# FINANCIAL SERVICES COMMISSION

## Office of Insurance Regulation

# Long-Range Program Plan

# 2006 - 2011

***Kevin McCarty***
***Commissioner***

**Table of Contents**

## OFFICE OF INSURANCE REGULATION

### MISSION

To ensure that insurance companies licensed to do business in Florida are financially viable; operating within the laws and regulations governing the insurance industry; and offering insurance products at fair and adequate rates which do not unfairly discriminate against the buying public.

Fair. Fast. Professional. These words represent the Office of Insurance Regulation's (Office) commitment to fairness in decision making, expeditious processing, and proficient performance from our staff.

### AGENCY GOALS

The Office has established the following goals as priorities. The paragraphs immediately following each goal describe the compelling trends and conditions that identify the goal as an Office priority.

**GOAL #1: Availability of insurance products that are not discriminatory, excessive or inadequately priced.** The Office is responsible for the review of form and rate filings submitted by insurers. Form filings include policy forms (contracts), new products or changes to existing products. Rate filings are requests from the insurer to either increase or decrease the rates of certain products. These policy forms and rates receive rigorous review by Office staff to determine their compliance with Florida Statutes and to ensure that the products are offered at a fair and adequate price and that they do not unfairly discriminate against the public.

There are many issues that can affect the affordability and availability of insurance to consumers. These issues, as described below, include the rising cost and decreased availability of health insurance, medical malpractice insurance, workers' compensation insurance, and the advent of credit scoring.

Workers' compensation affects most employers in the state and indirectly every consumer in Florida. Obtaining affordable coverage for workers' compensation in Florida is difficult for a number of employers. The Florida Workers' Compensation Joint Underwriting Association (FWCJUA) is the market of last resort. Per Florida law, the FWCJUA's premium charges are higher than the premiums in the voluntary market.

The Florida legislature passed Senate Bill 50A during the 2003 Special Session A. The bill became law on July 15, 2003 and included a number of reforms expected to reduce costs of the workers' compensation system. The rate level impact of this bill was a reduction of 14.0 percent to rates. The Office required insurers to reduce rates by this amount effective October 1, 2003, thereby making coverage more affordable. In addition, the Office approved a reduction in rates of 5.1% effective January 1, 2005, and there is a pending filing for a reduction of 7.2% effective January 1, 2006. If this filing is approved as filed, the cumulative change since Senate Bill 50A passed will be a reduction of

24.3%. This rate reduction and rate stabilization is a promising trend for Florida's workers' compensation marketplace.

SB 50A also made extensive changes in the premiums that the FWCJUA can charge. These changes became effective on July 26, 2003. SB 50A limited the premiums that the FWCJUA can charge certain, small employers in the new subplan "D". As a result, there was a deficit of almost $10 million incurred by December 31, 2003. This deficit would have to be funded by assessments on the subplan D policyholders. The Florida Legislature in recognition of the potential assessments addressed the issues in the Florida Workers' Compensation Joint Underwriting Association by passing HB 1251. HB 1251 substantially restructured the rating plans of the association and created funding mechanisms for the deficit. The Office has worked with the association to implement HB 1251 and continues to work with the FWCJUA, Governor's Office, and the Florida Legislature to address deficit funding. The FWCJUA has incurred a cash deficit for subplan "D" and has made five separate requests for funds from the Workers' Compensation Administrative Trust Fund, which have all been approved by the Legislative Budget Commission. The total amount of funds transferred to the FWCJUA for subplan "D" deficits as of September 2005 is $7,896,889. The current estimates as of September 2005 are that the FWCJUA will need the remaining $7,103,111 of the contingency fund plus a below the line assessment of $4,777,000 to fully fund the deficit in subplan "D". Future legislative changes will need to be made to create long-term solutions for the association.

Florida's environment for medical malpractice insurance has been of concern for several years, both from the standpoint of availability and affordability. Many physicians are unable to secure affordable coverage. The number of insurers writing in Florida had dwindled to single digits. Insurer losses continued to rise, resulting in significantly increased rates. Doctors felt they were being forced to: reduce policy limits they carried; cease providing certain types of medical care; leave the State; or retire early. In the 2003 Special Session D, the Legislature passed Senate Bill 2-D designed to address this critical situation. This bill included features indicated below:

- **Improved quality of care and physician discipline**
  - required certain patient safety systems
  - affords medical disciplinary boards more authority
  - required the Division of Administrative Hearings (DOAH) to designate at least two administrative law judges with health care experience to preside over disciplinary actions
- **Litigation reform**
  - established caps for non-economic damages where such caps are dependent on the relevant circumstances surrounding the injury
  - established caps for non-economic damages relative to emergency room injuries
  - relieved HMOs of the potential liability that could occur based on allegations of malpractice by contracted physicians
- **Insurance reform**

- required the Office to calculate the rate effect of the bill and required insurers to reduce rates by that amount
- authorized the establishment of alternative insuring mechanisms

Florida's environment for medical malpractice insurance has improved with the passage of SB 2-D, but there is still cause for concern. Coverage is still expensive, and in some specialties and areas it is difficult to obtain. However, there has been a sizable reduction in the level of rate increases compared with the rate filings of recent years, and in some cases rates have been reduced. Many of the provisions of SB 2-D are expected to yield even larger savings but cannot yet be quantified since they would be based on changes in practices, procedures and behaviors that will take time to be fully realized.

The number of carriers who are writing new policies has increased from single to double digits, and three companies have added medical malpractice to their Certificate of Authority. Additionally, there has been an influx of a dozen new medical malpractice insurance reciprocals and risk-retention groups. The Office is optimistic that when the provisions of SB 2-D are more fully instituted, and with the improving climate in the overall property and casualty markets, the beneficial changes seen in the medical malpractice line of business will increase.

The Office has seen many form filings that limit the risks insured. For example, insurers have attempted to limit or eliminate coverage in policy forms for mold, sinkholes, certain industrial risks like respirable dust, water damage, as well as many areas of health coverage such as: pregnancy, diabetic supplies, treatments for the severely obese patient, and other expensive treatments that may be necessary for some insureds.

The Florida Legislature passed Senate Bill 1486 (SB 1486) during the 2005 Legislative Session. SB 1486 contains several new features to address the problems associated with sinkholes in Florida. These are:

- A better definition of sinkhole
- Procedures for sinkhole claim investigation
- Creation of a database for known sinkholes
- Specific reporting requirements, including a requirement to file reports with local government when a sinkhole is detected

In the Property and Casualty lines, particularly auto and homeowners, the use of credit scoring is integral to underwriting and rating for many insurers. Florida law limits the use of credit scoring, but the Office is expecting substantial litigation as insurers push to use credit scoring to the greatest extent possible. The use of credit scoring and similar techniques isolate individual risk factors resulting in less spreading of risk, and potentially, increasing rates or decreasing the availability of coverage for many insureds. The Office's priority is to make certain that, pursuant to Florida law, this decreased availability and increased rating does not adversely impact certain racial and other groups in violation of recently enacted limitations on the use of credit scoring.

One of the biggest challenges today is reconciling the industry's desire for substantial deregulation with the Office's fundamental responsibility of protecting consumers. The Office agrees that competition can play a role in the regulation of rates. However, completely removing rate regulation and relying solely on competition to regulate rates would result in dramatic increases in rates. Filing requirements and pre-approval for products has a stabilizing effect on rates, avoiding dramatic changes in rates, and encouraging changes to be made over time. Accordingly, the real challenge is to facilitate objective competition while maintaining a rate and coverage environment that meets the needs of both consumers and the insurance industry.

The Office has taken steps to reduce the burden of rate regulation on the insurance companies by increasing the speed and efficiency of rate and form filing review. In 2002, the design and implementation of an Internet portal for submission of form and rate filings allowed our customers (the industry) to submit filings electronically, therefore eliminating the need to send copies of filings through the mail. These systems have increased our customer response time and the speed at which the industry is able to get new products or rates to the public.

Florida law requires the Financial Service Commission to periodically review title insurance rates to determine if the rates are either excessive, inadequate, or unfairly discriminatory and to revise premiums if warranted. The Office is currently engaged in an extensive review of title rates and related issues involving the title industry as a whole. A number of hearings regarding the appropriateness of the current rates and the current practices of the title industry will be scheduled. Significant litigation is anticipated. The Office's priority is to insure that the Commission has all the information necessary for its consideration of whether title rates should be revised.

A growing concern in the insurance industry is the rising cost and decreased availability of health insurance. In Florida alone there are more than 2.8 million people that do not have health insurance. To address this problem, the 2004 Legislature passed HB 1629 – "The 2004 Affordable Health Care for Floridians Act". The bill incorporates recommendations from: (1) this Office's "Florida Health Insurance Symposium", (2) "The Governor's Task Force on Access to Affordable Health Insurance" was co-chaired by Chief Financial Officer Tom Gallagher and Lieutenant Governor Toni Jennings and (3) The "Select Committee on Affordable Health Care for Floridians" chaired by Representative Frank Farkas.

While there is no sweeping solution to the health care affordability crisis provided in the Act, it does include a large number of initiatives that together will help to ameliorate the crisis. The bill establishes a residual market for health insurance. It requires small employer carriers to offer benefit plans that will qualify employees to establish the tax- advantaged Health Savings Accounts. With the trend toward consumer driven health care, the Act requires insurance carriers and health care providers to report pricing and quality of service information to the Agency for Health Care Administration. The agency

will post information on its web site to assist people in making informed decisions about their health care. Recognizing that many Floridians have been misled about what they are purchasing, the Act also provides regulation and disclosure requirements for medical discount cards. It expands the availability of health flex plans to the entire state, allows for small employer purchasing alliances and requires carriers to offer rebates for healthy lifestyles.

The Office continues to dedicate significant effort to the implementation of the components of the Act. While many of these efforts have resulted in success, obstacles have limited the progress on other initiatives.

The Office has ensured that all carriers that are required to offer premium rebates for healthy lifestyles have developed and implemented meaningful programs and that required carriers are offering benefit plans that qualify individuals to establish health savings accounts. A comprehensive system to license discount medical program organizations and the review of their products has significantly reduced the number of consumer complaints and has ensured that Floridians are not misled into dropping legitimate health insurance in favor of lower priced discount cards.

The Office staff play a major role in other initiatives that resulted from the Act, including the Comprehensive Health Information System (CHIS) Advisory Board and the Governor's Health Information Infrastructure Advisory Board (GHIIAB). CHIS, managed by the Agency for Health Care Administration, was made responsible by the Act for ensuring the transparency of information to consumers. GHIIAB is an entity appointed by the Governor to encourage and facilitate the creation and use of electronic medical records. Both of these initiatives are aimed at reducing the cost of health care itself, and thus health care insurance.

Efforts to implement the residual market and the small employer purchasing alliances have not yet met with success. The legislation establishing the new residual market calls for funding from general revenue appropriations, and as of this date no appropriations have been made. A request for information issued to small employer carriers seeking their interest in bidding for a purchasing alliance carrier produced a few questions but no proposals. Nevertheless, the Office is in the process of issuing a formal request for proposals.

The Office is participating in several National Association of Insurance Commissioners (NAIC) initiatives to include Coordinated Advertising Rate and Form Review Authority (CARFRA), a working group to achieve uniform form and rate review; improvements in state-based systems which includes initiatives such as uniform product coding that allow companies to use common product names and codes for filings in states, uniform transmittal forms for product filings which will eliminate companies having to use different forms for each state that they are filing a new product; and speed to market goals which sets a standard turnaround for the final disposition on a policy form or premium rate filing.

The Multi-State Review Program (MSRP) offers companies the opportunity to submit an individual, online annuity filing simultaneously to seven states. Florida, Texas and California established the MSRP in 2003 and to date Nevada, Georgia, Louisiana, and the District of Columbia have joined. Annuity filers use Florida's online I-File system to submit filings, which are subject to the combined annuity review standards of Florida, Texas, and California while providing companies a simultaneous product approval in all participating states.

Participating insurers see a noticeable increase in their product speed to market and a reduction in administrative costs. Each paperless submission offers insurers the opportunity to obtain approval in 60 days or less and reach over a-quarter of the country's annuities market. As of September 2005, 26 annuity filings have been processed in 60 days or less.

**GOAL #2: Protect the public from unethical insurance practices.**
Market Investigations monitors the activities of the Florida insurance marketplace to assure proper compliance under the Florida Insurance Code.

Market Investigations may conduct examinations, investigations or other regulatory activities of insurers and related parties regarding the business practices and patterns to ensure that alleged violations of the Florida Insurance Code are identified and corrected. Market Investigations is comprised of four sections: Property and Casualty, Life and Health, Unauthorized Entities, and Market Analysis.

The Florida marketplace has recently undergone changes in the area of insurance regulation. New trends in the marketplace include the evolution of the Discount Medical Plan Organizations and implementation of standards and procedures to ensure that annuities purchased by seniors are appropriate to address their insurance and financial objectives. Market investigations is responsible for ensuring compliance with these new laws.

During periods of hardened markets, the decreased availability of some insurance products creates a climate ripe for unauthorized and unlawful insurance activity and insurance fraud.

Critical components for successfully halting these types of activities include: communication, cooperation, collaborative actions among state regulators and education. Communication between the Office, consumers, agents, and the insurance industry is critical to the Office's ability to deter these activities.

In recent years the altered market conditions within the health care industry has produced a significant increase in fraudulent health plans. Market Investigations usually becomes aware of the fraudulent activity due to consumer complaints or inquiries shortly after the unauthorized entities stop paying claims. In many cases, by the time a fraudulent activity reaches this stage, the fraudulent entity has either shut down permanently or has re-established itself under a new identity. The swiftness and efficiency with which the Office identifies, investigates, and stops these fraudulent health plans will

directly depend on available resources and personnel. Statutory changes in this area in recent years have strengthened the Office's position by establishing that the presence of an unauthorized or unlicensed entity transacting insurance in or from this state represents a clear and immediate danger to the insurance consuming public.

In the new regulatory environment, there has been a shift in the type of examinations performed on licensed entities. Historically, routine examinations were performed on insurers at regular intervals. However, the recent trend has moved toward target or multi-state examinations. Target or multi-state examinations allow the regulatory body to focus on the issues relative to the business practice of individual or multiple companies. These type of examinations also allow regulators to work together to resolve problems or issues that may affect consumers in numerous states.

**GOAL #3: Financially viable companies.**

The Office has the statutory responsibility of reviewing the financial books and records of insurance companies and related entities to ensure that they are financially viable and operating within the laws of Florida.

The activity of reviewing financial statements is divided into three bureaus of expertise, Life & Health, Property & Casualty and Specialty Insurers. Each bureau performs analysis of financial statements and on-site examinations of financial records for entities transacting insurance business in Florida.

In order to effectively regulate the financial viability of entities transacting business in Florida, the Office must establish and maintain communication channels with other states, the NAIC, the industry and consumers.

The 2004 Hurricane Season saw four major storms impact Florida resulting in 1.66 million policyholder claims worth an estimated $22 billion. Many safeguards instituted since Hurricane Andrew, including the Florida Hurricane Catastrophe Fund, increased building code standards and Citizens Property Insurance Corporation, proved very effective in girding the financial stability of the property insurance market. In addition to these legislatively implemented measures, the Office developed a comprehensive Disaster Reporting System that allowed Property and Casualty Financial Oversight to respond more quickly to insurers that appeared to be facing financial distress as a result of the storms. Hurricanes Charley, Frances, Ivan and Jeanne resulted in a single insolvency, where Hurricane Andrew, with 700 claims and $15.5 billion in insured losses, caused 12 insolvencies.

The financial health of the insurance industry remains an ever-changing landscape and continues to challenge the Office's responsibility for regulating the financial health of the industry in Florida. Financial regulation is a delicate balance between ensuring that all entities maintain a sound financial position for its particular type of business without being so onerous as to negatively impact competition in the marketplace.

A major concern in the life and health arena is the long-term care insurance marketplace. Long-term care insurance was originally developed as a level premium product to provide for the long-term care needs of an aging population. Potential policyholders were encouraged to buy a policy at a young age in order to lock into an affordable premium. This product is relatively new in the development lifecycle and, it has become increasingly clear that many early carriers significantly underestimated the risk. As people are living longer, they are utilizing more long term care than had been anticipated when the early products were priced. Also, the early products assume lapse rates similar to other forms of insurance, which proved to be much higher than actual. Therefore, some of the major players in the market have requested substantial rate increases in order to cover the costs of increased utilization of these types of products and to maintain financially viability.

In this environment, the legislature authorized the Office to promulgate a Long Term Care rule that emphasizes the need that rates be established to withstand moderately adverse conditions and that provides consumers with options in the event of rate increases. Although only time will tell for certain, this new regulatory structure appears to have stabilized rates, but at a level where many now find the product unaffordable. And, the new regulation only applies to newly issued policies. There are still many policies issued before the regulation that are inadequately priced and significant rate increase requests are anticipated.

The Office is conducting a comprehensive study of Long Term Care Insurance in an effort to find solutions to rate increases on older policies and to enhance sales on newer adequately priced products.

Florida is home to nearly 3.1 million persons 65 years of age and over. Of this group, the Centers of Medicare & Medicaid Services (CMS) report that 2.6 million persons are enrolled in one or both of the Medicare Plan Parts A and B. Part D will soon be available. The projection in Florida's annual population increase for persons 65 years of age or over is estimated to be about 2.2% annually.

Medicare Supplement insurance (Medigap) is a health policy sold by private insurance companies to fill the "gaps" in the federal Medicare coverage. Medigap policies help Florida's seniors pay some of the health care costs that the Medicare Plans do not cover. There are more than 95 companies insuring nearly 700,000 Florida lives with Medigap coverage. These insurers generated more than $1.9 billion dollars in taxable premium payments in 2003. By concept and design, Medigap policies are standardized for easy benefit comparison by the consumer. Currently, there are 12 standardized Medigap plans called "A" through "L." Each plan, A through L, has a different set of benefits. Plan A covers only a basic set of benefits, while the remainder of the plans build on each other and provide more comprehensive coverage.

The current Medigap system requires manual entry of rate data cells by the submitting insurer. The number of individual data cells requiring manual entry can range into the hundreds and, when multiplied by the various plans, can

exponentially increase the completion time for the submission procedure. The envisioned enhanced rate collection system would allow a more automated method for the insurer.

The Office proposes a system to efficiently collect rate information from insurers and provide an interactive web application to consumers, with which they can enter their demographic statistics and obtain prices for different packages and from different carriers. The application will be readily available to everyone—including the Department of Financial Services' Consumer Services group who provide one-to-one consumer counseling and the Agency of Health Care Administration (AHCA) for its various reporting needs and the Department of Elder Affairs' outreach program to senior citizens, Serving Health Insurance Needs of Elders (SHINE).

Issues in the property and casualty marketplace include the availability and affordability of medical malpractice insurance for a variety of providers, including individual practitioners, hospitals, and managed care entities. Recent legislative changes were intended to enhance the availability and affordability of medical malpractice coverage, but at this point in time it is too early to determine the impact of such legislative initiatives. Since the legislation passed on September 15, 2003, there has been a total of 19 companies enter the Florida medical malpractice market.

Another issue facing the property and casualty marketplace is the increased utilization of employee leasing organizations as a vehicle for small employers to gain access to lower cost workers' compensation coverage. This remains a closely watched arena given past abuses in this area relating to misrepresentation of the type of employee in order to reduce ultimate premium costs. Several entrants in this market have emerged and are being closely monitored for compliance with underwriting criteria in order to avoid substantial losses associated with misrepresentation that have occurred in the past.

Continuing Care Retirement Communities (CCRC's) present a continuing issue of concern within the Office. These entities provide a continuum of long-term care services for the retirement population in Florida. CCRC's offer a variety of services to residents, including food, housing, nursing care and personal services and they serve a crucial need for the senior population in Florida. Economic conditions have proven a challenge for some of these entities with reduced investment revenues, increased staffing requirements, increased health care and insurance expense and aging facilities.

Viatical settlement provider entities present continuing issues of concern within the Office. These entities buy life insurance policies for less than the death benefit of the policy and resell them to investors who expect to profit upon the death of the insured. While legislation was passed and signed into law in Florida in 2005, making most viatical investments subject to securities laws, many areas of concern remain. Among the more complex issues requiring attention are the premium financing of life insurance premiums as a method of generating new policies for sale into the viatical market place, the erosion of the

long established concept of "insurable interest" , circumvention of licensing requirements through so-called "secondary market transactions" and claims of exclusion under the current definition of "financing entity". In addition, current "conflict of regulation" statutes inhibit the ability of the Office to effectively regulate viatical settlement provider entities doing business in Florida, from offices in Florida, or with Florida residents.

During the 2004 Legislative Session, the Office received approval to initiate Phase IV of the Company and Other Regulated Entities (CORE) Navigator system. This phase includes an electronic document management system (EDMS) and workflow for financial monitoring and analysis. The Financial Analysis and Monitoring EDMS (FAME) is a state-of-the-art financial analysis and monitoring system combining on-line filing with electronic workflow and document management.

To ensure successful deployment of FAME, the Office divided the project into two phases, Phase I, discovery and design and Phase II, development and implementation.

Phase I – Discovery and Design was completed during the fiscal year 2004-2005. Activities completed during Phase I include:

- Modeled core processes
- Conducted Joint Application Development (JAD) sessions
- Defined requirements
- Defined Traceability matrix
- Designed workflows
- Designed user interface
- Designed reports
- Designed system interfaces
- Designed data model
- Assessed hardware & software needs

Phase II – Development and Implementation will be completed during the fiscal year 2005-2006. Activities will include:

- Reviewing Phase I requirements and design
- Validate hardware and software needs
- Develop FAME code
- Install and customize FileNet EDMS
- Develop test plan
- Conduct integration testing (CORE and NAIC)
- Conduct acceptance testing
- Convert Financial Analysis Tracking System (FATS) data

The key capabilities of the system include:

- A web-based electronic filing system that allows insurers to submit original and amended documents
- Integration with the NAIC to download documents and data and include them in workflow processes
- Automated workflow that electronically routes documents to the appropriate OIR personnel

- New capabilities to capture key financial data through the use of electronic filing forms
- Business rules to automatically sort reviews based on specific priorities and established criteria
- Reporting on the progress and status of reviews as well as dates and priorities for open items
- Real-time integration with CORE to allow CORE users to view a "snapshot" of key financial data

The completed system will allow financial/solvency staff and management to simultaneously review company financial documents, ensure continued compliance with accreditation standards, increase interface accuracy with national systems, and provide a more efficient turn around time to our customers. In addition, these enhancements will increase the Office's productivity by eliminating the need for manual entry and staff intervention, while allowing professional staff to focus on financial analysis and decision-making.

## GOAL #4: Expand and retain companies doing business in Florida and provide transparency of insurance related data.

During 2005, the Office created a new unit "Business Development and Market Research" (BDMR). The new unit is responsible for the expansion and retention of companies in the Florida marketplace and serves as the information clearinghouse for the collection and dissemination of public data for the Office.

The purpose of the Business Development Section is to promote the benefits of expanding or moving lines of business to Florida and facilitating the process for established and new insurance companies. The primary role of Business Development is to identify solvent companies, communicate the positive aspects of the Florida marketplace, and encourage them to apply for a Certificate of Authority.

As the marketing arm of the Office, the Business Development Section will play a proactive role in promoting the profitable opportunities available to companies in the Florida marketplace, as well as the expansion of the Multi-State Review Program.

The mission of the Market Research section, within the unit, is to ensure the efficient and transparent management of the collection, validation, and analysis and subsequent republication of data, information and resource materials relating to the oversight and development of Florida's insurance markets for the Florida insurance consumer's ultimate benefit.

The unit is also responsible for creating original comprehensive research relevant to the economic and financial impact of developing insurance issues on the Florida marketplace. The unit's research products are disseminated across a variety of venues, state, federal and increasingly, international. As Florida is a leading market for the insurance industry and a leader in the state insurance

regulatory process, requests for analysis, input and research from the Financial Services Commission (FSC) and OIR have grown since the Unit's inception, and are expected to continue.

As part of a technology plan that optimizes technology resources and provides a sustainable framework for integration and growth for insurance regulatory functions; the Office has identified a need to web-enable Company Admission Applications. Upon legislative appropriation and approval, the Office will contract with a vendor for the design, development and implementation of an electronic submission component of AppCORE and to enhance the workflow component to allow electronic submission of admission applications and a seamless integration with the NAIC Uniform Certificate of Authority Application (UCAA) system. The UCAA allows companies to file one application for numerous states saving the company money and time since there is one application.

By moving to an electronic workflow for company admission applications processing, the Office has decreased the number of days to process an application from 141 days in 2002 to 54 days in 2004.

The Office is seeking the funding through the legislature to reengineer the aforementioned applications to eliminate the remaining manual processing and to create a more efficient mechanism for commercial filers.

The Office is also seeking additional positions to recruit qualified staff to collect and conduct statutorily required research and reports and to promote the Florida Insurance Marketplace. Additional funds are being requested to prepare marketing materials and cover costs associated with attending trade association conventions and regulatory conferences to promote the Florida Insurance Market to insurance companies.

## OBJECTIVES

## GOAL #1: Availability of insurance products that are not discriminatory, excessive or inadequately priced.

OBJECTIVE 1A: Shorten the time it takes to make new products and services available.

OUTCOME: Percentage of rate and form reviews completed within 90 days

| Baseline Year 2003-2004 | FY 2006-2007 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-2011 |
|---|---|---|---|---|---|
| 91% | 95% | 96% | 96% | 96% | 96% |

OBJECTIVE 1B: Shorten the time it takes to allow new companies to enter the market

OUTCOME: Maximum number of days from date of applications for a new certificate of authority initially submitted to the OIR to the date the OIR approves or denies the application pursuant to 120.80(9), F.S.

| Baseline Year 2003-2004 | FY 2006-07 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 |
|---|---|---|---|---|---|
| 180 | 100 | 95 | 90 | 90 | 90 |

## GOAL #2: Protect the public from unethical insurance practices.

OBJECTIVE 2A: Ensure that allegations of unethical or fraudulent practices are acted upon.

OUTCOME: Percentage of market-conduct examinations that result in corrective action.

| Baseline Year 2003-2004 | FY 2006-07 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 |
|---|---|---|---|---|---|
| 63% | 71% | 75% | 80% | 80% | 80% |

## GOAL #3: Financially viable companies.

OBJECTIVE 3A: Review, monitor and respond quickly to correct companies that are not meeting the required financial standards.

OUTCOME: Percentage of companies meeting required financial standards

| Baseline Year 2002-2003 | FY 2006-07 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 |
|---|---|---|---|---|---|
| 95% | 96% | 96% | 96% | 96% | 96% |

OBJECTIVE 3B: Timely review of company financial condition.

OUTCOME: Percentage of financial reviews completed within set standards.

| Baseline Year 2003-2004 | FY 2005-06 | FY 2006-07 | FY 2007-08 | FY 2008-09 | FY 2009-10 |
|---|---|---|---|---|---|
| 90% | 95% | 97% | 99% | 100% | 100% |

## GOAL #4: Expand and retain companies doing business in Florida and provide transparency of insurance related data.

OBJECTIVE 4A: Provide requested data to Cabinet, Legislature, state agencies and consumers in a timely manner.

OUTCOME: Percent of legislative/public information requests completed within customer requested time frames.

| Baseline Year 2005-2006 | FY 2005-06 | FY 2006-07 | FY 2007-08 | FY 2008-09 | FY 2009-10 |
|---|---|---|---|---|---|
| 95% | 95% | 96% | 97% | 97% | 99% |

OUTPUT 1: Number of legislative/public information requests completed.
OUTPUT 2: Number of project requests received.

OBJECTIVE 4B: Provide a user friendly website with pertinent regulatory information.

OUTCOME: Percentage increase in the number of website hits, from the baseline year.

| Baseline Year 2005-2006 | FY 2005-06 | FY 2006-07 | FY 2007-08 | FY 2008-09 | FY 2009-10 |
|---|---|---|---|---|---|
| TBD | TBD | TBD | TBD | TBD | TBD |

OBJECTIVE 4C: Increase competition in the insurance market

OUTCOME: Number of new applications filed with the OIR

| Baseline Year 2005-2006 | FY 2005-06 | FY 2006-07 | FY 2007-08 | FY 2008-09 | FY 2009-10 |
|---|---|---|---|---|---|
| TBD | TBD | TBD | TBD | TBD | TBD |

## SERVICE OUTCOMES WITH PERFORMANCE PROJECTION TABLES

### Program: Office of Insurance Regulation

43900110 Compliance and Enforcement – Insurance

Authority: Chapters 20, 112, 120, 440, 624, 625, 626, 627, 628, 629, 630, 631, 632, 634, 635, 636, 641, 642, 648, 651 and 817, Florida Statutes and applicable rules of the Florida Administrative Code

Description: This service protects the public through regulatory oversight of company solvency, policy forms and rates, and market investigations performance.

Service Outcome: Percent of reviews (financial, form & rate, market investigations) completed within set standards.

| FY 2006-07 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 |
|---|---|---|---|---|
| 95% | 95% | 97% | 97% | 97% |

43900120 Executive Direction and Support Services

Authority: Chapters 20, 186, 215, 216, 282, 283, and 287, Florida Statutes and applicable rules of the Florida Administrative Code.

Description: This service provides overall direction in carrying out the Office of Insurance Regulation's statutory and administrative responsibilities. The Commissioner and support staff provide administrative support, leadership, direction and executive guidance in carrying out the Office's statutory responsibilities.

Service Outcome: Administrative costs as a percent of total program costs

| FY 2006-07 | FY 2007-08 | FY 2008-09 | FY 2009-10 | FY 2010-11 |
|---|---|---|---|---|
| 12% | 12% | 12% | 12% | 12% |

## TRENDS & CONDITIONS

The Director of the Office of Insurance Regulation, also known as the Commissioner of Insurance Regulation, is the agency head for purposes of final agency action under Chapter 120 for the Office of Insurance Regulation (Office) and is appointed by, and serves at the will of, the Financial Services Commission. The Financial Services Commission consists of the Governor, Chief Financial Officer, Attorney General and Commissioner of Agriculture. The Department of Financial Services provides administrative and information systems support to the Office.

It is within the Office that the mission of protecting insurance consumers is implemented through regulatory oversight of: company solvency; policy forms and rates; market investigation; and new company entrants to the Florida market. In June 2004, the Office regulated 3,495 insurance entities and by June 2005, the total number of regulated entities in Florida increased to 3,751.

The Office is responsible for monitoring the financial condition of all regulated entities through the use of internal financial analysis and on-site examinations. During financial analysis and examination of each regulated entity, a determination is made as to the quality of assets, adequacy of stated liabilities, general operating results to see if the condition of the company warrants continuation of its certificate of authority to operate in Florida. The Office is also responsible for the admissions process for new entities as well as those proposing to expand into additional lines of business. The Office has responsibility for enforcing the provisions of Chapters 20, 112, 120, 440, 624, 625, 626, 627, 628, 629, 630, 630, 631, 632, 634, 635, 636, and 641, 642, 648, 651 and 817, F.S., and applicable rules, as they relate to the review of policy contracts and associated rates. Filings are reviewed to determine compliance with applicable actuarial standards, statutory provisions, and administrative rules. Additionally, the Office has responsibility in the area of policyholder treatment. To fulfill this responsibility, the Market Investigations Bureau investigates and analyzes market trends for the fair treatment of policyholders. Examinations and investigations are conducted as required to address consumer issues and marketplace trends.

The Office participates in activities that are initiated and coordinated by the National Association of Insurance Commissioners (NAIC). One important NAIC

activity is accreditation; in that being accredited by the NAIC lets the insurance industry know that Florida is meeting or exceeding national standards regarding the financial regulation of insurance entities. The Office also participates in NAIC Committees, Task Forces and Working Groups that develop national standards and model laws for insurance activities and regulation. Being a member of the NAIC also allows the Office to participate in forums with regulators from other states as well as industry personnel, thus gaining valuable information concerning industry related trends and conditions that are appearing nationally. As a member of the NAIC, the OIR can take advantage of NAIC professional development programs in the area of general staff education, financial regulation, market analysis, insurance product regulation, statutory accounting principles, legal continuing education, fraud detection and many others.

In addition, the Office participates in the National Conference of Insurance Legislators (NCOIL). NCOIL consists of state legislators from around the country that serve in leadership positions or are active members of the committees responsible for insurance and banking in their respective legislative houses. NCOIL assists legislators in making informed decisions on insurance issues that affect their constituents and improves the quality of state legislation by providing interaction and open dialogue with elected legislative officials from around the country. Office staff participates in and attends committee meetings, special subcommittee meetings, roundtable discussions, and general sessions.

The Professional Liability Claims Reporting (PLCR) System, which is automated and web-enabled, has been implemented and permits insurers to prepare and submit professional liability closed claims forms, as well as annual aggregate claims reports, to the Office, using the Internet. This system includes all data fields that are required in order to meet statutory reporting requirements, permits collection of open claims financial information, and permits system users to file reports that reflect reconciliation of closed claims and financial data filed in required annual statements.

The Office produces annual reports, using the PLCR System, to identify insurers that conduct business in the State of Florida that have reported medical malpractice claims. The Office also produces annual reports, using this system, to identify health care facilities and health care practitioners within the State of Florida that have reported medical malpractice claims. These reports are then forwarded to the Agency for Health Care Administration (AHCA) and to the Department of Health (DOH), together with requests that each agency reconcile their respective reports with licensed entities and to take appropriate corrective action with regard to those entities that have failed to report in accordance with Florida Statutes.

The Office is currently involved in completing development of rule making activities that are associated with Medical Malpractice Claims Reporting. When completed, this rule will:

- Require reporting entities with no closed claims to file a "No Claims Submission" report each calendar year;
- Require reporting entities to file claims data using internet facilities; and
- Require entities regulated by the Office to provide a financial reconciliation.

The Auditor General's staff audited the Medical Malpractice Claims Database in September 2004. The OIR agreed with the Auditor General's findings, including: development of a rule to require that insurers submit, on an annual basis, a reconciliation of the number and amounts of closed claims reported to this Office to the amounts of "Direct Losses Paid" reported by insurers to the National Association of Insurance Commissioners (NAIC); verification of the accuracy and completeness of closed claims submissions during triennial on-site examinations by the Office of domestic insurers that are required pursuant to Section 624.316, Florida Statutes; and provision of additional assurance that claims are reported by self-insurers by obtaining information from the Department of Health (DOH) and the Agency for Health Care Administration (AHCA) that will enable the Office to monitor the existence and status of claims. The Office has also recently developed a comprehensive internal Professional Liability Claims Reporting Policies and Procedures Manual that provides the staff with policy and procedural direction with regard to essentially all aspects of the PLCR System.

Implementation of CS/Senate Bill 2-D and related rules, including enforcement with appropriate penalties, data acquisition, processing and reporting support provided by the PLCR System, and coordination among the Office, AHCA, and DOH will result in more accurate Medical Malpractice Claims data and related reporting.

The 2005 Florida Legislature enacted numerous pieces of legislation that will profoundly enhance the viability of the insurance market in the state of Florida. The most notable acts of legislation which the Office of Insurance Regulation has a direct role in the process of implementation, includes: HB 811 – Relating to Health Insurance, SB 1486 – Relating to Property Insurance, and 1662 – Relating to Unauthorized Entities.

HB 811 {Chapter Law 2005-231} created an act relating to health insurance and included the following provisions:

- Florida law must conform to federal law for continuation of coverage (COBRA) and increases the amount of time Floridians are able to elect to take continuation of coverage or Mini-COBRA after leaving an employer's small group coverage for 63 days instead of the current 30-day period (a benefit for consumers).
- Individual health policies and individual HMO contracts may elect to offer premium rebates to policyholders who participate in a wellness program instead of mandating the offer. Revisions made to provisions relating to premium rebates for group policies and contracts.

- Office of Insurance Regulation (OIR) is authorized to disapprove a health flex plan if the officers or directors are incompetent, untrustworthy or lacking in insurance managerial experience. The financial examination interval for HMOs is increased from three to five years, allowing the OIR to focus examination resources on those companies requiring additional oversight and is consistent with the National Association of Insurance Commissioners model and accreditation parameters. The maximum amount an HMO is charged for an examination is increased from $20,000 to $50,000.

SB 1486 {Chapter Law 2005-111} created an act relating to property insurance which included the following provisions:

- Reduce the retention in the Florida Hurricane Catastrophe Fund (Cat Fund), to one-third of the full retention for the third and each additional hurricane in a one-year period, in order of loss magnitude.
- Require the OIR to study standard rating territories for residential property insurance and to submit the findings to the President of the Senate and Speaker of the House of Representatives by January 15, 2006.
- Require hurricane loss models approved by the Florida Commission on Hurricane Loss Projection Methodology to be admissible and relevant in a rate proceeding only if the Commission, the OIR and the insurance consumer advocate of the Department of Financial Services (DFS) have access to all aspects of the model.
- Require public hearings for any rate request is in excess of 15 percent. Prohibit insurers from recouping more than one year of reimbursement premium paid to the Cat Fund at a time.
- Insurers are to report exposure and loss data for the development of the public hurricane model to the OIR or to a type I center within the State University System, such as the Hurricane Research Center at the Florida International University.
- OIR is to develop a pilot project in Monroe County to require that rates be actuarially sound and not excessive, inadequate, or unfairly discriminatory, instead of the current standards of the highest average rate in the county as compared to the top 20 insurers in the state, for those areas where OIR determines a reasonable degree of competition does not exist. Provides that Citizens may issue bonds and incur other indebtedness to refinance outstanding bonds or other indebtedness.
- Create an advisory committee to develop a standard personal lines residential policy and file a report with the Legislature by January 15, 2006.
- OIR is provided with the authority to disapprove a policy form with provisions that are unfair or inequitable or encourage misrepresentation, similar to current law wherein the health policies in Florida have had these protections since 1982.
- Prohibits the cancellation or nonrenewal of a personal or commercial residential policy for homes that have been damaged by a hurricane but extends the period from 60 days to 90 days after the home has been repaired. Allows for cancellation or nonrenewal for nonpayment of

premium, fraud, intentional delay in repair of the dwelling, or if the insurer has paid policy limits. Permits the Financial Services Commission (FSC) to promulgate rules and the OIR to issue orders necessary to implement this section.

- FSC is to adopt a checklist of homeowners, mobile homeowners, dwelling or condominium unit owners' coverage and an outline of coverage for any policy delivered or issued for delivery in this state.
- The option of Law and ordinance coverage of 25% or 50% of the dwelling coverage is required on policies issued or renewed on or after October 1, 2005 (current law is only 25%). OIR is required to submit a report to the Legislature to include findings and recommendations on law and ordinance coverage by January 1, 2006.
- Insurers are required to notify applicants and policyholders of the availability and amount of premium discounts for fixtures and construction techniques that reduce the amount of loss in windstorm.
- Denial of a sinkhole claim is allowed if it is determined no sinkhole loss exists. Sinkhole coverage is required to include the cost of stabilizing the land and building as well as repair of the foundation. Insurers are required to provide an engineer or geologist to conduct sinkhole testing at the request of the insured. Payment of sinkhole claims are limited to actual cash value. Insurer must report payments made to sinkhole claims to the county property appraiser. Seller of property must disclose all aspects of a sinkhole claim to the buyer. DFS is required to create a sinkhole database, which will include reports and certifications pertaining to claims paid for sinkholes.

SB 1662 {Chapter Law 2005-144} relating to unauthorized entities, provides that OIR and DFS may issue an immediate and final order against an unauthorized insurer to cease and desist activity that violates the unauthorized entities insurance law, and includes the following provisions:

- A violation of the prohibitions relating to representing or aiding unauthorized insurance entities constitutes an imminent threat to the health, safety, and welfare of the residents of the state of Florida.
- OIR and DFS are authorized to investigate records, accounts, transactions and documents pertaining to activities of any unauthorized insurer or person aiding or representing such insurer.
- Unauthorized insurers must initially obtain a certificate of authority (COA) or deposit, securities, cash or bond when such insurers seek to defend against an enforcement action filed in circuit court by OIR or DFS.
- Unauthorized insurers have 30 days after the service of process in which they may file a motion to challenge the service of process.
- Penalties for representing an unauthorized insurer do not apply to the actions of persons who assist OIR or DFS, at the agency's discretion, in the administration of OIR's responsibilities under the Unauthorized Insurers Process Law.

The 2005 Legislature appropriated $415,000 for development of the Small Employer Health Insurance Rate Data Collection System.

When completed the system will:

- Provide accurate, current rate data to Florida's small employers to enable them to make more informed health coverage purchasing decisions for their businesses, their employees and their families.
- Simplify the Small Employer Group Health Coverage rates filing process for insurers and HMOs expediting new products and services into the marketplace
- Enable the Office to quickly organize carrier submitted data for useful analysis by stakeholders (i.e., Governor's Office, Legislature, Financial Services Commission, etc.)

This new application will allow for full integration with the more advanced Office technology systems. It will provide a transparent, broadly visible pricing mechanism, which will result in more informed consumers, policymakers and existing insurers and potential market entrants.

In the 2004 Legislative Session, HB 1629 (Chapter Law 2004-297) created an act relating to affordable health care based upon the work and recommendations from the Select Committee on Affordable Health Care for Floridians. The Office is responsible for two studies under the law:

- The first study requires the Florida Health Insurance Plan board of directors (the Director of the Office of Insurance Regulation or his or her designated representative shall serve as chair) to submit an actuarial study to the Governor, the President of the Senate, and the Speaker of the House of Representatives that determines the impact the plan's creation will have on the small group market, the number of individuals the pool could reasonably cover at various funding levels, a recommendation as to the best source of funding for anticipated deficits, and the effect on the individual and small group market by including persons eligible for HIPAA coverage. Requires the report to be submitted by December 1, 2004 and annually thereafter to the Governor and the Legislature.
- The second creates the "Small Employers Access Program" that authorizes the Office to select an insurer, through competitive bidding, as an alternative method to provide coverage to small employers with 2-25 employees within established geographical areas. Requires the Office to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than March 15 following the close of the prior calendar year. Requires the report to summarize the activities of the program in the preceding calendar year, including the net written and earned premiums, program enrollment, the expense of administration, and the paid and incurred losses.

SB 1926 (Chapter Law 2004-82) requires the Office to submit an annual report evaluating competition in Florida's workers' compensation market.

- Defines the reporting criteria, to include: an analysis of the availability and affordability of workers' compensation coverage, whether the current

market structure, conduct, and performance are conducive to competition, based upon economic analysis and tests.
- Requires the annual report to document the Office's investigation and study of all workers' compensation insurers in the state, including any data, statistics, schedules, or other information that assists in the review of workers' compensation rate filings. The annual report is due to the President of the Senate and the Speaker of the House of Representatives by January 1 each year.

SB 2038 (Chapter Law 2004-370) and SB 2994 (Chapter Law 2004-290) requires two studies:
- The Florida State University Department of Risk Management and Insurance, under the direction of the Office of Insurance Regulation, is required to conduct a feasibility and cost-benefit study of a potential Florida Sinkhole Insurance Facility and other matters related to the affordability and availability of sinkhole insurance.
- Requires the university to submit a preliminary report of its analysis, findings, and recommendations to the Financial Services Commission and the Legislature by February 1, 2005, with a final report due on April 1, 2005.
- The Legislative Auditing Committee, in contract with the Department of Risk Management and Insurance at Florida State University, is required to conduct a detailed analysis of factors affecting costs and potential assessments on consumers, availability of personal lines property and casualty insurance in Florida, and areas in which coverage is underwritten by the Citizens Property and Casualty Insurance Company.
- Requires completion of the analysis by February 1, 2005. The Department of Financial Services, the Office of Insurance Regulation, and insurers shall cooperate with Florida State University and the Legislative Auditing Committee.

In 1997, the Division of Insurer Services (now known as the Office of Insurance Regulation) began the implementation of an electronic application that would allow insurers to electronically compile and submit insurance rate information required by Florida law. Each system had two components: a Rate Collection System (RCS) that insurers downloaded and used to compile and submit the data, and a Rate Management System (RMS) which allowed the Division of Insurer Services to manage and report on the data. Both RCS and RMS applications were created for Automobile, Dwelling/Fire, Small Group Health Coverage, and Homeowners insurance.

The applications for each line of insurance are called:
- The Auto Rate Collection System (ARCS) and the Auto Rate Management System (ARMS)
- The Dwelling/Fire Rate Collection System (DRCS) and the Dwelling/Fire Management System (DRMS)
- The Homeowners Rate Collection System (HRCS) and the Homeowners Rate Management System (HRMS)

These systems were designed with state of the art technology for that time, but were created before the introduction of other now integral systems within the Office. In the seven years since these applications were created, the main database at the Office, Company and Other Regulated Entities (CORE) Navigator, has been re-engineered, an Internet filing (I-File) application has been created which allows insurers to file rates and forms electronically, and a back-end electronic document management system (EDMS) was created that automatically receives incoming filings, separates them into components, and electronically routes them to the appropriate bureaus. In 2002, these RCS and RMS systems were web-enabled but were not linked to the CORE, I-File or EDMS applications, nor have critical functionalities been upgraded. The absence of this link means information received in RMS must be printed and then scanned into the Office's Electronic Document Management System (EDMS). This manual procedure is the only business process that is not currently performed within EDMS. I-File is also used to transmit commercial filings; however, the initial system has not been enhanced to provide filing component requirements, which would aid commercial insurance companies in the transmission of their filings.

The Office is also seeking funding to expand the application of the Public Hurricane Model. In order to develop an unbiased and non-proprietary model the Legislature approved funding beginning in Fiscal Year 2000-2001 for the development and maintenance of a risk assessment model for hurricanes. The model is public and non-proprietary, based on the best practices and scientific analysis available. The model is used for rate making and to assess the efficacy of disaster mitigation strategies. In its present stages of development, the model may only be used to evaluate losses from residential structures. The proposed expansion will facilitate the use of the model to estimate losses to additional structures such as apartment or condominiums. This is an important expansion as these types of structures are prevalent along the Florida coastline.

## GLOSSARY OF TERMS AND ACRONYMS

Activity - A set of transactions within a budget entity that translates inputs into outputs using resources in response to a business requirement. Sequences of activities in logical combinations form services. Unit cost information is determined using the outputs of activities.

Actual Expenditures - Includes prior year actual disbursements, payables and encumbrances. The payables and encumbrances are certified forward at the end of the fiscal year. They may be disbursed between July 1 and December 31 of the subsequent fiscal year. Certified forward amounts are included in the year in which the funds are committed and not shown in the year the funds are disbursed.

Ad Hoc - For a specific purpose, case or situation

Appropriation Category – is the lowest level line item of funding in the General Appropriations Act which represents a major expenditure classification of the budget entity. Within budget entities, these categories may include: salaries and benefits, other personal services (OPS), expenses, operating capital outlay, data processing services, fixed capital outlay, etc. These categories are defined within this glossary under individual listings. For a complete listing of all appropriation categories, please refer to the ACTR section in the LAS/PBS User's Manual for instructions on ordering a report.

ARTS - Automated Rate Tracking System

Baseline Data - Indicators of a state agency's current performance level, pursuant to guidelines established by the Executive Office of the Governor in consultation with legislative appropriations and appropriate substantive committees.

Budget Entity - A unit or function at the lowest level to which funds are specifically appropriated in the appropriations act. "Budget entity" and "service" have the same meaning.

CCRC – Continuing Care Retirement Communities

CFO - Chief Financial Officer

CIO - Chief Information Officer

CIP - Capital Improvements Program Plan

Citizens - Citizens Property Insurance Corporation

CORE - Companies and Other Related Entities

CPM - Certified Public Manager

CTI - Computer Telephony Integration

D3-A – is a legislative budget request (LBR) exhibit which presents a narrative explanation and justification for each issue for the requested years.

Demand - The number of output units which are eligible to benefit from a service or activity.

EDMS - Electronic Document Management System

EOG - Executive Office of the Governor

Estimated Expenditures - Includes the amount estimated to be expended during the current fiscal year. These amounts will be computer generated based on the current year appropriations adjusted for vetoes and special appropriations bills.

F.A.C. - Florida Administrative Code

FAJUA - Florida Automobile Joint Underwriting Association

FEMA - Federal Emergency Management Agency

Fixed Capital Outlay - Real property (land, buildings including appurtenances, fixtures and fixed equipment, structures, etc.), including additions, replacements, major repairs, and renovations to real property which materially extend its useful life or materially improve or change its functional use. Includes furniture and equipment necessary to furnish and operate a new or improved facility.

FRPCJUA - Florida Residential Property and Casualty Joint Underwriting Association

F.S. - Florida Statutes

FSC - Financial Services Commission

FTE - Full Time Equivalent

FWCJUA – Florida Workers' Compensation Joint Underwriting Association

FWUA - Florida Windstorm Underwriting Association

FY - Fiscal Year

GAA - General Appropriations Act

HMO - Heath Maintenance Organization

HR - Human Resource

ICHEIC - International Commission on Holocaust Era Insurance Claims

IG - Inspector General

Indicator - A single quantitative or qualitative statement that reports information about the nature of a condition, entity or activity. This term is used commonly as a synonym for the word "measure."

Information Technology Resources - Includes data processing-related hardware, software, services, telecommunications, supplies, personnel, facility resources, maintenance, and training.

Input - See Performance Measure

IOE - Itemization of Expenditure

IP - Internet Protocol

IT - Information Technology

JAD - Joint Applications Development

Judicial Branch - All officers, employees, and offices of the Supreme Court, district courts of appeal, circuit courts, county courts, and the Judicial Qualifications.

LAN - Local Area Network

LAS/PBS - Legislative Appropriations System/Planning and Budgeting Subsystem. The statewide appropriations and budgeting system owned and maintained by the Executive Office of the Governor.

LAST - Legal Assignment Tracking system

Legislative Budget Commission (LBC) – is a standing joint committee of the Legislature. The Commission was created to: review and approve/disapprove agency requests to amend original approved budgets; review agency spending plans; and take other actions related to the fiscal matters of the state, as authorized in statute. It is composed of 14 members appointed by the President of the Senate and by the Speaker of the House of Representatives to two-year terms, running from the organization of one Legislature to the organization of the next Legislature.

Legislative Budget Request (LBR)- A request to the Legislature, filed pursuant to section 216.023, Florida Statutes, or supplemental detailed requests filed with the Legislature, for the amounts of money an agency or branch of government believes will be needed to perform the functions that it is authorized, or which it is requesting authorization by law, to perform.

Long-Range Program Plan (LRPP) - A plan developed on an annual basis by each state agency that is policy-based, priority-driven, accountable, and developed through careful examination and justification of all programs and their associated costs. Each plan is developed by examining the needs of agency customers and clients and proposing programs and associated costs to address those needs based on state priorities as established by law, the agency mission, and legislative authorization. The plan provides the framework and context for preparing the legislative budget request and includes performance indicators for evaluating the impact of programs and agency performance.

NAIC - National Association of Insurance Commissioners

Narrative - Justification for each service and activity is required at the program component detail level. Explanation, in many instances, will be required to provide a full understanding of how the dollar requirements were computed.

NASBO - National Association of State Budget Officers

Nonrecurring - Expenditure or revenue which is not expected to be needed or available after the current fiscal year.

OCO - Operating Capital Outlay

OIR – Office of Insurance Regulation

OITS - Office of Information Technology Services

OPB - Office of Policy and Budget, Executive Office of the Governor

OPS - Other Personal Services

Outcome - See Performance Measure

Output - See Performance Measure

Outsourcing - Describes situations where the state retains responsibility for the service, but contracts outside of state government for its delivery. Outsourcing includes everything from contracting for minor administration tasks to contracting for major portions of activities or services which support the agency mission.

Pass Through - Funds the state distributes directly to other entities, e.g., local governments, without being managed by the agency distributing the funds. These funds flow through the agency's budget; however, the agency has no discretion regarding how the funds are spent, and the activities (outputs) associated with the expenditure of funds are not measured at the state level. NOTE: This definition of "pass through" applies ONLY for the purposes of long-range program planning.

PBPB/PB2 - Performance-Based Program Budgeting

Performance Ledger - The official compilation of information about state agency performance-based programs and measures, including approved programs, approved outputs and outcomes, baseline data, approved standards for each performance measure and any approved adjustments thereto, as well as actual agency performance for each measure.

Performance Measure - A quantitative or qualitative indicator used to assess state agency performance.

- Input means the quantities of resources used to produce goods or services and the demand for those goods and services.
- Outcome means an indicator of the actual impact or public benefit of a service.
- Output means the actual service or product delivered by a state agency.

Policy Area – is a grouping of related activities to meet the needs of customers or clients which reflects major statewide priorities. Policy areas summarize data at a statewide level by using the first two digits of the ten-digit LAS/PBS program component code. Data collection will sum across state agencies when using this statewide code.

Privatization - Occurs when the state relinquishes its responsibility or maintains some partnership type of role in the delivery of an activity or service.

Program - A set of activities undertaken in accordance with a plan of action organized to realize identifiable goals based on legislative authorization (a program can consist of single or multiple services). For purposes of budget development, programs are identified in the General Appropriations Act by a title that begins with the word "Program." In some instances a program consists of several services, and in other cases the program has no services delineated within it; the service is the program in these cases. The LAS/PBS code is used for purposes of both program identification and service identification. "Service" is a "budget entity" for purposes of the LRPP.

Program Purpose Statement - A brief description of approved program responsibility and policy goals. The purpose statement relates directly to the agency mission and reflects essential services of the program needed to accomplish the agency's mission.

Program Component - is an aggregation of generally related objectives which, because of their special character, related workload and interrelated output, can logically be considered an entity for purposes of organization, management, accounting, reporting, and budgeting.

Reliability - The extent to which the measuring procedure yields the same results on repeated trials and data are complete and sufficiently error free for the intended use.

Residual market premium - Insurance premium written by the insurer of last resort. In Florida, this would include the Florida Residential Joint Underwriters Association (JUA), The Florida Workers' Compensation JUA and all other JUA residual market entities within the state.

SERFF - System for Electronic Form and Rate Filing

Service - See Budget Entity

Standard - The level of performance of an outcome or output.

STO - State Technology Office

SWOT - Strengths, Weaknesses, Opportunities and Threats

TCS - Trends and Conditions Statement

TF - Trust Fund

Tort Liability Claim - Tort is a wrongful act other than a breach of contract that injures another and for which the law imposes civil liability: a violation of a duty (as to exercise due care) imposed by law as distinguished from contract for which damages or declaratory relief (as an injunction) may be obtained.

TRW - Technology Review Workgroup

Unit Cost - The average total cost of producing a single unit of output – goods and services for a specific agency activity.

Validity - The appropriateness of the measuring instrument in relation to the purpose for which it is being used.

"Viatical Settlement" – is the sale of a life insurance policy to a licensed viatical settlement provider in return for a negotiated payment. This payment is usually represented as a percentage of the policy's face value.

ZBB - Zero-Based Budgeting