent of the cases, the award was $500 or less.

Despite this record of meagre recoveries under the common law or employer liability acts, a study by Posner (1972) found that between 1875 and 1905 there was a tremendous growth in litigation over workplace injuries and that employees were increasingly recovering damages in negligence suits. In essence, the negligence suit approach was like a lottery, where employees usually recovered minuscule or no awards – which workers did not like – but where employers were increasing losing and paying large awards - which employers did not like.

Workers' compensation was designed to overcome some of the deficiencies of the negligence suit approach and of employer liability acts. All workers' compensation statutes incorporate the "workers' compensation principle," which has two elements. (1) Workers' compensation is a no-fault system, which means that in order to receive benefits, a worker does not need to demonstrate the employer is negligent and the employer cannot use the special defenses, such as contributory negligence. The employee only has to prove the injury is "work- related" (although there are legal tests that are obstacles to meeting the work-related requirement in many cases). (2) The other side of the workers' compensation principle is that the statutory benefits provided by the program are the employer's only liability to the employee for the workplace injury. If an injured employee prevailed in a tort suit, the resultant award could be very costly for employers as their liabilities potentially included all lost wages, medical expenses, and non-pecuniary damages for pain and suffering. The exclusive remedy aspect of workers' compensation means that employees cannot bring tort suits against their employers (subject to some limited exceptions).

• *National Developments – continued*

Workers' compensation laws also prescribe cash benefits by formulas, including weekly benefits that are a specified percentage of pre-injury earnings and durations of benefits for permanent impairments that are specified in the statues. The statutory specificity of benefits was intended to reduce the litigation, delays, and uncertainty associated with tort suits. In addition, workers' compensation statutes in most states removed workplace injuries from the general court system and established workers' compensation agencies and industrial commissions that were given the primary responsibility for resolving disputes between workers and employers. Reformers felt this delivery system would also reduce the delays, uncertainties, and inconsistencies of the court system (Berkowitz and Berkowitz 1985, 161-163).

For many members of the labor, employer, and insurer communities, workers' compensation rather than tort suits became the preferred remedy for work-related injuries or fatalities. The features of the statutes that were enacted in the early 20th Century are still basically present in current programs: a worker is eligible for benefits without having to prove that the employer is negligent; workers' compensation benefits are the exclusive remedy against the employer; benefits are largely prescribed by formulas and (for many serious injuries) by fixed durations; and workers' compensation agencies largely administer the program.

The legal context of the early 20th century also affected the level of government where workers' compensation programs were enacted. At that time, the U.S. Supreme Court interpreted the commerce clause of the Constitution in a narrow fashion, which limited the ability of Congress to regulate activities not directly involved in interstate commerce. The federal government was able to enact a workers' compensation program for its own employees.[2] However, most workers in the private sector as well as state and local government employees could not be regulated by the federal government, and therefore, of necessity, most of the initial workers' compensation laws were enacted by the states.

New York was the first state to enact a comprehensive workers' compensation statute in 1910. However, the act was held invalid in March 2011 by the New York Court of Appeals in *Ives v. South Buffalo Ry. Co*., 201 N.Y. 271 (1911) because it conflicted with the due process provisions of the state constitution and of the Fourteenth Amendment. Subsequently, the New York state constitution was amended to allow a mandatory workers' compensation law and the state enacted a new workers' compensation law in 2013 that was found constitutional by the New York Court of Appeals and ultimately by the U.S. Supreme Court in *New York Central Railroad Co. v. White*, 243 U.S. 188 (1917).

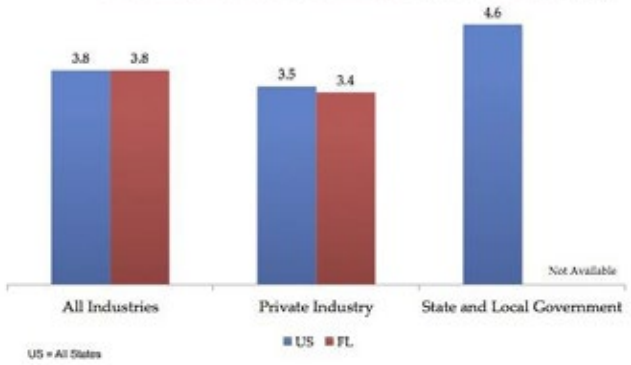
The first workers' compensation laws to withstand constitutional challenges were enacted in 1911, first by New Jersey and then Wisconsin.[3] By1920, all but five states had enacted workers' compensation statutes. Many of these early laws were made elective for employers in order to avoid constitutional challenges. The first Florida workers' compensation law was enacted in 1935 (Harger 2003, 3).

III. The Florida Workers' Compensation Program

A. Injuries, Benefits, and Costs

An examination of workers' compensation data in Florida needs first to consider the safety and health record in the state since a primary driver of benefits and costs is the number of workplace injuries and diseases. Figure 1, based on data from the U.S. Bureau of Labor Statistics (BLS), indicates that in 2010 the frequency of nonfatal occupational injuries and diseases in Florida was same as the national average for all industries and slightly above the national average for the private sector. There were no data available for the public sector in Florida in 2010. Nor are there any data available for Florida for more recent years, unlike most states, where data through 2014 are available from the BLS. Based on the fragmentary and outdated data available for Florida, the state appears to be comparable to national average in occupational safety and health.

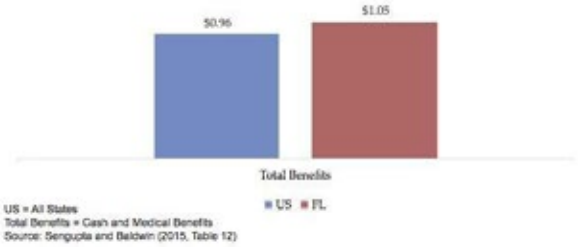
Figure 1: Nonfatal Occupational Injuries and Illnesses Per 100 Full Time Workers in 2010 (Total Recordable Cases)



The National Academy of Social Insurance (NASI) annual publishes the most comprehensive report on workers' compensation benefits, coverage, and costs. The most recent edition (Sengupta and Baldwin 2015) contains national and state data for 2013. Figure 2 provides information on total paid benefits (cash plus medical) per $100 of covered wages in 2013 for Florida and the US (which consists of the 50 states plus the District of Columbia, but not the federal workers' compensation programs). Florida's benefits of $1.05 per $100 of covered wages was 10 percent higher than the US average of $0.96 per $100 of covered wages.

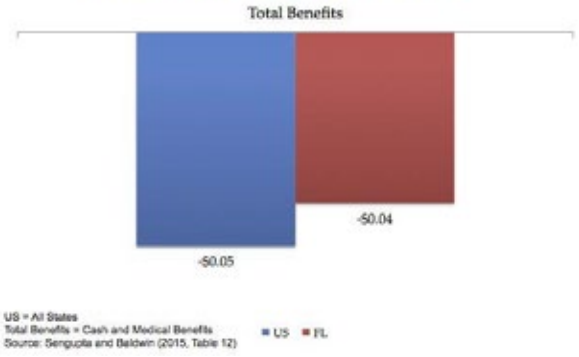
• *National Developments – continued*

Figure 2: Workers' Compensation Total Benefits Per $100 of Covered Wages, 2013



While workers' compensation benefits relative to payroll in Florida were somewhat above the US average in 2013, the benefits changed at a similar rate in recent years. Figure 3 indicates the decline in total benefits per $100 of covered wages between 2009 and 2013 in Florida and the US. While all states on average experienced a decline of $0.05 in total benefits per $100 of covered payroll over the four years, the benefits in Florida dropped by $0.04 per $100 of payroll from 2009 to 2013.

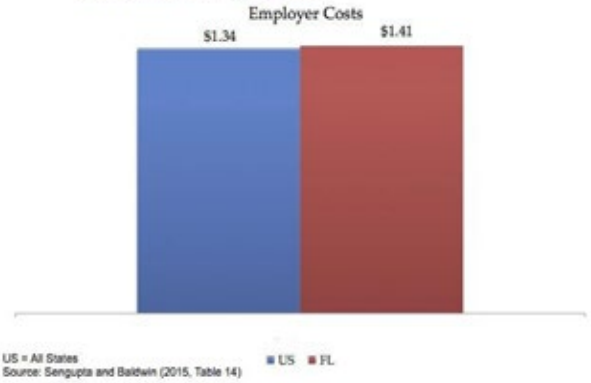
Figure 3: Workers' Compensation Total Benefits Per $100 of Covered Wages, 2009-2013 Changes



As can be expected, the employers' costs of workers' compensation in a state largely reflect the benefits paid to the workers in the jurisdiction. The data in Figure 4 indicate that the employers' costs of workers' compensation was $1.41 per $100 of covered wages in Florida in 2013, which was five percent above than the US average of $ .34 per $100 of covered payroll.

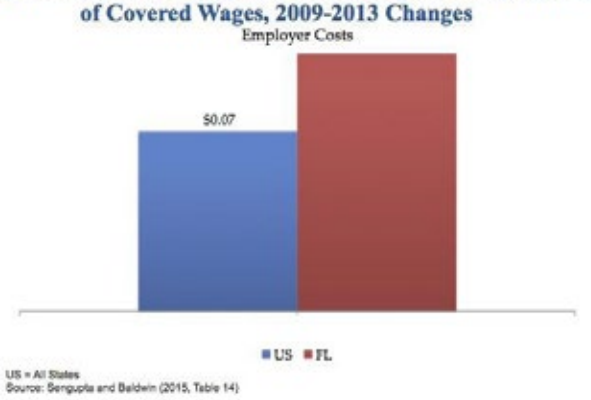
When workers' compensation benefits paid to workers decline in a state, the costs to employers typically decline in the jurisdiction, but there are exceptions. The data in Figure 5 indicate that on average in the US, the costs to employers of workers' compensation increased

Figure 4: Workers' Compensation Employer Costs per $100 of Covered Wages, 2013



by $0.07, even though (as shown in Figure 3) benefits declined by $0.05 per $100 of covered wages. For Florida, the four-year decline in total benefits per $100 of payroll (shown in Figure 3) was associated with an increase in the employers' costs of workers' compensation between 2009 and 2013 of $0.11 per $100 of covered wages, as shown in Figure 5.

Figure 5: Workers' Compensation Employer Costs per $100 of Covered Wages, 2009-2013 Changes



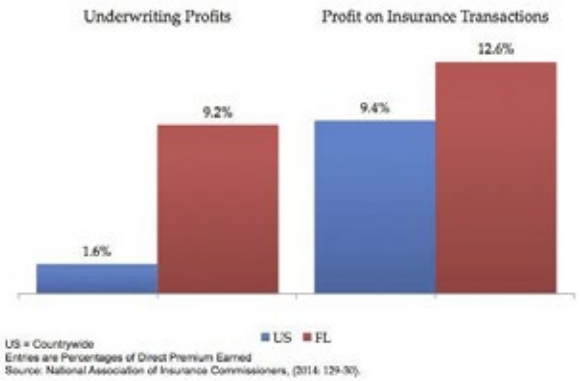
B. Workers' Compensation Insurance

A final comparison of the workers' compensation program in Florida with the experience nationally involves the profitability of the workers' compensation insurance industry. Two measures of profitability are shown in Figure 6. For the US, underwriting profits were 1.6 percent of premium in 2013, compared to profits of 9.2 percent of premium in Florida. A more comprehensive measure of insurance industry performance is profit on insurance transactions, which includes investment gains and taxes, and by that measure, Florida's profit of 12.6 percent of premium was also higher than the US average of 9.4 percent.

Three types of regulatory arrangements are used for workers' compensation insurance in the U.S. (Thomason, Schmidle, and Burton 2001a, 38-45).[4] The first category is *pure administered pricing*, in which a rating bureau develops manual rates for a detailed set of

• *National Developments – continued*

Figure 6: Insurance Industry Profitability, 2013



occupational and industrial insurance classifications. Manual rates are based on pure premiums (loss costs based largely on previous benefit payments), which are increased by a loading factor, which consists of an allowance for loss adjustment and other expenses and for profits. The manual rates are approved by the state regulatory agency and must be adhered to by all insurance carriers. Individual employers may receive premium discounts, depending on the amount of their premiums, and may have their premiums adjusted by experience rating modifications, depending on the firm's previous experience. These modifying factors are approved by the insurance commissioner and must be adhered to by all carriers. Most carriers can pay dividends, but only after the expiration of the policy. In short, there is virtually no chance for carriers to compete in terms of the price of the insurance at the beginning of the policy.

A second type of regulatory arrangement involves *partial deregulation*, although there are several variants of partial deregulation. For example, some states allow deviations, in which individual carriers can deviate from the published manual rates by a specified percentage, sometimes limited to employers in particular insurance classes. Deviations are generally subject to the approval of the state insurance commissioner. Some states allow schedule rating plans, in which a carrier can adjust the premium changed to an individual policyholder based on subjective factors

A third type of regulatory arrangement is *comprehensive deregulation*, in which rating bureaus only publish loss costs (not manual rates) and insurers are permitted to set their own rates without first seeking approval of state regulators.

Prior to the 1980s, all states with private carriers relied on pure administrative pricing to regulate workers' compensation premiums. The changes in the regulatory environment since then have been tracked by the NCCI (2016 and earlier editions, Exhibit 2) with the date for each state when the "Competitive Rating Law Effective," which is a term broad enough to include both comprehensive deregulation and partial deregulation. Arkansas adopted a competitive rating law in 1981, followed by 33 other jurisdictions by 1995. As of 2016, there are 38 jurisdictions (including the District of Columbia) in which a competitive rating law is effective, nine states with private carriers that still rely on administered pricing, and four states with exclusive state funds.

Thomason, Schmidle, and Burton (2001a and 2001b) examined the effects of deregulation relying on state-level data from 1975 to 1995. They found that most forms of partial deregulation were associated with higher costs for employers. However, they found that comprehensive deregulation – loss costs systems that do not require prior approval of each carrier's rates – was associated with about an 11 percent reduction in the employers' costs of workers' compensation insurance after controlling for other factors that affect the costs.

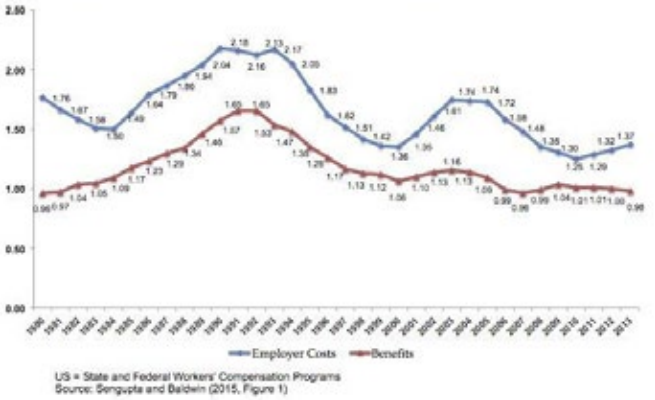
I have not paid much attention to the regulatory environment for workers' compensation insurance since our book was published. During the preparation of this manuscript, I reviewed recent developments in the NCCI *Annual Statistical Bulletin (2016)* and was surprised by two findings. Subsequent to the completion of the book, only one state – Nevada – has adopted a competitive rating law. Florida is one of the nine states nationally that still relies on administered pricing and is the only one of the Southeastern states that does not have a competitive rating law.[5]

IV. Workers' Compensation National Developments in the last 50 Years

A. Fluctuations in Benefits and Costs

Workers' compensation programs have varied over time in the benefits paid to workers and the costs for employers. Figure 7 indicates that benefits per $100 of covered wages increased from 1980 (the earliest year with comparable data) to the early 1990s, declined rapidly

Figure 7: Workers' Compensation Benefits and Costs Per $100 of Covered Wages in the US, 1980-2013



• *National Developments – continued*

during the 1990s, and then generally declined slowly from 2000 until 2013. Costs fluctuated very roughly in tandem with benefits: costs declined from 1980 to the mid-1980s, then increased until the early 1900s, followed by steep declines in the balances of the 1990s, followed by increases for several years in the early 2000s, and then generally declining until 2012. In recent years, both benefits and costs as a percent of payroll have been near their low points for the period since 1980.

B. Causes of the Changes in Benefits and Costs

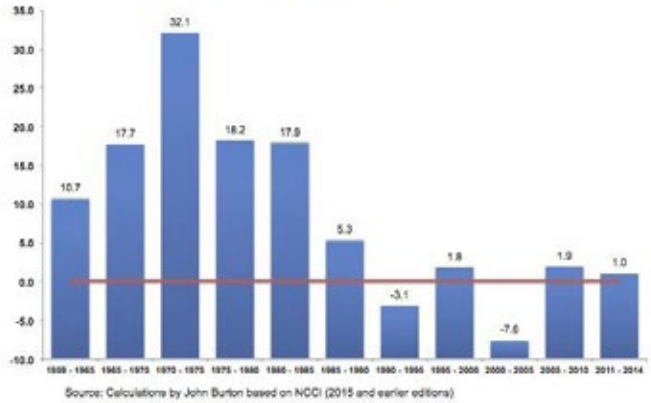
The changes in benefits and costs per $100 of covered wages since 1980 are explained in part by the changes in state workers' compensation statutes. The National Council on Compensation Insurance (NCCI) provides advisory ratemaking and statistical services for the workers' compensation programs in 36 states (including the District of Columbia) (NCCI 2016, 7). The NCCI publishes an *Annual Statistical Bulletin* (ASB), which includes data on these 36 states plus data from all other states except those with exclusive state funds. The NCCI publishes state and countrywide data on adjustments in premium level due to several factors, including benefit change, which "refers to adjustments in premium level to account for benefit changes adopted by the various state legislatures, as well as medical fee and hospital rate changes (NCCI 2016, Exhibit 1)." Figure 8 shows the changes in statutory benefits for the five year intervals from 1959 (when the NCCI data series began) to 2014.[6]

• **The 1960s.** Statutory benefits increase by more than 28 percent.

• **The 1970s.** Statutory benefits increased by more than 50 percent.

• **The 1980s**. Statutory benefits increased varied over the decade: up 18 percent in the first five years but only 5 percent in the last five years. 1985.

Figure 8: Workers Compensation Statutory Benefits Changes Percentage Changes in Sub-periods, 1959 – 2014



Source: Calculations by John Burton based on NCCI (2015 and earlier editions)

• **The 1990s.** For the first time since at least the 1950s, statutory benefits declined during the decade, although the decline was only one percent.

• **The 2000s.** Statutory benefits declined over five percent during the decade.

• **The 2010s.** Statutory benefits have been essentially been flat.[7]

The declines since 1990 have been due to several factors. In some jurisdictions the weekly benefit amounts or the durations of some types of benefits have been reduced. While the reductions in the statutory amounts and duration of benefits explain some of the decline in benefits shown in Figures 7 and 8, a less obvious set of changes that limit access for disabled workers to the workers' compensation programs may be more important (Guo and Burton 2010; Spieler and Burton 2012). These changes include limiting the compensability of claims involving particular medical diagnoses, such as stress claims; limits on coverage when the injury aggravates a pre-existing condition; and procedural and evidentiary changes, such as requiring "objective" medical evidence and imposing a stricter burden of proof on workers.

Although the decline in WC benefits shown in Figures 7 and 8 that were examined by Spieler and Burton (2012) and Guo and Burton (2010) began in the early 1990s, the rate of constriction in coverage and benefits may have accelerated in the last ten years. Grabell and Berkes (2015a) report that "Since 2003, legislators in 33 states have passed workers' compensation laws that reduce benefits or make it more difficult for those with certain injuries and diseases to qualify for them."

A recent example of effort to tighten compensability rules involves Illinois, where Governor Rauner made several proposals for changes in the Illinois workers' compensation program so the state will "become more competitive in order to increase jobs and grow the economy" (Rauner 2015). The proposed changes include a reduction in the medical fee schedule, a narrowing of what constitutes travel for purposes of workers' compensation coverage, change in the factors that can be used to determine the extent of permanent partial disability (PPD) to allow sole reliance on the *AMA Guides*, and a change in the causation standard. The proposed change in the causation standard is:

The causation standard should be raised from an "any cause" standard to a "major contributing cause" standard. The accident at work must be more than 50% responsible for the injury compared to all other causes.

The Governor's discussion of this proposed standard indicates that Missouri, Kansas, Oklahoma, and Tennessee have recently passed laws requiring the workplace to be "the *primary* cause for workers' compensation to be compensable," and indicates that "Florida's major contributing cause standard is identical to the one we are proposing."[8]

In addition to reductions in the duration or weekly amounts of cash benefits and the constriction of compensability rules, there is a nascent movement to reduce the coverage of workers. The most significant recent development concerning legally required coverage was Oklahoma's adoption of an opt-out provision in 2013, which applies to injuries sustained after January 1, 2014. Robinson (2013, 154-55) distinguishes the Oklahoma approach from the long- standing provision in Texas that allows employers to be "non-subscribers" to the workers' compensation statute and thus subject themselves to tort suits. (Many Texas employers have voluntarily established disability plans that provide some protection to injured workers.) The Oklahoma law allows employers the choice of (1) remaining with the "traditional" workers' compensation act or (2) opting out of the workers' compensation plan and establishing a written benefit plan that provides "for payment of the same form of benefits" that are at least equal to or greater than the state's workers' compensation act. Unlike the Texas provision, the Oklahoma law protects the employer from tort suits for workplace injuries even when the employer opts out of the state workers' compensation statute.

Several recent studies have criticized the Texas and Oklahoma provisions allowing employers to avoid workers' compensation coverage. Grabell and Berkes (2015b) examined the injury benefit plans of 120 employers who have opted out in Texas or Oklahoma and found many contained provisions that were more restrictive than the states' workers' compensation plans. For example, some plans deny benefits unless the worker reports the injury by the end of the shift. Other plans exclude illness from mold exposure, bacterial infection, or asbestos exposure. Several commentators, including Pennsylvania Workers' Compensation Judge David Torrey (2015b), have expressed serious reservations about the opt-out provisions. Legal challenges to the Oklahoma opt-out provision are discussed in Section VII.

C. Consequences of Changes

An example of the effects of restricting eligibility on workers is provided by Oregon, where Thomason and Burton (2001) estimate that a series of legislative provisions resulted in benefits (and costs) being about 25 percent below the amounts they would have been in the absence of the more restrictive eligibility standards. The legislative provisions included a requirement that the work injury be the major contributing cause (MCC) of the worker's disability in order for the worker to be eligible for any workers' compensation benefits. This requirement contrasts with the traditional approach in workers' compensation in which a worker is eligible for benefits so long as the work injury is a nontrivial source of his or her disability.

Another consequence of the reduction in permanent disability benefits and the tightening of eligibility standards in workers' 'compensation is that some disabled workers are turning to the Social Security Disability Insurance (SSDI) program for financial support. Burton and Guo (2016) provide four sources of evidence documenting the shifting of the costs of workplace injuries and diseases from workers' compensation to SSDI. For example, Guo and Burton (2012) examined the increase in SSDI applications between the 1980s and 1990s and found that, while most of the increase is applications was due to aging of the population and women's increasing workforce participation, nonetheless changes in state workers' compensation programs during the 1990s resulted in a modest but statistically significant increase in SSDI applications during that period. Cost shifting from workers' compensation to SSDI is a significant issue because the SSDI Trust Fund would have exhausted its reserves in 2016 if Congress had not provided a temporary solution in 2015 allowing the SSDI Trust Fund to borrow money from the OA Trust Fund.

V. The Fundamental Cause of Inadequate Workers' Compensation Benefits

Although WC statutory benefits were increasing in the 1960s (Figure 8), benefits and coverage were criticized in the period. One result is that when the Occupational Safety and Health Act (OSHAct) of 1970 was enacted, the National Commission on State Workmen's Compensation Laws (National Commission) was created and directed to determine if state workers' compensation laws "provide an adequate, prompt, and equitable system of compensation for injury of death arising out of in the course of employment."

The National Commission, whose 18 members included three representing Cabinet members and 15 appointed by the Nixon White House, issued a unanimous report in 1972. The *Report* of the National Commission documented serious deficiencies with state workers' compensation statues: for example, "the *maximum* weekly benefit for temporary total benefits in more than half of the states" did not reach the 1971 national poverty level for a non-farm family of four ($79.56 a week) (National Commission 1972, 61). The report also reported that in most states the maximum weekly benefits for temporary total disability benefits relative to the state's average weekly wage were lower in 1972 than they had been in 1940 (National Commission 1972, Table 3.6).

The conclusion of the National Commission (1972, 25) was that "State workmen's compensation laws are in general neither adequate nor equitable." Of greater relevance to an understanding of current workers' compensation programs is the National Commission's

analysis of a major source of the deficiencies of state programs (1972, 124-25):

> **Competition among States.** The economic system of the United States encourages the forces of efficiency and mobility. These forces tend to drive employers to locate where the environment offers the best prospects for profit. At the same time, many of the programs which governments use to regulate industrialization are designed and applied by States rather the Federal government. Any State which seeks to regulate the by-products of industrialization, such as work accidents, invariably must tax or charge employers to cover the expenses of such regulations. This combination of mobility and regulation poses a dilemma for policymakers in State governments. Each State is forced to consider carefully how it regulate its domestic enterprises because relative restrictive or costly regulation may precipitate the departure of the employers to be regulated or deter the entry of new enterprises.
>
> Can a State have a modern workers' compensation program without driving employers away? Our analysis of the cost of workmen's compensation has convinced us that no State should hesitate to adopt a modern workmen's compensation program…
>
> While the facts dictate that no State should hesitate to improve its workmen's compensation program for fear of losing employers, unfortunately this appears to be an area where emotions too often triumphs over facts… whenever a State legislature contemplates an improvement in workers' compensation which will increase insurance costs, the legislators likely will hear claims from some employers that the increase in costs will force a business exodus. It will be virtually impossible for the legislators to know how genuine are these claims. To add to the confusion, certain States have abetted the illusion of the runaway employer by advertising the low costs of workmen's compensation in their jurisdictions.
>
> When the sum of these inhibiting factors is considered, it seems likely that many States have been dissuaded from reform of their workmen's compensation programs because of the specter of the vanishing employer, even if that apparition is a product of fancy not fact. A few states have achieved genuine reform, but most suffer with inadequate laws because of the drag of laws of competing States.

VI. The Current Challenge for Workers' Compensation: A Race to the Bottom

The deterioration of state workers' compensation laws by the perceived threat of run- away employers is the major challenge for the program today in my opinion. There appears to be an accelerating movement to reduce benefits, tighten compensability rules, or allow employers to opt-out of the program.

VII. The Solutions to the Current Challenges to Workers' Compensation

A. Federal Standards

The National Commission made 84 recommendations for improving state WC programs. Of particular relevance to developing a strategy to deal with the deleterious effect of competition among states were the designation of 19 of these recommendations as essential and a recommendation (National Commission 1972, 127) that "compliance of the States should be evaluated on July 1, 1975, and, if necessary, Congress with no further delay in the effective date should guarantee compliance." There were no dissents to this recommendation for federal standards among the 18 members of the National Commission.

Federal standards for workers' compensation have not been enacted. The threat of federal intervention probably explains the surge in improvements in workers' compensation statutes in the 1970s shown in Figure 8. With the change in the national political environment since 1980, the threat of federal standards diminished as a threat in the 1980s and disappeared in subsequent decades.

Indeed, it is almost inconceivable that Congress would enact federal standards for the state workers' compensation program. Moreover, I do not think that federal standards are adequate to deal with the current threats to the state system (Burton 2015a).

B. A federal workers' compensation statute?

A federal workers' compensation program to replace state programs (i.e. federalization of the workers' compensation program) is even more unlikely to be enacted than federal standards. To use the analytical term of New Jersey: forgetaboutit.

C. Absorption of Workers' Compensation into Existing Federal Programs

Workers' Compensation Cash Benefits Absorbed by Social Security Disability Insurance

Another possible outcome for workers' compensation is that the responsibility for providing cash benefits to workers disabled by work-related injuries and diseases could be taken over by the SSDI programs, which already provides cash benefits to workers disabled from any cause. The SSDI program pays more than four times as much to disabled workers and their depen-

dents as does the workers' compensation program and so the whale could probably swallow the walrus.[9] One advantage of such a merger is the resources currently devoted by the workers' compensation program to deciding whether injuries or diseases are work-related could be reduced or perhaps even eliminated However, the SSDI program currently only provides benefits for permanent and total disability, while 62.6 percent of all workers' compensation claims involve temporary disability and 61.8 percent of workers' compensation benefits are paid for permanent partial disability. Of particular concern are PPD benefits, which are even more complex and litigious than current DI benefits, and so an SSDI program that absorbed the workers' compensation program would have to develop a much more elaborate delivery system to provide both temporary and permanent as well as with total and partial disability benefits.

As a practical matter, the folding of workers' compensation cash benefits into the SSDI program seems highly unlikely – not only because of the issues raised above but because of political considerations. Workers' compensation benefits are largely provided by private insurance carriers and the program is largely administered by state employees whose replacement by federal employees would not be universally acclaimed. So unless the new SSDI program, which absorbed workers' compensation, had a major role for private carriers and was largely administered by the states, the notion of a grand disability program seems doomed.

Another potential drawback of an SSDI program that absorbed workers' compensation concerns the manner of financing the new program. The SSDI program is financed by a portion of the FICA tax that is paid by both workers and employers and that does not vary among these contributors, while the workers' compensation premium is paid solely by employers and is experienced rated so that employers pay more or less depending on their industry and their own prior history of benefit payments. The historical rationale for experience rating is that the procedure promotes workplace safety and, although there is disagreement among scholars about whether experience rating actually improves workplace safety (Burton 2015c), nonetheless the absence of experience rating in the SSDI program will be of concern to some supporters of workers' compensation if the SSDI and workers' compensation programs are combined. Of course, the "obvious" solution is to experience rate the SSDI program, which has long been advocated by some (Burton and Berkowitz 1971, 351) and which has recently been proposed as a partial solution to the current SSDI financial problems (Burkhauser and Daly 2011, 110-13). Burton and Guo (2016) made three proposals for reform of the SSA program and in particular the relationship between workers' compensation and SSDI. Our most significant proposal is that the SSDI program should use experience rating to determine employer's contributions to the program. We think that experience rating – which has been used with general success in workers' compensation for over 100 years – would improve the outcomes for workers in the SSDI program and would decrease the incentives for employers to shift costs from workers' compensation to SSDI.

Workers' Compensation Medical Benefits Absorbed by the ACA

The relationship between the workers' compensation health care system and the Affordable Care Act[10] (ACA) health care system for non-work-related injuries and diseases is murky at best. Gruber (2014) suggested that because more workers will have health insurance there will less need for them to rely on workers' compensation if they are injured, which should lower the costs of workers' compensation. On the other hand, he recognized that effect could be offset by changes in the health care plans offered by employers for non-work-related medical conditions, such as high-deductible plans, provider networks with limited choices of providers, and caps on reimbursements for medical care providers. These changes could encourage workers and providers to shift marginal cases into the workers' compensation health care system unless workers' compensation quickly adjusts its own health care system. If these adjustment do not occur, then health care costs in workers' compensation could increase, which is reminiscent of what happened to workers' compensation health care costs in the 1980s when managed care in other parts of the health care system preceded changes in the workers' compensation program.

This raises the question of whether there should be separate health care systems for employees if their injuries or diseases are work-related or if their injuries or diseases are caused by other conditions. Is such a dual system of health care beneficial for workers, carriers, and employers? Carriers and employers expressed concerns about the unitary health care system included in the Clinton health care proposal because they feared that loss of control over health care would jeopardize their chances to quickly heal workers and return them to work, and the resulting lags would lead to higher payments of cash benefits. However, as discussed by Mustard and Sinclair (2005), Ontario has a health care system that essentially uses the same health care delivery system to treat all sources of disability for workers and the costs of both the medical care and the overall costs of the workers' compensation program in Ontario appeared to be lower than in most U.S. jurisdictions.

D. Court Challenges to Changes in State Workers' Compensation Laws

(1) Challenges in Other States to Laws Adopting the Dual Denial Doctrine

Prior to the enactment of workers' compensation statutes, workers had the right to bring negligence (tort) suits against their employers for work-related injuries. Negligent employers had several special defenses (such as contributory negligence), but employees were increasing successful in the negligence suits in the early 20th century. For this and other reasons, states began to pass workers' compensation laws around 1910. These laws had provisions of benefit to workers: they were no-fault laws (the employer is liable for workers' compensation benefits even if the employer is not negligent, and the employer can no longer use the special defenses). These laws also had features of benefit to employers: workers' compensation statutes provide cash benefits that are less than the potential recovery under tort suits. And workers' compensation is the exclusive remedy of the employee against the employer, which means that the employee cannot bring a tort suit against the employer (even if the employer is negligent). Needless to say, this is a short summary of a complicated topic, but I hope it is sufficient for this presentation.

Given this historical features of the workers compensation principle, a current issue is: Can a workers' compensation statute both (1) contain requirements that make it impossible for a worker to qualify for workers' compensation benefits and (2) contain provisions that preclude the worker from bringing a tort suit by stating that workers' compensation is the exclusive remedy for a workplace injury? In essence, can there be a dual denial doctrine that precludes both workers' compensation and tort remedies?

The Oregon legislature passed legislation in 1993 denying workers' compensation benefits unless the worker could prove that work exposure was the major contributing cause (MCC) of an occupational disease. A worker who experienced a work-related disease that did not meet the MCC requirement was denied workers' compensation benefits. The Oregon Supreme Court, in *Errand v. Cascade Steel Rolling Mills, Inc*., 888 P.2d 544 (Or.1955), relying on a statutory interpretation of the Oregon workers' compensation law, held that exclusive remedy provision did not preclude the worker from bringing a tort suit against the employer. In response to *Errand*, the Oregon legislature amended the workers' compensation statute in 1995 to provide that workers' compensation was the exclusive remedy for work-related injuries and-diseases, even if the condition was not compensable under workers' compensation because the work exposure was not the major contributing cause. In essence, the Oregon legislature said: when we say dual denial for diseases for which the workplace is not the MCC, we mean it. In *Smothers* v. *Gresham Transfer, Inc*., 23 P.3d 333 (2001), the Oregon Supreme Court responded by holding that the Oregon constitution did not allow the legislature to eliminate both the workers' compensation remedy and a tort remedy when the employment is not the major contributing cause of the condition.

The preceding paragraph was included in the May 2016 draft of this presentation. You can imagine my surprise and consternation when I subsequently learned the Supreme Court of Oregon had overruled *Smothers* in early May in *Horton v. Or. Health & Sci. Univ*., 359 Ore. 128 (2016). The *Smothers* decision involved an interpretation of the remedy clause in the 1857 Oregon Constitution, which the Oregon Supreme Court has now reinterpreted.

The dual denial doctrine appears to be clearly unconstitutional in Montana. Based on an extended review of cases such as *Stratemeyer v. Lincoln County (Stratemeyer II)*, 276 Mont. 67, 915 P.2d 175 (1996), McClure (2000 at 13) concluded that "Montana allows an employee whose injury is not compensable under the worker's [sic] compensation laws to file a tort action for recovery." While Stratemeyer and other cases established a clear limitation on the exclusive remedy provision in Montana, similar constitutional challenges in other states have not all been successful.[11] Nonetheless, adoption of states incorporating the dual denial doctrine may lead to a challenge that such provision violates a state's constitution and arguably also the U.S. Constitution.[12]

The challenge to the dual denial of both workers' compensation and tort remedies does not depend on a constitutional issue. A Pennsylvania Supreme Court decision, *Tooey v. AK Steel Corp*., 81 A.3d 851 (Pa. 2013), considered the statute of repose, which requires a disease to manifest within 300 weeks of the last exposure to the source of the disease.[13] Two workers, Tooey and Landis, were exposed to asbestos and developed mesothelioma, but their last exposures were 1,300 and 780 weeks before the manifestation of their diseases. Because the claims did not meet the 300 week manifestation rule, they did not qualify for workers' compensation benefits. As a result, the workers' brought tort actions against their employers, who invoked the exclusivity provision of the Pennsylvania workers' compensation act. The lower courts dismissed the cases, but the Supreme Court reversed the decision based on statutory construction:

> It is inconceivable that the Legislature, in enacting a statute specifically designed to benefit employees, intended to leave a certain class of employees who had suffered the most serious of work-related

injuries without any redress under the Act or at common law.

By basing the decision on the statutory construction of the Pennsylvania workers' compensation law, the Supreme Court avoided having to deal with constitutional challenges to the dual denial doctrine that were raised in the case.

The essence of this discussion is that there is in my opinion a significant risk that the adoption of a workers' compensation statute relying on the dual denial doctrine will result in challenges to the exclusive remedy provision that will make employers susceptible to tort suits for work injuries that are no longer eligible for workers' compensation benefits.

(2) Additional Court Challenges to Laws in Other States

In addition to challenges in other states to workers' compensation statutory provisions that adopted the dual denial doctrine, there are other cases involving additional matters that are worth noting. One of the most interesting challenge involves the Oklahoma law allowing employers to opt-out of the state's workers' compensation law and

One feature of the Oklahoma law is that the benefit plan adopted by the employer that opts-out of the workers' compensation program may qualify as an ERISA plan, which could mean that a dispute involving any provision of the benefit plan could only be resolved in Federal courts and could not be resolved by the Oklahoma Workers' Compensation Commission or Oklahoma state courts. Duff (2016, 23) provides a careful analysis of whether the alternative benefit plans are necessarily covered by ERISA and argues that the conclusion that the plans are necessarily covered by ERISA "though plausible, seems debatable given the significant impact that widespread employer opt-out could have on the national employer benefit landscape."

In addition to the issue of whether the alternative plans established the 2013 Oklahoma statute can preempt state oversight because of ERISA, the legislation faces other challenges. In February 2016, the Oklahoma Workers' Compensation Commission (CM-2014-11060L) held in *Vasquez v. Dillard's* that the provisions of the 2013 Oklahoma workers' compensation law establishing the requirements for a qualified benefit plan are unconstitutional because Section 203 deprives injured workers of equal protection and because the combination of Sections 203 and 209 deprive injured workers of access to the Court. The decision has been appealed to the Oklahoma Supreme Court.

(3) Challenges in Florida Courts to the Florida Workers' Compensation Law

Florida workers' compensation aficionados have been blessed/cursed by recent decisions of the Supreme Court of Florida and are anticipating further decisions with eagerness/trepidation. Other members of the panel at the Florida Workers' Compensation Educational Conference are experts of these cases, and so I will only provide a brief synopsis.

Castellanos v. Next Door Co., __So. 3d.__ 2016, was decided on April 28, 2016 by the Supreme Court of Florida. The court concluded "that the mandatory fee schedule in section 440.34, which creates an irrebuttable presumption that precludes any consideration of whether the fee award is reasonable to compensate the attorney, is unconstitutional under both the Florida and United States Constitutions as a violation of due process." Section 440.34 of the Florida statutes was adopted in 2009 and included a fee schedule for applicants' attorneys that allowed Castellanos' attorney a fee of $1.53 per hour for 107.2 hours of work that had been determined by the Judge of Compensation Claims to be "reasonable and necessary" in handling this complex case. The Court provided an extended discussion of the history of the regulation of the statutory regulation of applicants' attorneys' fees in Florida. The Court noted that 2003 legislation had amended the attorney's fee schedule to limit applicants' attorneys" fee, and that in *Murray v. Mariner Health*, 994 So. 2d 1051 (Fla. 2008) the Court had upheld the 2003 legislation because it permitted a claimant to receive a reasonable attorney's fee even when that amount exceeded the statutory attorney's fee schedule. Following the *Murray* decision, in 2009 "the Legislature removed any ambiguity as to its intent " by removing the word "reasonable" in relation to applicants' attorneys' fees and thus removed any discretion "to award the fee award in cases where the sliding scale based on benefits obtained results in either a clearly inadequate or a clearly excessive fee." The Court found that such a restriction on determining attorneys' fees was a violation of due process. I consider the Court's remedy for the lack of due process in the 20o9 legislation to be particularly interesting:

> Accordingly, our holding that the conclusive fee schedule in section 440.34 is unconstitutional operates to revive the statute's immediate predecessor. This is the statute addresses by this court in Murray, where we construed the statute to provide for a "reasonable" award of attorney's fees.

Westphal v. City of St. Petersburg, __So. 3d.__ 2016 was decided on June 29, 2016 by the Supreme Court of Florida. The case involved a gap in the system of cash benefits for workers with serious injuries. Section 440.15(2)(a), which was enacted in 2009, cut off disability benefits for a totally disabled worker after 104 weeks or

• *National Developments – continued*

sooner if the worker reaches the date of maximum medical improvement (MMI) before 104 weeks. The statute also provides that permanent total disability benefits cannot be awarded until the worker reaches the date of MMI. Westphal was still totally disabled after 104 weeks but had not yet reached the date of MMI and so the statute required all total disability benefits to cease. The Florida Supreme Court concluded "that the 104-week limitation on temporary total disability benefits results in a statutory gap in benefits in violation of the constitutional right of access to courts."

Of particular interest, the Court found that Section 440.15(2)(a) was unconstitutional because it created "a system of redress that no longer functions as a reasonable alternative to tort litigation." Arguably this would have led the Court to find that Westphal was entitled to bring a tort suit against the City of St. Petersburg. Instead, the Court provided an alternative remedy.

> "Florida law has long held that, when the legislature approves unconstitutional statutory language and simultaneously repeals its predecessor, then the judicial act of striking the new statutory language automatically revives the predecessor unless it, too, would be unconstitutional." B.H. v. State, 645 So. 987, 995 (Fla. 1994). We therefore conclude that the proper remedy is the revival of the pre- 1994 statute that provided for a limitation of 260 weeks of temporary disability benefits. . . .The provision of 260 weeks of temporary total disability benefits amounts to two and a half times more benefits – five years of eligibility rather than only two – and thus avoids the constitutional infirmity created by the current statutory gap as applied to Westphal.

Miles v. City of Edgewater/PGCS, __So. 3d __ (Fla. 1st DCA 2016), decided by the First District Court of Appeals on April 20, 2016, was not appealed to the Supreme Court of Florida and will have retroactive application. Miles was a law enforcement officer whose attorney filed two claims in 2013 alleging a chemical exposure during an investigation that resulted in disability. The employer/carrier disputed occupational causation of the claimant's condition. Because of the difficulties involved in establishing causation is this case, Miles was unable to obtain counsel who would accept the attorney's fees prescribed by the fee schedule for applicants' attorneys contained in Section 440.34 of the Florida statutes. Instead, two agreements concerning attorney's fees were signed: one between the law firm representing Miles and the Fraternal Order of Police (FOP) in which the FOP agreed to a flat fee of $1,500, and one between the law firm and Miles in which she agreed to pay an hourly fee for all attorney time expended beyond 15 hours. The Judge of Compensation Claims (JCC) denied the claimant's motion to approve the two attorney's fees agreements because conflicted with the schedule of fees in Section 440.34. On appeal, the Frist District Court of Appeals held that both Section 440.34 and Section 440.105, which provides that an attorney who receives a fee commits a first-degree misdemeanor unless the fee is approved by a JCC, were unconstitutional because they violated the claimant's First Amendment rights under the U.S. Constitution. The Court held that the two sections "are unconstitutional violations of a claimant's rights to free speech, free association, and petition" and "those provisions also represent unconstitutional violations of a claimant's right to form contracts." The Court held "that the proper remedy is to allow an injured worker and an attorney to inter into a fee agreement approved by the JCC, notwithstanding the statutory restrictions." The only limitation to applicant's' attorneys fee is that there is "a JCC's finding that the fee is reasonable."

(4) Challenges in Federal Courts to the Florida Workers' Compensation Law

The dual denial cases discussed earlier in this section involved situations where the state workers' compensation statute resulted in a total denial of workers' compensation benefits. An interesting question is whether a state workers' compensation law can be challenged in federal courts when the worker obtains some benefits from a state workers' compensation program but those benefits are inadequate.

One part of the Supreme Court's opinion in the landmark case, *New York Central Railroad Co. v. White*, 243 U.S. 188, 205-06 (1917), which upheld the constitutionality of the 1913 New York workers' compensation law, is:

> Viewing the entire matter, it cannot be pronounced arbitrary and unreasonable for the State to impose upon the employer the absolute duty of making a moderate and definite compensation in money to every disabled employee, or in case of his death to those who were entitled to look to him for support, in lieu of the common-law liability to cases of negligence.
>
> This, of course is not to say that any scale of compensation, however, insignificant on the one hand or onerous on the other, would be supportable.

Does this "ancient" pronouncement of a constitutional principle have any continuing validity as the basis for a challenge to a state workers' compensation statute when a state provides no remedy for a workplace injury or disease or provides a scale of compensation so meagre that arguably it is legally insignificant?

In *Stahl v. Hialeah Hospital*, the claimant argued that 1994 changes in the Florida workers' compensa-

tion statute eliminated cash benefits for partial loss of earning capacity by basing permanent partial disability benefits solely on the extent of the worker's medical impairment and by eliminating full medical benefits by requiring the worker to pay a copayment for every visit to a medical provider. The Florida First District Court of Appeals, 160 S0. 3d 519 (Fla. 1 DCA 2015), held that these statutory changes were constitutional. The Florida Supreme Court ultimately declined to review the decision, and a Petition for Writ of Certiorari has been filed with the U.S. Supreme Court.

The Supreme Court rarely grants petitions for certiorari, and if the Court does accept the case, it is not clear what remedy would be granted. In the *New York Central Railroad* case, a decision that the New York workers' compensation statute did not meet the Constitutional due process requirements presumably would have voided the entire statute and returned the handling of workplace injuries to tort suits based on the common law. If the specific provisions of the Florida workers' compensation law challenged in *Stahl* were held to constitute an "insignificant" scale of compensation, it is not evident what remedy the Court would impose. It is doubtful that the entire Florida workers' compensation statute would be found unconstitutional because of deficiencies in two provisions. It also seems doubtful that the Supreme Court would impose its own view of what constitutes a supportable scale of compensation for these two provisions.

(5) Speculation About Further Legal Challenges to the Florida Workers' Compensation Law

Let me stipulate that this discussion is speculative and that I anticipate that the other members of the panel will undoubtedly be elated that I have provided such an easy target for critical comments.

The Supreme Court of Florida has issues two decisions – *Castellanos* and *Westphal* – that are landmarks for both the state and the nation. The Court is obviously willing to reject decisions made by the legislature on important components of the state's workers' compensation statute, namely the limits on duration of total disability benefits and the fee schedules for applicants' attorneys. On the other hand, *Stahl* suggests that there are limits to the Courts appetite for intervention, perhaps because the introduction of a co-payment into medical benefits is not fundamentally different than the co-payments already used for cash benefits (where only a portion of lost wages is replaced by the benefit formula). A good test of how deep into the workers' compensation pond the Supreme Court is willing to dive would have been provided by an appeal of *Miles*, which appears to significantly limit the legislature's ability to regulate attorneys' fees.

If the Florida Supreme Court is willing to override the legislature on fundamental components of the current Florida workers' compensation laws, there are other provisions that appear to be logical targets. The *Castellanos* decision (in footnote 3) contains a list of seven "ways in which the workers' compensation system has become increasingly complex and difficult, if not impossible, for an injured workers to successfully navigate without the assistance of an attorney." I would reword this by deleting "without the assistance of an attorney" so that these seven represent provisions that have made it much more difficult for workers (even with attorneys) to receive benefits in the Florida workers' compensation program.

One of the seven provisions cited by the Court is the heightened standard of "major contributing cause" compensability standard found in Section 440.09(1). As previously discussed (in Section V), Thomason and Burton (2001) estimated that a series of legislative provisions in Oregon resulted in benefits (and costs) being about 25 percent below the amounts they would have been in the absence of the more restrictive eligibility standards. The legislative provisions included a requirement that the work injury be the major contributing cause (MCC) of the worker's disability in order for the worker to be eligible for any workers' compensation benefits. While there were other restrictive provision that probably interacted with the MCC requirement in Oregon to produce a reduction in benefits of that magnitude, many of those features (such as a heightened burden of proof) were also introduced into the Florida workers' compensation statute. I do not see how the Supreme Court of Florida could find Section 440.09(1) to be constitutional using the standards articulated in *Castellanos* and *Westphal*.

E. Tort Suits in Federal Courts: A Phantasmic Exercise

I am concerned about a number of recent developments in workers compensation, but let me focus on two "innovations": (1) the opt-out provision In Oklahoma, and (2) the adoption of the MCC causation standard, especially when the MCC provisions is linked with a prohibition on tort suits for workplace injuries and diseases that do not qualify for workers' compensation benefits – the dual denial doctrine (DDD).

Fortunately, the recent *Report of the National Commission on a Modern Employers' Liability Act* provides at least a partial antidote to the Dual Denial Doctrine. Here are the MELA Commission's key recommendations for the Modern Employers' Liability Act. (To reduce any confusion about the origins of the MELA, I would describe it as phantasmic. An alternative description provided by Professor Les Boden is phantasmagorical.)

(1) A worker who does not receive workers' compensation benefits from a state workers' compensation program for a work-related injury or diseases is entitled to bring a negligence suit in the federal courts.

(2) The causation standard in the negligence suit under the act is: "The defendant's conduct is a cause of the event if it was a material element and a substantial factor in bringing it about" (Prosser 1955, §44).

Prosser (1955, §44) describes another rule, commonly referred to as the "but for" rule," which is "The defendant's conduct is not a cause of the event, if the conduct would have occurred without it." However, Prosser states that the "substantial factor" test is "clearly an improvement over the "but for" test," although "in the great majority of cases, it amounts to the same thing."[14]

The MELA Commission interprets the causation standard endorsed by Prosser as equivalent to the causation standard that was traditionally used in workers' compensation, which is often described as "the employer takes the worker as it finds him or her." As such, the causation standard endorsed by the MELA Commission would find the employer negligent in many cases that no longer qualify for workers' compensation benefits in those states using the Major Contributing Cause standard of causation.

(3) The common law defenses available to negligent employers are abolished, including the fellow servant rule, the contributory negligence doctrine, and the assumption of risk doctrine.

(4) The injured worker has the burden of proof and must establish that it is more likely than not that the conduct of the employer was a substantial factor in causing the result of the injury.[15]

(5) The injured worker is entitled to the full range of damages available in negligence suits.

(6) The MELA Commission is still wrestling with the issue of whether negligence suits can be brought under the MELA when the worker obtains some benefits from a state workers' compensation program but those benefits are inadequate.

(7) The MELA Commission debated whether there was a need for a federal tort remedy instead of relying on remedies in state courts. The Oregon Supreme Court did an admirable job of striking down the dual denial doctrine as unconstitutional in 2001, the Pennsylvania Supreme Court implicitly repudiated the dual denial doctrine as inconsistent with the workers' compensation statute, and the recent Florida Supreme Court decisions all suggest that states can solve the problem without federal intervention. However, the MELA Commission decided to endorse a federal solution for three reasons. First, some states have upheld the dual denial doctrine in response to constitutional challenges but the successful challenge in Oregon has now been reversed. Second, even if a state holds the dual denial doctrine unconstitutional, the state may not allow tort suits that meet the recommendations of the MELA Commission.[16] Third, the opt-out provision as adopted in Oklahoma may allow employers to rely on ERISA preemption to fend off tort suits in state courts.

(8) The *Report of the National Commission on a Modern Employers' Liability Act* is an unpolished and incomplete document. The staff only had access to Wikipedia and an ancient edition of Prosser's *Handbook of The Law of Torts* during the drafting frenzy. The MELA Commission looks forward to constructive suggestions from legal scholars to provide assistance during the preparation of the next version of the MELA Report.

(9) The ultimate purpose of the enactment or threat of enactment of the Modern Employers' Liability Act is to persuade policymakers that expanding the coverage of state workers' compensation laws is a better strategy than shrinking the coverage.

VIII. The Future of Workers' Compensation

I suggested earlier that the current threat to the state workers' compensation system is a race to the bottom among states. Unfortunately, I do not think that any of the solutions to this threat I just discussed – such as Federal standards or a Modern Employers' Liability Act – will be enacted.

Does this mean the entire state workers' compensation system will eventually collapse into a black hole? Or will the state system survive largely in its current constellation, with some states maintaining adequate benefits, broad coverage of workers, and expansive compensability rules, while other states plunge into the abyss? One problem is that states that try to maintain decent programs will increasingly find their workers' compensation costs under attack as other states pass them by on the way to the bottom.

In my view, the state workers' compensation system is in its most dire situation in at least the last half-century.

But lest you take my prediction too seriously, allow me to close with two examples of bad prognostications. In 1986, I co-authored a chapter on the recent moderation in workers' compensation costs in which we predicted that the decline in workers' compensation costs in the early 1980s was likely to persist for many years (Burton, Hunt, and Kruger 1986). Alas, by the time the chapter was published, workers' compensation costs had already started a rapid increase in costs that persisted for the rest of the decade. I tried to retract our chapter, but it was too late to head off the dissemination of the unduly optimistic forecast.

And for those who are disturbed by my doleful assessment about the future of workers' compensation, it is

worth remembering that the premier study of workers' compensation published more than a half-century ago (Somers and Somers 1954) concluded with a chapter entitled "Workmen's Compensation at the Crossroads." The thrust of the chapter was that the problems of the program threatened its future unless fundamental changes were made. The program's name may have changed and the problems are different from those of concern in 1954. But the experience of the intervening years suggests that the fundamental attributes of workers' compensation – a system confined to work-related injuries that provides limited benefits on a no-fault basis – are hard to successfully challenge and may be immutable.

And so let us not be too pessimistic about the future of workers' compensation. Indeed, I look forward to joining you for the 100th Anniversary of the Florida Workers' Compensation Law.

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Endnotes

1 The other common law doctrines, which were part of the "unholy trinity" that severely limited the ability of workers to recover from their employers for workplace injuries in tort suits, were the contributory negligent doctrine and the assumption of risk doctrine (Willborn et al. 2012: 859-63). The contributory negligence doctrine precluded the employee from any recovery if he or she were negligent, even if the employer was the primary negligent party The assumption of risk doctrine barred recovery for the worker who was injured by the ordinary risks of employment as well as the extraordinary risks of employment if the worker knew of them or might reasonably have been expected to know of them.

2 The federal government was also able to enact an employers' liability act for railroad workers, since railroads were directly engaged in interstate commerce.

3 As noted by Sengupta and Baldwin (2015, note 1): "The New Jersey law was enacted on April 3, 1911, signed by Governor Woodrow Wilson on April 4, and took effect on July 4, 1911 (Calderone 2011). The Wisconsin law was enacted and took effect on May 3, 1911 (Krohm 2011)."

4 A brief article summarizing the book is Thomason, Schmidle, and Burton (2001b), which can be downloaded from www.workerscompresources.com.

5 The NCCI compared eight southeastern states in the August 2016 rate filing (NCCI 2016), including Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, and Tennessee

6 Recent data from the NCCI (2016, Exhibit 2) indicate that statutory benefits increased by 1.2 percent from 2011 to 2015.

7 The relative stability of statutory benefits in the national data shown in Figure 7 masks the significant changes in some jurisdictions. In 2014, for example, there was a 24.1% decline in cash benefits in Oklahoma and a 16.6% decline in cash benefits in Tennessee (NCCI 2016, Exhibit 3).]

8 The major contributing cause (MCC) causation standard varies among states. For example, the MCC requirement proposed by Illinois Governor Rauner has several significant differences than the MCC requirement contained in §39-71-407 of the Montana workers' compensation statute. The MCC requirement adopted in most states applies both to injuries and diseases, while the Montana provision applies only to occupational diseases. The MCC requirement in other states requires the workplace to be more than 50 percent responsible for the injury compared to all other causes, while the Montana MCC statute only requires the workplace to be "the leading cause contributing to the result when compared to all other contributing causes." My understanding of *Montana State Fund v. Clarence Grande*, 2012 MT 67, is that the MCC requirement in Montana does not require the work-related cause to be more than 50 percent responsible for the injury compared to all other causes, but rather only requires the work-related cause to me more important than any other cause. Moreover, in most states the MCC requirement has been designed both to deny the worker access to workers' compensation benefits and to deny the worker the right to bring a tort suit for claims that are precluded by the MCC requirement. This "dual denial doctrine" (DDD) is discussed later in this presentation.

9 The figures included in this paragraph are from Sengupta, Baldwin, and Reno (2014).

10 The Patient Protection and Affordable Care Act (PPACA) is commonly called the Affordable Care Act (ACA) or Obamacare.

11 A successful challenge was *Automated Conveyor Sys. V. Hill*, 362 Ark. 215 (2005), in which the Arkansas Supreme Court stated that disallowing a tort suit for injuries not expressly covered by the

• *National Developments – continued*

workers' compensation act "is not in line with its stated purpose and, in addition, would contravene . . . the Arkansas Constitution." An unsuccessful constitutional challenge to the dual denial doctrine In Kentucky is discussed in Willborn et al. (2012, 901.)

12 The basis for a challenge to the dual denial doctrine under the U.S. Constitution is provided in Willborn et al. (2012, 901-902).

13 This discussion of *Tooey* is largely based on Torrey (2014).

14 Prosser (1955, § 44) also states that "If the defendant's conduct was a substantial factor in causing the plaintiff's injury, it follows that he will not be absolved from responsibility merely because other causes have contributed to the result."

15 Prosser (1955, §44): "On the issue of the fact of causation, as on other issues essential to the case, the plaintiff has the burden of proof. He must introduce evidence which affords a reasonable basis for the conclusion that it is more likely than not that the conduct of the defendant was a substantial factor in the result."

16 Pennsylvania is an example of a jurisdiction where the tort remedy may be deficient. The Casey Act, Pennsylvania's variant of an employers' liability act, was interpreted narrowly to allow the fellow servant rule to be used as a defense by a negligent employer (McIntyre 2015, 55-61). Moreover, the Casey Act was repealed in 1983 (McIntyre 2015, 59), which presumably means that the full set of employer defenses used by negligent employers to avoid liability in tort suits, including contributory negligence, are available in Pennsylvania.

Congratulations to
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left to right: Michael Winer, Thomas Conroy, and Richard Chait

Legislative Update

By Fausto Gomez

I write this as the Florida Legislature recently concluded its session and all of us who have an interest in Workers' Compensation are waiting for the Florida Supreme Court to decide the three cases on their docket. Those rulings will govern our future political lives and the legislature will surely meet to address any issues that the Court may find deficient. It is impossible to predict with any certainty how the Supreme Court will rule, but it instructive that interest groups are positioning themselves for any eventuality. This includes the Section as we continue to meet with elected and appointed officials to give voice to our approved agenda.

The 2016 legislative session was a rather staid. Aided by a political environment in which all 40 Senators and 120 House members are facing election this November and overlaid with the recent history of Tallahassee dysfunction, legislators presided over a relatively smooth session. The main points of disagreement were with the Governor. His economic development priorities were not funded, his proposed tax package was significantly curtailed, his budget plan to primarily fund K-12 education with local property tax dollars ("Required Local Effort") was rejected, his negotiated gaming compact with the Seminole Tribe was mostly ignored, and his Secretary of the Department of Health was not confirmed. Because of this, a significant number of budget vetoes were expected and talk was rampant that legislators would convene to override the Governor's actions. Astoundingly, the budget passed both the Senate and the House with only one negative vote.

In the workers' compensation arena only CS/HB613 by Representative Sullivan passed. Of major import in the bill were changes to the Expert Medical Advisors (EMA's). These changes were proffered as a result of Judge of Compensation Claims (JCC) allegedly having difficulty finding an eligible EMA because there are either too few in a particular specialty or the EMAs present in the local area may have a conflict.

As you know, currently a JCC receives medical evidence and testimony in the course of administering their assigned cases. Whenever there is a conflict in medical evidence or medical opinion, the JCC will appoint an EMA to address the conflict. EMA's are certified by the Department of Financial Services (DFS).

CS/HB613 allows an injured worker and an insurer to jointly select a health care provider to participate in their case as an EMA. Since there are no particular qualification requirements specified for a jointly selected EMA, the parties have maximum flexibility in choosing a mutually agreed provider. This includes the ability to choose a provider who is not currently certified by DFS. If the parties are unable to jointly agree on a provider, the JCC may designate an EMA of his/her choosing. In both circumstances, the selected EMA is not required to be certified by DFS but will continue to be subject to all existing procedural requirements in statute.

Another item paid particular legislative attention by the Section was a request for an increase in judicial pay for the JCCs. Notwithstanding the fact that the request would be funded from the Workers' Compensation Trust Fund rather than General Revenue, we were told by legislative leaders that there would be no judicial increases. We were further told that a more appropriate time to discuss JCC compensation was when the legislature addressed the implications of whatever rulings are issued by the Florida Supreme Court.

As a point of comparison, the legislature did not fund a similar request from Chief Justice Jorge Labarga who argued that similar to JCCs, the last cost-of-living adjustment was in 2006 and in 2010 judges, for the first time, had to contribute their state pensions with 3% of their yearly earnings. Neither did the legislature fund 24 new Article V judgeships around the state; the 8th year in a row that the courts were denied a request for more judges. And in the Governor's budget request to the legislature, issued prior to the Session, there was no recognition of the $47 million requested for different judicial purposes. Included in these was monies to improve the system's technological staffing and infrastructure and the Governor did not either recommend $8.4 million in salary increases to retain prosecutors and almost $1 million to boost the pay of investigators.

As a Section and profession, and just like policy-makers in Tallahassee, we are waiting for the Supreme Court to rule. That will begin heated policy discussions and a period of intense legislative activity. As your representatives, the Section is squarely in the midst of all preliminary discussions to date and we will continue to actively advocate for the Section's legislative priorities.

My team and I take pride in representing you trust you will not hesitate to contact me if you have any questions or desire additional information.

To D or not to D? That is the Question.

By JCC David Langham

In 2013, the Florida legislature amended Fla. Stat. 90.792 to adopt the "Daubert" ("D") standard instead of the existing "Frye" ("F") standard. This affects the admissibility of expert evidence. A great article on what the change means for expert witnesses is Adoption of Daubert in the Amendment to F.S. §90.702 Tightens the Rules for Admissibility of Expert Witness Testimony.[1] The transition to Daubert seems straightforward at first glance, but it has become interesting lately. On January 1, 2016 the Florida Bar Board of Governors voted to endorse the Frye standard[2] and recommend to the Supreme Court to ignore the Florida Evidence Code.

America's legal system has many similarities with England's. The following may provide too much background for attorneys, but many non-lawyers also read these posts. Our foundation use of English law is a natural consequence of their prevailing presence on the continent and our colonial origins. Thus, we follow a system called the Common Law, which involves law being developed by courts over time, through interpretation and judicial opinions.

Statutes may adopt or change the Common Law. Statutes are not developed by judges, but are enacted in this country by the people's representatives in legislative bodies, like our Florida legislature. There is an advocated advantage to the statutory body of law, that it comes to us through those elected by us. It is perceived that a disgruntled populace may therefore change the law by electing different representation.

America is a Constitutional Republic, with the very definition of its governance imparted from the people to the government. The context of this grant of authority is the United States Constitution and those subordinate constitutions of the various states. Through these grants is government established and authorities are both defined and restricted.

There are two major legal divisions that define divisions of power or authority in American government. The first separates state authority from federal authority and is called "federalism." The second variation involves delineation and definition of authority between the various branches of either the federal or the state government and is called "separation of powers."

Through separation of powers, government branches, the Executive, Legislative and Judicial have respective specific powers. They are precluded from taking powers that are not granted to them, called "encroachment," and likewise are precluded in many instances from giving their respective powers to other branches, called "delegation."

The very existence of workers' compensation is an example of delegation. The legislative power over workplace injuries was delegated by the legislature to the Office of Judges of Compensation Claims, part of the Executive branch of government. Florida workers' compensation has reasonably recently experienced debate of appropriate delegation. The history of the Supreme Court's Rules of Workers' Compensation Procedure is explained in its 2004 opinion *In Re Amendments to the Florida Rules of Workers' Compensation Procedure*.[3]

Essentially, the Supreme Court promulgated workers' compensation procedural rules in 1973, directing how proceedings in this administrative (executive) agency would progress (this, it turns out was "encroachment"). The Court in 1973 explained that its authority was rooted in its inherent rule-making authority. Legislative action in 1974, endorsing the Court encroachment of procedural rules, was interpreted as delegating to the Court the legislative authority for rule-making, that is, rules to effectuate the statute.

For thirty years, the Court periodically updated the Rules of Workers' Compensation Procedure, until in 2004 it considered the question anew. Someone then did more than accept on faith that the Court had authority, and with this analysis it concluded "this Court lacks the authority to promulgate rules of workers' compensation procedure." The Court concluded that it neither had the inherent authority, and that the Legislature's grant of authority was inappropriate. In other words, the Court had been wrong all along, thirty years.

We return now to 2016 and the evidence code. The Common Law, that is judicial decisions, historically evolved in America generally and Florida specifically to provide standards that defined what evidence would be admissible in trials. There were decisions outlining and defining what demonstration or showing would be required to admit or exclude various kinds of evidence. In 1972, drawing from these court decisions, the *Federal Rules of Evidence* were adopted by the United States Supreme Court.

In 1976, following the federal example somewhat, the Florida Legislature enacted Florida Statutes Ch. 90, the "Florida Evidence Code." This statute purports to regulate the questions of evidence admissibility for disputes in Florida. The scope and applicability are defined in Fla. Stat. §90.103 "Unless otherwise provided by statute, this

• *To D or not to D? – continued*

code applies to the same proceedings that the general law of evidence applied to before the effective date of this code." The statute replaced then existing Common Law.

An issue was then raised by attorneys, questioning whether the Florida Legislature had the authority to enact this evidence code (note that Congress did not enact the *Federal Rules of Evidence*, those were adopted by the U.S. Supreme Court). The attorney's argument was essentially that some provisions of the Code affected procedure before the Courts, and thus was a legislative encroachment upon the inherent rule-making authority of the Florida Supreme Court.

In what may seem to many a strange process, it is the Florida Supreme Court that decides whether that Court does or does not have authority. By the same doctrine the Court is likewise the arbiter of whether any other branch is guilty of encroachment or improper delegation. In this regard the Court gets the last word. The Court makes its own rules, and decides constitutional issues, including those of separation of powers, encroachment, delegation, etc. See In Re Amendments to the Florida Rules of Workers' Compensation Procedure.

Thus the question came before the court in 1979, in *In Re Florida Evidence Code*, 372 So.2d 1369 (1979); does Chapter 90 F.S. control the processes of admitting evidence in Florida disputes?

It is noteworthy that this question was not brought to the Court in an adversarial proceeding. Adversarial proceedings are fundamental to the American judicial process as a whole. There is a core belief that legal questions will be best decided when they are presented in an adversarial setting, with all sides of the dispute being heard. In Constitutional law parlance, the people bringing such a dispute must have "standing," which is a personal interest in the dispute and an actual harm or benefit resulting from the dispute. The belief is that such parties will be zealous in prosecuting and defending, and the full breadth of the dispute will be presented for impartial decision.

Instead, this consideration of the applicability of the new Evidence Code was an administrative proceeding. Objections and comment about the Code were reviewed but there was no adversarial process as such. The Court concluded that the Code did apply. However, the Court perceived that there was a potential for various questions to arise regarding the applicability of the Code, and the Court therefore "adopted" the legislatively enacted "code" in a general sense, while deferring for another day any specific questions that might address particular elements of the new Code. Thus, in the 1970s, an evolution brought Florida evidence from a Common Law process to a legislatively adopted statutory process, and the Florida Supreme Court accepted or adopted that evolution.

Since that time, the Rules of Evidence have come before the Court periodically in similar administrative postures. This is a familiar process for attorneys, as the various procedural rules of court are likewise presented to the Court in a periodic cycle. The Florida Bar proposes and reviews changes, public comment is solicited, and the Court thus maintains various rules of procedure in civil, criminal, family, and other types of legal matters. The merits of those rules are generally accepted through this non-adversarial administrative process.

In the first such periodic consideration *In Re Florida Evidence Code*, 372 So.2d 1369 (1979), the Court discussed the potential for conflict and sought "to avoid multiple appeals and confusion in the operation of the courts." The Court therefore adopted "temporarily the provisions of the evidence code as enacted" as "rules of this Court." Any question of separation of powers was thus avoided for another day.

Months later, titled *In Re Florida Evidence Code*, 376 So.2d 1161 (1979), the Court reiterated its adoption and endorsement of the Code following input from the bar, and clarified the effective date of the Code, in so far as it was also procedural rules. There is again no discussion of separation of powers. The adoption process was repeated in 1981. In re Amendment of Florida Evidence Code, 404 So.2d 743 (Fla. 1981). It was repeated again in 1986. *In re Amendment of Florida Evidence Code*, 497 So.2d 239 (Fla.1986), and 1993. *In Re Florida Evidence Code*, 638 So.2d 920 (Fla. 1993). These appear to be fairly straightforward "adoptions" of of statutory amendments.

In 1996, the Court again considered evidence. Citing its authority under article V, section 2(a) of the state constitution (inherent authority), the Court rendered *In Re Florida Evidence Code*, 675 So.2d 584 (1996). It considered the recommendation of The Florida Bar to adopt multiple statutory changes to the Code, and "amend the Rules of Evidence to conform to statutory changes in the Evidence Code."

The Court thereupon, again, adopted "the amendments to the Evidence Code to the extent that they concern court procedure. These amended rules are effective on the dates the bills became law." In this decision appears the term Rules of Evidence (in capitals as a proper noun) in conjunction with the "Evidence Code." There is purportedly both a Code and Rules.

Then, in 2000, the Court departed from the legislature. *In Re Amendments to the Florida Evidence Code*, 782 So.2d 339 (Fla. 2000). The Court disagreed with the "admission of former testimony" from a witness, if that witness was at the time of trial "available as a witness." The Bar perceived the law passed by the legislature would broaden an exception to the hearsay prohibition (many out-of-court statements cannot be repeated in court except by those who uttered them out of court to begin with).

• *To D or not to D? – continued*

In declining to adopt the 2000 legislation amending Chapter 90 of the Florida statutes, the Court noted that a similar change previously passed the legislature, and was vetoed by the then Governor. The Court seemed to place some stock in what the former Governor said about the amendment in his veto message. The Court did not adopt the amendment to Fla. Stat. 90.803. Conversely, and curiously, the opinion does not discuss the approval (or absence of veto) of the 2000 amendment by the then-serving Governor. Again, this was not an adversarial proceeding with multiple parties presenting opposing views.

So, 2000 brings the first instance of rejection. The Florida Bar committee recommended rejection and the Court agreed.

In 2002, the Court returned to the pattern of adopting legislative changes. *In Re Amendments to the Florida Evidence Code*, 825 So.2d 339 (Fla. 2002). In the 2002 opinion, the Court noted a committee of The Florida Bar recommended against adopting one of the statutory changes. The recommendation was "unanimously approved by the Board of Governors of The Florida Bar." Nonetheless, the Court "after hearing oral argument, and carefully considering the committee's recommendation against," "decline(d) to follow this recommendation" and adopted all of the legislative amendments. It is notable that three of the justices dissented from the decision.

As an aside, appellate courts, including the Florida Supreme Court generally decide cases in a consensus fashion, rather than as individual judges. When a single judge or minority group of judges disagrees with the majority conclusion(s), the minority group writes a separate opinion, called a "dissent" explaining why the minority would have made a different decision.

The 2002 opinion also provides some insight into the administrative process. The Court noted, in adopting the contested change, that "in the absence of a true 'case and controversy,' we express no opinion on the substance of the amendments or on the challenges" raised by the committee, the bar or the public in comments. This is a reference back to the belief in an adversarial justice system in which those with a real interest in the outcome (standing) are charged with presenting to a court the arguments for or against a law. About 20 years into the habit of administrative review and adoption, the Court voices some deference to the adversarial system.

The Court's approval process essentially continued in 2004, *In Re Amendments to the Florida Evidence Code*, 891 So.2d 1037 (Fla. 2004) with one provision deferred but then adopted the next year. *Amendments to Evidence Code-Section 90.104*, 914 So.2d 940 (Fla. 2005). Statutory amendments were again adopted in 2007. *In Re Amendments*, 960 So.2d 762 (Fla. 2007).

In 2011, the Court again considered statutory amendments. In this opinion, the court again adopted statutory amendments. *In Re Amendments to the Florida Evidence Code*, 53 So.3d 1019 (Fla. 2011). The Court again in 2011, noting its caution in 2002, stated "we express no opinion on the substance of the amendment." Thus, another nod to the usual adversarial methodology of decision-making within the confines of cases and controversies.

In December 2013, the Court rendered *In Re: Amendments to The Florida Evidence Code*, No. SC13-98 (Fla. Dec. 12, 2013).[4] Leading up to this consideration, a committee of The Florida Bar recommended adoption of a variety of legislative amendments to the code. The Court declined that recommendation. The decision was based, regarding one provision, on the Court "question(ing) the need for the privilege (fiduciary)." In regards to another section ("statement offered against a party"), the rejection was based on "concerns about its constitutionality," and a third (regarding medical negligence) due to concerns regarding constitutionality and that it would be "prejudicial to the administration of justice."

Months later, in July 2014, the Court issued a "Revised Opinion" which withdrew the December 2013 opinion. *In Re Amendments to the Florida Evidence Code*, 144 So.3d 536 (2014). In this, it reiterated its conclusion and rejection regarding the privilege provision, and the medical negligence provision. But, the Court adopted the legislative change regarding the "statement offered against a party." Two justices dissented regarding this decision, one who would have adopted all the changes, and one who would have rejected all three as the Court initially did in December the year before.

This second dissent is interesting. The justice writing it concluded with a concern "that we are neither promoting the administration of justice nor furthering the goals of the Florida Evidence Code" with this adoption. The justice notes the Code is "designed to ensure and

• *To D or not to D? – continued*

increase the reliability and quality of evidence admitted in Florida Courts." The conclusion: "because of the nuances connected with this issue, I would await a case or controversy to consider this statute, determine its constitutionality, and if constitutional, ensure that the procedures for the predicate for admissibility are clearly set forth;" in dissenting, a reference to the generally accepted judicial process of adversarial proceedings.

Thus, in 2013, the Court again rejects legislative enactments. The "Rules" depart from the "Code." This instance is notable because, unlike the 2000 rejection of legislative change this departure disagrees with the recommendation from The Florida Bar.

And today, the Court has for consideration the recommendation of The Florida Bar to reject the 2013 statutory amendment to Fla. Stat. 90.792 adopting the "Daubert" standard instead of the existing "Frye" standard for admissibility of expert evidence.

What has this long (very long) history of the Florida Evidence Code taught us? First, is that the legislature's role in the evidentiary process seems to be generally accepted. The Court has repeatedly adopted those changes (to the extent they are procedural). The Bar has been involved in this process since the beginning. On occasions the Court has adopted Bar recommendations as presented, and has also rejected Bar recommendations. It has relied curiously upon the veto messages of former Governors in justifying decisions. It has changed its mind on questions of adoption. And the justices have not always been unanimous on their conclusions and views.

From these lessons, we can conclude that the Court may well adopt (as a procedural rule) Daubert for Florida courts. This would bring Florida in line with the American trend (Fourteen states still use Frye,[5] that is if Florida continues to do so). The Court may likewise reject Daubert for Florida courts.

But, from its 2004 opinion *In Re Amendments to the Florida Rules of Workers' Compensation Procedure*, it seems likely that the Florida Supreme Court decision regarding Daubert, if it rejects Daubert as recommended by The Florida Bar, will not affect the Florida Office of Judges of Compensation Claims (OJCC).

The Court authority cited, in adopting or rejecting various statutory amendments historically, has been its inherent rule-making authority. The Court has concluded that it has no such rule-making authority for the OJCC. Therefore it is probable that the statutory Evidence Code will control the questions of evidence before this executive agency.

In one potential outcome, from which many find no solace, it is possible that the Court could reject Daubert, rendering the Frye standard applicable in Florida state courts, and the legislative adoption of Daubert could be relegated solely to applicability in workers› compensation and other administrative, executive branch, disputes and cases.

Critics of the Daubert standard have repeatedly voiced their contention that in this administrative (OJCC) process, devoid of juries, the concerns addressed by Daubert are of less concern than in the Circuit and County court systems. In other words, they contend that Daubert has no place in a system in which all decisions are made by a judge (JCC) rather than jury. They find it ironic that ultimately this standard could become the norm in the dispute system in which it is (perceived) least needed.

Others question the entire administrative review process of the Court regarding laws passed by the Florida Legislature. They cite separation of powers and contend that the Court action regarding the Evidence Code is effectively either making law (a power constitutionally given exclusively to the legislature) or vetoing law (a power constitutionally given exclusively to the Governor). They contend that the Court's authority regarding such laws is limited to considering the law and effect in a true "case and controversy," that is an adversary proceeding, just as all other laws are considered or challenged in the courts.

Some suggestion of this conclusion comes from the Court's own opinions mentioning "case and controversy." Some suggestion of this comes from dissenting justices in various decisions. Some suggestion of this comes from attorneys who conjecture regarding how the Court will address this latest statutory amendment. One asked me recently if it is not possible that the Court has been mistaken about its administrative method of considering amendments to the Evidence Code for the last thirty years, just as it was mistaken regarding its authority to enact procedural rules for workers' compensation. My reply was that anything is possible.

These are some interesting issues and questions. Time will tell how this debate resolves. For now, the question is up to the Court and we all wonder for now "to D or not to D? that is the question."

Endnotes

1 Alex Cuello and Stephanie Villacencio, Adoption of Dabert in the Amendment to F.S. §90.702 Tightens the Rules for Admissibility of Expert Witness Testimony, *The Florida Bar Journal*, September/October 2014. http://www.floridabar.org/DIVCOM/JN/JNJournal01.nsf/c0d731e03de9828d852574580042ae7a/5bdc1338f1f5131785257d420051c1a5!OpenDocument&Highlight=0,Adoption,of,Daubert,in,the,amendment,to,Section,90.702,F.S,tightens,the,rules,for,admissibility,of,Expert,Witness,Testimony*, last visited February 2, 2016.

2 Gary Blankenship, Fry Standard Endorsed by Board of Governors, *The Florida Bar News*, January1, 2016. http://www.floridabar.org/DIVCOM/JN/jnnews01.nsf/cb53c80c8fabd49d85256b5900678f6c/03a3f1132f4308a685257f1d00698136!OpenDocument&Highlight=0,daubert,board*, last visited February 2, 2016.

3 In Re Amendments to the Florida Rules of Workers' Compensation Procedure, 891 So.2d 474 (Fla. 2004). http://www.floridalawweekly.com/forms/sc04-110.pdf, last visited February 2, 2016.

4 Supreme Court of Florida slip opinion, http://www.floridasupremecourt.org/decisions/2013/sc13-98.pdf, last visited February 2, 2016.

5 James W. Hunt, Admissibility of Expert Testimony in State Courts, http://www.fitzhunt.com/sites/default/files/news/Admissibility%20of%20Expert%20Testimony%20in%20State%20Courts-Hunt.pdf, last visited February 2, 2016.

Deju View All Over Again

Montanile and The Abrogation of 440.22 Assignment and Exemption From Claims of Creditor- How ERISA Disability and Group Health Subrogation Claims Can Destroy a Workers' Compensation Case and Settlement

By Nancy L. Cavey

Introduction

Workers' compensation claimants are often provided short term disability (STD), long term disability (LTD) and group health care benefits through their employer. Far too often, the injured claimant/policyholder, the employer/carrier and the parties' attorneys simply don't understand, ignore, and fail to deal with the impact of the receipt of these benefits on a workers' compensation claim and settlement because of F.S. 440.22 "Assignment and Exemption From Claims of Creditors."

This can be fatal and destroy a workers' compensation case and settlement.

F.S. 440.22 "Assignment and Exemption From Claims of Creditors" provides, in part:

> *"No assignment, release or commutation of compensation or benefits due or payable under this chapter except as provided by this chapter shall be valid, and such compensation and benefits shall be exempt from all claims of creditors, and from levy, execution and attachments or other remedy for recovery or collection of a debt, which exemption may not be waived."*

The U.S. Supreme Court's decision in *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan*, 2016 U.S. LEXIS 843 (2016) was a wake-up call for disability and group health insurance carriers.

The *Montanile* case reaffirms that insurance companies have a right to be repaid any benefits the carrier paid if the policy holder receives other income benefits. "Other income" benefits can include personal injury settlements, workers' compensation benefits and even the receipt of Social Security benefits.

As a result of *Montanile*, disability and group insurance companies are becoming more aggressive about pursuing reimbursement from policy holders who are paid workers' compensation benefits or who have settled their claims.

The first question we need to ask is whether F.S. 440.22 is preempted by Federal law.

ERISA Preemption of Anti-Subrogation Laws

A number of state have passed "anti-subrogation" laws that impact managed care, personal injury and workers' compensation cases.

For example, New Jersey's workers' compensation law prohibited a pension from offsetting benefits by the receipt of workers' compensation benefits. Two suits were filed in New Jersey state court by retired employees whose pension benefits were reduced by the amount of a workers' compensation award and these suits were removed to Federal District Court.

Each Federal judge held that the pension offset was invalid under the New Jersey Workers' Compensation Act and were contrary to the intent of ERISA. The United States Supreme Court in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) held that the New Jersey workers' compensation statute was preempted because pension plans are governed by ERISA.

How does preemption work and what about F.S. 440.22?

Preemption of Anti-Subrogation and the Eleventh Circuit

As a general rule, under ERISA's savings clause, 29 U.S.C. Section 1144(b) (2) (A), a state law that regulates insurance are saved from preemption. Anti-subrogation clauses like F.S. 440 have been challenged with no consistent result. There is no reported 11th Circuit case addressing whether F.S. 440.22 is preempted by Federal law.

So, how do we determine if F.S. 440.22 is preempted by ERISA?

The Eleventh Circuit follows the U.S. Supreme Court's decisions in *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987), *Unum Life Ins. Co. of Am. V. Ward,* 526 U.S. 358 (1999) and *Ky. Ass'n of Health Plans, Inc. v. Miller,* 538 U.S. 329 (2003) in determining whether a state statute is preempted by ERISA and removable to federal court.

Smith v. Life Insurance Company of North America, 466 F. Supp. 2d 1275 N.D. Ga. 2006) is instructive of how one federal court in the 11th Circuit views the issue of reimbursement of medical expenses for disability benefits providers in personal injury cases.

The case involved a CIGNA's plan which allowed the plan insurer to set off disability benefits by the amount of the participant's third party recovery. Smith challenged CIGNA's offset under Georgia's anti-subrogation statute C.O.C.G.A. Section 33-24-56.1 which prohibited such an offset.

The Georgia court held that "to effectively contract out

• *Deja View* – *continued*

of the default rule of the federal common law make whole doctrine, an ERISA plan must include language specifically allowing the plan the right of first reimbursement out of any recovery the participant was able to obtain even if the participant was not make whole."

CIGNA had not written the plan in a manner to contract out of the federal common law make whole doctrine.

The court then turned its attention to whether Georgia's anti-subrogation clause was preempted by ERISA and noted that under the ERISA "savings clause" a statute that relates to an employee benefit plan may not be preempted if it "regulates insurance." Even if state law regulates insurance and falls within the savings clause, ERISA's "deemer clause" may exempt ERISA plans from state regulations.

The United States Supreme Court ruled in *Kentucky Assn. of Health Plans, Inc. v. Miller,* 538 U.S. 329, 341-342, 123 S.Ct.1471, 155 L.Ed.2d 468 (2003) that a law regulates insurance if the law is specially directed toward the insurance industry and substantially affects the risk pooling arrangement between the insurer and the insured.

The *Smith* court noted that Georgia's anti-subrogration statute was related to employee benefit plan. C.O.C.G.A. Section 33-24-56 is located within Georgia's Insurance Code, is directed toward the insurance industry, and affects the risk pooling arrangement between the insurer and the insured.

The key factor in the Court's analysis which is easily overlooked is whether the plan in question is an insured plan or a self-funded plan.

ERISA Attorney Jeffrey S. Warncke, who represented Mr. Smith, reminds us that the federal common law "make-whole" and "common fund" doctrines are the default rules, even in the absence of anti-subrogation statute. A self-funded plan can reject federal common law only with clear language in the Plan, regardless of whether there is an anti-subrogation state statute.

An insured plan can reject federal common law only with clear plan language and a state anti-subrogation statute that survives preemption.

Does 440.22 Survive Preemption?

440.22 is not located in the Florida Insurance Code, is not directed toward the insurance industry and does not regulate insurance. It is the author's opinion based on the aforementioned cases that F.S. 440.22 is preempted by ERISA and any lawsuit would be removed to Federal Court.

This reasoning is supported by an Eleventh Circuit ruling finding that Florida's bad faith statute F.S. 624.155 is preempted in *Anschultz v. Conn. Gen. Life Ins. Co.,* 850 F.2d 1467 (11th Cir. 1988), most managed care issues are preempted in *Connecticut State Dental Ass'n v. Anthem Health Plans, Inc*., 591 F.3d 1337, 1345 (11th Cir. 2009) and a state law malpractice claim against an HMO is preempted in *Land v. Cigna Healthcare of Fla.,* 381 F.3d 1274 (11th Cir. 2004).

The issue then becomes whether the clear language of the self-funded or insured plan has clearly rejected the "make-whole" and "common fund doctrine" with clear Plan language.

The Evolution of ERISA Lien Case Law

Disability and health benefits provided by an employer other than churches or municipalities are governed by Employment Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. Section 1001, ET. seq., 29 U.S.C. Section 1003(a). As a result a reimbursement or subrogation dispute involving only an injured church plan or municipal employee will be governed by Florida state law.

ERISA Section 502(a) (3) provides, in part, that a plan fiduciary can file a civil suit to enforce the terms of the plan or policy. Plan or policy provisions commonly require reimbursement of the payment of disability and group health benefits and provide for an equitable lien on workers' compensation benefits and workers' compensation settlements.

An ERISA plan/policy cannot sue a tort feasor or the liable insurance carrier for a recovery. ERISA only creates reimbursement rights based on a recovery by a participant or beneficiary.

The Supreme Court has addressed in a series of cases the civil remedies available to fiduciaries under ERISA when the policy holder fails to reimburse the carrier/plan.

In *Great-West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204 (2002), the plan fiduciary sued Knudson based on the contract language found in the policy instead of asking for restitution from specific funds or identifiable property in the participant's possession.

An ERISA plan/policy's right of reimbursement is in equity and not in law. The plan must sue for restitution and not damages. An action against a specifically identifiable fund is a permissible equitable action.

The U.S. Supreme Court held that enforcement of a constructive trust or an equitable lien required that the money received by the policy holder had to be clearly traceable to particular funds or property in the defendant's possession.

If the workers' compensation claimant spent the money there was practically no remedy for the carrier, unless the policy holder continued to get disability insurance benefits. The disability insurance carrier would simply not pay any benefits until the overpayment was recouped.

However, if the injured claimant/policy holder spent the money on a new car, the disability carrier could proceed against the policy holder and go after the car.

What would happen if the injured claimant/policy holder placed the proceeds of the settlement in a sepa-

rate investment account? The U.S. Supreme Court held both in *Sereboff v. Mid Atlantic Medical Services, Inc.,* 547 U.S. 356 (2006) and *U.S. Airways, Inc. v. McCutchen,* 133 S.Ct. 1537 (2013) that the plan or carrier could enforce an equitable lien against specifically identifiable funds within the beneficiaries control – the settlement monies in the investment account. However, the Court went further and repudiated *Knudson* holding that a plan/carrier could go after funds not immediately in the possession of the injured party. The strict tracing rules were eliminated.

The U.S. Supreme Court upheld this line of reasoning in *Montanille* but strongly criticized the plan fiduciary for failing to respond to a notice of the distribution of settlement proceeds given by Montanile's attorney pursuant to the plan and the rules of ethics.

The next question a workers' compensation practitioner should ask is whether the disability or group health policy/plan permits the equitable remedy of reimbursement and/or subrogation under the 11th Circuit test found in *Popowski v. Parrott,* 461 F.3d 1367, 1374 (11th Cir. 2006); *James River Coal Co. Med. & Dental Plans v. Bentley,* 2009 U.S. Dist. LEXIS 65310 (E.D. Ky, July 23, 2009).

The Eleventh Circuit Test for ERISA Plan Reimbursement

Federal courts are not in the business of deciding what is right, fair or equitable in the division of a settlement recovery between a policy holder/claimant and the plan/carrier.

The 11th Circuit did not address these issues until it entered three key decisions in *Popowski v. Parrott,* 461 F.3d 1367, 1374 (11th Cir. 2006), *Popowski* v. *Parrott,* 2008 U.S. Dist. Lexis 71615 (2008) and *Admin. Comm. For The Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan v. Horton,* 2008 WL 123536 (11th Cir. 2008)

ERISA disability and group health benefits can be provided by a plan and any plan must be a self-funded from general assets or through insurance. Under the 11th Circuit test, the ERISA plan must:

1. Specify that reimbursement be made out of a particular fund that is distinct from the general assets,
2. Specify that reimbursement is not just a general reimbursement obligation based on a settlement, judgment or other payment related to an accidental injury or occupational illness,
3. Specify that the plan is entitled to reimbursement from only a particular share of a fund which a reimbursement should come from,
4. Specify and adequately reject the application of the "make whole", "common fund" and other equitable doctrines. *Popowski v. Parrott,* 461 F.3d 1367, 1374 (11th Cir. 2006).

Further:

5. The policy holder must be in possession of specifically identifiable funds,
6. The funds must belong in good conscience to the plan and,
7. The plan must assert an equitable remedy. *Admin. Comm. For The Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan v. Horton,* 2008 WL 1235536 (11th Cir. 2008)

A plan which does not meet this test cannot enforce its reimbursement or subrogation rights.

Montanile's Wake- Up Call and Workers' Compensation Claims

Since the *Montanille* case, disability and group health carriers/plans have been sending letters to injured claimant/policy holders letters about their liens.

For example, disability insurance carriers like Liberty Life Assurance of Boston (Liberty) are even sending Notice of Lien letters to workers' compensation carriers:

> *"Dear Travelers Indemnity Company:*
>
> *Liberty Life is the disability carrier for Mr. X and workers' compensation benefits are an offset to his disability benefits.*
>
> *While we are awaiting a determination of his claim for Workers' Compensation Benefits, we have begun issuing disability insurance benefits. Should a favorable decision be made on Mr. X's Workers' Compensation claim,* ***Liberty Life will require reimbursement for any amounts issued that were the responsibility of Travelers's.***
>
> ***I have enclosed a Notice of Lien for any settlement, judgment, or other recovery awarded to Mr. X for you to sign and return to Liberty Life in*** *the envelope provided. Also, I ask that you notify me as soon as a decision has been made.*
>
> Sincerely,
>
> *Financial Review Specialist II*
>
> *cc: Division of Workers' Compensation*

Amazing!

While there are no uniform disability and group health policies or plans, there are commonalities among policies that include terms like "other income", "exclusions", "reimbursement" and "subrogation" which can impact a workers' compensation claim and a settlement of the claim. Before we explore these policy terms in the context of a workers' compensation case, let's take a quick detour and consider the impact of the Rules Regulating the Florida Bar.

The Impact of The Rules Regulating The Florida Bar

• *Deja View* – *continued*

Rule 5-1.1 Rules Regulating the Florida Bar provides that:

"Upon receiving funds or other property in which a client or third person has an interest, a lawyer shall promptly notify the client or third person. Except as stated . . . a lawyer shall promptly deliver . . . to the third party any funds or property that the . . . third party is entitled to receive . . ."

The *Montanile case* reminds us that the failure to deal with the lien is a violation of the Florida Rules Regulating the Florida Bar and can subject you to a malpractice claim and even a lawsuit against you and your client.

We must also balance our duty to deal with the lien with our duty to zealously represent our clients.

Real Life Workers' Compensation Headaches Caused By Short Term Disability Claims

What happens if the injured claimant/policyholder has a short term disability policy or the employer self-funds a short term disability plan? Short term disability benefits can be as short as 3 months and as long as a year.

Can the injured claimant/policy holder collect both? Is there a reduction in either benefits for the receipt of the other benefit? Does the injured claimant/policy holder have to repay short term disability benefits that were paid while collecting workers' compensation benefits?

The answers depend on what the policy or self-funded plans provide. The policy or plan may exclude the payment of short term disability benefits if the policy holder has a disability that arises out of a work place injury. For example, a Union Security Insurance policy provides that:

> "We will not pay benefits for any *disability* caused by:
>
> - an *injury* that arises out of or occurs in the course of any *job* for pay or profit; or
> - A sickness that entitles you to benefits under any Workers' Compensation Act (or a similar law)."

That is easy. The injured claimant/policy holder isn't entitled to any short term disability benefits!

But what about the short term disability policy or plan that does allow the injured claimant/policy holder to collect both? The "other income" provisions of the short term disability plan or policy just might provide that worker's compensation benefits will reduce, dollar for dollar, any short term disability benefits.

As a result, the "over payment", "reimbursement" and "subrogation" clauses become applicable. The cash-strapped claimant/policy holder will either have their STD benefits reduced as they receive their workers' compensation benefits, or have to pay the STD carrier back at some point. This issue often comes to life at the workers' compensation mediation when the claimant gives his attorney a lien letter from the disability carrier! The mediation can quickly come to a halt!

While a claimant attorney's might be tempted to tell their client NOT to apply for short term disability benefits, most long term disability policies require the policy holder to have gotten short-term disability benefits first. If they don't, there is NO claim for LTD benefits. You've just committed malpractice and violated Rule 5-1.1.

The headaches are worse when the injured claimant/policy holder has a long term disability policy.

The Huge Headaches Caused By Long Term Disability Claims

There are three problems that workers' compensation attorneys have to be aware of if the claimant/policyholder is collecting long term disability benefits. Unlike short term disability policies or plans, most long term disability policies or plans pay disability insurance benefits arising out of a workers' compensation claim.

Problem No. 1 Workers Compensation Benefits as "Other Income"

The first problem will arise because of the receipt of workers' compensation benefits. But what kind of workers' compensation benefits can the disability carrier use to reduce the payment of benefits? Sorry, the answer depends on how the long term disability policy or plan defines "other income".

For example, the Union Security Insurance policy provides:

> **"Offset Amount**
>
> If you are eligible for any of the following benefits or other amounts, the total of all monthly benefits and the other amounts plus the pro-rated amount of any lump sum payments will be subtracted from the Schedule Amount:
> *any benefits (except medical or death benefits) or any amount received in a settlement or compromise of your rights, under:
> - any Workers' Compensation Act (or a similar law);"

This policy reduces the disability insurance benefits by temporary total, rehab TTD, temporary partial, IB's, permanent total and permanent total supplemental benefits.

Other disability policies broadly define "other income" as ***any*** workers' compensation benefits.

What the workers' compensation carrier gives the disability carrier takes away and creates a lien if the not repaid.

Problem 2. We Will Still Reduce Your Benefits If You Don't Apply For Workers' Compensation Benefits

The Union Security policy allows Union Security to estimate the amount of the workers' compensation benefits and to calculate an offset:

• *Deja View – continued*

"If it is reasonable to believe that you would be paid such benefits or other amounts from any of the above sources or it is reasonable to believe that you would be paid such benefits or other amounts if you had applied for them or had applied for them on time."

The practical impact of this provision is that even if the injured claimant/policyholder did not apply for workers' compensation benefits or the statute of limitations has run, Union Security can reduce disability insurance benefits as if those benefit were being received.

Problem 3. Blowing Up a Workers' Compensation Settlement

The next problem comes with the settlement of a workers' compensation case. The disability carrier/plan expects to be reimbursed what is owed because of the receipt of "other income" workers' compensation benefits which were paid before any settlement. But is gets worse!

The disability carrier/plan has the right to reduce the payment of future long term disability benefits because of the workers' compensation settlement. This can make the workers' compensation settlement worthless to the injured claimant and destroy the long term disability claim if ignored by the attorneys. After all, why would an injured claimant want to settle their case if they have to pay all the money back to the disability carrier or see their future disability insurance benefits vanish? This presents a challenge to both the employer/carrier attorney and the injured claimant/policy holder attorney.

Not only does the disability policy require that the injured claimant/policy holder protect its interests in the settlement of a workers' compensation claim, the letter from Liberty Life to Traveler's illustrate, the disability carrier expects that the workers' compensation carrier to do the same.

For far too long disabled claimants, employer/carriers and workers' compensation attorneys ignored these problems which can result is a lawsuit by the disability carrier/plan to recover its overpayment. Those days are over.

Creating a Win-Win Solution

It is crucial that the parties (a) obtain from the employer the long term disability policy, (b) review the policy so as to understand whether the other income settlement monies are just indemnity benefits or both medical and indemnity benefits, (c) how long the disability carrier will reduce the disability insurance benefits and (d) the formula that will be used to calculate the amount of the reduction.

The amount of the settlement and limitations on the ability to classify a portion of the settlement monies as medical or other benefits just might destroy the ability to settle the workers' compensation case. After all, why would an injured claimant/policy holder want to settle the workers' compensation case if they have to give some or all of the settlement to the disability insurance carrier?

Depending on the terms of a disability policy, the parties may have to:

(1) Give notice of the proposed settlement to the disability carrier.

(2) Obtain the disability carrier's approval of the allocation.

(3)Allocate the settlement monies in a way that minimizes the financial impact on the long term disability claim by obtaining appropriate documentation that supports the allocation of the settlement monies to medical, indemnity, rehabilitation and attorney fees and costs.

Innovative and out of the box thinking may be required by the parties if the "other income" language is broad. Perhaps one solution is to settle the workers' compensation case for a small sum, and then settle any potential employment related claims for the balance of any monies that would have otherwise been used to settle the workers' compensation claim. The tax consequences to the injured claimant/policy holder would also have to be addressed.

Remember that any attorney fees for the settlement for employment related claims would not be governed by F.S. 440.34

However, this must be done in a matter that does not violate the terms of the disability policy, violate Rule 5-1.1 or the proposed medical lien rule.

How Group Health Insurance Claims Makes the Headache Worse

Workers' compensation adjusters regularly make claims decisions about the compensability of an industrial accident, major contributing cause or the medical necessity of care which can result in the injured claimant/policyholder's using their group health plan to get treatment.

Let's look at a common "reimbursement" and "subrogation" clause found in a group health insurance policies or plans.

Most group health insurance policies have clauses that deal with expenses for which a third party may be responsible. For example, Cigna's Group Health Plan has the following terms:

This plan does not cover:

- Expenses incurred by a Participant to the extent any payment is received for . . . as a result of a settlement, judgment . . . in connection with any workers' compensation insurance.

"**Subrogation/Right of Reimbursement**

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claims

administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interest that a Participant may have against such Party and shall automatically have a lien upon the proceeds of any recovery . . . to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment or otherwise. . ."

In this example, Cigna has the right of subrogation and reimbursement from the proceeds of the workers' compensation settlement to the extent the group carrier has paid medical expenses for the workers' compensation injury.

But it Gets Worse!

The Cigna policy provides that by accepting the group health benefits, the Participant grants a lien and assigns to the plan:

"An amount equal to the benefits paid under the plan against ***any recovery made on or behalf of the Participant which is binding on any attorney…. who represents the Participant whether or not an agent of the Participant or any insurance company or other financially responsible party against who a Participant may have claimed provided said attorney, insurance carrier or other party has been notified by the plan or its agents***;

- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a ***security interest*** thereon;
- Agrees to hold the ***proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan."***

This policy creates a world of potential problems for both the claimant, claimant's attorney, the employer/carrier, and the defense attorney which must be addressed as part of any settlement.

The Cigna policy prohibits any assignment of any rights the Participant has to recover any medical expenses from the Employer/Carrier and ***prohibits any settlement that "specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan***. Cigna has the right to ***enforce the terms of the policy and seek attorney fees and costs for enforcement of the policy".***

The Cigna policy also allows Cigna to limit their payment for future medical care if the lien is not paid. *Cagle v. Bruner,* 112 F.3d 1510 (11th Cir. 1997).

The Cigna policy also ***abrogates any theory that would defeat the plan's recovery, including "allocating the proceeds exclusively to non-medical expense damages".***

This policy requires out of the box solutions if the workers' compensation case is to be settled! If not, you might find yourself being served as a defendant in a suit by the disability or group carrier. The 11th Circuit has even allowed the equitable tracing of attorney fees in *AirTran Airways, Inc. v. Elem,* 767 F.3d 1192 (11th Cir. 2014).

What You and Your Client Must know About the Carrier's Right to Reimbursement or Subrogation!

As you can see, what you need to know and what you have to do depends on the plan or the policy. It is not uncommon to see other terms in a group health plan/policy like:

- The injured claimant/policy holder is required to notify the plan or the carrier of the receipt of workers' compensation benefits.
- The injured claimant/policy holder is required to obtain the approval by the plan or the policy of any settlement before the settlement.
- The injured claimant/policy holder is required to notify the plan or the carrier of a workers' compensation settlement.
- The employer/carrier and their attorney have affirmative obligations to insure that the interests of the disability and group health carrier's lien is addressed.

The majority of disability and health insurance policies have language that requires reimbursement of any overpayment as a result of the receipt of benefits and *Montanile* has awoken the sleeping giant!

Practical Solutions for The Workers' Compensation Attorney

Regardless of whether you are the claimant/policy holder attorney or the employer/carrier's attorney you should do the following:

1. Ask the claimant/policy holder if they have short or long term disability insurance and group health insurance.
2. Obtain and review the claimant/policy holder's insurance enrollment forms from the employer.
3. Obtain and review the claimant's pay stubs to confirm disability and/or group insurance coverage.
4. Determine if disability and/or group health benefits have been paid.
5. Obtain the Summary Plan Description and policy/plan documents for the disability and group insur-

• *Deja View – continued*

ance coverage from the employer.

6. Review the policy/plan to understand the terms "other income", "subrogation" and "reimbursement".
7. Determine if and how workers' compensation benefits are treated under the policy/plan.
8. Determine if and how a workers' compensation settlement are treated under the policy/plan.
9. Determine what notice must be given to the carrier or plan of the payment of benefits and settlement.
10. Determine if and how the settlement monies can be favorably allocated in a settlement.
11. Determine how the claimant/policy holder will repay the group health carrier.
12. Determine how the claimant/policy holder will repay the disability carrier.
13. Determine what impact the failure to repay the group health carrier can have on continued eligibility for group insurance coverage.
14. Determine what impact the failure to repay the disability carrier can have on continued payment of disability benefits.
15. Hire a Workers' Compensation/ ERISA disability expert to give a legal opinion on these issues and chart a path to resolution of the ERISA issues and a workers' compensation settlement.
16. Have a pre-settlement demand or mediation call with opposing counsel to address these issues.
17. Explain to the claimant/policy holder how the workers' compensation proceeds should be handled by the claimant/policy holder.
18. Determine what you need to document in your file to protect you from further claims by the disability and group carrier and your clients.
19. Properly value the file for settlement and make a demand that addresses the need to repay short term disability, long term disability and group health care liens.
20. Track the disability and health care language in the mediation agreement, including notice to the disability and group carrier/plan, the disability and group carrier/plan response to notice, how these issues will be addressed in the future should the carrier/plan file suit against the parties and their counsel, and the allocation of the settlement monies.
21. Review and negotiate the release so that these issues are addressed and there is no release of any ERISA disability, health or life insurance rights or claims.

Conclusion

You can no longer say "the disability and group health carrier's lien isn't my problem" if you want to reach a settlement of a workers' compensation case. Hiding you head in the sand can result in a poor outcome for the injured claimant/policyholder, potential liability on the part of all of the parties and their counsel, and a bar grievance.

Don't put your law license at risk!

Nancy Cavey *is a Board Certified Workers' Compensation Attorney with over 36 years of workers' compensation experience as a claimant and employer / carrier attorney. She also represents ERISA and Individual Disability policy holders nationwide and pays a 25% referral fee in accordance with the Florida Bar Rules. Nancy would like to thank those ERISA practitioners who reviewed and contributed to this article!*

Workplace Safety: A Broken Promise

By Mark Zientz, Miami

"The whole is no greater than the sum of all the parts, and when the individual health, safety, and welfare are sacrificed or neglected, the state must suffer", *Holden v. Hardy*, 169 U.S. 366, 397.

At 4:40 pm on Saturday, March 25, 1911, the Triangle Shirtwaist Factory located on the 8th, 9th and 10th Floors of what was then the Asch Building in lower Manhattan. Within 18 minutes 146 sweatshop workers finishing up their 6th workday of the week perished. They were mostly teenage girls recently arrived from Europe. From a safety standpoint the workplace was a disaster. The building had only one outside fire escape that collapsed during the attempted rescue. The doors that weren't locked to prevent theft by the employees, opened inward, causing the rush to back up so the doors could not be used. There were no fire extinguishers, only a few buckets of water. Firefighters ladders could not reach above 6 floors, safety nets tore to shreds as workers flung themselves from the windows, just to land dead on the concrete.

The Triangle fire is credited with sparking (no pun intended) interest in workplace safety and the creation of workers' compensation laws. The Florida act, enacted in 1935 as one of the last states to adopt a workers' compensation law, recognized the need for government oversight of safe workplaces. A division of Safety was ultimately created with the cost borne by employers via contributions to the Administrative Trust Fund. Section 440.56 remained in the act until its eventual repeal in 2000. The act required all employers, not just those covered by the act to provide employees with a safe workplace.

Fast forward to 1970. The congress, at the urging of Republican President Richard Nixon passed the Occupational Safety and Health Act (OSHA) making Federal law on safety applicable to all private businesses in interstate commerce. That meant a presumption that employers of less than 10 employees were not in interstate commerce and exempt from compliance and monitoring. OSHA also exempted all state and local government operations from coverage and inspections. In Florida the largest segment of the employment sector is government. Adding in all the small businesses makes the exempt category a large majority of Florida workers. When 440.56 was on the books, small business, government and large private employers were all covered by the regulations enacted to make workplaces safer. After July 1, 2000, the vast majority of Florida employers were not covered by any safety rules or regulations and not subject to statewide inspections or penalties for violations as they were before the repeal of Safety in Florida.

Large private employers have little to fear from OSHA. In 2011, the last year for which statistics are available, OSHA reported to the U.S. Dept. of Labor the number of years it would take for the existing OSHA inspection staff to inspect each covered workplace one time. Oregon came in first place at 26 years. South Dakota came in last place at 243 years. Florida was next to last at 230 years. (See Chart)

What this means for the vast majority of Florida workers is that they are no better off from a safety standpoint than were the employees of the Triangle Factory, 105 years ago. There was no workers' compensation law to provide family relief for those killed in the fire. With the current workers' compensation law in Florida, many of those same workers are still no better off than the 146 who died.

Although workers' compensation is supposed to be a no fault scheme, don't let the advertising mislead you, it is not. One of the main causes of injury at work in Florida is exposure to deleterious substances. Not only Mold and Fungus, but paint fumes, pesticides, silica dust, fertilizers, carbon dioxide fumes, the sun, MRSA, and the list is endless. Exposures are not injuries by accident arising out of the employment pursuant to section 440.02(1) Fla. Stat. 2003. It is necessary to prove employer fault by clear and convincing evidence in order to obtain medical care and/or indemnity for any alleged exposure injury. Imagine an auto body shop with 7 employees, workers' compensation coverage in place and an unsafe paint booth. The booth is not properly ventilated an the employees doing the painting are not given respirators notwithstanding the Material Data Sheets for the paints say respirators and proper ventilation are required. OSHA will not inspect the work place; it is not within their jurisdiction. The state has no inspectors; they were all sent packing on July 1, 2000. There is no official entity to complain to.

Our fictional painter complains of tightness in his chest, problems breathing and coughing that won't stop. He reports to his boss that he believes he has been injured by exposure to paint fumes. After calling his workers' compensation carrier, the boss advises the employee: "The insurance company said I can't send you to a doctor or hospital until you bring me clear and convincing evidence of what you were exposed to, exactly how much you were exposed to and that such an exposure can cause your symptoms". Florida's workers' compensation scheme is neither self-executing nor no fault. The employee has to prove the employer was at fault before he can get any medical or indemnity benefits.

A workers' compensation law without a safety component is like Florida without sunshine, worthless.

EDITORIAL NOTE: DUE TO PUBLICATION DEADLINE THE BELOW ARTICLE WAS SUBMITTED ONE WEEK PRIOR TO THE SUPREME COURT DECISION IN WESTPHAL

The Current State of the Grand Bargain in Florida: *Miles, Castellanos, Westphal*, and the Looming Legislative Struggle Over Constitutional Imfirmities in the Florida Workers' Compensation Act

By Geoff Bichler, Maitland

On April 20, 2016, the Florida First District Court of Appeals issued its sweeping decision in *Miles v. City of Edgewater / PGCS*, finding that the restrictions contained in Sections 440.105 and 440.34 were unconstitutional violations of both the First Amendment and the right to form contracts. Eight days later, on April 28, 2016, the Florida Supreme Court decided *Castellanos v. Next Door Company / Amerisure Insurance Co.*, and concluded that the "unyielding formulaic fee schedule" applicable to attorney fee awards to prevailing claimants was a violation of due process under both the Florida and United States Constitution. The two cases have arguably set the baseline for any future legislation related to attorney fees in the Florida Workers' Compensation Act. There are broader implications, however, since it is imperative that any statutory scheme provide a viable "enforcement mechanism" to insure compliance with statutory entitlements whatever they might be. In other words *Miles* and *Castellanos* were not just about attorney fees, but were rather part of an ongoing struggle over what must be provided for a workers' compensation system to remain viable constitutionally as an exclusive remedy. That larger and far more important discussion continues as cases challenging both individual provisions of Chapter 440, and the Act as a whole, make their way through the courts. A bit of perspective on the current state of the law is warranted as we approach the next legislative session.

As readers are no doubt aware, the Supreme Court dismissed *Stahl v. Hialeah Hospital / Segwick Claims Management Services* on the same day *Castellanos* was decided. The dismissal of *Stahl*, on jurisdictional grounds, avoided the thorny constitutional issues presented; hardly a ringing endorsement, or even a vindication, of the Florida Workers' Compensation Act as some have suggested. In fact, the *Stahl* case settled nothing, and may simply be another important stepping stone in the ongoing battle over benefit adequacy fundamental to "The Grand Bargain". I say this because, even in a losing cause, much was learned about what the Court is looking for in an appellate record challenging the adequacy of the Act writ large. Additionally, much was learned about the potential defenses to such a challenge. In short, *Stahl*, like *Florida Workers' Advocates v. State of Florida (Padgett)*, helped refine the arguments related to benefit adequacy necessary to sustain a constitutionally viable workers' compensation system. In that regard, it is important to note that there are numerous other challenges currently working their way through the court system with the potential to invalidate specific parts of the Act and/or challenge the continued viability of the entire Act. The uncertainty related to these challenges is understandably making a lot of people very nervous.

While those of us toiling away in the practice continue to wait for the Supreme Court to decide *Westphal v. City of St. Petersburg*, with its potential for even more disruption, NCCI actuaries have finished crunching numbers and finalized recommendations for a rate hike of 17.1% in the wake of *Castellanos* (Miles being largely lost in the shuffle). As a consequence policy makers are preparing for the first major revisions to the Act since 2003 and battle plans are being drawn along typical fault lines. Perhaps, however, it is time to consider a new approach. Since Workers' Compensation is going to be on the legislative agenda (potentially in special session), the time is right for stakeholders and legislators to take a serious look at reforms beyond the attorney fee issue that would eliminate constitutional infirmities and remove the uncertainty related to coverage and benefit adequacy. A collaboration of this nature, if successful in crafting legislation, could ensure the continued viability of "The Grand Bargain" and thus workers' compensation in Florida for a generation.

The tension between benefit adequacy (a concept that must include "coverage") and the forfeiture of common law rights has always been present in workers' compensation law. In *New York Central Railroad v. White*, 234

• *Grand Bargain – continued*

US 188, 188, 37 S.Ct. 247, 61 L. Ed 667 (1917) the United States Supreme Court confirmed the constitutionality of the general concept of workers' compensation, and found the New York system sufficient to warrant the elimination of common law rights and remedies as part of a quid pro quo commonly known as "The Grand Bargain." The Court was careful to point out, however, that the adequacy of the trade-off could always be evaluated at a later time:

> "viewing the entire matter, it cannot be pronounced arbitrary and unreasonable for the state to impose upon the employer the absolute duty of making a moderate and definite compensation in money to every disabled employee, or, in case of death, to those who were entitled to look to him for support, in lieu of the common law liability confined to cases of negligence. This, of course, is not to say that any scale of compensation, however insignificant, on the one hand, or onerous on the other, would be supportable. In this case, ***no criticism is made on the ground that the compensation prescribed by the statute in question is unreasonable in amount, either in general or in the particular case. Any question of that kind may be met when it arises."***

White, @ 205, 206. The *White* Court also invokes the concept of "natural justice" in two places. In the first instance the Court said: "we cannot ignore the question of whether the new arrangement is arbitrary and unreasonable from the standpoint of natural justice." *White* @ 202. Later the *White* Court affirmed the viability of the New York law stating that: "…on the grounds of natural justice, it is not unreasonable…" *White* @ 203. The reader will note that in each case where "natural justice" is mentioned, the question of "reasonableness" and/or "arbitrariness" follows. It seems clear then that the *White* Court left open for future consideration whether specific legislative schemes were "reasonable" or "adequate" under this broad notion of "natural justice." Of course it was the application of "natural justice" that caused such a stir in the original panel decision in *Westphal v. City of St. Petersburg/St. Petersburg Risk Management*, No. 1D12-3563 (Fla. 1st DCA, February 28, 2013) (*Westphal I*). Specifically the panel decision in *Westphal I* found the 104 week restriction unconstitutional in part because:

> "This system of redress does not comport with any notion of natural justice, and its result is repugnant to fundamental fairness, because it relegates a severely injured worker to a legal twilight zone of economic and familial ruin."

Given the historical context, and the precedent of *White*, it seemed completely appropriate to some that the Court applied the concept of "natural justice" when considering the law as it applied to Mr. Westphal and those similarly situated. Industry reaction at the time, however, with a palpable undercurrent of nobles oblige, suggested that the there was no place for such analysis and that virtually any "system of benefits", regardless how limited, would be sufficient to sustain "The Grand Bargain." This sentiment ignored the recognition in *White* that benefit sufficiency or reasonableness could always be addressed when the question arose.

A fine summary of legalistic (read: industry) concerns over *Westphal I* appeared in this very publication in the Summer of 2013. See "Of Waistcoats and Powdered Wigs: First District Panel Invokes Natural Justice to Invalidate 104 Week limitation on TTD Benefits" by William Rogner, News and 440 Report, Volume XXXI, No. 2 Summer 2013. Readers will recall that Mr. Rogner raised concerns about judicial overreach when applying vague notions like natural justice, and its companion in this context "fundamental fairness", and concluded that such an analysis had no place in deciding whether individual statutory provisions pass constitutional muster. This conclusion was built on a critique of the *Westphal* Court's utilization of *Kluger v. White*, 281 So. 2d 1, (Fla. 1973) to strike the 104 week restriction on temporary total disability benefits. Ultimately, under *Kluger*, Mr. Rogner argued that:

> "A reduction of benefits that does not eliminate the system in its entirety, and which leaves in place a system that compensates injured workers in a no-fault and self-executing manner, satisfies the Florida Constitution."

While this assessment may have been a defensible interpretation of *Kluger*, the analysis arguably minimized the fundamental problem of disappearing benefits for injured workers even as immunity for employers had been enhanced. In fairness, Mr. Rogner recognized that *Kluger* would allow any Court to find Chapter 440 unconstitutional in its entirety and warned the Florida legislature to take note, but his artful arguments against the piecemeal approach to invalidation may have provided a false sense of security to entrenched powers seeking to maintain the status quo. As the debate raged over the summer of 2013, the 1st DCA considered the *Westphal* matter en banc. Unfortunately, the ultimate decision in *Westphal II*, 122 So.3d 440 (Fla. 1st DCA 2013), while finding a way to get benefits for a severely disabled firefighter, only served to extend the uncertainty over the requirement of benefit "adequacy" as part of "The Grand Bargain" while once again ignoring the elephant in the room: the constitutional impact, if any, of the 104 week cap on temporary total disability benefits. This was, in effect, like trying to put the genie back in the bottle.

If the initial decision in *Westphal I* was fairly subject to

• *Grand Bargain – continued*

criticism for exceeding judicial authority under *Kluger*, the Court in *Westphal II* was subject to criticism for creating an entirely new classification of benefits called "temporary permanent total disability" in violation of established precedent. See *Thompson v. Fla. Indus. Comm'n*, 224 So.2d 286 (Fla. 1969). Indeed, Judge Thomas dissenting, in part, raised concerns that the majority opinion was abrogating legislative power by:

> "transforming a statutory limitation of temporary disability benefits, which was enacted to reduce costs, into an entitlement to permanent disability benefits. The majority opinion thus disregards express legislative intent to reduce costs imposed on Florida's employers from inappropriate awards of permanent total disability benefits."

Westphal II @ 452. Whether the 1st DCA exceeded its judicial authority in *Westphal II* became an important question in the ongoing debate related to benefit adequacy when the Florida Supreme Court took jurisdiction of the case in December of 2013. If the creation of "temporary permanent total disability" was not a legitimate answer to the 104 week limitation of temporary total disability benefits, the question became, and remains, whether and how it should be addressed. The Court now finds itself squarely on the horns of the dilemma first recognized in *White*, namely: whether the "compensation prescribed by the statute in question is unreasonable in amount, either in general or in the particular case." *White* @ 205,206. While it is conceivable that the Court could simply affirm the analysis of the 1st DCA, such a result seems unlikely, as does any result construing the statute against Mr. Westphal without providing relief on constitutional grounds. A decision on constitutional grounds would likely require the Court to address the isolated issue of the 104 week cap on benefits in light of the suggested limitations of *Kluger*, or consider the continued viability of the entire statutory scheme as an exclusive remedy.

Most agree that it is extremely unlikely that the Florida Supreme Court, in what we can call *Westphal III*, will find the entire Act unconstitutional when faced with such a limited and discreet issue. An appellate record was not built in the case to challenge the entire Act, and although briefs submitted to the Court have included arguments that "The Grand Bargain" is no longer viable in Florida, the Court would have to make an enormous leap to invalidate the Act. As a consequence, once the dust settles after the decision in *Westphal III*, countless other statutory limitations, restrictions, and procedural hurdles will likely remain a fertile playing ground for constitutional legal challenges. As mentioned above, some of these challenges are already working their way up on appeal and others may come in the form of actions seeking declaratory relief where massive records will be built to challenge the not only specific statutory provisions, but the entire statutory and regulatory scheme. The outcomes of such challenges are impossible to predict, but the dreaded uncertainty related to such cases can, and should, be eliminated with a comprehensive and enlightened approach to revising the Act in the coming session.

Professor Burton, in his wonderful article included in this edition, discusses the current state of workers' compensation programs both in Florida and around the country. He warns that the state workers' compensation system: "is in its most dire situation in the last half century" due in large measure to what he refers to as a virtual "race to the bottom" where states compete with each other to attract employers by reducing or eliminating benefits thereby reducing premiums. The reality of this assertion is undeniable. In the effort to reduce premiums, and attract employers, States like Florida have created statutory schemes that are so full of holes and constitutional problems that the delicate balance of "The Grand Bargain" is called into question. How can immunity from suit be conferred where an injured employee is entitled to unreasonably limited benefits or none at all? This "dual denial doctrine" as Professor Burton refers to it, is at the heart of the war currently raging in Florida and around the country.

Miles, *Castellanos*, *Stahl* and *Westphal*, not to mention countless other challenges currently pending, have attacked specific weaknesses in the Act, but they also expose the soft underbelly of Section 440.11 and employer immunity. This may be the greatest danger to Florida employers related to workers' compensation: that benefit inadequacy or non-existence under Chapter 440 could expose them to civil liability even though they have purchased workers' compensation insurance. The Florida Legislature can, and should, eliminate general uncertainty over the Grand Bargain at the same time they address recent court decisions and specific constitutional problems.

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Complex Presumption Cases Require Special Care

By JCC Castiello

Those of us who have practiced long enough have heard a few too many non-comp lawyers comment that workers' compensation, our field of practice isn't exactly rocket science. We have also typically seen over the courses of our respective careers the occasional practitioner who does not understand our field of law - one who promptly walks into one of our courtrooms (yes, I do consider us to be a court) and does the proverbial "crash and burn" routine for all to see (and for which there will be public record). For those not wise in the ways of Chapter 440, the 60Q rules and all other things comp, death becomes their case(s) all too often. And it ain't pretty!

Sometimes, it is not enough just to know workers' compensation law. Within our practice, there are many specialized areas which generate their own nuances and demands for expertise. They are best served by those who have committed themselves to being well versed in the subject matter at issue. No area of the workers' compensation law is as challenging as litigation involving the Heart/Lung bill presumptions applicable to law enforcement officers, firefighters and other public servants we typically refer to as first responders. These are the people who oftentimes risk their lives - if not their safety - on an almost daily basis to serve all of us. They certainly deserve the best in the handling of their cases.

Twenty plus years ago, I defended these cases regularly for municipal clients. Rarely were these cases contested. Where a pre-employment physical had demonstrated no evidence of heart disease and a later physical showed evidence of some abnormality or heart disease, the cases were typically accepted as compensable without litigation. The doughnut shop diabetic might have been viewed differently, but by and large municipalities were giving the benefit of any doubt to their public servants.

The environment has changed considerably over the last twenty years. Caselaw has evolved significantly in virtually every aspect of Heart/Lung bill litigation. We have burdens of proof which are different based on the facts supporting the theory of compensability. We have EMA involvement. We have shifting burdens of proof. We have questions as to when the onset of disability is recognized. Adjusters and risk managers are oftentimes called upon to make a decision in very short time on whether to pick up medical bills that run into six and seven digits. It is the proverbial catch 22. Pay out on the wrong claim and it is easy to make a $100,000.00 plus mistake. Deny a claim that ultimately proves compensable and you have caused needless stress to someone badly in need and who was the neither needed nor deserved it.

It is by nature of the underlying condition at issue that these cases are disproportionately costlier per case. Not surprisingly, more of these cases are challenged by municipalities than ever before. The medical care alone in these cases tends to be significantly costlier than in your average workers' compensation case. Years ago, one municipality shared with me that Heart/Lung bill cases accounted for a little less than 10% of their workers compensation case volume but more than 30% of their workers' compensation costs.

Some NASA friends gave me a tour a few months back. One hallway had photographs of every single launch that a particular launch system had realized going back to the 1960s. It was pretty impressive. It also included photos of both the successful launches and the unsuccessful ones.

In a Heart/Lung bill case, the stakes tend to be high for both sides. At the same time, every good trial lawyer knows that you won't win them all. If you do, you are probably not trying some cases that you should be. That doesn't mean that you should or would ever accept handling a matter you were ill equipped or unprepared for.

When handling a heart/lung bill matter, it is imperative that you, the practitioner - whether you are for the claimant or the employer- make every effort to be thoroughly familiar with the controlling authorities. If you are handling these cases, become intimately familiar with the applicable statutes and caselaw or seek the assistance of someone you trust who is knowledgeable in the field. A Heart/Lung bill case may not be rocket science, but your best efforts will go a long way in assuring that your client's case is not the one that goes "crash and burn."

District Court of Appeal Cases

Doerr Trust re. Central Fl Expressway Authority, 177 So. 3d 1209 (Fla. 11/5/15)

Attorney Fees/Eminent Domain Proceedings

No, the Supreme Court *still* hasn't ruled on Castellanos or any of the other pending WC cases, but they did issue an opinion on a case with similar concepts recently. This case considered the question of attorney fees in Eminent Domain proceedings, which generally are paid as a percentage of "benefits achieved." Specifically, the court found that a property owner may invoke a secondary fee calculation under the statute if the condemning authority engages in excessively litigious tactics. The fee statute is not the same as F.S.§440.34. However, there are enough similarities that make for interesting reading into the possible mindset the court may have in relation to the pending WC cases on fees.

Hawkins v. Publix Super Markets, Inc/ Publix Risk Management, 177 So.3d 1045(Fla. 1st DCA 11/12/15)

TPD/Refusal of Suitable Employment

The JCC denied benefits pursuant to F.S.§440.15(6), which may disqualify a claimant from receipt of TPD based on a refusal of suitable employment. In reversing and remanding the DCA noted that disqualification, however, applies only "during the continuance of a refusal of employment". The opinion notes the refusal does not permanently limit TPD, and the employer has to establish the availability of the job for each applicable period to be able to deny TPD. As the JCC's Order failed to make specific findings as to the date of the initial offer of employment, the dates of continued availability of the suitable job, the dates of the claimant's refusal, or whether the refusal continued after employment was terminated, the Order lacked sufficient facts to be affirmed.

Miles v. City of Edgewater Police Department/PGCS, ____ So. 3d ___ (Fla. 1st DCA 4/20/2016)

Claimant Paid Attorney Fees

This case involved a law enforcement officer who alleged she was exposed to chemicals and an "intense smell" that caused her to be disabled. The police department rejected both of her claims. She then entered into two retainer agreements (one with the Police union and one with counsel) for legal services that her attorney presented to the court for approval. Pursuant to F.S. s. 440.105 (3) (c) makes it unlawful for a claimant's attorney to collect any fee in WC matter without the approval of the JCC. F.S. s. 440.34 also requires judicial approval of any claimant attorney fees and sets forth the percentage formula upon which those fees must be paid.

The JCC denied the motion for approval of those fees and the attorney withdrew but then appeared as "an observer" at the final hearing in which the claimant appeared Pro Se but without medical evidence to support her toxic exposure claim. At the hearing the prior attorney presented six affidavits of claimant attorneys stating that they would not accept the case due to the complexity of the matter and the fee limitations in the Florida statutes. The JCC denied the claimant's motion to admit those affidavits and denied her claim as well.

The First DCA reversed, ruling that the restrictions in sections 440.105 and 440.34, when applied to a claimant's ability to retain counsel under a contract that calls for the payment of a reasonable fee by a claimant (or someone on his or her behalf), are unconstitutional violations of a claimant's rights to free speech, free association, and petition - and are not permissible time, place, or manner restrictions on those rights. They further ruled those provisions also represent unconstitutional violations of a claimant's right to form contracts - and are not permissible police power restrictions on those rights. Finally, they held that the criminal penalties of section 440.105(3)(c), Florida Statutes, are unenforceable against an attorney representing a workers' compensation client.

https://edca.1dca.org/DCADocs/2015/0165/150165_1287_04202016_022330_i.pdf

Boley Centers, Inc./Comp Options v. Vines, 179 So. 3d 464 (Fla. 1st DCA 11/16/15)

Psychiatric Injuries/Compensability

The E/C appealed four separate issues related to the JCC's award of certain psychiatric treatment and resulting disability. The claimant also cross appealed. The DCA found that although the JCC erred under F.S. s. 440.13(5) (e) in admitting certain medical opinions, that error was harmless. They found no error regarding the awards of compensability or disablement, but agreed the JCC did not have the authority to order the E/C to pay medical providers and third party payers after a certain date, only to find that those visits were medically necessary. Finally, the DCA agreed with the claimant the both psychiatric visits were compensable emergency care and not just the first visit.

• *District Court of Appeal Cases – continued*

Gomez-Lujano v. Palm Beach Grill-Houston's/Travelers Ins., 178 So. 3d 546 (Fla. 1st DCA 11/19/15)

PTD benefits/Westphal

Claimant received medical care, 104 weeks of temporary indemnity and IB benefits from his compensable injury. The DCA found the JCC improperly denied the claim for additional IB benefits, as that claim had not been mediated. They ruled, however, that the JCC correctly interpreted the en banc Westphal ruling in denying PTD and additional temporary benefits. Although Westphal "supplants a claimant's need to establish MMI" it did not relieve the claimant of his burden to prove the other elements of his claim for PTD benefits. The opinion also rejected the claimant's argument that the denial of additional temporary benefits past 104 weeks violated his constitutional rights to access to courts and due process.

Gobel v. American Airlines/Sedgwick, 177So. 3d 1289 (Fla. 1st DCA 11/24/15)

Costs payable by E/C

The E/C agreed to provide certain medical benefits and stipulated to attorney fees and costs payable by the E/C. The Motion for approval of fees and costs listed payment of $200 in costs without explanation. The JCC indicated he would not approve these costs as the lack of description suggested it may be an attempt to obtain additional fees. The claimant attorney argued under 60Q-6.123(5) she was not required to list the costs as they were under $250. The DCA noted that Rule 6.123(5) applies only to washouts under F.S. 440.20(11) and was inapplicable here. Rule 60Q-6.124(2) applies to payment of non-washout attorney fees and costs, and allows the parties to submit fees and costs for approval without documentation, as the E/C rather than the claimant is paying those fees and costs. No specific rules apply in that situation, rather general rules of contract and settlement. The E/C wisely took no position in this appeal.

Humana Medical Plan v. Reale, 180 So. 3d 195 (Fla. 3d DCA 12/2/15)

Federal Jurisdiction/MSPA actions

Humana runs a Medicare Advantage plan that issues Medicare payments on behalf of Medicare recipients. The plaintiff settled her personal injury case for $135,000 without taking into account the $19,155.41 Humana paid for her injuries under Medicare. While Humana pursued a Federal MSPA (Medicare Secondary Payer Act) claim against the claimant in Federal Court, the plaintiff filed a separate declaratory action in state court under Florida subrogation and collateral source law. In a lengthy opinion, the Third DCA held the trial court erred in determining that a personal injury plaintiff could remove Humana's attempt to collect payments under Medicare to state court, finding the state court lacked jurisdiction, and Florida law was inapplicable and pre-empted by Federal law in regard to MSPA actions.

Mathis v. Broward County School Board, 181 So. 3d 1237 (Fla. 1st DCA 12/18/15)

Standard for awarding Advances under $2,000

The DCA reviewed the JCC's denial of an advance, ruling she abused her discretion in finding the claimant did not show a substantial reduction in wages or the requisite nexus between the need for the advance and the work place injury. Claimant alleged a foot injury on 3/2/15, which the E/C initially accepted, paying indemnity through 3/16/15. The E/C then denied compensability, prompting the claimant to request an advance on 3/25/15. She returned to work full duty on 4/15/15. In addition the statutory requirements of showing either (1) failure to return to employment at no substantial wage reduction, (2) a substantial loss of earning capacity, or (3) an actual or physical impairment, a claimant must also show "adequate justification", meaning a "plausible nexus" between the injury and the loss of income. The DCA found the JCC erred in finding no nexus as the claimant was "already behind in her bills" when she requested the advance, only eight days after the E/C last paid compensation. The DCA noted that even with that request, she was still without wages from the 17th to the 24th, and since her indebtedness "could only grow worse due to her loss of wages" (no citation or evidence is presented for this statement), the requisite nexus existed.

Jennings v. Habana Health Care Center/Gallagher Bassett, 183 So. 3d 1131 (Fla. 1st DCA 12/28/15)(reh. den.1/14/16)

Prevailing Party Costs/Applicable Statutes

The claimant appealed the JCC's denial of prevailing party costs, arguing the JCC based her denial upon the incorrect subsections of the statute. Claimant requested authorization of an orthopedic evaluation in a PFB which the adjuster received on 9/11/14. The next day, the adjuster informed the claimant attorney an appointment had been set for 9/15/14. The JCC denied prevailing party costs under F.S.§440.192(8) and s. 440.34(3) finding that as the E/C responded within 14 days under the first subsection, and within 30 days (eliminating attorney fee entitlement) under the second subsection, no fees or costs were due from the E/C. The DCA, however, noted that neither of those subsections pertains to costs. Prevailing party costs under F.S.§440.34(3) are available to

the party that prevails "in any proceedings", which here were initiated with a PFB. The agreement to provide the benefit after the PFB designated the claimant as the prevailing party for the purpose of costs (presumably certified mail costs). The opinion notes the E/C did not challenge the "good faith" efforts to resolve the dispute prior to the filing of a PFB. However, Palm Beach County School Dist. v. Blake-Watson held "The JCC erred in dismissing the July PFB because section 440.192 does not independently give the JCC authority to "go behind" a counsel's representations of good faith effort to resolve the dispute in a PFB".

Certistaff, Inc./Summit Holdings, 181 So. 3d 1218 (Fla. 1st DCA 12/11/15)(reh. den. 1/25/16)

MCC/Pre-existing Conditions/EMAs

The DCA reversed the JCC's ruling that the MCC of the claimant's need for shoulder replacement surgery was his 2013 industrial accident. The E/C denied ongoing care based upon evidence of pre-existing osteoarthritis and rotator cuff arthropathy. The claimant testified he had a right rotator cuff repair in 1999 or 2000 with two prior left rotator cuff repairs as well. He testified thereafter he would take over the counter meds for pain, but that he was able to work albeit with adjustments to his schedule. Based upon disagreements regarding MCC, Dr. Greene was appointed as the EMA, and ultimately testified the MCC of the need for surgery was the pre-existing condition. He testified there was a "high probability" the claimant would have needed the surgery without any intervening accident based upon his underlying degenerative arthritis. The DCA noted the JCC's error was in focusing solely on whether the claimant had been undergoing ongoing medical care prior to the industrial accident, to the exclusion of his testimony regarding ongoing pain. They found the evidence supported the EMA's opinion, and no clear and convincing evidence existed to reject the presumptively correct opinion that the pre-existing shoulder condition was the MCC for the requested procedure.

Thyssenkrupp Elevator/Sedgwick v. Blackmon, 180 So. 3d 250 (Fla. 1st DCA 12/31/15)

Entitlement to Appellate Attorney Fees

Under F.S.§440.34(5), claimants may be awarded an E/C paid appellate fee on a discretionary basis. As the opinion states: "*Ordinarily, entitlement is not established where an appellant files a notice of appeal and soon thereafter seeks dismissal, leaving little doubt about whether the appeal will be pursued. In sharp contrast, the facts here show that the Appellant received an extension of time for filing its initial brief, missed the extended deadline, and told Appellee's counsel that the brief was almost done and the he intended to file it. Even after this Court issued a show cause order, a brief never materialized; instead, a voluntary dismissal was filed. Under these circumstances, Appellee's appellate counsel was justified in undertaking typical appellate tasks that required the expenditure of attorney time.*"

Beck v. MMI Dining Sys./Montverde Academy/Travelers, 183 So. 3d 1160 (Fla. 1st DCA 12/31/15)(reh. den. 2/11/16)

Constitutionality/Standing

The DCA dismissed claimant's appeal, finding no standing or preservation of argument. Additionally, they confirmed that prior decisions of the 1st DCA have affirmed the constitutionality of the 2003 law's elimination of wage loss benefits.

MBM Corp./Sedgwick v. Wilson, ___ So. 3d___ (Fla. 1st DCA 2/10/2016)(reh. den. 3/15/16)

Evaluations/Burden of proving MCC

The DCA reversed the JCC's award of an evaluation of the cervical spine. On 10/16/10, claimant fell injuring his head and right shoulder. The E/C only authorized treatment for a diagnosed shoulder injury. Four years later, the claimant filed a PFB for a cervical evaluation, based upon the authorized shoulder doctor's recommendation. Notably he gave no opinions as to causal relationship between the shoulder and spine complaints. The DCA reproduced the entirety of F.S.§440.09(1) in the opinion, and noted that the claimant failed to meet his burden of proof in seeking the cervical evaluation. They noted the JCC used the incorrect standard in awarding the evaluation, conflating "the burden to prove entitlement to an investigation of the causal connection between voiced complaints and a previously accepted compensable condition with the burden to prove the causal relationship between a condition and the workplace accident in the first instance."(Emphasis added). They noted that while the claimant's report of ongoing complaints could be relevant in supporting expert testimony connecting the complaints, no such evidence existed here. A footnote indicates that as the PFB did not seek compensability of the neck condition, that issue may be litigated in the future.

• *District Court of Appeal Cases – continued*

Soca v. Advanced Auto Parts & Sedgwick Claims Servs., No. 1D15-795, 2016 Fla. App. LEXIS 2629 (1st DCA Feb. 23, 2016)

The claimant filed petitions for benefits and the E/C provided the benefits so the petitions were withdrawn. The E/C then filed a motion for costs. The claimant argued that none of the costs sought were due to the defense of the claims and eventually sent a 21 day sanctions letter and filed a motion for sanctions. The E/C withdrew the motion to tax costs after the sanctions motion was filed and the JCC ruled he was without jurisdiction. The DCA reversed the jurisdiction finding and directed the JCC to make a determination as to the merits of the claim for costs.

Steinberg v. City of Tallahassee/ Tallahassee Risk Mgmt., No. 1D15-1794, 2016 Fla. App. LEXIS 2645 (1st DCA Feb. 23, 2016)

Reversed an order denying EMA appointment. The DCA found that there was a conflict and that the claimant timely filed a Banuchi notice, preserving the issue for appeal.

Mitchell v. Miami Dade Cnty., No. 1D15-2153, 2016 Fla. App. LEXIS 2630 (1st DCA Feb. 23, 2016)

In a presumption claim on remand, the JCC found the claimant's slow pathway condition was congenital. The evidence was that there was a triggering event which caused the development of SVT (tachardia). The JCC found that as the slow pathway condition was congenital, the E/C rebutted the presumption. The DCA remanded to the JCC to determine if the triggering event was occupational in nature. The DCA details the nature of the 112.18 presumption and the fact that even with contrary evidence, the presumption remains until the JCC finds that it has been rebutted.

Rojas v. Rodriguez, No. 3D15-277, 2016 Fla. App. LEXIS 2247 (3d DCA Feb. 17, 2016)

In this personal injury case, the defense objected at trial to plaintiff's neurosurgeon's testimony that HNP was caused by twisting motion plaintiff described upon impact of accident. The defense objected that the doctor was testifying outside of his expertise and wasn't an accident reconstructionist, but didn't assert an objection under F.S.§90.702 or Daubert. The defense did not articulate their objection fell under Daubert until a post trial motion. The 3rd DCA remanded to reinstate plaintiff's verdict based on the lack of a timely Daubert objection.

Lowe's Home Centers/Sedgwick CMS v. Beekman, ___ So. 3d ___ (Fla. 1st DCA 3/4/2016)

Admissibility and presumption of correctness of EMA opinions outside scope of JCC assignment

On 2/5/15 the JCC appointed Dr. Vega as an EMA regarding the issue of authorization of shoulder surgery. The JCC's letter posed two questions to Dr. Vega asking him to address (1) medical necessity and (2) causal relationship of the proposed shoulder surgery. The same day, the parties filled out a Pre-Trial where the E/C for the first time asserted the affirmative defense of apportionment. Several months later, the EMA testified the shoulder injury was an aggravation of a pre-existing condition. The JCC subsequently granted the claimant's motion to strike these opinions, noting no party had requested that issue be addressed, nor did the EMA's report address that issue. The DCA reversed in a lengthy opinion discussing the history and scope of an EMA's appointment. Noting that the Evidence Code generally favors consideration of otherwise admissible, relevant evidence along with prior decisions (allowing admission of an authorized treater's opinions for conditions they were not specifically authorized to treat) the DCA held such EMA opinions are admissible, but only those opinions that address already identified disagreements carry the presumption of correctness. The opinion also allowed the parties to re-open the evidence on the issue of apportionment.

Gonzalez v. St. Lucie County Fire Dist./ Fla. Municipal Ins. Trust/Fla. League of Cities, ____ So. 3d ____(Fla. 1st DCA)

F.S. s 112.18 Presumption/Findings to overcome presumption

The JCC denied the claim, finding the E/C successfully rebutted the presumption of occupational causation. Claimant was a firefighter who experienced light headedness and a racing heart while engaged in fighting a fire. He was diagnosed with AVNRT, a heart disease involving a congenital abnormality which causes rapid heart rate when there is a triggering event. Some people with AVNRT may never experience rapid heart rate. Claimant's IME testified the triggering event was the adrenaline from exertion while at work. The E/C IME testified there was nothing claimant did at work that would cause the AVNRT. He went on to testify that aging may contribute but the triggering event is often unknown. The DCA examined the JCC's ruling that the E/C rebutted under both the competent evidence and clear and convincing standard. As the claimant did not

rely solely on the presumption however, the E/C had to establish either that the trigger was non-occupational or that there was a specific non-occupational cause for it. The DCA noted the JCC did not have the benefit of the recent (2/23/2016) Mitchell II decision, which holds that medical evidence of a congenital condition is sufficient to rebut the presumption, but because the presumption does not disappear when the presumption is rebutted, the E/C also bears the burden of overcoming the presumption by competent evidence that the trigger is also non occupational. The case was remanded for the JCC to make specific findings as to whether the E/C overcame the presumption by establishing that there are one or more possible non-occupational causes for the trigger or that there are no occupational causes.

Caterpillar Logistics Services v. Amaya, ___ So. 3d ___ (Fla. 3d DCA 3/2/16)

F.S. s. 440.205 Retaliation Claim/Legal Cause of Damages

A jury awarded Plaintiff Amaya back pay and front pay on his claim that Caterpillar unlawfully retaliated against him for filing a workers' compensation claim in violation of F.S. s. 440.205, Florida Statutes (2008). After a post trial reduction for TTD benefits paid, the amount was $571,883.64. At trial, Plaintiff's psychologist testified that the Plaintiff suffered from depression related to the retaliation, and this condition did not allow him to work. The jury rejected his claims that the retaliation caused these conditions or resulted in any psychological condition or need for psychological treatment. The DCA found that because Amaya was not physically able to work prior to and after Caterpillar's alleged retaliation (including through the date of trial), Caterpillar's retaliation could not be the legal cause of any of Amaya's economic damages. The DCA reversed the final judgment and remanded with directions to enter judgment in favor of Caterpillar.

THG Rental and Sales of Clearwater/ Summit Holdings -Claims Center v. Arnold, ___ So. 3d ___ (Fla. 1st DCA 3/17/16)

Misrepresentation/Scope of Defense and Pleading with Specificity

The claimant alleged injury to his back and right knee. After the third (of five) PFBs, the E/C responses denied benefits solely "based on misrepresentation." The E/C clarified on the Pre-Trial, stating "misrepresentation per 440.09(4) and 440.105 –physical abilities and post accident earnings". At trial the claimant sought benefits only for the right knee. For the first time two days before the trial, the claimant objected the E/C's defense lacked the specificity required under 60Q-6.113(2)(h). The E/C presented video and medical testimony related to alleged misrepresentations regarding the back condition. The JCC denied the specificity objection and denied the misrepresentation defense, finding the misrepresentations concerned the back, which was not an issue at the time.

Both parties cross appealed. The DCA agreed that the misrepresentation defense need not address a specific body part, and that if the JCC determines any misleading statements were made with the intent to secure benefits, all benefits must be denied. They further agreed that the E/C's defense did not specifically "detail the conduct" forming the basis of the misrepresentation. However, the rule allows the party to amend within 10 days of such objection. As the objection came two days prior to trial, the E/C did not have sufficient time to amend the defense. The case was reversed and remanded to allow the E/C to amend and the claimant to respond, and thereafter the JCC will consider the defense without limitation as to the specific right knee injury. Finally, the opinion dismissed outright the E/C's position that the claimant needed to offer evidence of an unsuccessful job search to be entitled to TPD.

Mathis v. Sacred Heart Hospital, ___ So. 3d ___ (Fla. 1st DCA 3/24/2016)

WC Immunity/Issues of Fact re. Contractual Duties precluding Summary Judgment

The plaintiff's injury occurred at Sacred Heart Hospital while employed with a separate cleaning company. After collecting WC benefits, she filed suit against the hospital. The hospital sought immunity under F.S.§440.10(1)(b) as a statutory employer. That section provides immunity where the hospital was performing "contract work" for a third party to which it sublet part of its duty under the contract. The hospital argued its patients were the third party for whom it sublet contract work. However, citing to the 1997 Rabon case and subsequent cases, the DCA noted no evidence of any contract between the hospital and a third party existed in the limited record. Summary Judgment was reversed and the case remanded.

Fuentes/Estate of Escalera v. Sandel, Inc./Rolling Shield, Inc., ___ So. 3d ___(Fla. 3d DCA 3/23/2016)

Negligence/Duty owed to subcontractors by property owners

Rolling Shield leased a warehouse from Sandel. Shield hired a contractor to paint the warehouse roof, who subcontracted the work to a business owned by Escalera. Evidence showed that Escalera was familiar with the warehouse and skylights and worked previously on roofs.

The record also showed he met with the owner and contractor on the day of the accident and he was specifically warned about the dangers of stepping on the skylights and that he was not to paint them. The contractor testified when he left the roof on the date of the accident, Escalera and another man were wearing safety harnesses. Shortly thereafter though, Escalera fell through a skylight without a harness on and died. His widow sued alleging multiple counts of negligence including failure to maintain and guard the roof/skylight and failure to warn. The DCA affirmed summary judgment for the defendants. Property owners are generally not liable for injuries suffered by subcontractors on their premises, with two exceptions: (1) liability may attach where the property owner actively participates in the work or exercised direct control over the work and failed to exercise that control with reasonable care, or (2) the property owner fails to warn the contractor about concealed dangers he or she had actual or constructive knowledge, and were unknown to the contractor or couldn't have been discovered through reasonable care. The DCA analyzed these issues and affirmed summary judgment. They also struck plaintiff's expert architect's affidavit that was "permeated with improper legal conclusions".

Wert v. Camacho, ___ So.3d ___(Fla.2d DCA 3/30/2016)

Subcontractor Immunity/Related Works Exception

The 2d DCA reversed and remanded a 2.3 million dollar verdict which found a subcontractor 90% liable for injuries sustained by another subcontractor on a job site. Wert and his employer Rubber Applicators (Wert/RA) worked as subcontractors on a maintenance project on the property of the Mosaic fertilizer plant. Camacho and his employer Mid-State (Camacho/MS) also worked on the site, each however with a separate contract with Mosaic. Wert accidentally injured Camacho while backing away from a shed where MS stored equipment. Camacho and his wife brought claims against Wert/RA which proceeded to trial. Wert/RA asserted WC immunity under F.S. s. 440.(10(1)(e) alleging horizontal immunity. They also argued Mosaic was the statutory employer of both subs and that they were dependent horizontal subs. Camacho argued Wert/RA was engaged in unrelated works which created an exception to WC immunity. The trial court found the two subs were not engaged in related works and instructed the jury they were not to assign immunity to Wert/RS. Appealing the verdict, Wert/RS renewed their arguments at trial that the issue of statutory employment was not applicable as the subs were not working under the same contract with Mosaic. They further argued that if the statutory employer concept in section 440.10(1)(b) were to apply to this horizontal relationship between R/S and M/S, it would render meaningless the immunity for horizontal subcontractor relationships provided in s. 440.10(1)(e). The DCA held that s. 440.10(1)(b) does not apply to create an employment relationship of any kind between R/A and M/S. While they were both subs of Mosaic and thus employees of Mosaic, they were not part of the same "contract work" with them. No vertical relationship existed between the subs, and therefore, s. 440.10(1)(b) does not "deem[] [them] to be employed in one and the same business or establishment." As such, because they are not employees of the same employer, the unrelated works exception to immunity in section 440.11 does not apply. On remand Wert/RA may assert horizontal immunity.

Scott v. Sears Holding/Sedgwick, ___ So.3d ___ (Fla. 1st DCA 4/14/2016)

The DCC rejected both of claimant's arguments arising out of a denial of increased attendant care. They found "ample" evidence to support the JCC's determination of reasonable hours, and found claimant's constitutional challenge to the rate of attendant care "meritless". The claimant argued the Florida Constitution mandated a minimum wage higher than the federal minimum wage. The DCA noted this provision applies only to "employees", which prior case law specifically holds does not encompass providers of attendant care. As such, paying attendants the federal minimum wage does not violate the Florida Constitution.

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