Office of Insurance Regulation

FINANCIAL SERVICES COMMISSION

Long-Range Program Plan

FY 2007-08 through 2011-12

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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 and Discount Medical Plan Organizations. Form filings include policy forms (contracts), new products or changes to existing products. Rate filings are requests from the insurer to maintain, 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 property insurance, health insurance, medical malpractice insurance, workers' compensation insurance, and the advent of credit scoring.

Florida's property insurance market has reached a critical level, both from the standpoint of availability and affordability. Many consumers are unable to secure affordable property coverage. While the number of insurers writing property coverage in Florida has increased, the volume of business written has been curtailed by many insurers. This is primarily due to the dramatic increase in reinsurance costs, but is also impacted by factors such as increased capital requirements from the rating agencies as well as decreased risk appetite from commercial market carriers. In the 2006 Session, the Legislature passed Senate Bill 1980 which included a number of reforms intended to enhance and provide some temporary relief in the Florida property market:

- Layer of reinsurance below the Florida Hurricane Catastrophe Fund for Limited Apportionment eligible insurers

- Established funding for a $250 million hurricane damage mitigation program to fortify Florida residential structures to better withstand tropical and hurricane force winds
- Established funding for a $250,000 million insurance capital build-up program to encourage new or better capitalized entrants into the market

Citizens Property Insurance Corporation (Citizens)

- Appropriates $715 million to Citizens to offset the 2005 deficit, which is estimated at $1.7 billion.
- Effective July 1, 2008, a personal lines residential structure or a single condo unit that has a combined dwelling and content replacement cost of $1 million or more would not be eligible for coverage.
- Requires the Financial Services Commission (FSC), rather than the Office, to approve Citizens' Plan of Operation. Requires the Executive Director of Citizens to be confirmed by the Senate.
- Requires the Office to perform a market conduct examination of Citizens every two years.
- Allows Citizens to adopt policy forms that contain more restrictive coverage than provided in the voluntary market.
- Allows Citizens to assume policies of an insolvent insurer under such forms and rates deemed appropriate and approved by the Office.
- Requires insurers writing the non-wind coverage to contract with Citizens to provide claims adjusting services for the wind coverage, but delays the requirement until July 1, 2007.

Emergency Orders; Rules

- Authorizes the Commissioner of the Office of Insurance Regulation to issue orders when the Governor declares a state of emergency.
- Requires the FSC adopt rules standardizing requirements that may be applied to insurers after a hurricane, addressing claims reporting requirements, grace periods for payment of premiums, and temporary postponement of cancellations and non-renewal.
- Provides that any emergency rule that conflicts with the standardized rules must be by unanimous vote of the Financial Services Commission.

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 projected 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. Subsequently, the Office approved a

reduction in rates of 5.2% effective January 1, 2005, and a reduction of 13.5% effective January 1, 2006. Currently, there is a pending filing for a reduction of 13.3% effective January 1, 2007. If this filing is approved as filed, the cumulative rate change since Senate Bill 50A passed will be a reduction of 38.9%. This is a remarkable series of rate reductions and is a promising trend for Florida's workers' compensation marketplace.

SB 50A also 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 FWCJUA by passing HB 1251 in the 2004 Legislative Session. 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 Administration Trust Fund, which has been approved by the Legislative Budget Commission. The total amount of funds transferred to the FWCJUA for subplan "D" deficits is $7,896,889. The current estimates as of June 2006 are that the FWCJUA will need an additional $3.9 million from the contingency fund to fully fund the deficit in subplan "D". Future legislative changes will be needed to access the contingency fund and 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 were 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. Since the legislation passed on September 15, 2003, there have been a total of 19 companies that have entered Florida's medical malpractice market.

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 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. The 2006 Legislature appropriated $150,000 to the Office to gather title insurance data in accordance with section 624.501(27)(e)(2), Florida Statutes. The data will be collected from licensed agents, agencies, and insurers. In addition, the Office shall retain the services of an independent actuary with experience and expertise in the title insurance industry to assist with the title data collection and analysis.

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 three (3) 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”, 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 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.

Furthermore, the Act requires insurance carriers, health care providers and the Office to provide easily accessible data about pricing and quality of service information so that insurance consumers are empowered to make informed decisions about their health care and health insurance options. In June 2006, the Office launched a website that provides Floridians the ability to compare and search the benefits and premiums for small employer health plans offered in the state. Small businesses can use the site to obtain a sample monthly cost to provide health insurance for their employees. The Small Employer Rate Collection System (SERCS) website gives small employers the ability to view small group major medical health insurance rates for standard, basic and high deductible health plans currently available in the state. Small businesses can enter the number of employees in various categories and calculate an estimated monthly cost for their company. In addition to searching for small group employer rates, the website will have links for frequently asked questions on small employer heath insurance, links to various health insurance consumer guides and information for consumers to request assistance for information on health insurance. All small group carriers made their filings by September 2006, and the Office expects the consumer website to be populated with all of the choices and options by November 2006.

Numerous Floridians have been misled by unscrupulous actors and entities about what they are purchasing. A recent trend has been consumers purchasing discount medical cards from discount medical plan organizations (DMPOs) and the Act implements certain regulatory and disclosure requirements. As of September 2006, there are 70 known discount medical plan organizations operating in Florida, 56 filed an application for licensure, 37 were granted a Certificate of Authority, and 3 authorized insurers have added the DMPO Line of Business to their existing certificate of authority. The Office of Insurance Regulation received a total of 527 form and rate filings from DMPOs of which 333 have been approved. The Act also expanded 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.

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 most recent DFS complaint statistics show that complaints for DMPOs have dropped over 90% since the new law became effective. Some of the additional accomplishments of the law include:

Financial Stability – the new law requires DMPOs to maintain a net worth of $150,000, and requires submission of annually audited financial statements. This has enabled the Office of Insurance Regulation (Office) to suspend one DMPO, and intervene with other troubled plans to ensure that DMPOs could honor the advertised benefits.

Stability in the Marketplace – Of the roughly 60 DMPOs operating in Florida prior to the law, only 37 received certificates of authority upon passage of the new law eliminating many of the "bad actors" that were preying on consumers.

Reasonably Priced Products – Prior to the new law some DMPOs charged up to $100 for nonrefundable application fees, and $269 monthly fees. Consumers often confused such high priced plans with health insurance. The new law and subsequent revision in 2005 capped the monthly fees to $30 a month. This has helped ensure that consumers received benefits in relation to their monthly fee, and that consumers are not confusing the product with health insurance.

The Office continues to dedicate a 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.

The 2006 Legislature passed HB 299, which makes it an unfair trade practice to use travel plans in underwriting life insurance policies unless the insurer can prove that it is based on sound actuarial principles and actual or reasonably anticipated experience and provides a process to make exceptions to the bill using the rulemaking authority of the Florida Cabinet. Under the legislation, the Office is required to review all applications that are denied based on travel in future market conduct examinations and triple the fines for such violations.

The law prevents insurance companies from unfairly discriminating against people who travel outside the country. The measure prohibits charging higher rates or refusing coverage to those applying for insurance solely on the basis of that individual's past lawful foreign travel experiences or solely on the basis of the individual's future lawful foreign travel plans (unless the insurer can provide justification as to why the travel has an adverse effect on their health or life expectancy).

Similarly, the Financial Services Commission (FSC) unanimously approved Rule 690-125.003, Relating to Unfair Discrimination Because of Travel Plans, F.A.C. as authorized by the Unfair Insurance Trade Practices Act. The rule prohibits insurance companies from refusing coverage or charging different rates to consumers without actuarial justification.

The Office staff plays a major role in other initiatives that resulted from previous legislative enactments, 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, is responsible 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. The Office sent requests for statements or qualifications/request for quotes to 459 licensed small employer carriers soliciting their participation in the program. Through January 15, 2006, the closing date for proposals, no bids or proposals were received by the Office.

The Office is participating in several National Association of Insurance Commissioners (NAIC) initiatives to include 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. In addition, the Office of Insurance Regulation serves on committee and sub-groups designated to develop standards for an InterState Compact. The Compact will allow companies to submit their life, annuity, disability income and long-term care policies and, upon approval, be allowed to market those products in each of the participating states.

Finally, to enable the NAIC to compare all insurance department policy filings and processing standards on a nationwide basis, the Office instituted several electronic form and rate I-File system enhancements. These changes allow Florida to conform to the National Association of Insurance Commissioner's (NAIC) product matrix and coding standards. In addition to making Florida's codes consistent with the national standards, the changes made the filing system more user-friendly.

The Multi-State Review Program (MSRP) offers insurance companies the opportunity to submit an individual, online annuity contract filing simultaneously to seven states (Georgia, Louisiana, Florida, Texas, California and Nevada) and the District of Columbia. Annuity filers use Florida's online I-File system {https://iportal.fldfs.com/ifile/default.asp} to submit filings, which are subject to the combined annuity review standards and provide companies with 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 with an average review period of 35 days and reach over a-quarter of the country's annuities market. The Office began work on developing life standards to allow for simultaneous review and approval of life insurance products, including

riders, through the MSRP. Company participation in the MSRP is free (although some existing participating state filing fees may apply) and only requires an Internet connection.

GOAL #2: Protect the public from unethical insurance practices.
Market Investigations monitors the activities of the Florida insurance marketplace to detect and remedy unfair trade practices and other Insurance Code violations that pose a risk of harm to consumers.

Nationally, there has been a shift away from routine examinations of insurers performed at regular intervals. The recent trend has moved toward target or multi-state examinations. Florida continues to be a national leader in identifying significant issues through market analysis; review of information reported in financial statements, analyzing complaint data, lawsuit activity and other data sources to determine that a particular practice may be affecting consumers. This enables the Office to concentrate its efforts on those practices that have the most potential for public harm. The Office uses target examinations to efficiently address issues that may affect a large number of Floridians. Multi-state examinations are used more frequently than in the past to work in coordination with other state regulators to resolve issues that may affect consumers in numerous states.

This shift toward investigations, particularly focusing on the more significant issues will require more sophisticated staffing and a more creative approach. Efforts to make this transition are underway and are expected to continue during the years 2007-2012.

Much of the effort of the Market Investigations staff in the aftermath of the 2004-2005 hurricanes has been focused on property insurance issues and the myriad of issues surrounding hurricane claim payments. In the years before that, the sale of unauthorized insurance was a prominent issue. Some of the unauthorized activity has been addressed, although this activity is typically cyclical, increasing with the hardening of legitimate insurance markets.

In the coming years, property insurance is likely to remain a high priority along with issues affecting older Floridians. One of the issues affecting the elderly that will be a source of activity for Market Investigations is the sale of annuities to seniors. The law now requires the agent or the company to keep records substantiating the suitability of the annuity purchase to meet the insured's financial goals. Market Investigations is responsible for ensuring compliance with these new laws.

Market Investigations has also taken on more responsibility to verify that data sent from insurance companies to the Office is accurately reported. The Legislature and other policymakers rely on this data for important policy decisions. Recent reviews have confirmed that the Office needs to have an audit program in place to emphasize data quality and on the companies' attention to accurate reporting. This activity is expected to continue.

Goals for the years 2007-2012 include refining our ability to detect harmful market practices early; efficiently conducting investigations; timely reporting the results of investigations; and taking swift, appropriate administrative action to address violations of the law. Emphasis is also being placed on encouraging future compliance and on restitution to policyholders or other victims.

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 areas of expertise: Life & Health, Property & Casualty and Specialty Insurers. Each unit 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.

Similar to 2004, the 2005 Hurricane Season saw four major storms impact Florida resulting in 1.2 million policyholder claims worth an estimated $11 billion. Many safeguards instituted since Hurricane Andrew, including the Florida Hurricane Catastrophe Fund, increased building code standards, and Citizens Property Insurance Corporation, again proved very effective in girding the financial stability of the property insurance market. The 2005 Hurricane Season caused the insolvency of three insurers, all from the same group. Added to the single failure after the 2004 Hurricane Season, there have been only four insolvencies after eight storms resulting in 2.8 million claims and $36 billion in insured losses compared to Hurricane Andrew, with 700,000 claims, $15.5 billion in insured losses and 12 insolvencies. However, a significant number of insurers have withdrawn from the residential property market and others have significantly curtailed writing. The Office has also seen issues with availability and affordability of catastrophe reinsurance. This contraction of private insurers offering residential property coverage has caused an increase in the number of policies being written by Citizens Property Insurance Corporation.

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 are 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 regulations took place that are inadequately priced and significant rate increase requests are anticipated.

In 2005, the Office conducted a comprehensive study of Long Term Care (LTC) Insurance in an effort to find solutions to rate increases on older LTC policies and to enhance sales on newer adequately priced products. The collected feedback from the study, private insurers, consumers and the regulators as well as from the 2005 public hearing in Tampa, which ultimately led to the Long-Term Care Insurance market reforms of 2006.

In 2006, Florida Legislature approved a senior protection bill, HB 947, which makes Long-Term Care Insurance (LTC) more affordable, available, and marketable. The law is designed to restore confidence in the LTC market and increase overall sales which have declined in recent years due to problems in the market. The legislation establishes a Long-Term Care Partnership Program with Medicaid, which provides seniors incentives to purchase more affordable Long-Term Care Insurance, by allowing them to protect their personal assets in an amount equal to the benefits provided by their policy from Medicaid spend-down requirements.

In closed blocks of business, the law protects seniors by limiting the amount of a rate increase applicable to in-force long term care policies and provides a non-forfeiture benefit on lapse as well as an incontestability provision. As a result, seniors will know that their insurer did a thorough job of reviewing their application and will be protected from post-claim underwriting or any frivolous allegations of fraud when applying for benefits. Seniors and their families are protected from excessive rate increases in the future that result from an insurer choosing to close a block of business and sending it into a rating “death spiral.” In the event of justifiable rate increases, seniors now have options to reduce benefits or cancel their policy but at least walk away with a paid up policy equal to the amount of premiums already paid. This is currently available to seniors that purchased a LTC policy after March 2003; however, at that time, the Legislature did not include the same protections to policies already in force.

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).

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, and increased health care and aging facilities. This is especially true with the recent changes in the property insurance market. Many of the CCRC's are finding it more difficult to afford their historical levels of property insurance. Several have voiced concerns of not being able to find an insurer willing to write a policy.

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".

Third Party Administrators (TPA's) have historically presented issues of concern within the Office. These entities provide administrative services to Life and Health Insurers, which include, but are not limited to: solicitation of insurance coverage, collection of premiums, and claims adjustment and settlement. TPA's generally handle millions of consumer premium dollars. Mismanagement and misappropriation of these funds, including a lack of proper internal controls can result in financial harm to insurers and consumers. In an effort to better ascertain the financial condition of TPA's and provide increased consumer protections, legislation was passed in 2005 which requires that all TPA's submit annual audited financial statements.

During 2005 and early 2006, the Office completed Phase II of the Financial Analysis and Monitoring Electronic Data Management System (FAME). FAME is a state-of-the-art financial analysis and monitoring system combining on-line filing with electronic workflow and document management.

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 allows 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, the system increases 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 unit called "Business Development and Market Research" (BDMR). The BDMR is responsible for the retention and expansion of insurance companies in the Florida marketplace and serves as the information clearinghouse for the collection and dissemination of public data for the Office. BDMR also manages the company application process and is responsible for the coordination of licensure approvals by the Commissioner.

The purpose of the Business Development Unit is to work with Enterprise Florida and other economic development councils throughout the state to promote the benefits of expanding or moving lines of business to Florida and facilitating the regulatory process for established and new insurance companies. The primary role of Business Development is to facilitate the regulatory process for companies and to streamline the many steps companies must take to comply with the Florida Insurance Code. The goal of this effort is to retain companies, while attracting new insurers and products to increase competition that ultimately benefits Florida's consumers. To that end, the Unit redesigned the Office's website to make all required filings paperless and error-free. Another goal of the Unit is to identify financially fit, highly rated companies not writing in Florida, communicate the positive aspects of the Florida marketplace by leveraging existing marketing efforts undertaken by Enterprise Florida, and incentivize them to expand or domesticate in Florida.

As the marketing arm of the Office, the Business Development Unit works with Enterprise Florida and other economic development councils throughout the state to play a proactive role in promoting the opportunities available to insurance companies in the Florida marketplace. The unit is charged with continuously modifying the Office's website to accommodate the ever-changing statutory and business requirements in Florida's insurance market. Finally, while working in conjunction with the Market Research Unit, the Business Development Unit makes every effort to assist companies that have submitted applications for licenses or amendments to licenses as the application goes through the review process.

The mission of the Market Research Unit (MRU) 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. To accomplish the goals of the unit, MRU staff is responsible for the management of various OIR applications. The activities associated with the management of the applications include the collection, validation and dissemination of data associated with various regulatory functions.

The MRU provides research support and assistance in the preparation of reports and studies. Other services provided by the Market Research Unit include the publication of a wide range of standardized reporting for its varied constituency. Many of these reports are also found or are slated to be published at the Office's web site {www.floir.com}. These include the statutory data collections enumerated above, rate change reports by company and product type, and market share reports by line of business (coverage type).

The unit is responsible for the day to day management of the Office's development of major technology systems. Serving as project managers, subject matter experts and data consultants, the MRU has contributed to such technology projects as:

- The establishment of a centralized data warehouse for mission critical OIR data;
- The development of the Catastrophic Event Data Collection and Analysis (CEDRA) reporting module;
- The development of the Small Employer Rate Collection (SERCS) solution; and
- The Financial Analysis and Monitoring Electronic Document Management System (FAME).

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 will undertake several technology projects in the 2006-2007 fiscal year, and is requesting funding to re-engineer existing applications in 2007-2008.

In 2006, the Office received an appropriation to 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 companies time and financial resources, ultimately benefiting the consumer.

The Office remains committed to fostering and developing a robust competitive market for risk capital in Florida. The hurricanes of 2004 and 2005 resulted in a significant disruption in the pricing and availability of the risk capital upon which primary insurers rely to finance Florida's property insurance market.

The Office has initiated a systematic program to introduce a series of innovations that reflect recent developments in the risk transfer and capital markets. The objective is to reduce the frictional cost to primary insurers of obtaining catastrophic risk finance, while at the same time ensuring that effective risk transfer using these mechanisms enhances the financial solvency of the primary insurers, for the benefit of Florida's property insurance policy holders.

This is a long-term process. New markets and solvency frameworks take time to develop and expand. With continued effort and market acceptance, the end result will be a more stable insurance market in the state. Related objectives are as follows:

- Adapt the financial solvency oversight framework to reflect developments in the market with respect to legitimate effective risk transfer.
- Working with the legislative and executive branches, aid in creating market opportunities and structures to attract catastrophic risk finance capital.

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 2007-2008	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
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 2007-2008	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
180	100	95	90	90	90

NOTE: The statutory requirement is processing an application within 180 days of receipt by the Office; however, for the 2005-06 Fiscal Year, the average number of days to process an application was 65.

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 2007-2008	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
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 2007-2008	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
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 2007-2008	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
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 2007-2008	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
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 2007-2008	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
303,610	303,610	349,151	401,523	461,751	531,013

OBJECTIVE 4C: Increase competition in the insurance market

OUTCOME: Number of new applications filed with the OIR

Baseline Year 2005-2006	FY 2007-2008	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
567	567	625	656	689	723

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 2007-2008	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 2007-2008	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. At the end of Fiscal Year 2005-2006, the total number of regulated entities in Florida was approximately 3,800.

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; being accredited by the NAIC demonstrates 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. During 2006, Florida is serving as the Chair of the Property & Casualty Insurance Committee (C) Committee. The (C) Committee covers issues such as natural and manmade catastrophes, uninsured motorist availability and affordability of insurance, and coordination with the Federal Insurance Administrator on the regulation of flood insurance. Of the 55 Committees/Task Forces/Working Groups, in which Florida is a member, Florida staff serves as the Chair of the Southeastern Zone, one Committee and four working groups. Florida serves as vice-chair of three task forces and two working groups and is co-chair on one working group.

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. During 2006, the Commissioner has provided testimony to Congress relating to natural disasters and insurance related issues on behalf of the NAIC. Commissioner McCarty was also instrumental in the passing of a resolution by the NAIC requesting Congress to create a commission to study the need for a national catastrophe insurance plan. As part of the Commissioner's work on natural catastrophes, he has collaborated with the National Council of Insurance Legislators in drafting a National Catastrophe Insurance Plan. As a member of the NAIC, the Office 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.

Proposed Rule 69O-171.003, FAC, Reports by Insurers of Professional Liability Claims, workshop was held in July 2005; and a Notice of Proposed Rulemaking was published in February 2006. The Office conducted a Rule Hearing in March 2006 where insurers and any interested parties could provide additional comments and feedback. In addition, Proposed Rule 69O-171.009, FAC, Relating to Reporting Open claims, workshop was held in October 2003; and a Notice of Proposed Rulemaking was published in February 2006. The Office conducted a Rule Hearing in March 2006 to provide insurers and interested third parties comments and feedback. At this time, both Rules are being challenged and no court date has been set.

The Auditor General's staff audited the Medical Malpractice Claims Database in September 2004. The Office 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. At the present time, the Auditor General is conducting an

Operational Audit of the PLCR System and findings to improve the application will be made available to the Office.

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 2006 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: SB 1980 – Relating to Property Insurance (pages 3-4), HB 299 – Relating to Life Insurance (page 9), HB 541 – Resolution Supporting the Creation of a National Catastrophe Insurance Plan, HB 947 – Relating to Long-Term Care Insurance (see pages 13-14), and SB 1506 – Relating to Electronic Filling of Financial Statements.

HB 541 – {Resolution} - National Catastrophe Insurance
The resolution memorializes the Florida Legislature's support of the creation of a comprehensive National Catastrophe Plan. The Office, in conjunction with the National Association of Insurance Commissioners and the National Coalition of Insurance Legislators, continues to advance this effort with the United States Congress to create a viable National Catastrophe Plan to include the following:

- Provide consumers with private insurance programs with all-perils protection; promote personal responsibility through mitigation.
- Enhance local and state government role in catastrophe preparedness, emergency management and response.
- Engage federal government assistance in risk management and financing of mega-catastrophes.
- Promotes a proposal that allows private insurers to develop reserves against future catastrophic losses on a tax deferred basis
- Allows property owners to accumulate savings in a personal disaster account on a tax deferred basis (similar to a Health Savings Account)
- Creates disaster funds similar to the Florida Hurricane Catastrophe Fund on a state-by-state or regional basis to assume the risk of a higher layer of loss through reinsurance.

SB 1506 {Chapter Law 2006-64} created an act relating to Electronic Filing Statements

- Grants the Office authority to adopt rules to require Viatical Settlement Providers, Premium Finance Companies, Continuing Care Retirement Communities, and Life Expectancy Providers to submit their annual audited financial statements electronically to the Office.
- Authorizes the Office to remotely access records of particular transactions of Viatical Settlement Providers, Premium Finance Companies, Continuing Care Retirement Communities, and Life Expectancy Providers.

- Modifies the implementation date for Viatical Settlement Providers to submit audited financial statements on a calendar year basis to January 1, 2008.

The Office currently collects data relating to personal and commercial residential polices to include, but are not limited to: number of policies in force, new policies written, policies non-renewed, policies cancelled, policies non-renewed or cancelled due to hurricane risk, exposure and written premiums. The information is reported quarterly using the Quarterly Supplemental Reporting System (QUASR). QUASR was built in the mid 1990's and web-enabled in 2000. The current system platform, thresholds and validation criteria is outdated. The data within QUASR provides the Office with the means to determine which companies have exposure in areas where a disaster has struck, which companies are writing new policies by geographic area as well as which companies are canceling policies. The Office will be requesting funding for fiscal year 2007-2008 to re-engineer the QUASR system to allow for more accurate reporting of personal and commercial residential policies and the addition of commercial non-residential policy information.

To continue meeting the requirements of s. 624.424(10), Florida Statutes and s. 69O-137.009, Florida Administrative Code, the Quarterly Supplemental Reporting System needs to be re-engineered. The Office has identified functionality in the current system that does not work, is out-dated or needed functionality does not currently exist. The Office has identified the following requirements:

- Interface with the Companies and Other Related Entities Database (CORE) and the Forms and Rates Electronic Document Management System (FREDMS)
- Provide automatic notifications to insurers and OIR analysts of missed filing deadlines.
- Provide enhanced business rules for filings to match the current insurance market place in Florida, i.e., average premiums
- Provide upfront validations data submissions, i.e., calculation of policies in-force
- Do not allow over-writes for validations and business rules
- Expand reporting to include commercial non-residential filings
- Expand Lines of Business for personal and commercial residential
- Provide enhanced searching and reporting capability for both OIR and consumers
- Update to new technologies such as .Net, and Oracle database

The Market Investigations Unit monitors the activities of the Florida insurance marketplace to assure proper compliance under the Florida Insurance Code.

To track progress on investigations and examinations, the unit utilizes a database built using Microsoft Access. The application currently houses approximately 10,000 investigation records and 4,300 examination records. The current system lacks scalability and has nearly reached its capacity for expansion. The unit is researching several alternatives to include off the shelf software that will allow for capacity planning as the records are stored off-site on a host server.

The Office is also seeking additional funding to expand the application of the Public Hurricane Model to include commercial property. 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 2006 Legislature approved $877,872 to start the design and development of the commercial residential portion of the model. The Office will be requesting funds to complete the second year of design and development of the commercial residential piece. This is an important expansion for Florida's consumers as these types of structures are prevalent along the Florida coastline.

GLOSSARY OF TERMS AND ACRONYMS

Activity – A unit of work which has identifiable starting and ending points, consumes resources and products outputs. 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 September 30 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 – 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 - Automobile 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.

CARFRA – Coordinating Advertising Rate and Form Review Authority

CCRC – Continuing Care Retirement Communities

CFO - Chief Financial Officer

CHIS – Comprehensive Health Information System

CIO - Chief Information Officer

CIP - Capital Improvements Program Plan

Citizens - Citizens Property Insurance Corporation

CMS – Centers of Medicare and Medicaid Services

CORE - Companies and Other Related Entities

CPM - Certified Public Manager

CTI - Computer Telephony Integration

D3-A – 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.

DOAH – Division of Administrative Hearings

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

FAME – Financial Analysis and Monitoring Electronic Data Management System

FEMA - Federal Emergency Management Agency

FFMIS – Florida Financial Management Information System

Fixed Capital Outlay (FCO) - 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.

FLAIR – Florida Accounting Information Resource Subsystem

FRPCJUA - Florida Residential Property and Casualty Joint Underwriting Association

F.S. - Florida Statutes

FSC - Financial Services Commission. Pursuant to Section 20.121(3), Florida Statutes, the FSC "shall not be subject to control, supervision, or direction by the Department of Financial Services in any manner, including purchasing, transactions involving real or personal property, personnel, or budgetary matters." The FSC is comprised of the Governor and Florida Cabinet and contains the Office of Insurance Regulation and Office of Financial Regulation.

FTE - Full Time Equivalent

FWCJUA – Florida Workers' Compensation Joint Underwriting Association

FWUA - Florida Windstorm Underwriting Association

FY - Fiscal Year

GAA - General Appropriations Act

GHIIAB – Governor's Health Information Infrastructure Advisory Board

GR – General Revenue Fund

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) – 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.

LOF – Laws of Florida

LTC – Long Term Care

MAN – Metropolitan Area Network (Information Technology)

Medigap – Medial Supplement Insurance

MSRP – Multi State Review Program

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 or Office – 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 – 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.

Primary Service Outcome Measure – The service outcome measure which is approved as the performance measure which best reflects and measures the intended outcome of a service. Generally, there is only one primary service outcome measure for each agency service.

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

UCAA – Uniform Certification of Authority Application

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.

WAGES – Work and Gain Economic Stability (Agency for Workforce Innovation)

WAN – Wide Area Network (Information Technology)

ZBB - Zero-Based Budgeting