Division of Workers' Compensation




2007 Annual Report

ALEX SINK
CHIEF FINANCIAL OFFICER
STATE OF FLORIDA

Florida Department of Financial Services

Message from the Director

REPRESENTING
ALEX SINK
CHIEF FINANCIAL OFFICER
STATE OF FLORIDA

September 14, 2007

Dear Governor Crist, President Pruitt, and Speaker Rubio:

It is my honor and privilege to present the 2007 Division of Workers' Compensation Annual Report as required by Chapter 440.59, Florida Statutes.

During the five years the Division has been an integral part of the Department of Financial Services, significant gains have been made establishing processes to make the Florida Workers' Compensation System more self-executing.

This Annual Report focuses on the Division's accomplishments and technological advancements, which allow the Division to effectively administer Florida's Workers' Compensation Law and provide value and benefit returns to the stakeholders of the system. The centerpiece of these initiatives is the implementation of Electronic Data Interchange (EDI). EDI provides an efficient and standardized exchange of electronic information between the Division and data submitters. Data currently submitted through EDI include proof of coverage information, medical cost data, and claims data.

In addition to the implementation of EDI, the Division has developed several other applications and databases that provide real-time information to the system's stakeholders. These include the Proof of Coverage Database, Construction Policy Tracking Database, Medical Data System, Centralized Performance System, and the DWC e-Alert System, with further details provided in the Annual Report.

With each technological improvement, the Division continues to make significant strides toward achieving the goals set forth in the Department of Financial Services' mission to safeguard the people of Florida and the State's assets through financial accountability, education, advocacy, and enforcement.

Your comments and suggestions regarding the 2007 Annual Report and the Division are always welcome.

Tanner Holloman
Director

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Mission

The mission of the Department of Financial Services is to safeguard the people of Florida and the state's assets through financial accountability, education and advocacy, fire safety and enforcement. The Division's mission, focus and accomplishments during FY 2006-2007 have contributed to the Department's mission in many significant ways.

Financial Accountability:

- **The Bureau of Monitoring and Audit**
  - Monitored the financial stability of former and current self-insured employers to ensure their ability to pay current and future liabilities.
  - Ensured continued eligibility and accuracy for injured workers who received Division paid Permanent Total Supplemental benefit payments.
  - Ensured the accurate calculation of experience modifications for self-insurers to ensure appropriate determination of assessments for the Workers' Compensation Administration Trust Fund, Special Disability Trust Fund and Florida Self-Insurers Guaranty Association.
  - Verified the accuracy of Permanent Total Disability payments and determined if benefits were accurately paid to the most seriously injured workers.

- **The Bureau of Data Quality and Collection**
  - Collected 4.4 million medical bills in electronic format and 875,307 Proof of Coverage filings during FY 2006-2007, utilizing a seamless business process to hold employers and insurers accountable for providing statutorily mandated benefits to injured workers. The electronic collection of this data also precluded the need for the promulgation and mailing of paper documents.

- **The Bureau of Compliance**
  - Developed and implemented formal procedures for receiving and tracking compliance penalty payments submitted in accordance with a Periodic Payment Agreement.
  - Developed and implemented formal procedures for identifying and tracking payments that are returned to the Bureau due to insufficient funds.
  - Initiated a process for forwarding delinquent employer accounts to the Division of Accounting and Auditing for submission to the Department's contracted collection agency.

- **The Office of Special Disability Trust Fund**
  - Audited and approved 2,737 Reimbursement Requests, which collectively sought reimbursement of $101,782,817 in reimbursement and resulted in authorized reimbursement of $90,311,104, a realized savings of $11,471,714.
  - Audited and returned for correction 1,928 Reimbursement Requests.
  - Distributed more than $268 million in audited and approved reimbursements to carriers for excess costs for FY 2006-2007 approved eligible Reimbursement Requests and unfunded obligations for prior fiscal years.

Education and Advocacy:

- **The Bureau of Employee Assistance and Ombudsman**
  - Telephoned all injured workers with lost-time claims to provide benefit information, serve as a resource, answer questions and work with carriers to resolve injured worker concerns.
  - Assigned Ombudsmen to assist injured workers in navigating the Workers' Compensation System, including drafting Petitions for Benefits when requested.
  - Conducted workshops for stakeholders to provide education about injured worker benefits and responsibilities.
  - Developed and established web-based educational materials for injured workers.
  - Reviewed carrier denials for appropriateness and assisted injured workers in obtaining benefits to which they are entitled.

- **The Office of Medical Services and Bureau of Employee Assistance and Ombudsman**
    - Worked jointly to resolve complaints on behalf of injured workers who were inappropriately billed for medical treatment by medical providers.

- **The Office of Medical Services**
    - Created a web-based tutorial regarding Expert Medical Providers to educate system stakeholders about this process.

- **The Bureau of Compliance;**
  The Bureau of Monitoring and Audit;
  The Bureau of Employee Assistance and Ombudsman;
  The Bureau of Data Quality and Collection; and
  The Office of Medical Services
    - Provided education and outreach programs for insurers, third-party administrators, medical providers, employers, and contractors regarding the various technological, process and regulatory improvements initiated by the Division.

Enforcement:

- **The Bureau of Monitoring and Audit**
    - Reviewed more than 85,000 First Report of Injury (DWC-1) forms to determine timely reporting of the injury and insurer's timely payment of initial indemnity benefits.
    - Assessed the performance of carriers' timely payment of 4.4 million medical bills.
    - Completed 31 onsite insurer audits of 6,738 claim files to assess the insurers' performance regarding the timely and accurate payment of benefits to injured workers.

- **The Bureau of Compliance**
    - Conducted onsite investigations of worksites to determine employer compliance.
    - Issued stop-work orders and assessed fines against employers determined not to be in compliance.
    - Adopted new rules and amended existing rules in order to clarify and interpret some of the various enforcement and compliance provisions in Chapter 440.

Each of the above activities and accomplishments also focuses specifically on the mission of the Division of Workers' Compensation which is:

> **To actively ensure the self-execution of the Workers' Compensation System through educating and informing all stakeholders in the system of their rights and responsibilities, compiling and monitoring system data, and holding parties accountable for meeting their obligations.**

Real-Time Information Initiative

The key component of the Division of Workers' Compensation's mission statement is to actively ensure the self-execution of the workers' compensation system. One of the three most critical processes necessary to achieve that mission is compiling and monitoring system data.

During the first Special Session of the 2003 Legislature, Senate Bill 50-A was passed, which implemented major changes to the Workers' Compensation System that were designed to reduce litigation, provide greater compliance and enforcement authority for the Department of Financial Services, combat fraud, revise certain indemnity benefits for injured workers, increase medical reimbursement for physicians and surgical procedures, and increase availability and affordability of coverage. Some provisions of the bill became effective when the bill was signed by the Governor on July 15, 2003, some became effective on October 1, 2003, and the balance went into effect on January 1, 2004.

In order to implement the mandates of these sweeping revisions, the Division of Workers' Compensation aggressively pursued the application and implementation of new and emerging technologies under authority granted in s. 440.593, F. S., which states:

> *(1) The department may establish an electronic reporting system requiring or authorizing an employer or carrier to submit required forms, reports, or other information electronically rather than by other means. The department may establish different deadlines for submitting forms, reports, or information to the department, or to its authorized agent, via the electronic reporting system than are otherwise required when reporting information by other means.*
> *(2) The department may require any carrier to submit data electronically, either directly or through a third-party vendor, and may require any carrier or vendor submitting data to the department electronically to be certified by the department. The department may specify performance requirements for any carrier or vendor submitting data electronically.*
> *(3) The department may revoke the certification of any carrier or vendor determined by the department to be in noncompliance with performance standards prescribed by rule for electronic submissions.*
> *(4) The department may assess a civil penalty, not to exceed $500 for each violation, as prescribed by rule.*
> *(5) The department may adopt rules to administer this section.*

Electronic Data Interchange (EDI)

Electronic Data Interchange refers to the transfer of information in a standardized computer format with those entities that are registered and approved by the Division to act as trading partners in the exchange of data. The process was carefully designed to phase in three primary programmatic areas. The first phase involved the electronic submission of all employer coverage information and has been operating successfully since 2002. The second phase involved the electronic submission by insurers of all medical bills received from individual health care providers, pharmacists and facility health care providers, including both hospitals and ambulatory surgical centers. This phase has been successfully operating since 2005. In order to reduce the administrative burden to the health care industry, the Division revised EDI submission requirements effective August 9, 2007, to conform to the National Uniform Billing Committee's adoption of the new 2007 nationally standardized billing forms which are used in the Workers' Compensation System. The third and final phase of implementation involves the electronic submission of all claim indemnity benefit data which becomes mandatory for all insurers beginning in November, 2007.

Phase One: Proof of Coverage System (POC)

Beginning on March 1, 2002, every insurer, except for individual self-insurers, was required to file policy information electronically with the Division in place of previously required paper forms. These insurers had to build the infrastructure for sending to the Division, by electronic data interchange, all policy information including Certificates of Insurance, Notices of Endorsement, Notices of Reinstatement, and Notices of Cancellation and Non-Renewal, within statutorily defined reporting periods.

"Florida Roofing, Sheet Metal and Air Conditioning Contractors Association (FRSA) applauds the creation by the Division of Workers' Compensation of the Proof of Coverage Database and the Construction Policy Tracking Database. For the construction industry, both of these tools are crucial for contractors, building departments, licensing officials, and insurers. With this and other improvements, the Division's dedicated efforts have given stronger meaning to Florida's 2003 workers' compensation reforms - Thank you."

Billy Cone, Florida Roofing, Sheet Metal and Air Conditioning Contractors Association

Under this system, policy information is sent in a standardized format originally developed in conjunction with the International Association of Industrial Accident Boards and Commissions (IAIABC). The IAIABC is a not-for-profit trade association representing government agencies charged with the administration of workers' compensation systems throughout the United States, Canada and other nations and territories. The Division adopted the IAIABC standard through the Proof of Coverage Electronic Data Interchange Implementation Manual, which was most recently revised in July, 2006. Since the Division no longer accepts paper filings and does not accept an electronic transaction that fails to comply with the electronic filing requirements, insurers either created information technology programs that were capable of sending electronic transmissions directly to the Division or contracted with a third-party vendor that could file electronically on their behalf.

Insurers must electronically file and receive notification that the filing has passed all structural and quality edits within the following time periods for any workers' compensation insurance policy, contract of insurance, or renewal:

- Certificate of Insurance - Within 30 days after the effective date of the policy.
- Notice of Endorsement – Within 30 days after the issue date of each endorsement.
- Notice of Reinstatement – Within 30 days after the effective date of each reinstatement of a policy.
- Notice of Cancellation or Non-Renewal – Within 30 days prior to the cancellation or non-renewal other than a cancellation for non-payment of premium or failure to pay deductible or when cancellation or non-renewal is requested by the insured.
- Notice of Cancellation or Non-Renewal – At least ten days prior to the cancellation for non-payment of premium or failure to pay deductible if the policy effective date is on or after October 1, 2003.
- Notice of Cancellation or Non-Renewal – Within ten days of the cancellation or non-renewal when an insured has requested cancellation or non-renewal.

Phase Two: Medical Data System (MDS)

With the 2003 enactment of Senate Bill 50-A, the Division of Workers' Compensation was given a massive and challenging responsibility to monitor all medical bills for timely payment or denial within 45 days of insurer receipt of the bill. Insurers falling below the following timely performance standards are assessed penalties as described below:

- $25 for each bill falling between 90% and 95% timely performance; and
- $50 for each bill falling below 90% timely performance.

Determination of timely performance for every medical bill assumes timely collection of approximately 4.4 million medical bills per year in Florida, including bills from physicians, pharmacies, dentists, ambulatory surgical centers and hospitals. In 2003, the Division received an estimated 80% of physician, dentist and hospital bills electronically, on a voluntary basis, through a relatively slow, mainframe-based processing system. At that time, the remaining 20% of those bills and all pharmacy bills were collected on paper forms with only random samples entered into the medical database when resources permitted. Such a system could never adequately handle real-time collection of all medical bills with the high standard of accuracy and speed required for timely examination and proper assessment of penalties.

"The Medical Data System is reliable and the submission responses and reports are always timely, however, working with the Division's staff is what makes the reporting experience seem effortless."

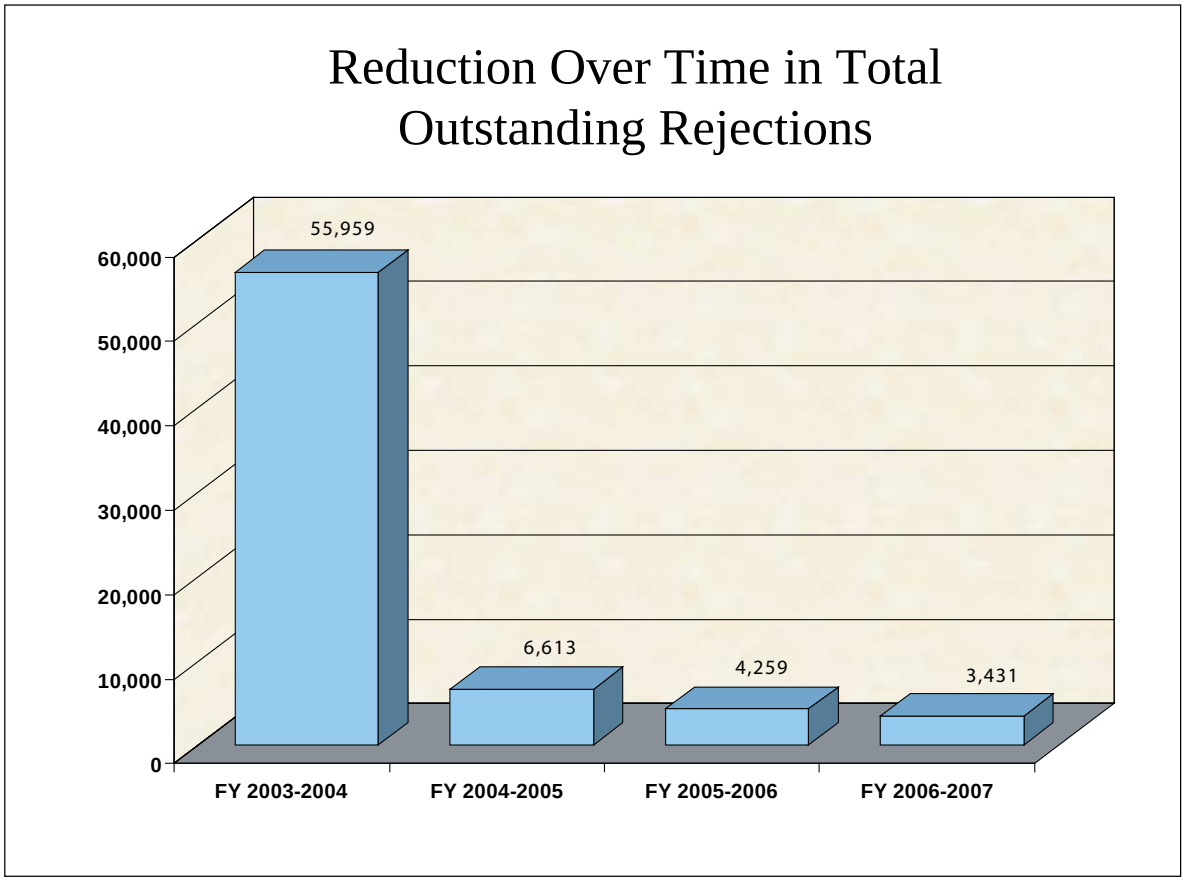
Courtland D. Abbott, PMSI

"Florida's Medical Data Management System provides valuable tools to assist partners in sucessfully submitting medical bill data. The Medical Filing Report Card identifies opportunities for improvement and the Outstanding Reject Report helps to manage timeliness of bill submissions."

Joan Henchey, Coventry, (formerly Concentra)

In addition to mandating penalties for late payment to providers, the 2003 reforms required the Division to assess fines for late filing of medical reports. In order to carry out these legislative mandates, the Florida Workers' Compensation Medical Billing, Filing, and Reporting Rule, 69L-7.602, F.A.C., was amended to impose fines when medical bills were not paid within 45 days of receipt by the insurer and to also impose fines when medical bills were not filed within 45 days of the date of payment or denial by the carrier. "Filing with the division" means submitting an accurate bill that passes all structural and quality edits and is thereby accepted into the medical database. Thus, bills rejected for failing edits are not considered "timely filed" until corrected, re-submitted, and accepted. Rejected items are subject to late filing penalties. Together, the statutory mandate to examine all medical bills for late payment or denial in order to assess penalties and the rule authority to impose fines for late filing with the Division constituted a mandate to create the technological infrastructure to collect, meticulously manage, and store in real time 4.4 million medical bills per year. Once stored, these medical data are then funneled into another system for assessing and managing the new penalty process – the Centralized Performance System (CPS), which is discussed further on page 8.

The electronic submission of medical bill information has resulted in the collection of significantly more accurate information. Graphic 1 below illustrates the dramatic reduction in items that are never corrected and resubmitted to the Division.



Prior to the enactment of Senate Bill 50-A, the Division initiated a plan to implement a state-of-the-art, server-based system to collect medical data efficiently, accurately, and quickly. The 2003 reforms proved to be the catalyst to bring the concept of this system "front and center" and the Medical Data System became a reality. The design, programming, and testing phases were completed by mid-2004, and featured a phased-in conversion over a nine-month period, which ended in March, 2005.

A feature of the Medical Data System that makes it truly unique among states is the inclusion of a website for small insurers with less than 200 medical bills per month to directly enter, review, and manage their claims. These small insurers do not have to hire outside vendors or hire technical staff, as large insurers normally do. Any small insurer with internet access can use this website at no cost and be in full compliance. Thus, Florida's system is "first-in-the-nation" to implement the complete infrastructure to enable all insurers to comply with the statutory mandate, regardless of size and resources. The website design, programming, and testing was completed by December, 2004, and the website made its debut in January, 2005.

Since April 1, 2005, all medical bills – from physicians, pharmacies, dentists, ambulatory surgical centers and hospitals – have been submitted to the Division electronically. Most reporting is completed either directly or through the use of one of several data submitters providing electronic reporting services via technology which provides security for server to browser transactions and file transfers to remote servers called Secure Socket Layer File Transfer Protocol or SSL/FTP. The balance of reporting is submitted by small insurers with less than 200 medical bills per month who have been approved to access a Division website where data from each medical bill is entered into a template modeled after each bill type.

On May 1, 2006, the Medical Data System completed a conversion that incorporated line item data on drugs from pharmacies for the very first time in Florida. Identifying pharmaceutical product data is required to analyze the frequency and usage of different drug types and classes and for review of individual cases, physicians and specialty groups.

On September 1, 2006, the Medical Data System began collecting data that describe the particular type of business arrangement between insurers, providers, and any entities that review and/or pay medical bills on behalf of the insurers. The identification of these arrangements was critical in order to determine who is responsible for "receiving" a medical bill, and who is responsible for "paying" a medical bill when multiple entities are involved in the medical bill review process. The dates "received" and "paid" are critical for properly calculating the 45-day window for late payment to providers and accurate assessment of late payment and late filings by the CPS, which draws all of its data for penalty and fine assessment directly from the Medical Data System.

Another major conversion was initiated in 2006 to accommodate the new nationally standardized medical billing forms that were federally mandated for use throughout the country during 2007, and developed by the National Uniform Billing Committee. Resources of all stakeholders were challenged as efforts focused on coordination of the workers' compensation system with the nation-wide adoption of these forms. Since the revised billing forms are used throughout the nation's health care system, the Division's goal was to coordinate adoption of these new forms for the workers' compensation system and revise the data submission requirements to the same timelines that health care providers were required to meet for all other health care plans. Through this action the Division reduced the administrative burden health care providers would have otherwise had, as physicians, dentists and hospitals changed business practices to use the newly mandated uniform bills.

Currently, the Medical Data System processes an average of about 86,000 medical bills each week, but has the capacity to handle up to five times that amount. The medical team is initiating an intensive analysis of data in the Medical Data System to identify reporting practices, outliers, and other data issues which will then be available for use in published statistics and research. These efforts will focus on such issues as identifying areas the Division auditors need to target for examination of medical bills during field audits, providing information needed by the Office of Medical Services for dispute resolution and utilization review and creating real-time early warning systems for cases requiring early intervention by the Division. Once the implementation of this process is complete, medical data will be immediately accessible to all Division staff via an interface to the new Medical Data System, which also includes historical data from the mainframe-based system.

Florida's Medical Data System now serves as a national model for other states seeking to use technology to efficiently and effectively collect, store, manage, and analyze workers' compensation medical data.

Phase Three: Claims Data

The Division has been working to design and complete the groundwork for EDI claims data since the early 1990s. By participating and assuming leadership roles in the Claims EDI efforts of the IAIABC, Florida has been instrumental in the planning and preparation of this technologically complex undertaking. Although this phase of the EDI shift involves fewer paper documents being replaced by EDI transmissions than either the Proof of Coverage System or the Medical Data System, it is by far the most sophisticated program because of the cumulative and sequential nature of claim reports. In order to minimize user compatibility issues when establishing the standard technical requirements for Claims EDI transmissions, the Division approved two methods of transmission for EDI data reporting, which allow insurers the flexibility to select the option most compatible with their existing technological infrastructure.

Training was provided to claims administrators during FY 2006-2007 and insurers may begin voluntary testing of data in October, 2007, prior to the commencement of mandatory testing during November, 2007. This final phase of EDI will be implemented in three "test to production" periods with all insurers required to submit indemnity filings electronically by July 31, 2008.

In the claims EDI business environment, all stakeholders will add new terms to the common lexicon used to discuss workers' compensation cases. While the Division would prefer to employ plain language terms rather than acronyms, these are nationally standardized terms which will cross state lines in their use. Some of the most important new terminology, which will become colloquial terms-of-art in the workers' compensation community over the next few months, include four acronyms.

- **FROI** - means 'First Report of Injury' and is the new national standard nomenclature for the initial reporting of accident data, comprising most of the information reported to the Division on its First Report of Injury (DWC-1) form.
- **JCN** – means 'Jurisdiction Claim Number' and is the new national standard nomenclature for the unique claim number assigned by the Division following the reporting of a new claim.
- **MTC** –means 'Maintenance Type Code' and is the new national standard nomenclature for representing the specific purpose of each electronic submission which equates to and replaces the various claim-related forms required by the Division.
- **SROI** - means 'Subsequent Report of Injury' and is the new national standard nomenclature for reporting initial and cumulative payment information associated with the First Report of Injury (DWC-1) form and Claim Cost Report (DWC-13) form, respectively, although it also includes elements from the Notice of Action/Change (DWC-4) form, and the Notice of Denial (DWC-12) form.

Under the new Claims EDI program, the most common way that insurers will report to the Division over the life of the claim can be summarized as follows:

1. The initial reporting of a lost-time case where total compensability of the claim has not been denied will be completed with a combined **FROI/SROI** filing. The FROI portion will identify the injured worker, the employer and the insurer and provide basic information about the accident such as the date, time, place and brief description of the accident. The SROI portion will provide details about average weekly wage, compensation rate and the date and type of benefits initially provided.
2. The Division will acknowledge receipt of the FROI/SROI and assign the **JCN,** which will be used to identify the claim in all future communications.
3. An **MTC** will be filed after any event or change in the claim including events such as a change in the average weekly wage and compensation rate, a change in the type of disability benefits being paid, and changes to any information previously reported.
4. A **SROI** will be filed every six months throughout the life of the claim, which will summarize all benefit payments to date.

Historically, human error in the completion of required paper reports has been a reality that all stakeholders have encountered on a routine basis. Insurers have generally been held accountable only for timely filing of required reports, regardless of completeness or accuracy. The Division and stakeholders have worked together to provide the safety net for these human errors through the manual examination and correction of periodic reports. However, in the Claims EDI program, insurers will be held accountable for, not just the timely filing, but also for the accuracy of required reports. If an insurer attempts to report a new claim that is incomplete or without required information, the report will be rejected and the insurer will not be credited with timely filing if the EDI filing is not corrected and resubmitted within the required filing timeframe. If an insurer has previously reported a claim under a particular date of accident or social security number and later files the next report with a different identifier without an intervening change report, the subsequent reports will not match and will be rejected and the insurer will not be credited with timely filing. If the EDI filing is not corrected and resubmitted within the required filing timeframe, insurers will be solely responsible for both the correction and the re-filing of reports. In EDI, reports are not considered filed until they are corrected, re-submitted and have successfully passed all structural and quality edits.

"An especially valuable feature of the current Claims EDI process is the periodic report card, an effective tool in identifying programming and training opportunities. In addition, the extended submission timeframe provides ample time to correct and resubmit data, if necessary, and still remain within the guidelines necessary for compliance."

Nancy Amee, Summit

" Our ability to monitor our data daily online allows us to ensure accuracy and assist us in managing our claims. It gives us the speed and efficiency to identify any areas that may need attention."

Lori Chamness, AmCOMP, Inc.

"As a result of our system edits and the EDI database created by the State of FL, we have the ability to manage our errors on a daily basis. The EDI monthly report card keeps us informed of our results and is a proactive approach to managing quality data submissions."

Jan Curry, FCCI Insurance Group

Just as EDI will "raise the bar" for timely and accurate reporting for the insurer, EDI will afford efficiency gains which will streamline insurer reporting of claims. The labor-intensive process of manually completing each report will be eliminated. Human error associated with each report will be minimized. Mailing delays connected to filing will be eliminated and the window for filing with the Division is extended from 5:00 p.m. to 9:00 p.m. Most importantly, the filing of cumulative reports based strictly on calendar deadlines at six month intervals should be automatically generated without the need for adjuster intervention. Generally, the insurer will only have to initiate a report to document the decisions in which they actively participate such as changing the disability type, changing the compensation rate, starting or stopping benefit payments, etc. As such, insurers' efforts will be focused on case management and reporting of significant "events" in the claim rather than calendar dates that are not directly associated with processing of the claim.

Once the third phase of EDI is completely implemented, the Division, in partnership with insurers, health care providers, and trading partners will be the first jurisdiction in the nation to have achieved these improvements in operational efficiency by streamlining administrative reporting requirements in such a comprehensive manner. Ultimately, these gains will merge with the legislative intent to ensure prompt and cost efficient delivery of indemnity and medical benefits to injured workers, thereby, facilitating their return to gainful employment at a reasonable cost to the employer. Our collective goal of making the system far more self-executing for all of the participants in the workers' compensation industry in Florida will serve as a national model for excellence.

Centralized Performance System

The 2003 Legislature enacted significant reforms to the Florida Workers' Compensation Law. Among those reforms, each stakeholder was directed to take a more proactive role to ensure that the Florida's Workers' Compensation law performs as a self-executing system. In response, the Division of Workers' Compensation developed, created and implemented an interactive web-based system that allows insurers to access and respond to their performance information in real-time.

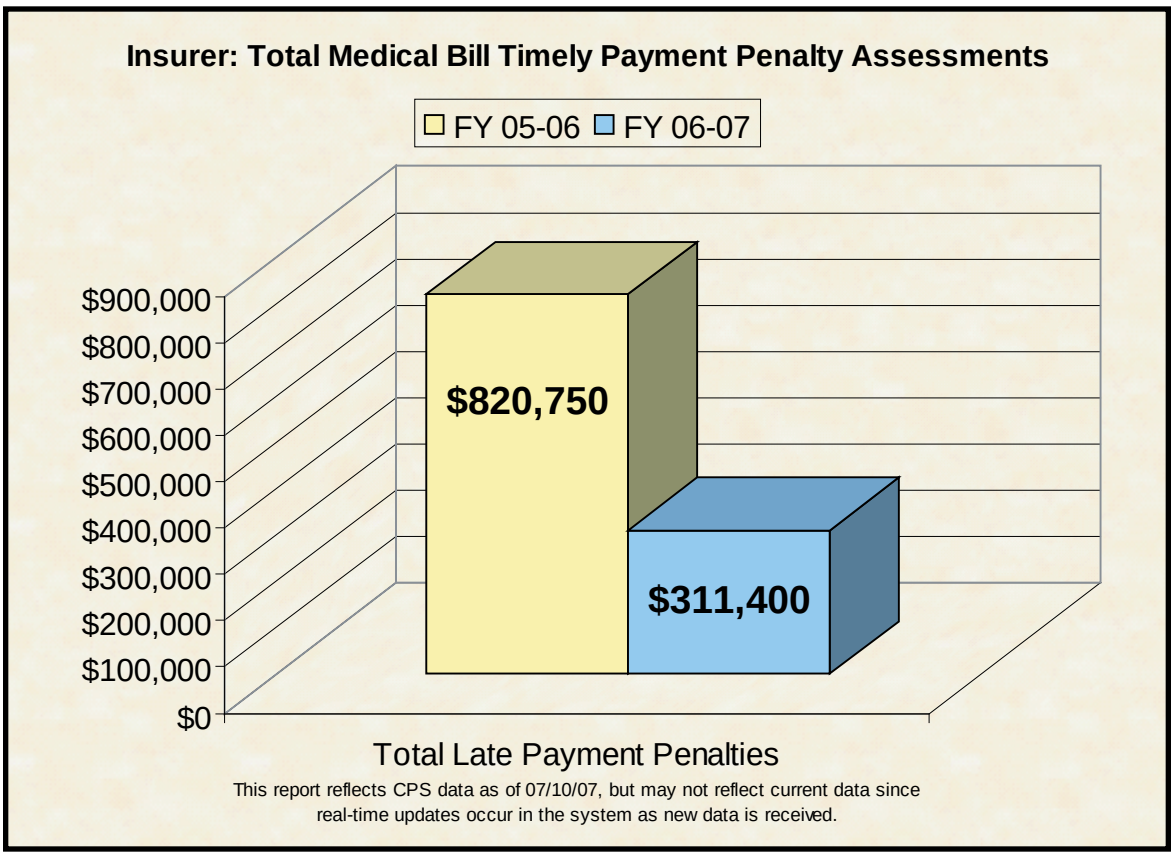
The Centralized Performance System (CPS) is a tool that provides essential performance information and trends that enables the Division and the insurer to monitor claim performance issues. CPS is now being used as a key component in identifying insurers and claims-handling entities that may require further monitoring that will trigger a Division investigation or examination. It is an essential web-based, real-time, interactive tool that helps monitor these obligations by assessing performance and providing useful feedback to aid in the improvement of both performance and process.

Prior to the implementation of CPS, the Division manually assessed timely submissions of First Report of Injury (DWC-1) forms and the initial indemnity benefit payments. In addition, the Division manually reviewed select medical bills to determine if they met statutory requirements for timely payment and timely filing.

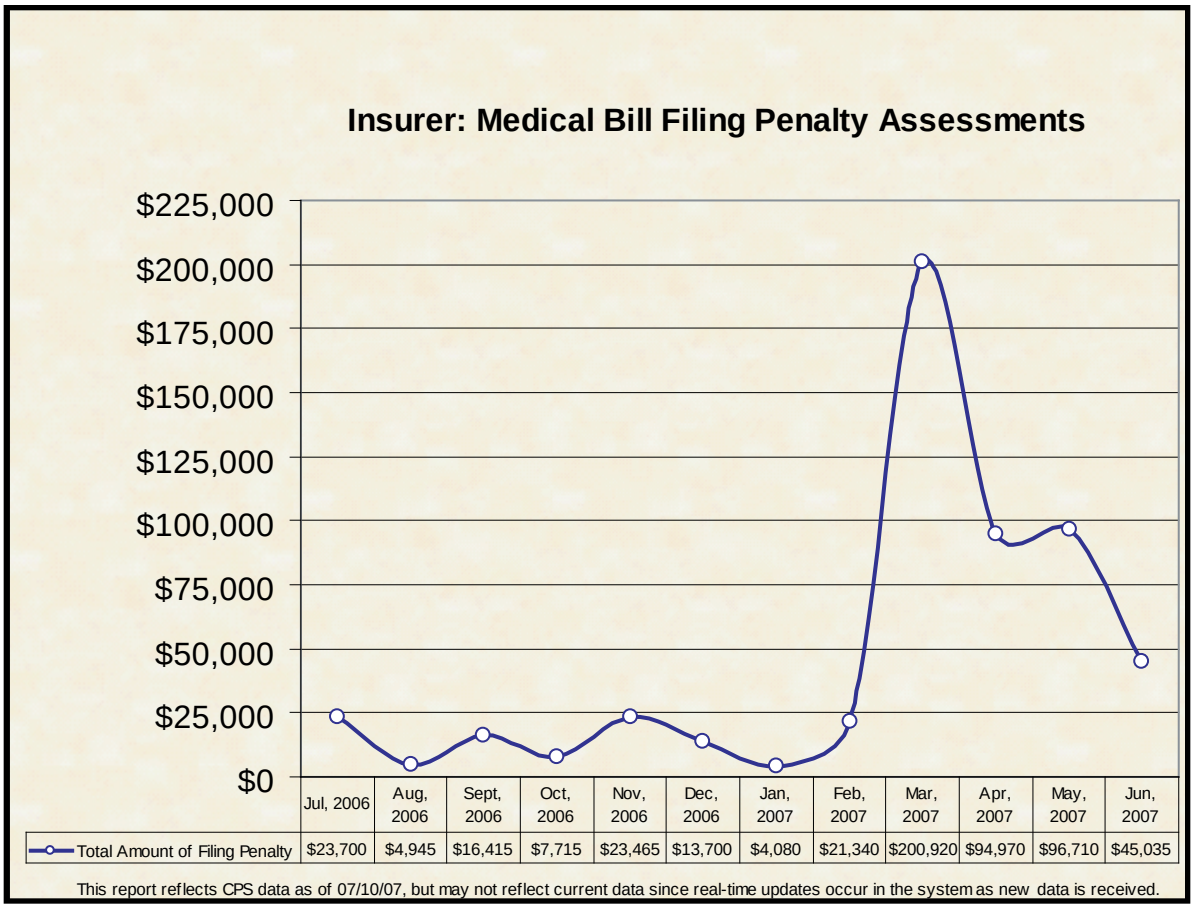
"The implementation and use of the Florida CPS System has provided a reliable and consistent means of tracking and monitoring workers' compensation claim handling results on an individual and departmental basis."

Sabrina Mitchell, The PMA Insurance Group

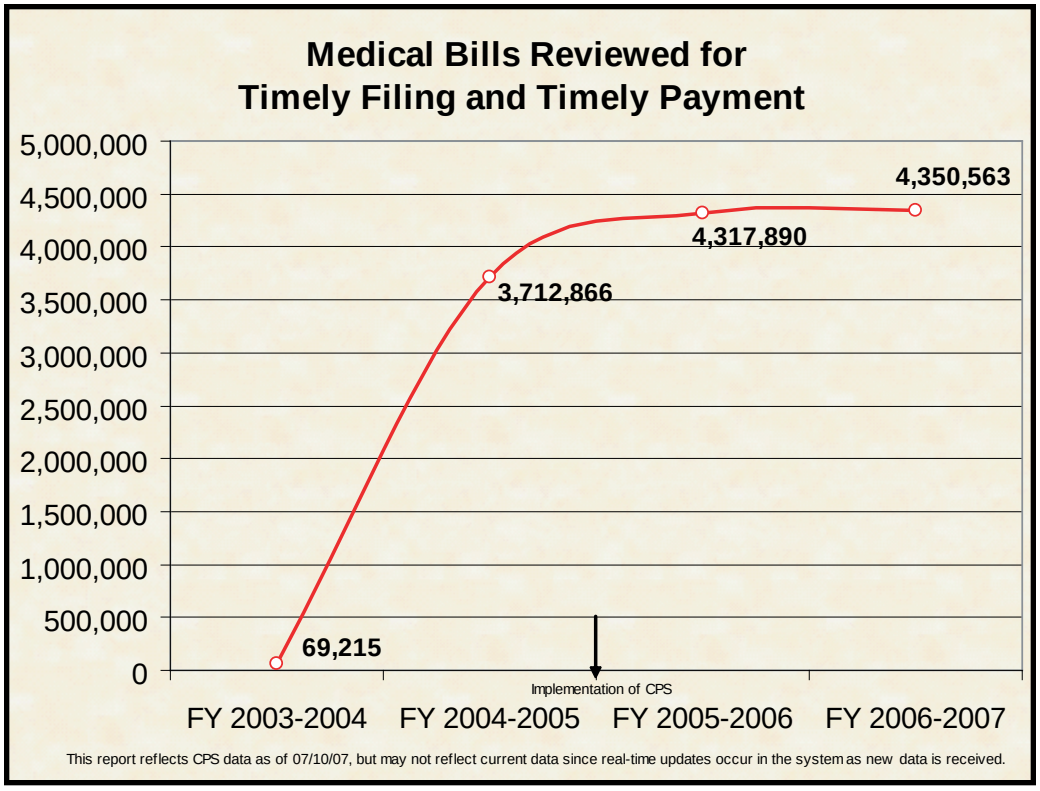
When Phase One of CPS was implemented in November, 2004, CPS began electronically evaluating monthly performance for the timely filing and timely payment of medical bills. Monthly bill payment information is reviewed and payment and filing performance penalties are assessed. CPS also tracks whether penalties have been paid or are still owed, automates and tracks all communications between the Division and claims handling entities and tracks proof of payment from the insurers. Graphic 2 on the following page illustrates the amount of penalties assessed for late payment of medical bills for the past two fiscal years.



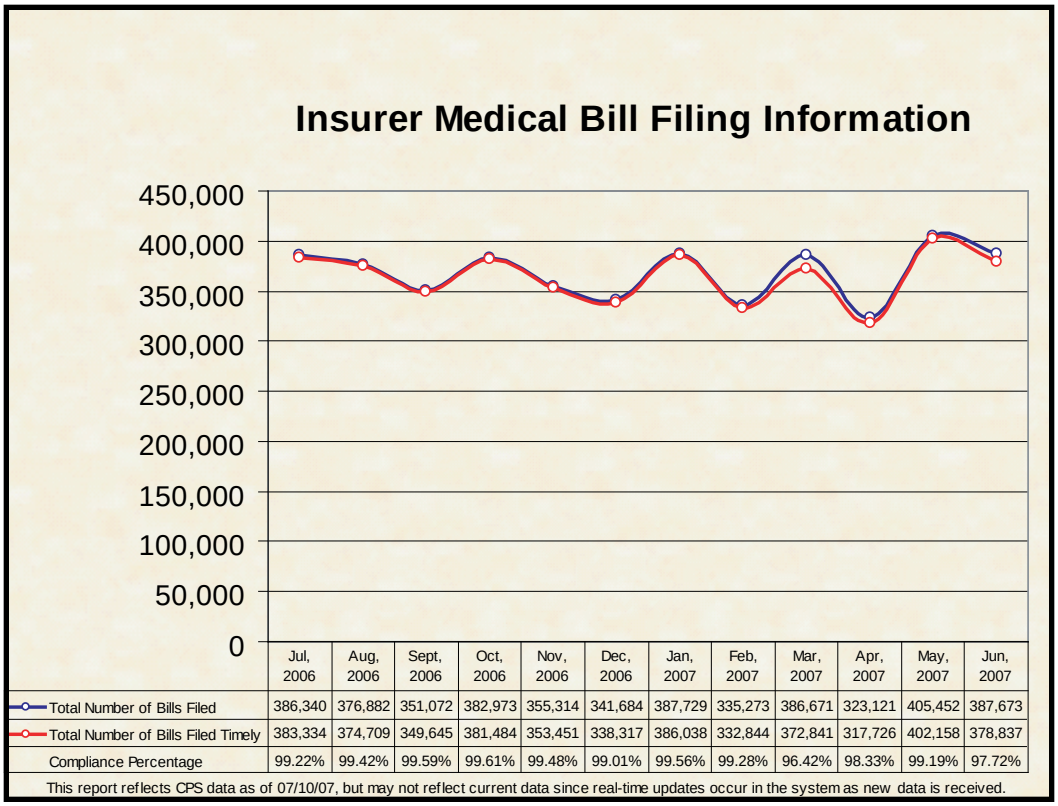
Graphic 3 below illustrates the assessment of monthly medical bill filing penalties during FY 2006-2007.



Prior to CPS implementation, the only way to review medical billing reports was to conduct onsite examinations of insurers. In FY 2003-2004, the Bureau of Monitoring and Audit reviewed 69,215 medical bills. The number of bills reviewed under CPS increased to 3,712,866 in FY 2004-2005; 4,317,890 in FY 2005-2006; and 4,350,563 in FY 2006-2007. Graphic 4 below illustrates these increases during the last four fiscal years.

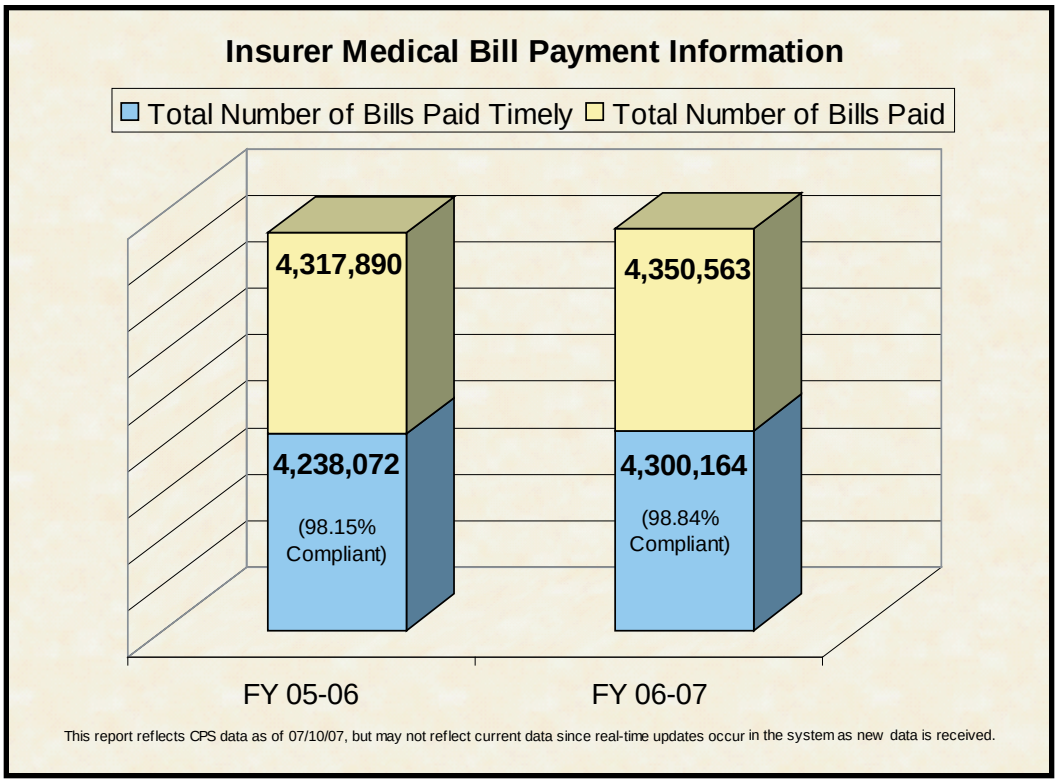


Graphic 5 below provides a monthly comparison of the number of medical bills filed to the number of medical bills timely filed during FY 2006-2007.

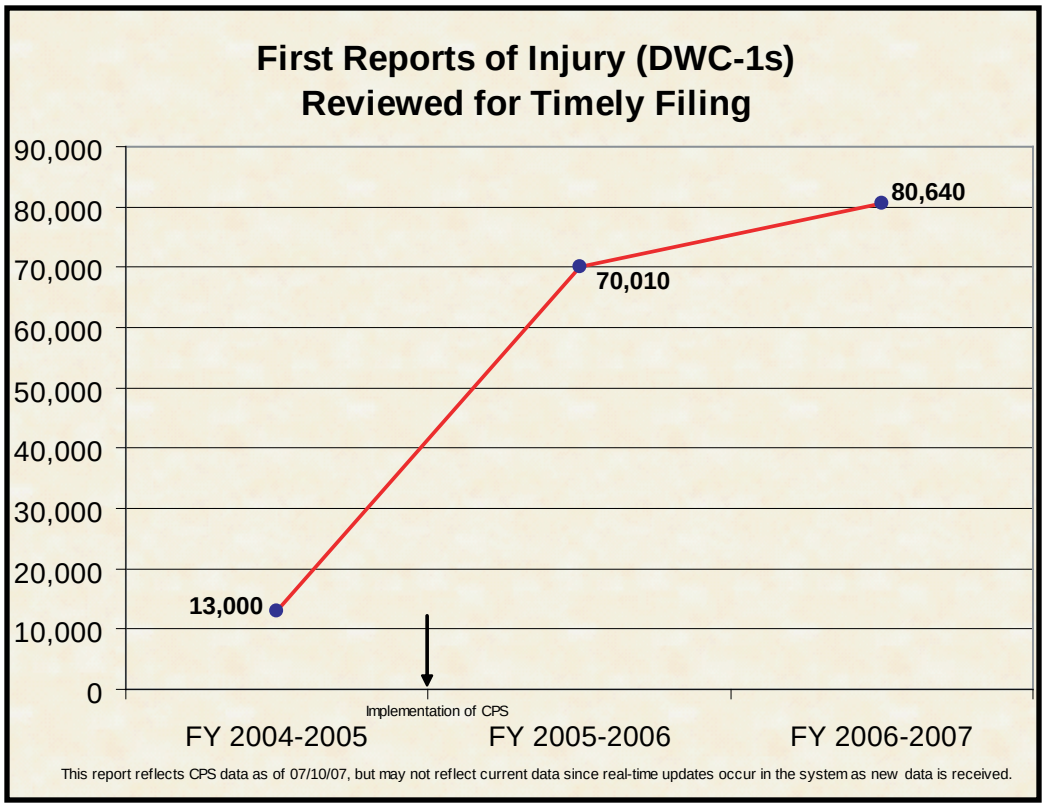


	Jul, 2006	Aug, 2006	Sept, 2006	Oct, 2006	Nov, 2006	Dec, 2006	Jan, 2007	Feb, 2007	Mar, 2007	Apr, 2007	May, 2007	Jun, 2007
Total Number of Bills Filed	386,340	376,882	351,072	382,973	355,314	341,684	387,729	335,273	386,671	323,121	405,452	387,673
Total Number of Bills Filed Timely	383,334	374,709	349,645	381,484	353,451	338,317	386,038	332,844	372,841	317,726	402,158	378,837
Compliance Percentage	99.22%	99.42%	99.59%	99.61%	99.48%	99.01%	99.56%	99.28%	96.42%	98.33%	99.19%	97.72%

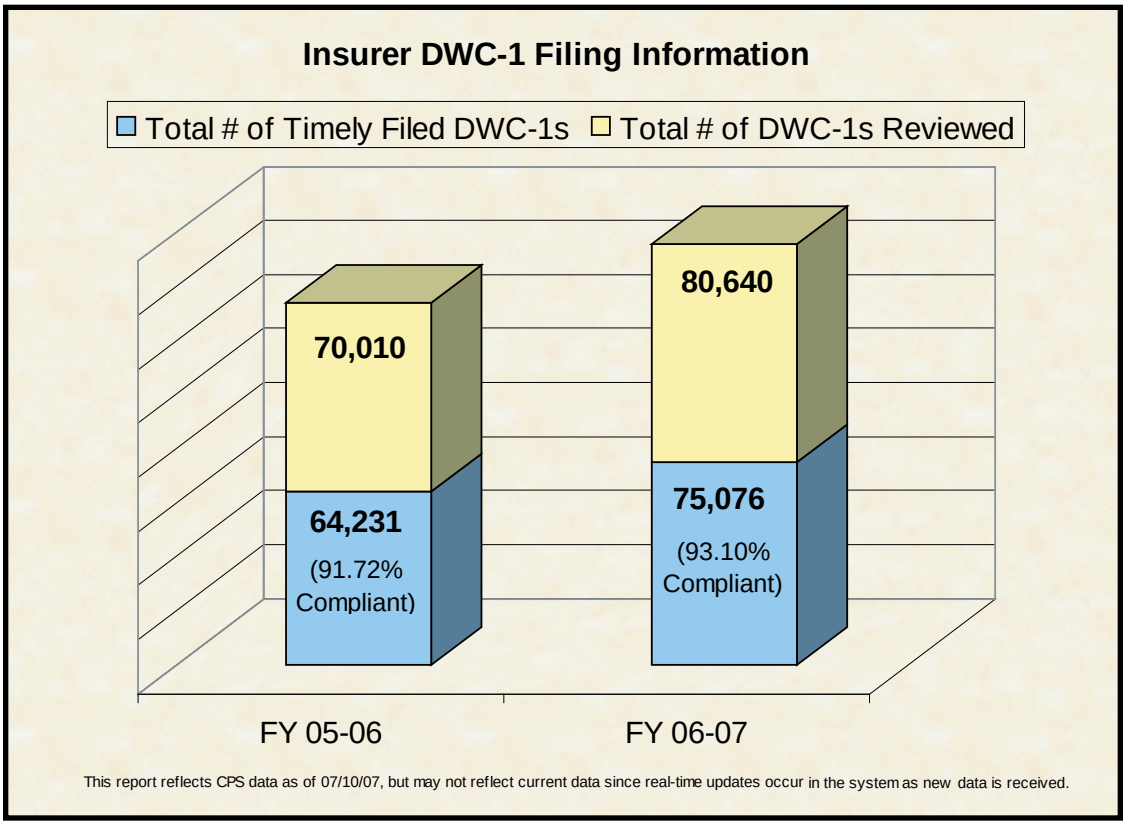
During FY 2003-2004, the performance for timely medical bill payment was 96%. With the implementation of CPS, insurer performance for timely medical bill payment increased to 98.15% during FY 2005-2006 and 98.8% during FY 2006-2007 as illustrated below in Graphic 6.



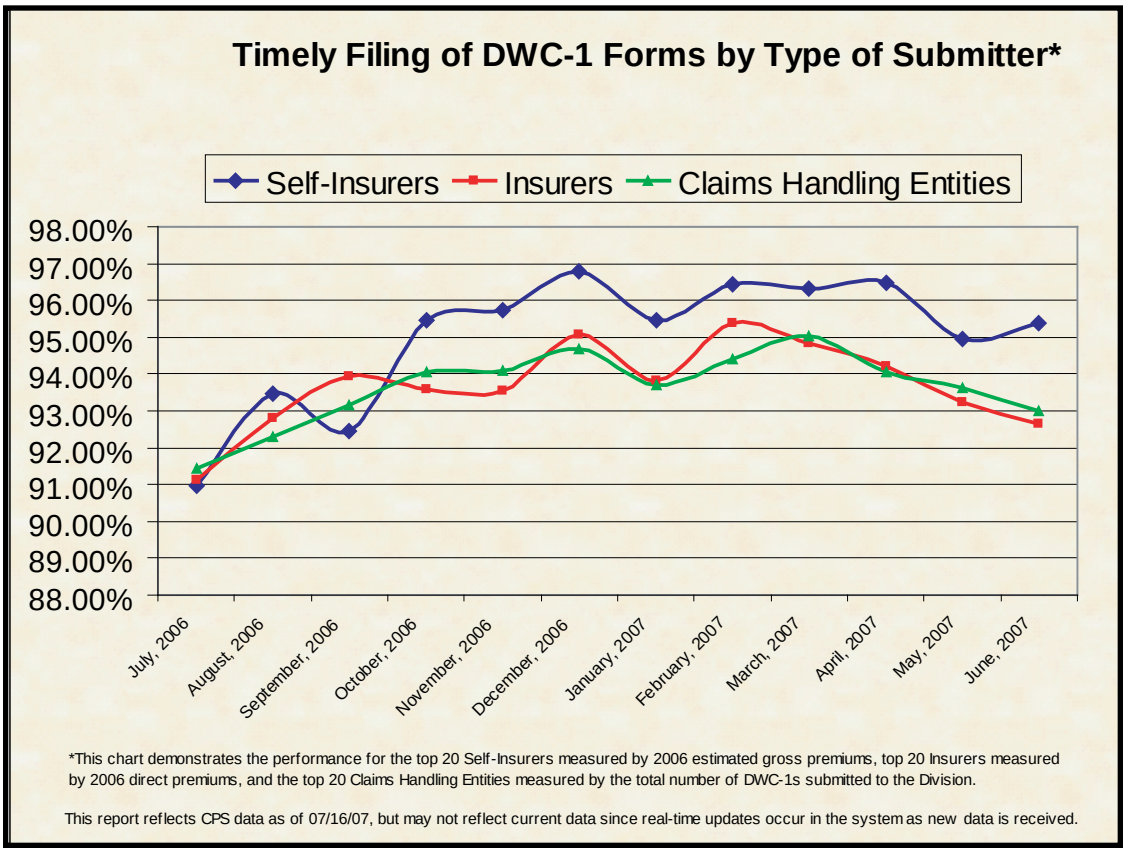
Phase Two of CPS was implemented in June 2005, and consists of the automatic review and evaluation of First Reports of Injury (DWC-1) forms for timely filing and timely payment of initial indemnity benefit payments. Prior to the implementation of Phase Two, the Division reviewed approximately 17% (13,000) of all filed First Report of Injury (DWC-1) forms. Subsequent to the implementation of Phase Two, the Division began reviewing 100% of all First Report of Injury (DWC-1) forms submitted. During FY 2005-2006, 70,010 forms were reviewed and 80,640 were reviewed in FY 2006-2007. This represents a 520% increase in productivity. Graphic 7 below illustrates the changes in the volume of First Report of Injury (DWC-1) forms reviewed.

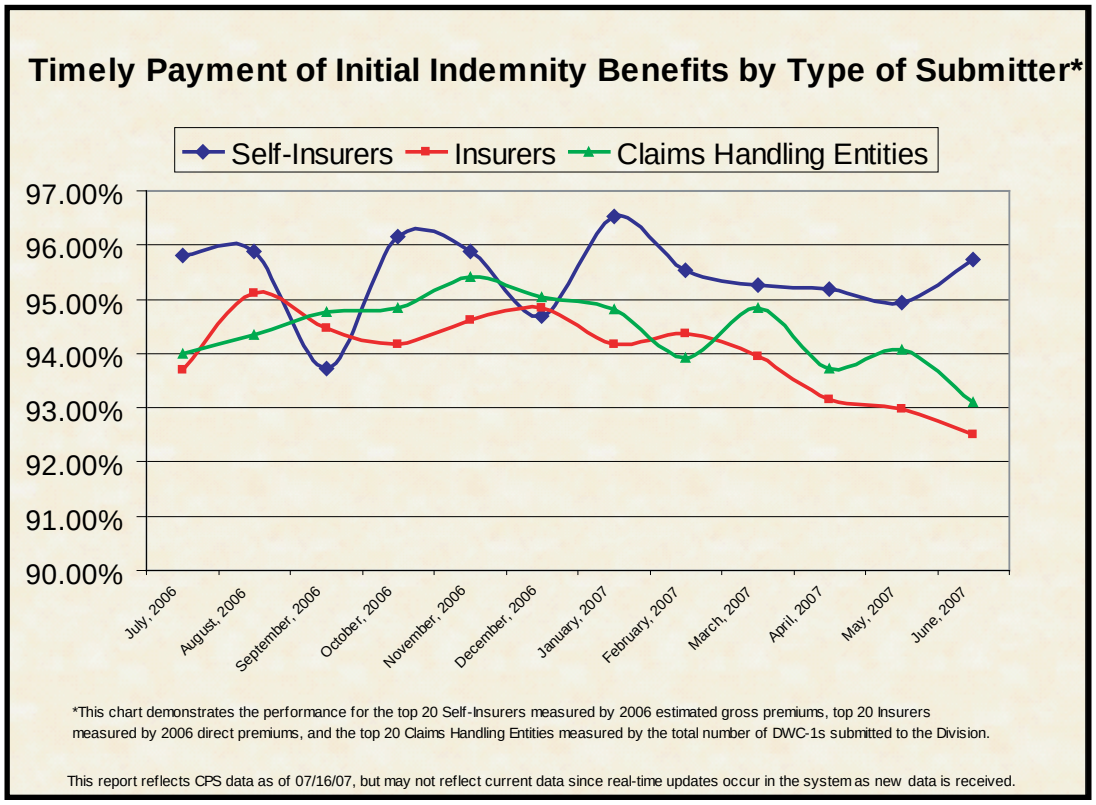


Timely filing of First Report of Injury (DWC-1) forms increased from 85% of those reviewed in FY 2003-2004 to 91.72% during FY 2005-2006 and further increased to 93.1% of filed forms during FY 2006-2007 as illustrated in Graphic 8 below.

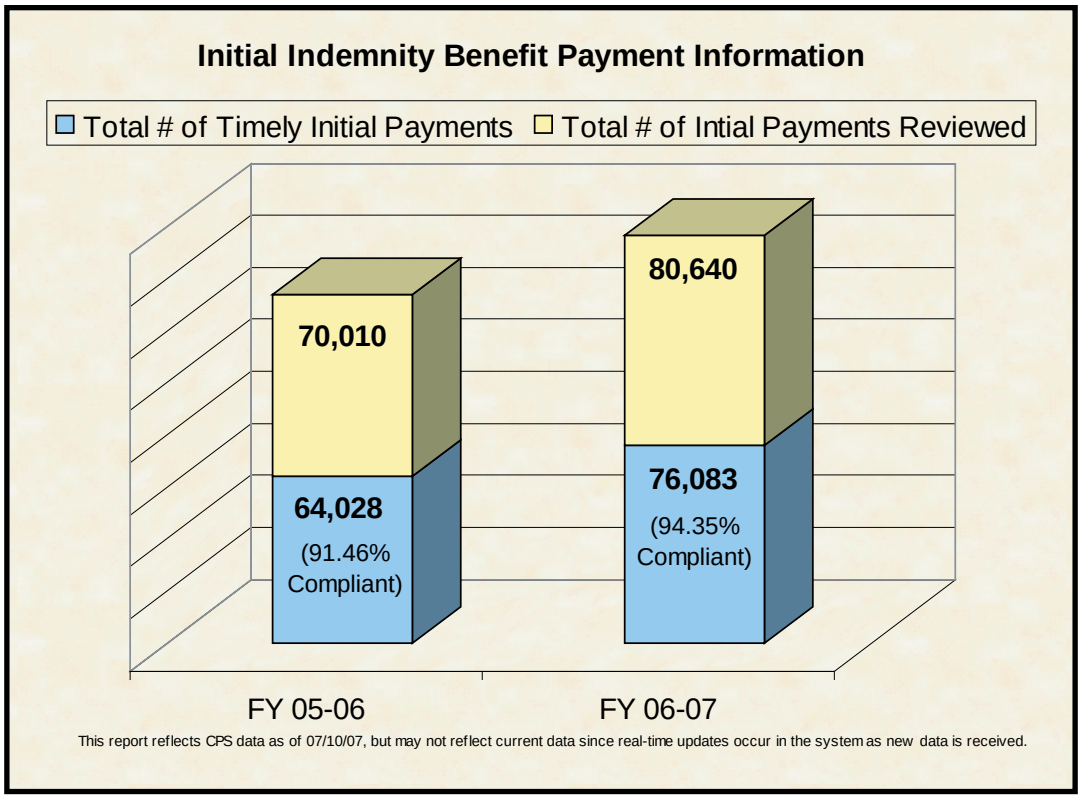


Graphic 9 below and Graphic 10 on the following page compare First Report of Injury (DWC-1) form timely filing and timely payment of initial indemnity benefit payment among the top 20 self-insurers, insurers and claims handling entities for FY 2006-2007.



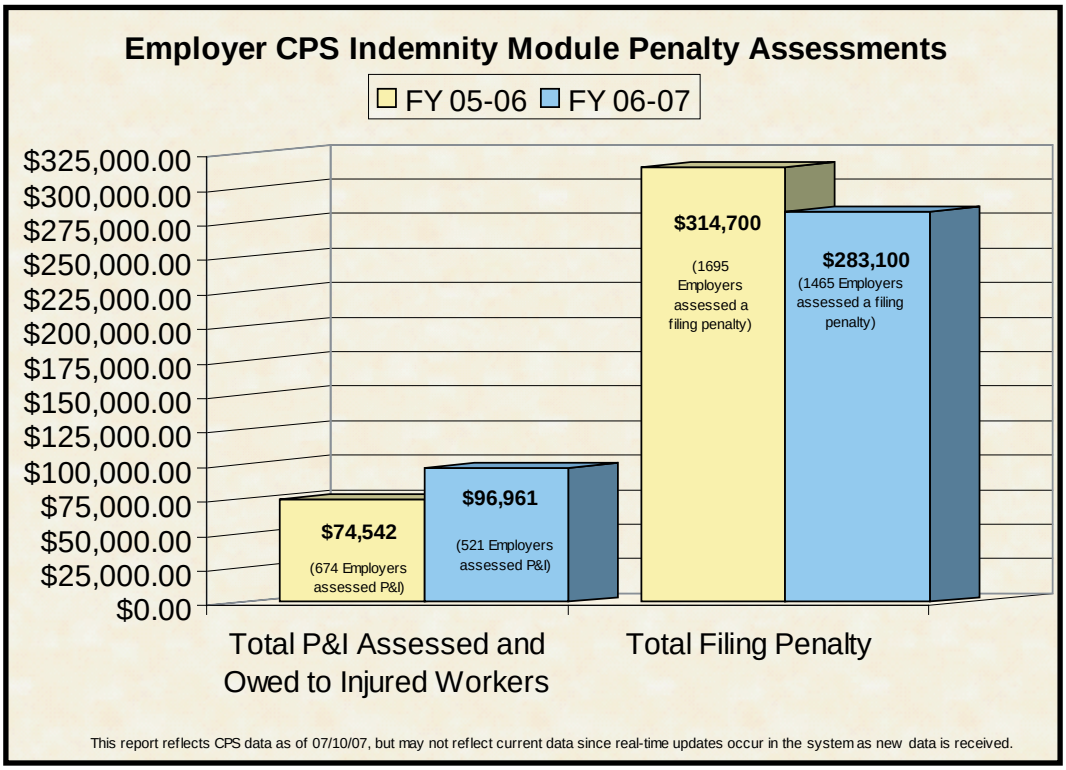


Insurer timely payment of initial indemnity benefit payments increased from 88.42% in FY 2004-2005 to 91.46% during FY 2005-2006 and further increased to 94.35% during FY 2006-2007. Prior to the implementation of Phase Two, the level of labor intensity required for the manual review process only permitted the Division to evaluate approximately 17% of all submitted First Report of Injury (DWC-1) forms and corresponding initial indemnity benefit payments for compliance with statutory requirements. Graphic 11 below illustrates the compliance rate for timely payment of initial indemnity benefit payments.

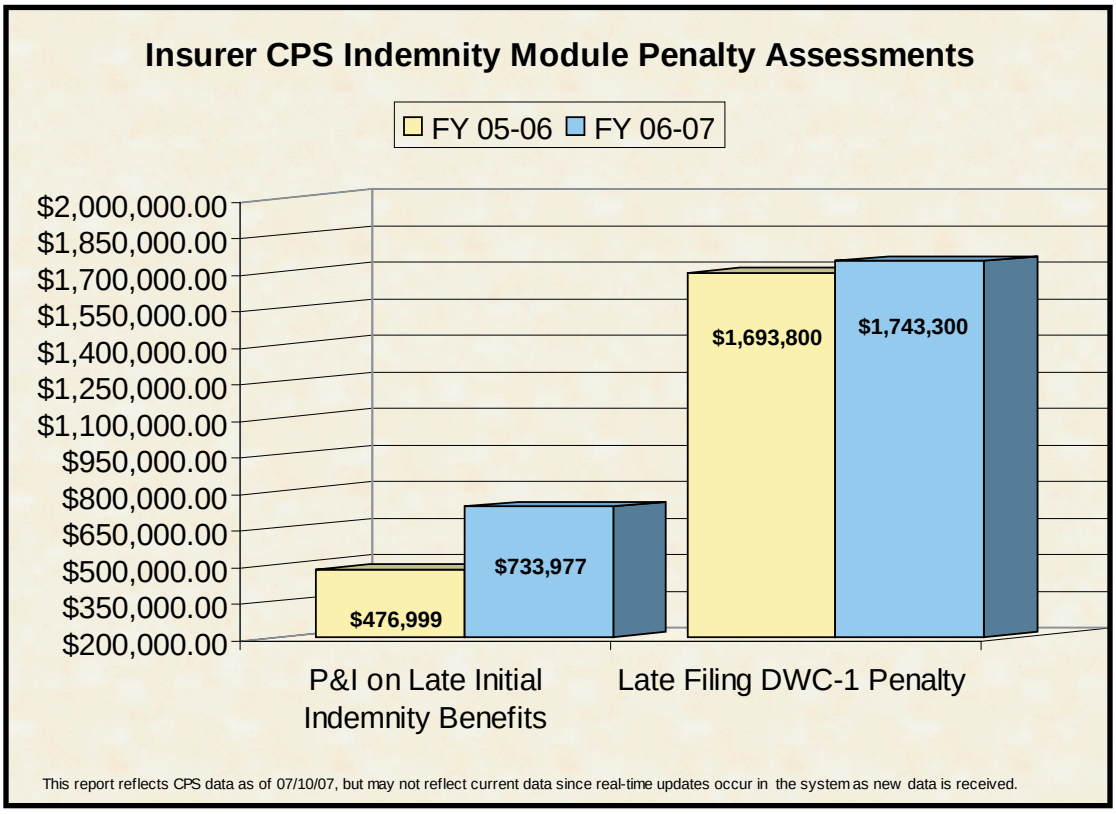


CPS also scrutinizes whether employers violate timely filing of the First Report of Injury (DWC-1) forms and assesses both penalties and interest payable to injured workers and administrative fines due to the Division. Graphic 12 below illustrates employer penalties and interest assessed and administrative fines levied for the last two fiscal years.

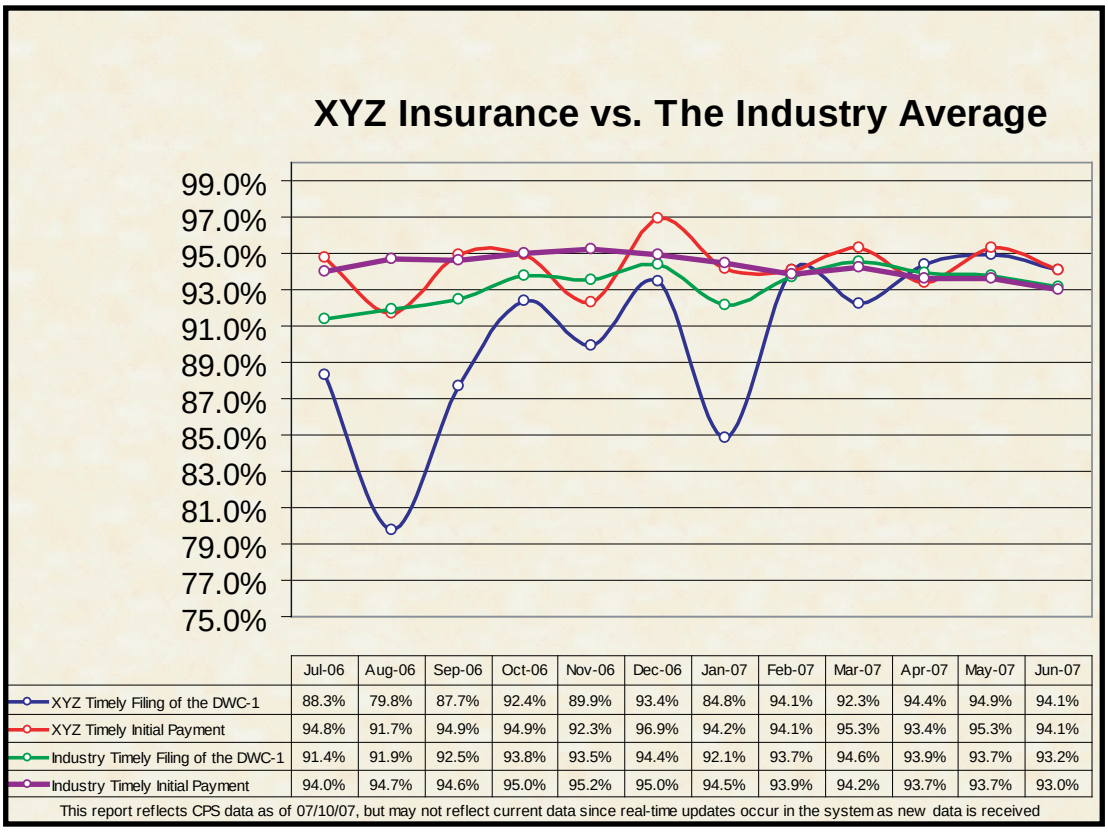
If insurers violate the statutory timely filing requirements regarding First Report of Injury (DWC-1) forms, statutory administrative fines are levied. Prior to the implementation of CPS, the Division reviewed approximately 17% of all filed First Report of Injury (DWC-1) forms resulting in administrative fines totaling $606,900. Utilizing CPS (FY 2005-2006), the Division reviewed 100% of filed First Report of Injury (DWC-1) forms resulting in administrative fines totaling $1,693,800 in FY 2005-2006 and $1,743,300 in FY 2006-2007.



This process also permitted the Division to increase the timeliness review of initial indemnity benefit payments from 13,000 in 2004 to 80,640 payments in FY 2006-2007. This increased level of scrutiny resulted in additional penalty and interest (P&I) payments to injured workers of $476,999 for FY 2005-2006 and $733,977 for FY 2006-2007. Graphic 13 on the following page illustrates the penalties and interest and administrative fines assessed to insurers during the last two fiscal years.



The Centralized Performance System enables insurers and claims-handling entities to evaluate their performance on a monthly basis with regard to timely reporting of all First Report of Injury (DWC-1) forms, and timely payment of all initial indemnity benefit payments to injured workers. The system also permits them to compare their performance to the composite performance of all other insurers as illustrated in Graphic 14 below which illustrates the performance of a hypothetical insurer.



	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07
XYZ Timely Filing of the DWC-1	88.3%	79.8%	87.7%	92.4%	89.9%	93.4%	84.8%	94.1%	92.3%	94.4%	94.9%	94.1%
XYZ Timely Initial Payment	94.8%	91.7%	94.9%	94.9%	92.3%	96.9%	94.2%	94.1%	95.3%	93.4%	95.3%	94.1%
Industry Timely Filing of the DWC-1	91.4%	91.9%	92.5%	93.8%	93.5%	94.4%	92.1%	93.7%	94.6%	93.9%	93.7%	93.2%
Industry Timely Initial Payment	94.0%	94.7%	94.6%	95.0%	95.2%	95.0%	94.5%	93.9%	94.2%	93.7%	93.7%	93.0%

This report reflects CPS data as of 07/10/07, but may not reflect current data since real-time updates occur in the system as new data is received

The real-time component of CPS provides insurers with a number of monthly performance reports that allow insurers to track the performance of its claim-handling entity against the industry average. Insurers are also discovering other innovative ways to use CPS to improve their performance both internally and externally.

Audit Component

After the Centralized Performance System was implemented in 2005, the Audit Section revised its examination procedure to include validation of the data reported to the Division by the insurer or claims-handling entity. As a result of the new procedure, medical bills, First Report of Injury (DWC-1) forms and the initial indemnity benefit payment receive further review for accuracy.

During FY 2006-2007, the Audit Section conducted 31 onsite insurer audits and reviewed 7,670 medical bills for data accuracy. As a result of the audits performed, it was determined that an accurate " Date Insurer Received" was reported 96.3% of the time and an accurate "Date Insurer Paid" occurred within statutory timeframes for more than 99% of the audited bills. In addition to data accuracy, the Audit Section examines insurer claim files to determine if all required medical bills have been appropriately filed with the Division.

In January, 2006, the Audit Section began comparing the accuracy of data filed electronically with the Division to information in the insurers' claim files regarding the First Report of Injury (DWC-1) forms. The Audit Section examines nine key data elements to evaluate timely filing of the form and timeliness of the initial payment of indemnity benefits. This component will be of increased significance when all lost-time First Report of Injury (DWC-1) forms are phased into the EDI process beginning in November, 2007.

DWC e-Alert

In February 2004, the Division introduced a program called DWC e-Alert which provides real-time notification concerning activities of the Division as well as significant events in the Workers' Compensation System. This email-based system has allowed the Division to communicate directly with system participants concerning public workshops, training sessions, public hearings, administrative rules, breaking news and other information announcements of general interest. This forum currently includes over 3,000 individuals and organizations that have registered for this service through the Division's website and now serves as one of the key vehicles for communication with all parties interested in workers' compensation issues.

"The DWC e-Alert notification is a great added enhancement to internal processes. It provides us with quick, 'at a glance,' up-to-the-minute notices of changes, workshops, etc."

Lynn Pannell, Claims Business Systems Support, Summit

"The DWC e-Alert notifications have allowed the flexibility to proactively prepare and plan for proposed regulatory changes and scheduled events sponsored by the Division. The electronic, real time, receipt of information affords us an opportunity to efficiently review the information with our internal business partners in order to meet our business needs."

Sandi Taylor, Zenith Insurance Company

"The DWC e-Alert is an exceptional tool allowing me to keep abreast of developments, rule makings, opinions and communications generated by the Florida DWC. The DWC e-Alert provides quick access to information, and other states should institute programs such as the DWC e-Alert."

Kevin C. Tribout, PMSI

Construction Policy Tracking Database

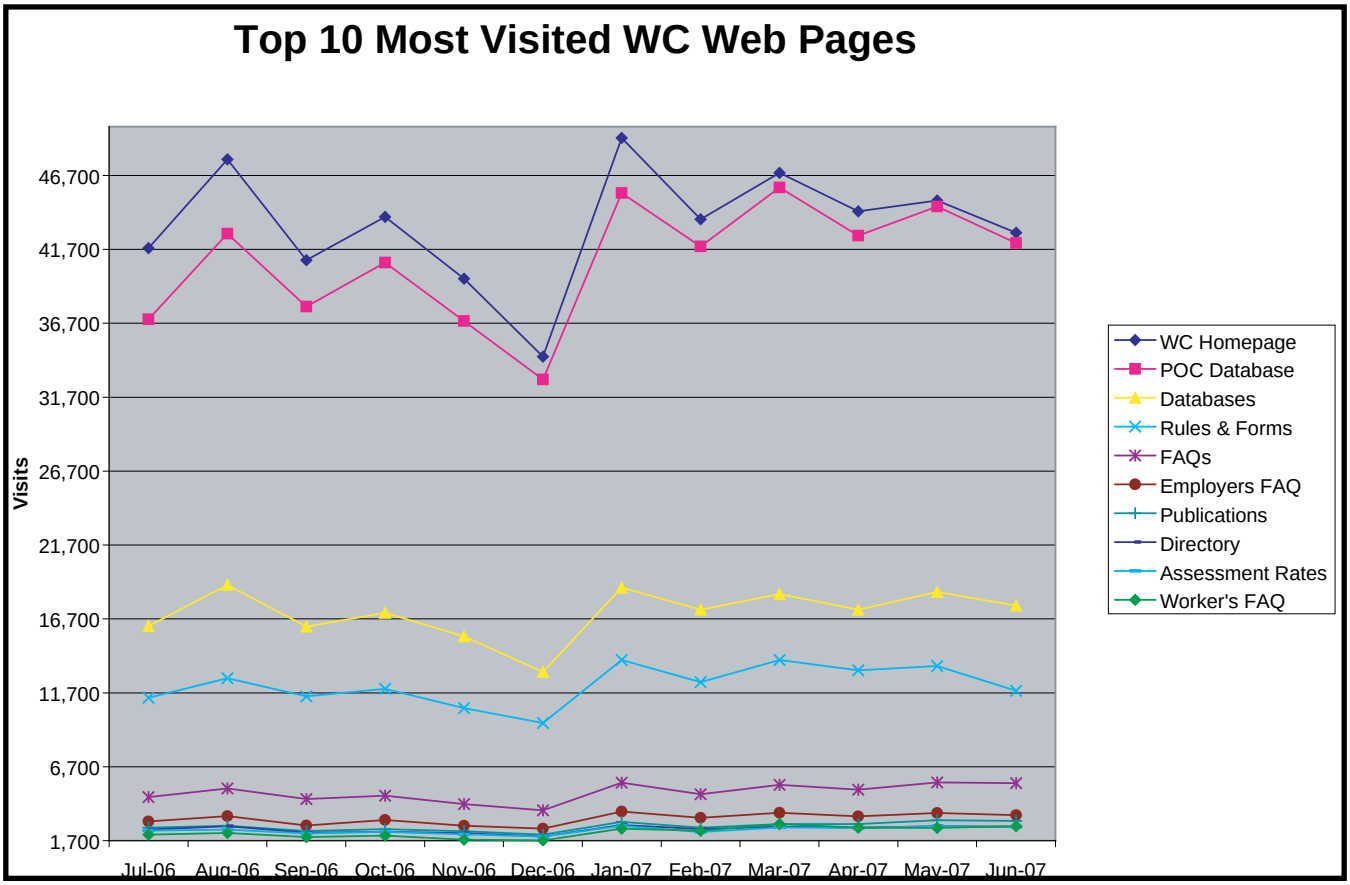
The Construction Policy Tracking Database provides information to contractors and other interested parties regarding changes to workers' compensation coverage. These changes may include changes to the status of subcontractors' coverage or changes to any policy specified by a registered user. The system is designed to send automatic electronic notification to the requestor concerning any changes to the status of the specified policy. This database is also a useful tool for local permitting and licensing officials and insurers. The database can be accessed through the Division's website at www.myfloridacfo.com/WC. As of June 30, 2007, a total of 5,682 Construction Policy Tracking Database registrants were tracking 26,594 workers' compensation policies.

"We insure thousands of construction businesses in the state of Florida, and we tell all of them to use the Construction Policy Tracking Database. This database is an invaluable tool in helping our insureds track their subcontractor's workers' compensation insurance policies. We also recommend using the Proof of Coverage database to all our insureds – having the access to coverage and exemption information, free of charge and in such a convenient format, is very important to our state's small businesses."

Karen Phillips, Florida United Businesses Association

Division of Workers' Compensation Website

The Division of Workers' Compensation website home page is located at: http://myfloridacfo.com/WC/index.htm and is designed to provide direct information access for all of the stakeholders in the Workers' Compensation System. During FY 2006-2007, the Division's home page was visited 499,520 times. The single page visited most often is the Compliance Proof of Coverage database. Graphic 15 below illustrates the 10 most frequently visited pages on the Division's website.



The following is a list and description of pages within the Division's website, grouped by stakeholder. In addition a description of databases, statutory and rule information and publications, along with the website addresses are provided.

Directory: This directory lists phone numbers and websites for each area of the Division and also provides phone numbers for other agencies peripherally related to workers' compensation.

Injured Workers:

1. **EAO Answer**. This allows injured workers to contact the Bureau of Employee Assistance with questions, requests for assistance or complaints. It is located in the "Contact Us" link on the left side of the Division's home page or through the radio button on the right side at the "Broken Arm Poster."

2. **An Online Tutorial entitled** You Have Been Injured on the Job – What You Need to Know. This presentation may be accessed from the Division's home page under "News."

3. **Injured Workers FAQs:** Click on "Frequent Questions" on the left side of the Division's home page and then click on "Injured Worker FAQ."

4. **Benefit Delivery Process**. This provides a flow chart of how benefit delivery is determined. Click on "Benefit Delivery Process" on the Division home page.

5. **Informational Brochure for Employees (English).**

6. **Informational Brochure for Employees (Spanish).**

Employers/Contractors:

1. **Employer FAQs**: Click on Frequent Questions" on the left side of the Division's home page and then "Employers FAQ."

2. **Proof of Coverage Database.**

3. **Construction Policy Tracking Database:** Click on "Databases" on the left side of the Division's home page.

4. **Informational Brochure for Employers (English).**

5. **Informational Brochure for Employers (Spanish).**

Insurers/Claims Handling Entities:

1. **Claims Database.**

2. **Division EDI Claims Data Warehouse.**

3. **Special Disability Trust Fund Rules for Reimbursement.**

4. **Special Disability Trust Fund Reimbursement Request Form.**

Health Care Providers:

1. **Medical, Medical Provider, Managed Care Arrangement FAQs:** Click on "Frequent Questions" on the left side of the Division's home page and then "Medical, Medical Provider, Managed Care Arrangement FAQ."

2. **Health Care Provider Reimbursement Manual Menu:** This page permits access to the complete Florida Workers' Compensation Health Care Provider Reimbursement Manual as well as text files of the Schedule of Maximum Reimbursement Allowances.

3. **Florida Workers' Compensation Reimbursement Manual For Hospitals.**

4. **Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers.**

5. **Reimbursement Dispute Resolution Forms.**

6. **Health Care Provider Directory.**

Workers' Compensation Databases:

The following includes a list and description of the various databases that are maintained to provide interested parties with direct access to information that is routinely utilized by various stakeholders.

1. **Insurer/Claim Administrator Database:** This database contains current address and contact information for claims administrators, self-insurers, and third party administrators approved to handle workers' compensation claims of injured workers in the State of Florida.

2. **Insurers licensed to do business in the State of Florida:** This link to the Office of Insurance Regulation company search service can provide full names, business addresses, and identifying information for companies/entities doing business in the State of Florida.

3. **Proof of Coverage Database**: The Compliance Proof of Coverage Database provides information regarding workers' compensation coverage and exemptions from workers' compensation.

4. **Download of Proof of Coverage Database**: This download combines the 11 tables that make up the Compliance Database that may be downloaded as one zip file, or individually.

5. **Construction Policy Tracking Database:** The Construction Policy Tracking Database provides information to contractors and other interested parties regarding changes to workers' compensation coverage. These changes may include changes to the status of subcontractors' coverage or changes to any policy specified by a registered user. The system is designed to send automatic electronic notification to the requestor concerning any changes to the status of the specified policy.

6. **Non-Compliance Referral Form (Whistle-Blower):** This form is completed to report an employer you suspect has failed to secure workers' compensation insurance coverage for all of its employees. This page also provides other options for reporting non-compliant employers.

7. **Provider Databases:** Daily updates of these databases offer the most current listing of AHCA's medical provider lists (Health Care Provider's and Expert Medical Advisor's), and the Department of Education, Bureau of Rehabilitation and Reemployment Service's approved companies, facilities or providers lists to treat or provide vocational rehabilitation services to injured workers.

8. **Claims Database:** The claims database contains workers' compensation accident data on an individual claim basis. The information relating to personal financial or health information has been redacted from the database in compliance with ss. 440.125 and 626.9651, F.S., and Rule 4-128, F.A.C.

9. **Statistical Reports Based on Claims Data:** Statistical reports can be generated from the end-of-month claims file. Records may be selected by county, year of injury, nature of injury, or other claim characteristics. Output consists of aggregated data by year of injury for: the number of injuries, total benefits (including indemnity, medical, and settlement payments), and average benefits for each category.

10. **WC Policy Search Page:** Allows a user to obtain a customized downloadable list of employers in the State of Florida whose workers' compensation insurance policies are either due to expire within the month and year selected or become effective within the month and year selected.

11. **Employer Loss Run Report:** Allows a user to obtain a list of lost-time injuries reported to the Division of Workers' Compensation for an employer since 1990.

12. **8th Day of Disability for EDI Submitters Database:** This database is one of the options authorized by rule for EDI claim administrators to report the employee's 8th day of disability and the claim administrator's knowledge of the 8th day of disability at the same time the electronic form equivalent of Form DWC-1 is required to be sent to the Division as specified in Rule 69L-24.0231 F.A.C.

13. **Compliance Stop-Work Order Database:** The Compliance Stop-Work Order Database lists employers that have been issued a Stop-Work Order based upon a determination that an employer has failed to secure the payment of compensation.

14. **Division Claims EDI Data Warehouse:** The Division Claims EDI Data Warehouse contains workers' compensation records for which an EDI First Report of Injury (FROI), Subsequent Report of Injury (SROI), or Electronic Supplement to the First Report of Injury (8th Day of Disability information) was electronically reported to the Division on or after October 1, 2000. Claims EDI Trading Partners have access to their EDI DWC-1, EDI DWC-13, and Electronic Supplement to the First Report filings and may view specific transactions/data elements in the manner and format received by the Division to aid in the reconciliation of filing errors. Also, Claims EDI Trading Partners have access to their monthly Claims EDI Report Cards and Rejected Records Not Resubmitted Successfully Reports, as well as proprietary Acknowledgement Reports produced in response to transmissions received/processed by the Division.

Statutes, Rules and Informational Memoranda/Bulletins:

The following list includes the website addresses to directly access Florida Statutes, the Florida Administrative Code, Division Forms and Division Memoranda/Bulletins.

1. **Florida Administrative Code Rules and Division Forms.**

2. **Workers' Compensation Law, Chapter 440, Florida Statutes.**

3. **Informational Memoranda/Bulletins.**

Publications and Manuals:

This page provides direct access to many reports issued over the last seven years on subjects pertinent to the business of the Division of Workers' Compensation. Examples of the type of reports posted include:

- Three Member Panel Reports;
- Joint Reports of the Bureau of Workers' Compensation Fraud and the Division of Workers' Compensation, Bureau of Compliance;
- Division Annual Reports;
- Medical Reimbursement Manuals; and
- Employer's Guide to a Drug-Free Workplace.

Bureau of Compliance

The Bureau of Compliance serves to ensure that employers comply with their statutory obligation, under Chapter 440, F.S., to obtain appropriate workers' compensation insurance coverage for employees. Attainment of this objective levels the economic playing field for all employers, adds premium dollars to the system that were previously evaded due to non-compliance, provides coverage for employees that were previously without coverage due to non-compliance, and ensures that covered employees with work-related injuries receive their statutory benefits.

The Bureau accomplishes its mission through:

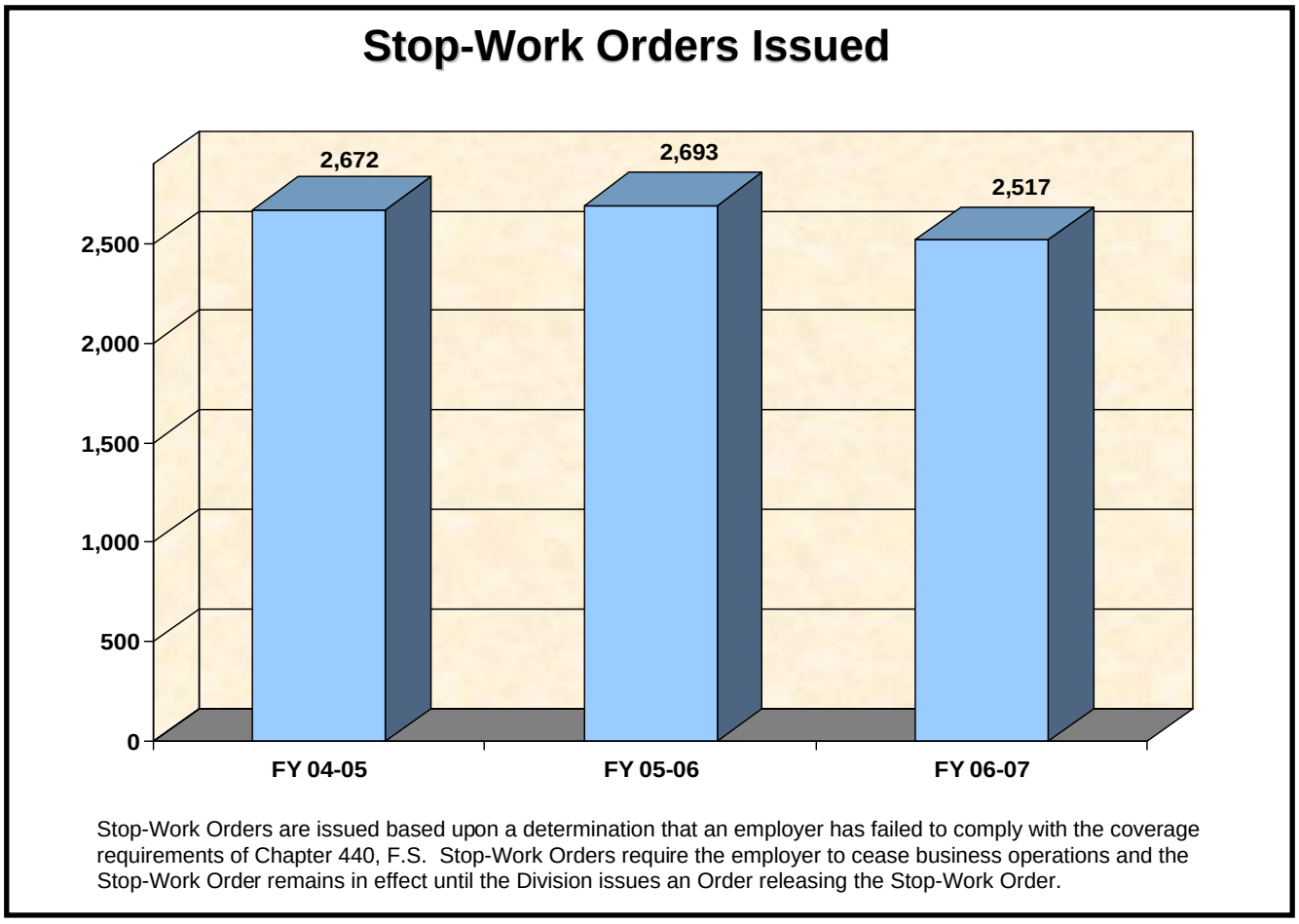
- Enforcement investigations
- Management of the exemption process
- Education of employers

The Bureau conducts onsite investigations of worksites to determine employer compliance and issues stop-work orders and assesses penalties against employers found not to be in compliance. The Bureau reviews applications from individuals seeking to utilize the exemption provisions of the Workers' Compensation Law and issues exemptions to those determined eligible. The Bureau participates in employer conferences and workshops to educate employers about workers' compensation coverage requirements.

Accomplishments:

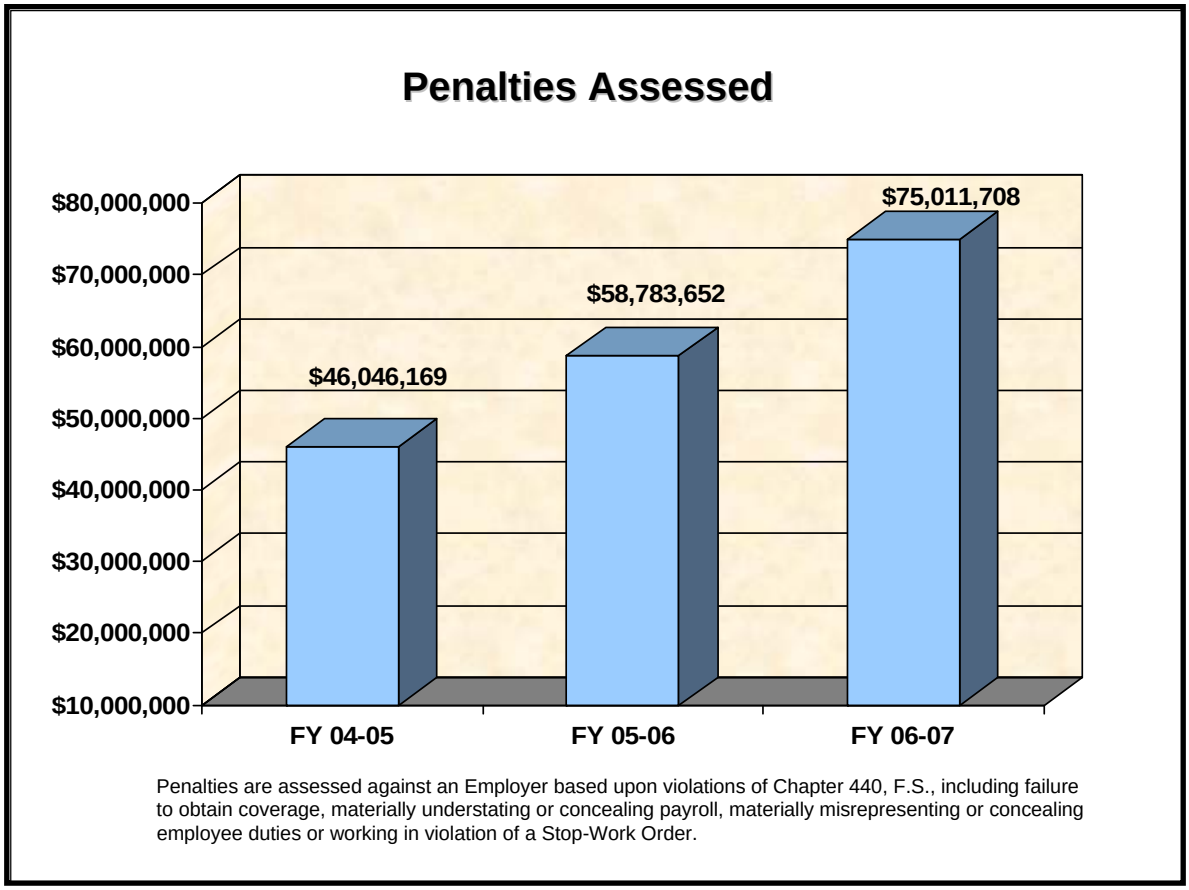
Through its enforcement and investigative efforts, in FY 2006-2007 the Bureau:

- Issued 2,517 Stop-Work Orders as illustrated by Graphic 16 below

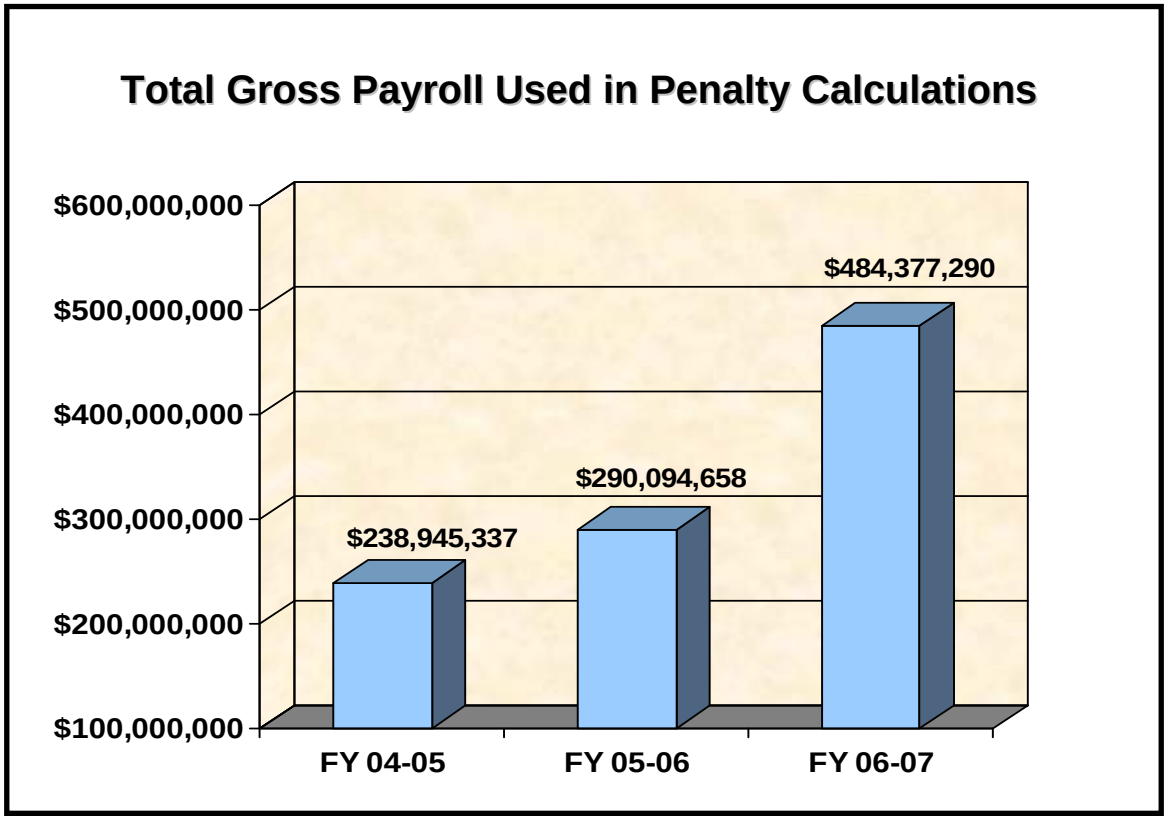


Stop-Work Orders are issued based upon a determination that an employer has failed to comply with the coverage requirements of Chapter 440, F.S. Stop-Work Orders require the employer to cease business operations and the Stop-Work Order remains in effect until the Division issues an Order releasing the Stop-Work Order.

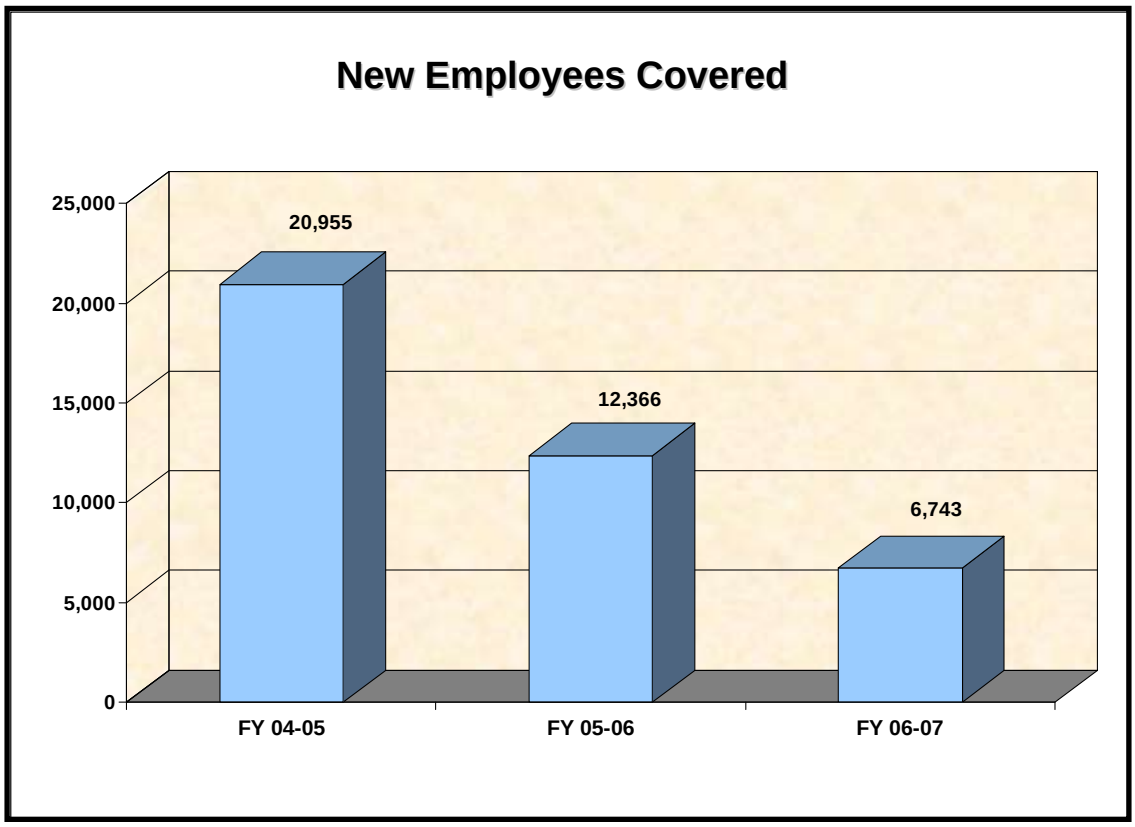
- Assessed $75,011,708 in penalties as illustrated by Graphic 17 on the following page.



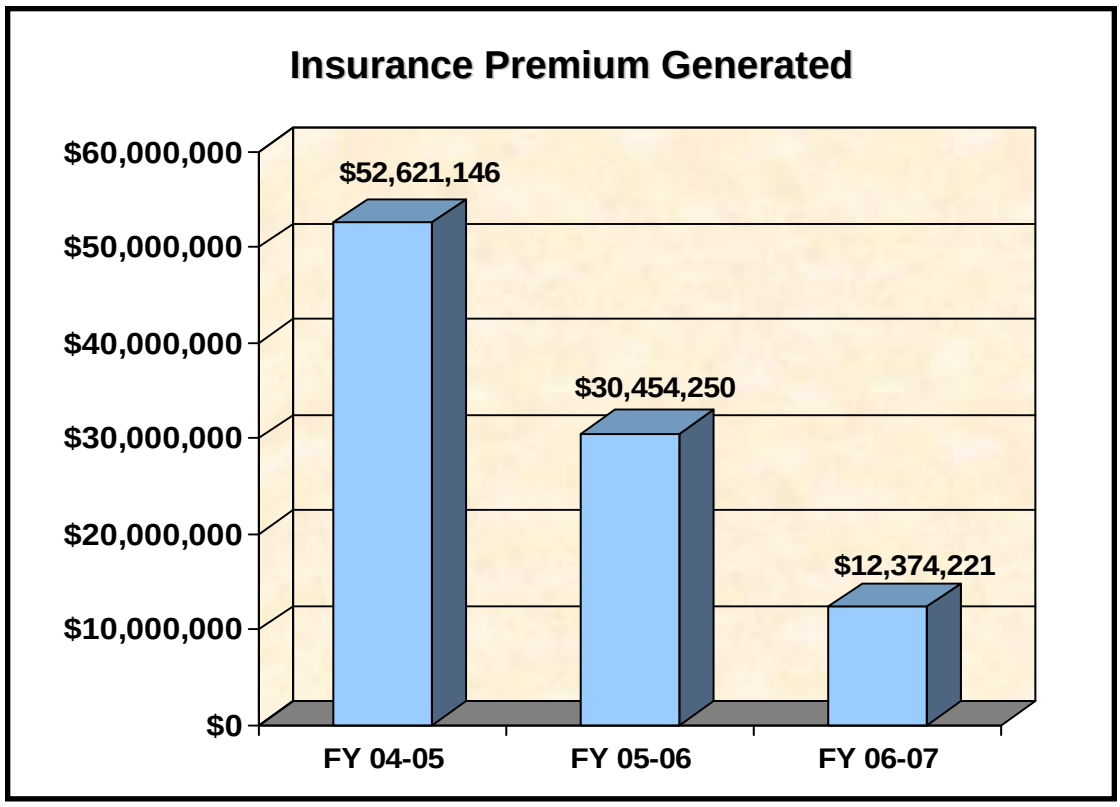
- Identified $484,377,290 in Total Gross Payroll (used in penalty calculations), as illustrated in Graphic 20 below. Gross Payroll represents the actual payroll that the employer paid during all periods of non-compliance throughout the previous three years. The gross payroll is used to assess penalty calculations pursuant to 440.107(d)(1) F.S. The increase in payroll parallels the increase in assessed penalties.



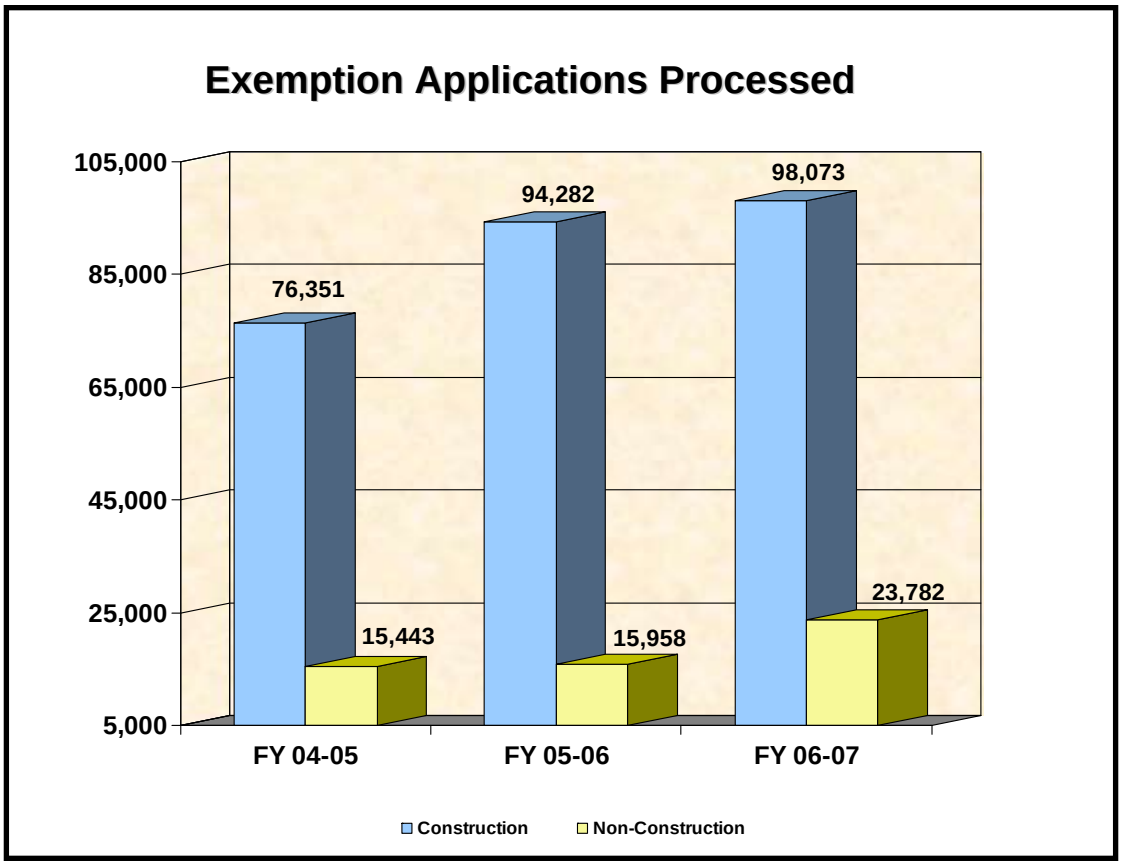
- Caused 6,743 new employees to be covered under the Workers' Compensation Law. While Graphic 18 below reflects a decrease in the number of new employees covered as a result of Bureau efforts during each fiscal year, it is important to note that the Bureau's more sophisticated investigative techniques have generated significant results. Specifically, the Bureau identified and sanctioned more employers for understating and concealing payroll in order to avoid paying the proper workers' compensation premium and for misrepresenting or concealing employee duties to avoid proper classification for premium calculations. While, all of the employers involved in these cases had secured coverage under a workers' compensation policy that was in effect at the time of the investigation, in most circumstances, there were very few, if any, new employees added to the policy. During 2006-2007, the number of individuals who filed for an exemption from workers' compensation coverage increased. Those individuals that obtain an exemption from workers' compensation coverage are not entitled to benefits under Chapter 440, F.S., thus they are not considered to be new covered employees.



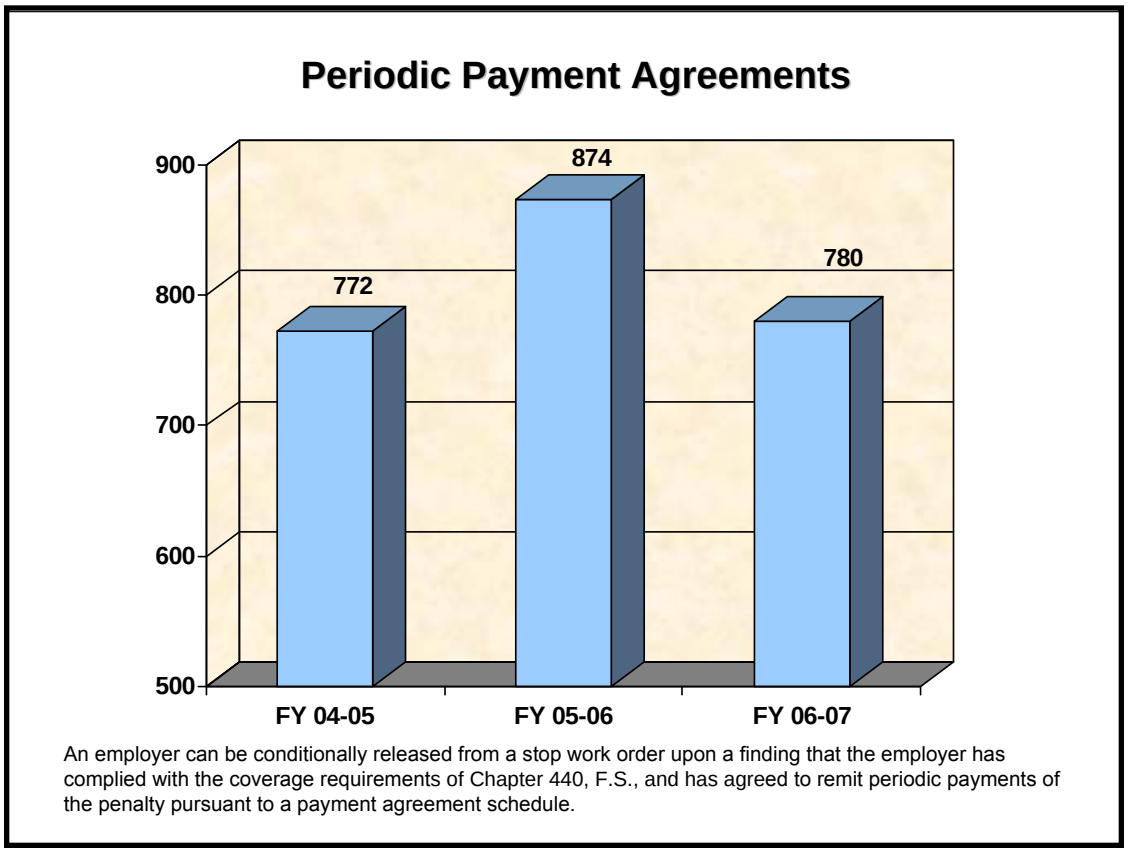
- Caused $12,374,221 to be added to the premium base that had been previously evaded. During the last four years, the workers' compensation rates have decreased by more than 40%. This reduction in workers' compensation rates results in a reduction in workers' compensation insurance premiums. Also, as noted above, the number of individuals who filed for an exemption from workers' compensation coverage increased. Since individuals that obtain exemptions from workers' compensation coverage are not covered under a workers' compensation policy, no premium is collected for employers who are exempt from coverage. The combination of these factors relate to the decrease in the amount of premium generated during FY 2006-2007 as denoted in Graphic 19 on the following page.



- Processed 98,073 construction industry exemption applications and 23,782 non-construction industry exemption applications as illustrated by Graphic 21 below;

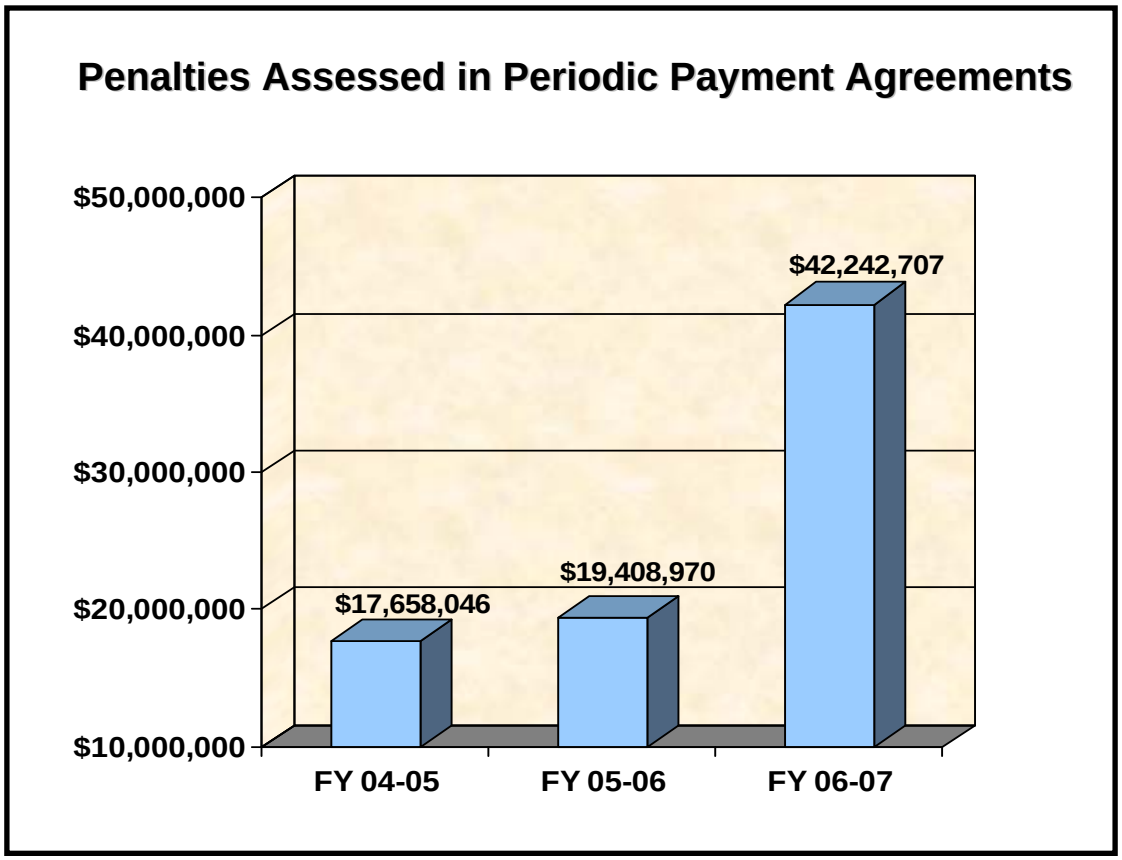


Effective July 1, 2004, s. 440.107(7)(a), F.S., was amended to authorize the Division of Workers' Compensation to conditionally release an employer from a Stop-Work Order upon a finding that the employer has complied with the coverage requirements of Chapter 440, F.S., and has agreed to remit periodic payments of the penalty pursuant to a payment agreement schedule. An employer is required to make an initial down payment that equals at least 10% of the total assessed penalty or $1000, whichever is greater. Pursuant to Rule 69L-6.025, F.A.C., an employer has to make 12, 24, 36, 48, or 60 equal monthly payments to pay the remaining penalty. During FY 2006-2007, seven hundred eighty employers entered into periodic payment plans with assessed penalties totaling $42,242,707. The number of periodic payment agreements entered into by an employer that has been conditionally released from a Stop-Work Order is illustrated in Graphic 22 below.



An employer can be conditionally released from a stop work order upon a finding that the employer has complied with the coverage requirements of Chapter 440, F.S., and has agreed to remit periodic payments of the penalty pursuant to a payment agreement schedule.

- Graphic 23 on the following page illustrates the total amount of penalties assessed against employers who entered into periodic payment agreements;



- During FY 2006-2007, the Division of Workers' Compensation referred 539 employers to the collection agency for non-payment of assessed penalties associated with Stop-Work Orders. The corresponding debt for those accounts totaled $21,211,663.

The Bureau of Compliance adopted and/or amended the following rules in order to clarify and interpret some of the various enforcement and compliance provisions in Chapter 440, F.S.:

69L-6.009: Forms and Instructions – The Notice of Election to be Exempt (DWC-250) Form, and its instructions were updated to provide applicants an area on the form to provide the Division with an email address and update current addresses for field offices.

69L-6.012: Notice of Election To Be Exempt – Provisions of the previously existing rule were deleted that are no longer applicable to the exemption process and guidelines were revised that relate to the submission of a Notice of Election To Be Exempt, and the issuance, denial, and revocation of a Certificate of Election To Be Exempt.

69L-6.021: Construction Industry Classification Codes, Descriptions, and Operations Scope of Exemption Discontinued class codes were deleted and new class codes were added.

69L-6.025: Conditional Release of Stop-Work Order and Periodic Payment Agreement – Procedures were clarified relating to the conditional release of stop-work orders and the reinstatement of stop-work orders when employers have defaulted on penalty payment obligations.

69L-6.028: Procedures for Imputing Payroll and Penalty Calculations – Procedures were clarified relating to the calculation of employer penalties when the employer has failed to provide business records sufficient to enable the Division to determine payroll for the period requested.

69L-6.031: Stop-Work Orders in Effect Against Successor Corporations or Business Entities – The Rule clarifies the Division's statutory authority to transfer Stop-Work Orders or Orders of Penalty Assessment issued against a corporation, partnership, or sole proprietorship to a successor corporation or business entity and outlines procedures relating to the issuance and withdrawal of such orders.

Training

Since the Bureau recognizes that investigator training is an integral component in identifying and sanctioning employers that are not in compliance, the Bureau held numerous workers' compensation training sessions during FY 2006-2007. The primary focus of the training sessions was to provide each investigator with greater technical skills to enhance their enforcement skills by reviewing and updating investigative procedures, comparing and analyzing data and identifying areas of improvement within the enforcement process. The training sessions are summarized below:

Comprehensive Investigator Training Program – Investigators and District Supervisors attended a three-day training course that provided a comprehensive review of the investigative and enforcement process. The training focused on penalty calculations, reviewing business and payroll records; recognizing and determining cases involving understating and concealing payroll; and several other specific areas within the investigative process.

CLEAR Training – The Council on Licensure, Enforcement and Regulation (CLEAR) provides a 24-hour Certified Investigator Training Course for regulatory investigators. During the three-day session, investigators were trained on professional conduct, interagency relations, administrative law, the investigative process, principles of evidence, interviewing techniques, report writing, and the administrative and criminal process. All investigators received national certification in completing the Basic and Specialized training curriculum.

Case Summaries

The following case summaries taken from actual FY 2006-2007 cases are examples of the types of investigations conducted by the Bureau of Compliance in their enforcement efforts.

Case One: Based on a public complaint, the Bureau commenced an investigation against a Ft. Myers employer, that recruits and places personnel for various forms of employment. The investigation revealed that the employer had no current Florida endorsed workers' compensation policy. It was determined that this employer hired hundreds of employees in the State of Florida in approximately twenty-eight different class codes. A Stop-Work Order, along with a Request for Business Records was issued and served to the employer. The penalty for non-compliance was assessed in the amount of $328,808.

The employer came into compliance by securing Florida workers' compensation coverage through a Professional Employer Organization (PEO) for 540 employees which generated $230,094 in premium and by entering into a Periodic Payment Agreement. Since the employer was not licensed through the Department of Business and Professional Regulation (DBPR) and was operating as an unlicensed employee leasing company in the State of Florida, a referral was submitted to DBPR.

Case Two: A roofing employer in Pasco County that was paying his workers through an employee leasing company at minimum wage came under investigation. The investigation revealed that the employer was also "reimbursing" each employee for "use of their own tools" in amounts equal to $8.00 to $10.00 per hour. It was determined that the "reimbursements" were actually additional wages, resulting in the employer misrepresenting his complete payroll. A Stop-Work Order was issued and penalty assessed in excess of $137,000. The employer came into compliance by adding the previously unprotected worker found on the job site to the leasing agreement. Additionally, salary adjustments were completed on six employees who had been receiving reimbursements directly through the business which were determined to be salary. The estimated premium added to the Workers' Compensation System from this case is $60,000.

Case Three: An investigator received a tip about coverage issues regarding a carpentry business in South Florida. The business entered into a leasing agreement with an employee leasing company, and then the next day attempted to use workers not listed with the new leasing company. A review of three years of records revealed the business had earlier periods of leasing coverage as well as periods of employment with no workers' compensation coverage. The investigation also confirmed that there were employees working on the jobsite that were not listed on the leasing agreement. A Stop-Work Order was issued and the employer was assessed a penalty of $72,157. This penalty included a fine of $1,000 a day for each day the company worked in violation of the Stop-Work Order. The business came into compliance by adding the additional employees to the leasing agreement and entering into a periodic payment agreement.

Case Four: While conducting routine investigations in the Jacksonville area, an investigator visited a commercial construction jobsite. The investigator observed approximately 22 workers doing framing work. The framing subcontractor was identified and the investigator determined that all 22 of the workers were undocumented employees for workers' compensation coverage. The subcontractor had a worker's compensation policy that included a reported payroll of only $4000 and did not cover the undocumented workers who were all paid in cash. A Stop-Work Order and Request for Business Records were served on the employer. Further investigation revealed that the 22 workers reported to two crew leaders working for this subcontractor. The crew leaders had no insurance and the subcontractor was withholding 36% of their earnings to cover their workers' compensation exposure. The investigator contacted the subcontractor's workers' compensation insurer who confirmed that their insured was not permitted to enter into contracts with individuals or subcontractors to provide workers' compensation coverage. The insurer also advised that this was an unacceptable risk.

The investigator issued a Stop-Work Order to the employer for "Materially Understating or Concealing Payroll." Based upon business records received from the employer, it was determined that the company had been working in Florida for the past three years and had received over $2,500,000 for work performed in Florida. Insurance audits determined that the company was reporting that the work actually performed in Florida was performed in North Carolina, therefore showing little to no payroll in Florida. The penalty assessed to the employer was $100,588. As a result of this investigation, the employer came into compliance (with $36,000 in additional premium generated for the Workers' Compensation System) and entered into a Periodic Payment Agreement.

Bureau of Monitoring and Audit

The Bureau of Monitoring and Audit is responsible for ensuring the timely and accurate payment of benefits to injured workers, timely filing and payment of medical bills, timely and accurate filing of required forms, accurate payroll reporting for self-insured employers, and ensuring that the resources of self-insured employers are sufficient to pay employees' claims.

The Bureau achieves its mission through four sections:

The Audit Section examines insurer claims handling practices pursuant to ss. 440.20, 440.185, 440.525, F.S., and administrative rules enacted by the Division. The examinations and investigations conducted by the Audit Section address patterns and practices of unreasonable delay in claims handling, timely and accurate payment of benefits to injured workers, timely and accurate filing of required reports, and inspection and enforcement of compliance with compensation orders of Judges of Compensation Claims.

The Penalty Section evaluates and assesses insurer performance with respect to the timely payment of initial indemnity benefits and medical bills and the timely filing of First Report of Injury (DWC-1) forms and medical bills. Performance is monitored via the Centralized Performance System (CPS), an interactive web-based system that allows insurers to access their performance information and respond to the Division in real-time. There are separate CPS Medical and CPS Indemnity Modules.

The Permanent Total Section ensures the accuracy and timeliness of the payment of Permanent Total Disability benefits and Permanent Total Disability Supplemental benefits. The Section is responsible for monitoring Permanent Total Disability claims to ensure payments are suspended, reduced or stopped based on statutory amendments or case law while making independent determinations concerning the correct amount of Social Security offset. In addition to reviewing/auditing forms filed with the Division, the section participates in hearings, depositions, and mediations to assist in resolving disputes, and performs audits of carriers and self-insured employers.

Furthermore, this section oversees Division payment of Permanent Total Disability Supplemental benefits on all Permanent Total Disability claims with dates of accident prior to July 1, 1984. The Division monitors supplemental benefits cases to ensure payments are suspended, reduced or stopped based on statutory amendments or case law and makes independent determinations concerning the correct amount of Social Security offset, Permanent Total Supplemental benefits, and Permanent Total benefits. In addition, the Division is responsible for approving payment of over $20 million annually on approximately 2,014 Division paid cases.

The Self-Insurance Section monitors the self-insurance programs of governmental and public entities, calculates experience modification factors, and authorizes service companies.

Accomplishments for FY 2006-2007

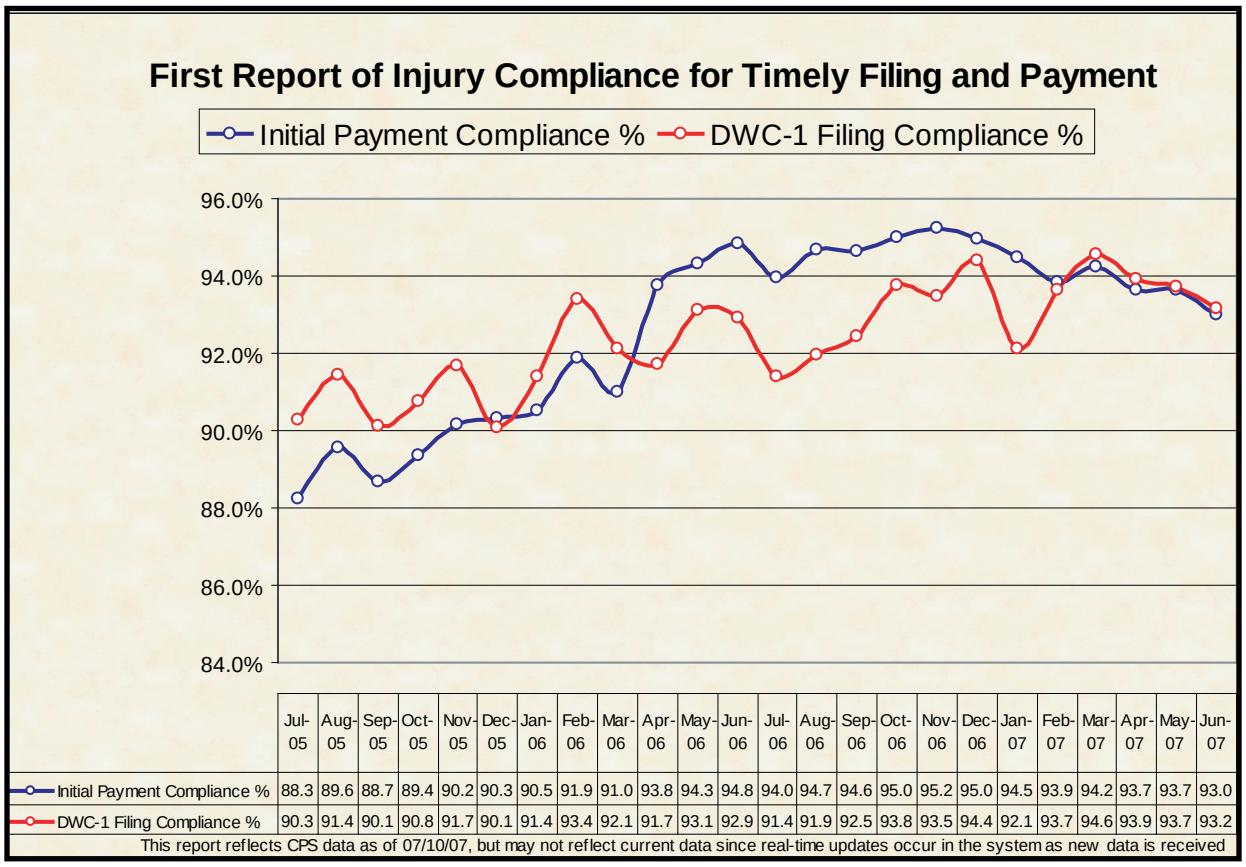
In Fiscal Year 2006-2007, the bureau accomplished the following:

- Through the efforts of the Bureau, a total of $1,860,913 in additional benefits were paid to injured workers.

- The Audit Section:
  - Audited 6,738 claim files and completed 31 insurer audits.
  - Reviewed 25,565 indemnity payments for accuracy and timeliness and identified 440 claim files with underpayments totaling $392,003. The identification of these underpayments resulted in the following:
    - $161,153 in indemnity benefits paid to the injured workers; and
    - An additional $230,850 in penalties and interest was also assessed on behalf of injured workers due to untimely payment and/or the failure of carriers to pay indemnity benefits.
  - The Audit Section confirmed that 94.77% of the informational brochures and Employee Notification Letters were mailed to injured workers pursuant to s. 440.185, F.S.
  - The Audit Section verified the accuracy and timeliness of 11,975 claim forms that are required by Statute and Rule 69L-3, F.A.C., to be reported to the Division.

- Reviewed 7,670 medical bills for filing and accuracy of data submitted to the Division.
- Twenty-four non-willful carrier practice penalties were assessed as follows:
  - 17 for the failure to report accurate medical data;
  - 3 for the failure to mail the Employee Notification Letter;
  - 2 for the failure to report accurate data on the First Report of Injury (DWC-1) forms;
  - 1 for the failure to pay indemnity benefits in a timely manner for the third consecutive audit; and
  - 1 for the failure to file Claim Cost Report (DWC-13) forms with the Division.
- The Penalty Section evaluated 4,350,563 medical bills, received from approximately 900 insurers, for timely payment and timely filing. Insurer performance for medical bill timely payment was 98.92% for Health Insurance Claim (DWC-9) forms, 98.81% for Statements of Charges for Drugs and Medical Supplies (DWC-10) forms, 97.70% for Dental Claim (DWC-11) forms, and 98.12% for hospital billing (DWC-90) forms.

- The Penalty Section evaluated 84,640 First Report of Injury (DWC-1) forms through the Centralized Performance System (CPS) for timely filing and timely payment by employers and insurers. The timely payment performance was 94.35% for FY 2006-2007. The timely filing performance was 93.12% for FY 2006-2007. Graphic 24 below illustrates the monthly performance by insurers for timely filing and timely payment.



	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07
Initial Payment Compliance %	88.3	89.6	88.7	89.4	90.2	90.3	90.5	91.9	91.0	93.8	94.3	94.8	94.0	94.7	94.6	95.0	95.2	95.0	94.5	93.9	94.2	93.7	93.7	93.0
DWC-1 Filing Compliance %	90.3	91.4	90.1	90.8	91.7	90.1	91.4	93.4	92.1	91.7	93.1	92.9	91.4	91.9	92.5	93.8	93.5	94.4	92.1	93.7	94.6	93.9	93.7	93.2

This report reflects CPS data as of 07/10/07, but may not reflect current data since real-time updates occur in the system as new data is received

- Penalties and interest assessed by the Penalty Section and owed to injured workers due to the late payment of indemnity benefits were $551,541 in FY 2005-2006 and $170,938 during FY 2006-2007.

- The Penalty Section developed a medical bill filings tracking report to aid the Division in monitoring Health Insurance Claim (DWC-9) forms, Statements of Charges for Drugs and Medical Supplies (DWC-10) form, Dental Claim (DWC-11) forms and hospital billing (DWC-90) forms for fluctuations in medical bill submissions.

- The Indemnity CPS team was recognized for its superior contributions by receiving a 2007 Davis Productivity Award for the implementation of the Indemnity Module.

- Experience modification factors were promulgated for 419 self-insured employers.

- Eight applications for self-insurance were processed, five service company applications were authorized and 56 service companies were re-certified.

- 67,876 payroll records were reviewed during 20 payroll audits of self-insured employers, resulting in $8,816,924 in underreported payroll dollars, which identified $1,338,228 in underreported premium dollars for assessment purposes.

- The Permanent Total Section audited more than 20,000 documents. The audits involved reviewing forms submitted to the Division, pay ledgers, and other documentation to verify the accuracy and timeliness of payments. The audits identified $850,796 in underpayment of Permanent Total Disability benefits to injured workers and resulted in $447,716 in penalties and interest being assessed. These audits resulted in an additional $1.3 million being paid to injured workers.

Bureau of Data Quality and Collection (DQC)

The Bureau of Data Quality and Collection (DQC) is responsible for collecting workers' compensation claims, medical, and proof of coverage data; ensuring data quality; organizing data to provide real-time feedback to data submitters; and accurate and readily accessible information to all workers' compensation stakeholders. As the central collection point for this information, DQC is the information hub that facilitates the distribution of data to other parts of the Division for their usage.

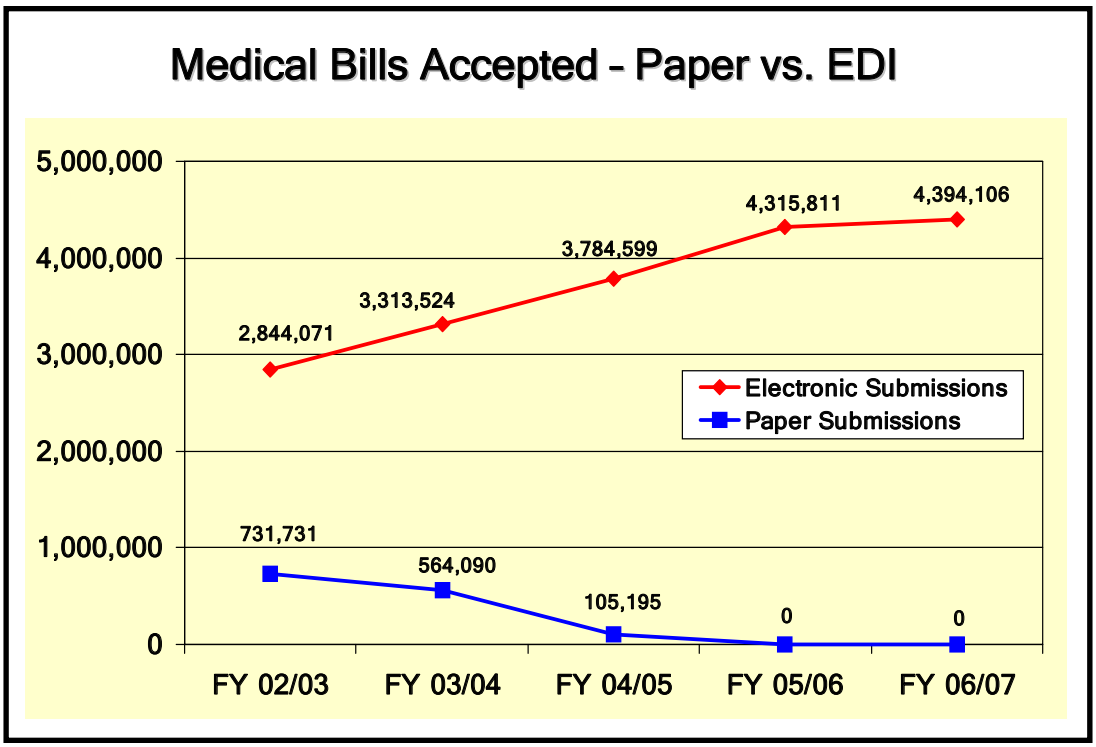
DQC accomplishes its mission by:

- Collecting, organizing, analyzing, and ensuring the quality of information submitted to the Division concerning injured workers' claims, medical services billings and employers' proof of coverage.
- Guiding and overseeing the transition process as workers' compensation stakeholders complete the conversion from paper to electronic submission of required reports.
- Establishing and implementing administrative rules, requirements, and processes for electronic reporting of the First Report of Injury (DWC-1) forms, Subsequent Report of Injury and Proof of Coverage forms, using national Electronic Data Interchange (EDI) standardized file formats.
- Establishing and implementing administrative rules, requirements, and processes for electronic reporting of medical services using Florida's model EDI standardized file formats.
- Serving as records repository for workers' compensation records which are archived using electronic imaging technology.
- Processing and complying with public records and subpoena requests.
- Facilitating electronic workflow distribution throughout the Division.
- Providing performance feedback to submitters on medical EDI submissions to allow submitters to review current performance on a monthly basis and a comparison with all other submitters.

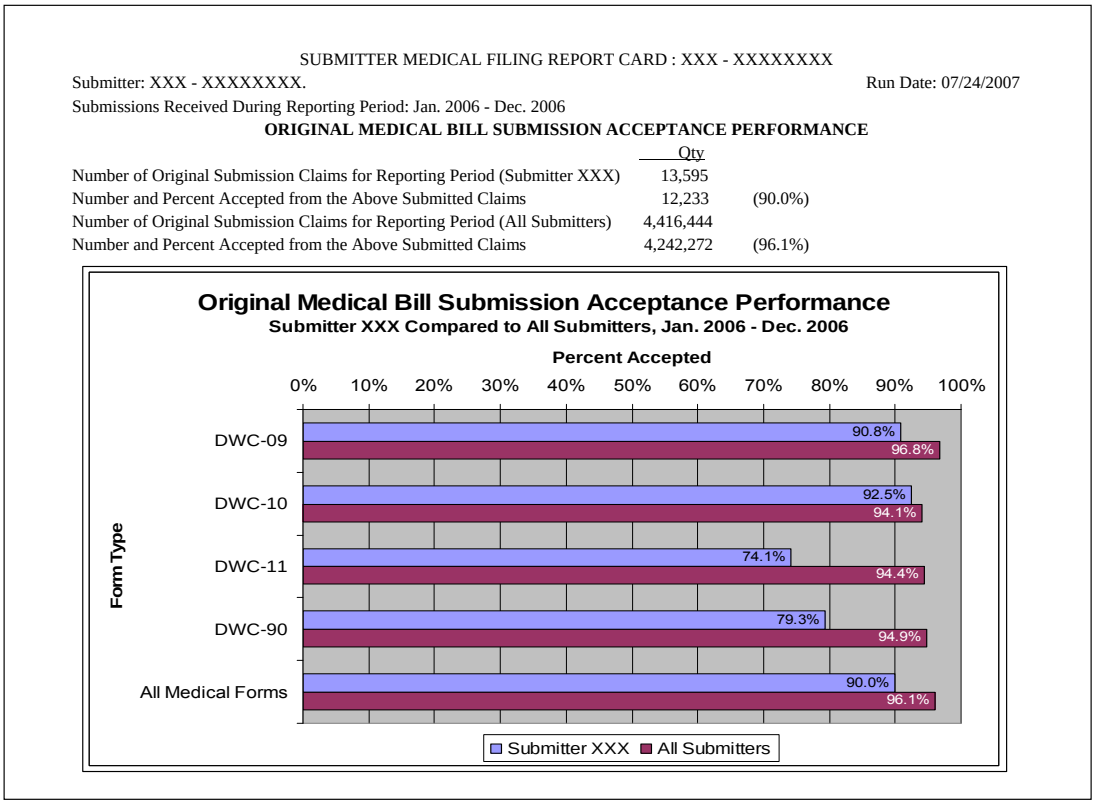
FY 2006-2007 Accomplishments:

- Received, accepted, and processed over 4.4 million medical bills from physicians, dentists, hospitals, and pharmacies. One hundred percent of required medical reports are filed electronically.

Graphic 25 on the following page illustrates the changes over time in the volume of medical bills submitted in electronic and paper formats.



Each medical bill submitter receives a monthly 9-page electronic Report Card which provides the submitter with feedback on the number and percentage of medical bills submitted that have been accepted as correct by the Division the first time the bills were submitted. The report provides this feedback for each medical form type as well as overall performance. The Report Card also provides feedback about the submitter's performance compared to the composite performance of all submitters. Graphic 26 below provides a composite view of submitter acceptance performance for FY 2006-2007 along with the acceptance performance of a hypothetical submitter.



SUBMITTER MEDICAL FILING REPORT CARD : XXX - XXXXXXXX

Submitter: XXX - XXXXXXXX. Run Date: 07/24/2007

Submissions Received During Reporting Period: Jan. 2006 - Dec. 2006

ORIGINAL MEDICAL BILL SUBMISSION ACCEPTANCE PERFORMANCE

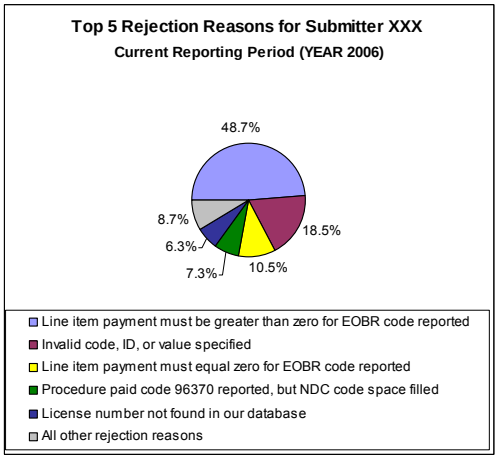
	Qty	
Number of Original Submission Claims for Reporting Period (Submitter XXX)	13,595	
Number and Percent Accepted from the Above Submitted Claims	12,233	(90.0%)
Number of Original Submission Claims for Reporting Period (All Submitters)	4,416,444	
Number and Percent Accepted from the Above Submitted Claims	4,242,272	(96.1%)

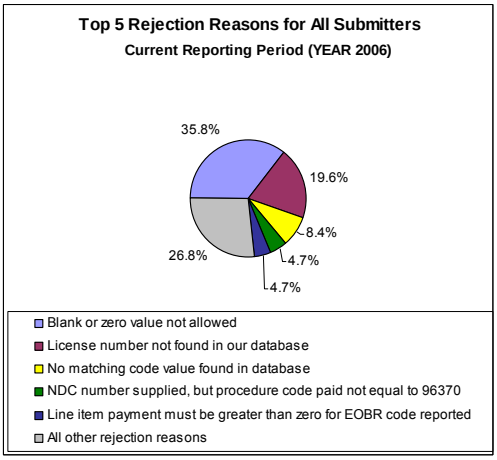
The Report Card also provides each submitter with the top 5 reasons for which items are rejected by the Division so the submitter can use that information for internal quality control and education of staff. Composite rejection information for all submitters is also included. Graphic 27 below, depicts a composite view of rejections for FY 2006-2007 for all submitters along with rejection information for a hypothetical submitter.

SUBMITTER MEDICAL FILING REPORT CARD : XXX - XXXXXXXX

TOP 5 REJECTION REASONS FOR CALENDAR YEAR 2006 (ALL FORM TYPES)

For Submitter XXX, Jan. 2006 - Dec. 2006	Qty	Percent
Line item payment must be greater than zero for EOBR code reported	931	48.7%
Invalid code, ID, or value specified	353	18.5%
Line item payment must equal zero for EOBR code reported	200	10.5%
Procedure paid code 96370 reported, but NDC code space filled	140	7.3%
License number not found in our database	120	6.3%
All other rejection reasons	166	8.7%
For All Submitters, Jan. 2006 - Dec. 2006	Qty	Percent
Blank or zero value not allowed	132,880	35.8%
License number not found in our database	72,851	19.6%
No matching code value found in database	31,328	8.4%
NDC number supplied, but procedure code paid not equal to 96370	17,376	4.7%
Line item payment must be greater than zero for EOBR code reported	17,310	4.7%
All other rejection reasons	99,681	26.8%





Additional FY 2006-2007 Accomplishments:

- Modified the Medical Data System to collect the first complete year of detailed pharmacy data and received, accepted and processed 1,041,731 Statement of Charges for Drugs and Medical Supplies (DWC-10) forms, which included 1,537,102 individual line items.

- Received 4,394,106 medical records during FY 2006-2007 that previously would have been promulgated, printed and mailed in hard copy documents. This brought the total number of records stored in the Medical Data Warehouse to approximately 36.5 million medical records.

- Received, accepted, and processed over 875,307 Proof of Coverage (POC) transactions. One hundred percent of POC transactions are submitted electronically.

- Received and processed over 105,115 electronic First Report of Injury (DWC-1) forms and Claim Cost Report (DWC-13) forms.

- Received and processed over 384,225 paper filed First Report of Injury (DWC-1) forms, Claim Cost Report (DWC-13) forms and Notice of Action/Change (DWC-4) forms.

- Received and processed 3,992 subpoenas for record production and 3,116 public records requests.

- Imaged and electronically archived more than one million pages relating to both workers' compensation claims and workers' compensation coverage.

Rules Amended in FY 2006-2007:

69L-7.020: Florida Health Care Provider Reimbursement Manual, 2006 Edition This amendment updated the reimbursement manual for individual health care providers to implement new reimbursement rates authorized by the Three Member Panel and the latest editions of adopted reference materials. The amendment became effective November 16, 2006.

69L-7.602: Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule This amendment adopted 2007 versions of nationally approved uniform billing forms for medical providers and conformed the data reporting requirements necessitated by medical form changes. In addition, the rule revised the Explanation of Bill Review Codes used by insurers to report bill review outcomes to health care providers, and adopted the latest editions of the Florida Workers' Compensation Medical EDI Implementation Guide and other reference materials. The amendment became effective March 8, 2007.

69L-56:_ Electronic Date Interchange (EDI) Requirements for Proof of Coverage and Claims This amendment revised the Proof of Coverage Electronic Data Interchange Implementation Manual and established new requirements for insurers to electronically submit claims information previously reported on paper forms, incorporating by reference the Florida Division of Workers' Compensation Claims EDI Release 3 Implementation Manual and the IAIABC Claims EDI Implementation Guide for Release 3. The amendment became effective January 1, 2007.

Bureau of Employee Assistance and Ombudsman Office

The Bureau of Employee Assistance and Ombudsman Office (EAO) educates system stakeholders on their rights and responsibilities under Florida's Workers' Compensation Law and assists injured workers in obtaining benefits to which they are entitled under Chapter 440.

During FY 2006-2007, EAO restructured its activities, launching a new "team" approach to fulfill its statutory responsibilities under s. 440.191, F.S. Under this new approach, six teams of employees – Ombudsman Team, Early Intervention Team, Denials Team, First Report of Injury Team, Injured Worker Help Line Team, and Outreach Team - each address particular needs within the Workers' Compensation System. An overview of the teams is as follows:

- Ombudsman Team: EAO Ombudsmen assist injured workers with complex claims, generally involving multiple issues. A specific Ombudsman is assigned to assist the injured worker for the life of the claim, serving as the injured worker's contact person within the Division and presenting his/her issues/ concerns to the insurer to facilitate resolution of issues within the informal dispute resolution process. Upon request of the injured worker, the Ombudsman may also assist in the drafting of a Petition for Benefits when outstanding issues need to be resolved at the formal dispute resolution level, including mediation and a hearing before a Judge of Compensation Claims. During FY 2006-2007, the Ombudsman Team resolved 73% of the issues presented by injured workers.

  Another critical function performed by the Ombudsman Team is "EAO Answer," which is a method by which injured workers can ask questions about their claim via email. The webpage that provides direct access to this email capability is: http://myfloridacfo.com/WC/contacts.html During FY 2006-2007, the team responded to 821 emails received from employers, employees, employee family members and medical providers via "EAO Answer."

- Early Intervention Team (EIT): Team members contact and maintain regular communication with workers who had the most serious workplace injuries. Through early and continuing contact, EIT remains abreast of developments in the claim and is able to bring any issues/concerns to the insurer's immediate attention for resolution. Enhancements to the EAO database to capture this team's activity were implemented in June, 2007. During June, 2007, forty-eight cases were referred to the EIT Team for review. Thirty-three cases met the criteria for assistance and will continue to be monitored.

- First Report of Injury Team: This team is responsible for contacting all injured workers for whom a First Report of Injury (DWC-1) forms has been filed with the Division ("lost-time" claims). When the worker cannot be reached by telephone, information is solicited from the employer regarding the progress of the claim. Team members inform injured workers of the services available to them through EAO, answer questions, and contact the insurer to assist in the resolution of issues raised by the injured worker. During FY 2006-2007, the team personally contacted 40% of injured workers with lost-time claims (and the team contacted the employer in an additional 18% of the cases.)

"You and your office were the only one(s) that truly helped me out. All I ever wanted was to be treated right. You were the only one that I could get a straight & honest answer from."

Injured Worker, Indentity Withheld

"She lent an ear to listen when I needed it. I mean she really, really helped with the financial and every aspect of my case including referring me for help with retraining. I'm now a licensed security officer. Thanks to EAO, I'm looking at the "green side" of things now."

Injured Worker, Indentity Withheld

"I am so moved by the way you helped us and I do not think it would ever get resolved without your intervention. My son and I are both very ordinary workers, in other words, we are very small potatoes. Yet you treated us with respect and warm heartedness."

Injured Worker, Indentity Withheld

"I received all my benefits because of the efficient and dedicated help of the Workers' Comp. Employee Assistance Office; Without your help I would have received nothing. You should receive an award for your excellent service."

Injured Worker, Indentity Withheld

- Denials Team: This team reviews all compensability denials filed with the Division to ensure compliance with the Workers' Compensation Law. Team members contact insurers when additional information or clarification is needed.

- Injured Worker Help Line Team: Help Line team members respond to calls from injured workers and other Workers' Compensation System stakeholders. Cases requiring more in-depth assistance are referred to an EAO Ombudsman.

- During FY 2006-2007, the Injured Worker Help Line Team's call volume was as follows:

  · Total number of calls handled: 71,752
  · Number of Hispanic-language calls handled: 7,145
  · Average length of call: 4 min. 24 sec.

- Outreach Team: The Outreach Team is responsible for providing education to stakeholders and members of the general public about the workers' compensation system. This team developed and presented an "Injured Worker" workshop. The program content is available on the Division's website and provides an overview of the injured workers' rights and responsibilities under the workers' compensation system as well as helpful tips for making claims go more smoothly.

The Customer Service Unit is a separate section of the Bureau whose function is to assist the public on a myriad of issues relating to workers' compensation, as well as answer calls from employers regarding drug free workplace, exemptions, compliance, and coverage requirements.

- Telephone statistics for FY 2006-2007 include:

  · Total number of calls handled 142,708
  · Average length of call 2 min. 06 sec.

In addition to receiving telephone calls requesting information and assistance, the Customer Service Unit is also responsible for managing all emails directed to Workers.CompService@myfloridacfo.com where website users are encouraged to direct all general questions, technical assistance inquiries, suggestions, or comments regarding the Division or the website. This Unit serves as the clearinghouse for these emails to streamline the routing and prompt response for all inquiries. During FY 2006-2007, responses were sent to 2,662 emails.

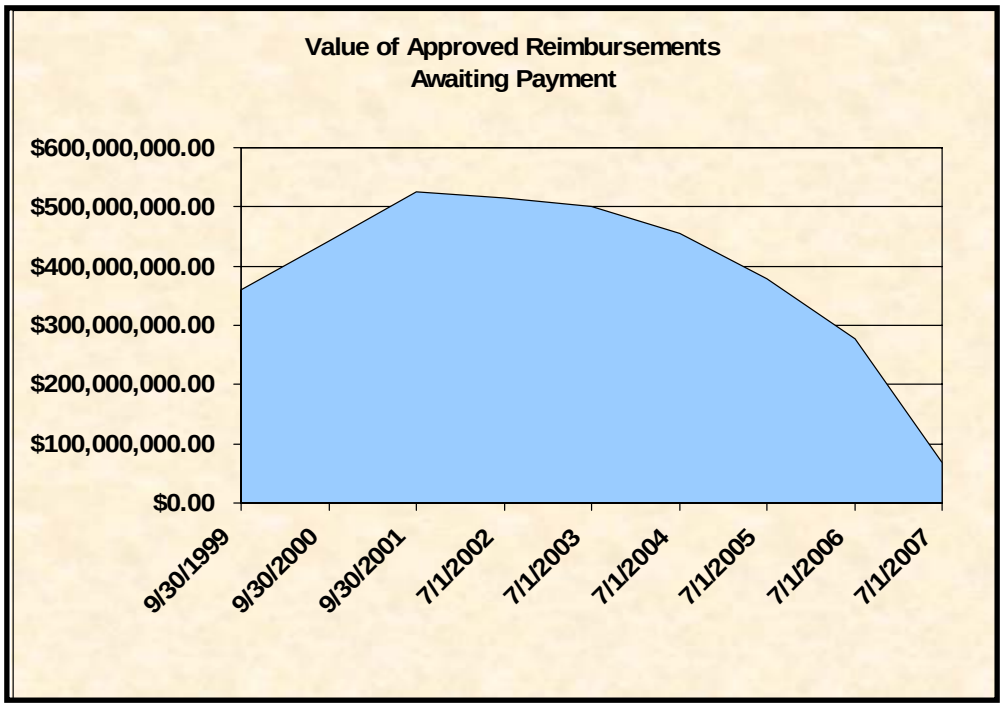
In addition, EAO reconfigured its database to better capture additional data elements to permit analysis and identification of potential trends and conditions relating to insurer conduct in the Workers' Compensation System. During the upcoming year, relevant insights will be shared with other areas of the Division responsible for financial accountability and enforcement.

Office of Special Disability Trust Fund

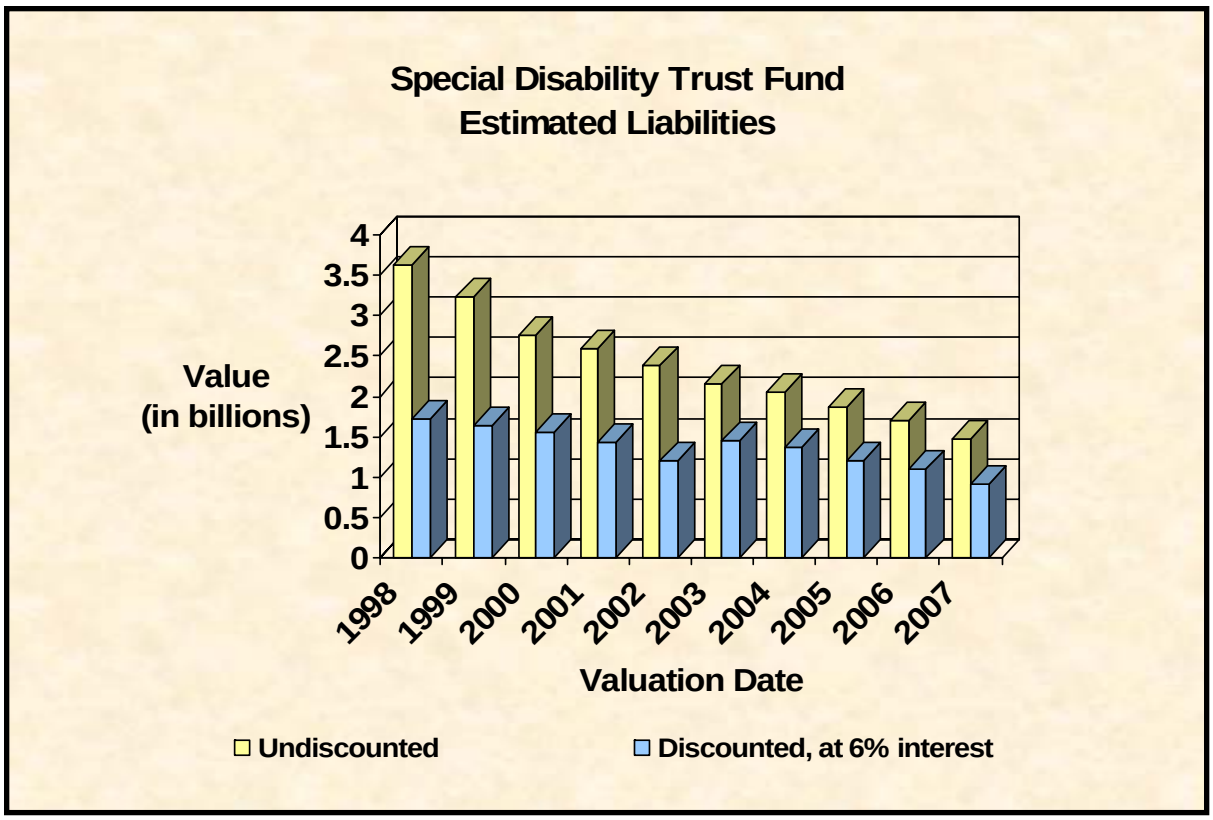
The Special Disability Trust Fund (SDTF) was established in 1955 to encourage employers to hire people with pre-existing permanent impairments by reimbursing excess costs for new work-related injuries that occur subsequent to hiring and result in an additional permanent impairment. The cost of the SDTF, including reimbursements to employers and claim administration, is funded through assessments on workers' compensation premiums written by insurers and estimated by the Division of Workers' Compensation for self-insured employers. The SDTF was "prospectively abolished" in 1997 and has transitioned to a "run-off" of eligible claims. However, assessments continue to be collected, by law, to fund the ongoing operations of the SDTF.

In the early 1990s, the SDTF began experiencing increased costs along with the rest of the workers' compensation system. If no restriction had been imposed, the SDTF assessment rate had been expected to rise into double digits. In 1994, the assessment rate for the SDTF was legislatively capped at 4.52% of net written workers' compensation premium. The SDTF was prospectively abolished by limiting claims against the SDTF to dates of accident occurring on or before December 31, 1997. This prospective abolishment required insurers to either proceed with their claim by filing a Proof of Claim or withdraw previously filed Notices of Claim. The STDF continues to receive and review Notices of Claim and Proofs of Claim for eligible dates of accidents.

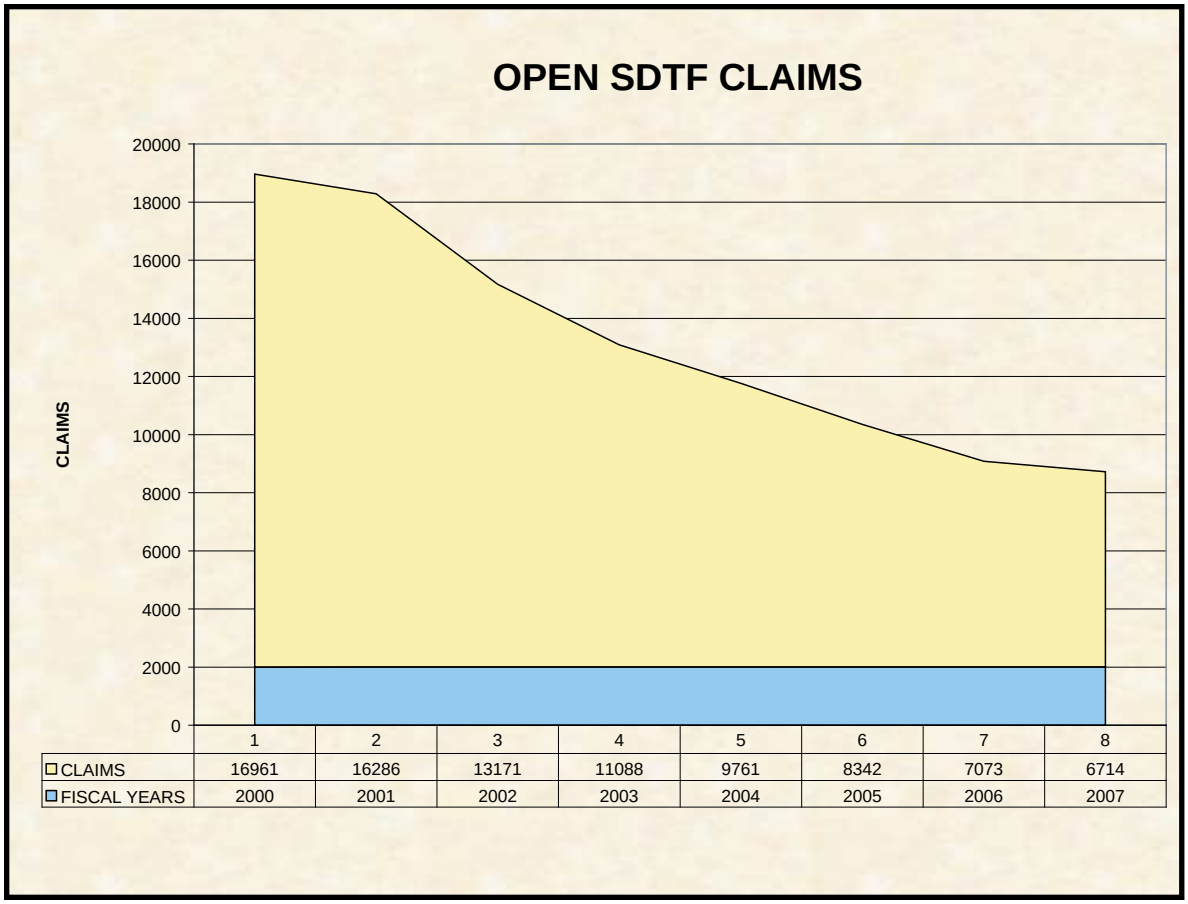
For several years, the amount of reimbursements approved exceeded the revenue that the capped assessment could produce. The result was a backlog of approved reimbursements awaiting payment. The queue of approved reimbursements awaiting payment reached over 15,000 approved reimbursements and was valued in excess of $525 million in FY 2001-2002. The wait time between filing a reimbursement request and receiving payment grew until FY 2004-2005 when the wait time on approved reimbursements reached a peak of almost forty-five months. By the end of that fiscal year, the trend had been reversed and the wait time began falling. During FY 2006-2007, the time between reimbursement request filing and payment was reduced to approximately twenty-seven months. By the end of FY 2006-2007, the average wait time was a little more than sixteen and one half months. The SDTF anticipates the elimination of the backlog of approved reimbursement requests awaiting payment during FY 2007-2008. Graphic 28 below illustrates the reduction in the backlog of approved reimbursements awaiting payment.



When the Fund was prospectively abolished, the estimates of unfunded undiscounted liability, which is the SDTF's expected total future payout on claims, ran from $2.5 billion to $6 billion. As post reform claims experience developed, the SDTF's unfunded undiscounted liability was estimated at a little over $3 billion in 1999. The most recent annual actuarial report, "Florida Special Disability Trust Fund Estimation of SDTF Liabilities as of June 30, 2006," prepared by Preferred Insurance Capital Consultants, estimates the unfunded undiscounted SDTF liability at about $1.7 billion, which is a drop of almost $176 million from the previous year. Graphic 29 on the following page illustrates the change in estimated discounted and undiscounted SDTF liabilities over the last ten years.



The number of open claims was reduced from 16,961 at the end of FY 1999-2000, to 6,714 at the end of FY 2006-2007. The number of new claims being filed has become negligible in recent years with only six filed in FY 2006-2007. Graphic 30 below shows the reduction in open claims over time.



Assessments and Funding

The Division of Workers' Compensation manages two trust funds: the Workers' Compensation Administration Trust Fund (WCATF) and the Special Disability Trust Fund (SDTF). Both funds are supported by annual assessments against workers' compensation insurance premiums, actual and estimated. For insurance companies, assessable mutuals and self-insurance funds, assessments are based upon actual premiums; for individual self-insurers, assessments are based on the amount of premiums calculated by the Division.

The Workers' Compensation Administration Trust Fund

Since January 1, 2001, the WCATF assessment rate has applied to a calendar year period and, by July 1st of each year, the Division of Workers' Compensation, in accordance with Section 440.51, F.S., determines the funding level for the WCATF for the upcoming calendar year, based upon anticipated administrative expenses for the next calendar year. Assessments are calculated by prorating these administrative expenses among insurance companies, self-insurance funds, assessable mutual companies and individual self-insurers.

The WCATF assessment rate is based upon a best estimate of expected costs to be incurred during the next calendar year. The estimated expenses include costs for the Division of Workers' Compensation (administrative costs and the payment of Permanent Total Disability Supplemental Benefits for eligible injured workers with dates of accident prior to July 1, 1984), administrative expenses for the Office of the Judges of Compensation Claims, and a portion of expenses for the Agency for Health Care Administration, the Department of Education, the Division of Insurance Fraud and the Department of Business and Professional Regulation.

Effective July 1, 2001, the WCATF assessment period was changed from fiscal year to calendar year. At the same time, the Legislature expanded the assessable premium base and required carriers to pay the WCATF assessment on net premiums, including the deductible premium discount amount of the policy and the nondeductible premium amount. Concurrently, the maximum assessment rate was lowered from 4% to 2.75%. Since that time, the WCATF assessment rate has steadily decreased. It was reduced to 0.5% for calendar year 2007 and will be further reduced to 0.25% beginning January 1, 2008.

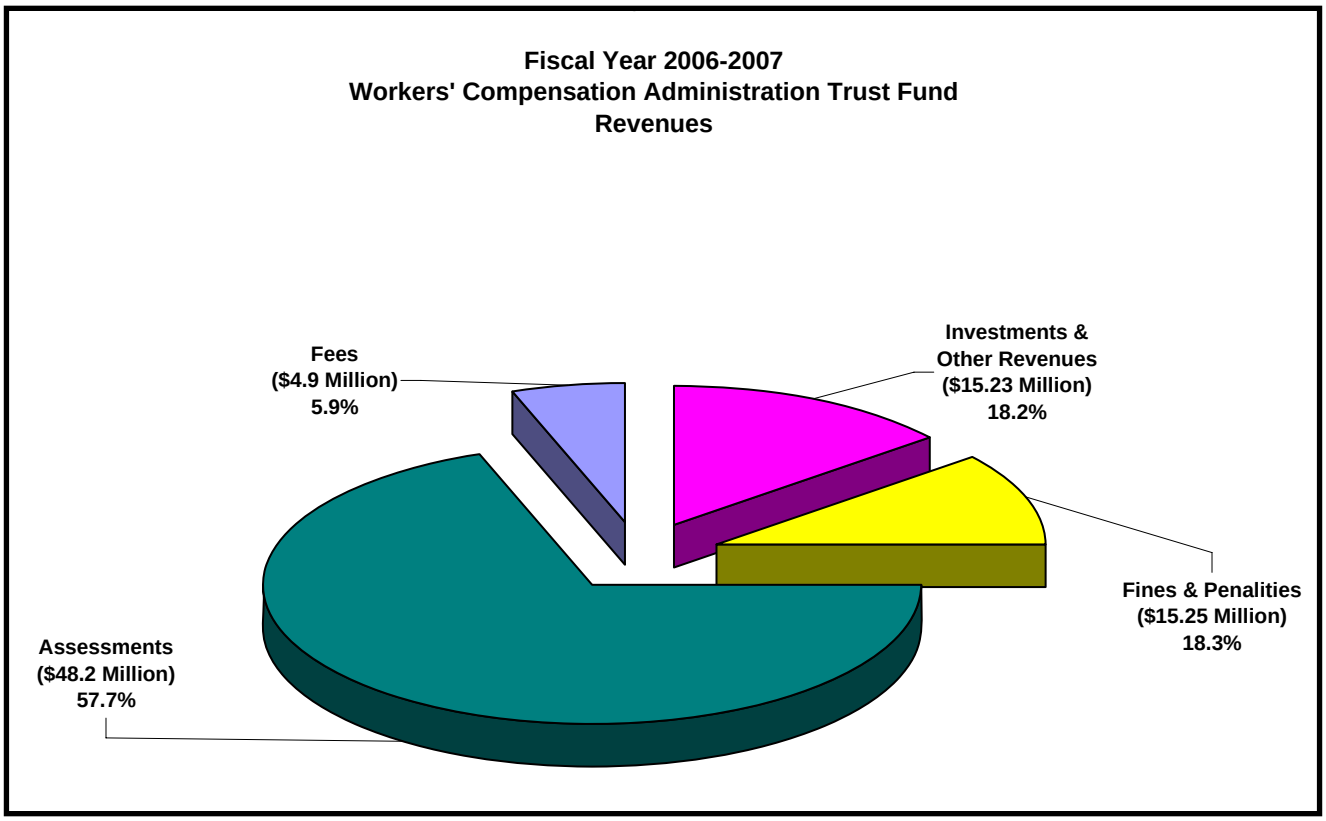
Graphic 31 below summarizes the WCATF assessment rates and total revenues generated from all sources for the past five fiscal years.

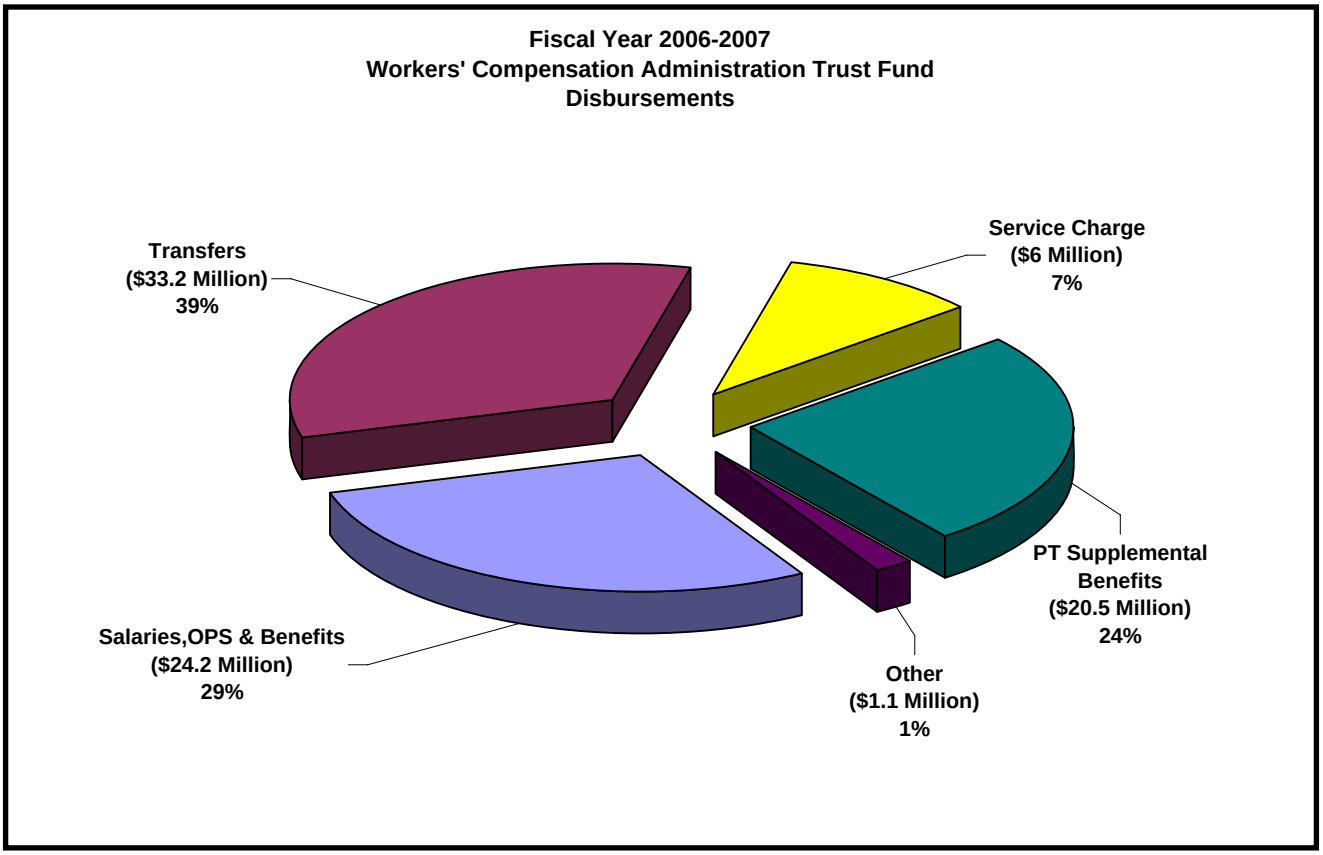
The Workers' Compensation Administration Trust Fund
Assessment Rates and Total Revenues*

Fiscal Year	Assessment Rates	Total Revenues
2003	2.56%/1.75%	$158,889,383
2004	1.75%/1.50%	$146,447,288
2005	1.50%/0.75%	$122,706,612
2006	0.75%/0.60%	$ 97,209,027
2007	0.60%/0.50%	$ 83,537,585

*Source of Revenue Data: Department of Financial Services, Revenue Processing Unit and Division of Treasury

Graphics 32 and 33 below illustrate the breakout of WCATF revenues and disbursements during Fiscal Year 2006-2007. The excess of revenues over disbursements is applied toward estimated expenses for the subsequent calendar year, and included in the computation of that year's assessment rate.





Special Disability Trust Fund Assessments

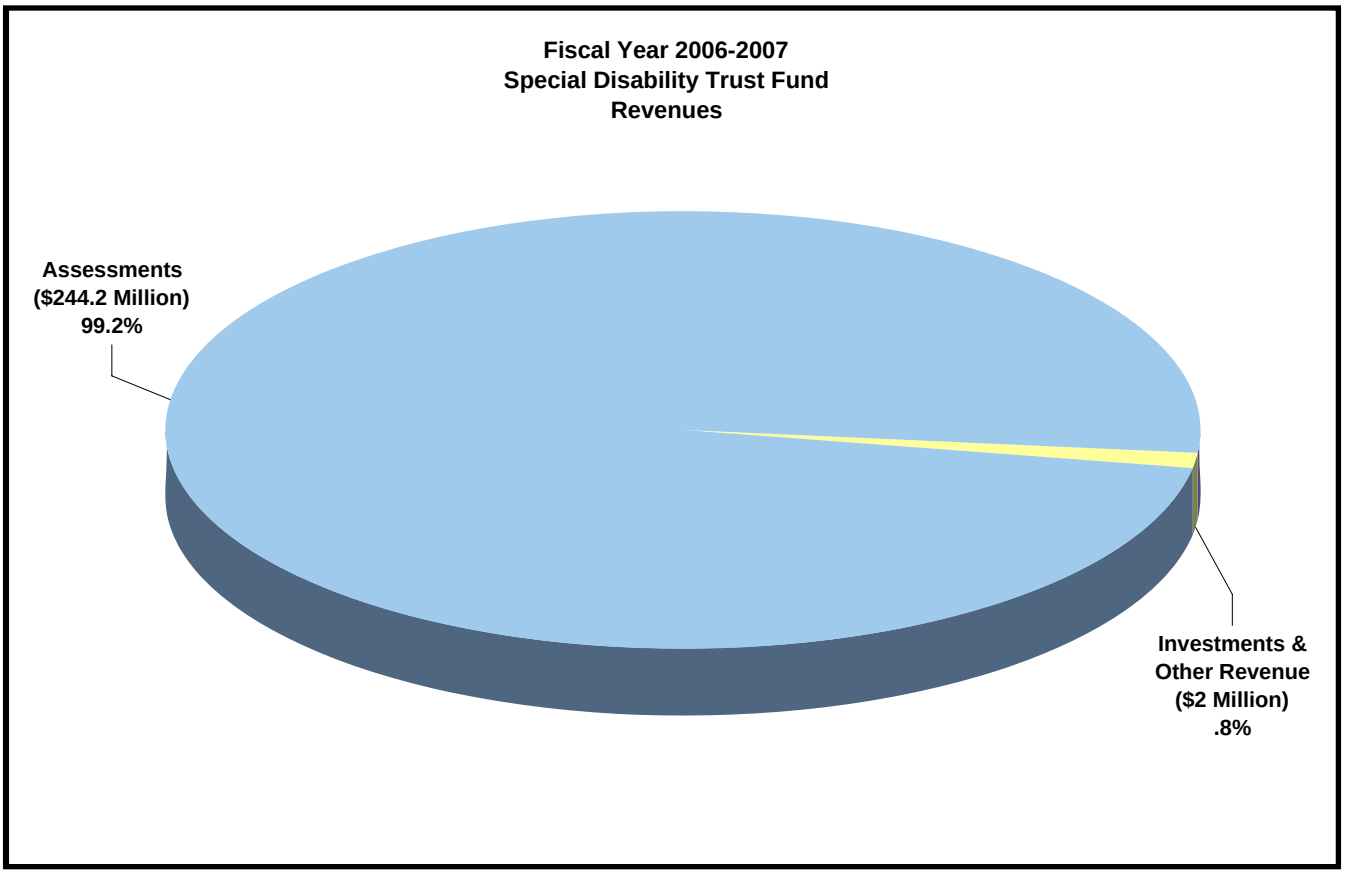
Graphic 34 below summarizes the assessment rates and total revenues generated from all sources by the SDTF for the past five fiscal years. The breakout of total revenues received between assessments and filing fees has not been provided, since assessment revenues have historically accounted for more than 99% of total revenue receipts.

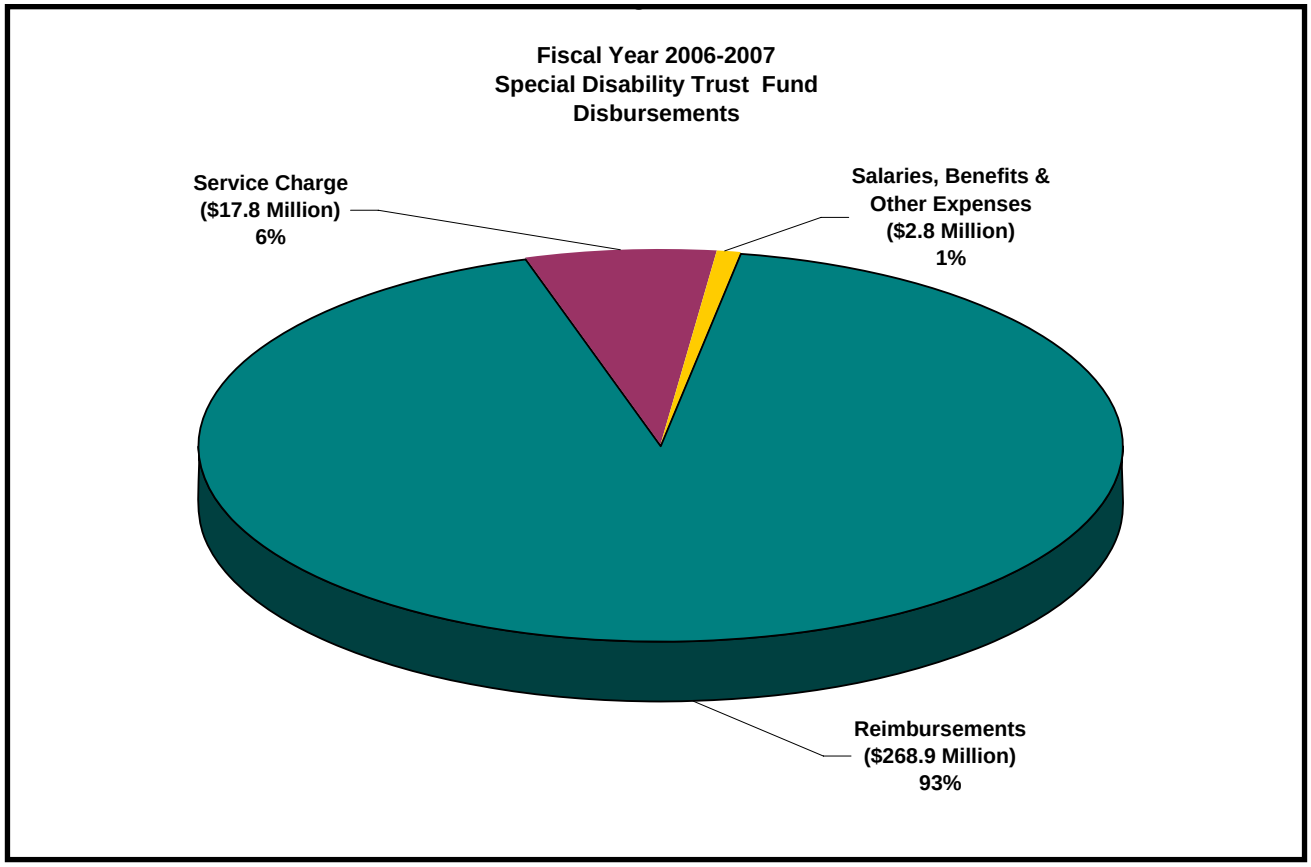
Special Disability Trust Fund
Assessment Rates and Total Revenues*

Fiscal Year	Assessment Rates	Total Revenues
2003	4.52%	$174,885,832
2004	4.52%	$200,261,453
2005	4.52%	$227,066,908
2006	4.52%	$250,779,908
2007	4.52%	$246,115,970

*Source of Revenue Data: Department of Financial Services, Revenue Processing Unit and Division of Treasury

Graphic 35 below and Graphic 36 on the following page illustrate the breakouts of SDTF revenues and disbursements during FY 2006-2007. More than nine out of every ten dollars disbursed by the SDTF were paid to carriers and self insurers for reimbursement of eligible claim costs.




Fiscal Year 2006-2007
Special Disability Trust Fund
Disbursements
Service Charge
($17.8 Million)
6%
Salaries, Benefits &
Other Expenses
($2.8 Million)
1%
Reimbursements
($268.9 Million)
93%

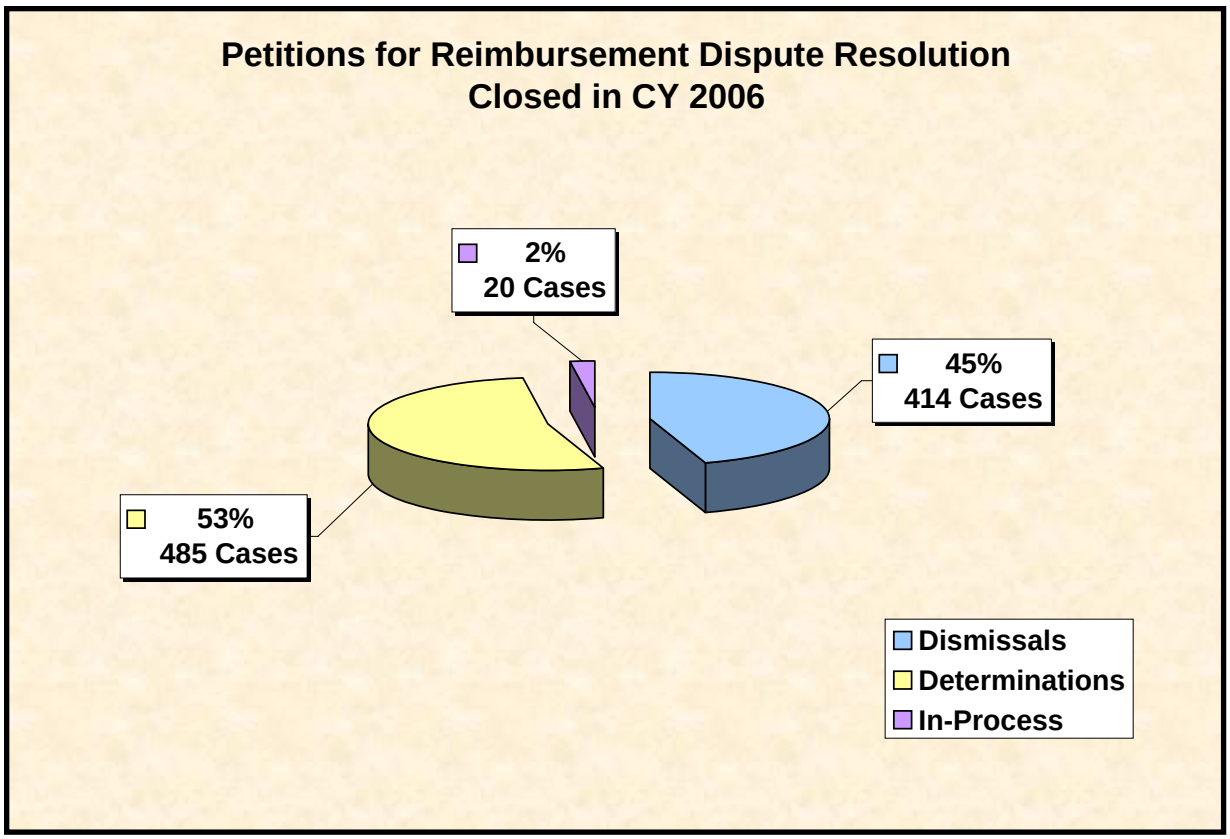
Office of Medical Services

The Office of Medical Services (OMS) continues to work under an Interagency Agreement, originally implemented in November, 2005, between the Division of Workers' Compensation and the Agency for Health Care Administration (AHCA). The Agreement is designed to ensure an efficient administration of agency programs in a manner that does not duplicate, neglect or impede essential inter-related activities necessary for the effective delivery of medical and, indemnity benefits, when required. Therefore, the Division currently provides ongoing direction and control over thirteen full-time AHCA employees in order to fulfill the following five primary statutory duties specifically delegated to OMS:

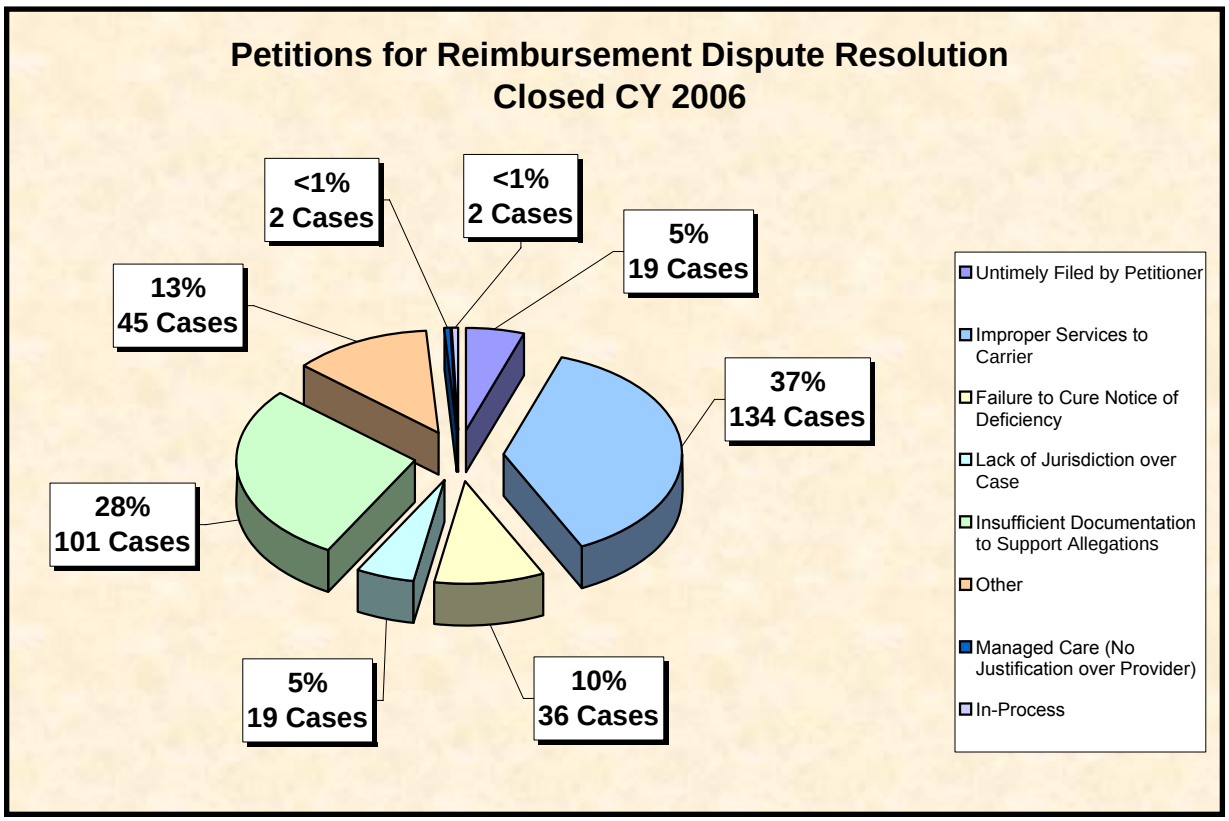
- Certification of health care providers pursuant to s. 440.13(3)(a), F.S.
- Certification of Expert Medical Advisers, pursuant to s. 440.13(9), F.S.
- Determination of whether any health care provider has engaged in a pattern or practice of overutilization or a violation of the Workers' Compensation Law or agency rules pursuant to s. 440.13(8), F.S.
- Resolution of reimbursement and utilization disputes concerning medical services pursuant s. 440.13(7), F.S.
- Works with the Bureau of Data Quality and Collection to revise administrative rules for medical billing and reimbursement manuals for health care providers, hospitals and ambulatory surgical centers.

The OMS implemented significant process changes related to the resolution of reimbursement disputes which resulted in an extensive revision of Rule 59A–31, F.A.C., effective November 28, 2006. The changes revised the medical service dispute resolution petition process over which AHCA is vested with exclusive jurisdiction, pursuant to s. 440.13(11)(c), F.S. In addition to conforming the rule to current statutory language governing reimbursement disputes, the revisions standardized the process for filing and responding to dispute petitions by incorporating a petition form and a carrier response form, both of which are available on the Division's website or upon request from OMS. The revisions also promote timely issuance of determinations by OMS based on required objective evidence delineated in the rule.

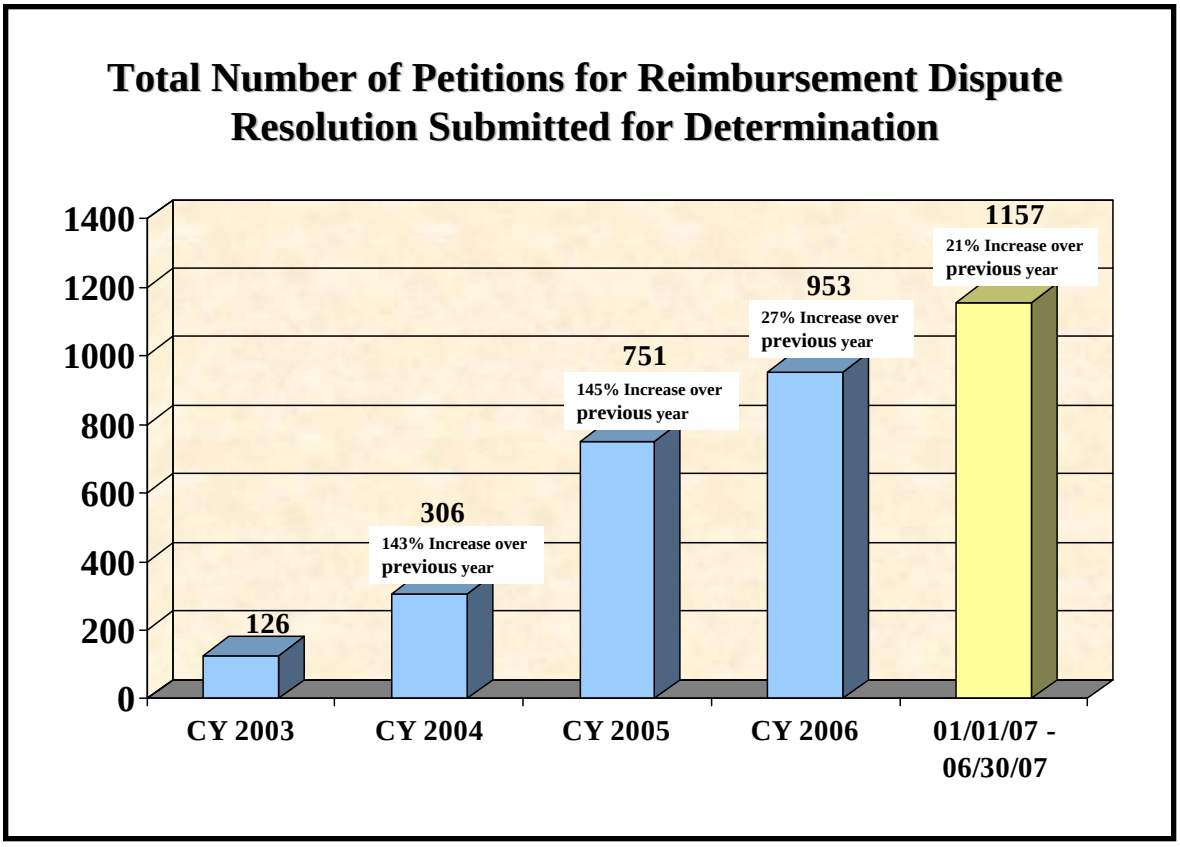
The OMS tracks reimbursement dispute petitions by provider type and whether a determination is rendered or the petition is dismissed. Graphic 37 on the following page shows Petitions for Resolution of Reimbursement Dispute closed during CY 2006.



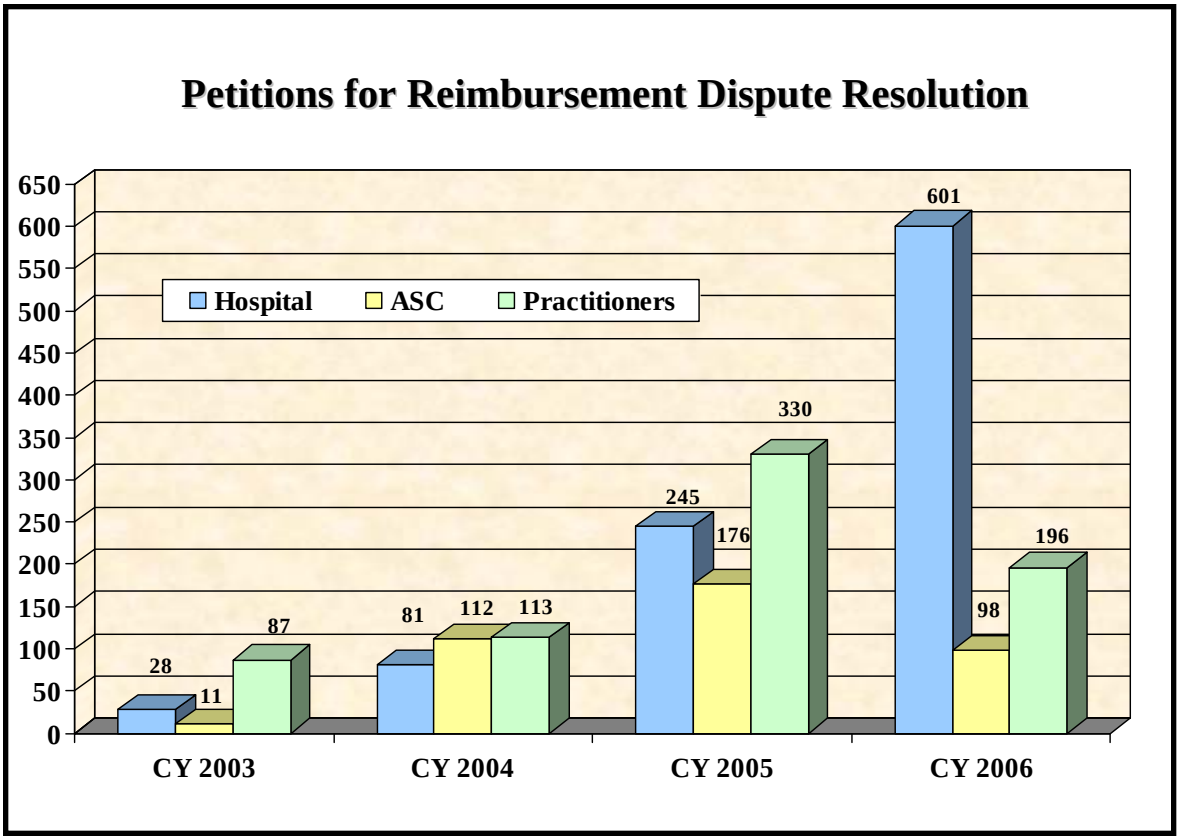
Reasons for dismissals are shown in Graphic 38 below.



Final determinations (i.e., findings of underpayments, correct payments or overpayments) are also tracked. Graphic 39 below reveals that the total number of reimbursement dispute petitions is increasing annually. It is noted that the number of petitions received during the first six months of 2007 exceeds all of 2006 petitions by 21 percent.



Data also show that the number of petitions from hospitals and ambulatory surgery centers has exceeded the number of practitioner petitions each calendar year for the last three years, as shown in Graphic 40 below.



The OMS has been an integral part of the Division's efforts in education, advocacy, compliance and enforcement during FY 2006-2007. The OMS provided education to stakeholders through web-based training modules and physician workshops, such as those conducted for the University of South Florida College of Medicine, Occupational Medicine Residency Program, that focus on the physician's role in delivering cost-effective medical care based on authorized treatment plans, identifying medical restrictions that promote safe and early return to work initiatives, and timely reporting of maximum medical improvement and permanent impairment.

To meet the specialized need related to reasonable access to medical information under s. 440.13(4), F.S., a referral process was implemented linking the Bureau of Employee Assistance and Ombudsman with OMS. Specifically, reports from attorneys, adjusters, nurse case managers and injured workers were referred to OMS to investigate any allegation that a health care provider failed (or refused) to produce medical records. Jointly with the Division's Ombudsman Team, OMS was able to resolve issues related to the obligations and requirements of health care providers and all parties concerning access to medical information.

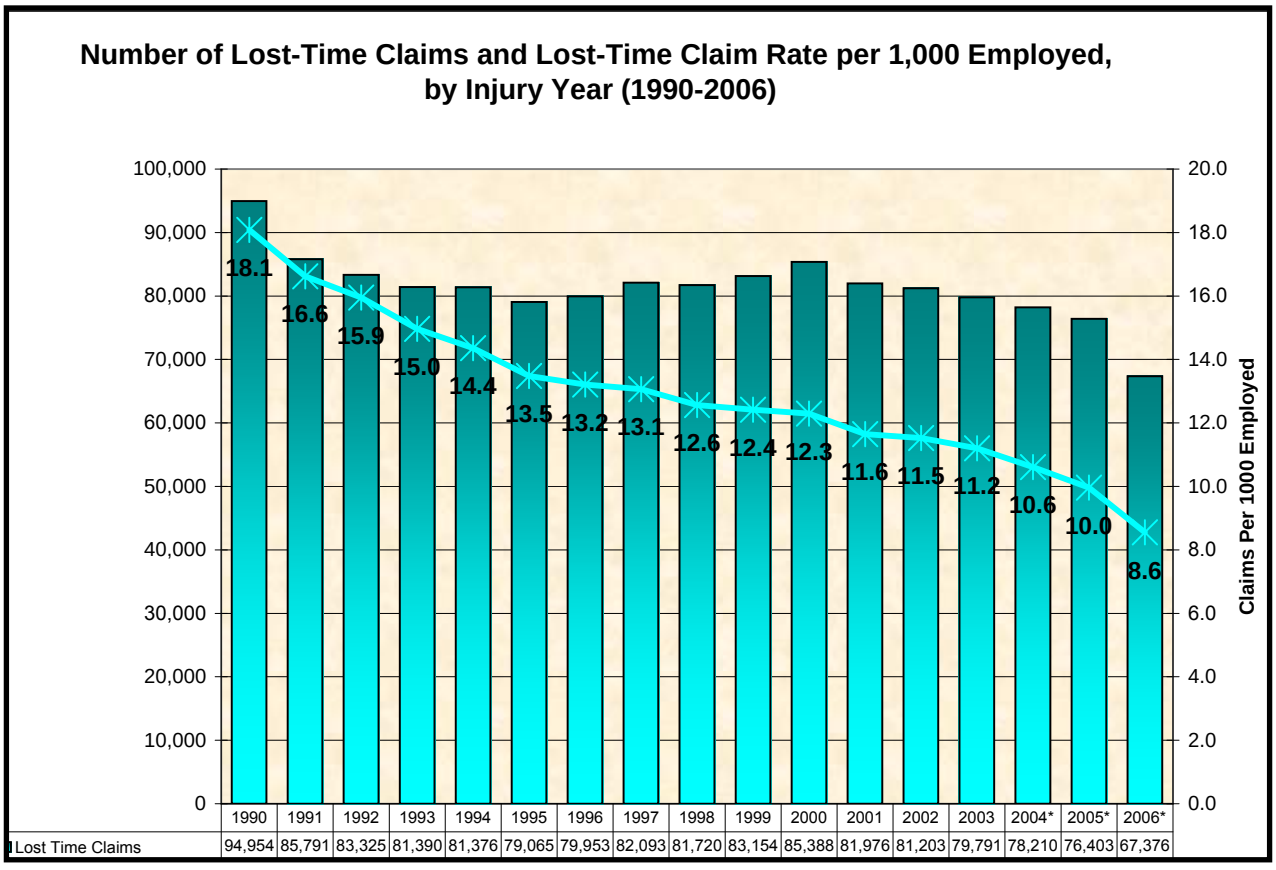
The next several initiatives to be undertaken by OMS include establishing an administrative rule to determine whether a health care provider has engaged in a practice or pattern of overutilization and revising the certification process for health care providers.

Claims Data

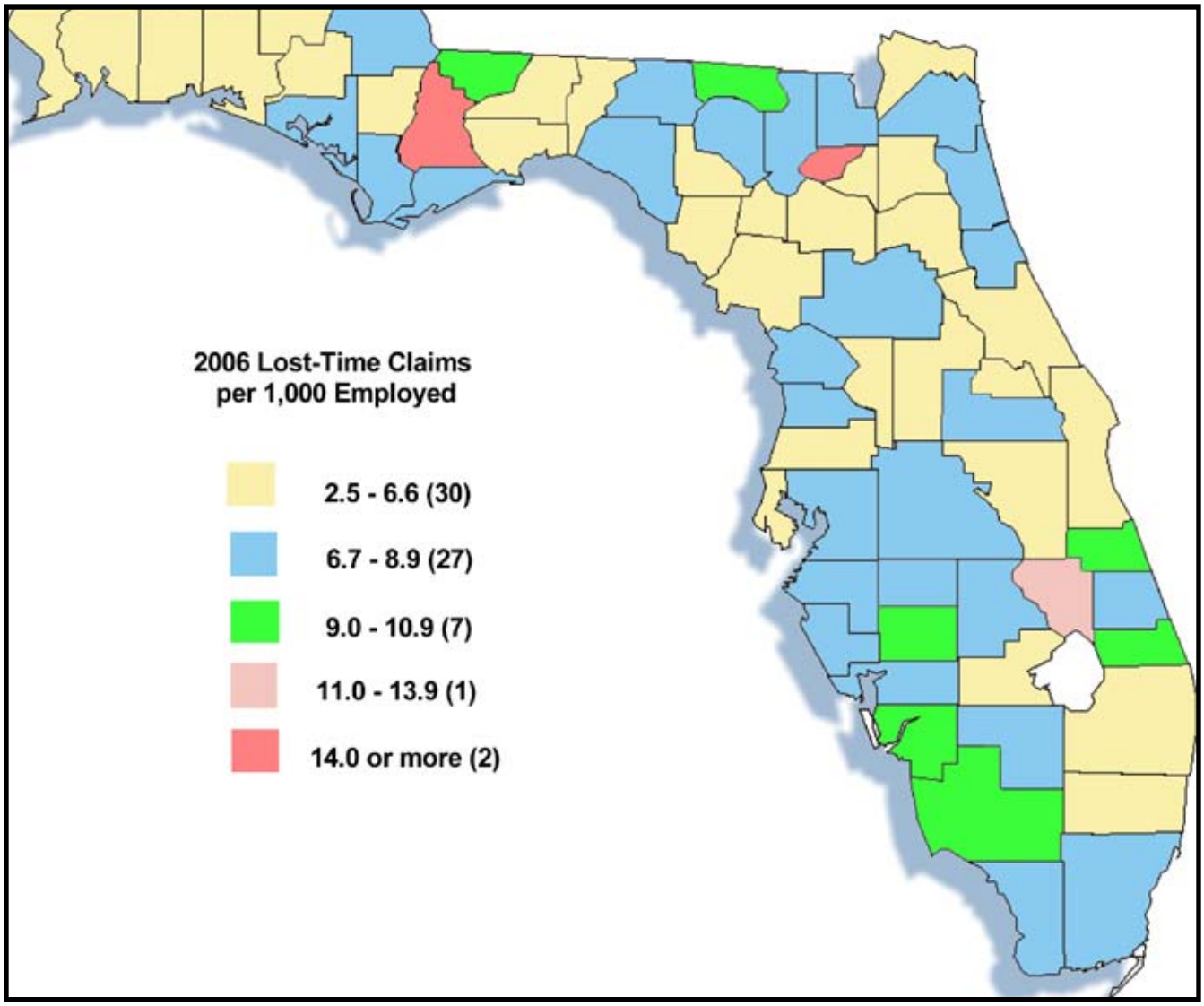
Lost-Time Claims

Following several years of modest declines in the early 1990s, lost-time claims leveled out somewhat in the late 1990s, peaking again in 2000, after which they began to trend downward again. Yet, over this same span of time, annual statewide non-agricultural employment levels have continued to rise. Consequently, the annual lost-time claim rate, i.e., the annual number of lost-time claims per 1,000 non-agricultural, non-federal government employees, has shown a distinct, albeit gradual decline, since the early 1990s. This trend can be seen clearly in Graphic 41 below. Considering that lost-time claims data for the three or so most recent years are not fully mature (meaning that many accidents which occurred in those years have yet to develop into lost-time claims), too much emphasis should not be placed on the level of claims reported for these years. However, even if claims levels over the past three years are ultimately shown to be flat rather than in actual decline, the fact that non-agricultural employment continued to rise during this period strongly suggests the annual claim rate, which is based here on current claims data and current estimates of the statewide total non-agricultural employment, is still decreasing overall, although perhaps not to the degree shown in Graphic 41 below.

In the following six sections, claim counts and benefit amounts reported for accident years 2004 through 2006 are marked with an asterisk (*) to indicate that they are based on 'immature' data; as more lost-time claims are reported and additional benefits are paid for these years of accident, the counts and amounts are likely to increase over their current, reported values.



Even though the overall claim rate appears to be trending downward throughout the state, there are several counties which continue to experience a somewhat higher than average claim rate locally. Graphic 42 below illustrates the 2006 lost-time claim rate for each of the state's 67 counties based on total employment, including agricultural workers and federal government employees. For 2006, ten counties have within-county claim rates at or above 9 per one thousand employed workers. The remaining majority of counties have a claim rate near or well below the average of 6.8 per 1,000 employed workers. Since the employment figures for the 2006 county claim rates are based on total employment, including agricultural employees, they are not strictly comparable to those reported on page 49.

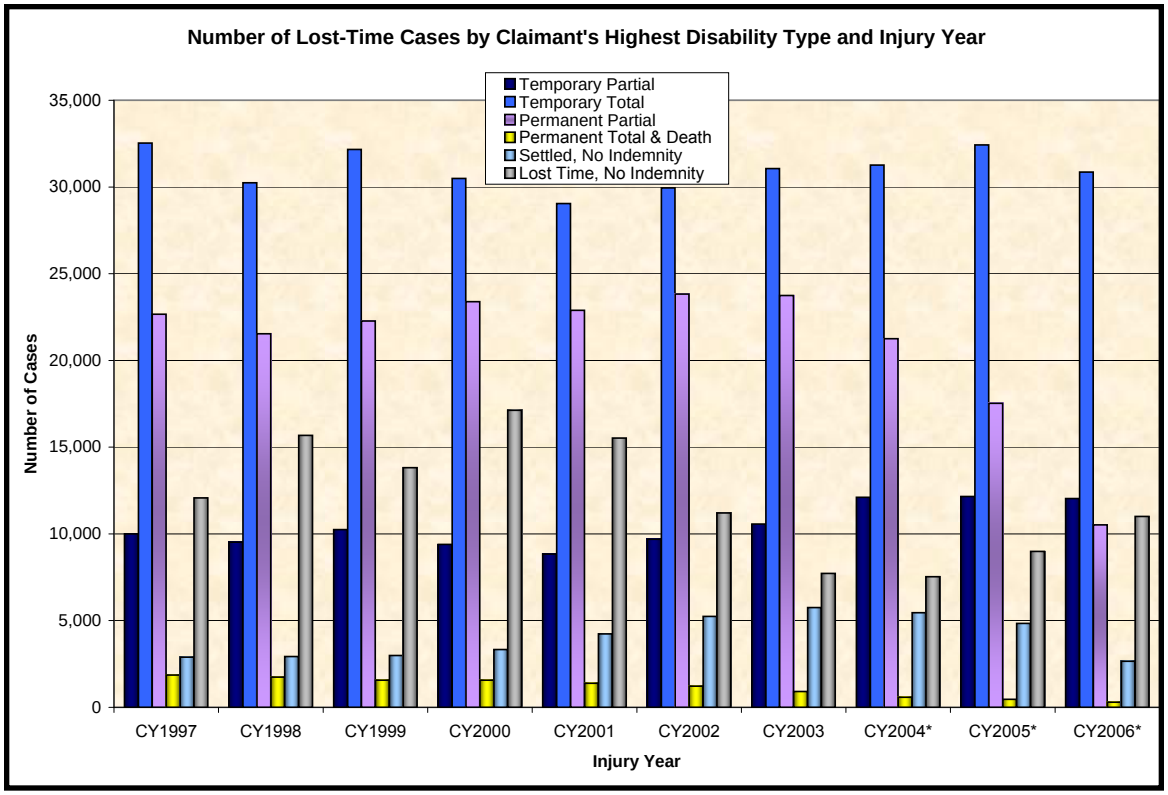


Injured Workers' Highest Disability Type

Depending on the severity and permanency of a workplace injury, each lost-time claim is classified into one of five main categories for the purpose of determining the type, level and duration of indemnity benefits to which the injured worker is entitled. These claim categories are known collectively as the disability type of the claim. These benefit categories include Temporary Partial, Temporary Total, Permanent Partial (which includes both Impairment and Supplemental Income), Permanent Total, and Death.

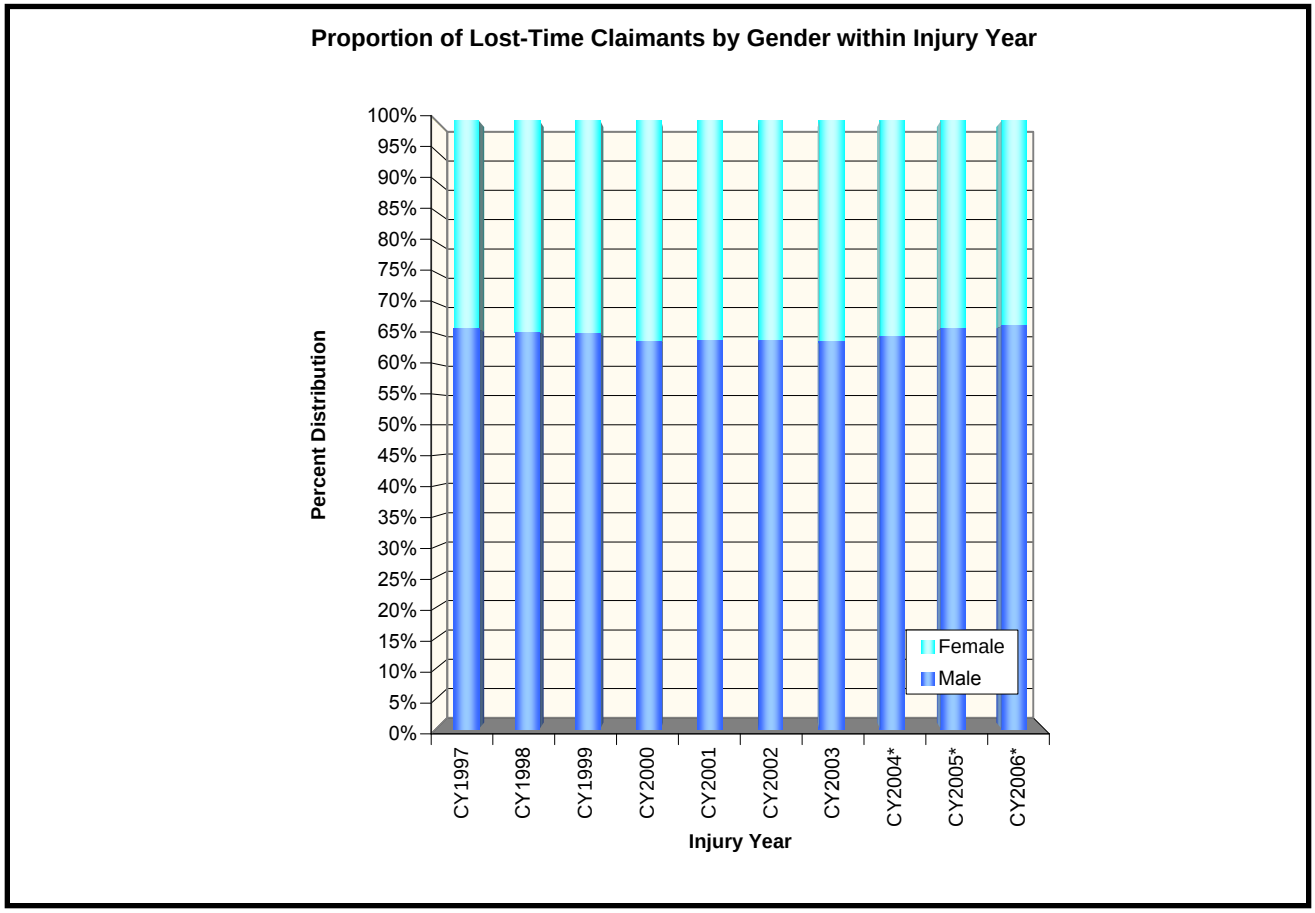
Unlike other claim attributes, such as the nature of injury, which remain relatively static over the life of a claim, the disability type of a claim may change several times from one benefit category to another depending on many factors. Most lost-time claimants are initially awarded temporary benefits, at least preliminarily. If the claimant is able to return to work with a diminished work capacity, he or she may qualify for Temporary Partial benefits. If the claimant is incapacitated and unable to return to work after seven days in any capacity, he or she may qualify for Temporary Total benefits. After reaching maximum medical improvement, the injured worker may be entitled to receive Permanent Partial Disability benefits if a competent medical authority determines that the injured worker has a permanent restriction in his or her capacity for work. Severely injured workers who are unable to return to work at any time may be entitled to receive Permanent Total benefits. Death benefits may be provided to families of injured workers in the event that a workplace accident results in the employee's death. As each injured worker's recovery progresses over time, the prospects for a full and complete recovery and return to work may improve or abate. The highest disability type for each lost-time claim is recorded as a watermark of the "highest" benefit type awarded, ranging from Temporary Partial (low) to Permanent Total & Death (high). Two other disability type categories exist to classify claims for which no indemnity payments have been reported. In cases where only settlement payment information has been provided, and no indemnity benefits specified, the claim is designated as "Settled, No Indemnity Reported." Other cases for which incomplete reporting of payment amounts prevent a more precise classification are designated as "Lost Time, No Indemnity Reported."

Over the ten-year period from 1997 to 2006, the highest disability benefit type awarded most lost-time claimants is Temporary Total, as can be seen in Graphic 43 below. Temporary Total claims comprise approximately 40% of total lost-time claims over this period. As with Temporary Total claims, Permanent Partial and Temporary Partial benefits do not evidence any particular trend over the past ten years. The data reflect a small but steady decline in the number of Permanent Total cases being reported over this same interval. In contrast, Settlement – No Indemnity Reported cases show a steady climb during the mature data period from 1997 to 2003. Lost Time – No Indemnity Reported cases show a marked decrease in the last five years over the previous five-year period.



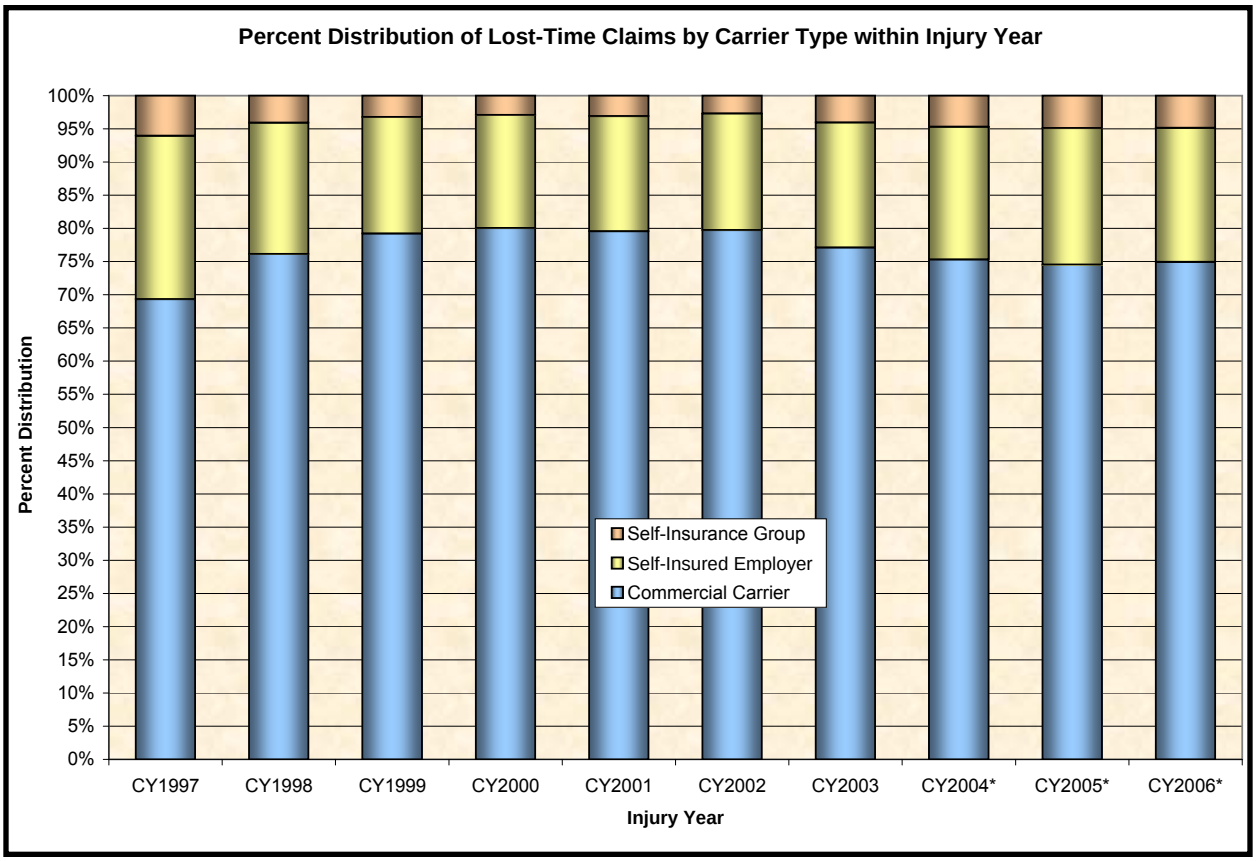
Lost-Time Claims By Gender

During the past ten-year period, males have consistently accounted for about two-thirds of all lost-time claims in the state. However, there appears to be a gradual shift in the relative contributions that each gender makes toward lost-time claims whereby male claimants make up about 2% less of the total claims in 2003 than in 1997 and the proportion of female claimants has increased an offsetting 2% during this same mature data interval. This pattern can best be seen in Graphic 44 below.



Carrier Type

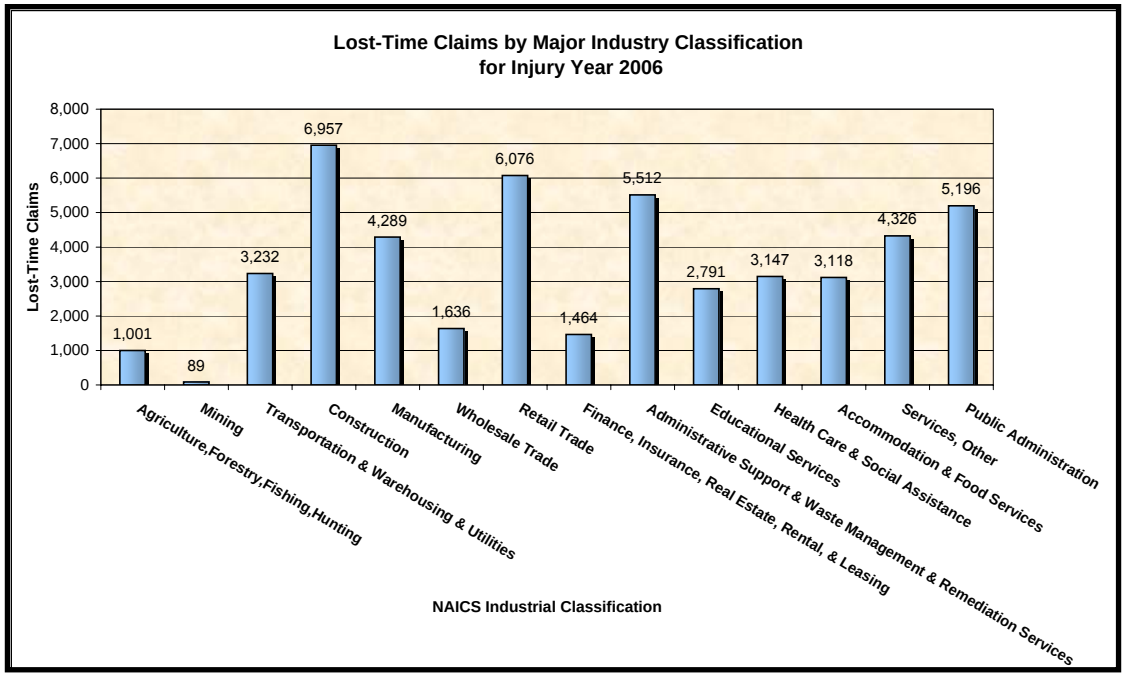
After a steady rise in the market share of commercial carriers during the six-year period from 1997 to 2002, self-insurance funds and self-insured employers have both increased their representation with respect to the handling of lost-time claims, as shown in Graphic 45 on the following page. Due to data maturity issues associated with workplace injuries over the past three years, it is not yet possible to determine if this increase is a one-time event or an indication of an actual structural shift in the workers' compensation insurers' market.



Industry Type

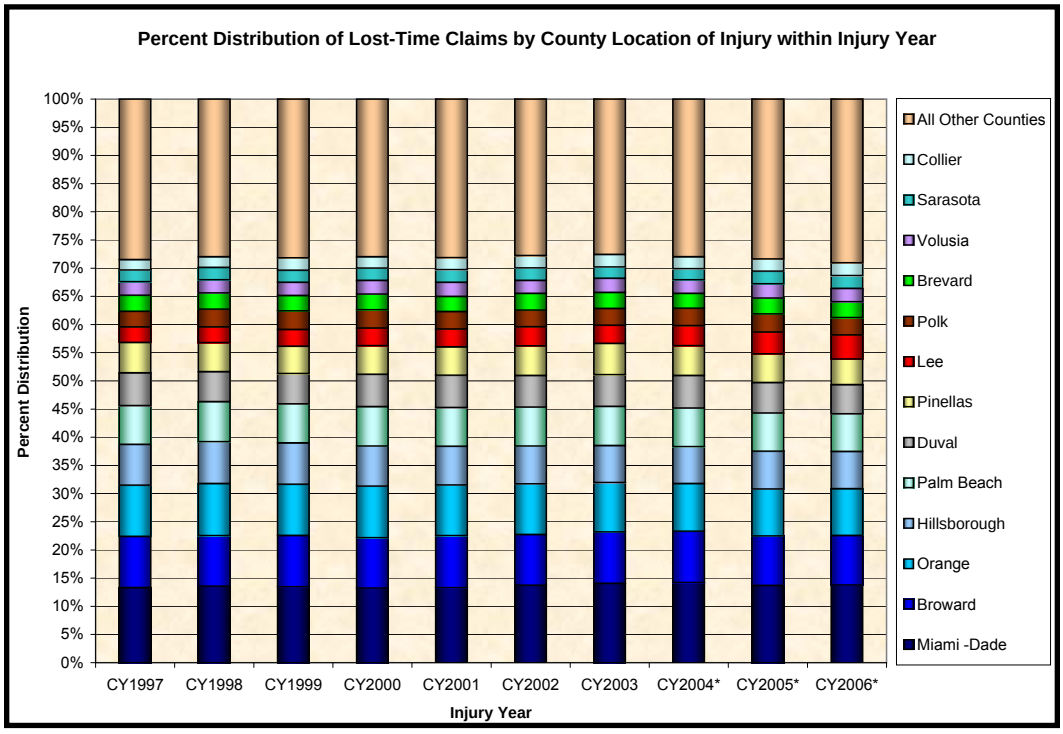
Calendar year 2006 marks the first complete year in which insurers have reported the industrial classification of employers according to the North American Industry Classification System (NAICS) encoding. Prior to October of 2005, industrial classifications were reported according to the older Standard Industrial Classification (SIC) system. While the SIC system uses a four-digit code to describe a particular industry, the NAICS system utilizes a six-digit format, which provides a much more detailed and expansive set of classifications. In the coming years, it should be possible to explore and investigate claims activity with respect to very specific sub-categories of individual industries to an extent not possible under the older system of classification.

Graphic 46 on the following page provides an indication of the number of lost-time claims reported for 2006 injury year by major (two-digit) NAICS-based industrial classification. Construction contributed the most to all 2006 lost-time claims, just ahead of the Retail Trade industry. Various service-related industries each contributed an amount less than that of the Public Administration sector; however, when combined, their collective total well exceeds that of Construction. Manufacturing and Transportation also contribute significantly to the number of lost-time claims. Agriculture and Mining, by comparison, appear to contribute a much smaller amount.

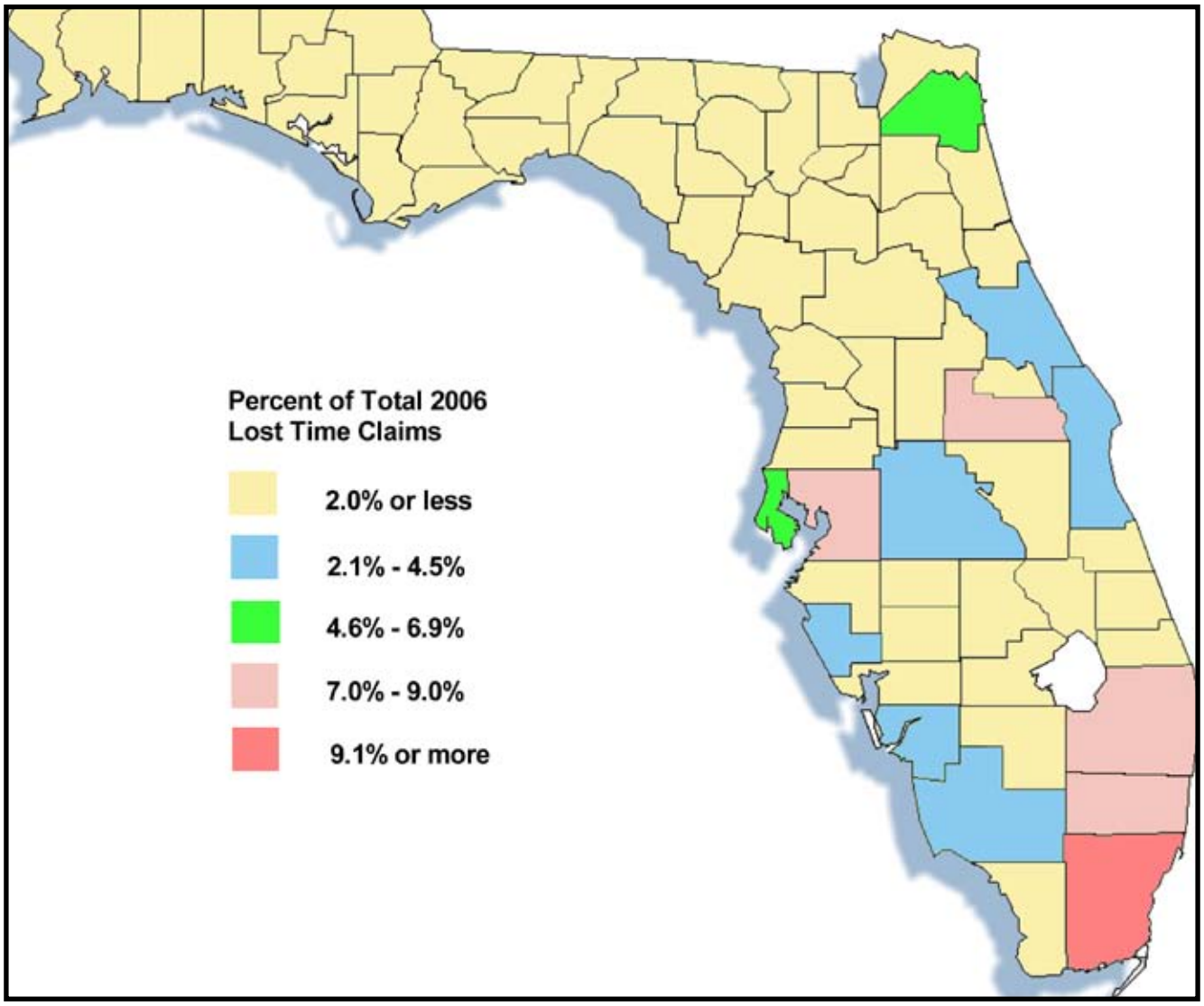


Lost-Time Claims by County

In calendar year 2006, ten counties accounted for 64% of the state's total lost-time claims on injuries that occurred in that year. Given the high degree of correlation between each county's employment levels and its corresponding contribution to lost-time claims (r = 0.98), it is not surprising to note that these 10 counties were also the largest in terms of employment in the state. In 2006, the largest county in terms of employment, Miami-Dade, made up 12.8% of the state's total employment and 12.1% of the state's lost-time claims. On the other end of the continuum is Lafayette County, which accounted for 0.03% of the state's total employment in 2006 and a corresponding 0.03% of the state's lost-time workplace injuries. Graphic 47 below shows the percent distribution of lost-time claims among the various counties from injury year 1997 to 2006. This chart demonstrates that just as population and employment have not changed significantly within any given county during recent years, neither has its overall contribution to lost-time claims, generally speaking.



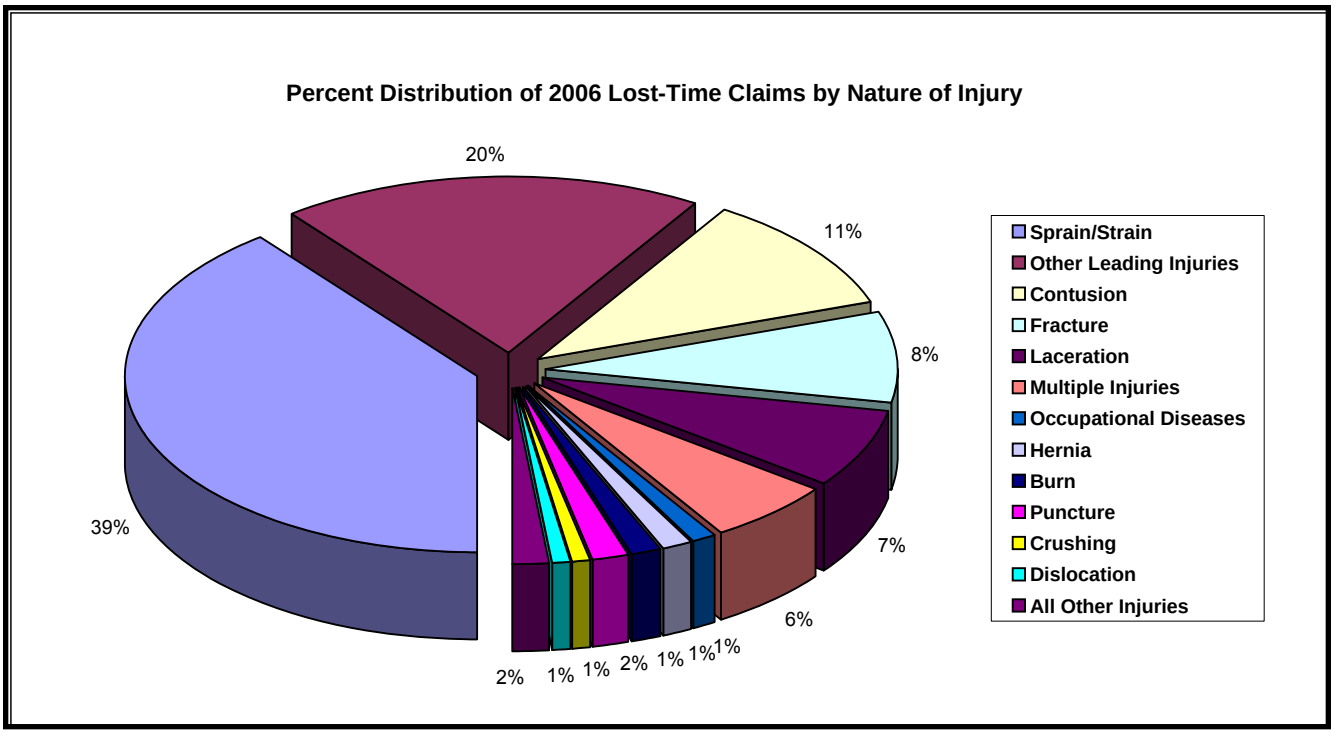
Graphic 48 below provides an additional view of the geographical distribution of 2006 lost-time claims throughout the state. The more populated areas of south and central Florida contribute heavily to the total claim count, whereas the more rural counties of the north, with the exception of Duval County, and west each accounted for 2% or less of the state lost-time injuries in 2006.



Nature, Cause, and Body Location of Workplace Injuries

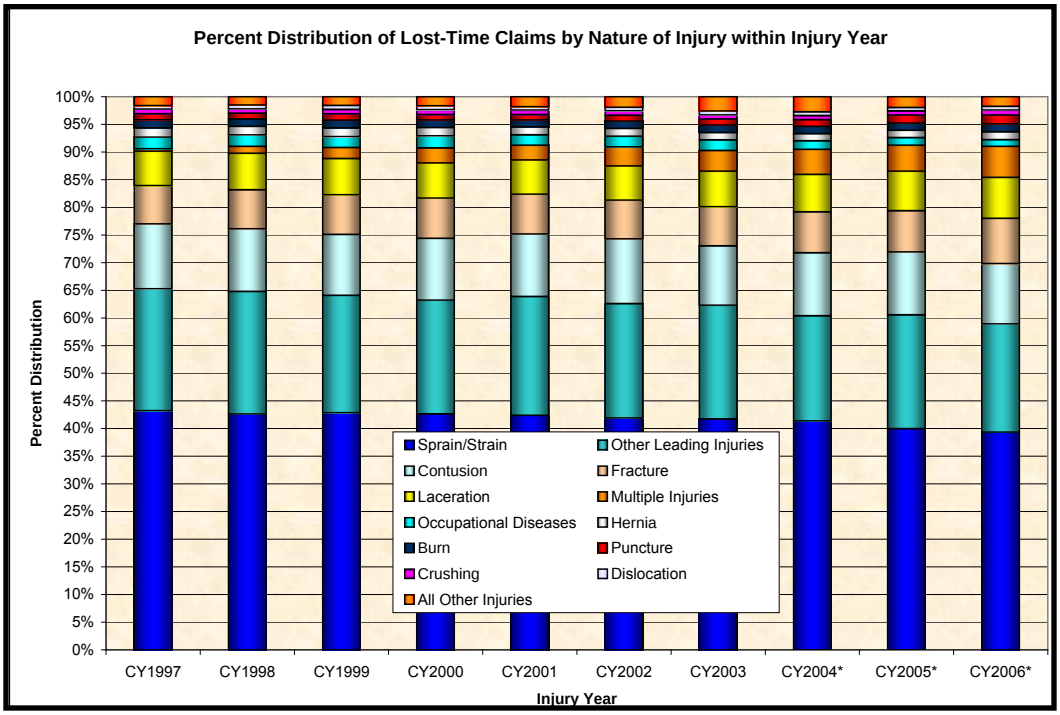
Nature of Injury

Strains and sprains remain the leading nature of injury among Florida's injured workers, as reported to the Division on the First Report of Injury (DWC-1) form. As illustrated in Graphic 49 below, among workers injured in 2006, strains and sprains were indicated as the nature of injury in 39% of all lost-time cases. This amount is only slightly below the average of 41.8% of all lost-time cases over the past ten years. The slight drop in 2006 may be due to of the immaturity of the 2006 data rather than to a structural shift in overall characteristics of workplace injuries. As more 2006 accidents are reported to the Division over the course of the next year or so, this number can be expected to increase slightly.



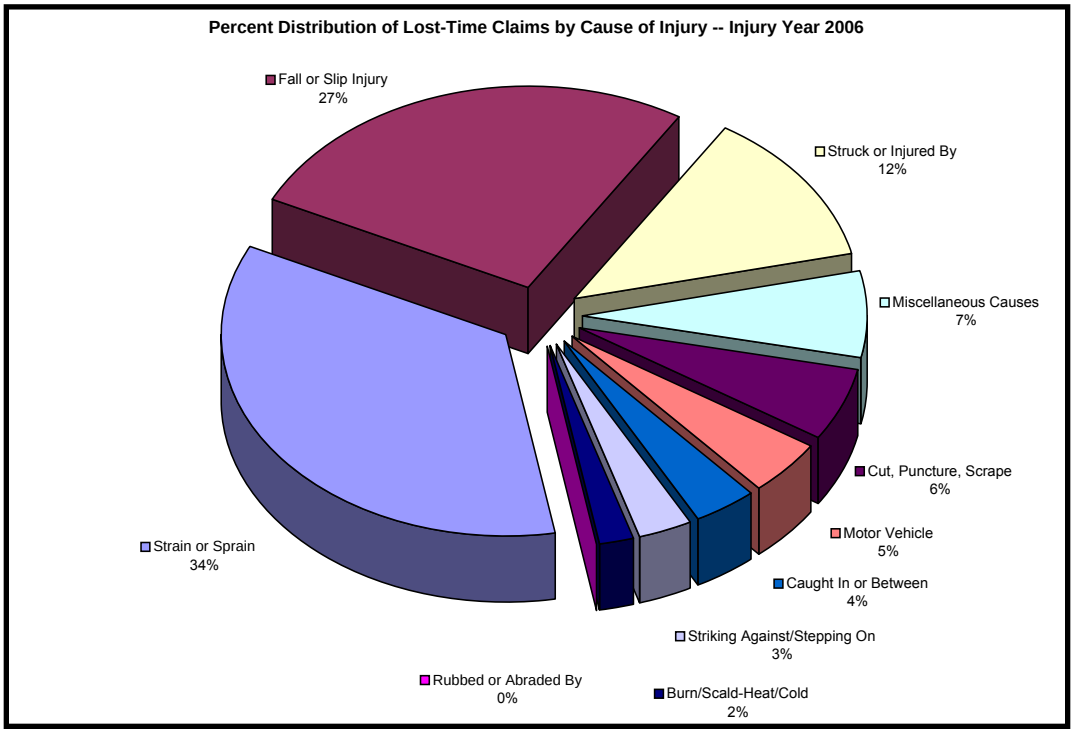
The second leading nature of workplace injury reported to the Division is an aggregate category labeled as "Other Leading Injuries." This category includes such diverse types as asphyxiation, rupture, severance, poisoning, inflammation, freezing, syncope (fainting), angina, vascular loss and foreign bodies. Collectively, these disparate types of injuries accounted for an additional 20% of workplace injuries for 2006. This figure is very near the ten year average of 20.8%, as can be seen in Graphic 50 on the following page.

Contusions, fractures, lacerations, multiple injuries, occupational diseases, hernia, burns and punctures complete the top ten natures of injury for 2006 lost-time cases, much as they have over the preceding nine-year period.

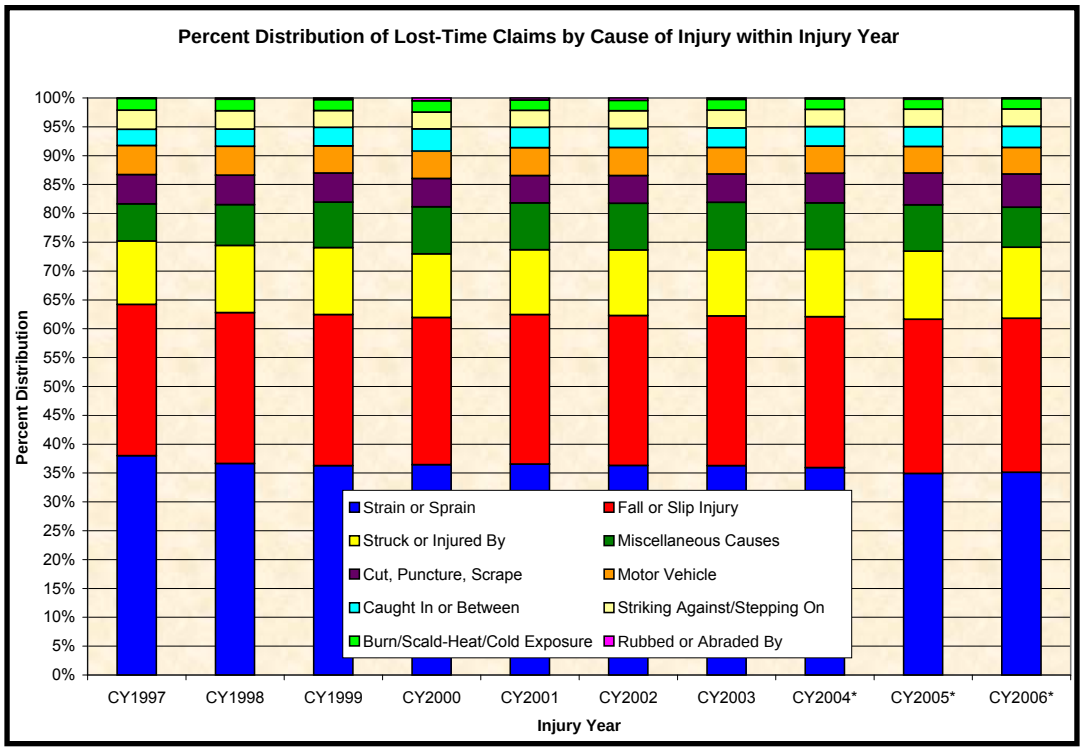


Cause of Injury

Strain or Sprain and Fall or Slip injuries were indicated as the primary cause of well over half (61%) of all lost-time injuries in 2006, as shown in Graphic 51 below. Completing the top five causes of injuries during this period were Struck or Injured By (12%), Miscellaneous Causes (7%), and Cut, Puncture or Scrape (6%).

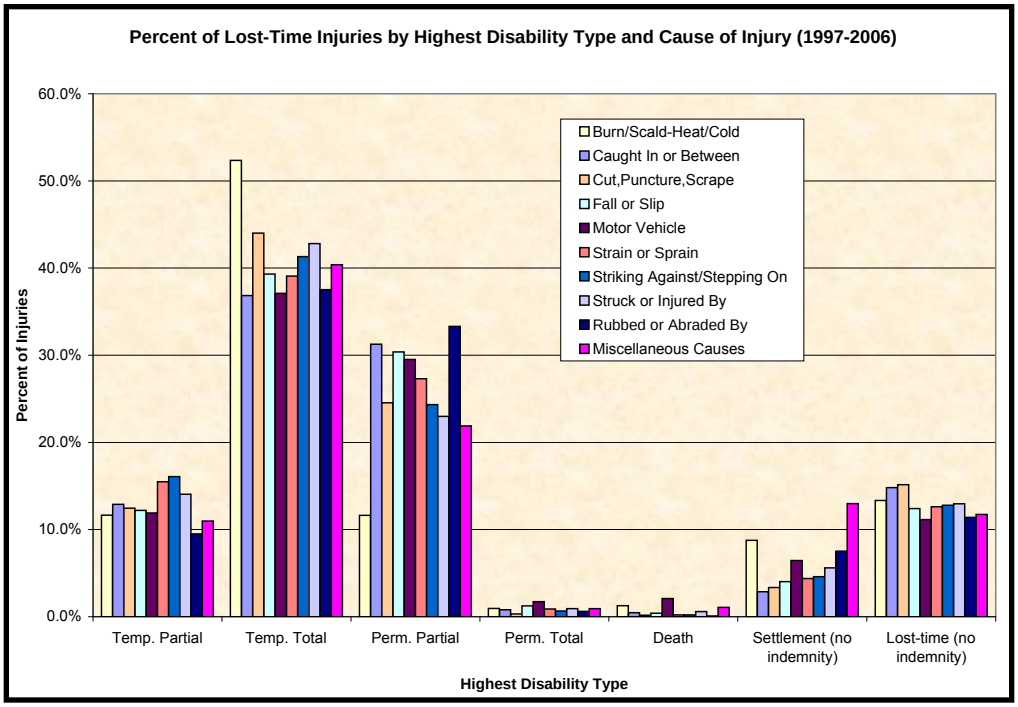


This same pattern has persisted with respect to lost-time injuries sustained over the previous nine year period as well, as evidenced in Graphic 52 below. For all injuries since 1997 that resulted in a lost-time claim, strains and sprains were identified as the principal cause of injury 36.3% of the time. Injuries caused by falls and slips were indicated as the principal cause for an additional 26.1% of these injuries. Overall, the percent of injuries by cause of injury appears to vary relatively little from year to year over the past ten years.



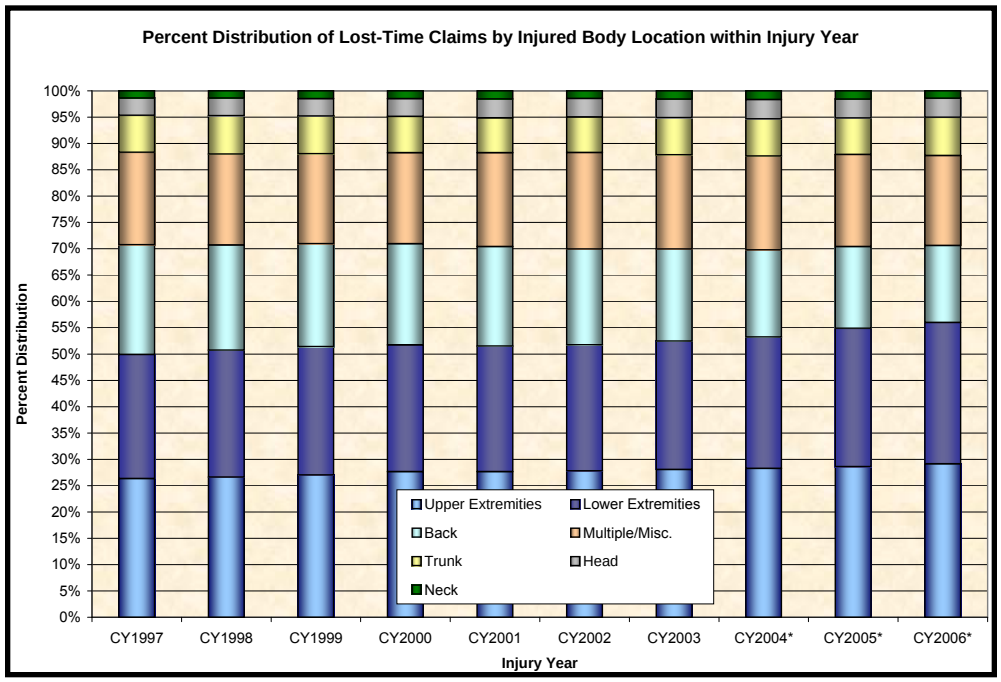
By studying Graphic 53 on the following page one can gain some understanding of the relationship between the known causes of workplace injuries and the highest types of disability to which they contribute. As can be seen in Graphic 53 a majority of lost-time claims over the ten-year period from 1997 to 2006 were awarded, at most, temporary total benefits. The next highest disability benefits awarded lost-time claimants over this period were Permanent Partial and Temporary Partial benefits, in that order.

Graphic 53 on the following page provides a breakout of all lost-time cases with an injury year between 1997 and 2006, inclusive, into the respective causes of injury, by highest disability type, and reports the percent of cases caused by each injury type that resulted in each particular disability type. This graphic illustrates, for instance, that 53.2% of all burn-related injuries eventually became Temporary Total claims. Additionally, burn-related injuries contributed relatively more to Temporary Total claims than any other category of injury, just as motor vehicle accidents appear to contribute relatively more to death cases than any other cause of injury.



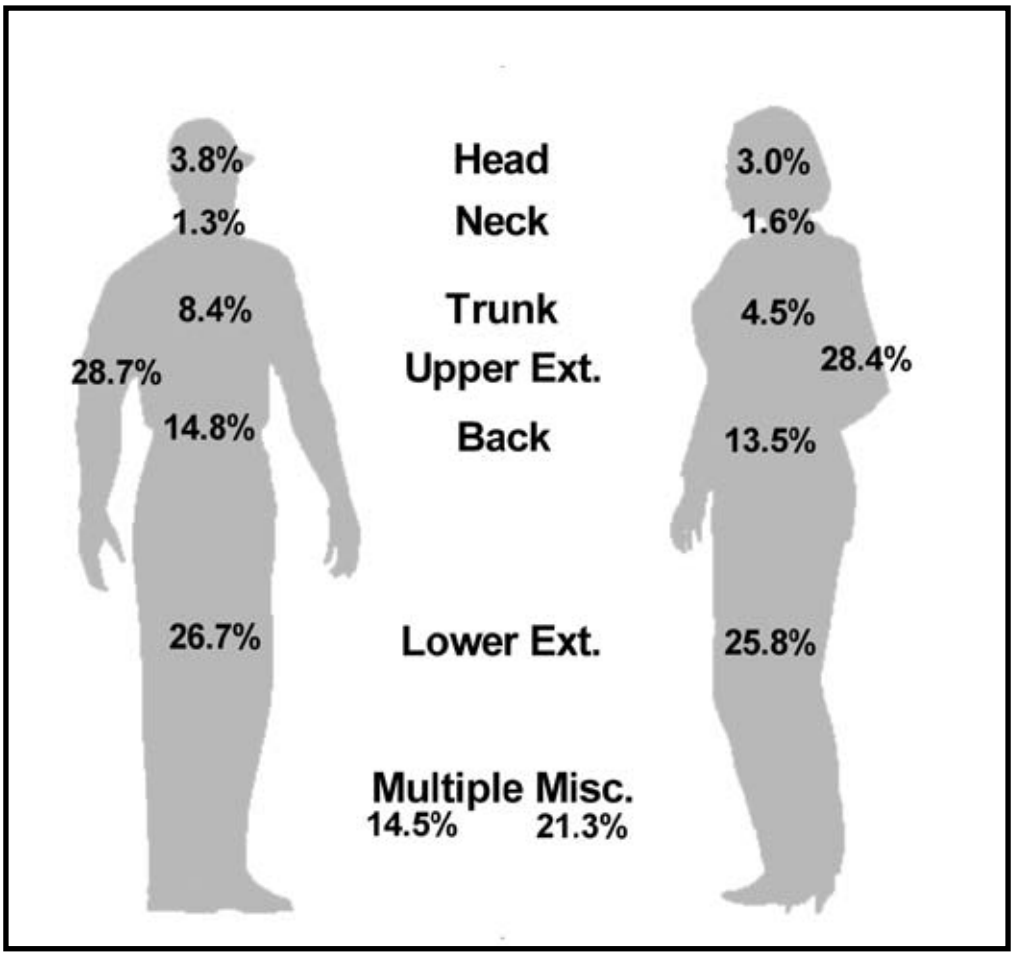
Body Location of Injury

In 2006, injuries to the upper and lower extremities held their respective positions as the leading two body locations most affected in workplace injuries during the past ten years as illustrated in Graphic 54 below. Despite issues with data maturity with respect to injuries sustained over the past three calendar years, injuries to the lower extremities have been rising slightly each year since 2001. Over the most recent ten-year period, injuries to the back appear to be declining somewhat in both absolute and relative terms. Whereas injuries to regions of the back accounted for 20.8% of all reported lost-time injuries that occurred in 1997, similar injuries in 2004 were similarly reported in only 16.5% of lost-time injuries. Correspondingly, injuries to the upper extremities have been somewhat flat over the past ten years in absolute terms, but since lost-time claims levels are somewhat lower now than ten years ago, the relative importance of injuries to the upper extremities appears to be increasing somewhat.



With respect to body location of injury, most workplace injuries do not discriminate with respect to gender; however a few differences are notable. Generally, men and women suffer injuries in relatively equal proportions to the various regions of the body. The two top injury sites for men injured in 2006 were the lower back (13.7%) and multiple body parts (12.9%). For women injured during this same year, this order is reversed; the top injury sites for women were “multiple body parts,” (19.9%), followed by the lower back (12.4%). Men also appear to experience finger injuries relatively more frequently than women with 6.6% of all injuries among men indicating the fingers, as opposed to just 3.4% of all injuries to women indicating the same. Women, on the other hand, seem to experience wrist injuries at a somewhat higher rate (5.0%) than men (2.8%). Relative comparisons between the two genders for grouped body locations can be seen in Graphic 55 below.

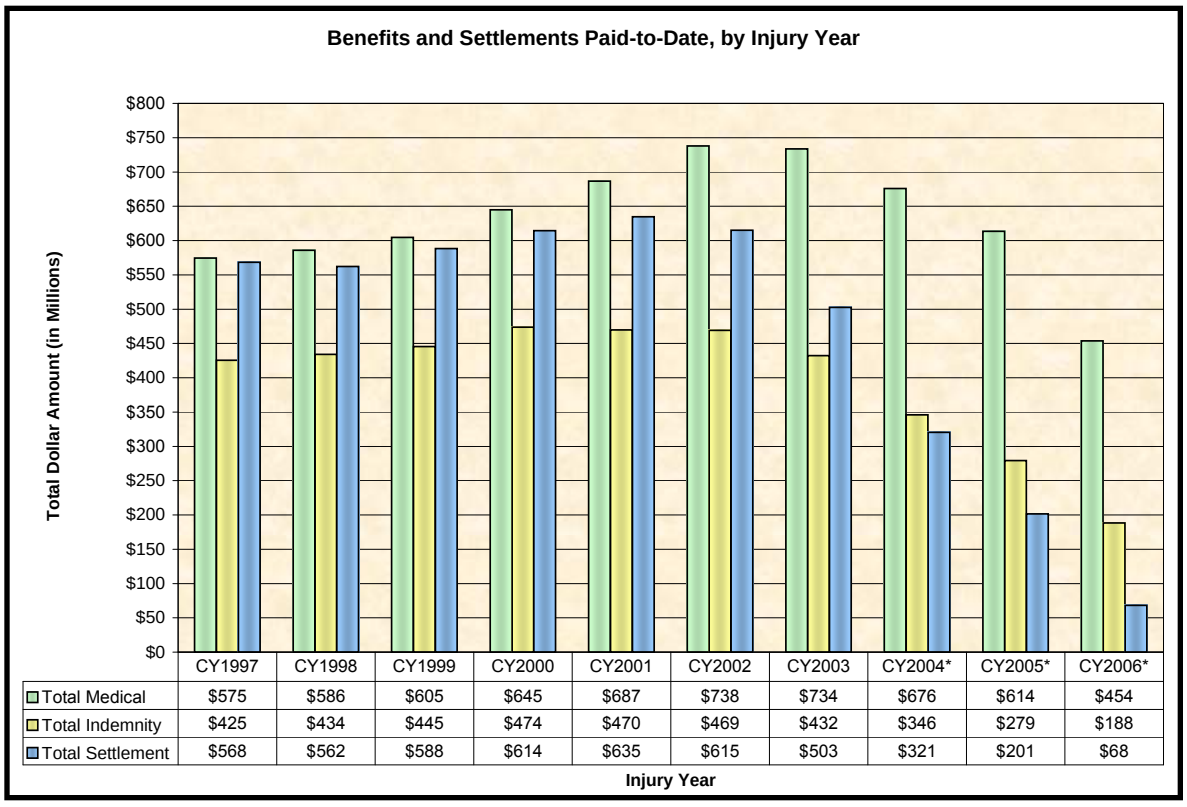
Body Location of Injury by Gender



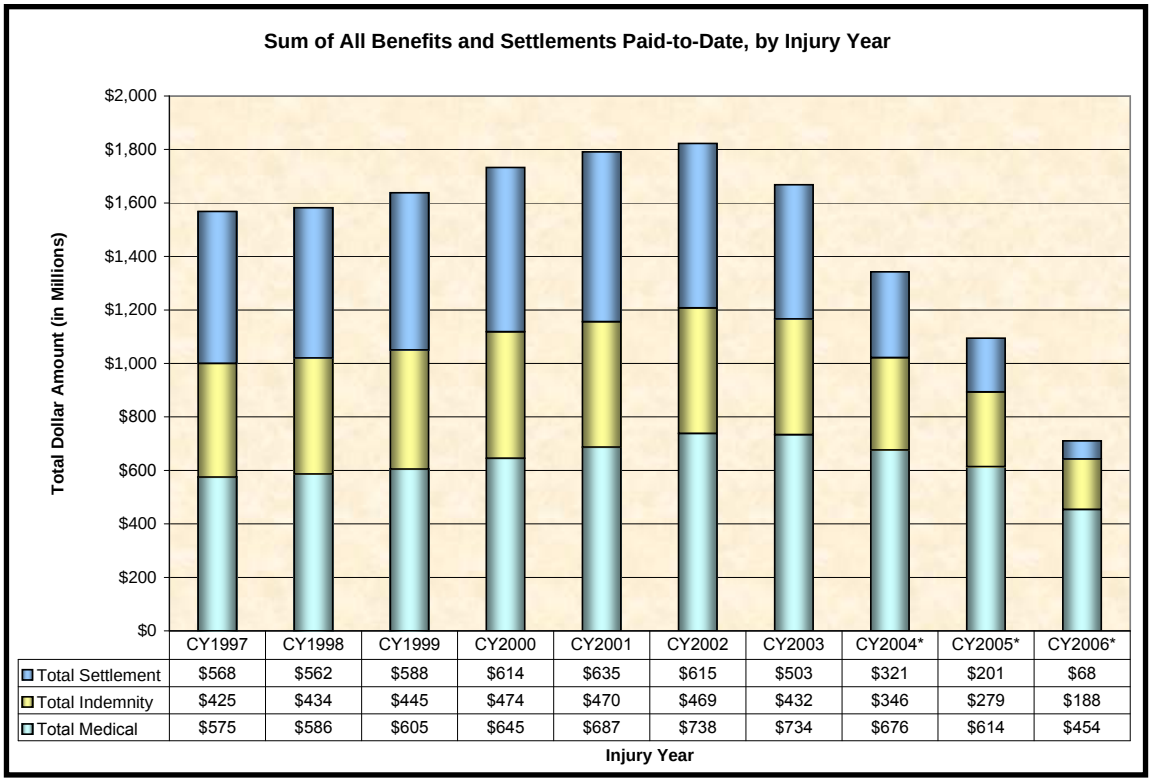
Benefits Paid

As the result of a compensable workplace injury, each covered employee may be entitled to receive certain medical as well as indemnity benefits. Indemnity benefits are payments intended to replace a portion of an injured worker's wages. In addition to indemnity benefits, the law also requires employers to provide necessary medical treatment for the period of recovery. In some cases the employee will receive these benefits over a period of time. In others, the employee may be eligible to receive these benefits as a single, lump-sum amount. Lump-sum payouts are classified as "settlements" and may include compensation for medical, indemnity or both. The combined payments for indemnity, medical, and settlement benefits comprise the total of workers' compensation benefits available to injured workers

Graphic 56 below shows the total dollar amounts paid by benefit type as reported to the Division as of June 30, 2007 for accident years 1997 to 2006. While Graphic 57 on the following page also illustrates total dollar amounts paid by benefits type, it illustrates more clearly the combined totals by accident year. Graphic 56 below reports the totals for all categories in each injury year. Here, one can easily see that medical benefits have continued to form the largest relative portion of total benefits over the past ten years. However, the medical benefits reported here only include amounts paid on lost-time claims; they do not include amounts paid on medical-only claims or claims not otherwise reported to the Division. Given that the sum of all medical bills submitted to the Division during the fiscal year ending June 30, 2007 puts the actual total of annual medical expenditures at over $1.3 billion, the medical amounts reported to the Division on lost-time claims cost reports may only comprise roughly 50% of the actual total.

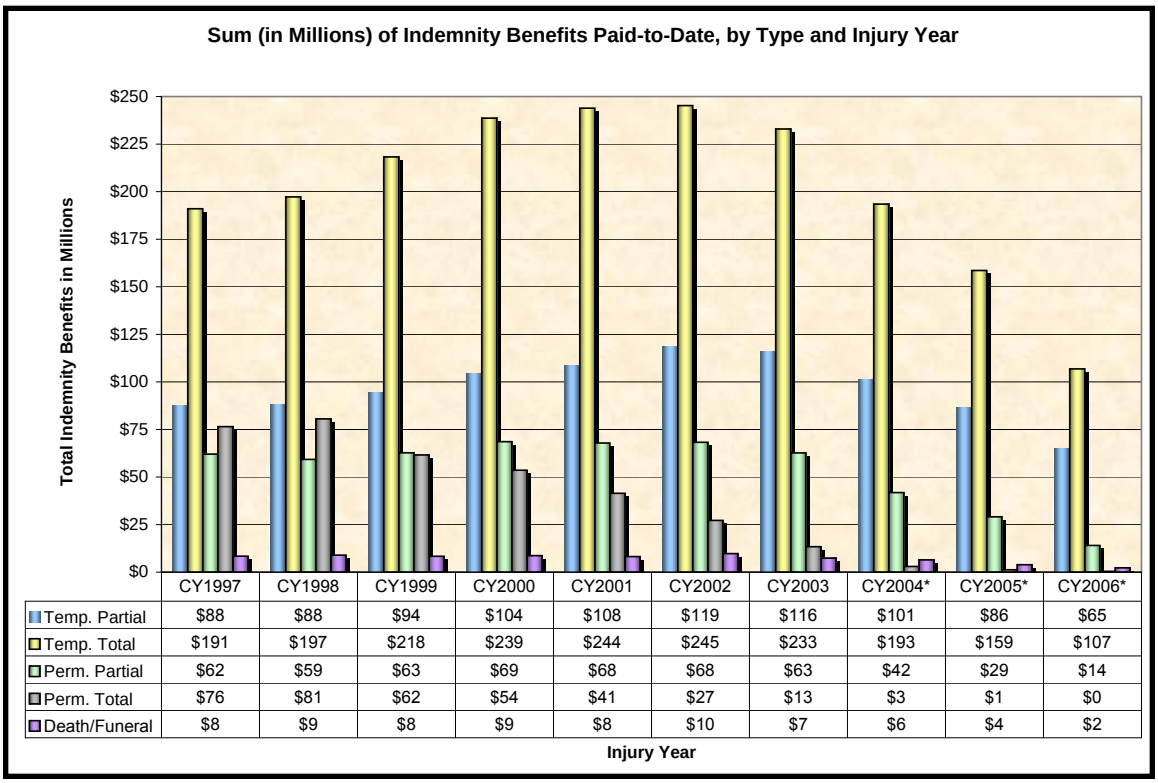


	CY1997	CY1998	CY1999	CY2000	CY2001	CY2002	CY2003	CY2004*	CY2005*	CY2006*
Total Medical	$575	$586	$605	$645	$687	$738	$734	$676	$614	$454
Total Indemnity	$425	$434	$445	$474	$470	$469	$432	$346	$279	$188
Total Settlement	$568	$562	$588	$614	$635	$615	$503	$321	$201	$68



	CY1997	CY1998	CY1999	CY2000	CY2001	CY2002	CY2003	CY2004*	CY2005*	CY2006*
Total Settlement	$568	$562	$588	$614	$635	$615	$503	$321	$201	$68
Total Indemnity	$425	$434	$445	$474	$470	$469	$432	$346	$279	$188
Total Medical	$575	$586	$605	$645	$687	$738	$734	$676	$614	$454

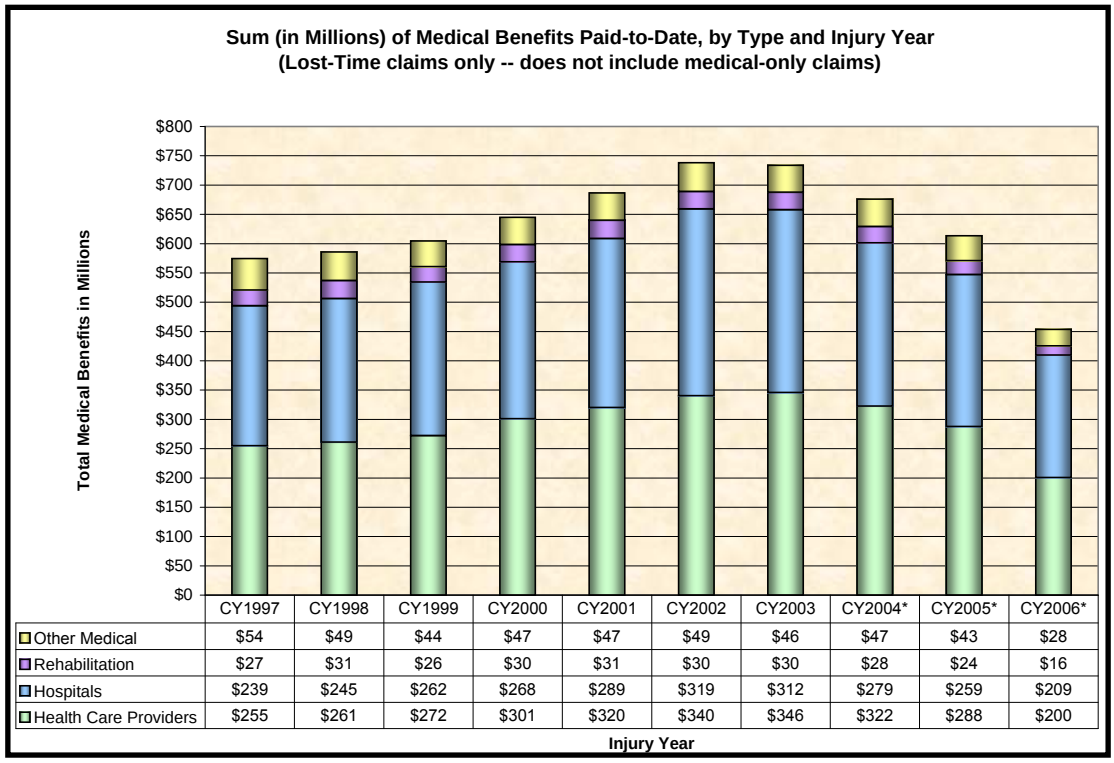
As illustrated in Graphic 58 below, the total amount paid for Temporary Total benefits on lost-time injuries that occurred from 1997 to 2006 tops $2 billion and accounts for slightly more than half (51%) of total indemnity benefits paid on claims over this period. Temporary Partial benefits account for an additional 24%, with Permanent Partial, Permanent Total, and Death benefits accounting for the balance.



	CY1997	CY1998	CY1999	CY2000	CY2001	CY2002	CY2003	CY2004*	CY2005*	CY2006*
Temp. Partial	$88	$88	$94	$104	$108	$119	$116	$101	$86	$65
Temp. Total	$191	$197	$218	$239	$244	$245	$233	$193	$159	$107
Perm. Partial	$62	$59	$63	$69	$68	$68	$63	$42	$29	$14
Perm. Total	$76	$81	$62	$54	$41	$27	$13	$3	$1	$0
Death/Funeral	$8	$9	$8	$9	$8	$10	$7	$6	$4	$2

Medical Costs

A breakdown of medical payments by type and injury year can be seen in Graphic 59 below. The problems associated with data maturity are easily visible for at least the past three calendar years. Over the mature data period of 1997 to 2003, however, total medical payments on lost-time accidents occurring during this timeframe as reported on Claim Cost Report (DWC-13) forms have increased at an approximate rate of $33 million per injury year. Health care providers and hospitals account for the majority of these medical expenses, at a ten-year average of 46% and 42% of the total, respectively. The relative proportion of medical expenses allocated among the various provider types does not change appreciably from year to year.

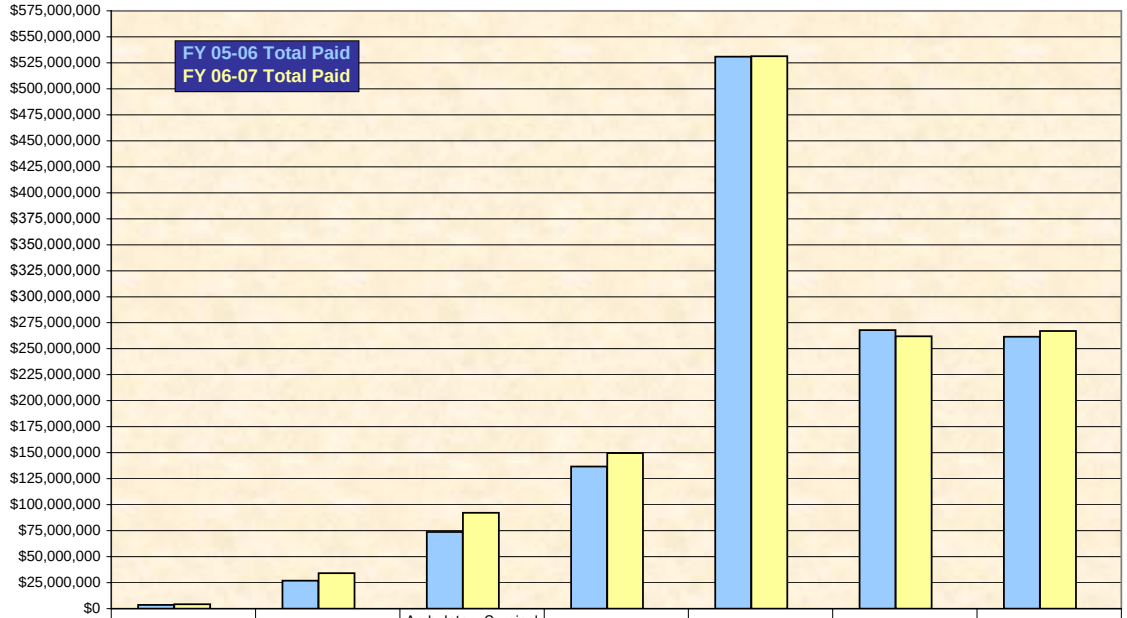


	CY1997	CY1998	CY1999	CY2000	CY2001	CY2002	CY2003	CY2004*	CY2005*	CY2006*
Other Medical	$54	$49	$44	$47	$47	$49	$46	$47	$43	$28
Rehabilitation	$27	$31	$26	$30	$31	$30	$30	$28	$24	$16
Hospitals	$239	$245	$262	$268	$289	$319	$312	$279	$259	$209
Health Care Providers	$255	$261	$272	$301	$320	$340	$346	$322	$288	$200

Medical Billing Data

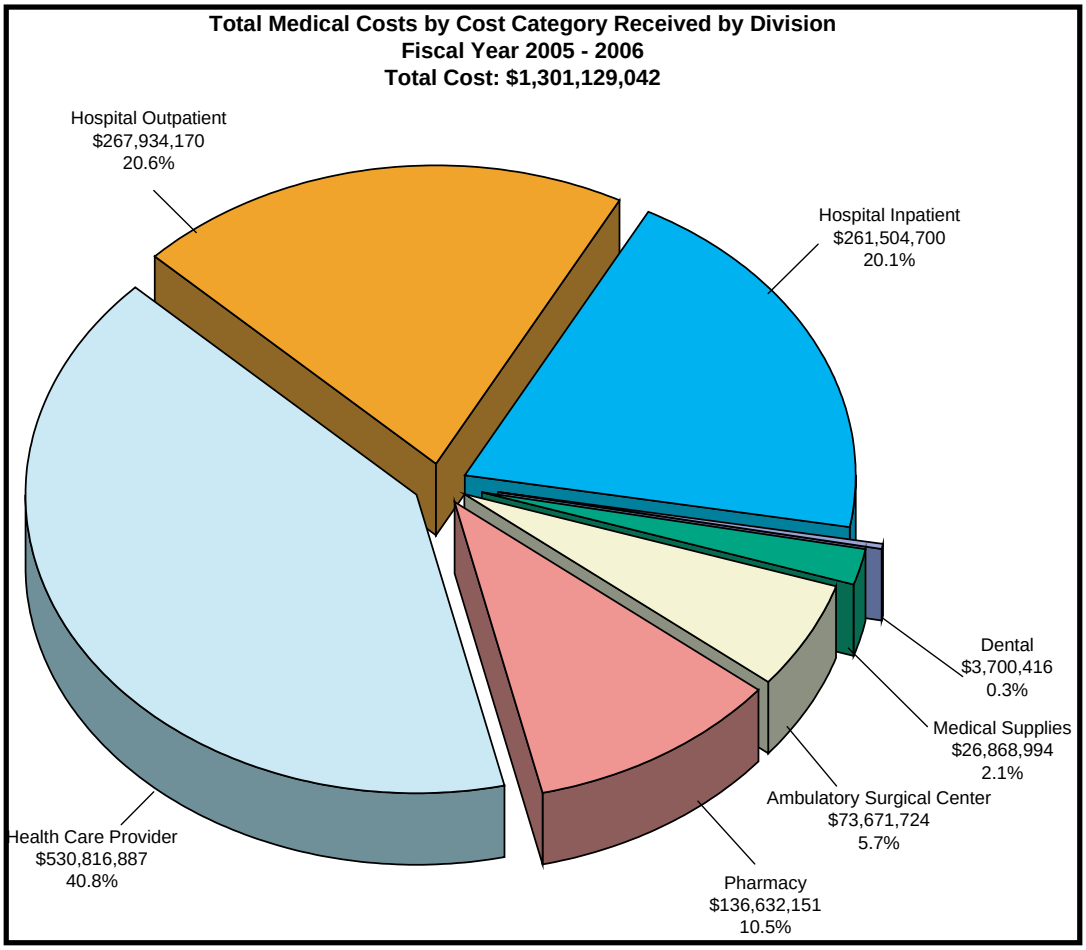
Medical billings for treating injured workers during FY 2005-2006 and 2006-2007 regardless of the date of accident, totaled $1,301,316,412 and $1,340,619,977, respectively, as illustrated in Graphic 60 below. This represents a 3% increase in FY 2006-2007 over the prior fiscal year. Health care providers comprised almost 40% of the total reimbursement with approximately $530.8 million during each fiscal year. Hospital costs remained relatively constant at $531 million, with outpatient costs decreasing 2% from $268 to $262 million, and inpatient costs increasing 2% from $262 to $267 million. Ambulatory surgical center costs increased by 24% from $74 to $92 million, pharmacy costs increased by 9% from $137 to $150 million and medical supply costs increased by 27% which is the largest category increase during FY 2006-2007 compared to the previous fiscal year. Dental costs continue to comprise less than 1% of total medical costs.

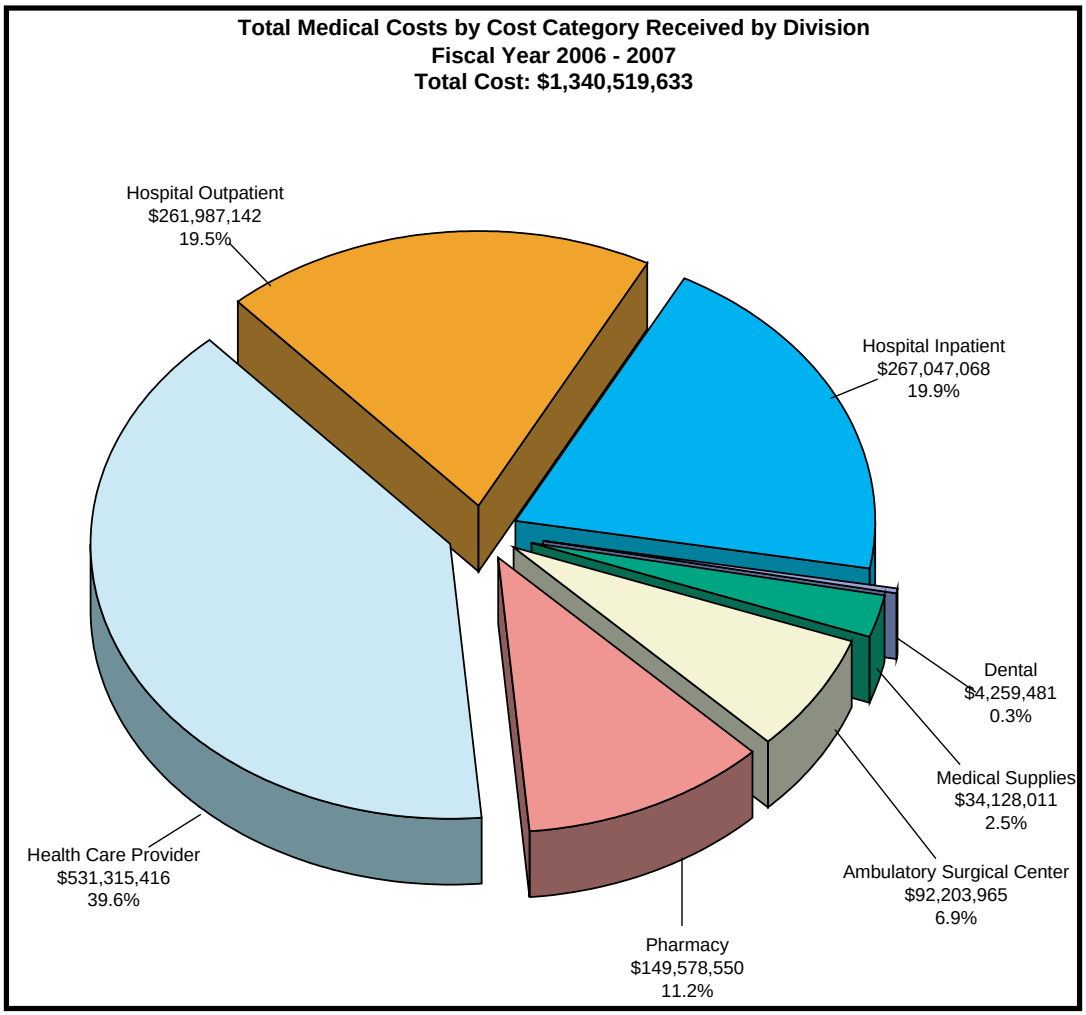
Total Medical Costs by Cost Category Submitted During Fiscal Year 2005-2006 and 2006-2007



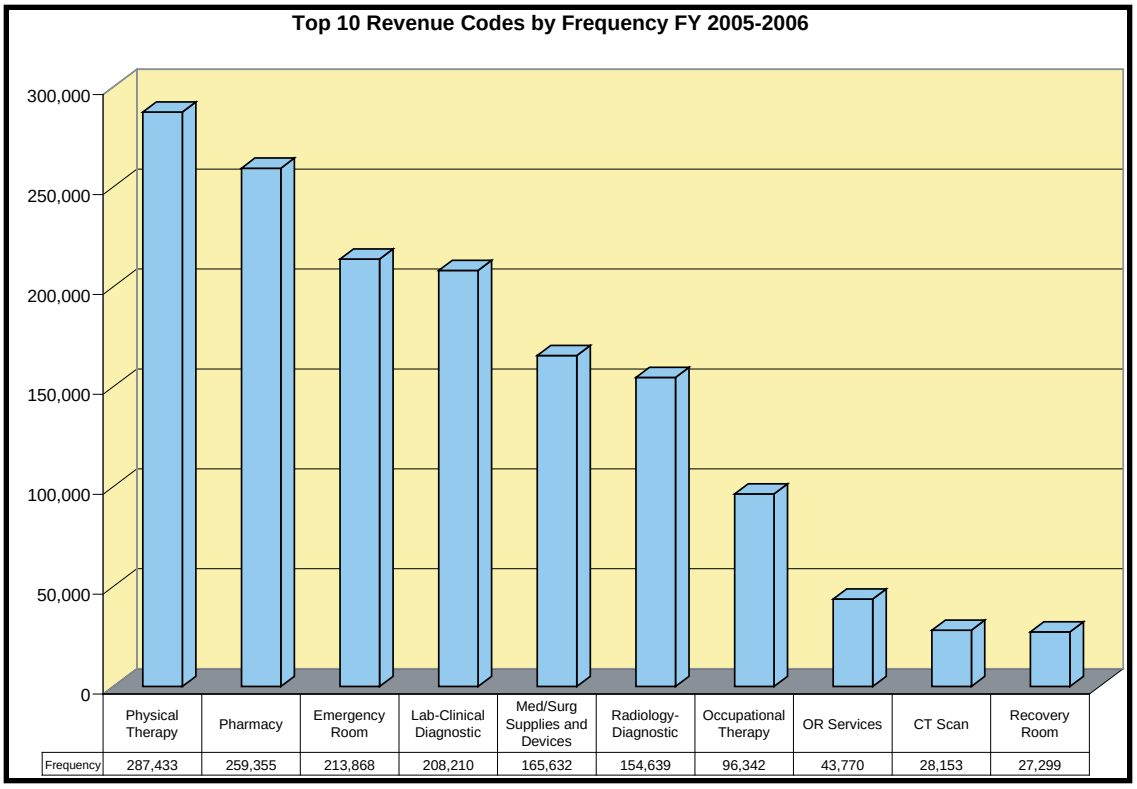
	Dental	Medical Supplies	Ambulatory Surgical Center	Pharmacy	Health Care Provider	Hospital Outpatient	Hospital Inpatient
FY05-06 Total Paid	$3,700,416	$26,868,994	$73,671,724	$136,632,151	$530,816,887	$267,934,170	$261,504,700
Percent of FY05-06 Total Paid	0.3%	2.1%	5.7%	10.5%	40.8%	20.6%	20.1%
FY06-07 Total Paid	$4,259,480	$34,128,011	$92,203,965	$149,578,550	$531,315,416	$261,987,142	$267,047,068
Percent of FY06-07 Total Paid	0.3%	2.5%	6.9%	11.2%	39.6%	19.5%	19.9%

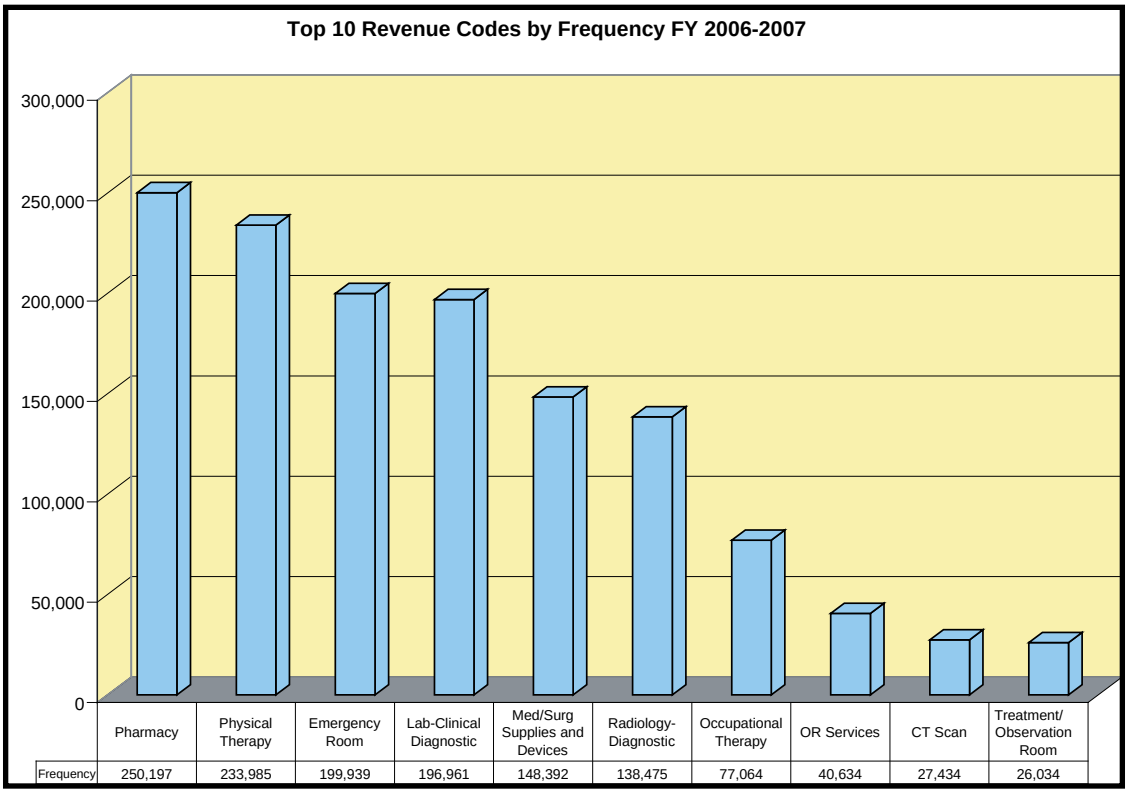
Graphics 61 and 62 on the following page depict the same information as Graphic 60 in separate pie charts.


Total Medical Costs by Cost Category Received by Division
Fiscal Year 2005 - 2006
Total Cost: $1,301,129,042
Hospital Outpatient
$267,934,170
20.6%
Hospital Inpatient
$261,504,700
20.1%
Dental
$3,700,416
0.3%
Medical Supplies
$26,868,994
2.1%
Ambulatory Surgical Center
$73,671,724
5.7%
Pharmacy
$136,632,151
10.5%
Health Care Provider
$530,816,887
40.8%


Total Medical Costs by Cost Category Received by Division
Fiscal Year 2006 - 2007
Total Cost: $1,340,519,633
Hospital Outpatient
$261,987,142
19.5%
Hospital Inpatient
$267,047,068
19.9%
Dental
$4,259,481
0.3%
Medical Supplies
$34,128,011
2.5%
Ambulatory Surgical Center
$92,203,965
6.9%
Pharmacy
$149,578,550
11.2%
Health Care Provider
$531,315,416
39.6%

Graphics 63 and 64 on the following page show the top ten hospital revenue codes by frequency that were billed by hospitals during FY 2005-2006 and FY 2006-2007. While there has been an overall decrease in the frequency of line items for most of the top ten hospital revenue codes, the top ten lists are the same with the exception of Treatment/Observation Room replacing Recovery Room as the tenth most frequently charged revenue code during FY 2006-2007. Pharmacy replaced Physical Therapy as the most frequently used revenue code during FY 2006-2007 with a frequency of 250,197 line item charges. During both fiscal years, Emergency Room was the third most frequent revenue code followed by Lab-Clinical Diagnosis. The fifth most frequent revenue code for both fiscal years was for Medical/Surgical Supplies and Devices which includes charges for surgical implants, as well as supplies and prosthetic/orthotic devices. The order for Diagnostic Radiology, Occupational Therapy, Operating Room Services and CT Scan remains unchanged during both fiscal years.





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Tasha Carter, Bureau Chief

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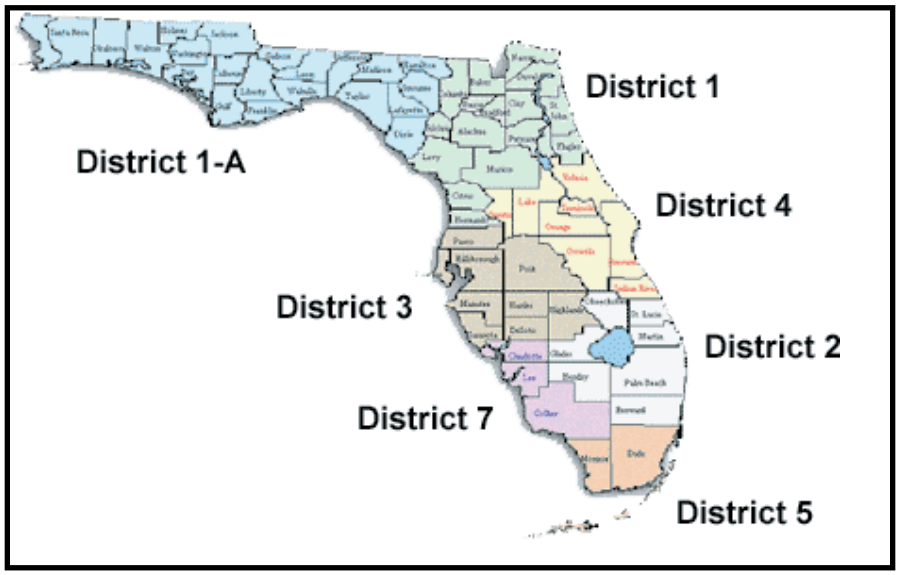
Employee Assistance Office Hotline: (800) 342-1741
Customer Service Center: (850) 413-1601

Bureau of Compliance District Offices



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