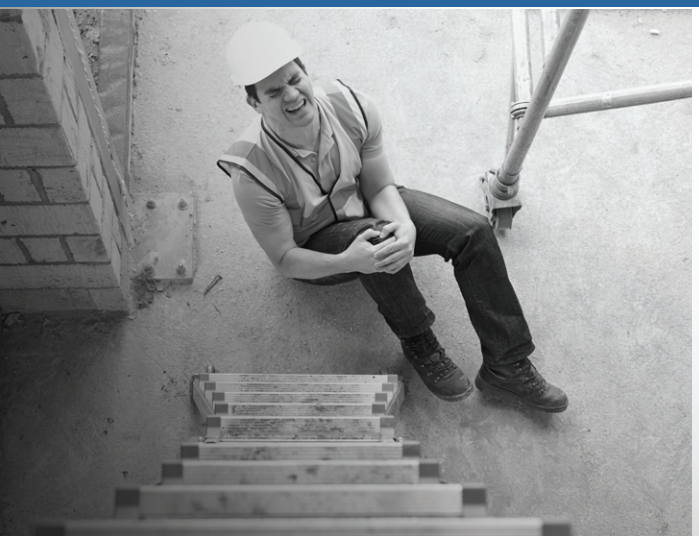


2015 RESULTS AND ACCOMPLISHMENTS REPORT

JEFF ATWATER | CHIEF FINANCIAL OFFICER | DEPARTMENT OF FINANCIAL SERVICES



DEPARTMENT OF FINANCIAL SERVICES MISSION STATEMENT

To safeguard the integrity of the transactions entrusted to the Department of Financial Services and to ensure that every program within the Department delivers value to the citizens of Florida by continually improving the efficiency and cost effectiveness of internal management processes and regularly validating the value equation with our customers.

DIVISION OF WORKERS' COMPENSATION MISSION STATEMENT

To actively ensure the self-execution of the workers' compensation system through educating and informing all stakeholders of their rights and responsibilities, leveraging data to deliver exceptional value to our customers and stakeholders, and holding parties accountable for meeting their obligations.

DIRECTOR'S MESSAGE

To Stakeholders and other Interested Parties of Florida's Workers' Compensation System:

We are pleased to present the Division of Workers' Compensation 2015 Results and Accomplishments Report. This report contains pertinent data and information about Florida's workers' compensation system and the regulatory activities of the Division for Fiscal Year 2014/15. We continually challenge ourselves and engage stakeholders to find innovative solutions to improve the self-execution of the system.

As stated in our Mission Statement, educating and informing stakeholders of their rights and responsibilities, and holding parties accountable for meeting their obligations are cornerstones of our regulatory efforts. Throughout this year's report, you will learn of innovative ways our program areas leverage technology and data to fulfill our statutory duties in the most cost-effective manner as possible. You will also find multiple examples of the Division's emphasis on educating the many stakeholders of Florida's workers' compensation system.

To highlight one very successful educational initiative, our Self-Insurance Unit developed a new program to improve self-insurers' reporting payroll and classification data to the Division. The three-pronged educational program was attempting to improve the accuracy of reporting overtime payroll, executive officer payroll, and classification codes. As a result of our industry training efforts, the accuracy of this data reported to the Division increased by 25%.

We welcome any suggestions and comments, as we continue to search for meaningful ways to improve the performance of the workers' compensation system for all stakeholders.

Sincerely,

E. Tanner Holloman

Tanner Holloman, Director
Division of Workers' Compensation

DIVISION OF WORKERS' COMPENSATION
2015 RESULTS & ACCOMPLISHMENTS REPORT

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Note: All data contained herein were extracted from the Division of Workers' Compensation resources as of 6/30/15, unless otherwise noted.

BUREAU OF COMPLIANCE

The Bureau of Compliance (BOC) is tasked with the responsibility of ensuring employers comply with statutory obligations to obtain workers' compensation insurance coverage for employees. To accomplish this mission BOC conducts investigations and issues enforcement actions in accordance with Section 440.107, Florida Statutes; processes workers' compensation exemptions to qualified applicants in accordance with Section 440.05, Florida Statutes; and provides educational outreach and training to employers and insurance industry representatives on workers' compensation coverage laws.

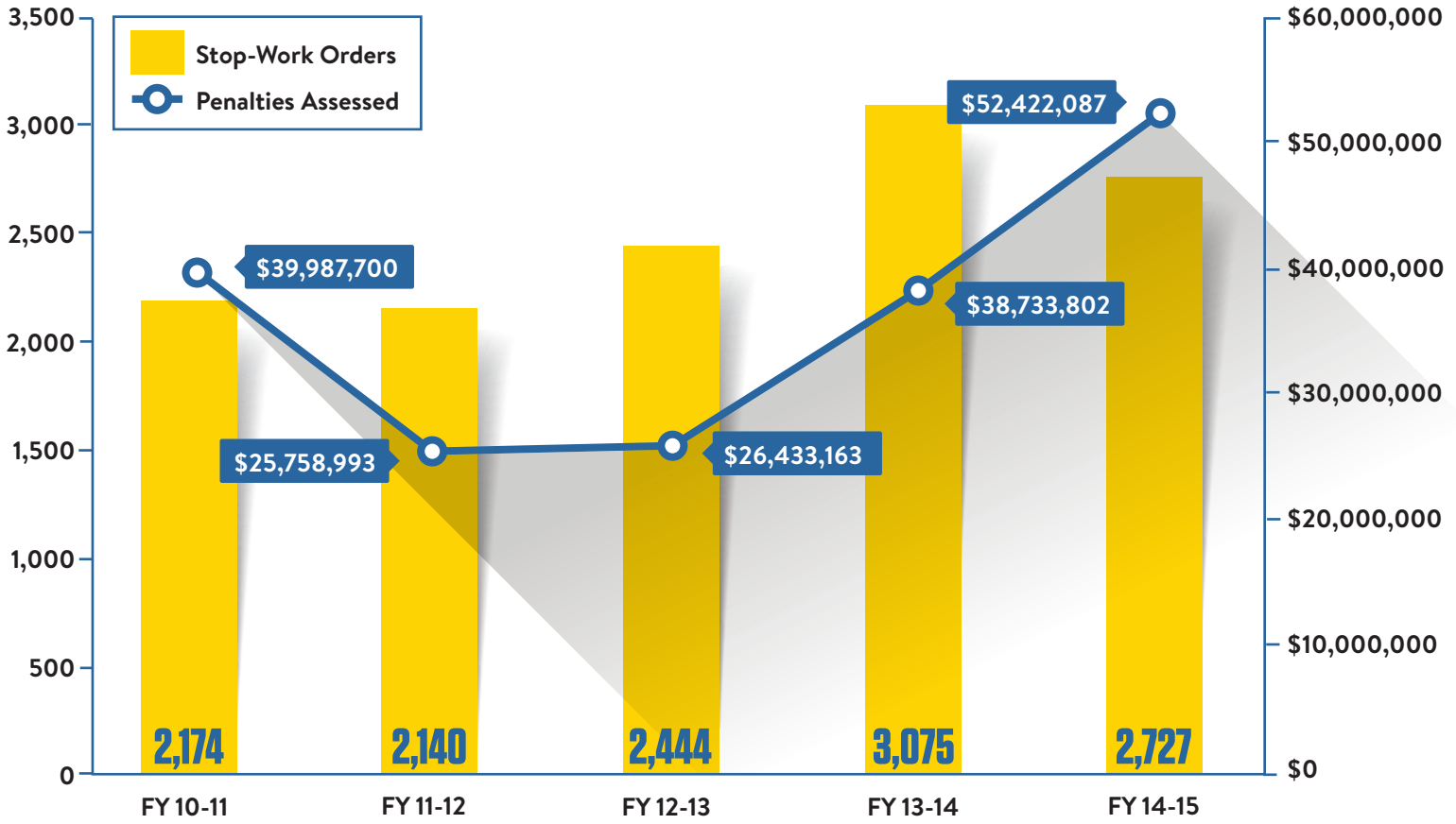
During Fiscal Year 2014-2015, BOC processed 99% of online exemption filings within 5 days of receipt; utilized data from various agencies to identify and successfully target non-compliant employers; investigated 1,794 public referrals alleging non-compliance; conducted 48 seminars and 23 webinars on workers' compensation and workplace safety for over 2,522 employers statewide.

Investigators conduct physical, on-site inspections of an employer's job-site or business location to determine compliance with workers' compensation coverage requirements. The total number of investigations conducted each year has held steady during the last 5 fiscal years.

INVESTIGATIONS CONDUCTED

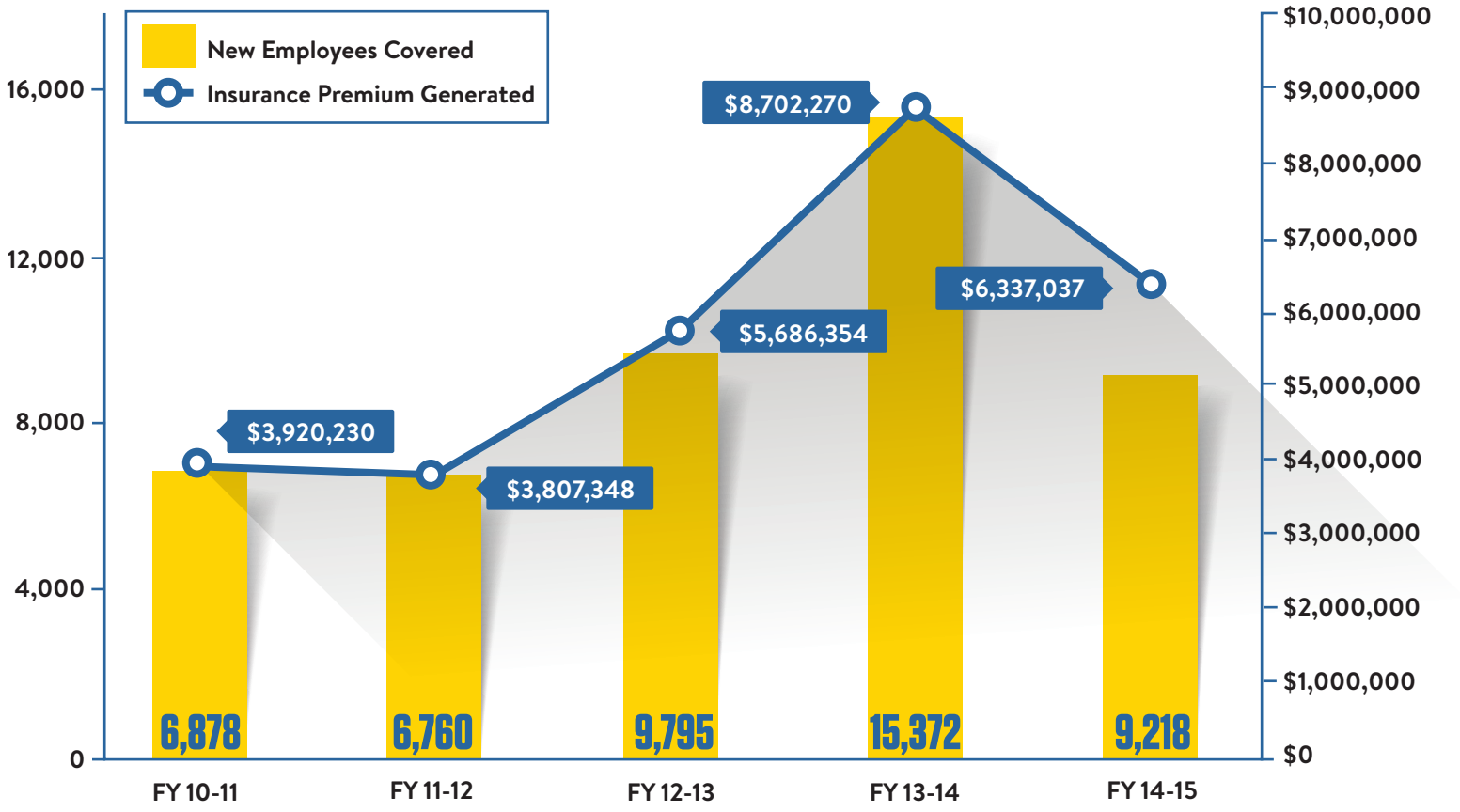
FY 10-11	34,252
FY 11-12	34,780
FY 12-13	34,150
FY 13-14	35,294
FY 14-15	34,282

STOP-WORK ORDERS ISSUED & PENALTIES ASSESSED



The number of Stop-Work Orders have generally increased during the last several years. The assessed penalties have increased due to employers lacking payroll records, which results in the Division imputing employers' payrolls pursuant to section 440.107(7)(a), F.S.

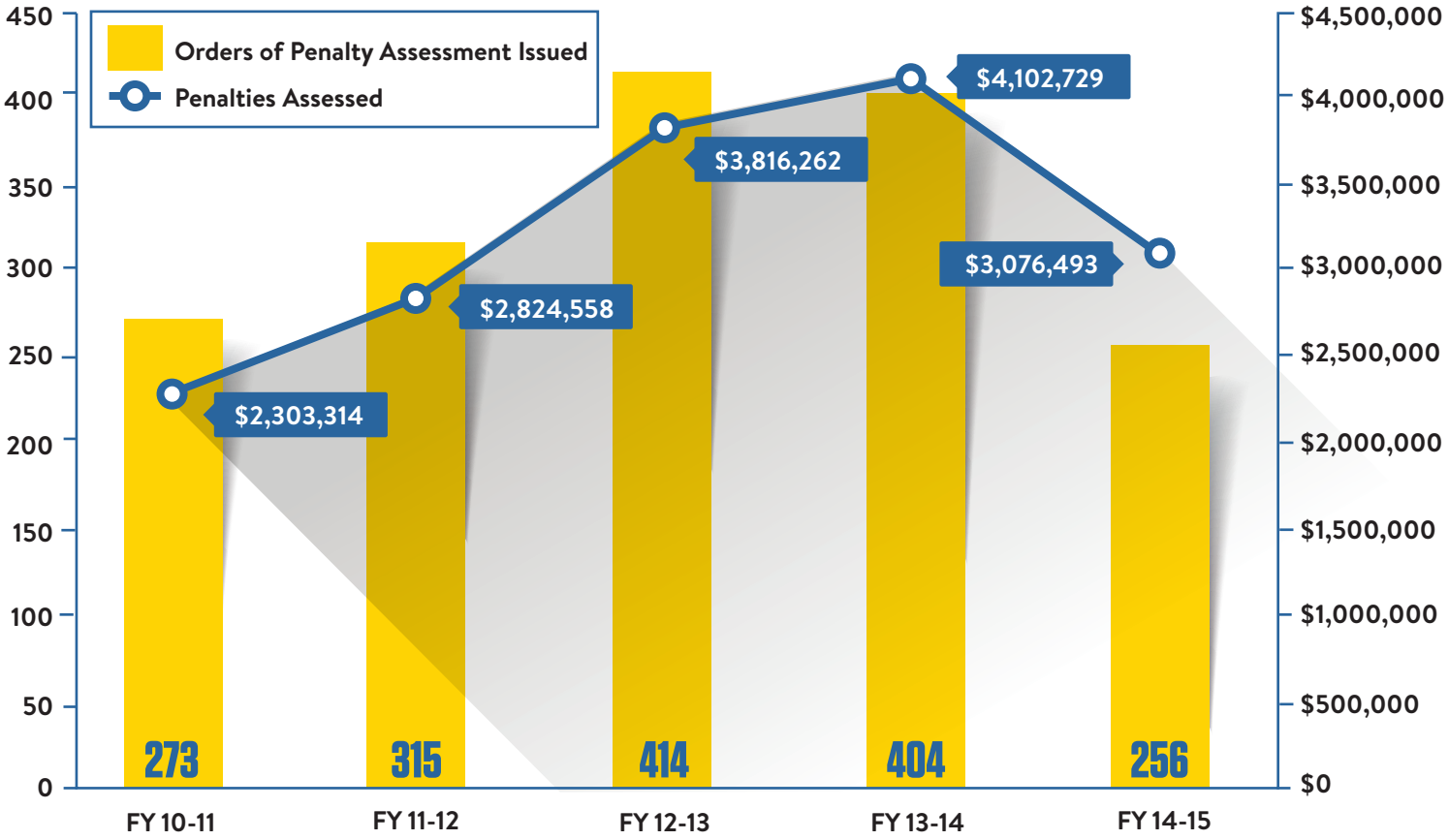
NEW EMPLOYEES COVERED AND INSURANCE PREMIUM GENERATED BASED UPON STOP-WORK ORDERS ISSUED



This graph illustrates the number of employees covered as a direct result of the Bureau's enforcement efforts and issuance of Stop-Work Orders and the monies added to the workers' compensation premium base that had been previously evaded.

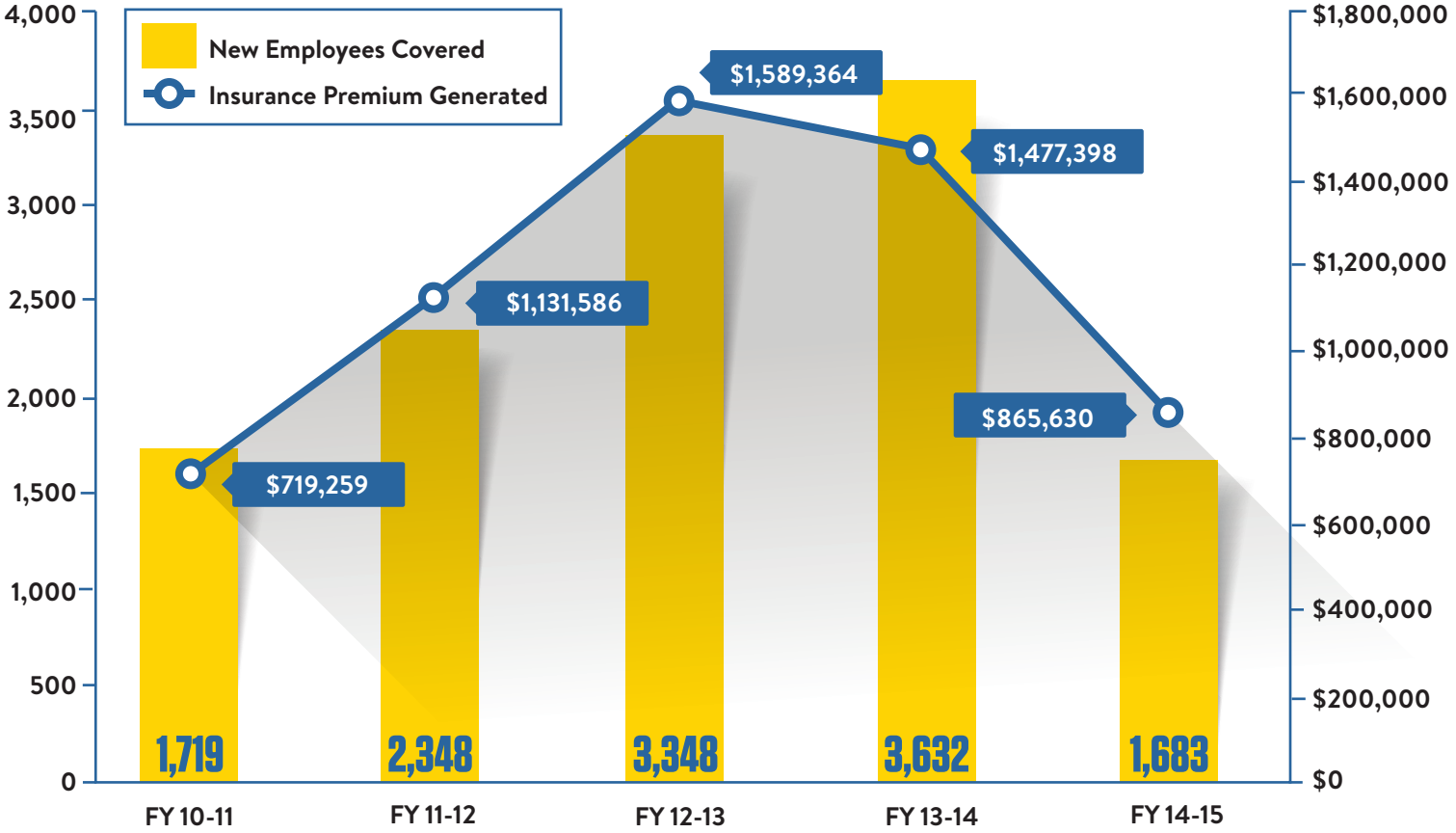
Orders of Penalty Assessment are issued when the employer obtains coverage as a result of the initiation of an investigation which negates the issuance of a Stop-Work Order.

ORDERS OF PENALTY ASSESSMENT & PENALTIES ASSESSED



This chart illustrates the volume of Orders of Penalty Assessments issued and penalties assessed.

NEW EMPLOYEES COVERED AND INSURANCE PREMIUM GENERATED BASED UPON ORDERS OF PENALTY ASSESSMENT

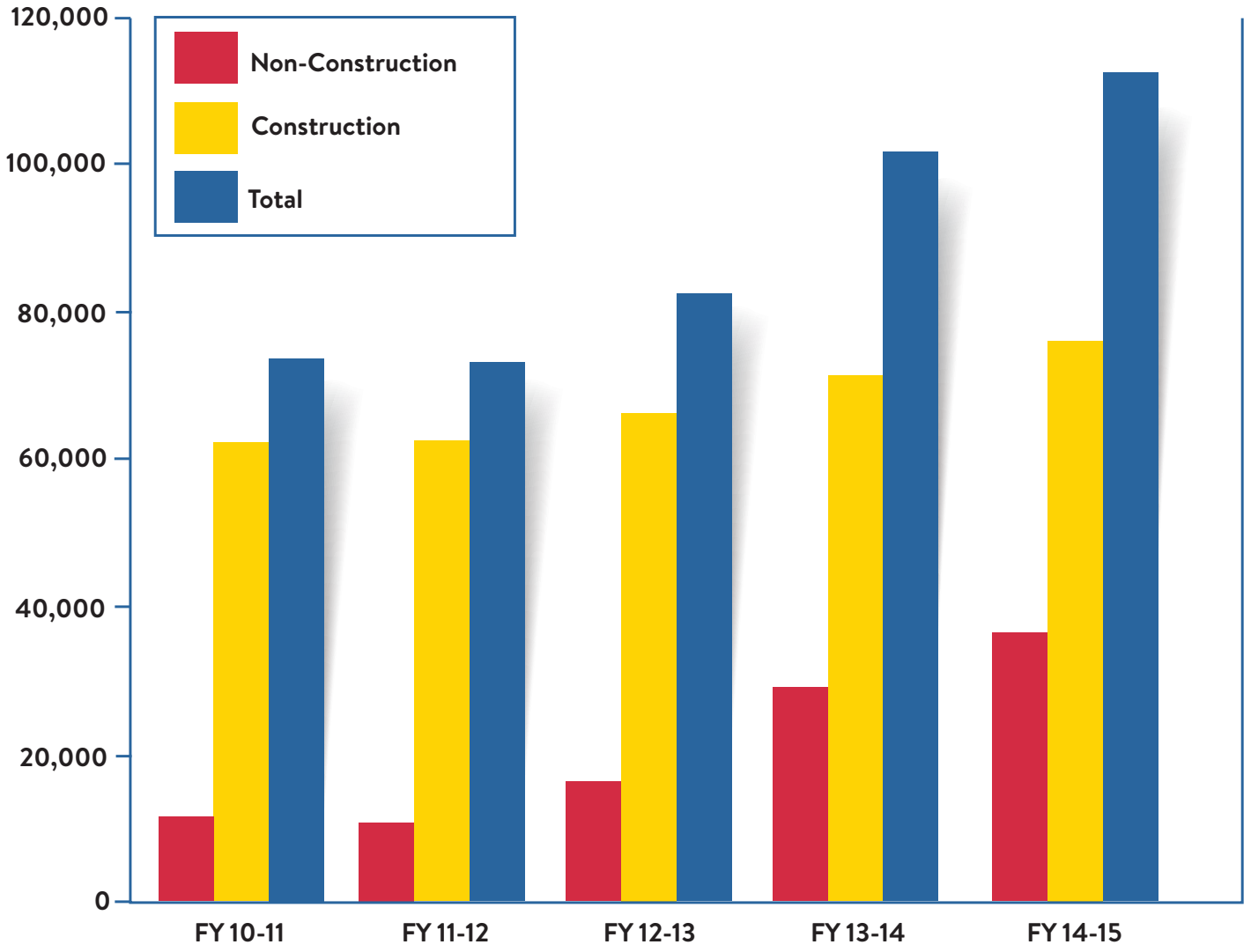


This chart illustrates the new employees covered and premium generated as a result of those Orders after the employers purchased workers' compensation insurance.

EXEMPTION APPLICATIONS PROCESSED

The increase in construction industry exemptions is reflective of the general improvement in Florida's economy and in the construction industry in particular.

The rise in non-construction exemptions is due to the statutory change that defines non-construction limited liability company members as "corporate officers". Corporate officers are employees but are allowed to exempt themselves.



Several key initiatives are allowing the Division to focus its investigative efforts on identifying non-compliant employers to maximize its resources for the benefit of the citizens of this state.

The Division utilizes several available data sources to identify non-compliant employers. This effort includes the use of information and data from other state agencies. For example, by utilizing payroll and employee information provided from the Department of Revenue to cross match with the Division's policy data, the Division is able to create lists of suspected non-compliant employers. The Division also reviews policy cancellation information to identify employers whose policies have been cancelled and no subsequent coverage has been obtained. Lastly, the Division acquires county and city permitting information to identify jobsites where construction activity may be occurring.

Employers identified as potentially non-compliant via our data sources listed above, are notified of the workers' compensation requirements and the penalties for failure to secure workers' compensation. Those employers that do not secure coverage following the notification are referred for investigation.

The Division conducted 2 state-wide construction sweeps, which resulted in 1,203 construction site visits, 1,928 employer investigations, and 123 enforcement actions.

BUREAU OF EMPLOYEE ASSISTANCE AND OMBUDSMAN OFFICE

The Bureau of Employee Assistance and Ombudsman Office (EAO), established pursuant to Section 440.191, Florida Statutes, assists injured workers, employers, carriers, health care providers, and managed care arrangements in fulfilling their responsibilities under the Workers' Compensation Law. A resource for all stakeholders in the Workers' Compensation System, EAO combines the use of print and electronic media, one-on-one interaction with individual shareholders, and group presentations to promote the self-execution of the system.

EAO relies on a team structure to successfully accomplish its mission. Each team focuses on a specific area of statutory responsibility in order to effectively assist injured workers. The EAO distributes workers' compensation information; proactively contacts injured workers to inform them of their rights and responsibilities and educates them about its services; and works to resolve disputes between injured workers and carriers to avoid unnecessary expenses, costly litigation or delay in the provision of benefits.

CUSTOMER SERVICE TEAM

The Customer Service Team focuses on assisting and educating employers about the requirements of workers' compensation coverage, exemptions from coverage, and drug free workplace and safety programs. This Team answers close to 92,000 calls per year.

FIRST REPORT OF INJURY TEAM

The First Report of Injury Team identifies and contacts injured workers with more than seven days of work lost due to the job injury. This contact takes place within two business days of the Division's receipt of a First Report of Injury or Illness. The First Report of Injury Team provides educational resources regarding the Workers' Compensation System, advises injured workers of their statutory responsibilities, and informs workers of EAO's various services.

CUSTOMER SERVICE CALL VOLUME FY 2014-2015

1st Qtr	23,034
2nd Qtr	19,649
3rd Qtr	25,703
4th Qtr	23,315
TOTAL	**91,701**

During Fiscal Year 2014-2015, the Team contacted 29,116 injured workers by telephone and 3,511 employers/carriers when the team was unable to reach injured workers. These contacts were made to inquire about the status of injured workers' claims and advise of EAO's services. The Team communicated by letter or responded by email to 37,408 injured workers in an effort to give assistance and advise of EAO's services.

INJURED WORKER CONTACTS

Fiscal Year	Number Contacted	Percentage Contacted
09-10	28,768	69%
10-11	32,140	71%
11-12	32,966	73%
12-13	31,303	81%
13-14	29,732	82%
14-15	29,116	81%

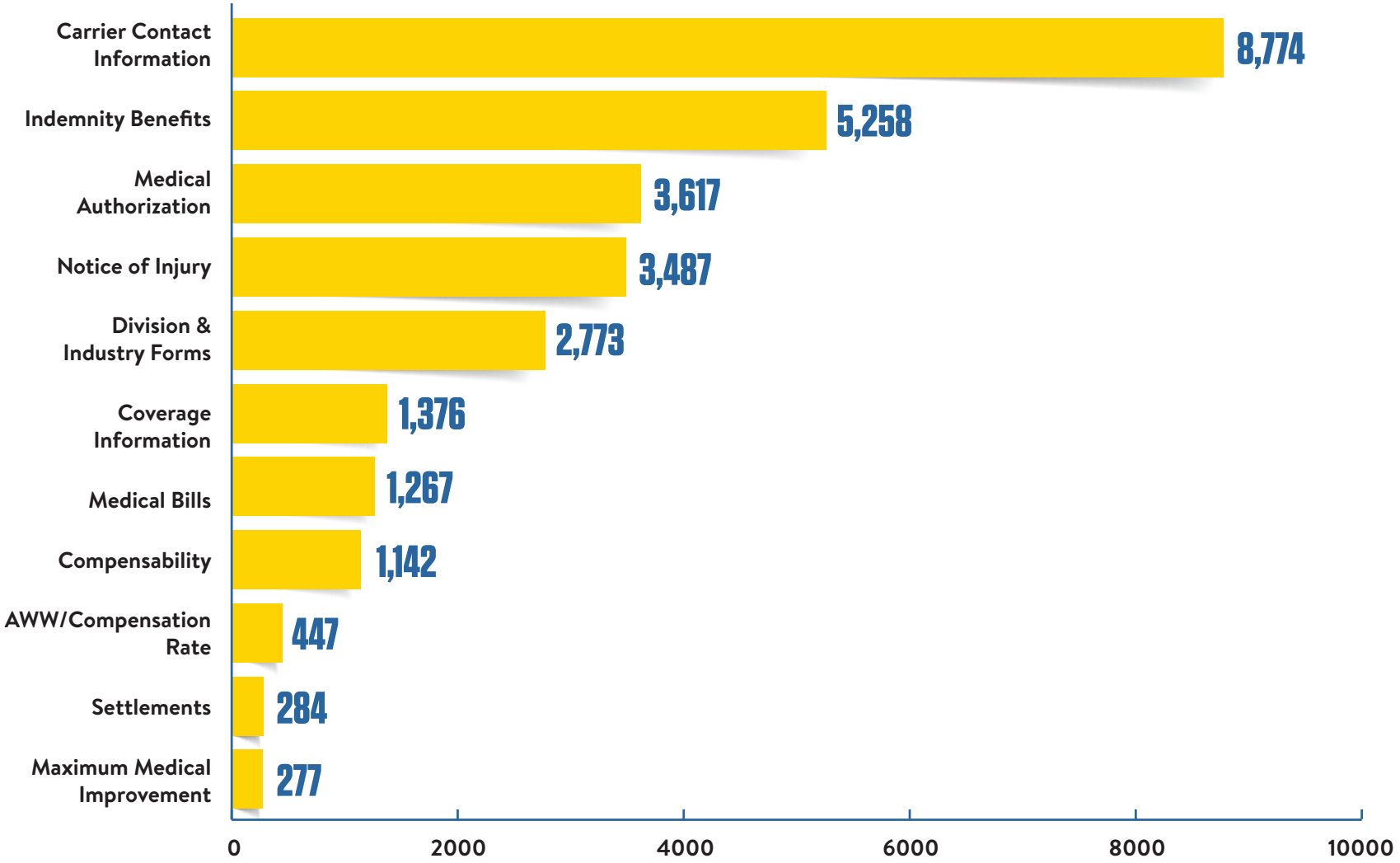
INJURED WORKER HELPLINE TEAM

The Injured Worker Helpline Team's responsibility is to educate callers from all system stakeholders: injured workers, employers, carriers, medical providers, attorneys, and the public. Through the Division's toll-free telephone line, the Team answers questions about the requirements of Florida's Workers' Compensation Law and provides assistance to injured workers who are experiencing problems obtaining medical or indemnity benefits.

The Team fulfills its mission by identifying disputed issues, researching injured workers' concerns and contacting employers, carriers, medical providers, attorneys, or other appropriate parties to aid in resolution. All disputes requiring extensive investigation are referred to the Ombudsman Team.

During Fiscal Year 2014-2015 the Injured Worker Helpline Team handled 40,517 calls, including 8,559 Spanish speaking callers.

INJURED WORKERS HELPLINE TEAM - EDUCATION CALLS FY 2014-2015



OMBUDSMAN TEAM

The Ombudsman Team is responsible for assisting injured workers to resolve complex disputes. In order to fulfill its role, the Team conducts fact-finding reviews, analyzes claim files, researches case law, promotes open communication between parties, and generally helps parties to understand their statutory responsibilities. The Team provides early intervention services to injured workers with catastrophic or severe injuries; assists walk-in customers in eight offices throughout Florida; assists in resolving disputes and providing workers' compensation information applicable to each injured workers' claim, including guidance on the Petition for Benefits process; and assists injured workers referred from the Governor's and CFO's Offices, legislators, and other elected officials.

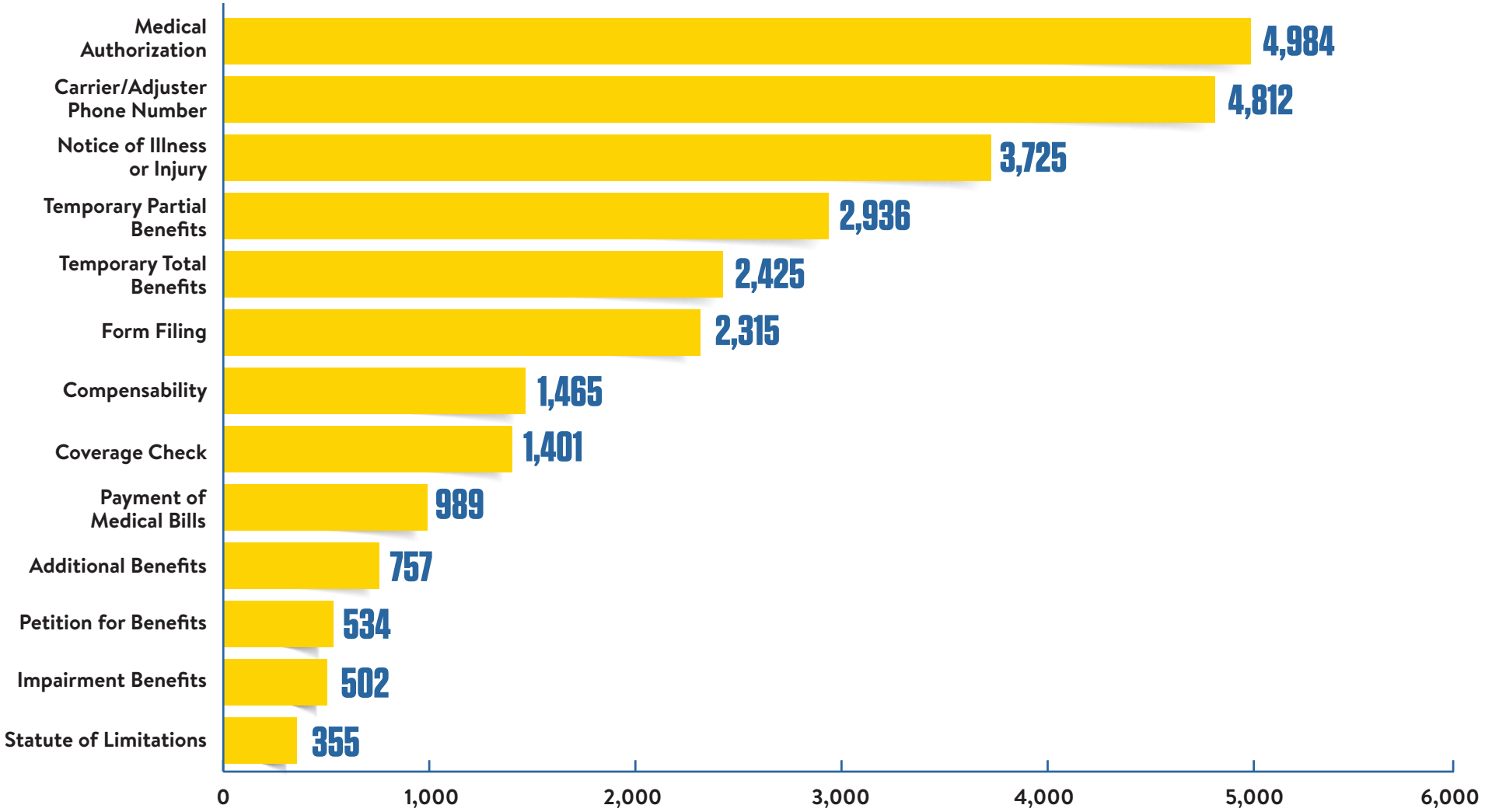
During Fiscal Year 2014-2015, the Ombudsman Team was involved in resolving 91% of the 754 disputes received. The medical bill disputes totaled $22,995 in previously unpaid medical bills. The Team resolved indemnity benefit disputes totaling $182,814. Additionally, the Ombudsman Team prevented 3,798 potential disputes by educating injured workers with in-depth, case specific information.

Contact the Ombudsman Team at **wceao@myfloridacfo.com** with questions.

OMBUDSMAN INTERVENTION FY 2014-2015

Issue	Resolved	Unresolved	% Resolved
Average Weekly Wage	14	1	93%
Medical Authorization	353	29	92%
Notice of Injury	1	2	33%
Indemnity - TPD	52	4	93%
Indemnity - TTD	60	5	92%
Compensability	2	17	11%
Penalties & Interest	32	0	100%
Medical Mileage	75	1	99%
Medical Bills	38	2	95%
Impairment Income Benefits	9	0	100%
Other	50	7	88%
Total	686	68	91%

ISSUES ADDRESSED BY OMBUDSMAN AND HELPLINE TEAMS FY 2014-2015



REEMPLOYMENT SERVICES TEAM

The Reemployment Services Team is responsible for educating injured workers about potential eligibility for reemployment services to assist in returning to appropriate gainful employment after an on-the-job injury. The Team provides services for: vocational counseling; transferable skill analysis; resume writing/development; job placement; job seeking skills; vocational evaluations; and training and education (including GED). Injured employees submit requests for screening for services through the Division's web portal. The Reemployment Services Team ensures the required documentation is received from injured workers requesting services. The Team educates carriers about reemployment services requirements under Florida's Worker's Compensation Law.

During Fiscal Year 2014-2015, the Reemployment Services Team received 264 requests for screenings through the Division's Injured Worker Web Portal. Additionally, the Team screened 277 injured workers for services and provided assistance to 164 injured workers who were eligible to return to suitable productive employment.

Success Stories from FY 2014-2015

- A 52 year-old female sustained a shoulder injury to her right shoulder while working in the environmental services department at a large medical facility. Upon reaching maximum medical improvement, her employer of injury was unable to accommodate her restrictions of no lifting, pushing or pulling over 25 pounds and no overhead use of the right upper extremity. Following a vocational evaluation, the injured employee was sponsored in a medical administrative assistance certificate program at the local vocational-technical center. Upon completion of the program, the injured employee was able to utilize her new skills and return to work as an administrative assistant with a new employer.

- While employed as a painter, the injured employee sustained an injury to his neck. He was released to return to work with permanent light duty (no lifting greater than 20 pounds) restrictions. He was provided assistance with locating employment opportunities through contracted vocational services. With these services he was able to locate employment as a painter with an employer who was willing to accommodate his restrictions, earning about $7.00/hour more than he was earning at the time of his injury.

Contact the Reemployment Services Team via email at WCRES@myfloridacfo.com. Injured workers may apply for reemployment services by completing the online application at: https://wcres.fldfs.com/resportal/ieweb/ielogin.aspx.

BUREAU OF MONITORING & AUDIT

The Bureau of Monitoring and Audit (M&A) is tasked with ensuring the timely and accurate payment of benefits to injured workers, timely filing and payment of medical bills, and timely and accurate filing of required claims forms and other electronic data. M&A is responsible for ensuring that the practices of insurers and claims-handling entities meet the requirements of Chapter 440, Florida Statutes and the Florida Administrative Code.

The Bureau of Monitoring and Audit consists of the following key areas:

- Audit Section
- Permanent Total Disability Section
- Penalty Section
- Medical Services Section

AUDIT SECTION

The Audit Section examines claims-handling practices of insurers, self-insurers, self-insurance funds, and other claims-handling entities pursuant to Sections 440.20, 440.185, and 440.525, Florida Statutes and the rules of the Florida Administrative Code. Examinations and investigations are conducted by the Section to identify: patterns and practices of unreasonable delays in claims-handling; untimely and inaccurate payment of benefits to injured workers; untimely and inaccurate filing of required forms and reports; and to enforce compliance with compensation orders of Judges of Compensation Claims.

The Audit Section completed 56 on-site insurer audits and examined 5,303 insurer claim files during Fiscal Year 2014-2015. The Section discovered 491 indemnity claim files with underpayments resulting in $226,318.12 of additional injured worker payments for indemnity benefits, penalties, and interest.

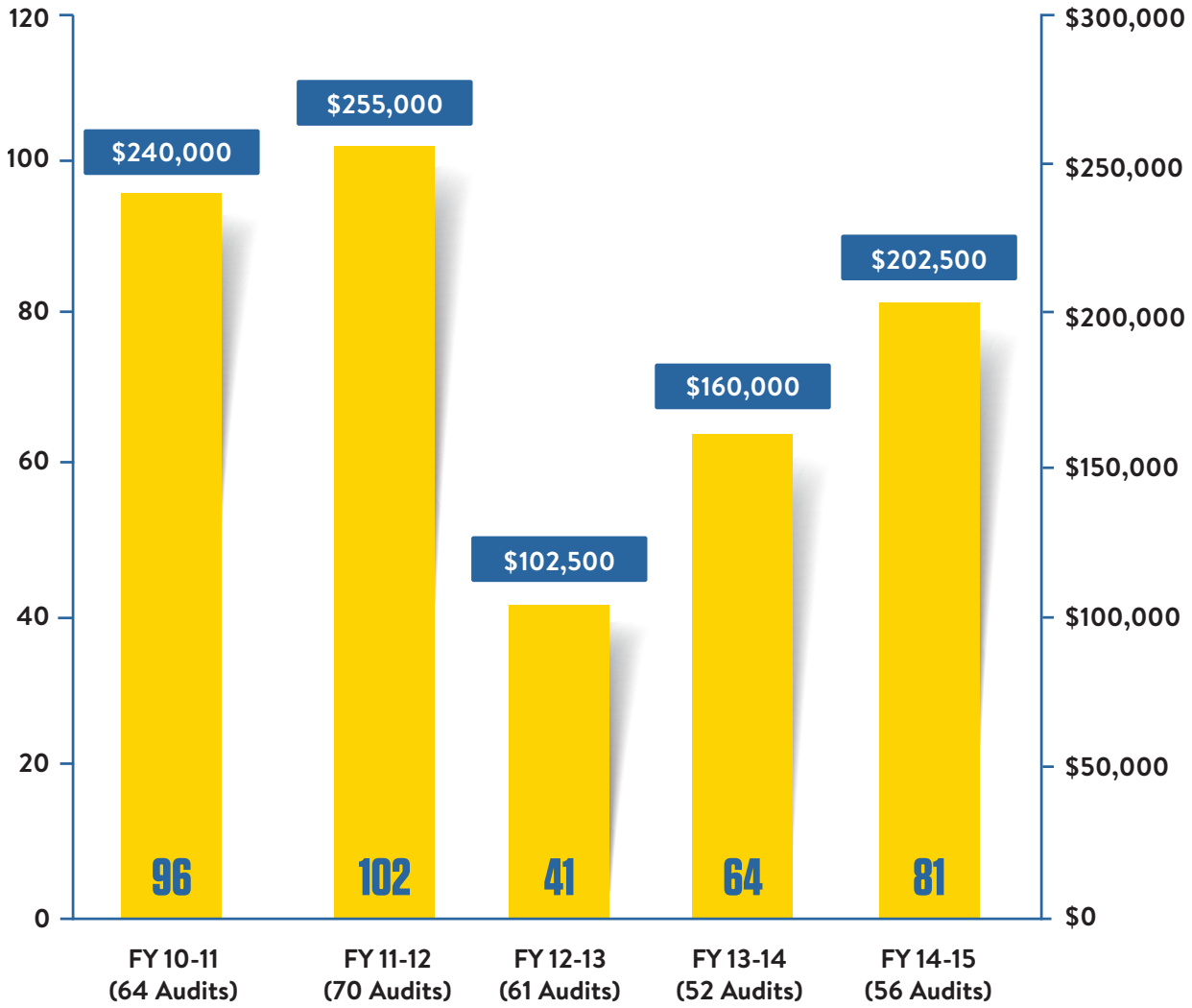
The table below illustrates penalties assessed during audits for untimely indemnity payments and untimely First Reports of Injury or Illness that were paid to the Division.

Fiscal Year	Total Amount of Penalties Issued for Untimely Indemnity Payments	Total Amount of Penalties Issued for Untimely First Reports of Injury or Illness
10-11	$90,400	$66,600
11-12	$87,000	$51,200
12-13	$64,200	$27,500
13-14	$70,850	$25,800
14-15	$83,300	$60,300

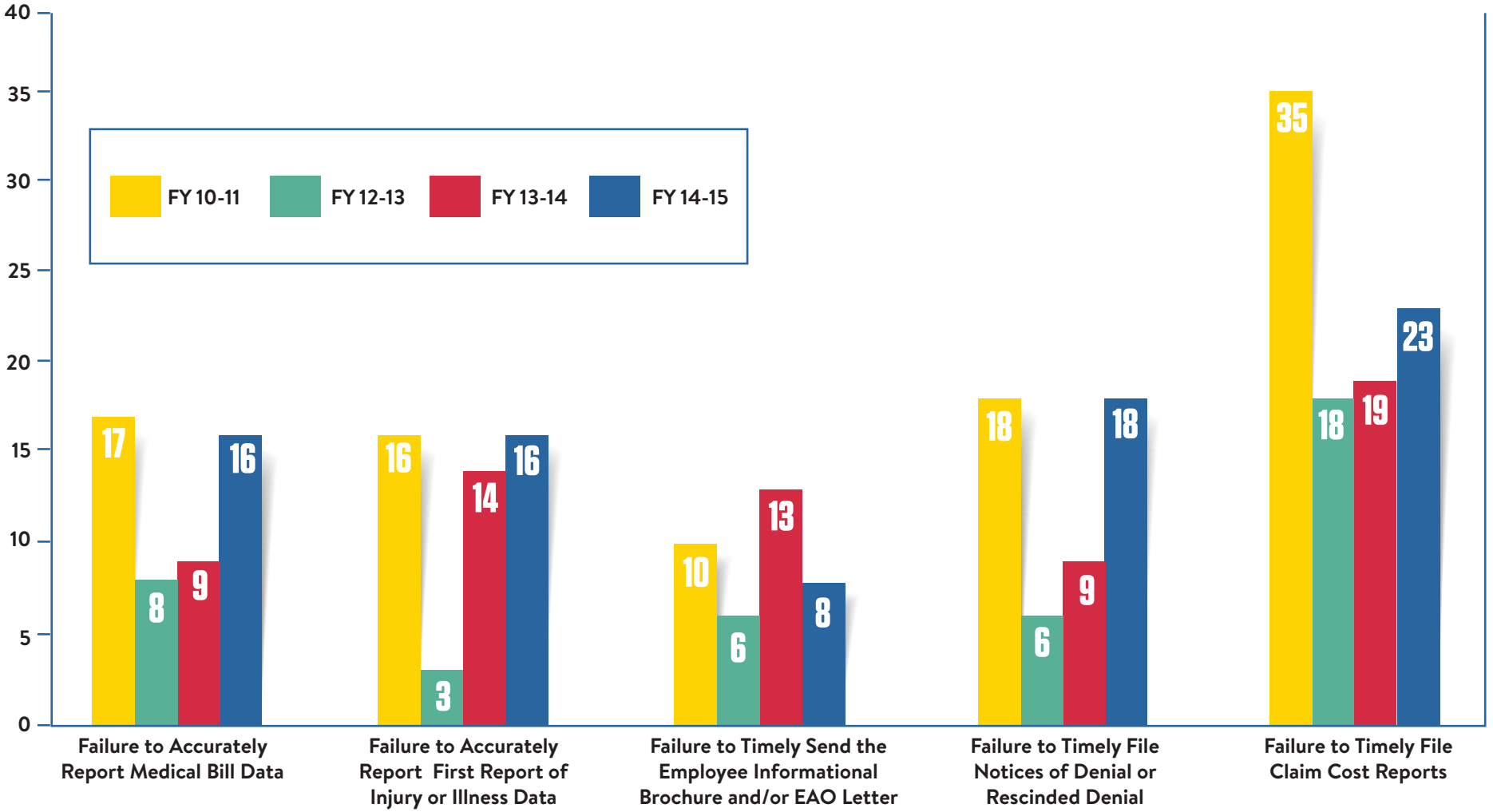
NON-WILLFUL PATTERN AND PRACTICE PENALTIES BY FISCAL YEAR

The next 2 graphs illustrate non-willful pattern and practice penalties assessed during audits for various claims-handling violations. Each pattern and practice penalty is assessed at $2,500.

Fiscal Year 2014-2015 saw an increase in assessed non-willful pattern and practice penalties over Fiscal Year 2013-2014. The 5-year average of the number of non-willful pattern and practice penalties is 77, while the total 5-year average of monetary penalties is $192,000.



NON-WILLFUL PATTERN & PRACTICE PENALTIES BY CATEGORY AND FISCAL YEAR



PERMANENT TOTAL DISABILITY SECTION

The Permanent Total Disability (PT) Section is responsible for paying permanent total supplemental benefits to eligible permanently and totally disabled workers who were injured prior to July 1, 1984. During Fiscal Year 2014-2015, the PT Section calculated, approved, and processed supplemental benefits for 1,084 claims totaling $15,563,120.

The PT section verifies eligibility of injured workers' entitlement to supplemental benefits by reviewing the following resources: Vital Statistics Report (Department of Health); Inmate records (Department of Corrections); Employee Earnings Reports; PT Claims data electronically submitted by insurer; and Judges of Compensation Claims data. Additionally, this Section verifies the accuracy and timeliness of permanent total and permanent total supplemental benefits due and paid by insurers. This includes verifying that payments are suspended, reduced, or cancelled based on statutory amendments or case law and that benefit offsets are correctly applied.

Throughout Fiscal Year 2014-2015, the PT Section reviewed 30,524 electronic claims transactions. The PT Section works in collaboration with other Division staffing units to determine the accuracy of benefits that are due to an injured worker including Special Disability Trust Fund, Bureau of Employee Assistance and Ombudsman Office, and the Audit Section.

PENALTY SECTION

The Penalty Section evaluates and assesses insurer performance of timely payments of initial indemnity benefits and medical bills. The Penalty Section also monitors the timely filing of First Reports of Injury or Illness and medical bills monthly using the Centralized Performance System (CPS). CPS is a web based application that electronically provides essential insurer performance information and trends. CPS also enables the Division and its stakeholders to monitor performance and respond to penalty assessments for untimely filing and untimely payment in real-time.

Fiscal Year	# of First Reports Received and Reviewed by CPS
10-11	53,285
11-12	53,211
12-13	51,690
13-14	52,344
14-15	53,929

Fiscal Year	Timely Initial Benefit Payments	Timely Filing of First Reports
10-11	95%	95%
11-12	95%	95%
12-13	95%	95%
13-14	95%	95%
14-15	95%	93%

FiscalYear	Timely Medical Bill Payments	Timely Medical Bill Filings
10-11	98%	98%
11-12	99%	99%
12-13	98%	96%
13-14	99%	98%
14-15	99%	99%

MEDICAL SERVICES SECTION

The Medical Services Section is responsible for establishing reimbursement rules and policy, implementing the Three Member Panel's uniform schedules for Maximum Reimbursement Allowances (MRAs), and resolving medical reimbursement disputes between providers and payers. This Section also provides educational assistance and consultation on issues related to medical bill filing and reimbursements, and administrative support to the Three-Member Panel who adopts uniform schedules of maximum reimbursement allowances for physicians, hospitals, ambulatory surgical centers (ASCs), and other service providers.

The Medical Services Section received over 9,600 Petitions for Resolution of Reimbursement Disputes (Petitions) during Fiscal Year 2014-2015. Reimbursement Disputes must be filed within 45 days from provider's receipt of the carrier's notice of disallowance or adjustment of payment.

PETITIONS SUBMITTED BY PROVIDER TYPE

	10-11	11-12	12-13	13-14	14-15
Practitioner	1,305	12,460	7,805	8,412	7,323
ASC	655	687	737	665	331
Hospital Inpatient	436	332	350	266	453
Hospital Outpatient	1,378	1,273	1,303	1,069	1,550
Total	3,774	14,752	10,195	10,412	9,657

The Medical Services Section issues Dismissals or Determinations for all Petitions received. In Fiscal Year 2014-2015 the Section issued 5,761 determinations (65%) and 3,091 dismissals (35%).

The top 3 reasons for Dismissals remain the same from Fiscal Year 2013-2014 although the numbers for all Dismissals has decreased.

PETITIONS DISMISSAL OUTCOMES BY PROVIDER TYPE

	10-11	11-12	12-13	13-14	14-15
Practitioner	478	1,647	2,605	4,432	2,374
ASC	219	157	216	173	104
Hospital Inpatient	133	109	140	96	181
Hospital Outpatient	411	346	448	270	432
Total	1,241	2,259	3,409	4,971	3,091

PETITIONS DISMISSALS ISSUED BY REASON

	10-11	11-12	12-13	13-14	14-15
Petition Withdrawn	295	437	1,167	2,448	1,469
Failure to Cure Deficiency	507	547	617	998	624
Untimely Filed	255	930	1,283	951	515

Though nominal in actual numbers, the number of under-payments found continues to increase.

The Medical Services Section discovered that the petitioner had been underpaid in 92% of all determinations issued for Fiscal Year 2014-2015. Of the 92%, most of the underpayments were related to medical bills involving medication dispensed by the practitioner.

DETERMINATIONS ISSUED BY REASON PER FISCAL YEAR

	10-11	11-12	12-13	13-14	14-15
Under-Payment	2,181	3,095	3,871	4,699	5,275
Correct Payment	41	83	118	127	40
Over-Payment	28	75	96	97	44
Other Finding	5	3	10	16	10
No Additional Payment Due	90	109	244	515	387

PETITION DETERMINATION OUTCOMES BY PROVIDER TYPE

	10-11	11-12	12-13	13-14	14-15
Practitioner	706	1,853	2,573	3,992	4,326
ASC	412	471	584	512	213
Hospital Inpatient	286	218	217	183	226
Hospital Outpatient	941	823	966	767	996
Total	2,345	3,365	4,340	5,454	5,761

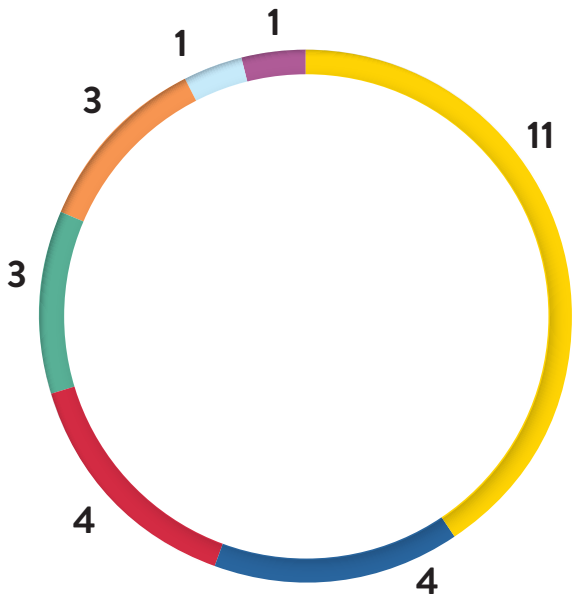
The Medical Services Section is responsible for certifying Expert Medical Advisors (EMAs). As of June 30, 2015 there were 137 certified EMAs.

The Section also has the responsibility of investigating reports of provider violations. In Fiscal Year 2014-2015, the Medical Services Section processed 31 reports which included 2 reports carried over from FY 2013-2014. Out of the 31 reports processed, 1 was an internal Division of Workers' Compensation referral, and 30 were referrals from insurers, attorneys or other. The table below illustrates the end of year case status for reports of provider violations processed during Fiscal Year 2014-2015. Open cases are carried over into the next fiscal year for further processing.

REPORTS OF PROVIDER VIOLATIONS CASE STATUSES AS OF JUNE 30, 2015

Status	Number of Cases
Open	4
Closed	27

14-15 HEALTH CARE PROVIDER VIOLATIONS CLOSURE TYPES



- Not a Violation per Rule 69L-34
- Improper Format/Deficient Form Completion
- Valid Referral - Educational Letter Issued
- Deficient Submission
- Insufficient Medical Evidence
- Invalid Referral - Pending JCC action
- Invalid Referral - Untimely Filed

The chart above describes the distribution of the various provider violation case outcomes for those cases closed during Fiscal Year 2014-2015. The most common reason for closure was the failure of the entity making the report of violation to reasonably support the report with documentation of a violation.

BUREAU OF FINANCIAL ACCOUNTABILITY

The Bureau of Financial Accountability houses the Division's largest monetary transaction programs and safeguards its assets by developing and implementing a broad range of financial accountability measures. The Bureau's programs work to implement and build upon its internal checks and balances while maintaining effective financial controls that focus on managing the daily functions of cash receipts, revenue and warrant payments. Included in these controls is a series of comprehensive reconciliation processes that balance each cash receipt and cash payment process.

The Bureau of Financial Accountability has the following monetary programs:

- Assessments Section
- Financial Accountability Section
- Self-Insurance Section
- Special Disability Trust Fund Section


earnings
capital
success
notes
detail
market
exchange
bank
concept
financial
research
corporate
pen
education
plan
count
accounting
udget
dollar
ram
ercial
bill
communication
management
expenditure
chart
marketing
analysis
graphs
benefit
business
banking
collection
paperwork
data
accountant
rate
stock
calculation
forecast
cash
investment
information
commerce
different
balance
document
annual
money
people
currency
payable
statistics
wealth
office
economic
euro

ASSESSMENTS SECTION

The Assessments Section calculates, collects, audits and reconciles quarterly assessment payments by insurance companies, assessable mutual insurance companies, self-insurance funds and individual self-insurers to the Special Disability Trust Fund (SDTF) and the Workers' Compensation Administration Trust Fund (WCATF). The section also calculates the annual assessment rate for both the SDTF and the WCATF.

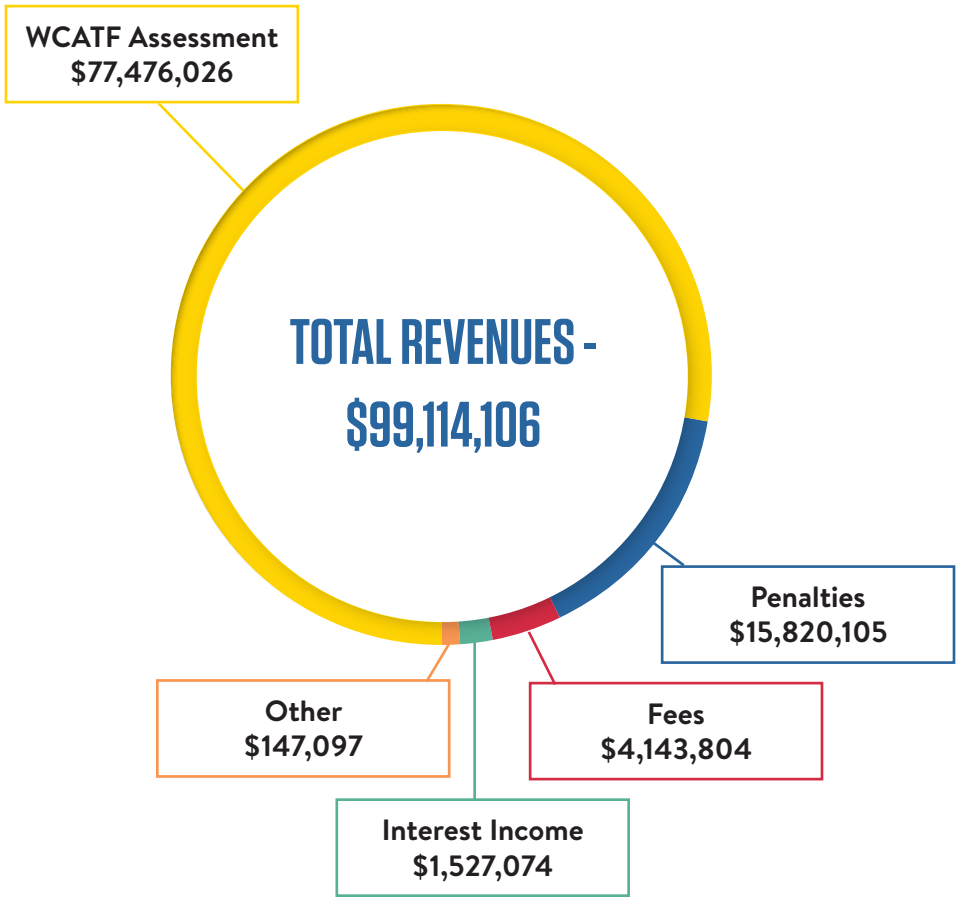
In Fiscal Year 2014-2015, the Assessments Section collected over $77 million in assessments for the Workers' Compensation Administration Trust Fund (WCATF) and over $43 million for the Special Disability Trust Fund (SDTF).

Both trust funds are supported by quarterly assessments. These assessments are based on insurance carriers' Florida workers' compensation net insurance premiums, as required by statute. Each quarter, the Assessments Section notified and provided all carriers with the necessary information to report premiums.

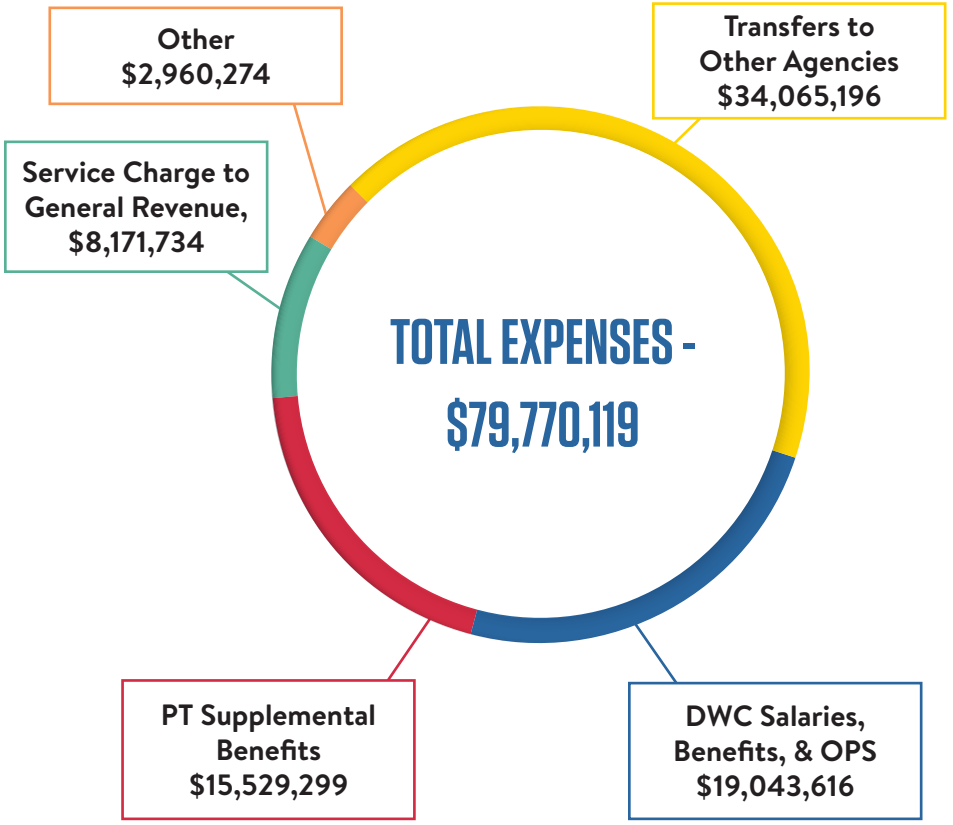
The Assessments Section subsequently collected, audited, and reconciled the quarterly assessments of 362 insurance companies and self-insurance funds. This Section also calculated the imputed premium of 395 individual self-insured companies (premium that the self-insurer would have paid had they not chosen to self-insure). This process utilized the required company payroll, volume discounts, approved credits, and experience modifications in determining the premium for which the assessment was applied.

In an effort to improve efficiency and cost effectiveness, the Assessments Section has developed a product that allows insurance carriers to report their assessments on-line. This application is called START – System for Tracking Assessments, Reconciliations and Transactions. The individual self-insurers phase is being developed.

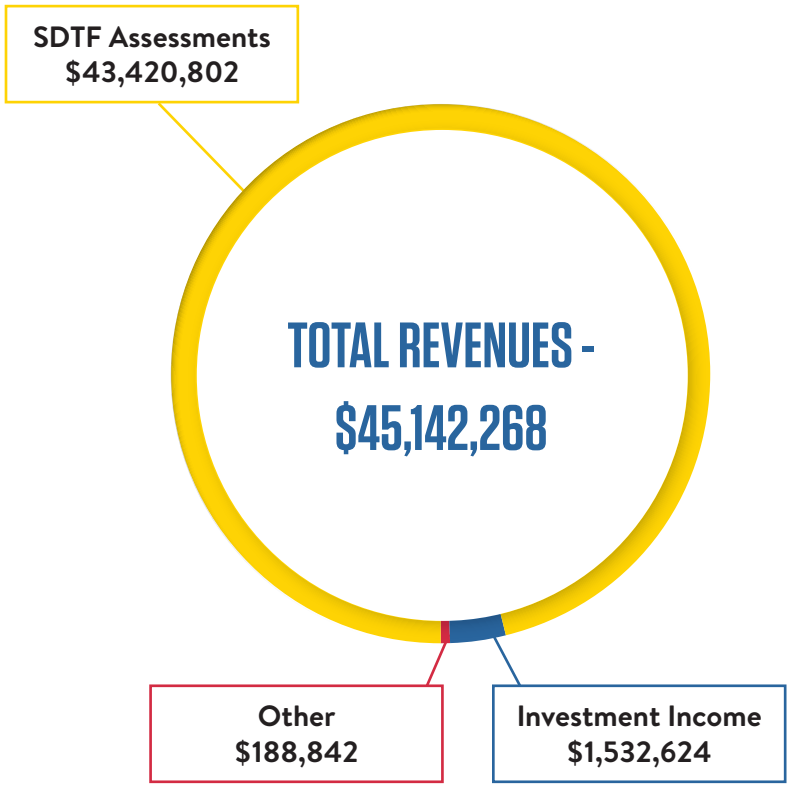
WORKERS' COMPENSATION ADMINISTRATION TRUST FUND (WCATF) REVENUES FOR FY 2014-2015



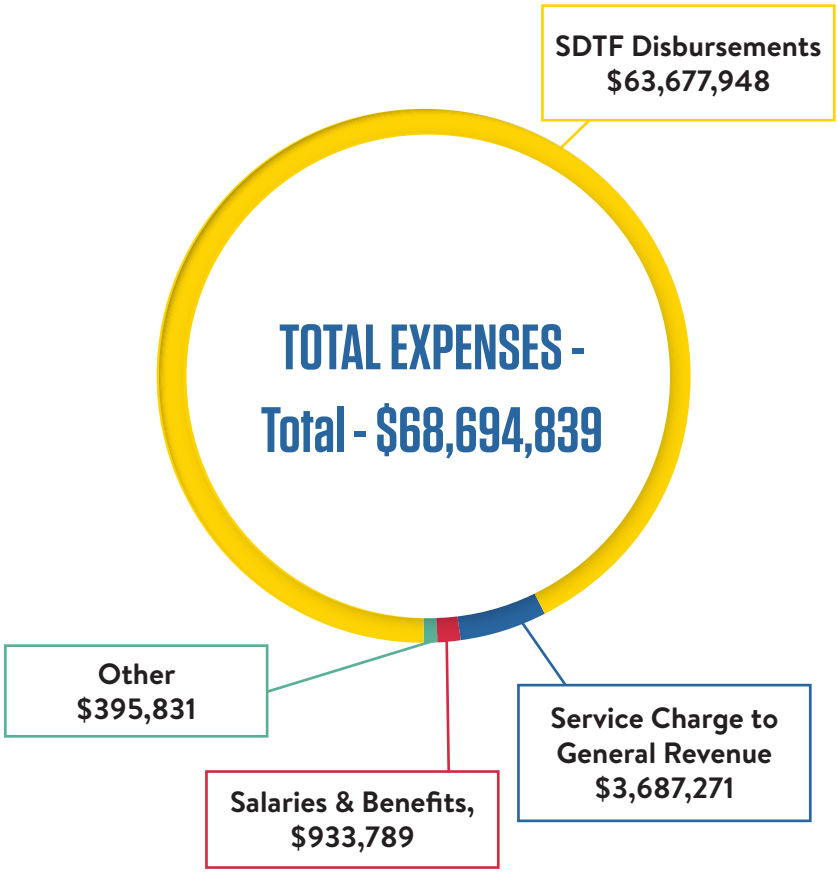
WORKERS' COMPENSATION ADMINISTRATION TRUST FUND (WCATF) EXPENSES FOR FY 2014-2015



SPECIAL DISABILITY TRUST FUND (SDTF) REVENUES FY 2014-2015



SPECIAL DISABILITY TRUST FUND (SDTF) EXPENSES FY 2014-2015

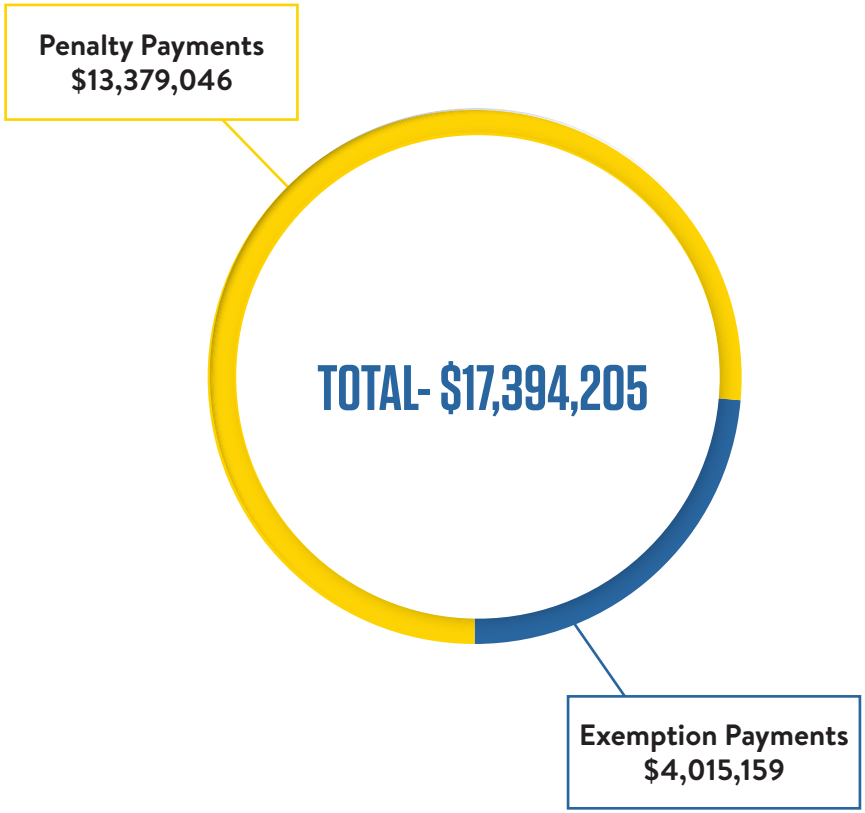


FINANCIAL ACCOUNTABILITY SECTION

The Financial Accountability Section monitors the receipt of all payments related to Notices of Election to be Exempt and employer penalty payments. The Section oversees the process of reinstating Stop-Work Orders to employers who default on payments, referring delinquent accounts to the collection agency, and filing liens against those employers.

The Financial Accountability Section (FAS) supports the activities pursuant to Section 440.107, Florida Statutes, by performing the following functions: collects and monitors revenues associated with payments from employers in the construction industry who elect to exempt themselves from workers' compensation benefits, collects and monitors revenues associated with employers who were out of compliance with the workers' compensation laws and have been assessed a penalty, and monitors monthly penalty payments associated with employers who have been assessed a penalty and have entered a Periodic Payment Agreement Schedule.

FINANCIAL ACCOUNTABILITY SECTION REVENUES FY 2014-2015



PENALTY PAYMENT COUNT BREAK-DOWN BY PAYMENT CATEGORY FOR FISCAL YEAR 2014-2015:

Payment Count Break-Down	Totals	Average Monthly Count	Average % of Total Count
Payment In Full	415	35	1%
Down Payments	353	29	1%
PPA Payments	34,591	2,883	90%
Collection Payments	421	35	1%
***Down Pay/Conditional Release	2,507	209	7%
TOTALS	38,287		

Payment Amount Break-Down	Totals	Average Monthly Amount	Average % of Total Amount
Payment In Full	$1,090,876	$9,906	8%
Down Payments	$409,600	$34,133	3%
PPA Payments	$9,294,242	$774,520	69%
Collection Payments	$264,335	$22,028	2%
Down Pay/Conditional Release	$2,319,992	$193,333	17%
TOTALS	$13,379,045		

SELF-INSURANCE SECTION

The Self-Insurance Section regulates private, individual self-insurers to ensure they have the financial strength required to pay workers' compensation claims. The Self-Insurance Section also regulates governmental individual self-insured employers to ensure timely reporting of Payroll and Loss Data. This Section promulgates experience modifications for all active individually self-insured employers and issues notices of violation for late filing of forms, reports and assessments.

The Self-Insurance Section is responsible for approving self-insurance programs for governmental and private entities that have met statutory requirements and demonstrated the required financial strength to fund their Florida workers' compensation liabilities. To ensure the financial stability of Florida self-insurers, the Self-Insurance Section contracts with the Florida Self-Insurers Guaranty Association (FSIGA) to review financial statements and monitor a self-insurer's ability to pay current and future workers' compensation liabilities.

The Self-Insurance Section, in conjunction with FSIGA: evaluates security deposits; grants self-insurance privileges; and collects, examines and processes self-insurance payroll, loss data, outstanding liabilities and financial statements.

The Self-Insurance Section conducts payroll audits of current and former self-insurers. The audits are conducted to determine the accuracy of payroll data reported annually on Self-Insurers Payroll Reports (DFS-F2-SI-5). During Fiscal Year 2014-2015, the Self-Insurance Section performed 6 desk audits, reviewed 7,714 employee payroll records, identified $700,223 in under-reported payroll and $62,140 in under-reported premium.

Entities applying for self-insurance authorization pursuant to Section 440.38(1)(b), Florida Statutes, shall submit a complete application package at least 90 days prior to the desired effective date of the self-insurance authorization. For private entities, the application package shall be submitted to FSIGA, Inc. Governmental entities shall submit their application package to the Division of Workers' Compensation.

During Fiscal Year 2014-2015, the Self-Insurance Section approved 3 entities to self-insure their workers' compensation liabilities and processed 13 entities' notices of self-insurance terminations. The Self-Insurance Section reviews applications requesting authorization to provide workers' compensation claims services to insurers and self-insurers. Once approved, these entities become Qualified Servicing Entities (QSEs) and must annually submit an Annual Report Form (DFS-F2-S1-23) for re-certification by March 1st to the Self-Insurance Section.

During Fiscal Year 2014-2015, the Self-Insurance Section monitored 97 active Qualified Servicing Entities that serviced claims for Self-Insurers and Commercial Carriers. All 97 Qualified Servicing Entities were re-certified. Two of the approved Qualified Servicing Entities withdrew from providing claims-handling services for self-insurers and commercial carriers.

The Self-Insurance Unit implemented a new education program on July 1, 2014 that was designed to improve self-insurers' accuracy in reporting payrolls and classifications. Staff designed a three-pronged education program to improve the accuracy of reporting overtime payroll, executive officers payroll, and classification codes. The unit **carefully targeted** each self-insurer, by phone and email, to provide important information about payroll reporting and classifications as the self-insurer was due to report its annual payroll and classification codes to the Division. The unit also designed and implemented a "Premium Audit - Payroll and Classifications Webinar" that was available to all self-insurers on a quarterly basis. Finally, the unit refined its Field Audit and Classifications Programs to focus on those self-insurers who have potentially reported incorrect payrolls or classification codes. Prior to the implementation of the new education program nearly 50% of all audits identified errors in both classification codes and payrolls. After the

implementation of the new education program, our audits determined that more than 75% of audited self-insurers reported payroll and classifications accurately.

FiscalYear	Self-Insurers
11-12	410
12-13	404
13-14	399
14-15	395

FiscalYear	Qualified Servicing Entities
11-12	97
12-13	97
13-14	95
14-15	97

SPECIAL DISABILITY TRUST FUND SECTION

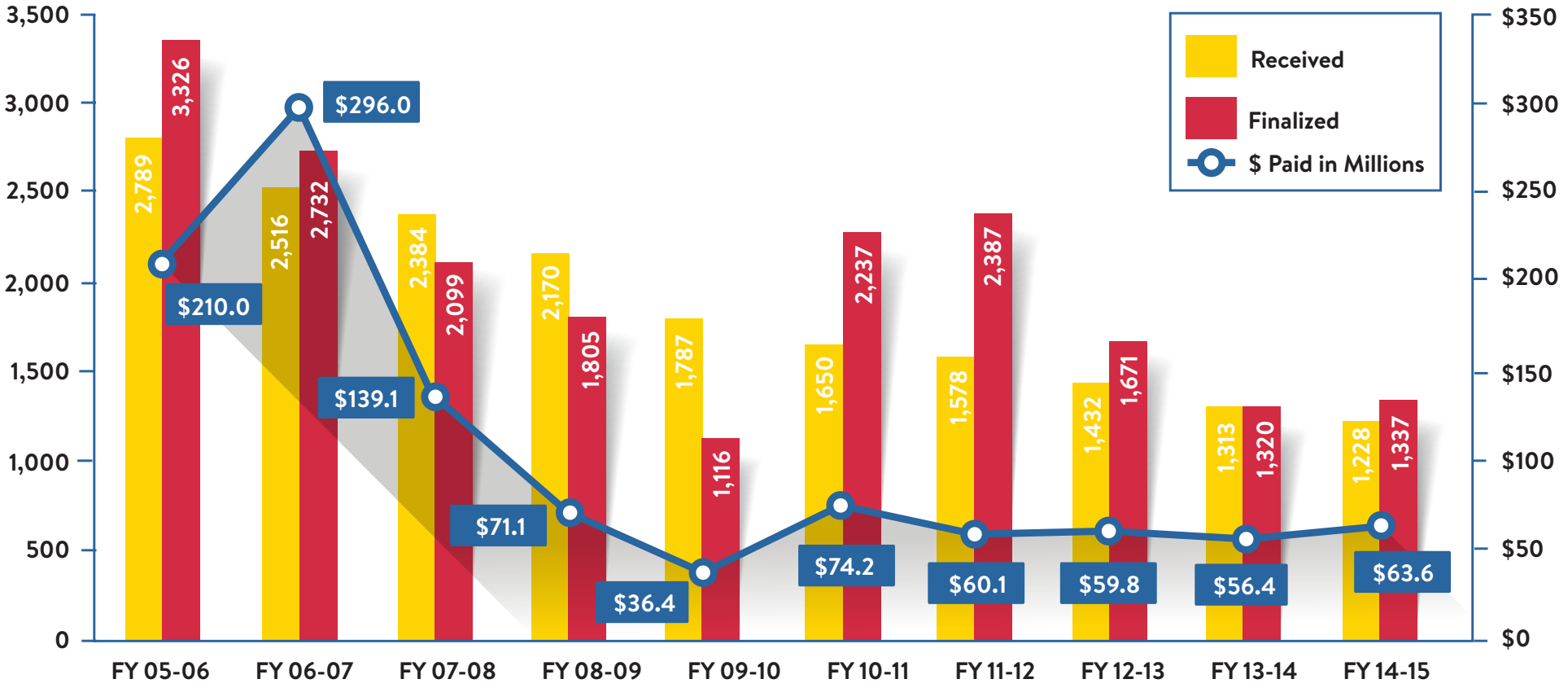
The Special Disability Trust Fund Section reviews all Proofs of Claims filed to determine if the claims meet eligibility requirements for reimbursement of benefits paid by the carriers. It then determines eligibility for reimbursement by the Fund through the audit of submitted requests for issuance of accurate reimbursements. Additionally, the Fund is responsible for the disbursement of Permanent Total Supplemental Benefits to certain injured workers.

The Special Disability Trust Fund (SDTF) was created by the Florida Legislature in 1955 to encourage employers to hire and reemploy individuals with a pre-existing permanent physical disability. If the employee experienced a new injury subsequent to being hired and that work-related injury resulted in a greater permanent impairment, the SDTF would reimburse the employer for excess costs. The cost of operating the SDTF, including reimbursements to carriers, is funded through annual assessments on workers' compensation premiums written by insurance companies and the imputed premium calculated by the Division for individual self-insured employers. Legislative changes in 1997 resulted in the SDTF being prospectively abolished and statutorily prohibited from accepting any new claims for dates of accident after December 31, 1997. However, in accordance with the statute, insurers and individual self-insured employers continue to be assessed to fund the run-off claims.

Presently, the SDTF has three primary business processes: (1) review all filed Proofs of Claim to determine if the claim meets eligibility requirements for reimbursement of benefits paid by the carrier and subsequently notify the carrier whether the claim has been accepted or denied; (2) determine eligibility for reimbursement by the Fund through auditing Reimbursement Requests and supporting documentation submitted by the carrier on claims that have been accepted; and (3) issue accurate reimbursements.

The Fund has created a new Computer Assisted Auditor Tool Suite which leverages the Medical EDI data submitted to the Division for use in evaluating and reviewing Reimbursement Requests submitted to the Fund. The next step will be to integrate this system into an electronic web portal to be used in the submission, review, and approval of Reimbursement Requests. The Fund will be able to utilize electronic data presently collected by the Division for use in this process, which will prevent the need for resubmission of some data by the carrier. Implementation of such a system will: dramatically reduce the paper used; allow for and encourage more fluid communication between the Fund and its customers; reduce the time between submission and final disposition of requests; and provide educational information.

REIMBURSEMENT REQUESTS



BUREAU OF DATA QUALITY & COLLECTION

The Bureau of Data Quality and Collection's (DQC) mission is to efficiently and effectively collect and store data in order to provide accurate, meaningful, timely and readily accessible information to all stakeholders within the workers' compensation system. DQC is responsible for facilitating data distribution to other Division bureaus and managing high volumes of data from claims-handling entities and vendors for Claims, Medical, and Proof of Coverage data as required by Chapter 440, F.S., and various corresponding Florida administrative rules. DQC also provides real-time feedback to data submitters.

Each electronic transaction received by DQC undergoes extensive program edits to ensure data quality, reliability and high degree of accuracy before being loaded to the appropriate Division databases. DQC is responsible for developing, improving and maintaining business processes that comingle with other Division systems to facilitate the monitoring of injured worker benefits, employer coverage and compliance, and health care provider payments.

PROOF OF COVERAGE EDI DATA COLLECTION

With the exception of self-insurers, every insurer is required by Rule 69L-56, Florida Administrative Code, to file policy information with the Division for Certificates of Insurance, Notices of Reinstatement, Endorsements, and Cancellations. Proof of Coverage (POC) data is collected and inspected 100% via Electronic Data Interchange (EDI). EDI is the structured transmission of data between organizations by electronic means. It is used to transfer electronic documents or business data from one computer system to another computer system, i.e. from one trading partner to another trading partner, without human intervention.

POC EDI data is used to populate several online Division databases including: "Proof of Coverage" database which provides information that can be used to verify if an employer currently has workers' compensation coverage in force; to view a prior policy period; or to validate if a person has a workers' compensation exemption; and "Construction Policy Tracking" database which provides the policy status of every subcontractor a contractor has chosen to track. Features include the electronic notification of any changes to a subcontractor's coverage status.

Questions or assistance regarding the electronic reporting of Proof of Coverage information can be sent to **poc.edi@myfloridacfo.com**.

PROOF OF COVERAGE ACCEPTED FILINGS

	FY 11-12	FY 12-13	FY 13-14	FY 14-15
New Policies	262,301	267,264	271,617	281,190
Binders	483	1,475	1,769	2,118
Reinstatements	79,958	78,089	83,449	84,765
Endorsements	208,553	246,040	389,596	415,389
Cancellations	157,405	150,321	156,300	160,193
Totals	708,217	741,714	900,962	943,655

In FY 2014-2015, 498 registrants signed up to use the Construction Policy Tracking database bringing the total registrants to 9,708. As of 6/30/15, the number of policies being tracked is 41,719.

MEDICAL EDI DATA COLLECTION

Pursuant to Rule 69L-7.710, all required medical billing (hospital, health care provider, ambulatory surgical center, dental, and pharmacy) forms must be submitted to the Division in accordance with the date-appropriate Florida Medical EDI Implementation Guide (MEIG). To assist with the electronic filing of medical bills, the Medical Data Management System (MDMS) web site was developed. Small insurers with a low volume of workers' compensation medical bills may utilize the MDMS web site to comply with the mandate for electronic submission of the DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, and DFS-F5-DWC-90 medical bills (no more than 200 per month including all four form types). Monthly report cards are generated that identify the primary reasons for initial medical bill rejection. The report cards also allow Medical EDI submitters to track their rejection rates and compare their rates with that of the industry.

For information on setting up an MDMS web account or assistance regarding Medical EDI reporting, email the Medical Data Management Team at **MedicalDataManagementTeam@myfloridacfo.com**.

ELECTRONIC MEDICAL BILLS ACCEPTED

FiscalYear	Bills Accepted
FY 10-11	3,884,341
FY 11-12	3,834,451
FY 12-13	3,929,214
FY 13-14	3,969,831
FY 14-15	4,332,002

CLAIMS EDI DATA COLLECTION

Claims EDI data is collected pursuant to Rule 69L-56, Florida Administrative Code and is used to populate the Division's primary accident database as well as several online web databases. As of Fiscal Year 2014-2015, claims data is submitted 100% via EDI.

In an effort to reduce the overall error rejection percentages of claims EDI filings, the Claims EDI Team took a more active approach by providing Triage Assistance. Triage Assistance consists of action plans with timelines, teleconferences, on-site visits, and webinars. Personalized sessions are available upon request. During Fiscal Year 2014-2015, the Team conducted 69 Training/Triage Sessions resulting in a 5% increase to the acceptance rate of the industry. Sessions consist of EDI Webinars and/or Triage sessions for individual trading partners covering:

- Claims EDI Warehouse Demonstration Insurer Access View
- Reporting Return to Work Information MTC S1 (Suspension - RTW) vs. FROI or SROI 02 (Change)
- Reinstatement of Benefits (MTC RB and MTC ER)
- Top Errors Affecting Claim Administrators and How to Correct Them
- Proper Reporting of Claim Type 'L' (Medical Only to Lost Time)

For questions or assistance regarding Claims EDI data, contact the Claims EDI Team by email at **claims.edi@myfloridacfo.com**.

ACCEPTED CLAIMS FORMS

FiscalYear	EDI	Paper	Total
11-12	500,613	2,223	502,836
12-13	474,780	422	475,202
13-14	469,652	0	469,652
14-15	475,125	0	475,125

RECORDS MANAGEMENT SECTION

Chapter 119, F.S., Florida's Public Records Law and Civil Rules of Procedure require the release of certain information for public inspection upon request. Upon receipt of a request documents must be identified, located, printed, assembled from multiple mediums, inspected for confidentiality, and redacted. Each request undergoes multiple quality reviews prior to the release of records.

During Fiscal Year 2014-2015, DQC processed 4,828 subpoenas and 2,498 public records requests. Subpoenas were invoiced in less than 2 business days of receipt on average. Public records requests were invoiced, or documents provided if no charge, on average in less than 2 business days of receipt. Documents are redacted and released upon receipt of payment as authorized by Section 119.07, Florida Statutes, if applicable. Public record requests may be submitted via email to the Division at **DWCPublicRecordsRequest@myfloridacfo.com**.

The Records Management Section assists Division Bureaus by converting paper files and microfilm documents to electronic records by scanning, indexing and verifying documents. During Fiscal Year 2014-2015, this Section processed 3,091,335 pages of documents.

RECORDS PRIVACY REQUESTS

Most workers' compensation accident information is releasable to any party upon request under Florida's public records law. Section 119.071(4)(d), Florida Statutes provides exemption of personal information for certain occupational classes (e.g., law enforcement personnel, correctional officers, firefighters, judges, etc.). The employee or employer may request an agency exempt personal information (i.e., home address, telephone number, and date of birth) from public records release if a person 's occupation qualifies. In Fiscal Year 2014-2015, the Records Management Section processed 1,366 requests for workers' compensation profiles to be exempt from public records inspection under Section 119.071(4)(d), Florida Statutes. For a list of qualifying occupations and educational information, visit **http://www.myfloridacfo.com/division/WC/employee/records.htm**.

Records privacy requests are processed in two or less business days on average and a follow-up email process allows notification to the requestor of the status of the exemption request. Questions regarding records privacy can be emailed to **DWCRecordsPrivacy@myfloridacfo.com**.

MEDICAL DATA

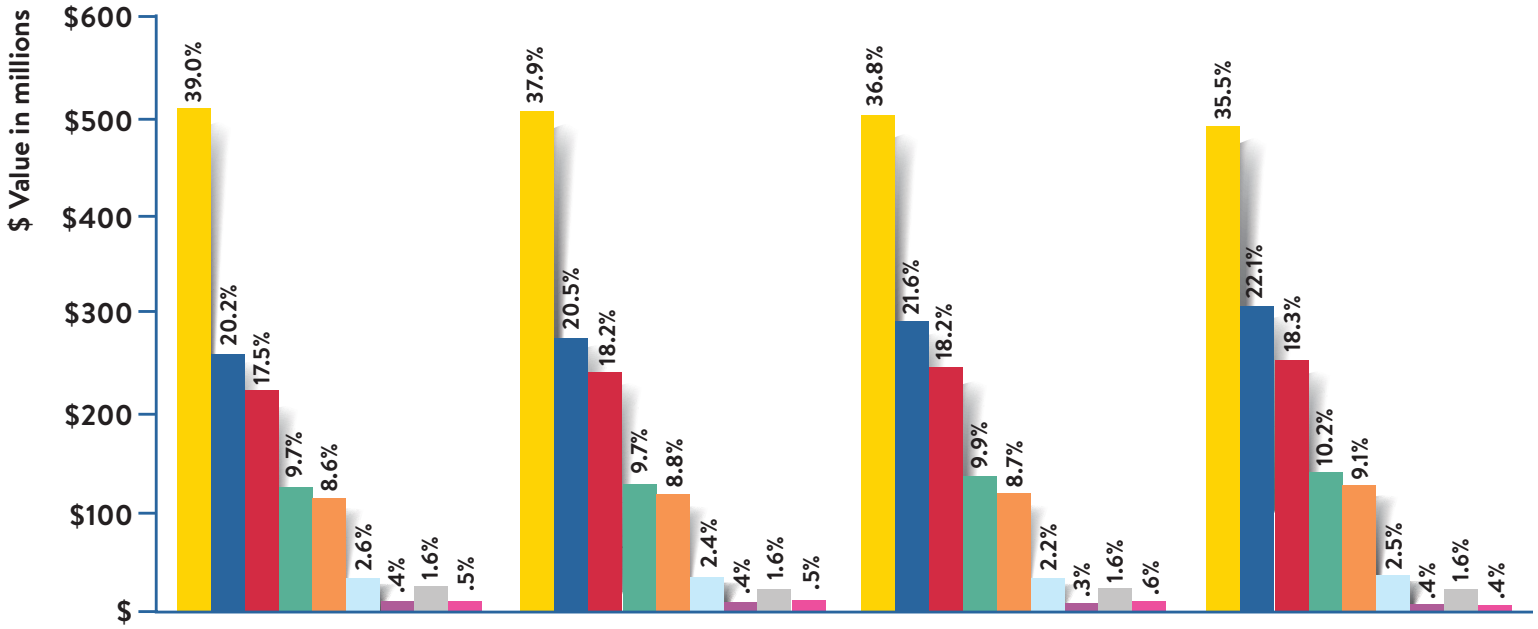
The Bureau of Data Quality and Collection receives 3.5 to four million medical bill records each year via electronic submission, which is the largest volume of data electronically received by the Division. Reporting of medical data begins with a workplace injury that required medical care from a physician, hospital, ambulatory surgical center (ASC), pharmacy, or other health care provider. The providers then submit medical bills to the applicable claim administrator for services rendered using the applicable medical claim forms (or electronic equivalents). The claim administrator or contracted medical bill review vendor adjudicates the medical bill.

Medical bill reimbursement amounts may be based on prices negotiated by the claim administrator or the maximum reimbursement allowance approved by the Three-Member Panel and contained in reimbursement manuals adopted by the Division of Workers' Compensation. Prescription reimbursement amounts are based on prices negotiated by the claim administrator, managed care contracts, or the statutory formula contained in Chapter 440, Florida Statutes.

Adjudication results and information about the medical services provided are transmitted via proprietary electronic formats to the Division, as required by administrative rule. When medical bills are received, the Division screens them by applying hundreds of edits that reject bills that do not meet Division requirements. The submitter is notified immediately if the submitted bill failed the edits and subsequently rejected. Rejected medical bills are not considered timely filed until corrected, re-submitted, and accepted by the Division.

The following charts pertain to both lost-time and medical only claims. Data aggregation is by calendar year of the date of service, rather than injury year. The data for each year is restricted to medical bills received and accepted by the Division no later than six months after the end of that year. Payment totals may differ in comparison to previous Division yearly reports due to payment disputes being resolved or adjustments to previously submitted medical bill data.

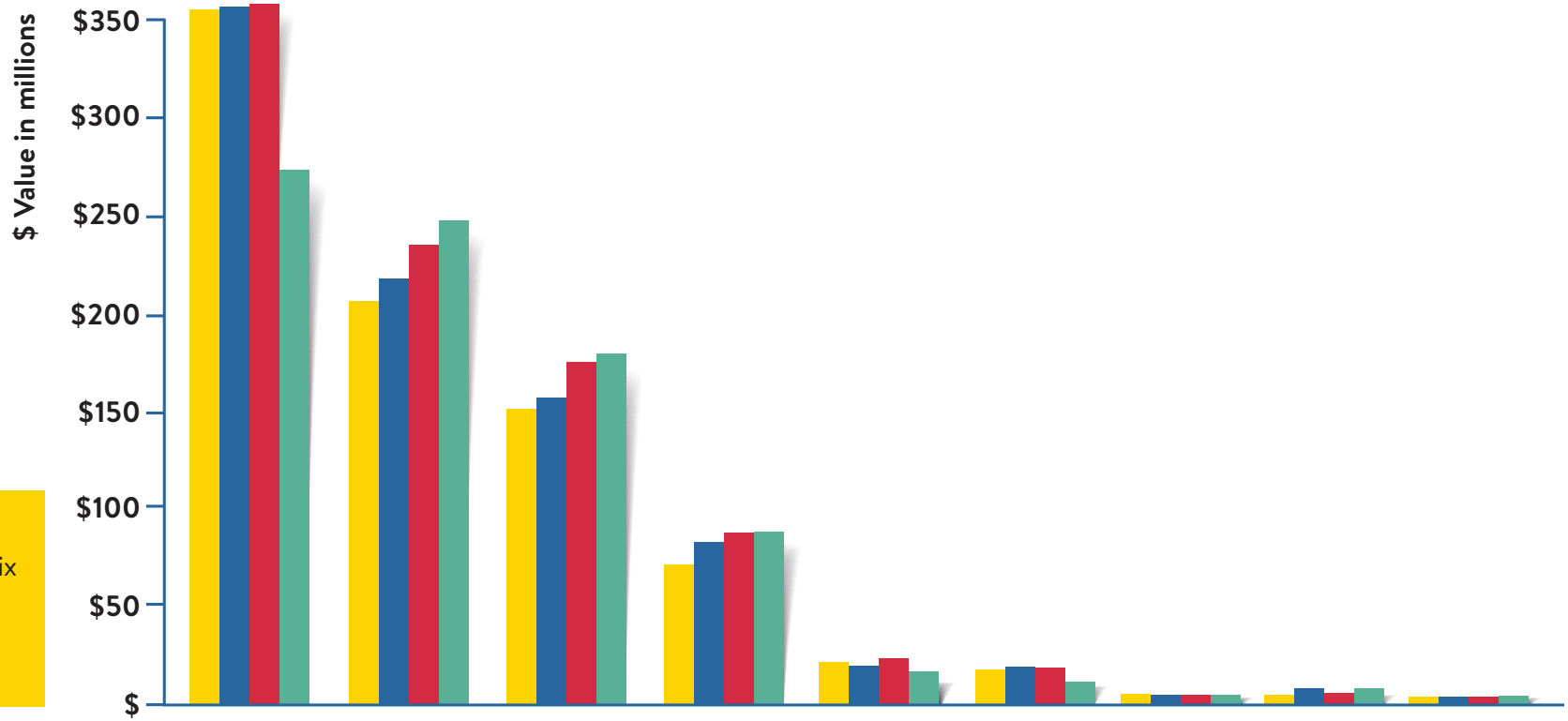
REIMBURSEMENT REQUESTS



* Excludes bills received beyond six months of the end of the calendar year of service.

	2011	2012	2013	2014
Health Care Provider	$508.0	$506.8	$500.2	$490.8
Hospital Outpatient	$262.3	$273.6	293.2	$306.0
Hospital Inpatient	$227.3	$242.9	$247.4	$253.2
Pharmacy	$126.6	129.0	$134.9	$140.5
Ambulatory Surgical Center	$111.6	$117.8	$118.5	$125.6
Medical Supplies	$33.7	$32.5	$30.3	$34.3
Dental	$4.9	$4.9	$4.7	$5.0
Home Health Services	$20.8	$21.7	$22.2	$22.6
Nursing Home	$6.5	$7.2	$7.5	$6.1

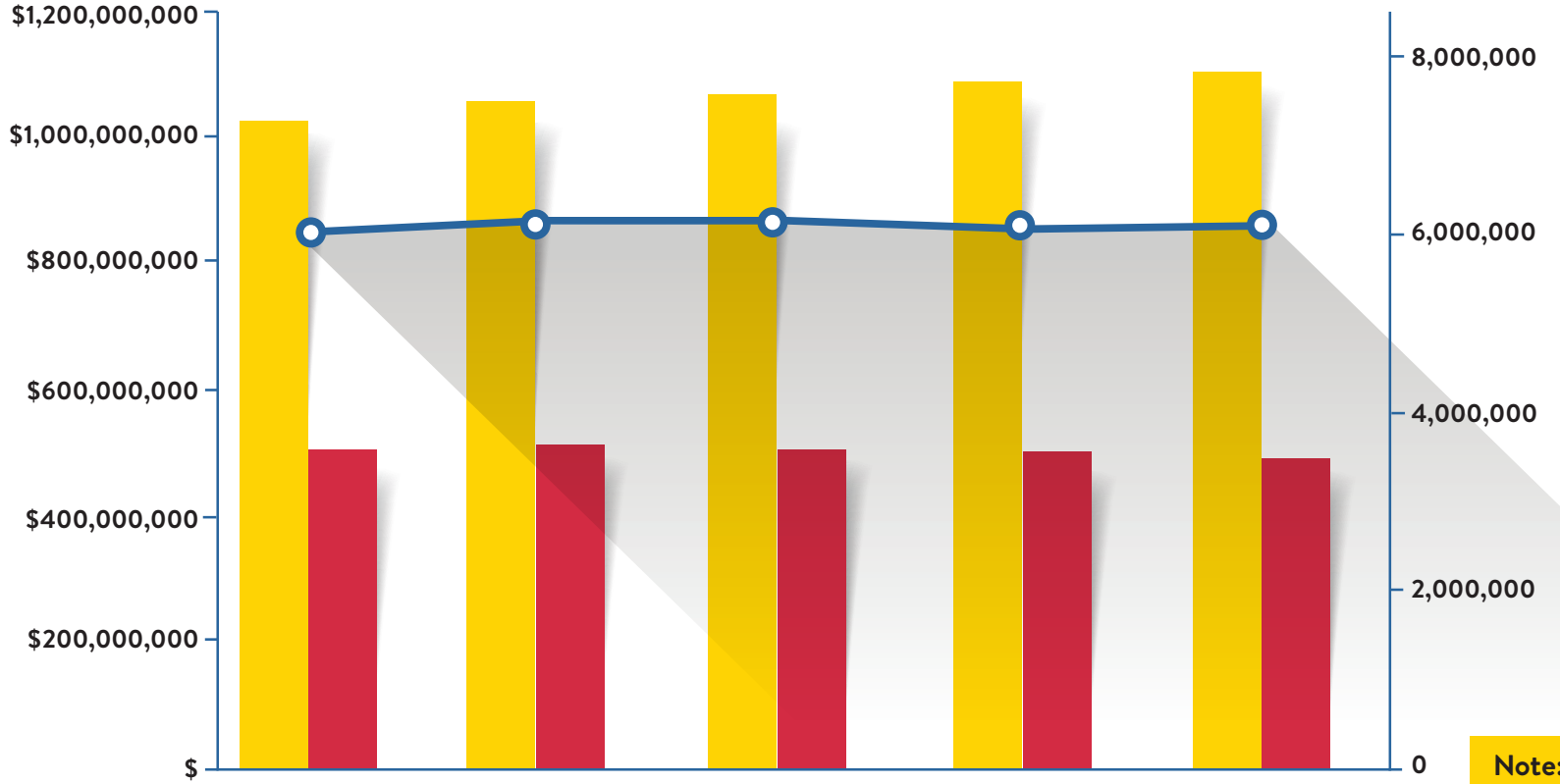
TOTAL MEDICAL PAID* FOR SERVICES PROVIDED WITHIN 12 MONTHS OF INJURY



	Health Care Provider	Hospital Outpatient	Hospital Inpatient	Ambulatory Surgical Center	Pharmacy	Medical Supplies	Dental	Home Health Services	Nursing Home
2010	$353.6	$203.5	$149.9	$69.3	$19.3	$16.5	$3.7	$2.8	$2.0
2011	$356.0	$215.2	$155.4	$80.7	$18.8	$17.1	$3.7	$6.0	$2.7
2012	$357.0	$232.0	$171.7	$85.6	$20.4	$16.0	$3.8	$4.8	$2.0
2013	$271.7	$244.7	$178.1	$87.7	$15.0	$10.0	$2.7	$6.1	$2.1

* Excludes bills received beyond six months of the end of the calendar year of service.

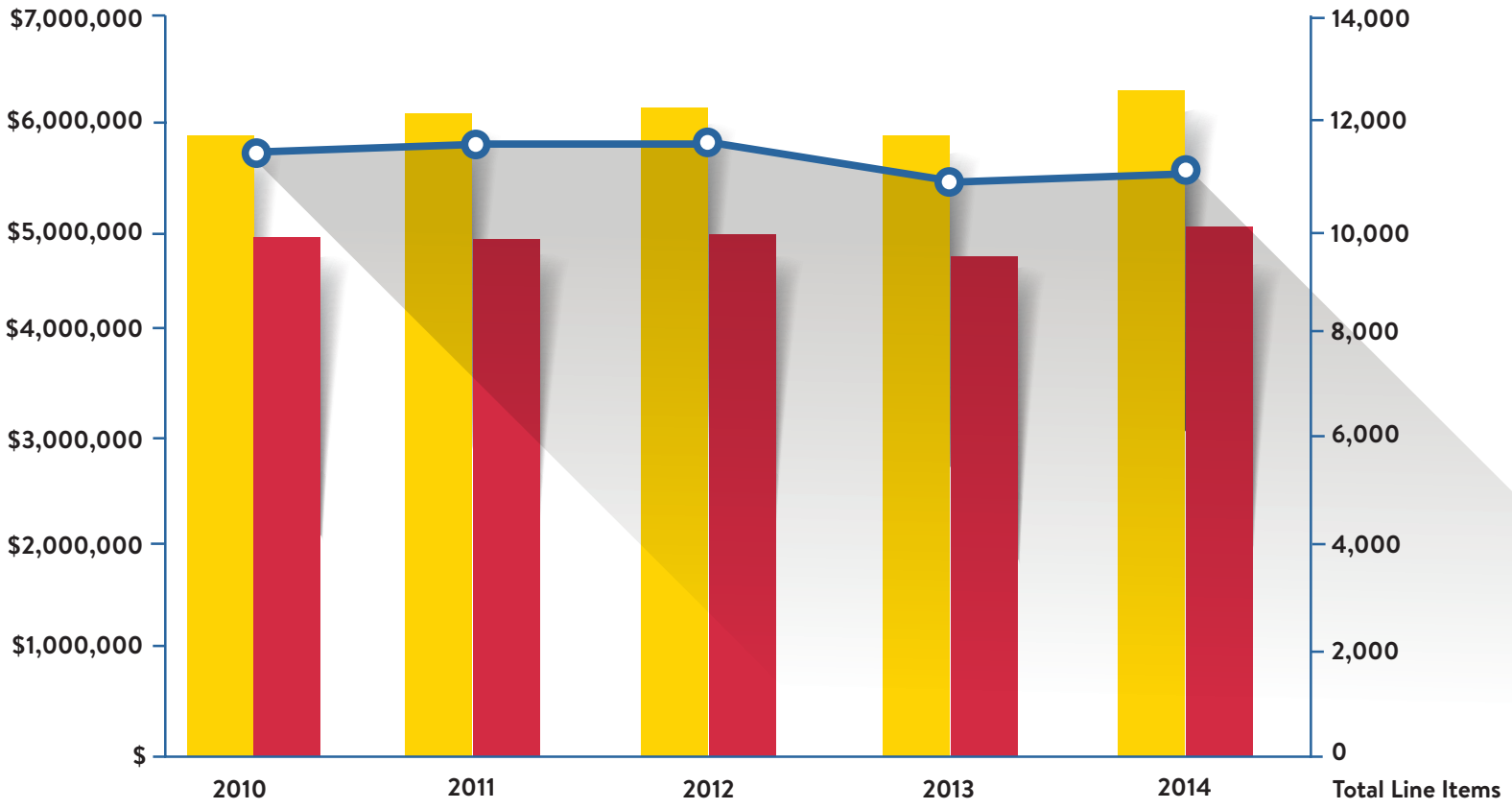
TOTAL CHARGES AND TOTAL PAID FOR HEALTH CARE PROVIDER SERVICES



	2010	2011	2012	2013	2014	Total Line Items
Charges	$1,024,863,456.56	$1,055,744,096.59	$1,065,938,674.25	$1,089,881,029.16	$1,104,779,507.60	
Paid	$503,714,792.97	$507,956,260.92	$506,860,171.24	$500,274,014.70	$490,913,794.94	
Avg Chg Per Line Item	$169.60	$171.76	$173.92	$180.51	$180.65	
Avg Paid Per Line Item	$83.36	$82.64	$82.70	$82.86	$80.27	
Total Line Items	$6,042,898	6,146,507	6,128,809	6,037,644	6,115,484	

Note: Only bills with payment amount >$0 are included. Prescription drugs & supplies are included when dispensed by a health care provider.

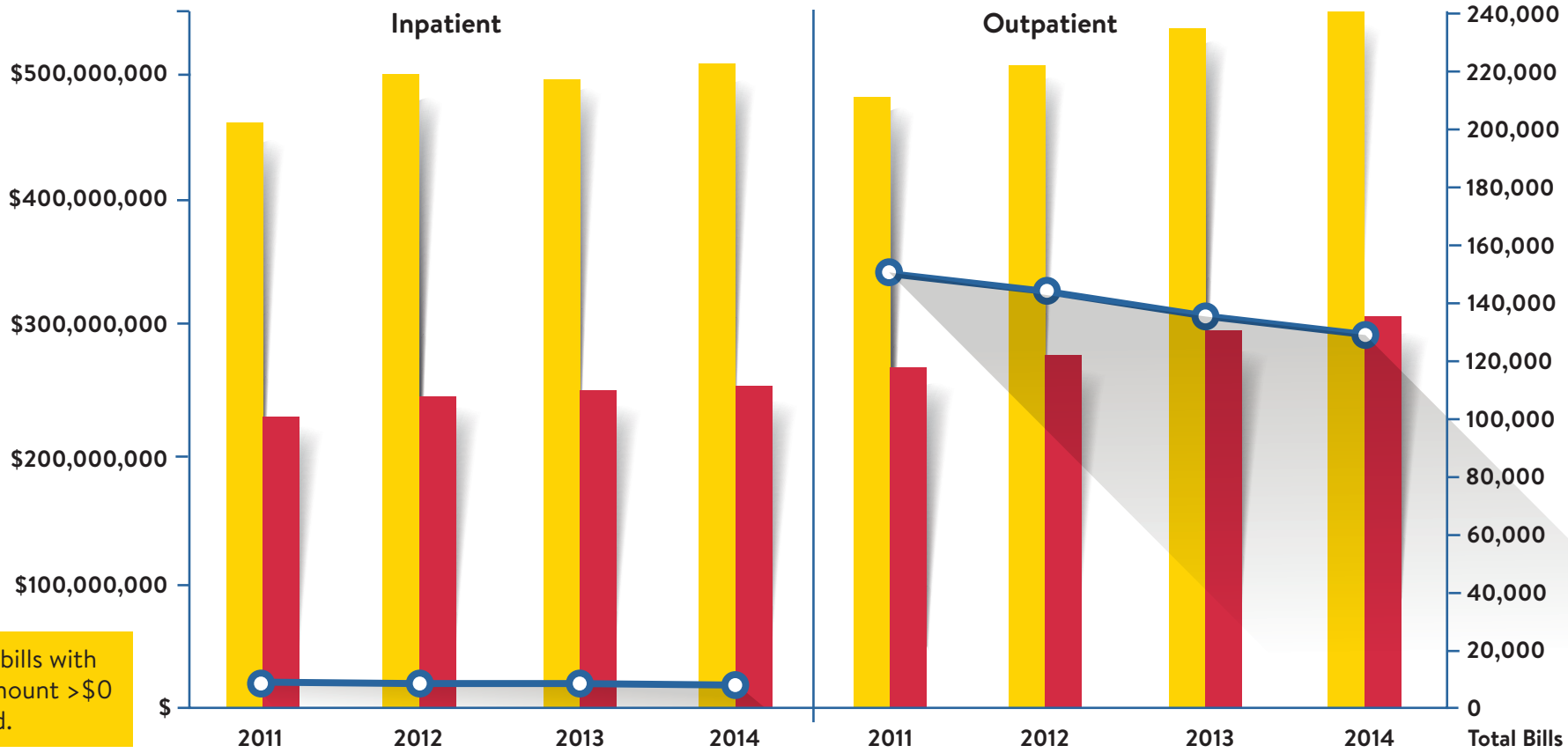
TOTAL CHARGES AND TOTAL PAID FOR DENTAL SERVICES



	2010	2011	2012	2013	2014
Charges	$5,853,953	$6,041,692	$6,114,348	$5,838,850	$6,265,713
Paid	$4,908,858	$4,887,736	$4,908,445	$4,701,272	$4,986,966
Avg Chg Per Line Item	$511	$523	$528	$540	$568
Avg Paid Per Line Item	$429	$423	$424	$435	$452
Total Line Items	11,450	11,552	11,575	10,804	11,026

Note: Only bills with payment amount >$0 are included.

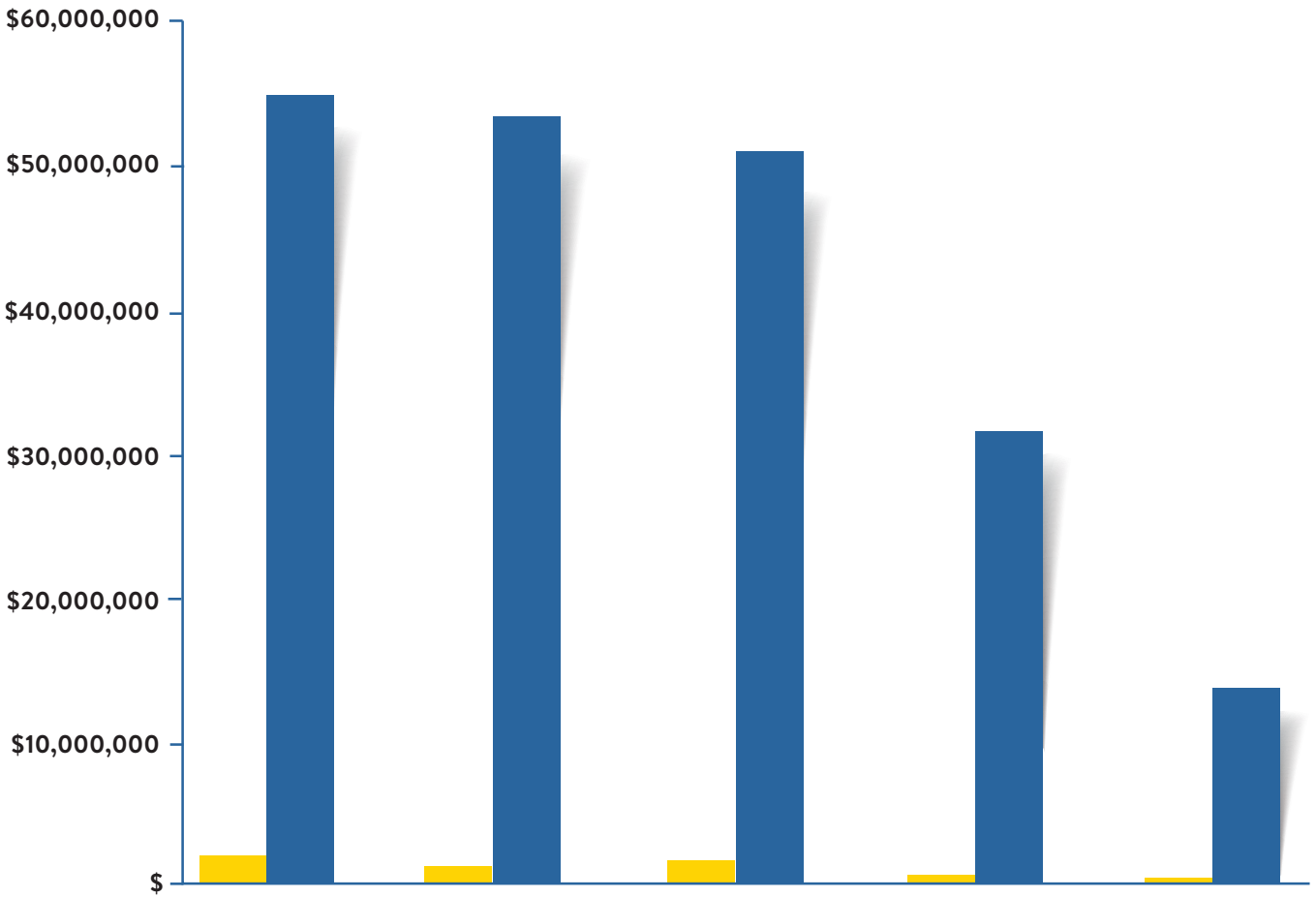
TOTAL CHARGES & TOTAL PAID BY HOSPITAL BILL TYPE



Note: Only bills with payment amount >$0 are included.

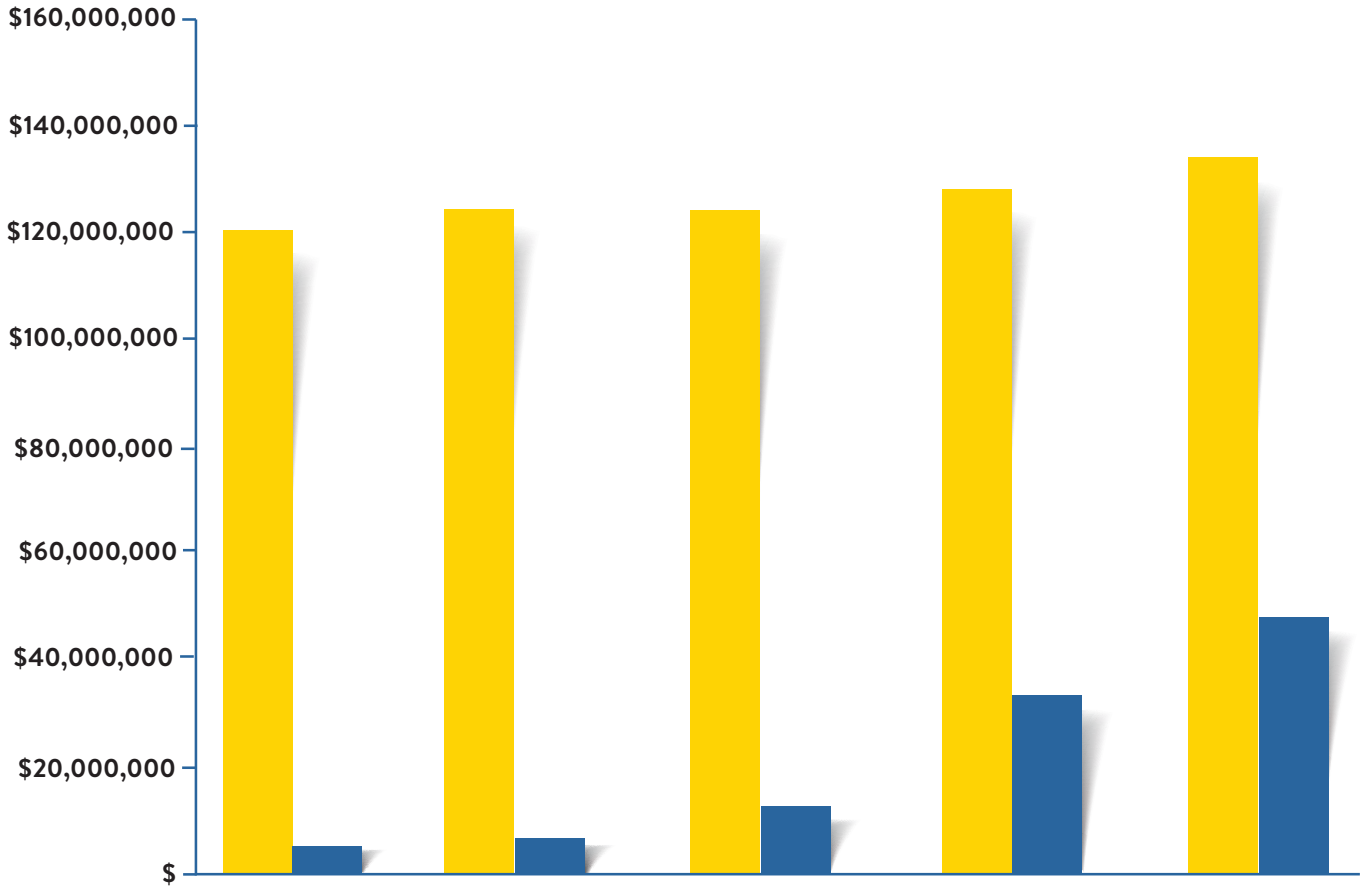
	Inpatient				Outpatient			
	2011	2012	2013	2014	2011	2012	2013	2014
Charges	$461,092,53	$499,306,23	$495,184,81	$507,369,63	$479,796,89	$504,493,25	$535,181,42	$559,882,51
Paid	$227,264,92	$242,950,12	$247,367,64	$253,206,29	$265,412,48	$276,231,39	$295,655,79	$307,797,14
Avg Chg Per Bill	$56,012	$60,647	$65,164	$71,001	$3,211.81	$3,520.34	$3,979.07	$4,317.28
Avg Paid Per Bill	$27,607	$29,509	$32,553	$35,433	$1,776.70	$1,927.54	$2,198.20	$2,373.44
Total Bills	8,232	8,233	7,599	7,146	149,385	143,308	134,499	129,684

PHARMACY VS. PHYSICIAN REPACKAGED DRUG PAYMENTS



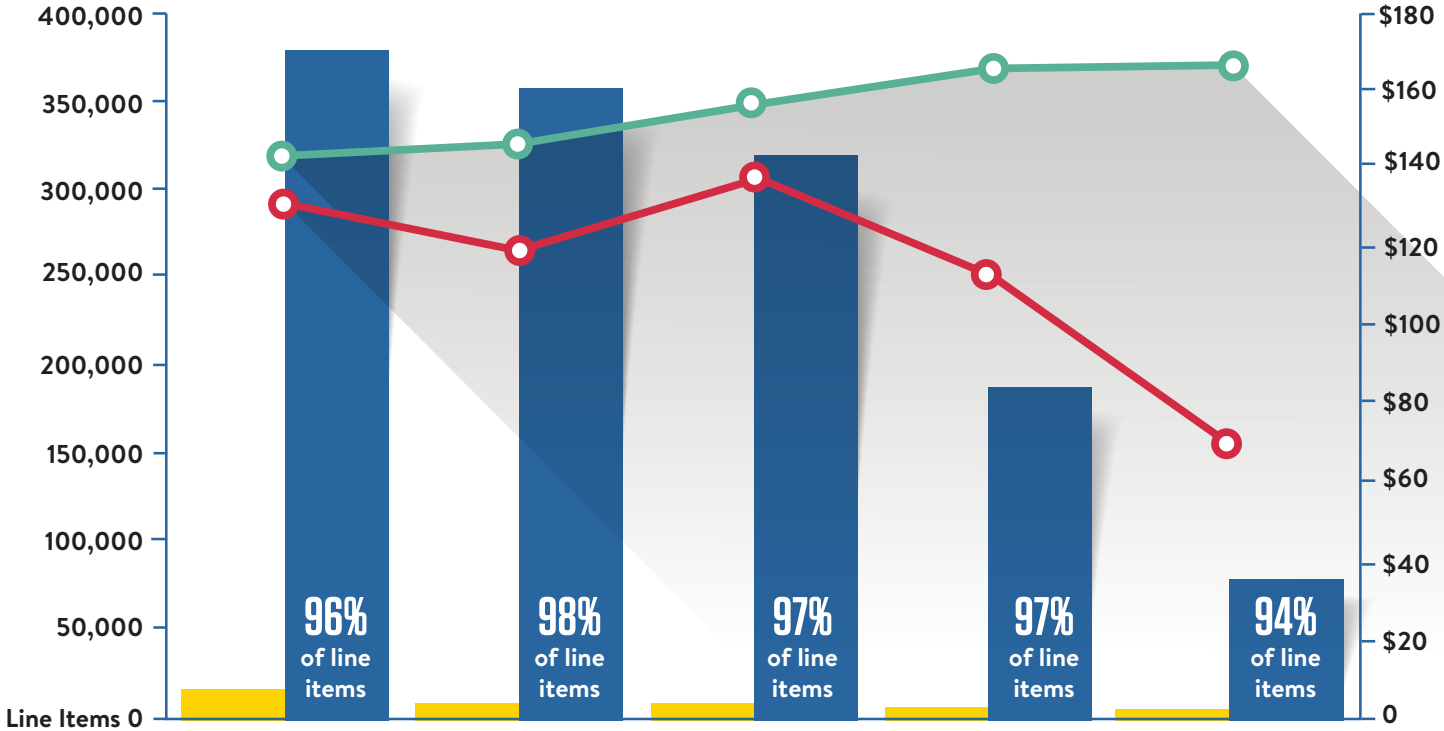
	2010	2011	2012	2013	2014
Pharmacy	$1,866,733	$1,071,147	$1,421,293	$685,273	$337,437
Physician Repackaged	$54,483,892	$52,598,975	$50,194,161	$31,114,701	$13,530,606

PHARMACY VS. PHYSICIAN NONREPACKAGED DRUG PAYMENTS



	2010	2011	2012	2013	2014
Pharmacy Nonrepackaged Total Payments	$120,171,702	$124,269,995	$123,828,322	$127,495,455	$133,757,774
Physician Nonrepackaged Total Payments	$4,494,377	$6,425,850	$12,071,919	$32,770,669	$47,364,562

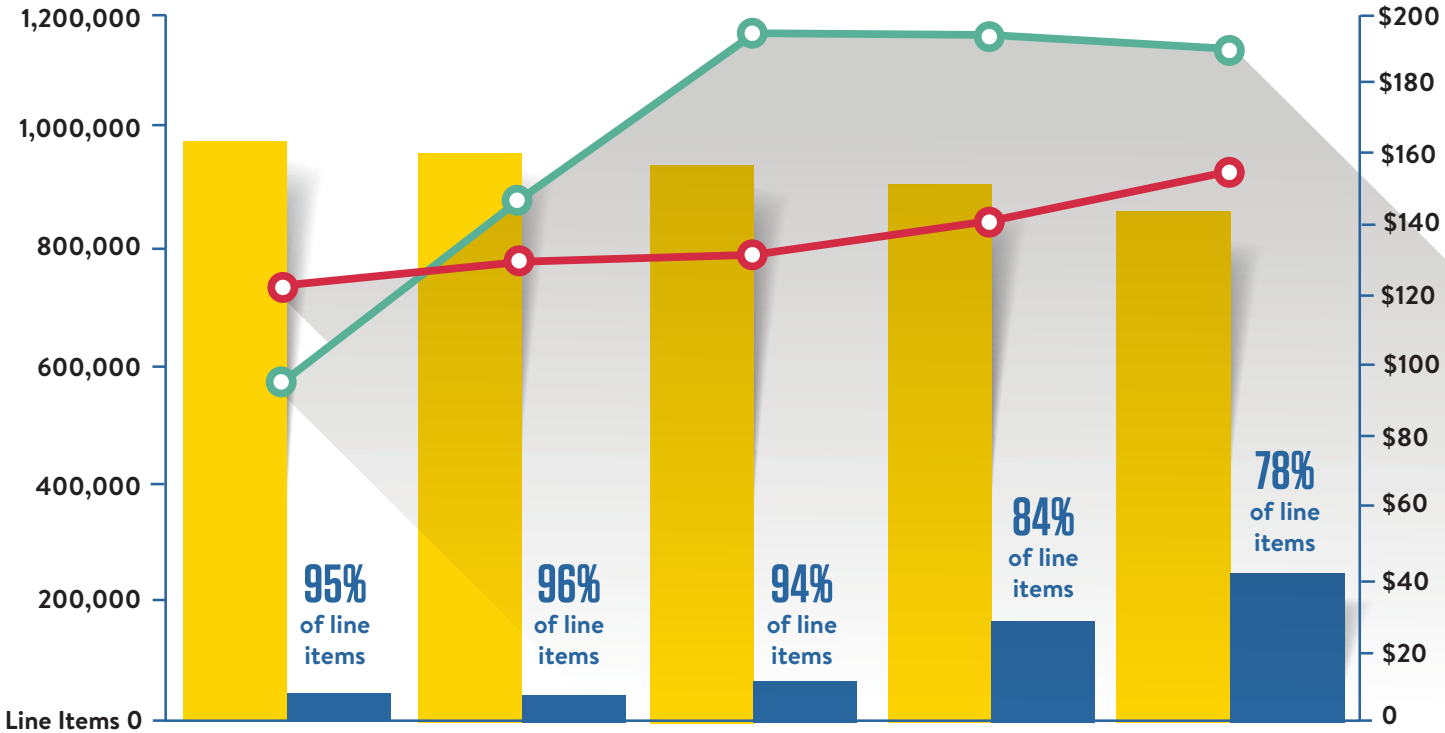
PHARMACY VS. PHYSICIAN REPACKAGED DRUGS



	2010	2011	2012	2013	2014
Pharmacy Repackaged Line Items	14,131	8,976	10,378	6,073	4,809
Physician Repackaged Line Items	378,163	367,957	320,927	188,388	81,413
Pharmacy Repackaged Avg $ Per Line Item	$132	$119	$137	$113	$70
Physician Repackaged Avg $ Per Line Item	$144	$147	$156	$165	$166

Graph compares drugs billed on DWC-10 forms (dispensed by pharmacies) to drugs billed on DWC-9 forms (dispensed by physicians). Reference to line items also means per prescription.

PHARMACY VS. PHYSICIAN NONREPACKAGED DRUGS



	2010	2011	2012	2013	2014
Pharmacy Nonrepackaged Line Items	974,687	952,405	935,439	901,692	857,689
Physician Nonrepackaged Line Items	46,580	43,315	62,288	170,210	248,726
Pharmacy Nonrepackaged Avg $ Paid Per Line Item	$123.00	$130.00	$132.00	$141.00	$156.00
Physician Nonrepackaged Avg $ Paid Per Line Item	$96.00	$148.00	$194.00	$193.00	$190.00

Graph compares drugs billed on DWC-10 forms (dispensed by pharmacies) to drugs billed on DWC-9 forms (dispensed by physicians). Reference to line items also means per prescription.

LOST-TIME CLAIMS DATA

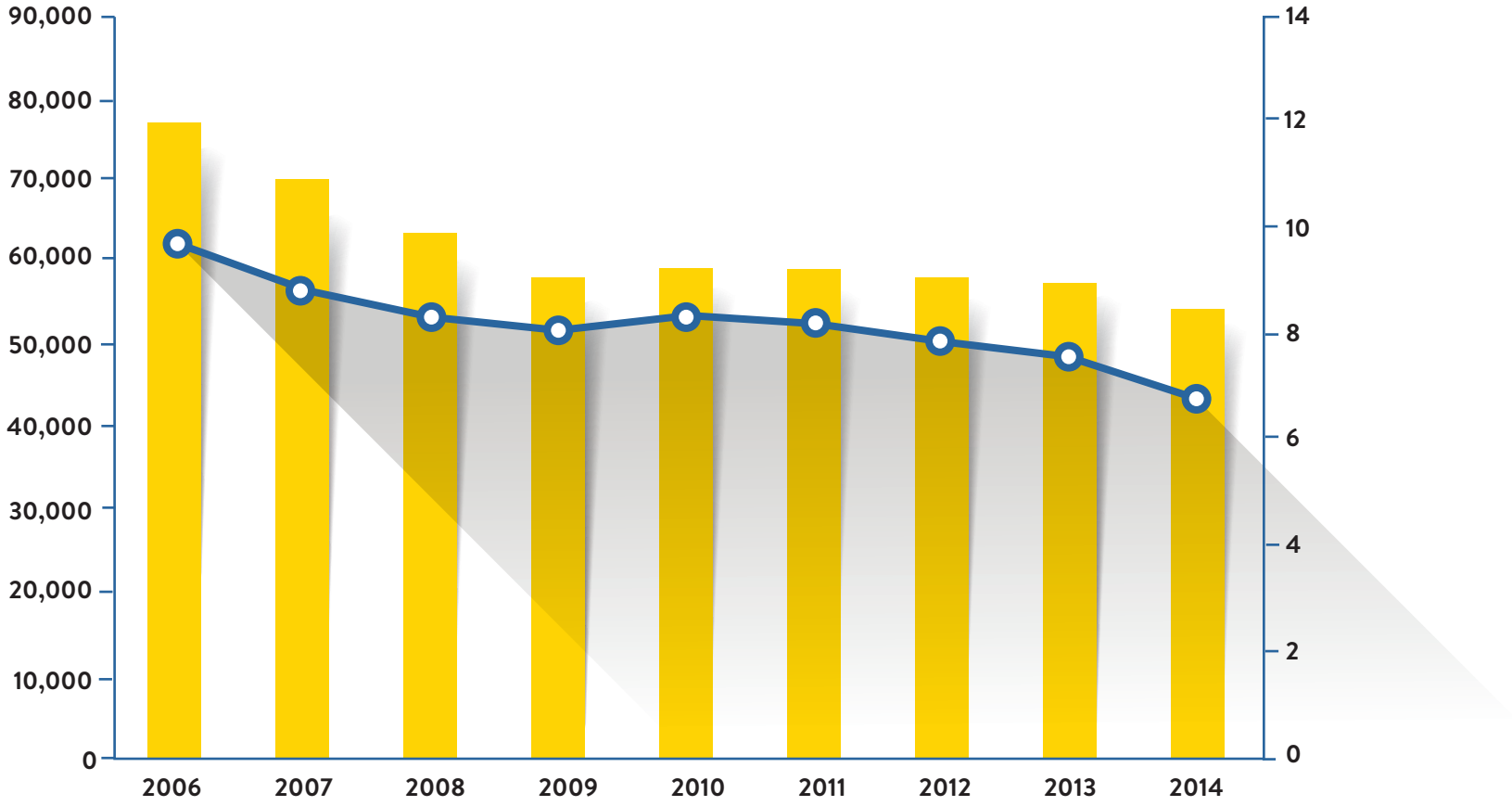
Workers sustaining a compensable injury are entitled to receive medically necessary treatment under Florida's workers' compensation statute. If the injury results in disability for more than 7 days, the injured worker is entitled to payment for a portion of lost wages. Injuries resulting in permanent impairment result in additional benefits being paid to the injured employee. When an injury results in a workplace fatality, survivor dependent benefits and funeral expenses may be paid.

Multiple factors are considered when determining if benefit payments for lost wages or permanent impairments are due: the injured worker's prior earnings, the nature and extent of the injury, the length of the healing period, and the worker's ability to return to work. To be deemed a Lost-Time case, an injured worker's disability must result in a benefit payment(s) for lost wages, a permanent impairment, or a settlement.

TOP TEN INDUSTRIAL CLASSIFICATIONS FOR 2014 LOST-TIME CLAIMS

	Number of Claims
Administrative, Support, Waste Management, Remediation	7,165
Retail Trade	5,899
Construction	5,453
Health Care & Social Assistance	4,940
Accommodation & Food Services	4,501
Public Administration	4,453
Manufacturing	3,599
Transportation & Warehousing	3,503
Educational Services	3,165
Wholesale Trade	1,898

LOST-TIME CLAIMS AND LOST-TIME CLAIM RATE**

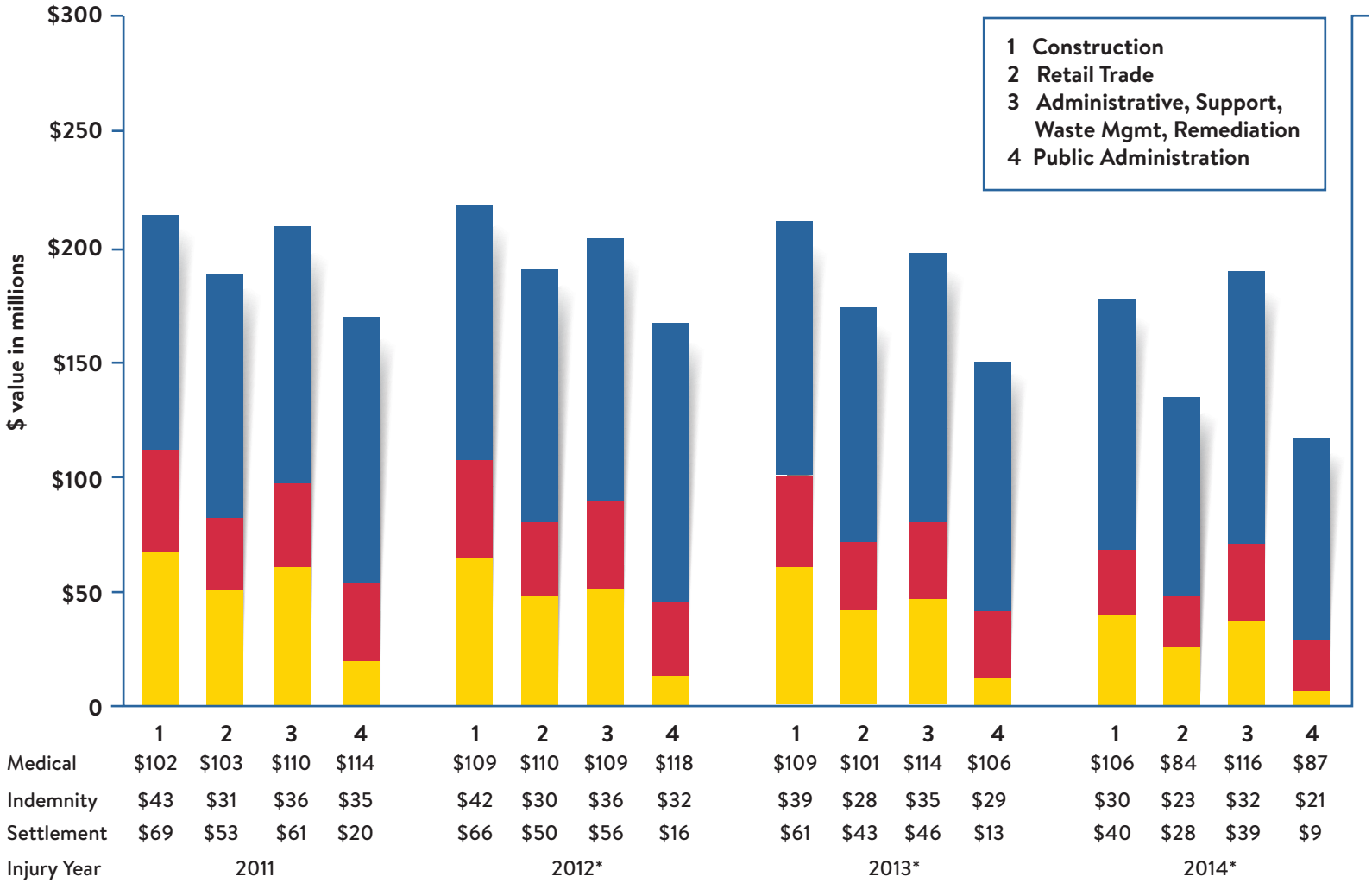


	2006	2007	2008	2009	2010	2011	2012	2013	2014
Lost-Time Claims	76,482	69,335	62,782	57,780	58,545	58,321	57,500	56,494	53,318
Rate Per 1,000 Employees	9.7	8.8	8.3	8.1	8.3	8.2	7.9	7.6	6.9

Source: Florida Department of Economic Opportunity, Current Employment Statistics, Office of Labor Market Statistics, July 2015
**Lost-time claim frequencies as of 7/30/15, based on the most recent information from insurers about determinations & dispositions.

The chart below illustrates the total benefit payments for the four industrial classifications whose benefit payments for medical, indemnity, and settlement benefits are the highest. Each year represents a different level of data maturity with 2011 being deemed mature.

BENEFIT PAYMENTS FOR THE FOUR LEADING INDUSTRIAL CLASSIFICATIONS



	2011				2012*				2013*				2014*			
Injury Year	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Medical	$102	$103	$110	$114	$109	$110	$109	$118	$109	$101	$114	$106	$106	$84	$116	$87
Indemnity	$43	$31	$36	$35	$42	$30	$36	$32	$39	$28	$35	$29	$30	$23	$32	$21
Settlement	$69	$53	$61	$20	$66	$50	$56	$16	$61	$43	$46	$13	$40	$28	$39	$9

*Preliminary Data

Medically necessary treatment for a work-related injury may involve : the services of physicians, physical therapists, chiropractors, dentists, or other health care providers; services of hospitals, ambulatory surgical centers, or skilled nursing facilities; and medicines, supplies, equipment, and related items such as prosthetic devices or implants. Until recovery is achieved, medical benefits continue.

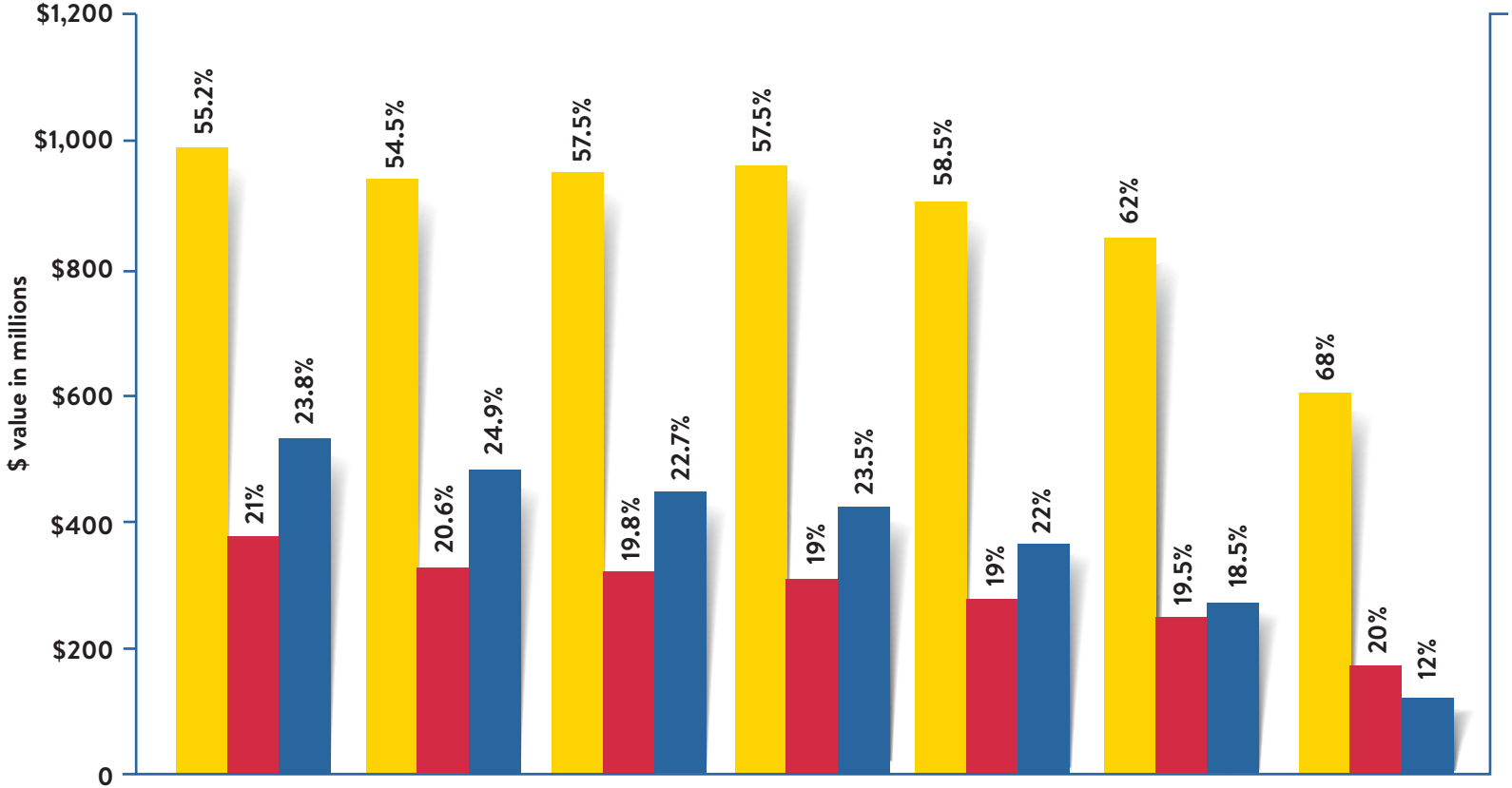
Claim development differences explain the priority of medical services early in the life of a claim and the increase in settlements as claims progress.

MEDICAL PAYMENTS FOR LOST-TIME CLAIMS

Calendar Year	Health Care Providers, Dental, Ambulatory Surgical Center	Hospital	Pharmacy	All Other Medical
2008	39.6%	35.2%	6.9%	18.3%
2009	38.6%	38.1%	6.4%	16.9%
2010	33.2%	44.4%	5.7%	16.7%
2011	30.9%	46.6%	5.3%	17.3%
2012*	30.5%	49.3%	4.7%	15.5%
2013*	28.7%	51.2%	4.2%	15.9%
2014*	27.8%	55.2%	3.6%	13.4%

*Preliminary Data

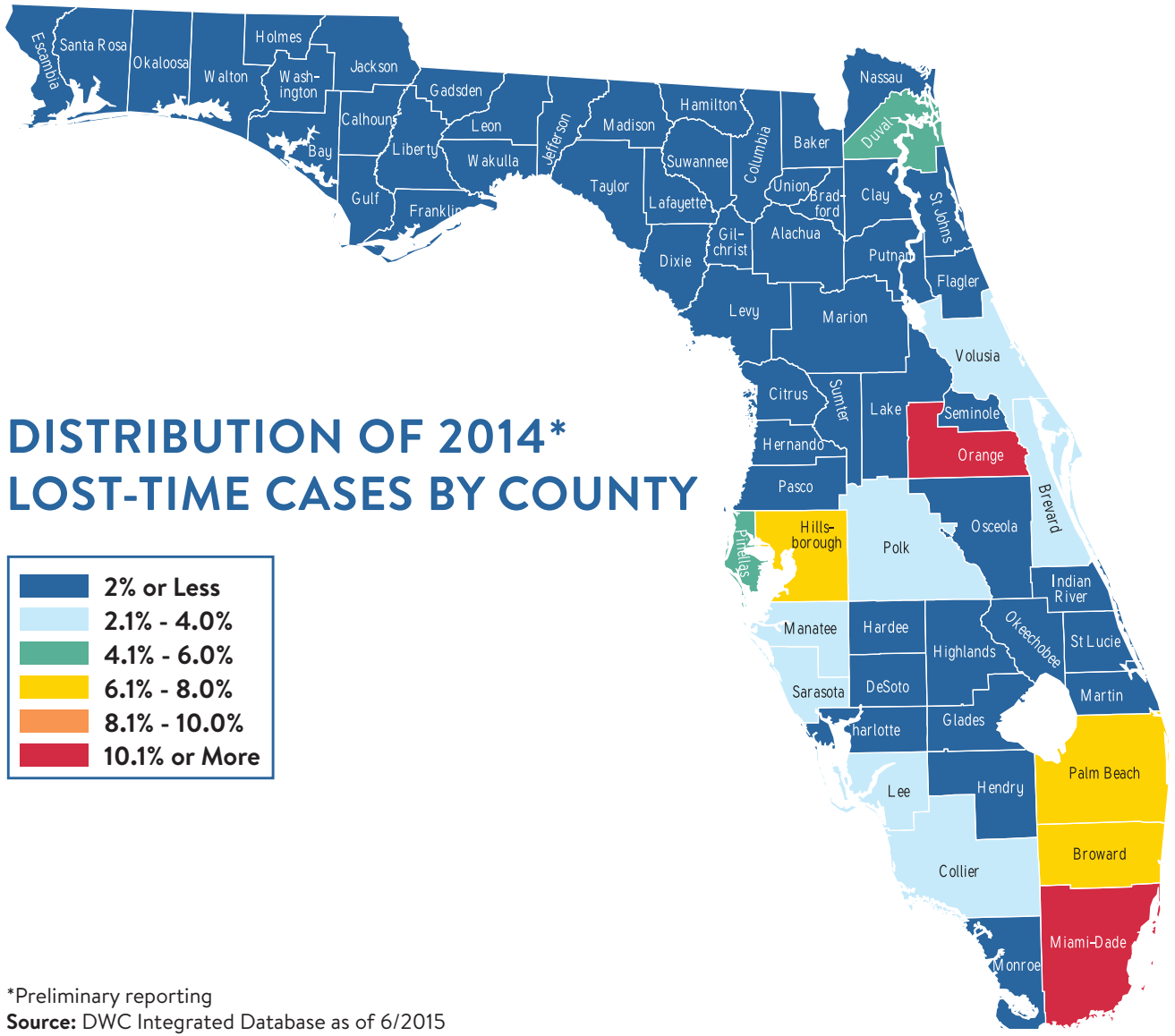
MEDICAL, INDEMNITY, AND SETTLEMENT COSTS FOR LOST-TIME CLAIMS



	2008	2009	2010	2011	2012*	2013*	2014*
Medical	$990.3	$939.5	$953.3	$960.3	$907.9	$838.7	$600.3
Indemnity	$374.9	$326.4	$315.4	$304.1	$280.1	$248.1	$172.5
Settlement	$528.2	$481.7	$446.8	$420.4	$367.6	$268.9	$119.5

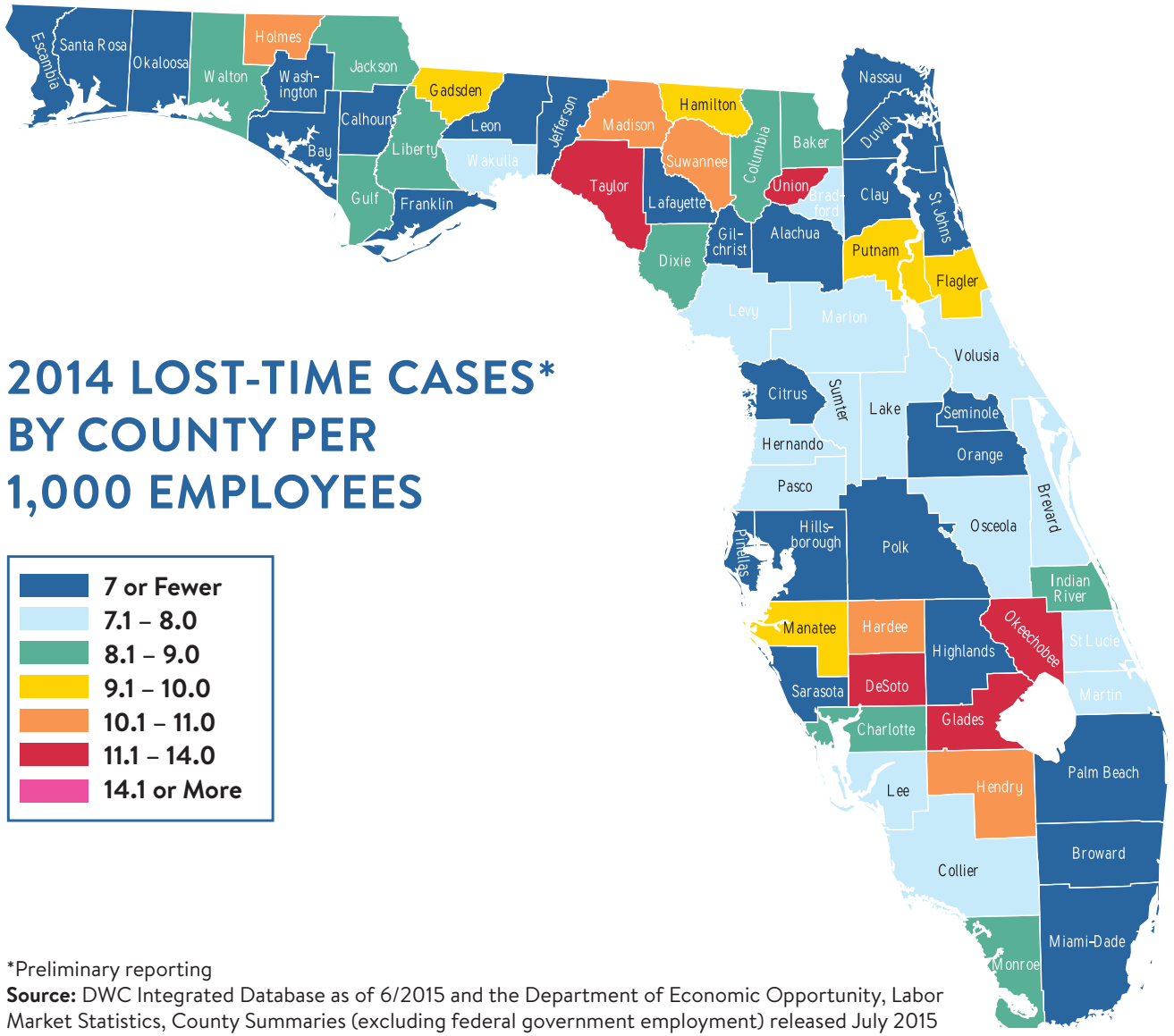
*Preliminary Data

DISTRIBUTION OF 2014* LOST-TIME CASES BY COUNTY



*Preliminary reporting
Source: DWC Integrated Database as of 6/2015

2014 LOST-TIME CASES* BY COUNTY PER 1,000 EMPLOYEES



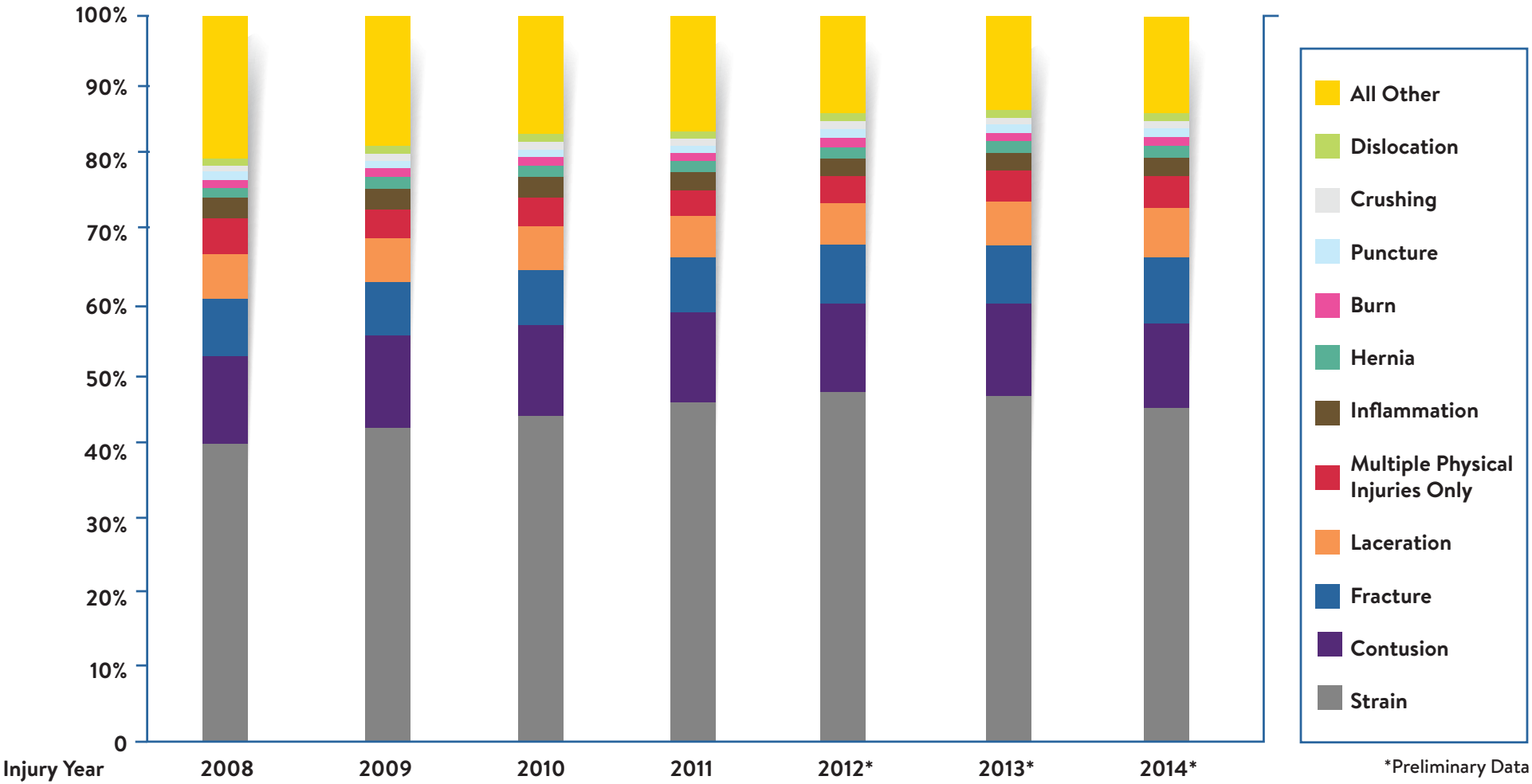
*Preliminary reporting

Source: DWC Integrated Database as of 6/2015 and the Department of Economic Opportunity, Labor Market Statistics, County Summaries (excluding federal government employment) released July 2015

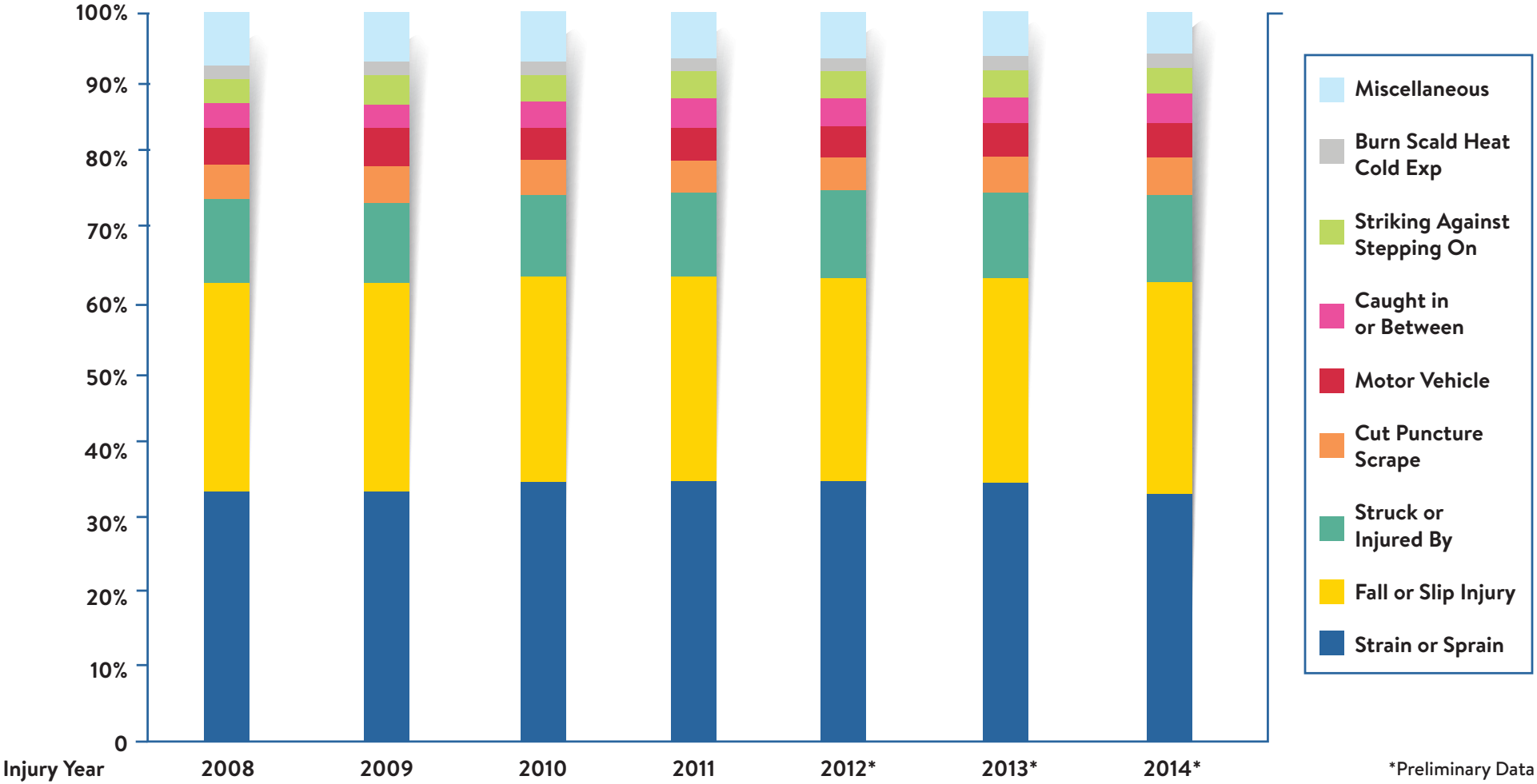
NATURE, CAUSE & BODY LOCATION OF INJURY

As part of the First Report of Injury or Illness, employers or claim administrators provide information on the nature, cause, and body part of each workplace injury. The following charts summarize that information to depict recent and historical patterns of lost-time injuries. Because the information is reported on the First Report of Injury or Illness, it may not correspond to a diagnosis made by a health care professional. Additionally, the figures may change slightly over time due to preliminary reporting of data.

LOST-TIME CLAIMS BY NATURE OF INJURY

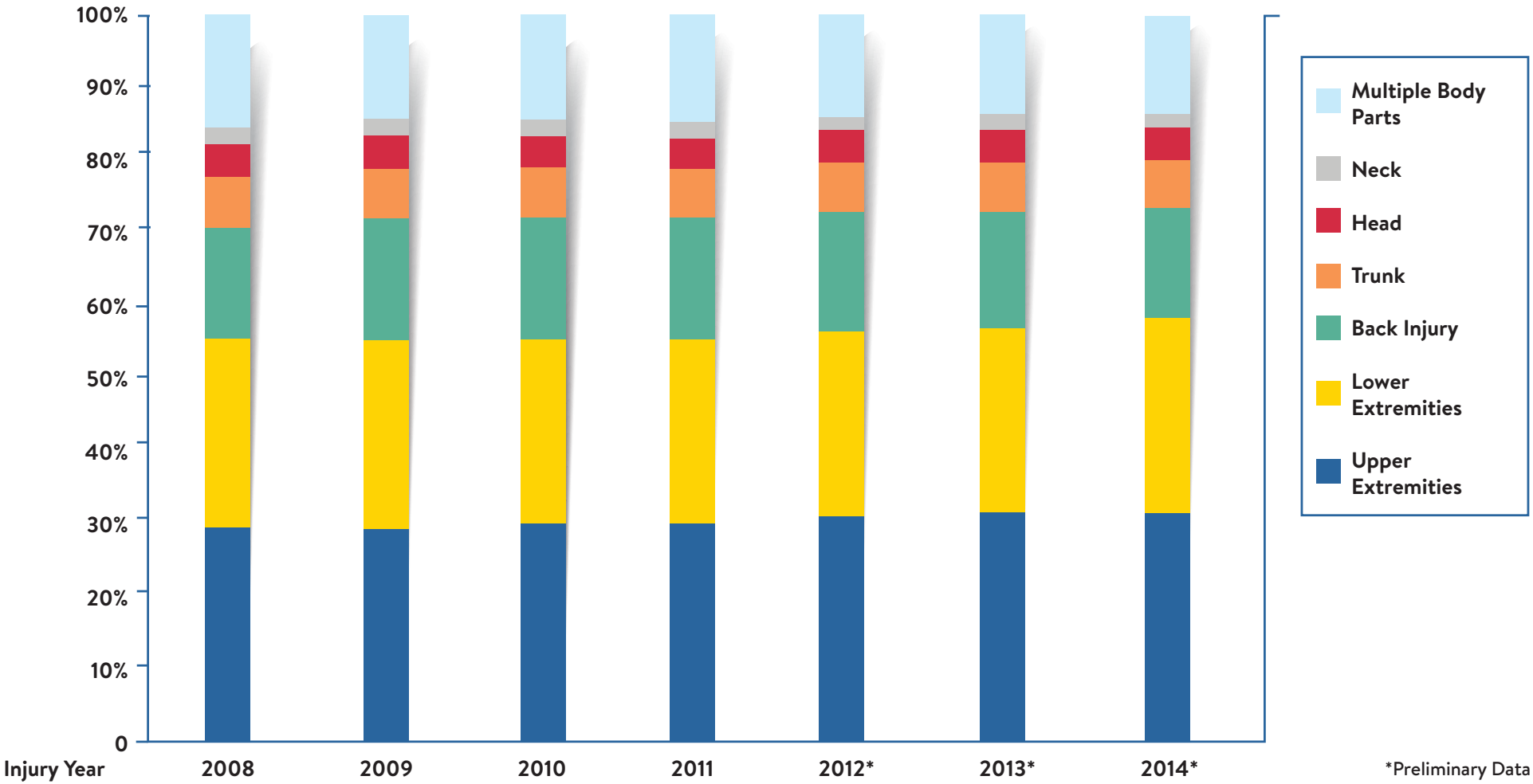


LOST-TIME CLAIMS BY CAUSE OF INJURY



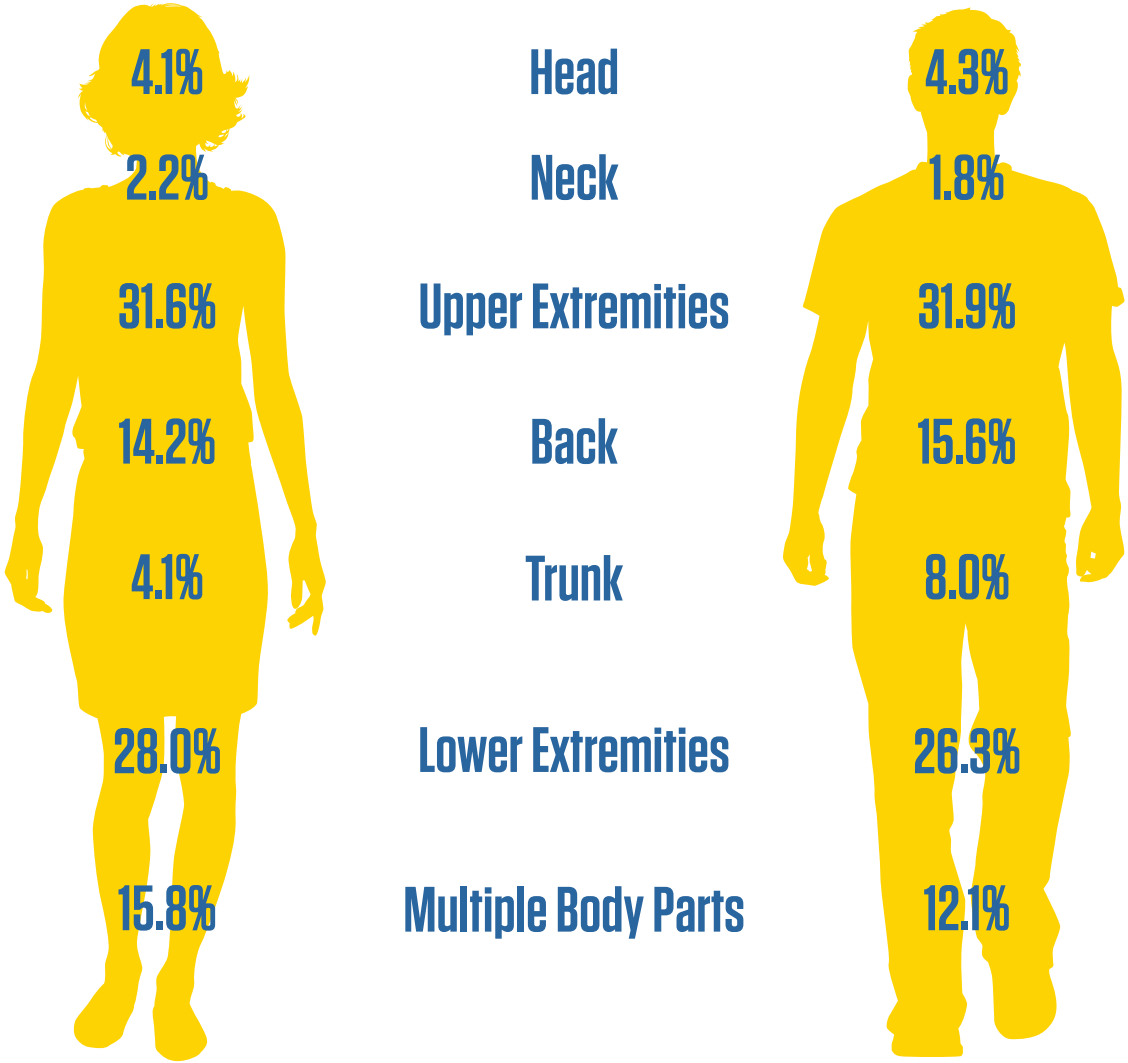
*Preliminary Data

LOST-TIME CLAIMS BY INJURED BODY PART



*Preliminary Data

INJURY BODY LOCATION BY GENDER FOR 2014 LOST-TIME CLAIMS



DWC CONTACTS

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Pam Macon, Bureau Chief

Bureau of Employee Assistance: (850) 413-1786
Stephen Yon, Bureau Chief

Bureau of Data Quality and Collection: (850) 413-1737
Lisel Laslie, Bureau Chief

Bureau of Compliance: (850) 413-1775
Robin Delaney, Bureau Chief

DWC HOTLINES & WEBSITES

HOTLINES:

Reporting Deaths: (800) 219-8953

Compliance Fraud Referral Hotline: (800) 742-2214

Employee Assistance Office Hotline: (800) 342-1741

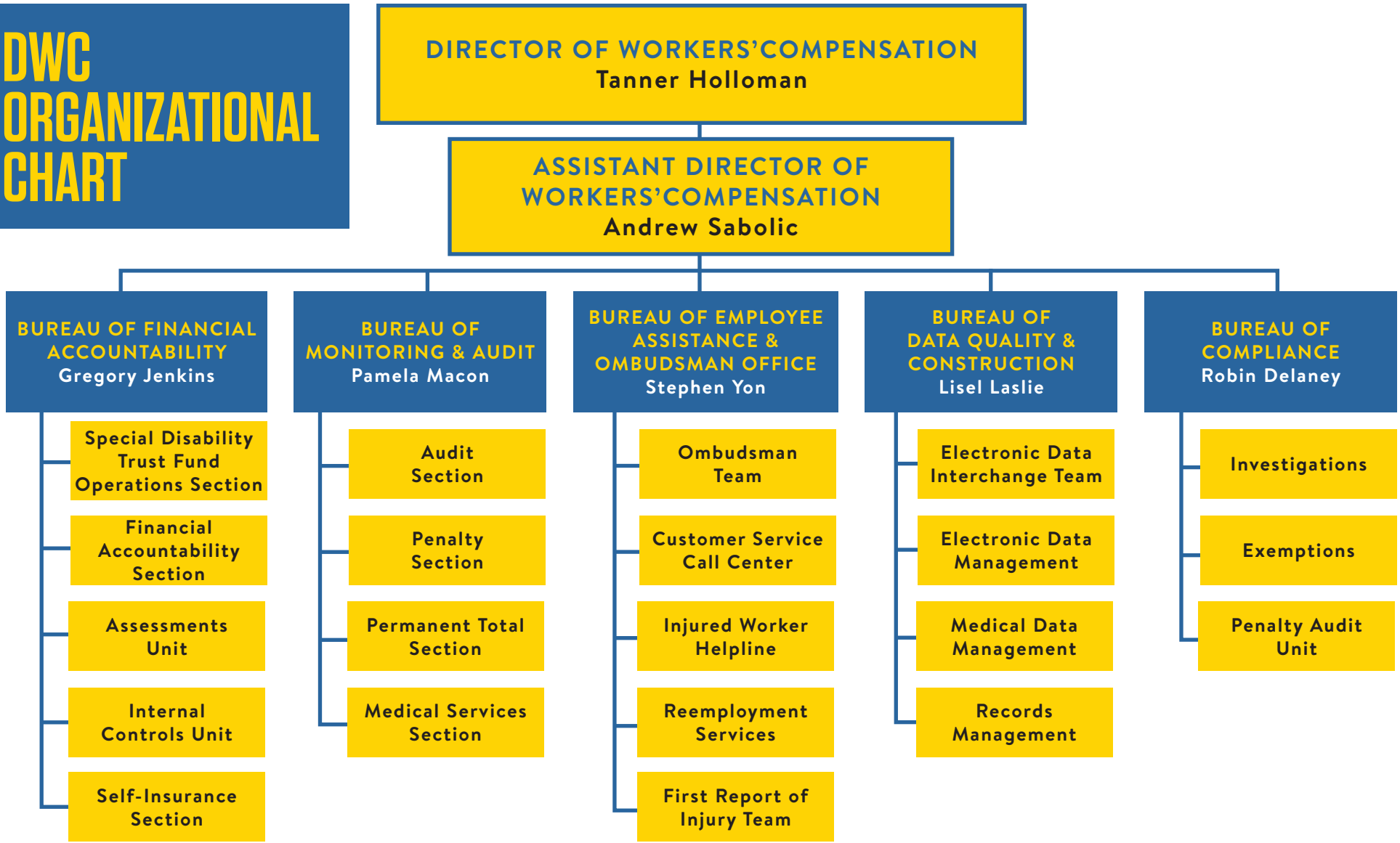
Customer Service Center: (850) 413-1601

WEBSITES:

Contact information for Bureau of Compliance and Bureau of Employee Assistance and Ombudsman District Offices may be found on the Division's website at: **http://www.myfloridacfo.com/Division/WC/dist_offices.htm**.

The Division of Workers' Compensation website home page is located at: **http://myfloridacfo.com/division/wc** and provides direct information access for all stakeholders in the Workers' Compensation System. The website organizes items of interest by stakeholder group with tabs for Employer, Insurer, Employee, and Provider.

DWC ORGANIZATIONAL CHART



CHIEF FINANCIAL OFFICER

JEFF ATWATER

FLORIDA DEPARTMENT OF FINANCIAL SERVICES

DIVISION OF WORKERS' COMPENSATION

2015 RESULTS & ACCOMPLISHMENTS REPORT