

Office of Insurance Regulation
FINANCIAL SERVICES COMMISSION

Long-Range Program Plan
FY 2009-10 through 2013-14
September 2008

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OFFICE OF INSURANCE REGULATION

The Florida Legislature created the Office of Insurance Regulation (Office) in 2003:

“The Office of Insurance Regulation, which shall be responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the insurance code or chapter 636. The head of the Office of Insurance Regulation is the Director of the Office of Insurance Regulation, who may also be known as the Commissioner of Insurance Regulation.”

--Section 20.121, (3)(a)1, Florida Statutes

The Commissioner is appointed by, and reports to, the Financial Services Commission. The Commission is comprised of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture. The Commission serves as agency head for purposes of rulemaking pursuant to Section 120.536-120.565, F.S. Commission action is taken by majority vote. The Director (Commissioner) of Insurance Regulation is considered the agency head for purposes of final agency action for all areas within the regulatory authority delegated to the Office.

The Office is, for purposes of administrative, personnel, and technology support, housed within the Department of Financial Services (DFS). Office funding is appropriated directly by the Legislature from the Insurance Regulatory Trust Fund (IRTF), funded by insurance company licensing fees, fines that may be levied for non-compliance with provisions of the Insurance Code, and a portion of premium tax paid by surplus lines carriers transacting insurance in this State.

Mission Statement

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.

Vision

The Florida Office of Insurance Regulation envisions a robust and competitive insurance market while maintaining protections for the insurance buying public.

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

20.121 Department of Financial Services.--

(3) FINANCIAL SERVICES COMMISSION.--Effective January 7, 2003, there is created within the Department of Financial Services the Financial Services Commission, composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture, which shall for purposes of this section be referred to as the commission. Commission members shall serve as agency head of the Financial Services Commission. The commission shall be a separate budget entity and shall be exempt from the provisions of s. 20.052. Commission action shall be by majority vote consisting of at least three affirmative votes. The commission 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.

(e) Administrative support.--The offices shall have a sufficient number of attorneys, examiners, investigators, other professional personnel to carry out their responsibilities and administrative personnel as determined annually in the appropriations process. The Department of Financial Services shall provide administrative and information systems support to the offices.

Pursuant to this provision, the Office develops and presents its budget requests directly to the Executive Office of the Governor and the Florida Legislature. The Office has developed performance measures and standards to assess the performance of its activities in support of its budget requests.

With respect to the Office's interaction with DFS in matters involving administrative support, the Office has inherited the responsibility to directly manage its personnel matters – i.e., to recruit, advertise, and hire personnel -- subject to DFS personnel office review for compliance with required state agency hiring and personnel policies and procedures.

With respect to the Office's interaction with DFS in matters involving information systems support, the Office seeks independent and project specific appropriations for technology initiatives and upgrades. The Office has direct liaison with DFS technology support staff and it is the DFS Division of Information Systems that provides the Office with standard desktop, network, and programming assistance for integrated computer systems in use by both the Office and DFS.

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 other insurance related entities. 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.

Property Insurance

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 2007 Special and Regular Session, the Legislature passed HB 1-A and SB 2498 which included a number of reforms intended to enhance and provide relief to Florida's consumers and the Florida property market:

HB 1A – Hurricane Preparedness and Insurance, Passed During the 2007 Special Legislative Session.

- ⤴ Requires property insurers to make a rate filing with the Office reflecting the savings or reduction in loss exposure to the insurer due to the expanded Catastrophe Fund coverage. The Office must calculate a presumed factor to be used in the required rate filings to reflect the impact to rates of the changes, using generally accepted actuarial techniques and standards.
- ⤴ Requires insurers to make available to policyholders the option to exclude windstorm coverage, if the policyholder personally writes a statement that he/she does not want such coverage and provides documentation of approval by any mortgage or lien holder.
- ⤴ Eliminates maximum allowable deductibles, but requires a written statement by the policyholder and approval by a mortgage or lien holder if the deductible is in excess of 10 percent for a home valued at less than \$500,000. Insurers are still required to offer annual hurricane deductibles of 2 percent, 5 percent, and 10 percent of policy limits, with certain exceptions. The act allows, but does not require, the offer of a higher deductible.

- ⤴ Requires insurers to make available to policyholders the option to exclude coverage for contents, if the policyholder personally writes a statement that he/she does not want such coverage.
- ⤴ Requires 100 days written notice of nonrenewal of a residential property policy, rather than 90 days. Notice is required by June 1, or at least 100 days notice, whichever is earlier, for a nonrenewal effective between June 1 and November 30.
- ⤴ Requires insurers to allow personal lines residential and commercial policyholders to pay premiums on a quarterly or semiannual installment plan.
- ⤴ Prohibits, through January 1, 2009, the allowance for property and casualty insurers to implement a rate change prior to filing for approval with the Office (the current “use and file” option), unless the insurer files for a rate that is less than the insurer’s most recent rate approved by the Office. All filings that do not seek a lower rate must be made under the “file and use” procedures that require filing at least 90 days prior to the proposed effective date.
- ⤴ Prohibits the allowance for property and casualty insurers to submit a rate filing disapproved by the Office to an arbitration panel for final resolution for all filings made after the act’s effective date until January 1, 2009. Rate appeals would go to the Division of Administrative Hearings.
- ⤴ Deletes the provision that allows residential property insurers to increase or decrease rates by up to 5 percent on a statewide average, or 10 percent for any territory, without being subject to a determination by the Office that the rate is excessive or unfairly discriminatory, in areas where Office determines a reasonable degree of competition exists.
- ⤴ Requires the chief executive officer or chief financial officer and the chief actuary of a property insurer to sign a sworn affidavit, subject to perjury and administrative penalties, that the information in the rate filing does not contain any untrue statements of a material fact or omit material facts and reflects premium savings that are reasonably expected to result from legislative enactments and are in accordance with accepted actuarial techniques.
- ⤴ Prohibits excess profits by property insurers and requires refunds to consumers of any excess profits collected by an insurer over a ten-year period, if certain thresholds are met.
- ⤴ Allows a property and casualty insurer to provide a discount on a policy based on the fact that the insured purchased another policy or type of insurance from the insurer.
- ⤴ Requires insurers to specify on the premium renewal notice the:
 - Amount of any assessment by the Florida Hurricane Catastrophe Fund, Citizens Property Insurance Corporation, and the Florida Insurance Guaranty Association; and the full name of the assessing authority.
 - Amount of premium change due to a change in rate or coverage.
 - Combinations of discounts, credits, rate differentials, or reductions in deductibles, for windstorm mitigation.

- ⤴ Increases the minimum surplus requirement from \$5 million to \$50 million for a domestic residential property insurer that is a wholly owned subsidiary of an insurer authorized to do business in another state.
- ⤴ Requires insurers, effective January 1, 2008, writing private passenger automobile insurance in Florida and that write homeowners' policies in other states, to write homeowners' coverage in Florida, unless an affiliate writes homeowners insurance in Florida.
- ⤴ Requires the Financial Services Commission to take the following actions related to mitigation measures to strengthen homes against hurricane damage:
 - Adopt by rule a uniform home grading scale to grade a home's ability to withstand the wind load from a hurricane.
 - Develop by rule a uniform mitigation verification inspection form that must be used by all insurers to factor discounts for wind insurance.
- ⤴ Requires property insurers to provide coverage for catastrophic ground cover collapse, defined as geological activity that:
 - Results in the abrupt collapse of the ground cover that is clearly visible to the naked eye;
 - Results in structural damage to the building and its foundation; and
 - Results in the insured structure being condemned and ordered to be vacated by the appropriate governmental agency.
- ⤴ Authorizes the Office to require property insurers to report additional data on hurricane claims.

SB 2498 – Relating to Hurricane Preparedness and Insurance, Passed during the 2007 Regular Legislative Session

- ⤴ Prohibits a new certificate of authority for the transaction of residential property insurance to any insurer domiciled in Florida which is a wholly owned subsidiary of an insurer authorized to do business in any other state. Effective December 31, 2008.
- ⤴ Requires the rate filings of an insurer domiciled in Florida that is a wholly owned subsidiary of an insurer authorized to do business in any other state to include information relating to the profits of the parent company.
- ⤴ Requires an insurer to make available a policy that excludes coverage for windstorm coverage (rather than hurricane or windstorm coverage), and requires that all property insurers (commercial and residential) offer this coverage.
- ⤴ Specifies that the temporary prohibition against making a “use and file” rate filing applies to property insurance (but not casualty insurance) rate filings and clarifies that it applies to a rate filing submitted after January 25, 2007 (the effective date of HB 1-A).
- ⤴ Prohibits an insurer from recouping in its rates the interest payments the insurer makes for failure to pay or deny a property insurance claim within 90 days as required by statute.
- ⤴ Provides that 100 days' notice of non-renewal is required, rather than June 1, if earlier, for a nonrenewal effective during hurricane season, if the policy is being non-renewed for the sole purpose of revising the coverage for

sinkhole losses; or if the policy is non-renewed by Citizens for a policy assumed by an insurer that offers replacement or renewal coverage.

SB 2860 – the “Homeowner’s Bill of Rights,” passed during the 2008 Legislative Session

- ⤴ Eliminates the option for an insurer to appeal a property and casualty insurance rate filing (or other filing) disapproved by the Office to an arbitration panel in lieu of an administrative hearing. Current law prohibits use of arbitration until January 1, 2009.
- ⤴ Extends for one additional year, until December 31, 2009, the current prohibition on insurers using the "use and file" option for property insurance rate increases. This would continue to require that an insurer make a "file and use" filing that prohibits an insurer from increasing its rates prior to approval by the Office. Under current law it can be “deemed” approved if the Office fails to issue a notice of intent to disapprove within 90 days. Current law prohibits "use and file" rate increases until December 31, 2008.
- ⤴ Requires that projected hurricane losses must be estimated using a model or method found to be accurate or reliable by the Florida Commission on Hurricane Loss Projection Methodology.
- ⤴ Deletes the requirement that the Office approve a profit factor in a rate filing for an insurer that is commensurate with the risk, for that portion of the rate covering hurricane losses for which the insurer has not purchased reinsurance. By striking this language, the law requires the Office to consider "a reasonable margin for profit and contingencies."

Provides for an expedited hearing process for rate filings by:

- ⤴ Requiring Division of Administrative Hearings (DOAH) to conduct a hearing within 30 days after the request for the hearing.
- ⤴ Requiring the hearing officer to issue the recommended order within 30 days after the hearing (or after receipt of the transcripts).
- ⤴ Requiring parties to submit written exceptions within 10 days.
- ⤴ Requiring the Office to enter a final order within 30 days after the entry of the recommended order.
- ⤴ Allowing timeframes to be waived upon agreement of all parties.
- ⤴ Allowing an insurer to request an expedited appellate review of a final Office rate order and providing legislative intent that the 1st DCA grant the insurer's request.

Transparency in Rate Regulation (creating s. 627.0621, F.S.) - Requires Office to provide information on an Internet website of all assumptions made by any Office actuary for residential property insurance rate filings; the overall rate change requested by the insurer; a statement describing any assumptions that deviate from actuarial standards of the Casualty Actuarial Society; and a

certification by the Office's actuary that based on the actuary's knowledge, that his or her recommendations are consistent with accepted actuarial principles.

Specifies that, in any administrative or judicial proceeding, the work-product and attorney-client privilege exemptions from public disclosure do not apply to communications with the Office attorneys or records prepared by or at the direction of an Office attorney except when the communication or record reflects a mental impression, conclusion, litigation strategy, or legal theory of the attorney or the Office that was prepared exclusively for civil or criminal litigation or adversarial administrative proceedings *and* the communication occurred or the record was prepared after the initiation of a court action, after issuance of a notice of intent to deny a rate, or after the filing by an insurer of a request for a hearing.

Administrative Proceedings in Rate Determinations - Allows an administrative law judge (ALJ) to make certain findings of fact in an administrative hearing on a property insurance rate filing. The ALJ may find whether the factors used in a rate filing or applied by the Office are consistent with standard actuarial techniques or practices or are otherwise based on reasonable actuarial judgment. It may also decide whether the factor for underwriting profit and contingencies is reasonable or excessive, or whether the cost of reinsurance is reasonable or excessive. The ALJ may enter a recommended order that approves, modifies or rejects the requested change, as supported by the record.

Requirements for Trade Secret Documents (s. 624.4213, F.S.) - Specifies requirements for a person to claim that a document received by the Office or the DFS is a "trade secret." Requests that each page or portion that is a trade secret must be labeled as such and be separated from non-trade secret material. The submitting party must include an affidavit certifying certain information about the trade secret status of the documents.

Authorizes the Office to release a document marked as trade secret to a requestor if the Office provides the insurer with 30-days notice and an opportunity to obtain a court order prohibiting disclosure. Allows the Office or DFS to disclose a trade secret to employees or officers of another governmental agency whose use of the trade secret is within the scope of their employment.

Market Conduct Examinations—Required Filing of Claims Handling Practices (s. 624.3161, F.S.) - Authorizes the Office to order an insurer to file its claims handling practices and procedures as a public record based on the findings of a market conduct examination. The Office's findings must conclude that the insurer had a pattern or practice of willful violations of an unfair insurance trade practice related to claims-handling causing harm to policyholders. The requirement applies to the claims-handling procedures for the line of insurance that was the subject of the market conduct exam. Requests that the filings must be held by the Office for a 36-month period.

Administrative Fines for Violations of the Insurance Code (s. 624.4211, F.S.) - Doubles all current fines that may be imposed by the Office for violation of the Insurance Code or for violating any rule or order. A maximum fine of \$40,000

(rather than \$20,000) may be levied for a willful violation, not to exceed an amount equal to \$200,000 (rather than \$100,000), for all willful violations arising out of the same action. Also allows the Office or DFS to issue a maximum fine of \$5,000 (rather than \$2,500) for a non-willful violation, not to exceed an amount of \$20,000 (rather than \$10,000) for all non-willful violations arising out of the same action.

Administrative Fines for Unfair Insurance Trade Practices (s. 626.9521, F.S.) - Doubles all current fines that may be imposed by the Office or DFS upon a person who violates any unfair or deceptive act or practice related to insurance. A maximum fine of \$40,000 (rather than \$20,000) may be levied for a willful violation, not to exceed an amount equal to \$200,000 (rather than \$100,000), for all willful violations arising out of the same action. The Office or DFS may also issue a maximum fine of \$5,000 (rather than \$2,500) for a non-willful violation, not to exceed an amount of \$20,000 (rather than \$10,000) for all non-willful violations arising out of the same action.

Unfair Insurance Trade Practices; Payment of Undisputed Claim Amount (s. 626.9541, F.S.) - Prohibits an insurer from failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after determining the amount and agreeing to coverage. There is no exception if the payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed. Violations are grounds for a private civil remedy action, due to the cross-reference in current s. 624.155, F.S.

Notice of Non-Renewal - Increases the required notice of nonrenewal of a personal or commercial residential insurance policy from 100 days to 180 days if the policy has been in force for five years or more. Insurers that are planning to nonrenew more than 10,000 policies within a 12-month period must notify the Office 90 days prior to issuing any notices of nonrenewal.

Required Use of Models Approved by Florida Commission on Hurricane Loss Projection Methodology (s. 627.0628, F.S.) - Requires that for purposes of a rate filing insurers must use, and may not modify or adjust, a model or method found to be accurate or reliable by the Commission on Hurricane Loss Projection Methodology. Deletes the current law that requires an approved model to be admissible and relevant if the Office has access to all of the assumptions and factors used in developing the model. The Commission is required to adopt findings related to a model's probable maximum loss calculations. An insurer must use and may not modify or adjust models found by the Commission to be accurate or reliable in determining probable maximum loss levels for rate filings made more than 60 days after the commission has made such findings. Specifies that the processes, standards, and guidelines of the Commission do not constitute a final agency action or statements of general applicability that implement, interpret, or prescribe law and are exempt from chapter 120, F.S.

Use of Public Hurricane Loss Model - Allows insurance companies to use the Public Hurricane Loss Model to determine rate requests in advance of a filing, but requires the insurer to pay for use of the public model. It requires the Financial Services Commission (FSC) to establish by rule, by January 1, 2009, a fee schedule for access and use of the model, reasonably calculated to cover only the actual costs.

Hurricane Mitigation Premium Credits Tied to Uniform Home Rating Scale (s. 627.0629, F.S.) – The Office is required to develop, by February 1, 2011, a proposed method for insurers to establish windstorm mitigation premium credits (discounts) that correlate to the numerical rating of a structure pursuant to the uniform home rating scale. The FSC must then adopt rules by October 1, 2011, requiring insurers to make rate filings which revise their credits pursuant to this method, and consistent with generally accepted actuarial principles and wind loss mitigation studies. The rules must allow a period of at least two years after the effective date of the revised credits for a property owner to obtain an inspection or otherwise qualify for the revised credit, during which time the insurer must continue to apply the old mitigation credits.

Disclosure of Windstorm Mitigation Rating Upon Sale of Home (s. 689.262, F.S.) - Provides that, effective January 1, 2010, the potential purchaser of a residential property with an insured value of \$500,000 or more, insured by Citizens, and located in the wind-borne debris region be informed of the structure's windstorm mitigation rating.

Effective January 1, 2011, a purchaser of residential property located in the wind-borne debris region must be informed of the windstorm mitigation rating of the structure, either in the contract for sale or as a separate document attached to the contract. Authorizes the FSC to adopt rules, including the form of the disclosure and the requirements for the inspection or report.

Citizens Property Insurance Corporation (s. 627.351, F.S.) - Extends the freeze on rate increases in Citizens from January 1, 2009 to January 1, 2010. Requires Citizens to make an annual, actuarially sound rate filing beginning July 15, 2009, to be effective no earlier than January 1, 2010. Revises the required assessments to fund a deficit in *each* of Citizens' three accounts (high risk, personal lines, or commercial lines) to:

- ⋈ Require up to a 15 percent of premium surcharge for 12 months on all Citizens' policies, collected upon issuance or renewal;
- ⋈ If this is insufficient, require a regular assessment against insurers which may be recouped from their policyholders, of up to 6 percent (rather than 10 percent) of premium for most lines of property and casualty insurance or 6 percent of the deficit, whichever is greater;
- ⋈ Require any remaining deficit to be funded by a bond issue, funded by multi-year emergency assessments on policyholders on most types of property and casualty insurance, of up to 10 percent of premium for most lines of property and casualty insurance, or 10 percent of the deficit, whichever is greater.

- ✧ Grants the board of Citizens the discretion to apply the amount of any assessment or surcharge which exceeds the amount of the deficit to various business purposes.

Eligibility for Higher Value Homes - Provides that homes with a dwelling replacement cost of \$2 million or more, rather than current law's \$1 million or more, are ineligible for coverage, effective January 1, 2009, with limited exceptions for current policyholders who obtain rejections from three surplus lines insurers and one authorized insurer.

Eligibility for Properties Within 2,500 Feet of the Coast - Deletes current law requiring that new properties constructed after January 1, 2009, within 2,500 feet of the coast must meet "Code Plus" requirements to be eligible for Citizens coverage. By repealing this provision, the law still requires that any new home meet the Florida Building Code.

Forced Purchase of Bonds - Deletes current law requiring insurers to purchase bonds that remain unsold for 60 days.

Access to Claims and Underwriting Files - Provides that a policyholder who has filed suit against Citizens has the right to discover the contents of his or her claims file to the same extent that discovery would be available from a private insurer. Allows Citizens to release confidential underwriting and claims file information under certain circumstances.

Multi-Policy Discount - Allows an insurer to offer a multi-policy discount if the policyholder has wind-only coverage with Citizens or an insurer that has removed a policy from Citizens, provided that the same insurance agent services both policies.

Citizens Property Insurance Corporation Mission Review Task Force - Creates the Citizens Mission Review Task Force to analyze and report on changes needed to return Citizens to its former role as a state-created, noncompetitive residual market mechanism that provides property insurance coverage to risks that are otherwise unable to obtain such coverage in the private market. Requires the task force to submit reports by January 31, 2009, to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The task force is composed of 11 members and must be funded by Citizens.

Insurance Capital Build-Up Incentive Program (s. 215.5595, F.S.) - Revises the requirements for the Insurance Capital Build-Up Incentive Program (Program), which provides for surplus note loans to insurers of up to \$25 million, repayable over 20 years at the 10-year Treasury bond rate, as approved by the State Board of Administration (SBA). Insurers that apply by September 1, 2008 are eligible for a surplus note loan equal to the amount of new capital that an insurer contributes. Insurers that apply after September 1, but before June 1, 2009, may apply for a surplus note equal to one-half of the amount of new capital that the insurer contributes.

Revises the minimum premiums that the insurer must commit to write, by adding a minimum *gross* premium to surplus ratio requirement, as an alternative to the current *net* premium to surplus writing ratio requirement. The distinction is that net premiums deduct the reinsurance premiums that the insurer pays (cedes) to a reinsurer. Requires an insurer to write at least 15 percent of its premiums for new policies for policies taken out of Citizens, for each of the first three years of the surplus note.

Citizens is required to transfer \$250 million from its personal lines account and commercial lines account to the General Revenue Fund on December 15, 2008, unless the estimated year-end surplus in the Personal Lines Account and the Commercial Lines Account is less than \$1 billion. The State Board of Administration (SBA), beginning July 1, 2009, must make quarterly transfers to Citizens of interest and principal payments for surplus notes that were funded by appropriations from Citizens in FY 2008-09. Citizens is prohibited from using any of the amendments to the Insurance Capital Build-Up Program or any transfer of funds as justification or cause in seeking any rate or assessment increase. However, this provision does not limit the amount of an assessment that may be greater due to the transfer of these funds. (NOTE: The Governor vetoed this appropriation).

Requires the SBA to make annual reports to the Legislature on the results of the program and each insurer's compliance with the terms of its surplus note. The SBA must transfer to Citizens on January 15, 2009, uncommitted or unreserved funds, that were funded by transfers from Citizens.

Florida Hurricane Catastrophe Fund (FHCF); \$10 Million Coverage Option - Requires the FHCF to offer \$10 million of additional coverage to limited apportionment companies (having \$25 million in surplus or less and writing at least 25 percent of premiums in Florida), insurers approved to participate in the Insurance Capital Build-Up Incentive Program, and insurers that purchased the supplemental coverage in 2007. (Similar coverage was offered in 2006 and 2007.)

This coverage would reimburse the insurer for up to \$10 million in losses, for each of two hurricanes. The coverage will again be priced at a 50 percent rate on line (e.g., \$5 million premium for \$10 million in coverage) with a free reinstatement for a second storm. The insurer's retention for such coverage remains at 30 percent of the company's surplus. Coverage expires on May 31, 2009.

Annual Report by CFO - Requires the CFO to annually report to the Governor and Legislative presiding officers about the economic impact on Florida from a 1-in-100 year hurricane and the premium increase needed to fund such a hurricane.

Public Rate Hearings

After a devastating 2004 Hurricane Season with 1.65 million claims and \$25 billion in insured losses, Florida's property insurance market reached a critical

level. Many consumers were unable to secure affordable property coverage and others were not able to find coverage in the voluntary market at any price. The 2005 Florida Legislature modified the Florida Statutes to require the Office to hold public rate hearings for any company rate change request of 15% or more if the proposed rate change relies on a computer model. The previous threshold was 25%. Since February 2007, the Office has conducted 14 public rate hearings across the State of Florida. In the hearings, insurance company representatives are questioned by Office staff, in addition to consumer advocates and representatives from consumer organizations. The Office has worked with the Florida Channel to broadcast all hearings in order for interested stakeholders and policyholders to view the proceedings without having to travel to the hearing site. All hearing agendas and streaming videos are available 24 hours a day on the Office's website at: <http://www.flor.com/pcfr/RateHearingsIndex.htm>.

Property & Casualty Insurance

The 2007 Florida Legislature directed the Office to implement several new property insurance related forms for the purpose of providing policyholders with options to reduce their insurance premiums. These forms include options to exclude sinkhole, windstorm, contents coverage, and to increase deductible limits in excess of 10 percent. Additionally, the Office was directed to create a uniform mitigation verification inspection form to be used by all property insurers to verify that various mitigation techniques have been installed on homes to ensure the proper discount credits are applied towards the windstorm portion of the insurance policy.

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.

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.

During the summer of 2006, the Office learned the insurance problem in our state transcended the homeowners market, and began affecting the commercial markets as well. Anecdotal information was pouring in from policymakers, media, business owners, agents, and others about problems of the cost and availability of commercial business insurance following the 2004-2005 Hurricane Seasons. The Office designed and implemented a survey that was accessible via the internet. In only a two week period, 1,914 responses were received from Florida businesses.

The results were cause for concern. For commercial property insurance 17% of the business could not find any coverage at any price. Fifteen percent (15%) found coverage, but not as much as they needed, while 39% found coverage at rates which they deemed to be unreasonable. The anecdotal information was confirmed, which prompted Governor Bush and the Cabinet to establish the Commercial Property & Casualty Joint Underwriting Association (PCJUA) in September to provide the business community with an insurance safety net. To date, the PCJUA has bound 147 policies covering 226 buildings with more than \$60 million in insured value. While this number is only a fraction of the 1.8 million businesses that operate in the State of Florida – it does demonstrate the accomplishment of all of our state leaders in being proactive to prevent additional strain on the marketplace and Florida's consumers.

During the 2007 Special Session of the Legislature, Citizens Property Insurance Corporation (Citizens) was authorized to issue commercial nonresidential policies. The effect of this legislation was to provide Citizens with the authority to assume those policies currently covered by the PCJUA. Citizens was directed to develop a plan of operations, subject to the approval of the FSC, establishing the coverage limits and mitigation standards for the commercial nonresidential policies. Additionally, Citizens was directed to adopt a plan, subject to the approval of the Office, for the transfer of commercial nonresidential policies from the PCJUA.

Public Hurricane Model

The Office has received 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 to determine the reasonableness of insurer rate change requests making for personal residential property insurance 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 received 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. The development of the commercial residential piece should be complete by December 31, 2008.

In addition, the Public Hurricane Model (Model), pursuant to 627.06281, F.S., is now required to be submitted to the Florida Commission on Hurricane Loss Projection Methodology for review. The Model participated in the 2008 submission process and on June 23, 2008, Model Version 3.0 was determined to be acceptable for projecting hurricane loss costs for residential property in Florida. The Model is also required to provide access and use to a residential property insurer for a fee by January 1, 2009 by statute passed by the 2008 Legislature. Appropriate steps have been taken to allow this access and use.

Workers' Compensation

Another major aspect of Florida's insurance industry relates to workers' compensation and affects most employers in the state and indirectly every consumer in Florida. Obtaining affordable coverage for workers' compensation in Florida is difficult for some 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, a reduction of 13.5% effective January 1, 2006, a reduction of 15.7% effective January 1, 2007, and a reduction of 18.4% effective January 1, 2008. Currently, there is a pending filing for a reduction of 14.1% effective January 1, 2009. If this filing is approved as filed, the cumulative rate change since Senate Bill 50A passed will be a reduction of 58.3%. This is a remarkable series of rate reductions and is a promising trend for Florida's workers' compensation marketplace.

In addition, as of August 31, 2008, the FWCJUA policy count has been reduced to 1,639 (from more than 13,900 policies in 1994). This is another indication of an improved and healthier marketplace.

Medical Malpractice Insurance

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 29 companies that have entered Florida's medical malpractice market.

Technology Initiatives

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 (I-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.

In 2007, the Office contracted with a vendor to web-enable the submission of Company Admissions Applications and is in the process of implementing the new system. The current manual process of ensuring that application components are received was automated, therefore reducing staff time spent on the initial review by up to 3 days and allowing staff to focus on the substance of the filing. The statutory requirement for processing an application is driven by the "type" of application and ranges from 45 or 90 days after the application is

deemed complete to within 180 days of receipt. However for 2007-2008, the average number of days to process an application was 55 days.

The new system, called I-Apply, will decrease application processing time, thereby increasing speed to market of new insurance products for consumers and bringing enhanced competition to Florida's marketplace.

State Based Systems

The Market Investigations Unit monitors the activities of the Florida insurance marketplace to ensure proper compliance under the Florida Insurance Code. In 2007 Market Investigations began discussions and exploration of utilizing the SBS (State Based System) offered by the NAIC for data entry and tracking of investigations and examinations. In late 2007 the Unit began migration of data being maintained in a Microsoft Access data base to SBS. Full migration to SBS has now taken place. This system has unlimited capacity and will assist the Unit in efficiently conducting and tracking investigations and examinations, timely reporting results and taking appropriate action to address violations of the Florida Insurance Code.

Title Insurance

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 Office held a public hearing in August 2007, for the purpose of gathering information from the title industry regarding their operations with the long range goal of ascertaining the appropriateness of the current regulatory scheme and whether it is in need of modernization. At least one more hearing will be held before a report is issued. The Office's priority is to ensure that the Commission has all the information necessary for its consideration of whether title rates should be revised and that the regulatory scheme in place serves the public purpose intended by the Florida Legislature. In light of recent state and federal court decisions regarding surplus lines insurance the office will be reviewing the status of the surplus lines law and will continue to be engaged in litigation for the purpose of clarifying the current law.

During the 2008 Legislative Session, the Florida Legislature created the 2008 Title Insurance Study Advisory Council which is tasked with performing a comprehensive examination of the title insurance system in Florida and making findings and recommendations to the Governor and Legislative leadership on or before December 31, 2009. The Council is composed of 21 members, including the Commissioner of Insurance Regulation or his designee.

Life Insurance & Annuities

SB 2082 related to insurance and named the "John and Patricia Sebel Act", passed during the 2008 Legislative Session.

Increases penalties for specified unfair or deceptive trade practices related to the sale of life insurance and annuity contracts. It also strengthens the standards for making recommendations to seniors about the appropriateness of purchasing annuities.

Imposes increased fines and penalties for the unfair and deceptive insurance practices known as "twisting" and "churning," and adds a prohibited practice of submitting a document with a false signature to an insurer on behalf of a consumer. "Twisting" and "churning" involves misleading representations in an attempt to induce a consumer to cash in funds from a current investment or insurance product to purchase another product. Classifies this practice of "twisting" and "churning" as a first degree misdemeanor, and willfully submitting a false signature would now be a third degree felony. Increases fines (administrative penalties) for these practices:

- ⋈ \$5,000 for each non-willful violation (currently \$2,500), up to a maximum aggregate amount of \$50,000 (currently \$10,000).
- ⋈ \$30,000 for each willful violation (currently \$20,000), up to a maximum aggregate amount of \$250,000 (currently \$100,000).
- ⋈ Makes it an unfair or deceptive insurance practice for an agent to use designations or titles that falsely imply that he or she has special financial knowledge or training.

Sales of Annuities to Senior Consumers - Strengthens the standards that apply to recommendations to a senior consumer to purchase an annuity contract. Specifically:

- ⋈ Requires that the insurer or insurance agent have an objectively reasonable basis for believing that an annuity recommendation to a senior consumer is suitable.
- ⋈ Requires insurance agents, prior to recommending a product to a senior consumer, to obtain specified personal and financial information from the consumer relevant to the suitability of the recommendation on a form adopted by the Department of Financial Services (DFS).
- ⋈ Requires the insurer or agent to provide the consumer with an information form adopted by DFS concerning differences between the annuity recommended for purchase and the existing annuity that would be surrendered or replaced.
- ⋈ Authorizes the Office of Insurance Regulation (Office) to order an insurer to void an insurance policy or annuity and provide a full refund of the premiums paid or accumulation value, whichever is greater, when a senior consumer is harmed due to a violation of the suitability statute.
- ⋈ Requires insurers, managing general agents, and insurance agencies to make available to DFS (or Office) records of information collected from consumers and other information for five years after the insurance transaction has been completed.
- ⋈ Deems that any person who is registered with a member of the federal Financial Regulatory Authority, and who is required to make a suitability determination, is deemed to have satisfied the section's requirements.

"Free Look" Period; Annuity Regulation - Increases the "free look" period from 10 days to 14 days. Following the purchase of a life insurance or fixed annuity, the consumer has a "free look" period in which they can request a refund at no charge. Expands this benefit to all annuities, not merely "fixed" annuities. Clarifies the regulatory jurisdiction of the agencies under DFS regarding the sale of annuities.

Other Provisions

- ⤴ Requires applicants for agent licensure to provide their home and business telephone numbers and email address in the application and to notify the department within 60 days of any changes.
- ⤴ Requires all licensees to complete three hours of DFS-approved continuing education on the subject of suitability in annuity and life insurance transactions. The hours may be used to satisfy the current ethics continuing education requirement.

HB 299, cited as the "Freedom to Travel Act" was effective July 1, 2006.

Created a new unfair or deceptive trade practice provision under the Insurance Code (s. 626.9541, F.S.) which prohibits life insurers from refusing coverage or otherwise discriminating against an individual solely on the basis of that individual's past or future lawful foreign travel, unless life insurers demonstrate to the office that:

- ⤴ Individuals who intend to travel as a separate actuarially supportable class whose risk of loss is different from those individuals who do not intend to travel; and
- ⤴ Such risk classification is based on sound actuarial principles and actual or reasonably anticipated experience that correlates to the risk of travel to a specific destination.

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 filings for applications that contain foreign travel questions are being tracked and monitored by the Office.

Health Insurance

A growing concern both nationally and for the state of Florida, is the rising cost and decreased availability of health insurance. In Florida alone there are 3.6 million people that do not have health insurance. Commissioner McCarty serves as the Chairman of the Florida Health Insurance Advisory Board (Board) and is responsible for appointing qualified, representative individuals to serve on the Board. The Board was established by the Florida Legislature in 1992 as the Small Employer Health Reinsurance Program for the purpose of promoting availability of health care coverage to small employers. At that time, the Board was primarily composed of representatives of health insurers licensed under chapter 624 or 641, Florida Statutes, who were tasked with facilitating standard and basic health benefit plans by providing reinsurance protection to small employer carriers and improving fairness and efficiency in Florida's small group health insurance market.

In 2005, the Legislature expanded the composition of the Board to include representatives of employers, an individual policyholder and a representative from the Agency for Health Care Administration (AHCA). The Board's responsibilities have also been expanded to serve in an advisory role to the Office of Insurance Regulation, AHCA, the Department of Financial Services, other executive departments and the Legislature on health insurance issues. Annually, the Board meets to fulfill their charges to issue a report on the state of the health insurance market in Florida and to hear testimony and make legislative recommendations for health care reforms.

While there is no sweeping solution to the health care affordability crisis, the Office continues to monitor the activities of other states that are proposing health care reforms to cover their uninsured and under insured.

In 2008, the Legislature passed SB 2534 Related to Health Insurance.

This bill initiates two new programs designed to provide more affordable health care access to uninsured individuals and for small employers.

Cover Florida Health Access Program

Creates the "Cover Florida Health Access Program Act" designed to provide affordable health care options for uninsured residents. Allows insurers, HMOs, health-care-sponsored-organizations, and/or health care districts to offer consumers a choice of benefit plans at affordable prices. A Cover Florida plan entity must provide non-catastrophic coverage and may provide catastrophic coverage, supplemental insurance, and discount medical plan product options to enrollees.

Enrollment Eligibility Requirements:

- ⤴ Resident of Florida;
- ⤴ Ages 19 to 64;
- ⤴ Not covered by private insurance or eligible for public insurance; and
- ⤴ Uninsured for at least the prior six months, with exceptions for persons who lost coverage within the past six months under certain conditions.

Administration of the Cover Florida Health Access Program:

Designates the Agency for Health Care Administration (AHCA) and the Office of Insurance Regulation (OIR) are jointly responsible for establishing and administering the program. Requires OIR and AHCA to issue an invitation to negotiate no later than July 1, 2008, to health insurers, health maintenance organizations, health care provider-sponsored organizations, and health care districts ("Cover Florida plan entities"). Requires AHCA and OIR to approve at least one Cover Florida plan entity that must have an existing statewide provider network, and may approve at least one regional network plan for each Medicaid area.

Changes in plan benefits, premiums, and forms are subject to regulatory oversight by AHCA and OIR. Requires AHCA to ensure that the plans follow standardized grievance procedures, and submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the status of the program.

Health Flex Plan Program

Expands the population eligible to purchase health flex plans by raising the family income limit from 200 to 300 percent of the federal poverty level (FPL).

Allows a person who is covered under subsidized Medicaid or KidCare coverage and who lost eligibility due to the income limits to apply for coverage without a lapse in coverage if all other requirements are met. Under current law, these persons would be required to be uninsured for the prior six months prior to enrolling in a health flex plan.

Expands the population eligible for health flex plans by allowing individuals who are covered under an individual contract issued by an HMO that has an approved health flex plan (as of October 1, 2008) to enroll in the HMO's health flex plan. These individuals would not be subject to the current requirement of being uninsured for the prior six months.

Allows a person who is part of an employer group with at least 75 percent of the employees having income equal to or less than 300 percent of the FPL and not covered by private insurance during the last six months to be eligible for coverage. If the health flex plan is offered by an insurer, only 50 percent of the employees must meet the income test.

Extends the expiration date of the program from July 1, 2008 to July 1, 2013.

Florida Health Choices Program

Creates the Florida Health Choices Program (Program), which is designed to be a single, centralized market for the sale and purchase of health care products including, but not limited to: health insurance plans, HMO plans, prepaid services, service contracts, and flexible spending accounts. Exempts products sold as part of the program from regulation under the Insurance Code and laws governing health maintenance organizations.

Authorized Vendors

Authorizes the following entities to be eligible vendors of these products and plans:

- (1) insurers authorized under ch. 624, F.S.,
- (2) HMOs authorized under ch. 641, F.S.,
- (3) prepaid health clinics licensed under ch. 641, part II, F.S.,

- (4) health care providers, including hospitals and other licensed health facilities, health care clinics, pharmacies, and other licensed health care providers,
- (5) provider organizations, including services networks, group practices, and professional associations, and
- (6) corporate entities providing specific health services.

Specifies that vendors may not sell products that provide "risk-bearing coverage" unless those vendors are authorized by a certification of authority issued by OIR under the Florida Insurance Code. Requires all vendors to make all risk-bearing products offered through the program guaranteed-issue policies, subject to preexisting condition exclusions established by the corporation.

Administration of the Program

Creates Florida Health Choice, Inc., as a not-for-profit corporation under ch. 617, F.S. The corporation will administer the program and function similar to a third-party administrator (TPA) for employers participating in the program. The corporation is responsible for certifying vendors and ensuring the validity of their offerings.

Specifies the corporation is governed by a fifteen member board including:

four members appointed by the Governor;
four members appointed by the Senate President;
four members appointed by the Speaker of the House;
three ex-officio, non-voting members from the following agencies: Agency for Health Care Administration, Department of Management Services, and the Office of Insurance Regulation.

The board members may not include insurers, health insurance agents, health care providers, HMOs, prepaid service providers, or any other entity or affiliate of eligible vendors.

Requires the corporation to be subject to the ethics (conflict of interest) requirements of part III of ch. 112, F.S., as well as the public records and public meetings requirements of chs. 119 and 287, F.S.

Entitles Board Members to per diem and travel expenses but no other compensation is allowed. Allows the Board to secure staff and consultant services necessary to the operation of the program. Appropriates a total of \$1.5 billion (the sum of three separate appropriation categories) in non-recurring funds from the General Revenue Fund for this program.

Eligibility and Enrollment

Provides that small employers (1-50 employees), certain eligible individuals, cities (population less than 50,000), fiscally constrained counties, municipalities having a population of fewer than 50,000 residents, school districts in fiscally constrained counties, and statutory rural hospitals are

eligible to enroll. Eligible individuals include individual employees of enrolled employers, state employees ineligible for the state group insurance plan, state retirees, and Medicaid reform participants who opt-out.

Pricing; Risk Pooling

Specifies that prices for products sold through the program must be based on age, gender, and the location of the participants. Requires the corporation to develop a methodology for evaluating the actuarial soundness of the product; this methodology must be reviewed by OIR. Requires the corporation to use this methodology to compare the expected costs and benefits of the products, which must be reported to individuals participating in the program. Prices must remain in force for at least one year. The corporation must add a surcharge not to exceed 2.5 percent to generate funding for administrative services provided by the corporation and payments to buyer's representatives (including insurance agents).

Requires the program to utilize methods for pooling the risk of individual participants and to prevent selection bias, including a post-enrollment risk adjustment of the premium payments to the vendors. Monthly distributions of payments to vendors must be adjusted based on the assessed relative risk profile of the enrollees in each risk-bearing product for the most recent period for which data is available.

OIR Recommendation on Risk-Bearing Products

Prior to making a risk-bearing product available through the program, the corporation must provide OIR information about the product. OIR has 30 days to review the product and make a recommendation that it should, or should not, be made available through the program. If OIR recommends that a risk-bearing product should not be made available, the product may be offered only if a majority of the Board votes to include the product.

Florida KidCare Program

Expands eligibility and enrollment for the KidCare program by eliminating the 10 percent cap on enrollment for MediKids (ages 1-5) and Healthy Kids (ages 6-19) enrollees who have a family income of greater than 200 percent of the federal poverty level and pay full premiums. Requires Healthy Kids Corp. to submit a report to the Legislature and Governor, by February 1, 2009, on the impact of the premium to the subsidized portion of KidCare from the inclusion of the full pay program, and recommendations on how to eliminate or mitigate possible impacts to the subsidized premiums.

Dependent Coverage

Requires individual and group health insurers and HMOs to offer policyholders and certificate holders (parents) the option to continue coverage of their children on their family policy until age 30, if the child is: (1) unmarried with no

dependents; (2) a resident of Florida or a full-time or part-time student; and (3) does not have insurance coverage under any private or public plan.

Requires dependents to be covered until age 25 if the child is dependent on the parent for support, or if the child either lives in the household of the parent or is a full-time or part-time student. This requirement currently applies only to group health insurance policies, which the bill interprets as including individual health insurance policies and all HMO contracts.

Insurance Code Exemption for Certain Religious Organizations

Creates an exemption from the Florida Insurance Code for nonprofit religious organizations that qualify under Title 26, sec. 501 of the IRS Code. To meet this exemption, the nonprofit religious organization must:

- ⤴ Limit its membership to members of the same religion;
- ⤴ Act as an organizational clearinghouse for information between participants who have financial, physical, or medical needs and those with the ability to pay for the benefit of those members in need;
- ⤴ Provide for medical or financial needs of participants through payments directly from one participant to another;
- ⤴ Suggest amounts that participants may voluntarily give with no assumption of risk or promise to pay either among the participants or between the participants.

In the 2007 Legislative Session, Senate Bills 2708 and 2710 were introduced; however, they failed to pass and were not addressed in the Special Session. These bills would have created the Healthy Florida Small Employer Program, a standardized health insurance subsidy program available to small employers and sole proprietors. These bills were aimed at increasing access to affordable health insurance to those who are currently uninsured or underinsured and providing an incentive to insurers to insure individuals and qualified employees (full and part-time) of small employers. The program is a state subsidized reinsurance mechanism or a stop-loss subsidy that reimburses health plans for 90% of claims paid between \$5,000 and \$75,000 on behalf of a member in a calendar year.

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 Sample Rate Search (SESRS) 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 has links for frequently asked questions on small employer health insurance, links to various health insurance consumer guides and information for consumers to request assistance for information on health insurance.

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 2008, of the 74 known DMPOs, 44 currently have an active license with one more pending, and 4 authorized insurers have added the DMPO Line of Business to their existing certificate. The Office has received a total of 1154 filings. A total of 766 have been approved with 9 currently pending.

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 known 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 programs and that required carriers are offering benefit plans that qualify individuals to establish health savings accounts.

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 integrate with 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.

The Market Investigations Unit monitors the activities of the Florida insurance marketplace to detect and address unfair trade practices and other Insurance Code violations that pose a risk of harm to consumers.

Nationally, there has been a shift away from performing routine examinations of insurers at regular intervals. The current trend is to conduct target (issue specific) examinations or to collaborate with other regulatory jurisdictions utilizing multi-state examinations. Target examinations more efficiently address issues that may affect a large number of Floridians, while multi-state examinations more efficiently address issues that may affect consumers in numerous states. Florida continues to identify significant issues through market analysis, which is a review and analysis of information reported in financial statements, complaint data, through lawsuit activity and other data sources, to determine whether or not a particular practice may be adversely affecting consumers. This enables the Office to concentrate its efforts on those practices that have the most potential for public harm.

In the aftermath of the 2004-2005 hurricanes, the Market Investigations Unit focused on property insurance issues and the myriad of issues surrounding hurricane claim payments. While property insurance issues will remain important in the years to come, the Unit will also focus on issues affecting senior consumers. In particular, sales practices to senior consumers in the annuity marketplace have drawn attention in recent years and these practices warrant further review by regulators and the industry. In addition, the Unit will continue to focus on preventing the sale of unauthorized insurance products to consumers.

In the coming years, Market Investigations will continue to take a proactive approach and conduct numerous examinations in order to verify that data required to be submitted by insurance companies to the Office is timely and accurately reported. This is an important task as the Legislature and other policymakers rely on this data when making policy decisions.

Goals for the years 2009-2014 include refining our processes and procedures in order to efficiently conduct investigations and examinations, timely report results, and take appropriate administrative action to address violations of the Florida Insurance Code.

Since the Cabinet Reorganization Act of 2002 and the creation of the Financial Services Commission, effective January 7, 2003, the Office has made significant successful efforts to provide restitution to Florida's policyholders. During 2007, the Office made restitution to policy holders in the amount of \$13.4 million.

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.

The 2004 and 2005 Hurricane Seasons saw eight major storms impact Florida resulting in 2.8 million policyholder claims worth an estimated \$36 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 compared to Hurricane Andrew's 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 from less than 800,000 policies prior to the 2004 hurricane season to more than 1.3 million in 2007.

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 financial 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.

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 May 2006, Florida lawmakers approved a monumental senior protection bill that provides marketplace reforms that make Long-Term Care Insurance (LTCI) affordable, available, and marketable. House Bill 947 was unanimously passed and directed the Agency for Health Care Administration (AHCA) to establish a qualified state Florida Long-Term Care Partnership Program (LTCPP), in consultation with the Office of Insurance Regulation and the Department of Children and Family Services. In addition to providing program requirements, the bill also provided that for purposes of determining Medicaid eligibility, assets in an amount equal to the insurance benefit payments made to, or on behalf of, an individual who is a beneficiary under a qualified state LTCPP in Florida shall be disregarded. Total countable assets for determining Medicaid long-term care eligibility are reduced by \$1 for each \$1 in paid out insurance benefits. The determination of eligibility for Medicaid benefits is complex and is determined separately from the LTCPPP policy. The asset disregard is exempted from the lien placed on the beneficiary's estate.

The bill also amended several laws governing long term care insurance as follows:

- ⤴ Incontestability – A long term care policy is incontestable after being in force for 2 years, except in instances of non-payment of premium; seniors know their insurer did a thorough job of reviewing their application and they will be protected from post-claim underwriting or any frivolous allegations of fraud when they apply for benefits. Under prior law, if an insurance company merely alleged fraud, a senior was denied benefits until a legal settlement was reached with seniors and their families, often settling for a lesser benefit than they originally purchased in their policy.
- ⤴ Prohibits an insurer from imposing a new waiting period when a policy is replaced through an affiliated insurer;
- ⤴ Requires that any long-term care insurance policy or certificate issued or renewed, at the policyholder's option, shall make available

to the insured a contingent benefit upon lapse as approved in the LTCI Model Regulation adopted by the NAIC;

- ⤴ Prohibits existing policyholders from being charged premiums that exceed the premiums the insurer is charging new policyholders; and
- ⤴ Requires insurers to pool the claims experience of all affiliated carriers when calculating rates rather than only the policy forms providing similar benefits of the insured.

The Florida Office of Insurance Regulation adopted rules including standards applicable to new and existing long-term care insurance policies under the new Long-Term Care Partnership Program, effective August 1, 2007. The Office is in the process of amending the rule to require more strenuous training standards for insurance agents who sell long term care insurance products.

Long Term Care Insurance Partnership programs are beginning to take shape across the country. With support from the Robert Wood Johnson Foundation (RWJF), the Center for Health Care Strategies (CHCS) is working with Florida and other states — including the Medicaid agency, Department of Insurance, and other key state stakeholders — as they design and implement programs. CHCS is developing multiple policy and technical briefs on topics relating to Long Term Care Partnership programs as part of this assistance to its grantee states. CHCS shares them with states as they plan, or consider planning, a Partnership program.

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 100 companies insuring nearly 630,000 Florida lives with Medigap coverage. These insurers generated nearly \$1.3 billion dollars in taxable premium payments in 2007. By concept and design, currently issued 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 2007 Legislature authorized the development of a Medigap rate collection system to provide accurate, current rate pricing and availability of Medicare supplement insurance plans for seniors, consumers and their families to enable them to make more informed health coverage purchasing decisions and to enable the Office to quickly organize carrier submitted data for useful analysis for its stakeholders.

The Office has developed 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 plans and from different carriers. The system is in the initial stages of deployment. 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 (CCRCs) present an ongoing issue of concern within the Office. These entities provide a continuum of long-term care services for the retirement population in Florida. CCRCs 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 increased medical care expenses due to higher staffing requirements, increased insurance expenses and aging facilities. This is especially true with the recent changes in the property insurance market. Many of the CCRCs are finding it difficult to afford their historical levels of property insurance. Several CCRCs have voiced concerns of not being able to find an insurer willing to write a windstorm policy. The latest challenge relates directly to the collapsed housing market. Many seniors are on waiting lists in anticipation of buying into the CCRC lifestyle pending the sale of their existing home to utilize those proceeds to pay the initial entrance fees that are required. This has led to reduced sales and declining occupancy rates. In turn, revenues have declined while expenses continue to increase. As of August 31, 2008, there were 74 CCRCs with certificates of authority to operate in Florida.

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 and stranger originated life insurance as a method of generating new policies for sale into the viatical market place, and the erosion of the long established concept of "insurable interest". The Florida viatical settlement industry continues to present issues of concern within the Office. Viatical settlement providers buy life insurance policies (from the owner of the policy) for less than the death benefit of the policy and resell them to investors who expect to profit upon the death of the insured. Among the more complex issues requiring attention are the methods and arrangements that are being utilized to generate new policies for sale into the viatical settlement market place. These include premium financing of life insurance premiums and stranger originated life insurance (STOLI) transactions. In a STOLI transaction, a person with no insurable

interest (a stranger) in another persuades the other person to obtain life insurance with the understanding that after a certain time (usually two years) the policy owner (insured or another individual or entity) will sell the policy to the stranger and typically involves the financing of the insurance premiums. These arrangements circumvent public policy requirements behind insurable interest laws, and may ultimately have other consequences, such as tax implications, limiting an individual's life insurance capacity and increasing the cost of life insurance.

Third Party Administrators (TPAs) 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. TPAs 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 TPAs and provide increased consumer protections, legislation was passed in 2005 which requires that all TPAs submit annual audited financial statements. Since inception of this law, there have been cases where the audited financial statements revealed statutory net worth violations and other financial problems that were not reported on the company's internally prepared annual report. The audited financial statements have been instrumental in helping the Office detect problems, seek corrective actions and resolutions from licensees, and provide greater consumer protections. As of August 31, 2008, there were 293 TPAs with certificates of authority to operate in Florida.

With respect to on-going regulation, the Office plans to fully utilize current and developing electronic filing systems, which will improve production, efficiency, and monitoring.

To meet the changing needs of the insurance industry and changes in technology, the Office identified the need to replace the existing rate collection and rate management systems for the property and casualty lines of business and to expand the I-File system to incorporate filings in the commercial insurance market. In 2006 and early 2007, the Office developed a new property and casualty rate data collection and management solution and expanded the capabilities I-File.

The project met the following objectives:

- ⤴ Automated data collection, receipt, transfer, review, analysis, tracking and reporting of commercial filings to increase the competition in the commercial insurance market thereby increasing premium taxes collected by the State.
- ⤴ Provides Consumer Rate Comparison data on the web so consumers can shop for insurance coverage for their personal property and business property.
- ⤴ Provides trending reports, thereby increasing the accuracy of economic analyses performed on rate histories.

- ⤴ Provides standardized data collection and management forms, thereby reducing input errors and decreasing technical staff time used to correct the errors by an estimated 12 hours per month and general analyst time by an estimated 25 hours per month.
- ⤴ Provides standardized data across systems for the management of filings thereby decreasing the time spent by technical staff on the review of filings.

The completed system provides Office staff with more enhanced management and reporting tools and provides consumers with the ability to search for sample rates for many property and casualty lines. The system also replaced six antiquated systems thereby decreasing the Office cost of maintaining systems.

In 2007, the Office contracted with a vendor to web-enable the submission of Company Admissions Applications and is now in the process of implementing the new electronic system. The project objectives included:

- ⤴ Providing an automated means for collecting and transferring data within Company and Other Related Entities Navigator (COREN) to facilitate collection, management and workflow of admissions applications and affiliated filings. During 2008, it is estimated that the Office will receive 1,650 applications and affiliated filings;
- ⤴ Providing a seamless integration with the NAIC Uniform Certificate of Authority Application (UCAA) and Form A (Acquisition Filings) Systems utilizing web-services solutions or dblink (whichever is appropriate) for data and document transmission;
- ⤴ Reducing errors and omissions that may otherwise be associated with employing a mixture of manual and automated methods for collecting, reviewing, analyzing and evaluating admission applications and affiliated filings;
- ⤴ Providing an interactive filing component solution to ensure all required information is completed during the filing process;
- ⤴ Designing enhancements to Applications Coordination's Workflow (AppCOORD) to allow the Office to more effectively manage the electronic routing and tracking of applications and affiliated filings;
- ⤴ Providing reports in formats that users can utilize and control;
- ⤴ Validating application data collected through the new electronic system prior to acceptance by Office;
- ⤴ Designing the system so that within Company and Other Related Entities (CORE)/AppCOORD, components can be added or removed due to changes in business requirements;
- ⤴ Designing the system so that it could interface with DFS applications (Agency & Agency Services, Rehabilitation and & Liquidation), and NAIC applications (RIRS, SAD, CDS (see definitions in section 2.6))
- ⤴ With the implementation of the new electronic system for submission of company applications, a decrease in application processing time should occur, thereby increasing speed to market of

new insurance products for consumers and bringing enhanced competition to Florida's marketplace.

- ✧ Interface with DFS applications (Agency & Agency Services, Rehabilitation and & Liquidation), and NAIC applications (RIRS, SAD, CDS (see definitions in section 2.6))

The new system will decrease application processing time, thereby increasing speed to market of new insurance products for consumers and bringing enhanced competition to Florida's marketplace.

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". The unit has since been segregated into two sections; Business Development/Company Admissions Unit which is responsible for the retention and expansion of insurance companies in the Florida marketplace, and the Market Research Unit that serves as the information clearinghouse for the collection and dissemination of public data for the Office. The Business Development/Company Admissions Unit also manages the company application process and is responsible for the coordination of licensure approvals by the Commissioner.

The purpose of the Business Development/Company Admissions 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 the unit 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. 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 required by statute, this outreach to the marketplace is a program that has been developed within the existing resources of the Office.

As part of the outreach program, the Business Development/Company Admissions 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 reviewing and where necessary, modifying certain of the Office's website information to accommodate the ever-changing statutory and business requirements in Florida's insurance market. Finally, the Business Development/Company Admissions Unit makes every effort to assist companies that have submitted applications for licenses or amendments to licenses as the application goes through the various steps in acceptance and the review process.

Since January 1, 2006 through August 30, 2008, the Office has licensed 25 new domestic homeowner's carriers, registered nine (9) surplus lines carriers and brought \$3.6 billion of new capital to Florida.

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, a Technology team was formed from the MRU staff to be responsible for the management of various Office computer applications. The activities of the Technology team include oversight of the development and maintenance of computer applications that are used in 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 by providing information from collected data to substantiate findings. Other services provided by the Market Research Unit include the production of standardized reports as well as ad hoc reports for its varied constituency. Many of these reports are found on the Office's web site (www.floir.com).

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.

In 1995, the former Department of Insurance initiated a Filing and Compliance Symposium to provide a forum for insurance industry personnel to learn about the Office's electronic filing system (I-File), to be briefed on new legislation and

current topics in the marketplace, and to discuss the basics about how companies can improve the quality of rate and form filings in order to facilitate more timely reviews and approvals. The Symposium has become a huge success and the Office's partnership with the industry has expanded participation and interest in the forum. In 2008, more than 400 industry representatives attended the Symposium. In 2010, it is anticipated that the Office will have staff participants from the Office and DFS, and more than 500 industry representatives from around the country.

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 2009-2010	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14
91%	92%	92%	92%	92%	92%

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 Office to the date the Office approves or denies the application pursuant to 120.80(9), F.S.

Baseline Year 2003-2004	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14
180	95	90	90	90	90

NOTE: The statutory requirement is processing an application within 180 days of receipt by the Office; however, for the 2007-08 Fiscal Year, the average number of days to process an application was 55.

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	FY 2009-	FY	FY	FY	FY

Year 2003- 2004	10	2010-11	2011-12	2012-13	2013-14
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 2009- 10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14
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 2009-10	FY 2010- 11	FY 2011-12	FY 2012-13	FY 2013-14
90%	98%	98%	98%	98%	98%

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.

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 2009- 10	FY 2010- 11	FY 2011- 12	FY 2012- 13	FY 2013- 14
303,610	1,000,000	1,050,000	1,102,500	1,157,625	1,215,506

For FY 2007-2008 there were over 1,000,000 hits on the OIR website.

OBJECTIVE 4C: Increase competition in the insurance market

OUTCOME: Number of new applications filed with the Office

Baseline Year 2005-2006	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14
567	625	656	689	723	760

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 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
95%	98%	98%	98%	98%

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 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
8.67%	Less than 12.6%	Less than 12.6%	Less than 12.6%	Less than 12.6%

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. At the end of Fiscal Year 2007-2008, the Office regulated 3,702 entities in Florida.

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 Unit 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). An 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.

Florida has exercised leadership within the NAIC by serving as Chair or Vice Chair of significant standing committees and continues to be actively involved in several key committees of the NAIC. In 2008, Florida is Chair of the following NAIC Committees:

- ⤴ Property & Casualty Insurance (C) Committee
- ⤴ Catastrophe Insurance (C) Working Group
- ⤴ Southeastern Zone (EX) – comprised of thirteen southeastern states
- ⤴ Disaster Reporting (E) Working Group

Florida is Vice-Chair of a variety of NAIC Committees including:

- ✦ Senior Issues (B) Task Force

Florida is a member of the following NAIC Committees:

- ✦ Executive (EX) Committee
- ✦ Military Sales (EX) Working Group
- ✦ Principles-Based Reserving (EX) Working Group
- ✦ Climate Change and Global Warming (EX) Task Force
- ✦ Government Relations Leadership Council (EX) Task Force
- ✦ Speed to Market (EX) Task Force
- ✦ Internal Administration (EX1) Subcommittee
- ✦ Life Insurance and Annuities (A) Committee
- ✦ Health Insurance and Managed Care (B) Committee
- ✦ Regulatory Framework (B) Task Force
- ✦ Senior Issues (B) Task Force
- ✦ Casualty Actuarial and Statistical (C) Task Force
- ✦ Workers' Compensation (C) Task Force
- ✦ Antifraud (D) Task Force
- ✦ Financial Condition (E) Committee
- ✦ Accounting Practices and Procedures (E) Task Force
- ✦ Capital Adequacy (E) Task Force
- ✦ Examination Oversight (E) Task Force
- ✦ Receivership and Insolvency (E) Task Force
- ✦ Reinsurance (E) Task Force
- ✦ Financial Regulation Standards and Accreditation (F) Committee
- ✦ Life and Health Actuarial (Technical) Task Force
- ✦ NAIC/Consumer Liaison Committee
- ✦ NAIC/Legislative Liaison Committee

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. The Commissioner has consistently been a leader in insurance regulation, which includes not only consumer protection for Florida policyholders, but also to strengthen insurance regulation on a nationwide basis. His leadership at the NAIC is demonstrated by Florida's participation on addressing numerous significant insurance issues such as solvency regulation, consumer protection initiatives, use of technology for greater transparency and speed to market. 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. NCOIL and the NAIC have made recent efforts to improve collaboration and communication of insurance issues affecting the states through Legislative Liaison committees.

The Professional Liability Claims Reporting (PLCR) System, which is web-enabled, permits insurers to prepare and submit professional liability closed claims, as well as annual aggregate claims reports, to the Office, using the Internet. This system includes data fields that are required 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 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 Auditor General's staff completed an Operational Audit of the Office's Professional Liability Claims Reporting (PLCR) System in January 2007. The Office agreed with the Auditor General's recommendations, including: completing follow through action with respect to a revised approach to achieve data correction and validation; and exerting continued efforts to implement procedures to detect unreported claims.

The revised approach employed for data collection and verification includes:

- ⤴ Review and validation of entities that are required to report closed claims;
- ⤴ Review of previously employed data editing criteria associated with the PLCR System on a field-by-field basis for purposes of ensuring that data requirements and editing criteria are complete, including relationship editing criteria that are deemed to be necessary;
- ⤴ Execution of refined editing criteria, including relational editing criteria, against closed claims data, creation of error records for each entity observed to have errors or omissions and initiate appropriate data correction action, including preparing error records for each affected entity and forwarding correction requests to each such entity;
- ⤴ Maintain logs and listings that will permit tracking of data and information exchanges between the Office and affected entities;

- ⤴ Complete review and analysis of date updates submitted by each entity in order to ensure that each submission is accurate and complete;
- ⤴ Execute database updates, using edited, complete and accurate data submitted by each affected entity and following up on any errors or omissions that are observed during database update processes.

The Office is committed to detection of unreported closed claims. This includes requiring entities to submit a notification of “no claims submitted” and reconciliation of closed claims reported to affected entities’ financial statements. The Office developed a Professional Liability Claims Reporting Instruction Manual in January 2007. This manual provides step by step instructions for handling and processing closed claims.

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 have resulted in more accurate Medical Malpractice Claims data and related reporting.

The Florida Legislature passed several significant bills during the 2008 Regular Legislative Session that will greatly impact the Office, the insurance industry and consumers. Most notable were several bills which have a direct impact on the business of insurance in Florida: Senate Bill 2082 Relating to Annuities; Senate Bill 2534 Relating to Health Care and Senate Bill 2860 Relating to Property Insurance. Summaries of these bills are referenced under Goal #1 of this report.

GLOSSARY OF TERMS AND ACRONYMS

Activity – A unit of work which has identifiable starting and ending points, consumes resources and produces 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

GHIAB – Governor’s Health Information Infrastructure Advisory Board

GR – General Revenue Fund

HMO - Health 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.

PBPP/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.

TPA – Third Party Administrators

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