APPENDIX A

Agency Overview

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The Texas Department of Insurance (TDI) was created in 1876. The current insurance industry business grew out of a common need for Texans to protect themselves, protect their property, and protect the equipment and other assets that helped them to earn a living. Throughout 130 years of regulation, a number of trends and issues have come and gone, but one remaining issue is the delicate balance of the department's multiple roles as regulator, a protector of consumers, and a promoter of competition in the industry.

Agency Structure and Functions

TDI is headed by the Commissioner of Insurance. With the inception of HB 7, the Division of Workers' Compensation (DWC) is headed by the Commissioner of Workers' Compensation. The Governor appoints both Commissioners to a two-year term, subject to Senate confirmation. TDI's mission is to regulate various types of insurance, including life, health, title, property and casualty, and workers' compensation.

TDI is organized into nine functional areas, in addition to the Commissioner's Office. Each functional area is lead by an Associate Commissioner, Senior Associate Commissioner, or the State Fire Marshal, who report directly to the Commissioner of Insurance and lead each of the programs listed below. The Commissioner of Workers' Compensation administers and exercises rule-making authority for DWC, in close coordination with the Commissioner of Insurance. The nine functional areas include:

- Consumer Protection
- Division of Workers' Compensation
- Financial
- Insurance Fraud Unit
- Legal and Compliance
- Life, Health and Licensing
- Property and Casualty
- State Fire Marshal's Office, and
- Administrative Operations

A brief description of the purpose of each program follows. For more information, see TDI's Organizational Chart in Appendix C.

Commissioner's Office supports the activities of the Commissioner. As the agency's chief administrator, the Commissioner enforces state insurance laws, establishes agency operating procedures, and oversees agency regulatory activities. Currently the Commissioner's Office is undergoing a realignment of duties to better reflect the structure of the organization; however, the office at this time includes: General Counsel and Chief Clerk, Executive Services, Commissioner's Ombudsman, Internal Audit, Government Relations, and the Public Information Office.

Consumer Protection answers general insurance inquiries, resolves consumer complaints, reviews insurance advertising, and educates consumers about insurance. The program provides information to consumers through a consumer help line, TDI's website, publications, and

presentations. It also helps to identify unfair practices through the review of consumer complaints and industry advertisements.

Division of Workers' Compensation (DWC) is administratively supported by TDI. DWC is organized into four functional areas, which include Legal and Compliance, Dispute Resolution, Field Services, Workplace & Medical Services, and are led by Deputy Commissioners to perform the responsibilities authorized by the Texas Workers' Compensation Act and to maintain a balanced workers' compensation system. A General Counsel and a Medical Advisor also advise and support the Commissioner and the Division's functions.

Financial enforces solvency standards for insurance companies and related entities. This enforcement encompasses an entity's entire life cycle from initial formation/licensure through subsequent surveillance, to implementing regulatory interventions involving troubled entities. The Financial Program seeks to rehabilitate companies that fall short of solvency standards, and through a court-sanctioned receivership process, it eventually liquidates the few that cannot be rehabilitated. The Program's over-arching objective is to ensure that insurance companies are financially capable of paying claims owed to policyholders when the claims come due. The Financial Program also promotes competition in the industry while identifying suspected fraud, misrepresentation, and unfair practices. The Financial Program is also responsible for oversight of the five guaranty associations, which help protect policyholders and claimants of insolvent insurance companies.

Insurance Fraud Unit is a law enforcement agency, employing licensed peace officers pursuant to Texas Insurance Code, Chapter 701 and the Texas Code of Criminal Procedure, Article 2.12 (28). Insurance Fraud professionals investigate fraudulent acts for referral to criminal district attorneys and federal prosecutors. Insurance Fraud staff include certified peace officers, prosecutors, Certified Fraud Examiners (CFE), Certified Internal Auditors (CIA), and criminal analysts.

Legal and Compliance provides legal support to the agency; responds to national and international trends in the various insurance lines; develops and enforces industry rules; acts against those entities and individuals engaging in fraud, misrepresentation, or unfair practices; and takes appropriate action to safeguard policyholders from operationally and financially troubled insurance companies.

Life, Health, and Licensing regulates policy forms and related documents for life, accident and health insurance; health maintenance organizations (HMOs); credit life insurance; credit accident and health insurance; viatical/life settlements; annuities; and non-profit pre-paid legal plans. The program licenses and regulates utilization review agents (URAs), insurance agents, adjusters, third-party administrators (TPAs), workers' compensation networks, and other entities. The program licenses independent review organizations (IROs) and viatical/life settlement providers, provider representatives and brokers. The program receives and performs an initial screening of filings for property and casualty lines, as well as the lines listed above. In addition, the program investigates and resolves complaints related to HMOs and workers' compensation networks, as well as conducts examinations of HMOs, workers' compensation networks, and other regulated entities. Finally, the program is responsible for collecting and analyzing extensive data related to

various types of insurance and conducting research studies related to the uninsured and options for expanding coverage.

Property and Casualty regulates policy form and rate filings for property and casualty lines, including workers' compensation; assists in promulgating title rates and forms; is responsible for oversight of the residual markets, Texas Medical Liability Insurance Underwriting Association (JUA), Texas FAIR Plan Association, Texas Windstorm Insurance Association (TWIA) and the Texas Automobile Insurance Plan Association; oversees safety and loss prevention services; handles field examinations of title agents; performs the agency's research, statistical data collection and analysis duties; and assists homeowners with finding insurance coverage.

State Fire Marshal's Office develops and promotes methods of protecting the lives and property of Texans from fire and related hazards through direct action and coordination with the public safety community.

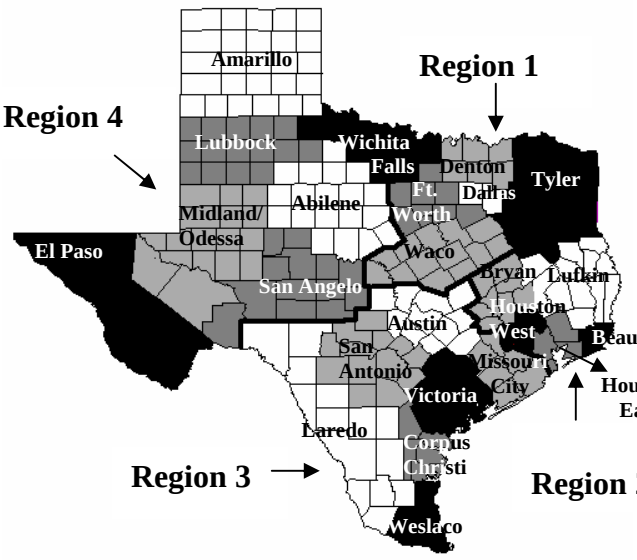
Administrative Operations supports the agency's regulatory duties through planning, accounting, and budgeting; information technology services; building and records management; purchasing; mail services; personnel and benefits; professional development; and the employee ombudsman and ethics advisor who is charged with helping encourage positive solutions to workplace problems.

Service Locations

The Texas Department of Insurance maintains two central offices located in Austin. All TDI programs, except workers' compensation programs under the Division of Workers' Compensation are located at the William P. Hobby State Office Building located at 333 Guadalupe Street. DWC's central office is located at 7551 Metro Center Drive. In addition to the central offices, DWC administers a record center in Austin, which provides safe storage and maintenance of more than 1.4 million workers' compensation claim files in paper form, approximately 31,000 reels of microfilm and 1 million microfiche with claim file information, and 2 million employer insurance coverage files in paper form. TDI also maintains a training and disaster recovery center in Austin.

The agency serves all geographic areas of Texas, although the services required in different regions may vary. Insurance consumers throughout the state purchase basics such as automobile or homeowners insurance. However, the Texas Gulf Coast region may require additional services on windstorm-related protection, which were realized during the 2005 hurricane season, and North Texas may require attention resulting from weather-related events that may lead to roof damage claims from tornadoes or other losses, such as fire protection, as seen with the wildfires during the 2006 drought. For these reasons, some TDI employees work in the field offices located throughout the state as required by various agency programs. TDI maintains offices in Dallas, Houston, San Antonio, Corpus Christi (serving the Gulf Coast), the Rio Grande Valley, and satellite offices throughout the state.

DWC has 24 field offices strategically located across Texas, as depicted in the map below. Field office locations are determined by claim activity and demand for services in the geographic area.



DWC field offices provide claims services, customer services, and dispute resolution services. Ombudsman services are also located in each field office and are provided by the Office of Injured Employee Counsel. Additionally, employees responsible for health and safety assistance are located in 19 field offices. Employees responsible for administrative fraud investigations are located in five field offices.

In addition to the dispute resolution services provided in all field offices, DWC has two facilities, located in Uvalde and Mount Pleasant, for the sole purpose of holding dispute proceedings. The Uvalde and Mount Pleasant facilities assist in ensuring that injured workers will have to travel no more than 75 miles from their residence to a benefit review conference or contested case hearing.

A customer service issue that is unique to all of the bordering areas of the state is how best to serve the needs of employees who were working in Texas when injured but now reside in other bordering states. If an injured employee lives in a bordering state and in a county or parish that is contiguous to the Texas border, the closest field office handles the workers' compensation claim. The Victoria Field Office handles claims for injured workers living outside Texas in counties that do not adjoin the Texas border.

Texas Louisiana Border

The Texas-Louisiana border region is the area set out in law as encompassing the following 18 Northeast Texas counties: Bowie, Camp, Cass, Delta, Franklin, Gregg, Harrison, Hopkins, Lamar, Marion, Morris, Panola, Red River, Rusk, Smith, Titus, Upshur, and Wood.

These counties are included as Commissioner-designated underserved areas for residential property insurance. As underserved, they are determined to encompass populations with difficulties obtaining insurance through the standard market. Residents of all these areas are eligible to apply for coverage through the Fair Access to Insurance Requirements (FAIR) Plan, the insurer of last resort that provides residential property insurance to qualified individuals.

The Texas-Louisiana border area is prone to weather-related events somewhat different from those experienced in other parts of the state. Hurricanes, tornados, ice storms, and hail include the types of weather-related events that may occur in the area. TDI's Disaster Recovery Team is prepared to provide assistance anywhere in the state when disasters occur.

In addition, a windstorm office is provided in Beaumont to determine eligibility for TWIA. One issue in this border region includes reductions in assessments by TWIA. Insurers are provided a statutory incentive for writing property insurance in the First Tier Coastal Counties, including the coastal counties along the Texas-Louisiana and Texas-Mexico border areas.

To serve the DWC customers located along the Texas-Louisiana border, the DWC has field offices in Tyler, Beaumont, and Lufkin and a dispute proceeding facility in Mount Pleasant.

Texas-Mexico Border

The Texas-Mexico border region is the area set out in law as encompassing the following 43 South Texas counties: Atascosa, Bandera, Bexar, Brewster, Brooks, Cameron, Crockett, Culberson, Dimmit, Duval, Edwards, El Paso, Frio, Hidalgo, Hudspeth, Jeff Davis, Jim Hogg, Jim Wells, Kenedy, Kerr, Kimble, Kinney, Kleberg, La Salle, Live Oak, Maverick, McMullen, Medina, Nueces, Pecos, Presidio, Real, Reeves, San Patricio, Starr, Sutton, Terrell, Uvalde, Val Verde, Webb, Willacy, Zapata, and Zavala.

In addition to the issue of assessments by TWIA, there are a number of other insurance issues in this border region. Legislation from the 78th Session addressed many of the issues related to rising medical malpractice costs both statewide and in the border region, and the agency is researching the technical and legal issues involved in developing cross-border health insurance coverage. In addition, TDI serves on the North American Free Trade Agreement (NAFTA) committee of NAIC and communicates with Mexico's insurance regulatory body, the Comisión Nacional de Seguros y Fianzas (CNSF).

A growing Hispanic workforce and its concentration in the high-growth border region has created unique challenges in the provision of services and injury prevention programs. To meet that challenge, DWC contracts with Spanish-speaking translators as needed for the most complex dispute resolution proceedings, and provides workplace safety and health training courses in Spanish. In addition, DWC requires Spanish-speaking proficiency of job applicants for particular positions; however, it is becoming increasingly difficult to find Spanish-speaking persons with the necessary training and education to meet job requirements in particular health and safety positions.

To meet the needs of DWC customers along the Texas-Mexico border, DWC has seven field offices and one dispute proceeding facility located in Uvalde. Field offices serving counties located along the Texas-Mexico border include Corpus Christi, El Paso, Laredo, Midland, San Angelo, San Antonio, and Weslaco.

Texas-New Mexico Border

The Lubbock, Amarillo, and El Paso field offices serve workers' compensation customers along the Texas-New Mexico border. This area also has a large number of Spanish-speaking customers which poses the same unique challenges as those faced by offices on the Texas-Mexico border.

Texas-Oklahoma/Arkansas Border

Field offices located in Amarillo, Wichita Falls, Tyler and Denton serve workers' compensation customers along the Texas-Oklahoma border. The Tyler field office also provides customer assistance to injured workers residing in Arkansas counties bordering Texas.

Public Outreach

The agency provides outreach by using the Internet, making presentations, providing special training, participating in state and national forums, issuing press releases, and distributing publications on insurance issues and on fire safety and protection. TDI also works to increase the availability of insurance in areas with underserved populations and provides outreach and consumer assistance following disasters. In addition, the agency has field offices throughout the state to provide efficient, economic service or to comply with legislative mandates. Field offices and public outreach entities are described below.

Consumer Education and Outreach

TDI's Consumer Protection Program provides outreach, education, and Speakers Bureau activities. The Speakers Bureau conducts presentations to civic, community, and consumer groups. The agency also develops and distributes insurance information publications throughout the state. These publications include information on various types of insurance and price comparison guides to help consumers shop for insurance. The following are examples TDI consumer outreach programs.

Outreach to Seniors
The agency provides special outreach to Texas seniors through the Health Information, Counseling, and Advocacy Program (HICAP). This outreach is in cooperation with the Department of Aging and Disability Services through an interagency contract. Other HICAP partners include the Texas Legal Services Center and the 28 Area Agency on Aging offices throughout the state. In addition, TDI provides a variety of educational materials for Texas seniors and conducts more than 50 outreach events annually on topics such as long-term care, Medicare supplement insurance, and Medicare prescription drug coverage.

Outreach to Homeowners and Renters
The agency conducts a number of outreach events at home and garden shows, neighborhood association meetings, homebuyer fairs, and other community events. In addition, TDI produces publications related to homeowners and renters insurance, including a homeowner insurance price comparison guide and publications to help consumers shop for insurance, file claims, and protect their homes from damage.

Outreach to Texans Seeking Health Insurance
TDI created a web resource page, www.TexasHealthOptions.com, to help consumers better understand health insurance and available coverage options. Outreach includes presentations, publications, and coordinated education efforts with the Health Coverage Awareness and Education Task Force. TDI conducts more than 100 health coverage presentations each year.

Disaster Response
When disaster strikes, TDI ensures that the insurance industry promptly responds to consumer claims and concerns. TDI answers inquiries, assists consumers at the disaster sites, and updates web resource pages to provide timely and disaster-specific information.

For additional information on disaster response, please see the Key Factors discussion on Disaster Response and Readiness.

Insurance Availability in Underserved Areas

In addition, the agency works to increase insurance availability in designated underserved areas through the FAIR Plan and Helpinsure.com. The Commissioner of Insurance implemented a market of last resort, the FAIR Plan, in 2002 due to a residential property insurance availability problem, sparked in part by growing mold and water damage claims. The Helpinsure.com website is a free and secure service of the State of Texas and the TDI that helps Texans shop for homeowners insurance. It offers a place for consumers looking for insurance to make their information available to agents. It also provides a resource for consumers to search for an agent on their own.

Employer Outreach for Safety Training and Return to Work

DWC educates employers and their employees across the state through on-site company training and regional seminars; safety and health videos and publications; and other forms of outreach. These outreach efforts include distribution information and consultations regarding workplace safety, as well as the providing information on the benefits of establishing return-to-work programs for employees who experience on-the-job injuries.

Thousands of Texas employers use the Resource Center Library to check out free safety and health training videos; and, employers and employees may download safety and health

publications from the agency's website. Many of the videos and publications are available in Spanish. Additionally, DWC conducts an annual statewide safety and health conference.

DWC provides free safety and health consultations to Texas employers through the Occupational Safety and Health Consultation (OSHCON) Program. The program is largely funded by a grant from the Occupational Safety and Health Administration (OSHA) but is non-regulatory in nature. OSHCON safety and health professionals help employers understand OSHA safety regulations, identify and correct workplace hazards, and establish required written programs. The focus of the program is on smaller employers (250 or fewer employees on site and no more than 500 nationwide) in high-hazard industries.

Health Care Provider Training and Outreach

The agency uses a number of outreach efforts to keep health care providers informed about the delivery of medical benefits to injured employees in the workers' compensation system. These outreach efforts include seminars, publications, newsletters, a section of the website devoted to health care provider issues, and educational programs for doctors participating the workers' compensation system and those serving as designated doctors. An online curriculum is available for doctors who apply to be on the Approved Doctor List, and impairment rating training seminars are provided, in coordination with TDI, for designated doctors and other doctors who assign impairment ratings for injured employees.

Insurance Company Examinations and Regulatory Interventions

TDI performs on-site financial and market conduct examinations of insurance companies, HMOs, and certain other entities regulated by TDI to determine financial condition and compliance with the Texas insurance laws. These examinations are similar to audits by Certified Public Accountant firms, though usually broader in depth and scope, since the examiners must ascertain compliance with various laws and regulations. Examiners collect and analyze annual operations reports filed by all licensed premium finance companies and coordinate the regulation and oversight of HMOs. The agency examination activity employs approximately 80 staff, including approximately 70 financial examiners, working out of three field offices in Houston, Dallas, and San Antonio, and TDI headquarters in Austin. TDI also performs on-site activities for companies requiring regulatory intervention.

Fraud Investigation Training and Outreach

Although TDI fraud investigations staff are based in Austin, the investigators conduct extensive fieldwork, outreach and training for insurance company staff, law enforcement agencies and others with an interest in combating insurance fraud. Each year, TDI holds an insurance fraud conference providing training for the Special Investigative Units (SIUs) of insurance companies that qualifies for continuing education credit. The conference invitation is also extended to law enforcement agencies and other state agencies involved in fighting insurance fraud. TDI fraud investigators attend monthly SIU meetings held in Dallas, Houston, and San Antonio and participate in regional insurance fraud task forces. The Insurance Fraud Unit adopted an

investigative liaison initiative in FY 2005 to enhance anti-fraud efforts and to assist local law enforcement agencies in the detection and prosecution of insurance fraud. TDI has assigned investigators to serve as dedicated liaisons to each of eight regions around the state.

State Fire Marshal's Office (SFMO) Outreach Efforts

SFMO has 41 field employees working throughout the state. Field staff members are equipped to go to any areas that historically have demonstrated a need for services. The SFMO hires staff who live in, or are familiar with, the area where they work, with particular emphasis on recruiting bilingual staff in areas with sizable Spanish-speaking populations.

Fire industry licensing investigations staff ensure that fire alarm, extinguishers, sprinkler systems, and fireworks stands comply with adopted safety standards. The unit has four licensing investigators located in Caldwell, Corpus Christi, Garland, and Spicewood.

Employees in the Fire Safety Inspections section are charged with inspecting public and private buildings and flammable liquid storage facilities of retail service stations. A total of 13 field staff are located in the areas of Austin, Belton, San Antonio, Clute, Corpus Christi, Lufkin, McDade, Midland, Stephenville, and Troup.

The Fire and Arson Investigation section maintains a significant presence across the state with approximately 25 field staff. The staff is responsible for investigating fire scenes upon request from local law enforcement agencies, and it maintains three canine teams available for all investigations. Fire and Arson Investigation staff are located in Abernathy, Alpine, Anson, Austin, Caldwell, Corpus Christi, Fort Worth, Henderson, Houston, Leander, Lubbock, Lufkin, McAllen, Mt. Pleasant, Nacogdoches, New Braunfels, Rockport, San Antonio and Tyler.

On September 1, 2001, the SFMO became responsible for investigating all Firefighter fatalities in Texas. The SFMO has been involved in 24 investigations since the inception of the program. The SFMO makes investigation reports available on the Internet to encourage fire departments to become aware of contributing factors to the fatalities and to take preventative measures.
Outreach programs include the distribution of grade-specific fire prevention learning modules, fire safety literature, and public service announcements. The fire safety house is deployed throughout the state, providing school children with near-real home fire escape skills. Other outreach efforts include Public Protection Classification (PPC) Oversight and the Juvenile Firesetter Intervention Program. The PPC Oversight officer assists local fire departments, upon request, with Public Protection Classifications and the ISO Fire Suppression Rating Schedule. The Juvenile Firesetter Intervention Program assists fire departments, upon request, in establishing their own community-based programs for juveniles.

Windstorm Inspections and Training

TDI's Property and Casualty Program employs 16 Windstorm inspectors in field offices located in Angleton, Beaumont, Corpus Christi, and La Marque. TDI also serves the Rio Grande Valley from the Corpus Christi field office. This program is responsible for inspecting structures for insurability through TWIA and ensuring the enforcement of building codes adopted by the

Commissioner of Insurance.

TDI staff also perform oversight on structures inspected and certified by Texas-licensed engineers appointed as qualified windstorm inspectors. The oversight inspections determine if structures are compliant with the applicable building code specifications and ensure that the appointed inspectors are providing uniform and consistent inspections along the Texas coast for those individuals participating in the windstorm program.

In addition to oversight, TDI staff provides training on the applicable building code standards for professionals involved in building or inspecting structures for compliance as well as homeowners seeking coverage through TWIA. The education programs include training for engineers, builders, architects, homeowners, insurance agents, real estate agents, lenders, and consumers. Training and educational programs are designed to inform and educate the public on major construction issues related to windstorm-compliant construction. Consequently, losses to structures are mitigated and financial exposure is reduced to the TWIA and the General Revenue fund.

Human Resources

Equal Employment Opportunity

TDI is committed to equal employment opportunity and strives to maintain a diverse workforce reflective of the customers the agency serves. The TDI workforce reflects the fast-changing demographics of Texas. As of May 2006, TDI's workforce is comprised of 46.5 percent minority employees and 65 percent female employees. The 2005 Texas state agency workforce was 45 percent minority and 50.7 percent female.[1] Of particular significance is the minority and female representation in TDI's management positions. Sixty-seven percent of TDI's managers are minority and/or female. In the sixteen executive staff positions, 75 percent are minority and/or female.

The average age of all state agency employees is 43.5.[2] The average age of a TDI employee is 46.

TDI compares favorably with the latest Texas Workforce Commission, Civil Rights Division (CRD) state civilian workforce analysis. The chart below reflects the workforce utilization for the agency. This information is provided as factual data only and is not intended coerce or pressure TDI managers with regard to hiring decisions, nor is it intended to create gender or racial preferences in hiring decisions.

[1] www.hr.state.tx.us/Workforce/Turnover2005/Ethnicity.html
[2] State Auditor's Office Online Systems, 2006 data

EEO Category	State Civilian Workforce*			Texas Department of Insurance**			
	African Americans	Hispanic Americans	Females	African American	Hispanic Americans	Females	Total Positions
Officials, Administration (A)	7.1%	15.2%	44.1%	12.86%	13.57%	47.14%	140
Professional (P)	7.9%	14.4%	54.4%	11.43%	22.96%	58.54%	945
Technical (T)	10.4%	19.8%	47.5%	11.00%	23.00%	37.00%	100
Para-Professional (Q)	17.86%	31.78%	55.61%	16.49%	45.96%	90.18%	285
Administrative Support (C)	9.9%	23.2%	61.5%	21.76%	48.82%	89.41%	170
Skilled Crafts (S)	4.7%	34.1%	7.0%	0	100%	50%	2
Service & Maintenance (M)	8.7%	33%	39.9%	0	75%	0	4
							1646

*Commission on Human Rights Annual Report, FY 2005, www.twc.state.tx.us
**Provided by TDI USPS data as of May 31, 2006

Employee Satisfaction

The agency must retain quality employees in order to carry out its mission. TDI relies on employee input to continually improve services and increase employee satisfaction. The University of Texas Survey of Organizational Excellence is one method TDI uses to collect employee input and measure satisfaction. The survey, administered by the School of Social Work, is traditionally conducted in odd number years. The 2005 survey, however, was delayed until May 2006 due to the significant organizational changes that began in September 2005 as a result of HB 7. HB 7 abolished the Texas Workers' Compensation Commission (TWCC) and transferred its functions to TDI as the Division of Workers' Compensation.

This survey uses five workplace dimensions including organizational features, accommodations, exchange of information, work group, and personal aspects. Sixty-seven percent of TDI employees responded to the 2006 survey and indicated that they continue to view their workplace positively. Detailed survey information is included in Appendix H.

The Workforce Plan (Appendix E) lists other benefits which TDI provides in order to increase employee satisfaction and retention. This list includes employee and management training, employee exit interviews, and access to an employee assistance program.

Staffing Strengths and Challenges

The agency recognizes that the quality of its staff is critical to the organization's mission and success. TDI continually strives to maintain the staff competencies required to serve its customers and to assess skills to meet future needs. The agency Workforce Plan documents this assessment by requiring program areas to review key economic and environmental factors facing their areas, staffing challenges, customer demands affecting staffing, and skills and competencies needed for critical functions.

Agency staff understand the needs of the customers they serve and work to continually improve services. Responses to the recent UT Survey of Organizational Excellence indicate that TDI employees have a high degree of job satisfaction. TDI has an experienced and capable staff. Turnover at TDI continues to be lower than other state agency turnover rates. However, future

turnover may be affected by the high percentage of potential retirees. Thirty-five percent of the agency's staff is eligible to retire in the next five years. The vacancies created by retirements have caused TDI to implement succession planning projects in all program areas.

Fair pay for state employee continues to be an issue for TDI, as confirmed in the most recent UT Survey of Organizational Excellence where fair pay is the lowest scoring construct for the agency. This dissatisfaction with fair may negatively affect recruitment and retention in the future.

TDI has undertaken and is currently researching additional efforts to address recruitment issues related to certain hard to fill positions. These positions are described and recruitment efforts are discussed in the TDI Workforce Plan.

In 2003, the 78th Legislature passed HB 3442. This legislation requires state agencies to achieve a management-to-staff ratio[3] of one manager for every 11 employees by August 31, 2007. TDI's management-to-staff ratio as of August 31, 2005 was 1:9.49, and DWC's ratio was 1:9.6. Mid-Year FY 2006 TDI's management-to-staff ratio was 1:10.06 and DWC's management-to-staff ratio was 1:8.31, giving the agency a management-to-staff ratio of 1:9.18.

Human Resources management has been discussing possible changes in organizational structures within program areas to assist the agency in achieving the 1:10 ratio by August 31, 2006. The agency is carefully reviewing management positions which become vacant and continues to review the possibility of moving some supervisors to team leaders within program areas. At present, the agency is on target to meet the August 2006 requirements.

Staff and Workforce Diversity

TDI relies on a skilled workforce of administrators who set broad policies; professionals with specialized and theoretical knowledge usually acquired through college training or work experience; and employees with specialized knowledge and technical expertise. In addition, TDI's workforce includes classified para-professionals, administrative support, and technicians.

Fiscal Resources and Management

The agency's FY 2006-2007 appropriations doubled due to the merger with TWCC pursuant to HB 7. The agency's adjusted appropriations for the 2006–2007 biennium total approximately $201 million, with 1,755.3 adjusted appropriated FTEs. The following information details TDI's operating fund Account 36, Subsequent Injury Fund Account 5101, the operating budget and the agency's capital budget rider.

GR Dedicated – TDI Operating Fund Account No. 36

The agency is primarily funded from GR Dedicated – TDI Operating Fund Account 36. This account receives revenue from two primary sources: 1) the Comptroller of Public Accounts,

[3] Management-to-staff ratio is calculated by dividing the total number of staff by the total number of managers/supervisors. The above ratios represent actual employees (head-count) rather than full-time-equivalents and do not include vacant positions.

which collects and deposits insurance company maintenance taxes and fees into the Account; and 2) TDI, which collects and deposits self-insurer maintenance taxes, examination fees and other fees into the Account.

In FY 2005, the Comptroller deposited $39.1 million and TDI deposited $35 million, for a total of $74.1 million in additional revenue into Account 36. The following chart reflects FY 2005 deposits into Account 36.

Amounts Deposited to Account 36 in FY 2005

Motor Vehicle Insurance Maintenance Tax	$4,827,278
Fire Insurance Maintenance Tax	$14,116,110
Workers' Compensation Insurance Maintenance Tax	$1,129,187
Casualty Insurance Maintenance Tax	$3,180,083
Title Insurance Maintenance Fee	$439,480
Life, Accident and Health Insurance Maintenance Tax	$5,919,601
Third Party Administrator Maintenance Tax	$628,875
Health Maintenance Organization Maintenance Tax	$1,387,823
Prepaid Legal Services Maintenance Tax	$623
Domestic Valuation Fees/Life	$7,303,797
Annual Statement Fees	$220,767
Workers' Compensation Research & Oversight Center Maintenance Tax	$4,406
Account 36 Total Deposited by Comptroller:	**$39,158,030**
Examination Fees – Collected by TDI	$11,294,878
Other Fees and Revenue- Collected by TDI	$23,683,756
Account 36 Total Deposited by TDI:	**$34,978,634**
GRAND TOTAL	**$74,136,664**

The Legislature appropriates funds from Account 36 to several other state agencies in addition to TDI, including the Office of the Attorney General, the Comptroller of Public Accounts, the District Courts-Comptroller's Judiciary Section, Texas Commission on Fire Protection, the Texas Building and Procurement Commission, the Texas Forest Service, the Health Professions Council, and the Cancer Council.

Pursuant to HB 7, the Division of Workers' Compensation (DWC) revenues including maintenance taxes were added to Account 36 in FY 2006. The Texas Workers' Compensation Commission revenues totaled $40.1 million in FY 2005.

In addition to funding from Account 36, the agency receives federal funds of which the majority relates to controlling and improving workplace safety and hazards. The agency also receives funding to pay lifetime benefits to injured workers. This fund, Subsequent Injury Fund 5101, is discussed below.

GR Dedicated – Subsequent Injury Fund Account No. 5101

The agency receives funding for the Subsequent Injury Fund (SIF) through GR Dedicated – Subsequent Injury Fund Account No. 5101. This account receives revenue from compensable death benefits on claims in which there is no legal beneficiary. The primary purposes of the fund are:

- To pay lifetime income benefits (LIBs) to injured workers who become eligible for those benefits because of a subsequent compensable injury.

- To reimburse insurance carriers for benefits paid based on a Division decision or interlocutory order that is later reversed or modified by the Division or a court;

- To reimburse insurance carriers for income benefits paid to injured workers based on employment held at the time of injury other than the employment during which compensable injury occurred; and

- To reimburse insurance carriers for payment of pharmaceutical benefits provided during the first seven days after an injury if the injury is determined not to be compensable.

The cash amount of the SIF as of May 31, 2006 was $47.75 million. The agency has appropriation authority which authorizes estimated SIF payments of $3.67 million each year of the FY 2006-2007 biennium. In the event that actual liabilities exceed the estimated amounts, the Comptroller is authorized to issue a finding of fact in support of a contingent appropriation to provide the additional funding, if there are sufficient balances in the fund.

Operating Budget

The agency's $101.6 million FY 2006 operating budget and workforce is allocated to its direct and support programs to accomplish its strategic goals. The agency has a $3.8 million veto reduction in FY 2006 and a $5.1 million reduction in FY 2007. The agency expects to operate within these reductions. The primary tools the agency will utilize to operate within the reductions and its funding authority are 1) elimination of positions due to duplication of administrative and program functions between TDI and DWC; 2) reduction in non-salary expenses; and 3) utilization of Unexpended Balance authority from FY 2006 to FY 2007.

Capital Budget

The agency's Capital Budget rider, listed in Article VIII of the General Appropriations Act, includes funding for the acquisition of information resource technologies and transportation items.

Information Resource Technologies
Information resource technology includes projects which reflect the division's emphasis on partnering technology and business processes in order to achieve quality customer service. These information resource projects include:

- Agency development of Web-based processes to provide direct automated services to agency clients via the Internet to fully participate in e-government initiatives.
- Implementing technological solutions to changes in state laws governing the regulation of the insurance industry.
- Increased electronic document/records management technology to increase the responsiveness of TDI's customer service.
- Maintaining/upgrading TDI's computing environment to ensure the environment remains current and reliable and in alignment with the State of Texas' proposal to include TDI in plans for a State data center.
- Implementation of a new technology infrastructure that would be more suitable for the rapidly changing business needs of the workers' compensation environment in Texas.

Transportation Items
The State Fire Marshal's Office (SFMO) field employees use state-owned vehicles to perform investigations and inspections throughout the state. TDI believes state-owned vehicles represent the best solution to SFMO's transportation needs, given the nature of work performed by the field staff. Some staff must carry fire scene investigation equipment in their vehicles, which raises the possibility of contamination with hazardous chemicals. It would be inappropriate to expose employees' families to the potential health and safety risks associated with the use of privately-owned vehicles for this type of work.

The SFMO continues to have an aging fleet of high-mileage vehicles. Fifty-two percent of the fleet has over 100,000 miles and thirty-nine percent has over 150,000 miles. The average mileage per vehicle is 116,000 miles. Funding was appropriated for partial replacement of these high-mileage vehicles in fiscal years FY 2006 and FY 2007. Twelve vehicles have been purchased in FY 2006 and at least an additional twelve vehicles will be purchased in FY 2007. SFMO must replace vehicles for field staff on a regular basis to ensure the safety of employees and its ability to perform mission critical activities.

Historically Underutilized Businesses

TDI Use of Historically Underutilized Businesses

The Historically Underutilized Business (HUB) program is governed by the Texas Government Code, Title 10, Subtitle D, Chapter 2161. The purpose of the program is to increase contracting opportunities with the State of Texas for minority and women-owned businesses.

TDI's HUB Participation

The agency is continuously developing strategies to increase the agency's HUB participation and to ensure that TDI remains in compliance with all of the laws and rules established for the HUB program. Over the years TDI has developed and implemented various approaches to promote the HUB program to ensure HUB participation in all agency procurements. For example, the agency sponsors a HUB forum each year. The agency invites HUBs that can provide goods and services that will meet the agency's specific needs. TDI also works closely with other state agencies by co-sponsoring HUB forums. TDI executive staff members participate in forums as presenters and participants in networking sessions with vendors.

In addition, TDI was recognized in FY 2005 by the Texas Building and Procurement Commission as being one of the top 25 agencies spending more than $5 million with the largest percentage spent on HUBs. Of the 25 agencies, TDI was ranked second with 46.8 percent of purchases going to HUB vendors. [4]

TDI's HUB Outreach

The agency focuses on how awards are distributed among the various ethnic HUB groups. TDI's goal is to ensure that contract awards are distributed among all HUB groups and not concentrated within just one or two ethnic HUB groups. The agency distributes information on an ongoing basis to HUB vendors about the specific changes that affect the HUB program and the procurement process. Dissemination of this information ensures HUBs are well informed and better prepared when bidding on contract opportunities.

The agency participates in various HUB events focused on minority and women- owned businesses. This includes forums sponsored by local Chambers of Commerce, Business Development Centers, and forums sponsored by other state agencies. In addition, the Purchasing division works closely with other agency programs to disseminate information about the HUB program. This information is distributed at various conventions, forums, and expositions that may have minority and women-owned business participants.

[4] As a special note, the Texas Workers' Compensation Commission, now the Division of Workers' Compensation at TDI was ranked sixth on that list with 38.95%.

TDI's Mentor Protégé Program

The agency has established a mentor protégé program in accordance Section 2161.065 of the Texas Government Code. The purpose of the program is to assist in fostering long-term relationships between prime contractors and HUBs and to increase the ability of HUBs to contract with the state or to receive subcontracts under a state contract.

TDI's has established two mentor protégé relationships. The first relationship established was with Dell Computers, the mentor, and Austin Ribbon and Computers (ARC), the protégé. The second mentor protégé relationship was with Dell Computers, the mentor, and Commonwealth Computers, the protégé. As a result of these relationships, the protégés were able to recognize increased procurement opportunities. They also gained access to a wider Dell product line, assistance from Dell Computers in developing web-based marketing tools, and increased annual sales.

Technology

Several bills passed during the 79th Legislative session resulted in significant impact to the technology environment at the Texas Department of Insurance. A brief description of these bills and their influence on the agency follows.

HB 7 – Merger with Texas Worker's Compensation Commission

HB 7, which merged the Texas Workers' Compensation Commission becoming a division of TDI, greatly affected TDI's technology environment. To address immediate technology requirements related to this merge, the Information Technology Services division performed analyses of all hardware and software technologies. Several systems were identified as potential areas for consolidation by leveraging existing technologies to reduce duplication. The following initiatives were addressed:

- Duplicative software products were compared, the best product selected, the other product's licenses cancelled as permitted by contractual agreements;
- Help Desk services were consolidated at one location; a single Help Desk contact number was provided to the agency;
- Software applications were modified to address the need to accept Workers' Compensation Network data;
- E-mail systems were consolidated;
- Network domains were merged;
- Agency Internet and Intranet sites were consolidated;
- TWCC personnel records were incorporated into TDI's Human Resources system;
- Purchasing processes were merged into a single software application;
- Information Security policies were aligned; and
- Disaster Recovery processes were modified.

The merger also resulted in TDI gaining responsibility for a major business process improvement project that is currently in year seven of an eight year implementation schedule. TDI has

assigned additional resources to the project and has recommended a re-prioritization of remaining project tasks as well as an aggressive timeline to migrate applications from a mainframe environment to a web server environment.

To address future technology needs related to the merger, TDI included Division of Worker's Compensation in its Technical Infrastructure Roadmap planning process.

Finally, in accordance with HB 7, TDI prepared a plan to offer ongoing information technology support for the newly created agency, Office of Injured Employee Counsel.

HB 1516 - Data Center Consolidation

TDI was identified as one of the agencies that will participate in the State's effort to create a state data center as outlined in HB 1516. In support of this effort, the Information Technology Services division has participated in several technology planning groups and has gathered and submitted documentation to the Department of Information Resources (DIR) related to TDI's current mainframe and server environments. DIR expects to execute a contract with a vendor to manage the Data Center by December 31, 2006 with a contract start date of March 31, 2007. At that time, TDI will be expected to begin the migration of TDI's data center equipment and affected staff to the state's data center facility.

Other Technology Initiatives

In addition to addressing the technology needs associated with recent legislation, TDI continues to ensure the agency is effective in responding to constituents' regulatory needs, to work toward making the national insurance regulatory process more uniform, and to ensure that injured workers are compensated fairly and appropriately for workplace injuries. The following initiatives support TDI's direct services to constituents and aid in lowering overall costs of complying with insurance regulation or using TDI services:

- TDI continues to support e-government as demonstrated by expanded participation to the TexasOnline portal site. TDI offers insurance agents and adjusters the ability to renew licenses online, including paying the associated renewal fees, as well as allowing citizens and businesses to search for information about insurance agents. Each month over 450,000 queries are executed to obtain license information and more than 3,000 license renewals are performed online. TDI also offers a web-based system on TexasOnline to allow requests for approval of attorney's fees online. This application receives over 3,000 visits per month. The State Fire Marshal's Office has initiated the process to offer fire industry licensing on TexasOnline with an anticipated completion date in FY 2007.

- TDI continues to enhance its Internet web site and to identify areas in which information and services can be made more readily available to TDI's customers through web-based, on-line applications.

- TDI supports the creation of Workers' Compensation Provider Networks. An employer may elect to purchase workers' compensation health care network coverage, and

employees are required to obtain medical treatment for a compensable injury through the health care network if they live within the network's service area. TDI is working to provide an automated means for tracking and reporting the certification of Workers' Compensation (WC) Networks, including a method to enter Workers' Compensation Network application data electronically; update Workers' Compensation Networks certification data; capture, store and retrieve Workers' Compensation Network-related document images; and track the status of the Workers' Compensation Network certification process.

- Texas and other states continue to improve national insurance regulatory processing efficiencies and coordination through automation. TDI supports these efficiencies by ensuring that the agency's technologies are compatible with the National Association of Insurance Commissioners' (NAIC) System for Electronic Rate and Form Filing (SERFF), which is a web-based electronic filing system designed to improve the efficiency of the rate and form filing and approval process, and with the NAIC's Online Fraud Reporting System.

APPENDIX B

Agency Planning Process

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Strategic Planning Process

TDI developed its Strategic Plan with participation from the Executive Management team and staff representing all agency programs. The Strategic Planning Office (SPO) is responsible for coordinating strategic planning activities and developing the agency's Strategic Plan.

In past years, TDI has consulted with analysts from the Legislative Budget Board (LBB) and the Governor's Office of Budget, Planning and Policy (GOBPP) to evaluate and revise the agency's goals, objectives, strategies, and performance measures. This year staff continue to build on these past efforts by incorporating HB 7 and other agency changes into the FY 2007-2011 Strategic Plan. The performance measures were updated to reflect HB 7 changes, as well as other agency changes which demonstrated better indicators of performance and workload. Finally, performance measures were revised to be more concise.

Agency Planning & Technology Team

The Agency, Planning & Technology Team (APTT) participated in the development of the strategic plan. Decision makers representing all of TDI's functional areas work together on information technology resource issues, strategic and business planning, and other efforts that required collaboration.

Strategic Plan Redesign

The SPO developed a streamlined plan focusing on key factors that will affect the agency in the next five years. The analysis of these factors describes how the agency will address challenges attributable to each factor.

To identify the key factors and develop the agency's assessment of these factors, the APTT members created a list of potential internal and external issues impacting the agency. TDI's Executive Management team and SPO reviewed the list and selected six key factors which influence the agency's mission.

Strategic Plan Budget Structure Changes

To develop the budget structure, SPO created a process and tools for evaluating and proposing changes to performance measures. Program staff reviewed current performance measures and proposed deletions, additions, and modifications to the existing measures. Program staff developed draft definitions for new measures and modified existing definitions based on program changes to these measures.

Upon completion of the performance measure evaluations, SPO compiled the proposed changes in accordance with the format required by the LBB and GOBPP. The compilation was distributed to the programs and Executive Management for final comment and approval. Upon

Executive Management approval, SPO delivered the requested changes to the GOBPP and LBB by April 7, 2006.

Strategic Plan Performance Measure Targets

TDI must submit performance measure targets for outcome measures in the strategic plan and for output, efficiency, and explanatory measures in the Legislative Appropriations Request (LAR).

SPO designed a spreadsheet to aid with performance measure target development. The spreadsheet contains a five-year history of the agency's performance measure targets which allows for a more focused review of proposed changes. The targets presented in this plan reflect current level funding. The FY 2008-2009 LAR instructions require agencies to submit their baseline request at a ten percent reduction level. The agency's LAR will reflect the necessary adjustments to performance targets based on the ten percent reduction.

Program staff evaluated their targets and proposed changes for FY 2007-2011. SPO reviewed the proposed changes and worked with program staff to determine the final performance measure targets. Executive management reviewed and approved the changes.

Strategic Plan Approval

In finalizing the Strategic Plan, SPO worked with Executive Management and APTT. Executive Management approved the document for delivery to the LBB, GOBPP, and other interested parties.

APPENDIX C

Organizational Chart

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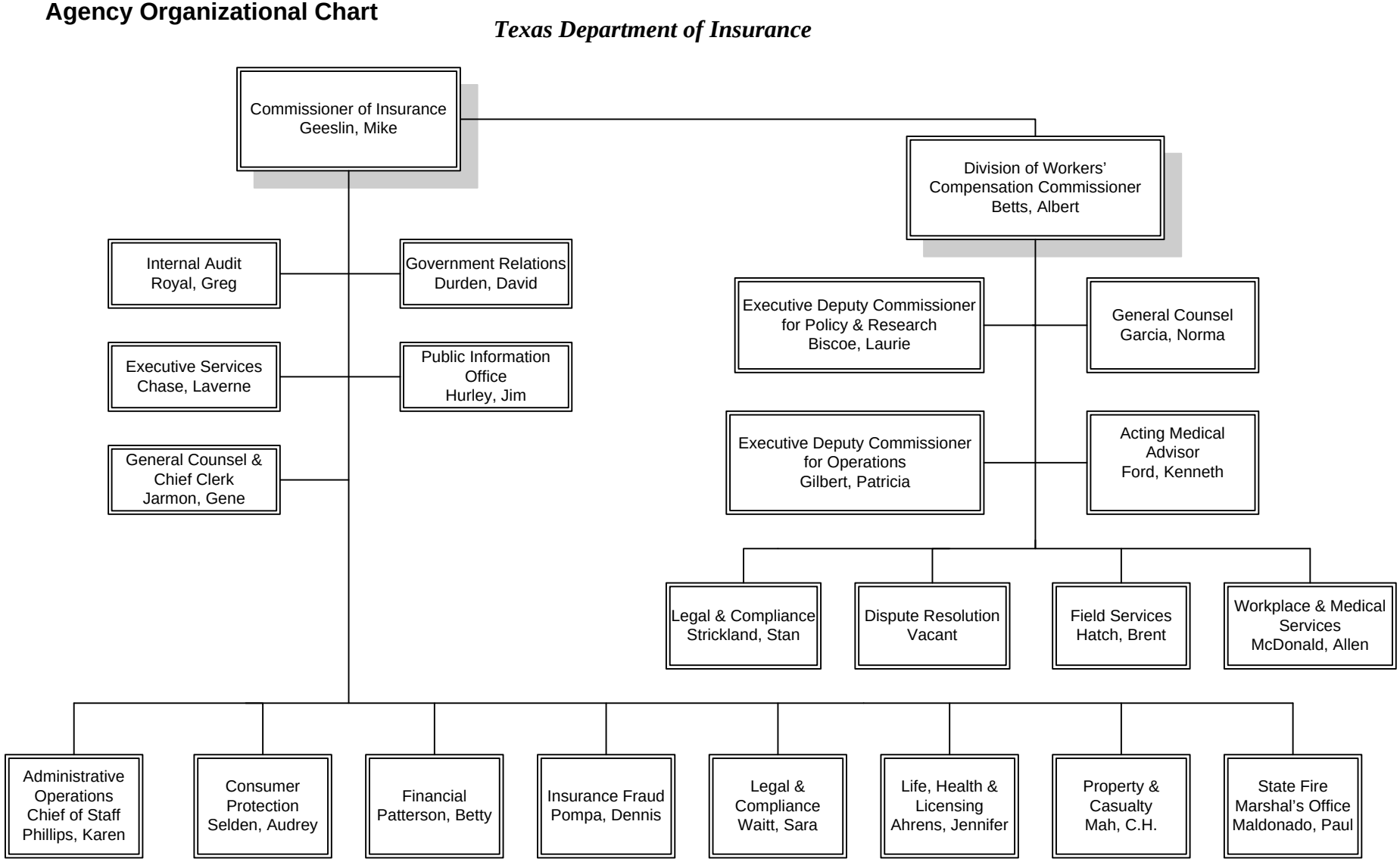
Texas Department of Insurance Agency Organizational Chart



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APPENDIX D

Agency Budget Structure

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Goal 1: Encourage Fair Competition in the Insurance Industry.

Objective 1.1: Reduce impediments to competition and improve insurance availability by fiscal year 2011 by: processing 96 percent of company, third party administrator, and premium finance license applications within 60 days, processing 92 percent of agent license filings within 15 days, completing 80 percent of statutory form and rate filings within 90 days; implementing a residential property insurance Market Assistance Program that results in insurance coverage for at least 50 percent of the qualified applicants; and by increasing the number of automobiles in underserved markets covered by voluntary policies.

1.1 Outcome Measures:

1. Percent of company, third party administrator, and premium finance licenses completed within 60 days.
2. Percent of agent license filings completed within 15 days.
3. Percent of statutory rate and form filings completed within 90 days.
4. Number of automobiles covered by voluntary policies as a percent of total private passenger automobiles in underserved markets.
6. Percent of personal auto and residential property form filings completed within 60 days.

Strategy 1.1.1: Collect and analyze market data, provide information to consumers and industry.

1.1.1 Output Measures:

1. Number of inquiries answered.
2. Number of rate guides distributed.
3. Number of consumer information publications distributed.
4. Number of consumer information presentations made.
5. Number of Texas Department of Insurance calls to insurance industry for data.

1.1.1 Explanatory Measures:

1. Aggregate overhead cost as a percent of premiums paid by consumers for all lines of insurance.
2. Number of insured private and commercial passenger automobiles as a percentage of total registered passenger vehicles.

Strategy 1.1.2: Process rates, forms and other required filings.

1.1.2 Output Measures:

1. Number of life/health insurance filings completed.
2. Number of Health Maintenance Organizations (HMO) form filings completed.

3. Number of property and casualty rate and form filings completed.

1.1.2 Explanatory Measures:
1. Total number of licensed agents.
2. Number of Texas-based regulated companies.
3. Number of non-Texas-based regulated companies.
4. Number of licensed Health Maintenance Organizations (HMOs).

Strategy 1.1.3: Identify underserved markets, and create incentives and implement requirements for insurers to write in underserved markets.

Objective 1.2: Reduce unfair and illegal practices: by assuring that 55 percent of insurer fraud referrals to prosecutors, other appropriate agencies or law enforcement authority result in legal action by fiscal year 2011; by resolving consumer complaints; and by reducing the dollar amount of harm to consumers.

1.2 Outcome Measures:
1. Percent of insurer fraud referrals to state or federal prosecutors resulting in legal action.
4. Percent of Licensees who renew on-line.

Strategy 1.2.1: Respond promptly to complaints against insurers, agents, and other regulated entities; assist consumers in recovering valid claims.

1.2.1 Output Measures:
1. Number of complaints resolved.
2. Number of insurance advertising filings reviewed.
3. Dollar amount returned to consumers through complaint resolution.
4. Number of complaints against HMOs resolved.

1.2.1 Efficiency Measures:
1. Average response time (in days) to complaints.
2. Average response time (in days) for HMO complaint resolution.

Strategy 1.2.2: Investigate apparent patterns of unlawful or questionable trade practices in the insurance industry; and bring enforcement actions as appropriate.

1.2.2 Output Measures:
1. Number of enforcement actions concluded.
2. Dollar amount of penalties assessed for unfair and illegal practices.
3. Dollar amount of restitution assessed for unfair and illegal practices.

4. Number of contested cases closed.
5. Number of quality assurance examinations conducted.

1.2.2 Efficiency Measure:
1. Average cost per quality assurance examination conducted.

1.2.2 Explanatory Measure:
1. Percent of contested cases finalized within 180 days.

Strategy 1.2.3: Investigate potential insurer fraud and initiate legal action when appropriate.

1.2.3 Output Measure:
1. Number of referrals of alleged insurer fraud to state and federal prosecutors.

1.2.3 Efficiency Measure:
1. Average number of days per insurer fraud enforcement case referred.

1.2.3 Explanatory Measures:
1. Estimated dollar amount (in millions) of insurer fraud referred.
2. Number of reports of insurer fraud received.

Strategy 1.2.4: Texas On-line.

Goal 2: Encourage the Financial Health of the Insurance Industry through Monitoring and Regulation.

Objective 2.1: Regulate insurance industry solvency in each fiscal year by assuring that all statutorily mandated on-site examinations are conducted; reviewing 99 percent of identified companies; and overseeing Special Deputy Receivers so their receivership asset recovery expenses do not exceed 30 percent of the total dollars collected by Special Deputy Receivers.

2.1 Outcome Measures:
1. Percent of statutorily mandated on-site examinations completed within 18 months.
2. Percent of identified companies reviewed.
3. Special Deputy Receiver receivership asset recovery expenses as a percent of the total dollars collected by Special Deputy Receivers.
4. Average number of days from company "at risk" identification date to the date of solvency-related regulatory action.

5. Percent of insurers meeting statutory or risk-based capital and surplus requirements.
6. Percent of companies rehabilitated after Texas Department of Insurance solvency-related intervention.

Strategy 2.1.1: Analyze the financial condition of insurers, identify weak companies, and rehabilitate, liquidate or take other action against financially weak companies.

2.1.1 Output Measures:

2. Number of entities receiving Texas Department of Insurance solvency related intervention.
3. Dollar amount (in millions) of net asset recoveries collected from receivership estates.
5. Number of actuarial examinations completed.
6. Number of on-site examinations conducted.
7. Number of reviews of annual and interim financial statements conducted.

2.1.1 Efficiency Measure:

1. Average state cost per examination.

2.1.1 Explanatory Measures:

1. Dollar amount (in millions) of insurance company insolvencies.
2. Number of estates placed in receivership.
3. Percent of companies subject to statutorily mandated examinations during the fiscal year.

Goal 3: Decrease Insurance Industry Loss Costs.

Objective 3.1: Reduce losses by assuring that 88 percent of insurance companies are providing adequate loss control services, that 40 percent of the total number of windstorm inspections result in an "approved" status code by the end of each fiscal year, and that 55 percent of consumer and provider fraud referrals to prosecutors, other appropriate agencies or law enforcement authority result in legal action by fiscal year 2011.

3.1 Outcome Measures:

1. Percent of insurers providing adequate loss control programs.
2. Percent of commercial property inspections that meet filed rating schedule requirements.
3. Percent of windstorm inspections that result in an "approved" status code.

4. Percent of consumer and provider fraud referrals to state or federal prosecutors resulting in legal action.

5. Percent of consumer and provider workers' compensation insurance fraud referrals to state and federal prosecutors resulting in legal action.

Strategy 3.1.1: Inspect insurance loss control programs offered to policyholders, and assure compliance with filed property schedules and windstorm construction codes.

3.1.1 Output Measures:
1. Number of windstorm inspections completed.
2. Number of inspections of insurer loss control programs completed.
3. Number of commercial property oversight inspections completed.

3.1.1 Efficiency Measure:
1. Average cost per windstorm inspection.

Strategy 3.1.2: Investigate provider fraud and consumer fraud and refer violations for prosecution when appropriate.

3.1.2 Output Measure:
1. Number of referrals of alleged consumer and provider fraud to state or federal prosecutors.

3.1.2 Efficiency Measure:
1. Average number of days per consumer or provider fraud enforcement case referred.

3.1.2 Explanatory Measures:
1. Number of reports of possible consumer and provider fraud received.
2. Estimated dollar amount (in millions) of consumer and provider fraud referred.

Strategy 3.1.3: Investigate workers' compensation insurance fraud and refer violations for prosecution.

3.1.3 Output Measure:
1. Number of referrals of alleged fraud relating to workers' compensation insurance to state or federal prosecutors.

3.1.3 Efficiency Measure:
1. Average number of days per workers' compensation insurance fraud enforcement case referred.

3.1.3 Explanatory Measures:
1. Number of reports of possible workers compensation insurance fraud received.

2. Estimated dollar amount (in millions) of workers' compensation fraud referred.

Goal 4: Reduce Loss of Life and Property Due to Fire

Objective 4.1: Protect the public against loss of life and property resulting from fire and related hazards by: increasing public awareness of fire safety and prevention, and enforcing statutes and rules relating to fire investigations, fire safety inspections, and fire protection and fireworks industries.

4.1 Outcome Measures:

1. Percent of referred State Fire Marshal's Office criminal referrals resulting in enforcement/legal action.
2. Percent of registrations, licenses, and permits issued, after receipt of a completed application, within 20 days to fire alarm, fire extinguisher, fire sprinkler, and fireworks firms, individuals and other regulated entities.

Strategy 4.1.1: Provide fire prevention and fire safety presentations, and enforce regulations related to fire safety through investigation, analysis of evidence, inspection of property, and licensing of the fire protection and fireworks industry.

4.1.1 Output Measures:

1. Number of individuals attending fire prevention and fire safety presentations coordinated by the SFMO.
2. Number of fire investigations completed.
3. Number of samples analyzed in the arson lab.
4. Number of State Fire Marshal's Office criminal referrals to prosecution.
5. Number of registrations, licenses, and permits issued to fire alarm, fire extinguisher, fire sprinkler and fireworks firms, individuals, and other regulated entities.
6. Number of licensing investigations or inspections conducted.
7. Number of buildings inspected or reinspected for fire safety hazards.
8. Number of communities or community partners accepting SFMO fire prevention programs or initiatives.

4.1.1 Efficiency Measures:

1. Average cost per fire safety inspection.
2. Average time to complete fire investigations.

Goal 5: Promote Safe Workplaces

Objective

5.1: To promote safe and healthy workplaces through appropriate incentives, education and other actions through 2011.

5.1 Outcome Measures:
1. Statewide incidence rate of injuries and illnesses per 100 full-time employees.
2. Percentage change in the injury rate for employers provided consultations and inspection services.

Strategy
5.1.1: Provide health and safety services in Texas workplaces.

5.1.1 Output Measures:
1. Number of consultations and inspections provided to employers.
2. Number of Texas employers receiving safety and educational products/services.
3. Number of Texas employers receiving educational products/services.

5.1.1 Efficiency Measure:
1. Average cost per consultation and inspection.

Objective
5.2: To encourage the safe and timely return of injured employees to productive roles in the workplace through 2011.

5.2 Outcome Measures:
1. Percent of temporary income benefits (TIBs) recipients returning to work within 90 days of injury (based on TIBs duration).

Strategy
5.2.1: Provide education to stakeholders on disability management requirements and return-to-work programs.

5.2.1 Output Measures:
1. Number of persons receiving return-to-work training.
2. Number of workers' compensation income benefit recipients referred to the Department of Assistive and Rehabilitative Services (DARS).

5.2.1 Efficiency Measure:
1. Average number of participants per return-to-work seminar.

Goal 6: Encourage the Appropriate Delivery of Workers' Compensation Benefits

Objective 6.1: To ensure appropriate payment of health care for injured employees, and reimbursement for healthcare providers through 2011.

6.1 Outcome Measure:
1. Percentage of medical bills processed timely.

Strategy 6.1.1: Establish and maintain rules and programs that ensure appropriate utilization of medial services and the quality of medical providers.

6.1.1 Output Measures:
1. Number of quality care reviews of health care providers, insurance carriers, and independent review organizations (IROs) completed.
2. Number of system participants who received medical benefit training.

6.1.1 Efficiency Measure:
1. Average number of days to complete quality of care reviews of health care providers, insurance carriers, and independent review organizations.

Objective 6.2: To promote compliance through performance-based incentives, and promptly detect and appropriately address acts or practices of noncompliance with the workers' compensation law and rules and through 2011.

6.2 Outcome Measures:
1. Dollar amount returned to workers' compensation system participants through complaint resolution.
2. Average number of days for required initial benefit payment to be issued after benefits begin to accrue.
3. Percentage of first benefit payment timely made by insurance carriers.

Strategy 6.2.1: Monitor stakeholder activity and take enforcement action.

6.2.1 Output Measures:
1. Number of complaints completed involving workers' compensation system participants.

2. Number of performance reviews completed.

6.1.1 Efficiency Measures:

1. Average number of days to complete a complaint involving workers' compensation system participants.
2. Average number of days to complete a performance review.

6.1.1 Explanatory Measure:

1. Total number of administrative remedies issued for violations.

Objective 6.3: To effectively educate and clearly inform each system participant of the person's rights and responsibilities, taking maximum advantage of technological advances to provide the highest levels of service possible to system participants through 2011.

6.3 Outcome Measure:

1. Percentage of documents received and maintained electronically by the division.

Strategy 6.3.1: Develop and implement processes to receive, provide and maintain information in an electronic format.

6.3.1 Output Measures:

1. Number of documents received and maintained electronically by the division.
2. Number of reportable injury records created.
3. Number of injury records in which indemnity benefits are initiated.
4. Number of workers' compensation educational publications provided to system participants in an electronic format.

6.3.1 Efficiency Measure:

1. Average number of days to create reportable injury records.

Objective 6.4: To certify and regulate large private employers that qualify to self-insure.

6.4 Outcome Measure:

1. Percentage of market share of certified self-insurance to the total workers' compensation insurance market.

Strategy 6.4.1: Process certified self-insurance applications.

6.4.1 Output Measure:
1. Number of active self-insured employers.

6.4.1 Efficiency Measure:
1. Average cost per certified self-insurance certificate holder.

Objective 6.5: To minimize the likelihood of disputes and resolve them promptly and fairly when identified through 2011.

6.5 Outcome Measures:
1. Percentage of indemnity disputes resolved prior to a benefit review conference.
2. Percentage of indemnity disputes resolved in dispute resolution.
3. Average number of days to resolve indemnity disputes through dispute resolution proceedings.
4. Percentage of medical fee disputes resolved by agency decision.

Strategy 6.5.1: Minimize and resolve disputes (indemnity and medical) as informally as possible.

6.5.1 Output Measures:
1. Number of indemnity disputes concluded in benefit review conference.
2. Number of indemnity disputes concluded in contested case hearings.
3. Number of medical fee disputes resolved prior to a decision.
4. Number of medical fee disputes decisions issued.

6.5.1 Efficiency Measures:
1. Average number of days from the request for benefit review conference to the conclusion of the benefit review conference.
2. Average number of days from the request of a contested case hearing to the distribution of the decision.
3. Average number of days from receipt of the medical fee dispute to date decision issued.

6.5.1 Explanatory Measures:
1. Number of indemnity disputes received by the division.
2. Number of medical fee disputes received by the division.

Objective
6.6: To ensure proper financial administration of and appropriate payment of benefits to injured employees and reimbursements to insurance carriers through the Subsequent Injury Fund.

6.6 Outcome Measure:
1. Total payments made out of the subsequent injury fund for lifetime income benefits and reimbursements to insurance carriers.

Strategy
6.6.1: Pay authorized benefits timely and appropriately to injured employees who meet the statutory criteria for lifetime income benefits (LIBs) due to a second work-related injury and reimburse insurance carriers for eligible: (1) overpayment of benefits; (2) multiple employment benefits; and (3) pharmaceutical benefits.

6.6.1 Output Measures:
1. Number of injured workers receiving lifetime income benefit (LIBs) payments through SIF.
2. Number of requests for reimbursement for overpayment of benefits processed.
3. Number of requests filed for reimbursements of multiple employment benefits paid.

6.6.1 Efficiency Measure:
1. Average number of days from close of quarter to payment of requests for reimbursement that are approved.

INDIRECTLY BUDGETED GOALS, OBJECTIVES AND STRATEGIES

Goal 7: Purchase from Historically Underutilized Businesses.

Objective
7.1: To make a good faith effort to increase the utilization of historically underutilized businesses to 20 percent for professional services, 12 percent for commodities and 33 percent for other services in each fiscal year of the plan.

7.1 Outcome Measures:
1. Purchases from historically underutilized businesses as percent of expenditures for professional services.
2. Purchases from historically underutilized businesses as percent of expenditures for commodities.
3. Purchases from historically underutilized businesses as percent of expenditures for other services.

Strategy 7.1.1: Utilize and promote historically underutilized businesses in the competitive bid process on all goods and services purchased to the fullest extent possible.

7.1.1 Output Measures:

1. Total number of bid solicitations.
2. Number of bid solicitations sent to historically underutilized businesses.
3. Number of bids awarded to historically underutilized businesses.
4. Number of HUB forums attended.
5. Number of bid solicitations passed out at HUB forums.

Goal 8: Value the contribution of each employee to TDI's mission and to the diversity of the agency.

Objective 8.1: To ensure that appropriate training is available for all employees to develop professionally.

Strategy 8.1.1: To continually assess agency training needs and develop training plan to meet agency needs.

8.1.1 Output Measures:

1. Number of professional development classes delivered.
2. Number of employees attending professional development classes.

Objective 8.2: To communicate to employees their value in the organization.

Strategy 8.2.1: To provide accurate, timely and meaningful feedback to employee performance through defined job descriptions and job objectives using the performance appraisal system.

8.2.1 Output Measures:

1. Number of employees with current performance appraisals.
2. Number of corrective action plans.

Objective 8.3: Recruit and retain a diverse workforce of qualified and skilled individuals.

8.3 Outcome Measures:

1. Percentage of females and minorities in professional positions.
2. Percentage of turnover in hard to fill positions.

Strategy 8.3.1: Identify agency staffing qualifications and target recruitment to obtain needed skills.

8.3.1 Output Measure:

1. Number of vacancies in hard to fill positions.

8.3.1 Efficiency Measure:

1. Average time to fill vacant position.

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APPENDIX E

Workforce Plan

Introduction

Overview

As required by Government Code 2056.0021, the Texas Department of Insurance (TDI) has conducted a strategic planning staffing analysis of its workforce in accordance with the guidelines developed by the State Auditor's Office (SAO). TDI's *Fiscal Years 2007-2011 Workforce Plan* is the product of that analysis.

Findings

The workforce plan assessment allows TDI to identify discrepancies between TDI's current workforce profile and its projected staffing needs, which are captured in a gap analysis. From the gap analysis, TDI developed strategies to address workforce needs. The gaps and their associated strategies are as follows:

I. Gap: Large number of retirees
   Strategy: Continue succession planning

II. Gap: Employee turnover
   Strategy: Maintain an effective retention program

III. Gap: Hard-to-fill positions
   Strategy: Use recruitment plans

IV. Gap: Staffing/skill surpluses and shortages
   Strategy: Respond to changing workloads, processes, and organization

Workforce Planning at TDI

TDI recognizes the importance of workforce planning and uses analyses of its workforce to ensure the appropriateness of its staffing levels, workforce skills and workforce composition. In 2002, TDI prepared its first formal workforce plan as part of its strategic plan. TDI workforce planning efforts have since included:

analyzing program annual workforce data and reviewing staffing issues with Executive Management
implementing a revised mandatory manager training program
incorporating workforce and succession planning into TDI's business planning process, and
monitoring progress on program workforce planning initiatives.

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Introduction, Continued

Methodology

To develop this workforce plan, TDI followed the State Auditor's Office February 2006 *Workforce Planning Guide* and built on TDI's FY 2004 workforce plan development. This process started with an assessment of the workforce planning issues identified through TDI's business planning, strategic planning and budgeting processes. This assessment was conducted by a small team of human resource and planning professionals in consultation with executive staff representing TDI program areas.

The team identified its strategic direction and reviewed programs' internal assessments of needs; it then gathered information about TDI's workforce and identified discrepancies between TDI's current and future work profile and its projected staffing needs. This gap analysis considered current and future staffing levels, demographics, employee skills, employment trends and program workload changes. Finally, the team developed strategies to mitigate potential staffing shortages and surpluses.

Report Components

TDI's Workforce Plan contains the following five sections:

Agency Overview
Workforce Supply
Workforce Demand
Gap Analysis, and
Strategy Development.

Agency Overview

Overview

TDI is headed by the Commissioner of Insurance. The Governor appoints the Commissioner for a two-year term, subject to Senate confirmation. Effective FY 2006, TDI's newly established Division of Workers' Compensation (DWC) is also headed by a Governor-appointed commissioner. The Commissioner of Insurance and Commissioner of Workers' Compensation regulate the Texas insurance industry and workers compensation system by administering and enforcing the Texas Insurance Code and other applicable laws. TDI's regulatory authority is fully described in the Texas Insurance and Labor Codes and its regulatory rules are contained within the Texas Administrative Code. Generally, TDI is charged with regulating the Texas insurance industry by:

reviewing and processing certificates of authority and other filings from insurance companies and other related entities
calculating reserves for companies transacting business in Texas
enforcing laws related to fraudulent insurance acts
enforcing solvency standards among insurers
protecting Texas consumers
promoting competition among Texas insurers
reviewing certain policies and rates
assisting in the prevention of fires and education on fire safety issues
educating employers and other customers about maintaining safe workplaces
regulating the Texas workers' compensation system through rule development, monitoring, and enforcement, and
resolving disputes among workers' compensation system participants.

TDI's Organizational Structure

The functional organization chart shown on the following page demonstrates how TDI is organized to fulfill its regulatory charge.

In Summer 2005, the 79th Legislature passed House Bill (HB) 7 transferring the functions of the Texas Workers' Compensation Commission to a newly created Division of Workers' Compensation (DWC), effective September 1, 2005. The goals of HB 7 include:

treating injured employees with dignity and respect
providing a fair and accessible dispute resolution process
providing access to prompt, high quality medical care within the statutory framework, and
providing services to facilitate an injured employee's return to work as soon as it is considered safe and appropriate by the employee's health care provider.

Continued on next page

Agency Overview, Continued

TDI's Organizational Structure, continued

The impact of HB 7 on TDI's workforce has been significant. In addition to broadening TDI's regulatory responsibilities, the bill effectively doubled TDI's staff and budget.

TDI had a FY 2006 operating budget of approximately $101.6 million, with 1,755.3 adjusted appropriated FTEs. An additional 32.5 FTEs are authorized to support liquidation oversight and title examiner activities. While a majority of TDI employees work in Austin, TDI gained 24 new field offices as a result of HB 7, increasing TDI's field presence significantly. Field employees include DWC staff, financial examiners, fire inspectors and investigators, title examiners, windstorm inspectors and support staff. This allows the agency to better meet the statewide needs of consumers and industry representatives.

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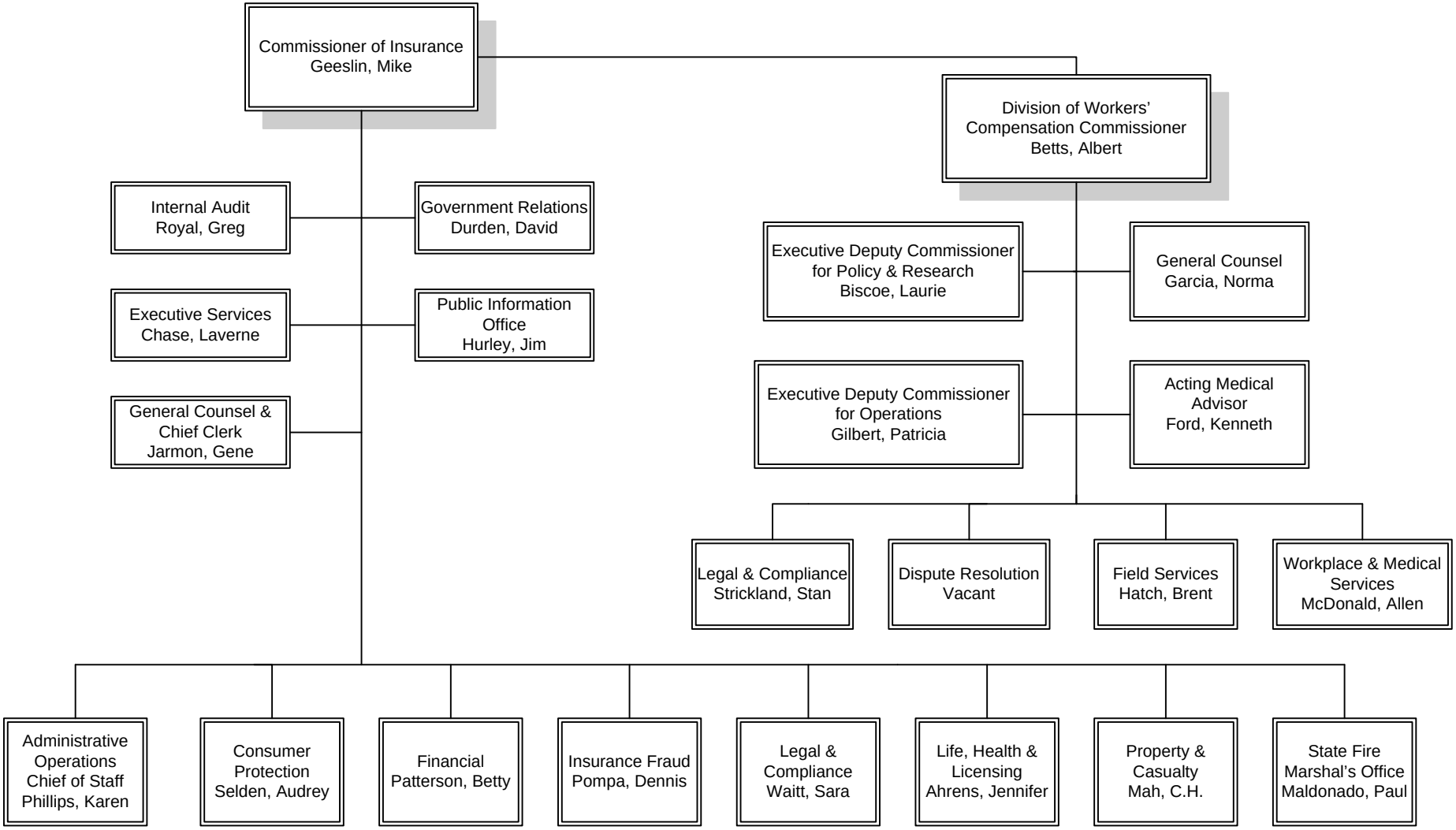
Texas Department of Insurance
Agency Organizational Chart



Agency Overview, Continued

Agency Vision

The Texas Department of Insurance envisions a financially stable and fair marketplace and an effective and efficient workers' compensation system.

Agency Mission

The Texas Department of Insurance regulates the marketplace firmly and fairly by enforcing and implementing the law. TDI strives to enhance internal and external communication for efficient and effective regulation and to promote outreach to educate the public.

Strategic Goals

TDI has identified strategic plan goals in the *2007-2011 Agency Strategic Plan*. TDI's seven funded goals are:

Goal 1: Encourage fair competition in the insurance industry
Goal 2: Encourage the financial health of the insurance industry through monitoring and regulation
Goal 3: Decrease insurance industry loss costs
Goal 4: Reduce loss of life and property due to fire
Goal 5: Provide health and safety services in Texas workplaces
Goal 6: Ensure the appropriate delivery of workers' compensation benefits
Goal 7: Indirect Administration

Two unfunded goals are also listed in the strategic plan, which are:

Purchase from Historically Underutilized Businesses, and
Value the contribution of each employee to TDI's mission and to the diversity of the agency.

Continued on next page

Agency Overview, Continued

Staffing Levels by Strategic Goal

Each of the above listed goals has objectives and strategies that help meet the larger agency goals. The objectives and strategies are described in detail in TDI's *FY 2007-2011 Agency Strategic Plan*. The table below presents each strategic plan goal, the objectives associated with that goal, and the staffing level supporting the goals.

Strategic Plan Goals		**Objectives**	**FTEs**
Goal 1	Encourage fair competition in the insurance industry	Reduce impediments to competition and improve insurance availability Reduce unfair and illegal insurer practices	409.5
Goal 2	Encourage the financial health of the insurance industry	Regulate insurance industry solvency by: assuring mandated examinations are conducted reviewing companies overseeing Special Deputy Receivers	190.1
Goal 3	Decrease insurance industry loss costs	Reduce losses by assuring that: insurance companies provide adequate loss control services windstorm inspections result in "approved" status consumer and provider fraud referrals to other entities result in legal action	73.7
Goal 4	Reduce loss of life and property due to fire	Protect the public against loss of life and property resulting from fire and related hazards by: increasing public awareness of fire safety and prevention enforcing statutes and rules relating to fire investigations, fire safety inspections, fire protection and fireworks industries	70.0

Continued on next page

Agency Overview, Continued

Goal 5	Provide health and safety services in Texas workplaces	Encourage the safe and timely return of injured employees to productive roles in the workplace	850.0 (Goals 5 and 6 combined)
Goal 6	Ensure the appropriate delivery of workers' compensation benefits	Objectives for appropriate service delivery address: payment, health care and reimbursement detecting and addressing noncompliance educating system participants, utilizing technology for improved service certifying and regulating self-insured employers minimizing and promptly and fairly resolving disputes financial administration of the Subsequent Injury Fund	
Goal 7	Indirect administration	Support agency operations through: central administration information Resources other support services.	162.0
Unfunded	Purchase from Historically Underutilized Businesses	To make a good faith effort to increase the utilization of historically underutilized businesses for: professional services commodities other services	0
Unfunded	Value the contribution of each employee to TDI's mission and to the diversity of the agency.	Ensure that appropriate training is available for all employees to develop professionally. Recruit and retain a diverse workforce of qualified and skilled individuals. Communicate to employees their value in the organization.	0
Total			1755.3

Continued on next page

Agency Overview, Continued

TDI Business Functions

TDI's regulatory and administrative responsibilities can be categorized into the broad functions described below.

Function	Explanation
Regulation	TDI is responsible for regulating the insurance industry. TDI's involvement begins at the moment of application for incorporation or licensure and continues throughout a company's entire life cycle. The regulatory function includes the following: granting regulatory authority reviewing rates and policy forms monitoring for company solvency, and taking action in those cases where an insurer is financially troubled or insolvent to mitigate the harm to the greatest extent possible.
Enforcement	The agency has authority to take administrative, civil and/or criminal action against companies, agents, health care providers, employers, and other entities that violate the state's insurance laws. TDI has the authority to enact rules for clarification, administration and proper implementation of insurance laws. Enactment of administrative rules can be used to curb or correct industry-wide deficiencies or improper practices.
Education and Consulting Services	TDI provides education and consulting services for employees and employers to promote safe work practices, prevent occupational injuries and illnesses, and improve return-to-work outcomes.
Dispute Resolution	TDI administers dispute resolution processes to resolve medical and other benefit disputes among workers' compensation system participants.

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Agency Overview, Continued

Fire Prevention and Industry Regulation	The State Fire Marshal's Office of TDI provides assistance to local governments and other entities to improve fire suppression and fire prevention capabilities.
Consumer Services	TDI assists consumers in a variety of ways, such as aiding in the resolution of complaints, responding to information requests and providing consumer education.
Agency Support	As with any agency, TDI has administrative functions to support its regulatory duties. Support operations include human resources, budget, accounting, planning, purchasing, building maintenance, copying, mail service, and acquiring, operating, and maintaining automated information systems.

Anticipated Changes to Mission, Strategies and Goals

HB 7 expanded TDI's strategic responsibilities to include implementing reforms to the Texas workers' compensation system. Major accomplishments in FY 2006 include:

adopting rules to create workers' compensation health care networks
implementing improvements to the dispute resolution process
coordinating with other state agencies on return-to-work efforts to train internal and external customers
consolidating TDI's administrative services
coordinating with and assisting in establishing the Office of Injured Employee Counsel (OIEC), and
reorganizing the Division of Workers' Compensation to address customer service needs and workers' compensation system reforms.

Implementation of HB 7 will remain a priority for TDI in FY 2007 and beyond. As such, TDI's strategic direction, functional organization and staffing levels may be affected as the agency responds to the demands of this important legislation.

Continued on next page

Agency Overview, Continued

Anticipated Changes to Mission, Strategies and Goals, continued

TDI has identified other environmental factors that are likely to impact the agency's mission, strategies and goals through the strategic planning process. Some of the key factors include:

Changing Market Conditions
Fire Safety
Workers' Compensation Reform
Insurance Fraud
Disaster Response and Preparedness, and
Legislative Change.

Information about these factors is detailed in TDI's *FY 2007-2011 Agency Strategic Plan*. Additionally, these issues are discussed in this workforce plan under the Workforce Demands section.

Workforce Supply

Overview

To meet its strategic plan goals, the Texas Department of Insurance (TDI) relies on competent and knowledgeable staff. This section of TDI's *FY 2007-2011 Workforce Plan* describes TDI's current workforce, including its:

demographic profile
critical workforce skills
retiree profile
employee turnover
factors influencing turnover, and
hard-to-fill positions.

Demographic Profile

TDI is committed to equal employment opportunity and strives to maintain a workforce that reflects the diversity of Texas. As of February 2006, TDI's workforce was comprised of 47 percent minority employees and 66 percent female employees. These statistics are similar to the 2005 Texas state agency workforce which was 45 percent minority and 51 percent female.[5] Of particular significance is the minority and female representation in TDI's management positions. Sixty-seven percent of TDI's managers are minority and/or female. Among executive staff positions, 75 percent are minority and/or female.

The average age of all state agency employees is 43.5.[6] The average age of a TDI employee is 46.

The Equal Opportunity Employment Commission has established categories for workforce groups, including:

Officials and Administrators
Professionals
Technicians
Para-Professionals, and
Administrative Support.

Continued on next page

[5] www.hr.state.tx.us/Workforce/Turnover2005/Ethnicity.html
[6] State Auditor's Office Online Systems, 2006 data

Workforce Supply, Continued

Demographic Profile, continued

A demographic comparison of TDI's workforce and the state civilian workforce by classification is shown below.

EEO Category	State Civilian Workforce*			Texas Department of Insurance**			
	African Americans	Hispanic Americans	Females	African American	Hispanic Americans	Females	Total Positions
Officials, Administration (A)	9.08%	12.54%	48.92%	12.60%	15.40%	48.59%	142
Professional (P)	11.30%	15.16%	54.67%	11.30%	23.80%	59.72%	1033
Technical (T)	15.09%	19.62%	51.98%	11.10%	23.20%	36.36%	99
Para-Professional (Q)	19.27%	26.67%	77.77%	16.9%	46.00%	91.05%	313
Administrative Support (C)	18.66%	27.56%	88.24%	21.1%	48.50%	90.00%	171
Skilled Crafts (S)	8.82%	22.69%	4.67%	0%	100.00%	50.00%	2
Service & Maintenance (M)	29.93%	30.74%	49.75%	0%	75.00%	0%	4
							1764

*Commission on Human Rights Annual Report, FY 2005, www.twc.state.tx.us
**Provided by TDI USPS data as of February 28, 2006

At mid year FY 2006, approximately 67 percent of TDI's workforce was classified as either officials/administrators or professionals. TDI positions included in these categories are listed on the table below.

Official/Administrator	Professional	
Senior actuaries	Actuaries	Health and safety professionals/ inspectors
Senior financial examiners	Financial examiners	Inspectors
Executive staff	Auditors	Nurses
Directors/managers	Attorneys (including administrative law judges)	Program specialists
	Insurance specialist	Program administrators
	Engineers	System analysts
	Investigators	

Continued on next page

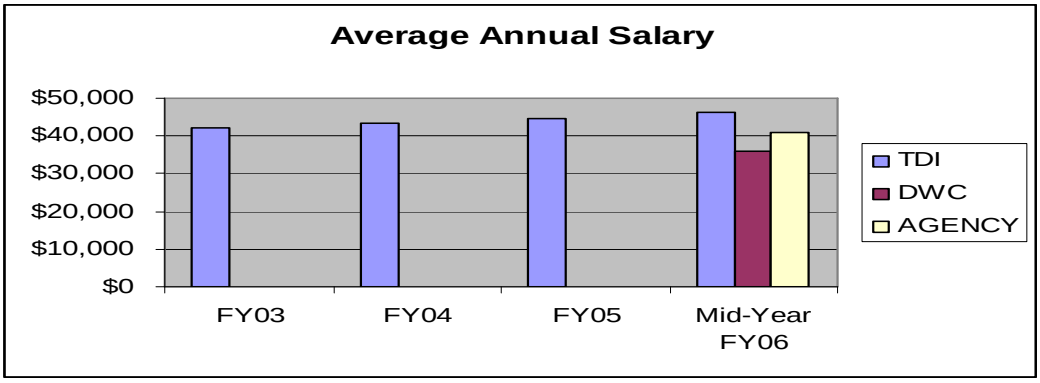
Workforce Supply, Continued

Demographic Profile, continued

In FY 2005, the average annual TDI salary was $44,471 as compared to FY 2004's average annual salary of $42,423.

For mid-year FY 2006, the average annual TDI salary, excluding the Division of Workers' Compensation (DWC), was $46,065 and the average annual salary for DWC was $35,800, giving the agency a mid-year average annual salary of $40,896. (These annual salaries do not include the Commissioners, part-time employees, the Medical Advisor, or the Chief Actuary.)

Because TDI staffs many positions in the professional job series, the mid-year 2006 average salary of $40,896 for agency employees is well above the state employee average annual salary of $34,682.[7] The following chart shows the average salary growth for TDI over the past five years.



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[7] State Auditor's Office Online Systems FY 2006 data

Workforce Supply, Continued

Critical Workforce Skills

TDI relies on a skilled workforce of administrators, who set broad policies, direct individual departments and supervise the agency's operations. The agency also employs professionals with specialized and theoretical knowledge usually acquired through college training or work experience.

Through the Career Advancement Planning System (CAPS), developed by TDI's Human Resources (HR) division, TDI identified the following skill requirements for TDI employees working in administrative and professional positions. These competencies enable staff to effectively perform key business functions and are critical to TDI's mission.

effective oral and written communication
ability to explain complex technical material to consumers
ability to analyze and solve problems
time management
leadership and coaching skills
negotiation strategies and techniques
conduct investigations
interpreting and enforcing statutes and policies
records management, including the use of electronic document management tools
actuarial expertise, and
computer literacy.

Additionally, HR conducts periodic assessments of agency training needs. In December 2004, program management and staff identified the following training needs to develop critical workforce skills:

understanding of insurance and administrative laws
interpersonal skills for improved customer service
conflict management, mediation and dispute resolution
group facilitation skills
process analysis and redesign
project management
decision making
database management, and
web page development.

Continued on next page

Workforce Supply, Continued

Retiree Profile

According to Samuel M. Ehrenhalt, a senior fellow at the Rockefeller Institute of Government, "The aging workforce is one of the greatest problems the public sector faces today." Like the rest of the nation, the Texas population is aging. Between 2004 and 2009, the Texas population over age 65 is expected to increase 14 percent to a total of almost 3.5 million. (Jobs in the 21st Century, Employment Projections 2000-2010, December 2003, Texas Workforce Commission)

House Bill (HB) 3208 passed during the 78th legislative session, created a retirement incentive for eligible state employees beginning on August 31, 2003. The intent of the legislation was to reduce state agency staffing levels and payroll costs. Eligible retirees received a bonus equal to 25 percent of their salary for the prior 12 month period. In turn, the agency's appropriation was reduced by 35 percent of the retiring employee's salary for the remainder of the biennium. In addition to appropriation reductions, TDI also paid lump sums of annual leave and overtime to retiring employees upon separation. According to the State Auditor's Office, of those eligible for retirement within the incentive period, 22 retired from TDI and 29 retired from the Texas Workers' Compensation Commission (TWCC) representing 0.5 percent and 0.7 percent of the statewide retirements, respectively.[8]

Thirty-three percent of TDI's total workforce and 42 percent of TDI managers will be eligible for retirement within the next five years. Projected retirements include three Executive staff. These retirement percentages are up from 2004, in which 30 percent of all employees and 35 percent of managers were eligible to retire. With 11 percent of TDI's workforce eligible to retire in FY 2006, the agency is likely to feel the impact in the near future.

Retirement of key staff creates a large potential for loss of experience and institutional knowledge and is the most significant staffing issue facing TDI, along with fair pay.

Continued on next page

[8] www.hr.state.tx.us/Workforce/Turnover2005/RetirementbyAgency

Workforce Supply, Continued

Retiree Profile, continued

Of the staff eligible for retirement in the next five years, many are managers or individuals with highly specialized skills in the following positions:

Chief of Staff
Senior Associate Commissioner of Financial
Chief Actuary
Staff Services Director, and
several other key positions in the Life, Health & Licensing, Financial, Legal and Compliance, and Property & Casualty programs.

Additionally, HR is reviewing DWC retirements to determine which specific positions will be eligible for retirement in the next five years.

Although retirement incentives will entice certain eligible retirees to leave TDI, the impact of the incentives will be offset slightly by another legislative mandate limiting certain retirees' access to health insurance. Senate Bill (SB) 1370, 78th Legislative Session, requires employees to be age 65 with at least 10 years of service or meet the rule of 80 before qualifying for health insurance.

According to the State Auditor's Office Online Systems, 20 percent of eligible retirees returned to work for their agency statewide. Approximately 28 percent of TDI employees eligible for retirement since 1999 have chosen to return to TDI. Most retirees who returned to TDI have highly specialized skills and upon re-employment continue working in their respective programs. This has mitigated the potential loss of their significant experience. However, TDI cannot rely on this as a solution. HR has worked with programs to begin developing succession plans in order to ensure minimal disruption to program operations in the event of separation by managers or other key staff.

Employee Turnover

Due to changes in demographic trends and the demand for higher skills, there will continue to be workforce challenges for the State of Texas. These challenges include employee turnover which cost the State approximately $345 million in fiscal year 2004.[9] According to the State Auditor's Office Online Systems, statewide turnover for full-time, classified employees was 17 percent in FY 2005. This represented a 2 percent increase from FY 2004.

Continued on next page

[9] A Summary of the State of Texas Workforce for Fiscal Year 2004, December 2004, Report Number 05-704

Workforce Supply, Continued

Employee Turnover, continued

Changes in the labor market impact employee turnover. According to the State Auditor's Office Online Systems, "there is an inverse relationship between the unemployment rate and the turnover rate." When the unemployment rate increases, the turnover rate decreases; when the unemployment rate decreases, the turnover rate increases. The past fiscal year has provided an improving economy with lower unemployment rates. In the last year, the Austin area has seen a decrease in unemployment rates from 5 percent in 2004 to 4 percent in March 2005.[10] As of March 2006, the unemployment rate was 4 percent. As confidence in the local job market increases turnover may also increase. Although the turnover rates for TDI were relatively low in FY 2005, improvements in the local economy may affect retention and recruitment of critical positions as the market becomes more competitive.

In FY 2005, TDI's turnover rate was 10 percent which is the lowest turnover rate for the agency since 1996. The turnover rate for the Texas Workers' Compensation Commission (TWCC) was 17 percent, which was slightly higher than the FY 2004 turnover rate of 14 percent, but is comparable with the turnover rate for other state agencies. The increased turnover for TWCC may be partly attributed to the organizational changes associated with the merger with TDI.

Through FY 2005, TDI's turnover continued to be below the turnover rates of other state agencies. The following chart shows turnover rates for other comparable entities.

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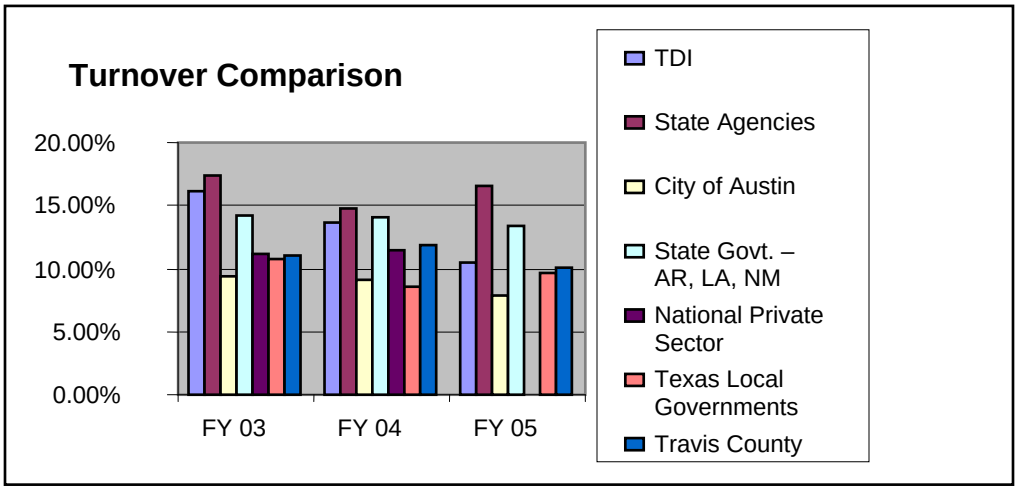
[10] U.S. Department of Labor, Bureau of Labor Statistics Data, www.bls.gov

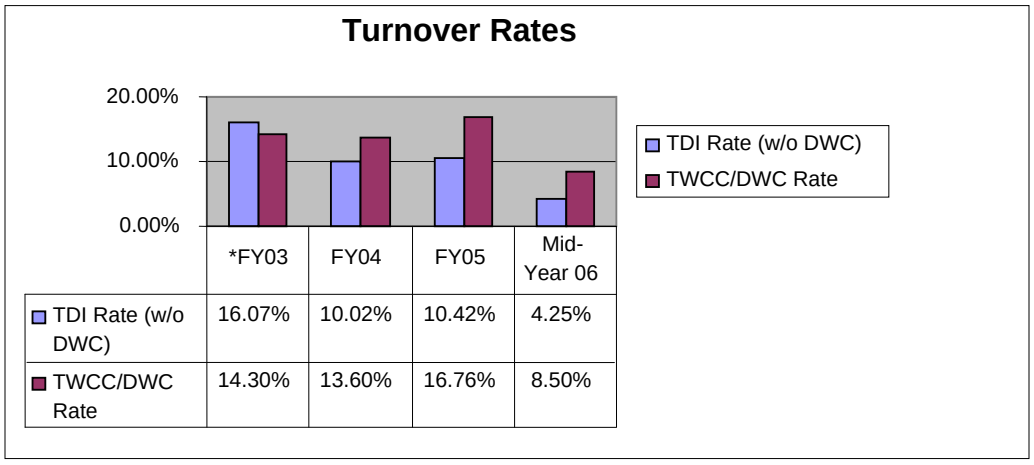
Workforce Supply, Continued

Employee Turnover, *continued*



Note: National Private Sector statistics are not yet available for FY 2005.
Source: http://www.hr.state.tx.us/Workforce/Turnover2005/Default.html

TDI's mid-year 2006 turnover rate was 6 percent agency-wide and is projected to be at or near 13 percent by the end of the fiscal year. The following chart compares turnover rates for the last three fiscal years. Because the chart reflects data that precedes the merger of the two agencies, rates are reported by agency for comparison purposes.



	*FY03	FY04	FY05	Mid-Year 06
TDI Rate (w/o DWC)	16.07%	10.02%	10.42%	4.25%
TWCC/DWC Rate	14.30%	13.60%	16.76%	8.50%

FY 03 includes separations due to reduction in force and retirement incentive

Continued on next page

Workforce Supply, Continued

Employee Turnover, *continued*

In FY 2005, TDI positions with the highest turnover included attorneys, systems analysts, and fraud investigators at 26 percent, 18 percent, and 33 percent respectively.

Attorneys

TDI attorneys on average make less than their counterparts in the private sector as well as other state agencies with an average salary of $52,725, an amount significantly lower than the $73,050 national average salary for state-employed attorneys. In FY 2005, the attorney turnover rate at TDI was 26 percent, which is significantly higher than the 3 percent reported in FY 2004, and somewhat higher than the FY 2003 rate of 19 percent. An analysis of FY 2005 exit survey data shows that the majority of legal staff leaving TDI cited pay dissatisfaction or lack of career advancement as their reason for resigning. Also, a reorganization of the agency and reallocation of staff may have contributed to the high turnover of staff.

Systems Analysts

Turnover for TDI's Information Technology Services (ITS) division in FY 2005 was 22 percent, with Systems Analyst reporting a turnover rate of 18 percent. Although turnover in this area decreased slightly in the last fiscal year, it is expected to increase in FY 2006 and 2007 as the market for technology positions changes, and HB1516 is implemented. ITS anticipates that HB 1516, which consolidates technology data centers for state agencies in Texas, will significantly impact ITS division turnover in FY 2007. Once fully implemented, HB 1516 will outsource specific technology positions within the agency. Outsourced FTEs will be counted as separations which will consequently increase turnover rates. In reaction to the prospect of having their positions outsourced, many technology staff at TDI may opt to retire or resign. Already in FY 2006, ITS turnover has increased because of this legislation. TDI will continue to monitor the division to reduce turnover rates where possible.

According to the U.S. Department of Labor, one of the fastest growing occupations between 2004 and 2014 will be in the computer field.[11] Consequently, the increased need from businesses in fields such as information technology will require state agencies to find new methods to increase applicant pools in these areas.

Continued on next page

[11] U.S. Department of Labor, Bureau of Labor Statistics, www.bls.gov

Workforce Supply, Continued

Employee Turnover, *continued*

Fraud Investigators

Fraud investigator turnover has decreased as well, from 58 percent in FY 2004 to 32 percent in FY 2005. Turnover in this position in FY 2006 is expected to be comparable to the FY 2005 number. As of January 2006, turnover for fraud investigators was 13 percent. Despite the decrease, this continues to be an area of concern. Fraud employs commissioned peace officers with white collar crime and financial crime investigation experience. Investigative staff need to be proficient in the use of specialized investigation analysis software. Additionally, staff must understand insurance industry terminology and products, which is addressed through an accelerated course taught by HR. A major obstacle in retaining qualified staff stems from competition with trade associations, the insurance industry, and other state agencies that need staff with investigative skills.

A factor affecting turnover rates is employees' levels of satisfaction with their workplace. Each biennium, TDI participates in the University of Texas, School of Social Work, *Survey of Organizational Excellence*. TDI employees respond to questions about their satisfaction on twenty constructs grouped into five workplace dimensions. Due to the recent reorganizations resulting from HB 7, the May 2006 survey revealed decreased levels of satisfaction compared to 2004. However, employees still rated 19 out of 20 constructs more positively than negatively.

According to the results of the May 2006 survey, employees' ratings of the Fair Pay construct continued to decline, and Fair Pay was the only service area where employees were more dissatisfied than satisfied. Constructs with no change and those with the least change since the 2004 survey were: Benefits, Empowerment, Supervisor Effectiveness, Change Oriented, and Diversity.

Eighty-four percent of TDI employees responded through the UT survey that they see themselves working for TDI in the next two years. TDI believes that the agency's turnover rate will continue to be below the average of other state agencies.

Continued on next page

Workforce Supply, Continued

Employee Turnover, continued

In addition to the issues identified in TDI's Survey of Organizational Excellence, TDI reviewed current workforce literature to identify issues affecting turnover. Issues include:

shift in how employees view their careers
changes in the job or relationship between employer and employee
changes in social moral attitudes
life balance
a new generation of workers
poor working conditions
lack of appreciation
lack of support
lack of opportunity for advancement, and
inadequate compensation.[12]

Factors Influencing Turnover

Salary and benefits are key factors influencing recruitment and retention. Non-competitive salaries and rising health care costs continue to be issues which challenge state government employers. The state's expenditures for employee health care have risen 47 percent from 1999-2004 and are expected to continue.[13] Some of those costs may be passed onto state employees, making state jobs less competitive. And though pay and benefits will continue to be at or near the top of employees' reasons to stay or leave, the emerging workforce is developing very different attitudes about their role in the workplace. Today's employees place a high priority on the following:

family orientation
sense of community
quality of life issues
volunteerism
autonomy, and
flexibility and nonconformity.[14]

Continued on next page

[12] A Changing Work Force and Workplace, Herman, Hankin and Moore, TEC Inc., www.teconline.com
[13] A Summary of the State of Texas Workforce for Fiscal Year 2004, December 2004, Report Number 05-704
[14] A Changing Work Force and Workplace, Herman, Hankin and Moore, TEC Inc., www.teconline.com

Workforce Supply, Continued

Factors Influencing Turnover, continued

With careful management of limited budget funds, TDI strives to equitably distribute salary increases through merits and promotions. Additionally, in keeping with the ideals listed above, TDI has a number of non-monetary initiatives in place to reduce turnover rates and retain qualified staff. Among these initiatives are:

flex-time
mandatory management training program
employee and manager roundtables
cross-training opportunities
an agency wellness program
continued Reality Check meetings, and
continued participation in the Employee Assistance Program.

Hard-to-Fill Positions

Positions that are most critical to TDI functions include upper level management positions such as Directors, Associate Commissioners, Managers, Chiefs, and Team Leads, as well as positions in highly specified fields such as Medicine, Investigation, Law, and Regulation. These positions all require extensive experience, specialized certifications, and an intimate knowledge of the agency's functions, missions, rules, and regulations. The majority of critical positions identified have succession plans to ensure business continuity should those positions become vacant.

TDI has identified a need to improve succession planning and cross-train staff for the following positions: the Assistant Medical Advisor (Compliance and Regulation), Research Specialist positions (Compliance and Regulation), Prosecutors (Fraud), General Counsel (Commissioner's Administration), Senior Auditors (Internal Audit), Web Administrator (PIO), State Fire Marshal (SFMO), Director of Fire Industry License (SFMO), and the Actuarial Team Lead (Life/Health Division). These positions are of high importance for the agency, as they are hard to fill due to the specialized nature of the required skills and abilities, and the difficulty of recruiting qualified candidates when competing with salaries offered by private industries.

Continued on next page

Workforce Supply, Continued

Hard-to-Fill Positions, continued

Although turnover for most positions has improved, the agency must still be prepared to quickly fill positions once they become vacant. In particular, certain TDI positions are difficult to fill due to their specialized nature. TDI had previously reported difficulty filling the following job classifications.

actuaries
attorneys
information technology staff
financial examiners
fraud investigators
engineers
nurses
safety professionals, and
budget analysts.

In FY 2005, the average time to fill a position at TDI was 58 days[15]. TDI continues to have difficulty filling the following positions: engineers, financial examiners, and safety officers (for positions in DWC). For employees with these specialized skills, salary and perceptions of fair pay directly impact turnover rates. While actuarial positions have historically been challenging to fill, increased recruitment efforts have helped the agency address this need and TDI currently maintains a full staff of actuaries. Additionally, due to the competitiveness in the marketplace, nurse positions can be difficult to fill. As with the actuarial position, TDI has increased recruitment efforts and is currently operating with a full staff of nurses. Because of the highly specialized and marketable skills required for these positions, TDI will continue to monitor recruitment efforts.

Engineers

TDI's State Fire Marshal's Office and Property and Casualty program employ engineers and both programs have reported difficulty filling these positions when they become vacant. TDI has had difficulty recruiting engineers both because it is not able to offer salaries competitive with the private sector in this area and because of the specific nature of skill sets required for the job.

Continued on next page

[15] Time to fill is determined by calculating the days between the date the job is posted until the date the job is offered.

Workforce Supply, Continued

Hard-to-Fill Positions, *continued*

Engineers at TDI play a key role in the Inspections division of TDI's Property and Casualty program area. These engineers perform oversight audits of private engineers, who are appointed by TDI to inspect structures along the coast and to certify their compliance with the applicable code for wind resistant construction. There is a scarcity of qualified civil and structural engineers with the required and specialized skills necessary to oversee windstorm inspections.

The agency also has an engineer position in the State Fire Marshal's Office. The employee in this key engineer and management position is a subject matter expert. Filling this position, should it be vacated, would prove to be difficult for the agency because of the unique combination of required skills and knowledge in both the engineering and fire safety fields needed to advise the fire industry and other entities on designing buildings for fire safety.

In order to address recruitment and retention issues for engineers, TDI is working with the University of Texas to provide part-time employment for engineering graduate students. This program will give graduate engineering students an opportunity to learn the necessary skill sets while completing their graduate degrees. The program aims to retain some of these students once their graduate studies are complete.

Financial Examiners

Examiner positions are unique and challenging to fill due to the educational requirements of applicants, which include holding a degree from an accredited four-year university with a major in accounting, finance, insurance, statistics, computer science, math, actuarial science, general business administration or economics. Pursuant to the career ladder for this position, which coincides with National Association of Insurance Commissioners (NAIC) accreditation standards, these employees are required to work towards a specific professional designation of Accredited Financial Examiner (AFE) and Certified Financial Examiner (CFE) on their own initiative within a specific timeframe.

While salary enhancements related to designation achievement, combined with the general economic slowdown, did slow the departure of Financial staff in FY 2004-2005, it did not result in significant gains in the recruitment of new staff. Likewise, the availability of adequate salary enhancement funds for FY 2006-2007 is uncertain.

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Workforce Supply, Continued

Hard-to-Fill Positions, continued

Recruitment efforts are of growing concern for Financial, as 30 percent of TDI's Financial Examiners are eligible to retire within the next five years. Once recruited, retention of qualified, well-performing staff is particularly important because it takes two to three years to train most financial examiners. The training period is lengthy because most new examiners do not have insurance backgrounds, even if they have accounting and auditing backgrounds. As mentioned previously, the financial examiner classification is subject to market conditions. When the economy is good and unemployment is low, this classification is difficult to retain.

Safety Officers

TDI's Division of Workers' Compensation has faced difficulty attracting safety officers with the training and experience necessary for the job functions required of the position. TDI is not able to offer compensation competitive with that of the private sector or the federal government. In order to increase the pool of qualified applicants for safety officer positions, TDI is working to develop an apprenticeship/internship program for safety professionals, modify the required experience provisions for safety professional positions, and encourage educational institutions to develop and offer safety curriculum.

Actuaries

The Actuarial positions at TDI provide a critical examination and regulatory function. An actuarial career path is rigorous in terms of technical difficulty, the number of hours of study, and the high cost of exams to become certified. Actuaries tend to be in high demand and seek employment which provides competitive compensation, good programs for passing exams, and good experience.

Historically, TDI has faced difficulty in recruiting actuaries, as the salaries it offers are not competitive with those of the private sector. In previous years, turnover for this position has been high because as staff gain experience and earn professional designations, they are often recruited into better paying jobs in the private sector. To address this issue, the 77th Legislature approved the creation of a new actuarial classification, Actuary VI, pay group B21. This classification has assisted in recruiting and retention for these positions. TDI also offers non-monetary incentives to recruit and retain actuaries. TDI provides junior actuaries with materials and study time for examinations. As a result of the increased recruitment and retention efforts for actuaries, TDI currently has a strong and stable staff of actuaries. At the end of FY 2005, Property and Casualty had five actuaries with professional designations (three fellows and two associates) and

Continued on next page

Workforce Supply, Continued

Hard-to-Fill Positions, continued

four junior actuaries. The Life/Health Division employs two actuaries with a professional designation of Associate and the Financial program also has a small actuarial staff. In an effort to retain qualified actuaries, the agency should develop ways to provide continuing education and travel revenue for the actuaries so that they keep their designations in good standing. Despite this marked improvement, TDI will continue to monitor recruitment and retention efforts in this field in order to ensure continued success in staffing.

Nurses

TDI employs nurses for both the Life, Health and Licensing (LHL) program and the Division of Workers' Compensation. Both the Life, Health and Licensing program and the Division of Workers' Compensation have had difficulty filling nurse positions but recently, the LHL program has reduced nurse staffing levels making recruitment less of a concern. Nurses are critical in performing reviews of medical cases to determine the appropriateness of health care being provided. Attracting the skill sets necessary for this function has proven challenging for TDI, which programs attribute to salary levels. Both TDI programs require registered nurses with experience to fill these positions. TDI is exploring methods of recruiting nurses such as recruiting from the pool of candidates created by the consolidation of Health and Human Services Commission and offering non-monetary incentives such as flexible and/or reduced work schedules where possible.

Workforce Demand

Overview

This section describes demands anticipated for the Texas Department of Insurance's (TDI) workforce, including:

critical functions
technology
future workforce skills needed
staffing demands, and
workforce changes.

Critical Functions

The core functions performed by TDI are discussed in the Agency Overview section of this report and include: regulation; enforcement; fire prevention and industry regulation; dispute resolution; consulting and education services; consumer assistance; and agency support. TDI does not anticipate a significant shift in these critical functions but the strategic planning process helped identify key environmental factors that are likely to impact the agency's strategic direction and, consequently, the workforce. Key factors identified include:

Workers' Compensation Reform
Changing Market Conditions
Disaster Response and Preparedness
Insurance Fraud
Fire Safety, and
Legislative Changes.

Additional information about these factors is detailed in TDI's *FY 2007-2011 Agency Strategic Plan*, and a brief assessment of each follows.

Workers' Compensation Reform

In 2005, the 79th Texas Legislature passed House Bill (HB) 7, which represents the most significant reform to the Texas workers' compensation system in more than 15 years. Effective September 1, 2005, HB 7 created the Division of Workers' Compensation (DWC) as part of TDI to regulate and administer the workers' compensation system. Since that time, TDI has been working with system participants to implement these reforms within the workers' compensation system, which include changing the system for delivering health care to injured employees, encouraging timely return to work after an injury, streamlining and improving dispute resolution processes and establishing a performance-based regulatory approach. Additionally, there have been organizational changes within DWC to address customer service needs and workers' compensation system reforms.

Continued on next page

Workforce Demand, Continued

Workers' Compensation Reform,

continued

Among the key changes, the reorganization:

better positions each program to accomplish DWC goals
develops a centralized customer service and complaint resolution area
creates a section dedicated to data monitoring and analysis
revises the investigation and compliance effort, and
dedicates legal support to the program areas.

Changing Market Conditions

Due to the complex relationship among insurance industry insolvency, guaranty funds and revenue to the State, TDI and the Legislature have placed a high importance on financial analyses and examination of companies. Insolvencies adversely impact policyholders and, ultimately, state revenue. Thus, the increasing practice of insurers merging into large multi-state companies creates challenges for state regulators, as a more comprehensive approach to insurance regulation is needed to monitor the solvency of these national companies.

Property and casualty insurance policy holders in Texas have not experienced the widespread drastic rate increases or availability problems that were seen a few years ago in, for example, the homeowners and medical malpractice market. This is largely due to stabilizing loss trends and legislative reforms mitigating losses for all major lines of Property and Casualty insurance.

Although TDI is hopeful that this favorable climate continues, the following external changes may affect market conditions and require TDI attention.

Recent hurricane experience could have an impact on the price and availability of residential property insurance in Texas coastal region due to rising catastrophe reinsurance costs, readjustment of catastrophe models, and reevaluation of business models that manage catastrophe exposure.

TDI has not seen large, across-the-board increases in rates in the last two years, but individual policyholders may have experienced large rate swings as insurers try to further segment their market. As more companies adopt new classification schemes to predict differences in expected losses among insureds, individuals disadvantaged by them may not be able to find affordable alternatives and may forgo insurance altogether.

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Workforce Demand, Continued

Changing Market Conditions, *continued*

Texas has one of the highest uninsured rates in the country for health insurance and faces an increasing number of Texans who may be underinsured. Rising health insurance costs, high percentage of immigrants, low participation rates in employment-based insurance, and low enrollment rates in government-sponsored plans all contribute to Texas' growing uninsured population. Developing affordable alternatives and educating the public about health insurance will remain a priority for TDI. TDI will also continue to evaluate the effect of newly established health care cooperatives and consumer choice health care plans on insurance costs and rates of participation.

Hispanic Americans are the nation's largest and fastest growing demographic group. Texas has the second largest number of Hispanics in the nation at approximately 6.7 million. Texas can only expect its Hispanic population to continue increasing as national projections predict that by 2050 one out of every four Americans will be Hispanic. The second most common language in the United States is Spanish. In addition to the Hispanic population, Korean, Chinese, and Vietnamese demographic groups are growing in Texas, creating a need for TDI to bridge these language barriers. Like the rest of the nation, the Texas population is aging. Between 2004 and 2009, the Texas population over 65 is expected to increase 14 percent to a total of almost 3.5 million.

Changes in the size and composition of the population will affect the insurance industry, Texans' insurance needs, and, consequently, TDI. The demand for state services will increase as the population grows. Additionally, an aging population will likely mean greater need for health care and increased healthcare costs associated with elder care. Similarly, while TDI has addressed the need of non-English speaking consumers by printing publications in Spanish, Korean, Chinese, and Vietnamese and employing Spanish-speaking customer representatives on phone banks, TDI will need to plan staffing to address this demographic trend.

Disaster Response and Preparedness

The Hurricanes that struck the U.S. Gulf Coast in 2005 highlighted the critical need for preparedness and rapid, coordinated response to disasters and other emergencies. TDI was a key participant in state and federal assistance efforts for these evacuees, maintaining staff presence in Federal Emergency Management Agency (FEMA) Disaster Recovery Centers (DRCs) to assist with questions and complaints about insurance. TDI staff were also called to assist consumers in the field, deliver ice and water, and inspect homes and governmental buildings for fire safety and building code compliance.

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Workforce Demand, Continued

Disaster Response and Preparedness, *continued*

Strategic planning is key to meeting the unique demands posed by a disaster or similar emergency and will focus on:

increasing efforts to foster communication and coordination among key players
promoting public awareness and continuing public assistance efforts
ensuring that insurers have catastrophe plans and business continuity plans
monitoring insurers' financial condition to ensure solvency following an area- or state-wide disaster, and
maintaining and refining planning to ensure continuity of operations following a disaster affecting the agency.

Insurance Fraud

Fighting insurance fraud continues to remain a significant economic problem for consumers and businesses. Technological advancements have fueled new insurance fraud schemes. The Internet alone has facilitated increases in identity theft, as well as the number of bogus insurance companies and products marketed. In order to meet strategic goals, the Fraud Unit will:

adapt investigative processes to keep pace with schemes allowed by recent technological advances
develop and enhance cooperative efforts between the industry, government and law enforcement, and
educate the public and industry on insurance fraud trends and issues.

Fire Safety

Currently, the State Fire Marshal's Office's (SFMO) utilizes its resources to achieve its mission mostly by conducting individual fire safety inspections and fire cause investigations. The SFMO's leadership challenge is to multiply the effects of its services and "reduce loss of life and property due to fire and related hazards," by reengineering and reprioritizing operations. To do this, SFMO will:

organize operations to meet enforcement responsibility
provide community outreach programs to develop strategies for fire prevention, and
enhance fire prevention services through partnerships.

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Workforce Demand, Continued

Legislative Change

The Texas Legislature passed legislation that have or will have significant impact on agency operations.

In addition to creating changes in workers' compensation regulation and service delivery, HB 7 merged two formerly independent agencies of equal size. This merger has created opportunities to examine the agency functions. Staffing processes and policies are being streamlined to improve customer service.

The McCarran-Ferguson Act is a 1945 federal law that gives states the authority to regulate the business of insurance. Despite McCarran-Ferguson, the industry has advocated moving to federal regulation of insurance to address problem of non-uniformity in insurance regulation by the 50 states. There are several draft bills in the United States Congress that impact the future of state regulation. While there has been no wholesale preemption of state insurance regulation, the federal government has passed laws that supersede state insurance law.

The National Association of Insurance Commissioners (NAIC) continues to address the need to coordinate regulation of multi-state insurers. TDI is working with other states through the NAIC to create and implement more uniform standards for insurance regulation, when appropriate. TDI continues to monitor activities at both the state and national level and has a number of key staff chairing or participating in NAIC committees, projects and workgroups.

Technology

TDI's functions are evolving to meet the increasing developments in automation and technology. Automation and use of the Internet/intranet will affect staffing and operations in three ways: increasing efficiency and productivity, changing staffing patterns, and creating staff needs.

Overall, automation and technological advances at TDI will allow for greater customer service, increased efficiency and productivity by departments, and the streamlining of processes. TDI will utilize technology to provide the highest levels of service possible. Software such as TXCOMP, Teammate, Violation Records Support System (VRSS), and the Fire and Arson Investigations system will allow the agency to move toward a paperless environment in which unnecessary manual operations will become largely obsolete, and automated processes will free staff time to focus on higher level analysis and better customer service. While generally automation and technology has improved efficiency, programs noted that software compatibility may impact the short-term efficiency gains by creating increased workload.

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Workforce Demand, Continued

Technology, continued

The automation of services provided by programs may require a reorganization of staff assignments and duties to address technological rather than manual processes. For example, Consumer Protection has noted a decrease in phone calls since more information is available online. Staff patterns could be shifted to address this operational trend. Software such as TXCOMP, which provides additional automated services to customers, results in increased questions that staff must address. In order to accommodate customer needs created by the implementation of TXCOMP, TDI will reallocate staff to optimize customer service.

An increase in technology and automation throughout the agency has resulted in the need for additional staff and training. For example, since the process for reporting insurance fraud has been automated, the number of reports has substantially increased, creating a need for additional staff to investigate the reports. The Public Information Office (PIO) has also experienced an increase in staff demands due to the implementation of Collage software, which has required PIO staff to train other agency staff on the program. As more information is posted to the Internet, staff identified a need for additional training to better understand what constitutes public information. Internal Audit plans to implement a paperless workflow and will require training in Teammate software, as staff are currently unfamiliar with its functions.

Future Workforce Skills Needed

TDI management reported that analytical/problem-solving skills are essential to perform TDI's critical functions and that they anticipate a need for higher skilled staff due to the complexity of insurance issues. Other general competencies include effective oral and written communication, and project management. In general, TDI has found that it can train staff to be knowledgeable about technical insurance matters as long as they are receptive to learning and have good problem-solving skills.

Human Resources (HR) is responsible for providing training at TDI. After each training session, HR surveys participants to determine the effectiveness of the course as well as what training they feel would be beneficial in the future. Through these surveys, HR has identified a need for more online courses, and more customized courses that provide one-on-one options for employees with specialized needs in areas such as writing and presentation skills. Other areas of focus for training in FY 2007 will be group facilitation, which would provide additional options to employees who are team or group leaders. HR will evaluate ways to address these needs in their training plan, including performing the functions using existing staff as well as outsourcing the activity.

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Workforce Demand, Continued

Future Workforce Skills Needed, continued

Staff at all levels must be proficient in using computer and have knowledge of various software applications. With the passage of the Uniform Electronic Transactions Act and other laws that promote electronic government, computers and the Internet have transformed agency processes. Staff with Web design, database design, and document management skills will be critical to TDI as more information is collected and maintained electronically. Additionally, customers are more computer literate and rely more on the Internet for information than in the past. This will make Web design and content management skills increasingly important. TDI staff must be able to adapt to changing and advancing software programs, which will create additional training needs in the future.

Other skills that will be important to target in TDI's recruitment efforts and that are critical to its primary regulatory functions include engineering, actuarial science, and accounting. Staff with these skills are in high demand in the private sector. Moreover, these skills typically require formal training in a full-time university setting and cannot be adequately learned through on-the-job training.

TDI identified a variety of skill sets that will need to be developed as a result of HB 7. These include knowledge and processes related to new or expanded regulatory responsibilities such as Independent Review Organizations (IRO) assignments and certification and regulation of Workers' Compensation Health Care Networks. Additionally, the Division of Workers' Compensation technical infrastructure created new challenges for TDI. The Information Technology Services Division will have to adapt project management skills to accommodate the implementation of larger scale projects.

Finally, management identified a need for more bilingual (English and Spanish-speaking) staff. Texas has seen an increase in its Hispanic population and as a result more consumers and industry professionals speak Spanish as their primary language. Critical functions that would benefit from Spanish speaking staff include: safety consultations and inspections; training, education and public information efforts; and customer service.

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Workforce Demand, Continued

Future Workforce Skills Needed, continued

TDI anticipates a continued need for staff in the following areas. In addition to the previously mentioned skills, the following competencies will be essential:

Professional Positions/Designations	Competencies/Skills
Attorneys Actuaries Accountants Examiners Management Investigators Database administrators and Web development staff Systems Analyst Application Developers Fire Protection Engineers Fire Data Analysts Adolescent/Adult Education Specialist	Change management Process analysis Collaboration Negotiation and facilitation Project management Performance management Strategic planning Engineering

Staffing Demands

TDI's strategic planning process allows the agency to assess current and future performance on key functions. Additionally, TDI monitors performance measures along with industry trends, legislative changes, and consumer needs to determine workload shifts and the need to reallocate staff to meet the demand for services.

Based on events which had the greatest impact on staffing and operations in the last biennium, TDI expects that the following will have the greatest impact in the future: HB 7, natural disasters, and legislative sessions. HB7, which consolidated TDI and TWCC has created an increase in customer service demands and workload for TDI staff and will continue to do so in the future. Hurricanes Katrina and Rita in 2005 alerted TDI to the impact that natural disasters can have on the agency, specifically the increases in staff hours (as experienced in the Licensing division of the Life, Health and Licensing program, Consumer Protection, Windstorm division, and State Fire Marshal's Office) and resources that are required to provide services to customers. Finally, legislation presents challenges for programs and staff in managing workloads by potentially altering functional or regulatory responsibilities and staffing levels.

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Workforce Demand, Continued

Staffing Demands, continued

Of the 2006 Strategic Planning issues, HB 7 will likely have the most significant overall impact on TDI programs and staff. HB 7 will impact every TDI department. Some departments, such as Fraud may require more staff to handle DWC issues, while other departments such as Field Services and Internal Audit will need training on procedural aspects of new DWC requirements. LHL assumed the additional responsibility of implementing the legislative mandate to certify workers' compensation health care networks and assure they provide a high quality of care to their members. Additionally, LHL will assume workers compensation IRO requests which will substantially increase the number of IRO requests processed by staff. The number of staff required to certify and regulate the networks and process an increased number of IRO requests will increase over the current staffing levels, and staff will be needed to address increases in workload related to complaints resolution. The division has reorganized and is undergoing substantial cross training and education. TDI views HB 7 as an opportunity to improve customer service and streamline the complaint handling process. The Consumer Protection program has lead several initiatives including cross-training on contact points for various agency services and a project to create a paperless workflow for complaints about the workers' compensation system.

In 2005, hurricanes Katrina and Rita required TDI to expend significant monetary and staffing resources to assist affected communities with disaster response and recovery efforts. Executive management considers disaster response an important activity for the agency and in order to effectively respond to a disaster, involvement of all program areas is essential. TDI is evaluating options for more efficient disaster response in the future. Options to address increases in workload associated with disaster response include: the use of automation, increased planning, possible utilization of a temporary workforce, and collaborative partnerships.

In 2005, numerous bills were passed that will impact the workload and staff demands at TDI for FY 2007 and beyond. HB 1516, which consolidates technology data centers for state agencies in Texas, will redefine ITS responsibilities and significantly impact division organization and staffing levels in FY 2007. SB 1670 requires TDI, in consultation with the Texas Department of Public Safety, the Texas Department of Transportation, and the Texas Department of Information Resources, to establish a program for verification of financial responsibility. The bill aims to reduce the number of uninsured

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Workforce Demand, Continued

Staffing Demands, continued

motorists in the state of Texas. TDI is leading this project, with an implementation date of December 2006. Additionally, upon implementation the project will be expanded to include ongoing verification of insurance, impacting staff's short- and long-term workload.

As agency budgets are legislatively appropriated, TDI is mindful of potential budget reductions that may impact staffing levels. At the request of the Governor, state agencies plan to operate at a reduced budget in FY 2008-2009. In response to this request, TDI is assessing staffing levels to ensure resources are dedicated according to agency priorities in order to optimize service delivery. This approach helps the agency respond to budget shortfalls with minimal disruption in operations.

Each biennium, TDI surveys customers about their satisfaction with TDI services. As part of this process, TDI analyzes survey results and identifies areas for improvement. Management reviews these findings as part of the business planning process to identify program initiatives to improve service. Depending on the nature of the problem, program business plan initiatives may include process improvements, training, workload analyses, or automation, and may result in the reallocation of staff resources to meet customers' service needs.

In February 2004, TDI Executive Management performed an internal review of agency functions to assess the effectiveness of certain current operations. The goal of the review was to assess certain critical agency functions for efficiency, effectiveness, statutory authorization, responsiveness to consumer and industry interests, and furtherance of agency mission. The review considered internal processes, technology, staffing responsibilities, and other factors that impact performance. Executive Management will consider the assessment results and identify actions to improve agency operations. Additionally, TDI is embarking upon an Enterprise Risk Management project to identify and prioritize risks in order to optimize resource allocation for managing those risks. The outcome of these two agency projects could potentially affect agency staffing allocations.

The 78th Legislature passed HB 3442 which requires that state agencies achieve a management-to-staff ratio of one manager for every 11 employees by August 31, 2007. TDI's management-to-staff ratio as of August 31, 2005 was 1:9.49, and DWC's ratio was 1:9.6. Mid-Year FY 2006 TDI's management-to-staff ratio, excluding DWC, was 1:10.06 and DWC's management-to-staff ratio was 1:8.31, giving the agency a management-to-staff ratio of 1:9.18.

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Workforce Demand, Continued

Staffing Demands, continued

Human Resources management has been discussing possible changes in organizational structures within program areas to assist the agency in achieving the 1:10 ratio by August 31, 2006. The agency is carefully reviewing management positions which become vacant and continues to review the possibility of moving some supervisors to team leaders within program areas. At present, the agency is on target to meet the August 2006 requirements.

Workforce Changes

According to the Bureau of Labor Statistics, professional and technical occupations such as engineers, architects, and science technicians are expected to grow faster and open more new positions than other occupations. Staff in these higher skilled professions will require more education and must have good communication, math, and reasoning skills.[16]

The State Auditor's Office *Workforce Planning Guide* notes that within the next decade the State of Texas can expect to see the following workforce changes:

an older and more diverse workforce
an increasing number of employees retiring
a shift toward higher-skilled jobs
increased competition for talent
workers changing values and expectations, and
an increasing demand for government services due to population growth.

Additionally, TDI surveyed the Senior/Associate Commissioners to identify key issues and environmental factors impacting program staffing. The factors identified by executive staff will be discussed in further detail in the *Gap Analysis* section.

[16] www.hr.state.tx.us/workforce/whitepaper.html

Gap Analysis

Overview

Gap analysis involves comparing the workforce supply projection to the workforce demand forecast. After analyzing the workforce information, Texas Department of Insurance (TDI) has determined that there are four main gaps between the agency's current workforce and the demand for future workforce skills. They are:

large number of retirees
turnover
hard-to-fill positions, and
staffing/skill shortages and surpluses.

Each of these gaps are explained in further detail below.

Large Number of Retirees

Human Resources (HR) closely monitors and tracks positions eligible for retirement and provides information on eligibility to program areas. Approximately 33 percent of TDI's total workforce and 42 percent of TDI's managers will be eligible for retirement within the next five years. Retirement of key staff creates the potential for loss of experience and institutional knowledge and is the most significant staffing issue facing TDI, along with fair pay. Of the staff eligible for retirement in the next five years, many are managers or individuals with highly specialized skills.

Some recent retirees with key expertise have returned to TDI to continue working in their respective programs. This has mitigated the potential loss of their significant experience. TDI, however, cannot rely on this as a solution. HR continues to work with programs to develop succession plans in order to ensure minimal disruption to program operations in the event of separation by managers or other key staff.

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Gap Analysis, Continued

Large Number of Retirees, continued

Staff retirement has created an opportunity to assess resource allocation. The 35 percent salary reduction, linked to the vacancies created by employees accepting the retirement incentive bonus, has caused programs to reallocate staff funding since not all of these vacancies can be filled at the reduced salary level. In these instances, programs must redistribute funding from other vacant positions after determining an appropriate salary for all affected positions and classifications. Assessments of vacancies provide an opportunity to make appropriate adjustments, add staff strength where needed, and ensure compliance with the mandated management-to-staff ratio.

Turnover

In Fiscal Year (FY) 2005, the turnover rate for TDI was 10 percent and for the Texas Workers' Compensation Commission (TWCC) was17 percent. Although TDI's FY 2005 turnover rate was below the state average, retention efforts remain a priority for TDI, as even a low rate of turnover can be costly to the agency. Loss of experienced staff can cause instability and morale problems, reduce productivity among newly hired and departing employees, and increase hiring and training costs.

The agency's employee survey shows salary levels remain a concern to TDI employees, which can affect retention. Salary increases, through merit raises and promotions to eligible qualified employees, is an important agency retention strategy, but budget limitations require the agency to continue seeking creative non-monetary incentives and benefits.

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Gap Analysis, Continued

Hard-to-Fill Positions

In conjunction with employee retention, TDI must seek ways to recruit employees for hard-to-fill positions. These positions typically require specialized skills such as actuarial, engineering, financial examination, nurse, and safety officer duties. Recruitment efforts encompass the entire pool of potential applicants, including the insurance industry, information technology companies, law firms, law enforcement organizations, staff in other state agencies, and universities. Additionally, recruitment strategies include communicating the advantages of state employment.

Staffing/Skill Shortages and Surpluses

As of FY 2005, TDI was operating at an efficient staffing level with no immediate staffing/skill surpluses or shortages. The recent merger of the TWCC and TDI, however, prompted the agency to revisit organizational patterns focusing on streamlining similar functions and improving customer service. Additionally, the Governor's request for FY 2007-2008 budget reductions necessitates further prioritization and optimization of resources, which could include organizational and staffing changes.

To identify specific issues that may affect staffing levels and patterns, TDI surveyed the Senior/Associate Commissioners about key workforce issues and examined external factors identified through the supply analysis. The following environmental changes and skill shortages were identified:

changes in the use of automation
customer service demands
strategic planning issues such as legislation, and
skills and competencies that will be needed to perform critical functions.

Continued on next page

Gap Analysis, Continued

Staffing/Skill Shortages and Surpluses, *continued*

Automation and Customer Service Demands

The use of automation and technology has and will continue to change the way TDI does business. Increased access to the Internet has allowed consumers to research a greater number of insurance-related and workers' compensation claim processing questions online. Similarly, the use of the Internet has fueled customer demand for information to be delivered virtually around the clock. Greater consumer use of the Internet will likely lead to a decrease in the number of Consumer Help Line calls and associated staff. Reductions in workload for staff responding to requests for public information are also anticipated. These staffing surpluses could be offset by the need to maintain additional staff to provide accurate and timely information on the agency's Web site. Use of the Internet also allows greater ease in reporting insurance fraud to TDI resulting in an increase in the number of incoming reports. It is anticipated that this increase in the number of reports will result in a heavier workload for intake, investigative and support staff.

Customer expectations for faster processing of filings and the agency's growing commitment to customer outreach impact staff operational priorities. The Filings Intake and Operations Division, Agents Licensing Division, Fraud Division, and State Fire Marshal's Office (SFMO) all indicated that the volume of filings is increasing while customers expect reduced processing times. While implementing automated processes to eliminate manual processes should improve efficiency, it is not expected that it will lead to a surplus of staffing based upon increasing volume of filings received. Automated processes will, however, create a need for increased technology. Automation will also require staff to perform certain administrative and scanning functions that were not done previously as well as develop the skill sets needed for electronic review of filings as opposed to reviewing paper-based filings. Customer demands may require frequent tailoring of the agency's website, reconstruction of various pages and presentations, and more interactivity, which will increase the workload of current webstaff.

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Gap Analysis, Continued

Staffing/Skill Shortages and Surpluses, *continued*

Automation and Customer Service Demands, continued

The strategic direction of the State Fire Marshal's Office's focuses on becoming more proactive and prevention-focused, resulting in a greater need for specialized skills and knowledge, and also to utilize technologies such as the Internet, for example, allowing individuals and companies to obtain licenses through the Texas On-Line Internet portal. As these systems and processes are implemented, SFMO staff may require additional training.

The Life/Health Division began accepting electronic filings for annuity products through System for Electronic Rate and Form Filing (SERFF) and I-File some years ago. This has been a customer service success as insurers are pleased and continually request electronic filing be extended to other products. Although the front end process of accepting filings electronically has been completed, the back end process to transfer the completed file into the agency's VisiFLOW software system is not yet automated. Automating this back-end process must be completed in order to maximize efficiency of the process.

The Division of Workers' Compensation is in the process of implementing automation changes developed under the Business Process Improvement Project. This project includes development of web-enabled reporting and communications; moving off of a mainframe environment; and reducing communication among DWC and system participants in paper formats through the implementation of a document management system. Ultimately, it is anticipated that the use of new technology will be more efficient and will allow resources currently dedicated to handling paper processes to be re-allocated.

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Gap Analysis, Continued

Staffing/Skill Shortages and Surpluses, *continued*

Strategic Planning Issues

Many of the strategic planning issues that had the greatest impact on program staffing were the result of recent statutory changes. State Legislation, including HB 7, HB 1516, and HB 3442, create a need for new and revised processes and functions to which the agency must adapt.

TDI anticipates a shift in regulatory functions for Life Health and Health and Workers' Compensation Network Certification and Quality Assurance (HWCN) division staff. The number of Health Maintenance Organizations (HMOs) in Texas and HMO-related complaints is decreasing and TDI expects this trend to continue. Increased regulatory oversight of Preferred Provider Organization (PPO) networks is anticipated. The agency is involved in the oversight and regulations of Workers Compensation Healthcare Networks, a new managed care entity created by HB 7. These new responsibilities offset any decreases in workload. Additionally, the assignment and processing of Workers' Compensation Independent Review Organization (IRO) requests is being consolidated with the assignment and processing functions that are in place for HMOs. HWCN staff currently perform this function for group health IRO requests; however, the addition of the Workers' Compensation IRO requests will increase the number of IRO requests from an average of 500 to approximately 5,000 per year. The process for handling workers' compensation IRO requests requires additional steps that are not currently performed for group health requests. This shift in workload will require assessing appropriate staffing levels and possible re-allocation of resources between the DWC and HWCN staff. Additionally, all staff will require training on the revised processes.

HB 1516, legislation consolidating the technology data centers for state agencies in Texas, has created a need for TDI to examine and possibly redefine the organizational structure of the Information Technology Division. In addition to modifying the agency's technology procurement processes, HB 1516 will outsource specific technology positions.

The 78th Legislature passed HB 3442 requiring that state agencies achieve a management-to-staff ratio of one manager for every 11 employees by August 31, 2007. This mandate creates an opportunity for TDI to further flatten the organizational structure.

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Gap Analysis, Continued

Staffing/Skill Shortages and Surpluses, *continued*

Skills and Competencies

Based on input from TDI's Executive Management about key issues impacting program staffing, we identified the potential for following skill shortages.

- ability to analyze and solve problems
- effective oral and written communication
- interpersonal and customer service skills
- technical expertise about insurance products, laws and regulation
- ability to explain complex technical material to TDI customers
- knowledge of the systems used to track filings and complaints
- competency with using electronic processes
- medical expertise and familiarity with medical billing and reimbursement processes
- project management
- knowledge of Web design and content management techniques
- knowledge of database design techniques
- computer literacy
- time management, and
- bilingual communication skills.

Environmental Changes

Changes to the demographic profile of the Texas population will also impact staffing. As the population ages, TDI can assume that health care needs will increase. As the population's needs change, so will the insurance marketplace. As a regulatory body, TDI must be prepared to review and approve new products and provide consumers with information regarding these products. Similarly, Texas has seen growth in its Hispanic population and with that, more consumers and industry professionals who speak Spanish. To serve these Spanish-speaking customers, the agency has identified a need to recruit and hire bi-lingual (English/Spanish-speaking) staff.

Changing economic conditions also affect staffing surpluses and shortages. If the economy continues to improve, the agency anticipates that turnover could increase and specialized positions may become difficult to fill.

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Gap Analysis, Continued

Staffing/Skill Shortages and Surpluses, *continued*	TDI's business planning process creates a formal ongoing process for programs to examine opportunities for performing business operations more efficiently. Program business plan projects assess program strengths and weaknesses, identify opportunities for improvement and suggest technology and process improvements that result in program improvements. As efficiencies in operations are gained, programs will review workload and staffing for opportunities to reallocate staffing surpluses, if any, to a more efficient organizational structure.

Strategy Development

Overview

In order to address the deficits between the current workforce and future demands, the Texas Department of Insurance (TDI) has developed several goals for the current workforce plan. These are based on a range of factors identified through analyzing the agency and its workforce. TDI's future workforce requirements can be grouped according to following key goals intended to address workforce needs:

I. Continue Succession Planning
II. Maintain an Effective Agency Retention Program
III. Use Recruitment Plans, and
IV. Respond to Changing Workloads, Processes and Organization.

TDI's business planning process has been designed to develop and track progress on program level workforce plans. TDI has incorporated program level workforce plans into the goals and strategies described hereafter.

Continued on next page

Strategy I. Continue Succession Planning

Gap	Large number of retirees
Goal	Implement succession planning to assure that vital knowledge is not lost when key employees retire.
Rationale	A large number of retirees could result in loss of institutional knowledge. An organization should plan for the retirement of personnel and knowledge should be shared among remaining employees. Succession planning ensures that knowledge of policies and procedures is not lost with the separation of key employees. The gap analysis in this workforce plan identified areas in TDI where attrition will have the greatest impact, which is in management and upper level technical positions. Succession plans that document policies, procedures and planning for the training of less experienced staff will assure a smooth transition as retirees leave the workforce.
Actions Taken	TDI has implemented the following initiatives to improve succession planning: Internal procedure manuals in some programs for documentation of standard operational procedures to be used in cross-training and succession planning. A comprehensive training program to educate current and future managers to prepare them to be more effective leaders. A succession plan whereby a Senior Actuary serves as the Chief Actuary's primary backup so that the Senior Actuary will have the knowledge and skills for this position when the Chief Actuary choose to retire. Identification of critical positions and skills for effective succession planning. A retirement analysis report providing agency and program retirement projections.
Ongoing/ Future Activities	TDI values succession planning strategies to minimize the impact on the agency when tenured staff retire. Ongoing/future succession planning activities are described below. TDI's Business Planning and Redesign division is leading a project to research the conceptual framework of succession planning in order to recommend a model methodology for agency succession planning. HR will identify eligible retirees and closely monitor positions nearing retirement. Review job functions and identify staff for cross-training. Continuously assess training needs to develop less experienced staff to ensure continuity of operations following retirements. HR will provide guidance to program areas on succession planning and assist in establishing specific training for developing needed skills. TDI will inventory programs' documented policies and internal operating procedures and develop or finalize as needed. Monthly Deputy Commissioner meetings facilitate intra-agency communication and prepare mid-level management for leadership positions by furthering participants' understanding of agency policy and regulatory issues.

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Strategy II. Maintain an Effective Agency Retention Program

Gap	Employee turnover
Goal	Establish an effective agency program to retain competent employees.
Rationale	Turnover at TDI in Fiscal Year (FY) 2005 was 10 percent, which was significantly lower than the state average. The turnover rate for the Texas Workers' Compensation Commission (TWCC) was 17 percent, which is consistent with the turnover rate for other state agencies. Additionally, in the 2006 Survey of Organizational Excellence, employees reported satisfaction with their work environment and 84 percent see themselves working for TDI in the next two years. Nonetheless, given the cost and time necessary to hire and train new employees, retention remains an on-going concern.
Actions Taken	TDI programs have worked with the HR division to retain qualified employees, and successful strategies included: Conducting employee and manager roundtables to facilitate discussions of workplace issues. Participating in the Employee Assistance Program. Delivering Wellness Program events. Researching opportunities for flexible work arrangements including allowing staff to telecommute from their homes on a limited basis. Reducing employee burnout by expanding the Consumer Protection's 35/5 workplace strategy which allows employees to spend five hours of cross-training weekly. Holding annual recognition ceremonies to present awards for state service, taking care to include field staff. Providing tuition reimbursement for eligible employees as well as education leave when appropriate. Delivering training, including new employee orientation, and segments on communication, customer service, and management training. Providing management training for new managers/team leaders and DWC managers based on results of the 2004 Training Needs Assessment, including contracting with vendors on special topics which build on core management topics.

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Strategy II. Maintain an Effective Agency Retention Program, Continued

Ongoing/ Future Activities	HR, in conjunction with executive management, will do the following to retain competent employees: Continue to assess employee satisfaction and address areas where satisfaction is lowest (assessment tools include the Survey of Organizational Excellence and Employee Exit Interviews). Ensure that appropriate training is available for all employees. Value the contribution of each employee to TDI's mission and to the diversity of the agency. Create and maintain a supportive work environment for all employees. Maintain high work standards through motivation and accountability training. Plan potential merit salary actions as part of the budget planning process and to periodically review merit and promotion actions to ensure that deserving employees are being rewarded when possible. Seek creative non-monetary incentives to recognize and reward deserving employees.

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Strategy III. Use Recruitment Plans

Gap	Hard-to-fill positions
Goal	Develop and use recruitment plans to assure that vacancies for critical functions are filled in a timely fashion.
Rationale	TDI programs have had difficulty hiring for certain positions. Filling these positions can be difficult because qualified staff can do similar work in the private sector at a higher salary level. Developing recruitment plans helps programs identify strategies for attracting qualified applicants for hard-to-fill positions. By planning for recruitment before a vacancy occurs, the agency is ready to fill a position as soon as it becomes vacant.
Actions Taken	Actions taken have included the following: The agency Recruitment Plan, drafted by HR, includes provisions to recruit and hire qualified employees that represent the diverse backgrounds within the Texas labor market while meeting the needs of the agency. It is also in compliance with Labor Code Section 21.502. Recruitment efforts to date include: – general recruitment (e.g. news ads, job fairs, the Texas Workforce Commission (TWC) Job Bank), – targeted recruitment (i.e., use business contacts to target applicants with desired skill sets), – public relations recruitment (i.e., use organizational partnerships to publicize employment opportunities), and – recruiting from a resume database (i.e., maintain database of resumes gathered). Programs have developed business plan projects to address workforce issues with certain projects specifically targeting recruitment needs. Another effective strategy has been recruiting individuals who have retired from the private sector or other governmental agencies. TDI has found applicants starting their second career are a viable recruitment pool that saves training time and the associated costs. TDI is working with the University of Texas to offer part-time employment for civil and structural engineering graduate students, giving them an opportunity to learn the necessary skill sets while completing their degrees. The program aims to retain some of these students in the agency once their graduate studies are complete. A need was identified for the development of an apprenticeship/internship program for safety professionals; however, implementation was delayed due to the inter-agency merger. HR and the Fraud Unit have placed job postings for investigator positions in newsletters and publications subscribed to by prospective candidates, such as police and fraud examiner publications.

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Strategy III. Use Recruitment Plans, Continued

Ongoing/ Future Activities	As part of the recruitment plan, TDI identified internal and external strategies. The following are the internal strategies: – *Applicant Tracking* – Track TDI applicants, their degrees, licenses, certifications and designations. – *Program Support* – Assist the divisions in recruiting for qualified applicants in areas that are deficient. – *Event Reports* – Report the outcomes of recruitment activities and analyze for cost effectiveness. – *Recruitment Source Database* – Track program recruitment resources for targeted hiring. – *Postings in TDI Publications* – Include employment information in agency publications and highlight commitment to hiring excellence and to equal opportunity employment. – *Employee Participation* – Encourage employees to refer applicants. – *Benefit Information* – Provide information to candidates during job interviews outlining state and agency related benefits as well as a general description of TDI positions. – *Internet Recruiting* – Use the Internet to promote employment opportunities at TDI, especially for hard-to-fill positions. To target professionals with experience in insurance regulation, TDI will post employment opportunities to the career page on the National Association of Insurance Commissioners' (NAIC) Web site. – *WorkInTexas.com* – Post job vacancies on WorkInTexas.com, a state-based recruitment web site. This site allows TDI to track interest levels and recruiting successes, as well as search for potential candidates for hard-to-fill positions. – *Partnership with Local Colleges and Universities* – Continue the partnership with Huston-Tillotson University (HTU) to assist in establishing an insurance program at the university. TDI will approach other local and state colleges and universities about establishing similar partnerships. – *Internship Program* – Provide college students with the opportunity to gain knowledge and work experience needed for employment at TDI. TDI is developing a Commissioner's Honor Program, an internship initiative to recruit and develop the skills of talented university students in the areas of insurance policy making, regulation and enforcement.

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Strategy III. Use Recruitment Plans, Continued

Ongoing/ Future Activities, continued	The following are external strategies: – *Texas Recruiter's Association* – Participate in association to network and obtain information on successful recruiting efforts. – *External Organizations and Recruitment Events* – Participate in professional and community organizations, and University or other job fairs to recruit a well-qualified and diverse workforce. – *Minority publications and web sites* – Advertise in local, statewide, national, minority publications and web sites to promote diversity. HR will work with programs to develop recruitment plans, including identifying: – critical positions – sources for recruitment – features of state employment and the TDI workplace that attract candidates, and – budget opportunities to attract senior level employees.

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Strategy IV. Respond to Changing Workloads, Processes, and Organization

Gap	Staffing/Skill Surpluses and Shortages
Goal	Review allocation of agency resources for opportunities to improve efficiencies and align the organizational structure more effectively.
Rationale	Changes in regulatory responsibilities, greater use of automation, and workforce attrition create an opportunity to realign organizational structure to improve efficiencies and meet changing skill requirements. The recent merger of TDI and the Texas Workers' Compensation Commission broadened TDI's regulatory responsibilities and effectively doubled TDI's staff and budget. This creates an opportunity to streamline functions and staff for more effective and efficient service delivery. With 33 percent of TDI's total workforce and 42 percent of TDI managers eligible for retirement within the next five years, TDI has an opportunity to realign programs to improve the programs' management-to-staff ratios in order to meet the 2007 goal of one manager to 11 staff. TDI has also identified potential staffing shortages and surpluses that could result from implementing automated processes. These include efficiencies gained by automating filing submissions, using online forms and automating workflow processes.
Actions Taken	Actions taken have included the following: TDI has used attrition to realign staff to reach a management-to-staff ratio of 1:9.18 at mid-year FY 2006. Where appropriate, TDI will continue to assess organizational structure to achieve the target ratio. TDI Executive Management initiated an internal review of agency functions to assess the effectiveness of certain current operations. The FY 2006-2007 Program Business Plans included projects to assess program workforce planning issues and process improvement projects.

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Strategy IV. Respond to Changing Workloads, Processes, and Organization, Continued

Ongoing/ Future Activities	TDI will utilize the following methods to address staffing/skill surpluses and shortages: TDI uses its strategic planning and business planning processes to formally assess opportunities for improved efficiencies. This review helps ensure that staffing and activities are aligned with the agency's vision and strategic goals. The Fraud Unit will continue outreach efforts with local, state, and federal law enforcement entities to more effectively prosecute insurance fraud cases. HR and Senior Associates will identify vacant management positions and evaluate their necessity prior to reposting. TDI will work toward a more horizontal organizational structure, as it can allow an organization to improve productivity as well as workplace communication. A horizontal organization requires fewer managers, is less bureaucratic, can produce more cross-functional employees and improves service to both internal and external customers. HR, Executive Management and the division of Business, Planning and Redesign will work with programs to review staffing and workloads for opportunities to improve resource allocations as they develop program succession plans. This review will include an evaluation of the agency's performance measures. TDI has planned a number of automation projects to provide more efficient customer service, including: further implementation of TXCOMP to provide system participants with online Workers' Compensation claims information, creation of an online application for Utilization Review Agents' annual summary report, further automation of TDI's complaint handling process, expanding our capacity for accepting electronic filings, and better utilizing the Web to provide and accept information. HR will identify and address any skill deficiencies to ensure agency staff can effectively perform their functions. HR will continue to improve its professional development program in creative ways, including the use of technology. TDI will use videoconferencing equipment to increase communication with and deliver training to field staff. TDI will broaden its consumer outreach by offering information in various languages including Spanish, Korean, Chinese, and Vietnamese through printed publications and online translation software. TDI will provide staff development opportunities by conducting brown bag luncheons which will create a forum for employees to broaden their understanding of agency activities.

APPENDIX F

Performance Measure Definitions

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1.1.1. OP 1	**Number of Inquiries Answered**
Short Definition:	The number of inquiries through telephone calls or written requests that are answered by Consumer Protection, and Internet hits that occur on TDI's practice and complaints company inquiry (PCCI) "Search for a Company Profile" (pcci.search) web page. An inquiry is a request for insurance information received from an external customer during business hours. Customers include individual consumers, business consumers, regulated entities, state agencies, and legislators.
Purpose/Importance:	To measure the number of inquiries answered, including telephone calls, written requests and PCCI Internet hits.
Source/Collection of Data:	Telephone inquiries are taken by Consumer Protection staff who are in an Automatic Call Distribution group (ACD). Automatic Call Distribution is a method to manage resources associated with answering large volumes of incoming calls. An ACD group contains a number of operators who support the same pilot number. A pilot number is the directory number used to channel incoming calls to idle lines in an ACD pilot group. The ACD group in Consumer Protection is the 1-800 Helpline ACD pilot number 46471. Written inquiries are entered by Consumer Protection staff on the automated Complaint Inquiry System (CIS) and coded as "F40" (inquiry only). A written inquiry is closed on CIS when staff have determined that they have provided in writing the information deemed appropriate.
Method of Calculation:	Sum the number of telephone inquiries for the reporting period. The number of telephone inquiries are from the "#ACD" column on the ACD reports provided by the Texas Building & Procurement Commission (TBPC). The source of written inquiry data is the number of inquiries closed by the Complaints Resolution section (which has section code MDC) in the CIS Summary Work Measures Report for the reporting period.
Data Limitations:	If a day's ACD report is not available from GSC, that day's ACD number will be estimated by averaging the previous and succeeding day's ACD reports.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.1. OP 2	**Number of Rate Guides Distributed**
Short Definition:	Number of Rate Guides Distributed.
Purpose/Importance:	To measure the number of rate guides distributed including rate guides distributed through TDI's website.
Source/Collection of Data:	A rate guide is distributed when it is: a) shipped from the TDI mail room and recorded as such in the Publications Tracking System; or b) counted as a "hit" on the TDI Internet site. The sources of the data are the monthly "Shipped" report from the Publications Tracking System and the TDI Webmaster's summary file.
Method of Calculation:	Sum the number of rate guides shipped from the TDI mail room and counted as a "hit" on the TDI Internet site.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.1. OP 3	**Number of Consumer Information Publications Distributed**
Short Definition:	The number of consumer information publications (brochures, rate guides and consumer bulletins) distributed to consumers.
Purpose/Importance:	To measure the number of publications (brochures, rate guides and consumer bulletins) distributed to consumers, including publications distributed through TDI's website.
Source/Collection of Data:	A publication is distributed when it is: a) shipped from the TDI mailroom and recorded as such in the Publications Tracking System; or b) counted as a "hit" on the TDI Internet site. The sources of the data are the monthly "Shipped" report from the Publications Tracking System and the TDI Webmaster's summary file.
Method of Calculation:	Sum the number of publications shipped from the TDI mail room and counted as a "hit" on the TDI Internet site.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.1. OP 4	**Number of Consumer Information Presentations Made**
Short Definition:	The sum of all presentations coordinated by the TDI Speakers Bureau that TDI staff makes to external consumer groups.
Purpose /Importance:	To measure the sum of all presentations coordinated by the TDI Speakers Bureau that TDI staff makes to external consumer groups.
Source/Collection of Data:	The source of the data is the file for each presentation and the monthly Speakers Bureau report. A presentation is any event where TDI staff educates agency customers on insurance matters using one or more of the following methods of communication: speeches, training, exhibits, seminars, teleconferences, and/or TV, radio and print interviews. External customers include individual consumers, business consumers, regulated entities, state agencies, and legislators. A presentation counts as "one" though it may include more than one of the methods of communication listed above. For example, a staff member who gives a workshop and staffs an exhibit at a two-day seminar will count the result of this work as one presentation. A presentation counts as one regardless of the number of staff involved.
Method of Calculation:	The sum of all presentations coordinated by the TDI Speakers Bureau that TDI staff makes to external consumer groups.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.1 OP 5	**Number of Texas Department of Insurance Calls to Insurance Industry for Data**
Short Definition:	The number of statistical calls asking insurers or other entities for specific data used for setting rates or to monitor the marketplace. A statistical call is defined as a request for data from multiple insurance entities and disseminated as a Texas Department of Insurance (TDI) Commissioner's Bulletin.
Purpose/Importance:	The number of statistical calls asking insurers or other entities for specific data used for setting rates or to monitor the marketplace. A statistical call is defined as a request for data from multiple insurance entities and disseminated as a TDI Commissioner's Bulletin.
Source/Collection of Data:	The Commissioner's authority to issue such bulletin requests is specified in various sections of the Insurance Code, by line of insurance. The cite for the specific authority for a particular bulletin request is given in each such bulletin.
Method of Calculation:	The number of statistical calls asking insurers or other entities for specific data used for setting rates or to monitor the marketplace.
Data Limitations:	This measure does not include data calls issued by the Division of Workers' Compensation.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Lower than target

1.1.1 EX 1	**Aggregate Overhead Costs as a Percent of Premiums Paid by Consumers for All Lines of Insurance**
Short Definition:	Aggregate Overhead Costs as a Percent of Premiums Paid by Consumers for All Lines of Insurance.
Purpose/Importance:	To measure the percentage of premiums that are attributable to overhead costs.
Source/Collection of Data:	Aggregate overhead costs are defined as the sum of general expenses plus the expenses set forth in the Property and Casualty Insurance Experience by Coverage and Carriers as "Commissions and Brokerage Expenses" and "Taxes, Licenses, and Fees." Premiums paid are defined as calendar year direct premiums written. All data elements, with the exception of general expenses, will come directly from the Summary of Texas Experience from the Annual Statement Texas Page 14, part of the annual Property and Casualty Insurance Experience by Coverage and Carriers prepared by TDI from NAIC data.
Method of Calculation:	Aggregate overhead costs of the insurance industry divided by premiums paid to the insurance industry. General expenses for Texas will be calculated as the percentage of direct premiums written calculated in the Country- wide Totals for All Property and Casualty Lines Combined, Insurance Expense Exhibit (IEE), Part III - Direct Business multiplied by Texas direct premiums written from the Annual Statement Texas Page 14.
Data Limitations:	Data is for Stock, Mutual, Reciprocal and Lloyds Insurance carriers licensed to write coverages in the State of Texas that developed Texas business for the previous calendar year.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

1.1.1 EX 2	**Number of Insured Private and Commercial Passenger Automobiles as a Percentage of Total Registered Passenger Vehicles**
Short Definition:	Number of Insured Automobiles as a Percentage of Total Registered Vehicles.
Purpose/Importance:	To measure the percentage of total registered passenger vehicles, which are insured by private or commercial passenger automobile insurance.
Source/Collection of Data:	The source of private passenger vehicles covered by bodily injury liability insurance is the Texas Private Passenger Automobile Statistical Plan data. The source of commercial passenger type vehicles covered by bodily injury liability insurance is the Texas Commercial Lines Statistical Plan. The source of registered passenger vehicles is the Texas Department of Transportation.
Method of Calculation:	Total private and commercial passenger vehicles covered by bodily injury liability insurance divided by total registered passenger vehicles.
Data Limitations:	NONE
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.2 OC 1	**Percent of Company, Third Party Administrator, and Premium Finance Licenses Completed Within 60 Days**
Short Definition:	The percent of company, third party administrator, and premium finance applications completed in 60 days or less.
Purpose/Importance:	To ensure the timely processing of company, third party administrator, and premium finance applications.
Source/Collection of Data:	The data source is maintained on Excel spreadsheet tracking systems. Applications include documents such as new, amended or cancelled licenses and miscellaneous amendments to charters. Entities refer to companies, Third Party Administrators and Premium Finance companies. The processing time begins on the date that all documentation and required fees have been received. The processing time is completed for company applications on 1) the date of the letter to the applicant which includes the Certificate of Authority and/or Commissioner's Order, 2) the date on the Memo to File if no Certificate of Authority or Commissioner's Order is issued, or 3) the date a No Action Letter is issued. The processing time is completed for Third Party Administrator applications on the date of the Commissioner's Order. The processing time is completed for Premium Finance applications on the effective date as indicated on the license.
Method of Calculation:	The number of company, Third Party Administrator, and Premium Finance applications completed in 60 days or less, divided by the total number of applications completed for these entities.
Data Limitations:	Health Maintenance Organization entities are not included in this measure. Health Maintenance Organizations are reported in measure *Percent of agent license filings completed within 15 days.*
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.2 OC 2	**Percent of Agent License Filings Completed Within 15 Days**
Short Definition:	The percent of agent license filings completed within fifteen days of receipt.
Purpose /Importance:	To ensure the timely processing of agent license filings. An agent license filing is submitted for the issuance of a new license, renewal of an existing license, issuance or cancellation of an appointment, certification of a license or of records, issuance of a clearance letter, authorization of an address or name change of an agent or agency, Licensing Division Trade name Location (LDTL) processed, license cancellations by agents (due to, death, retirement, move to another state or other non-disciplinary cancellation), and continuing education provider applications, course submissions, exemptions, and extension requests.
Source/Collection of Data:	The starting date is the date a complete and correct filing is received by TDI. The "completed" date for each of these filings is as follows: New License, License Renewals, Appointment Issued, Appointment Cancellation, Name/Address Change LDTLs, License Cancellation by Agent, and Clearance Letters/License Certifications—Process date assigned in the agent tracking system; Certified Records—Date action pertaining to the record request is completed; Continuing Education Filings—Date on notification letter of approval or denial; (except title agents' address changes, which are on a PC database).
Method of Calculation:	The number of agent license filings completed within fifteen days of receipt divided by the total number of agent license filings completed.
Data Limitations:	NONE
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.2 OC 3	**Percent of Statutory Rate and Form Filings Completed Within 90 Days**
Short Definition:	This measure monitors the number of form and rate filings that are processed by TDI and completed within 90 days of receipt of the filing.
Purpose/Importance:	To ensure the timely processing of rate and form filings. A "filing" is a submission of rates or rating factors, forms or other documents required by TDI for use by insurance carriers, viatical and life settlement entities and HMOs to define the terms of coverage, develop rates or to transact the business of insurance or maintain a certificate of authority.
Source/Collection of Data:	Filings completed are tracked in an agency electronic database. Processing of a rate or form filing is completed on the date final agency action is taken on the filing. Final action is defined as approval, disapproval, rejection, withdrawal, acceptance, deemed approved date and verification that a form is exempt from review or filed for information only. A form filed as a substitution for a prior approval is counted as a separate filing. The completion period to be used in determining a completed filing begins on the date the filing is received by TDI and ends on the date of final agency action related to the filing.
Method of Calculation:	The number of form and rate filings that are processed by TDI and completed within 90 days of receipt of the filing divided by the total number of form and rate filings completed. The total number of rate and form filings completed is the sum of three output measures: "Number of life/health filings completed", "Number of HMO form filings completed", and "Number of property and casualty rate and form filings completed".
Data Limitations:	NONE
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.2 OP 1	**Number of Life/Health Insurance Filings Completed**
Short Definition:	The number of insurance policy-related rate and form filings submitted by insurance carriers and/or viatical and life settlement entities pursuant to their business needs or in response to statutory or rule provisions by the Life/Health Division, and completed.
Purpose/Importance:	To measure the volume of completed rate and form filings. A "filing" is a submission of rates, forms, or other documents required by TDI for use by insurance carriers and/or viatical and life settlement entities to define the terms of coverage or to transact the business of insurance or maintain a certificate of insurance.
Source/Collection of Data:	Filings completed are tracked on a mainframe application. Processing of a rate or form filing is "completed" on the date final agency action is taken on the filing. Final action is defined as approval, disapproval, rejection, withdrawal and verification that a form is exempt from review or filed for information only. A form filed as a substitution for a prior approval is counted as a separate filing.
Method of Calculation:	Sum the number of insurance policy-related rate and form filings submitted by insurance carriers and/or viatical and life settlement entities pursuant to their business needs or in response to statutory or rule provisions by the Life/Health Division, and completed.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.2 OP 2	**Number of HMO Form Filings Completed**
Short Definition:	The number of completed form filings submitted by health maintenance organizations (HMOs) and approved non-profit health corporations (ANHCs) in accordance with statutory and Texas Department of Insurance (TDI) rule requirements.
Purpose/Importance:	To measure the number of completed HMO and ANHC rate and form filings. A "form filing" is a submission of rates or forms required by TDI for use by HMOs and ANHCs.
Source/Collection of Data:	Processing of a form filing is completed when final agency action is taken. Form filings include approval, disapproval, withdrawal, rejection, or verification of an informational filing during the reporting period. Completed form filings are tracked in an Oracle database. Form filings include rates, evidence of coverage (EOC), provider contracts, enrollment applications, EOC amendments and other HMO-related forms.
Method of Calculation:	Sum the number of completed form filings submitted by HMOs and ANHCs.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.2 OP 3	**Number of Property and Casualty Rate and Form Filings Completed**
Short Definition:	The number of insurance policy-related rates and forms filed by insurance carriers pursuant to statutory or rule provisions for review for all property and casualty lines except workers' compensation.
Purpose/Importance:	To measure the number of insurance policy-related rates and forms filed by insurance carriers pursuant to statutory or rule provisions for review of all property and casualty lines except workers' compensation.
Source/Collection of Data:	A form filing consists of policy forms, endorsements and rules used by insurance carriers to define the terms and conditions for insurance coverage. A rate filing consists of rates, rating plans and rating manuals used by insurance carriers to determine the premium charged for insurance coverage. Processing of a form filing is completed on the date of final agency action related to the filing, including approval, disapproval, rejection, withdrawal and verification that a form is filed for information only. Processing of a rate filing is completed on the date of final agency action related to the filing including approval, acceptance, disapproval, withdrawal, or deemed approved date. Form and rate filings are tracked in an agency electronic database.
Method of Calculation:	The number of insurance policy-related rates and forms filed by insurance carriers pursuant to statutory or rule provisions for review for all property and casualty lines except workers' compensation.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.2 EX 1	**Total Number of Licensed Agents**
Short Definition:	The total number of individuals and entities licensed as agents as tracked in the agent tracking system.
Purpose/Importance:	To measure the total number of individuals and entities licensed as agents.
Source/Collection of Data:	Obtained by querying the agent tracking system at the end of the reporting period.
Method of Calculation:	Sum the total number of individuals and entities licensed as agents as tracked in the agent tracking system. An individual or entity who holds more than one license authority is counted only once.
Data Limitations:	This measure will not reflect the total number of agents license authorities issued by the agency, because many agents hold multiple license authorities.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.2 EX 2	**Number of Texas-based Regulated Companies**
Short Definition:	The number of Texas-based entities chartered in Texas holding a Certificate of Authority or Certificate of Approval.
Purpose/Importance:	To measure the number of Texas-based entities chartered in Texas holding a Certificate of Authority or Certificate of Approval.
Source/Collection of Data:	Tracked on the Company-License mainframe system and obtained by querying the system at the end of the reporting period.
Method of Calculation:	Sum the total number of Texas-based entities chartered in Texas holding a Certificate of Authority or Certificate of Approval for the reporting period.
Data Limitations:	This measure is driven by the industry needs in Texas and is intended to provide information about the number of Texas-based entities chartered in Texas. It is not within the control of the Financial program.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.2 EX 3	**Number of non-Texas-based Regulated Companies**
Short Definition:	The number of non-Texas-based entities licensed in Texas holding a Certificate of Authority or Certificate of Approval.
Purpose/Importance:	To measure the number of non-Texas-based entities chartered in other States or by a foreign government holding a Certificate of Authority or Certificate of Approval in Texas.
Source/Collection of Data:	Tracked on the Company License mainframe system and obtained by querying the system at the end of the reporting period.
Method of Calculation:	Sum the total number of non-Texas-based entities licensed in Texas holding a Certificate of Authority or Certificate of Approval for the reporting period.
Data Limitations:	This measure is driven by the industry needs in Texas and is intended to provide information about the number of non-Texas-based entities licensed in Texas. It is not a measure of the success of the Financial program.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.2 EX 4	**Number of licensed HMOs**
Short Definition:	The total number of licensed HMOs that hold a Certificate of Authority to operate in Texas.
Purpose/Importance:	To measure the total number of licensed HMOs that hold a Certificate of Authority to operate in Texas.
Source/Collection of Data:	Tracked on an Oracle system and obtained by querying the system at the end of the reporting period.
Method of Calculation:	Sum the total number of licensed HMOs that hold a Certificate of Authority to operate in Texas for the reporting period.
Data Limitations:	This measure is driven by the industry needs of Texas and is intended to provide information about the number of HMOs licensed in Texas. This measure is affected by industry trends such as mergers, acquisitions and other market trends. The number of HMOs have declined, and this measure is not a measure of the success of the Financial Program.
Calculation Type:	Non cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.3 OC 4	**Number of Automobiles Covered by Voluntary Policies as a Percent of Total Private Passenger Automobiles in Underserved Markets**
Short Definition:	Percent of Autos in Underserved Markets with Voluntary Coverage.
Purpose/Importance:	To measure the percentage of total registered passenger vehicles which are insured by private or commercial passenger automobiles insurance through the voluntary market.
Source/Collection of Data:	The source of data for total vehicles written on voluntary policies in underserved markets will be the data from the TDI Quarterly Market Report of the Texas Private Passenger Automobile Statistical Plan. The source of data for registered vehicles is the Texas Department of Transportation. Underserved markets are those ZIP codes designated by the Commissioner as underserved, as required by Article 21.81, Sec 3(e) of the Insurance Code, which provides that underserved geographic areas "shall be determined and designated by the Commissioner by rule." Under Title 28 of the Texas Administrative Code, Section 5.206, the Commissioner is to categorize each ZIP code in the state into Category 0 through Category 4, to indicate the number of Texas Automobile Insurance Plan Association credits awarded an insurer for writing a vehicle in a given ZIP code.
Method of Calculation:	The number of vehicles covered by voluntary private passenger automobile policies in underserved markets divided by the total number of registered vehicles in underserved markets.
Data Limitations:	The Commissioner may increase the category (and the attached credits) of a ZIP code at any time by rule, but may only decrease the category (and the attached credits) of a ZIP code three years after the initial designation, or at any time thereafter, with a minimum of one year's notice.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

1.1.3 OC 5	**Percent of Personal Auto and Residential property form filings completed in 60 days**
Short Definition:	The percent of personal auto and residential property form filings whose processing by TDI is completed within 60 days of receipt of the filing during the monthly reporting period.
Purpose/Importance:	To ensure the timely processing of personal auto and residential property form filings.
Source/Collection of Data:	Filings completed are tracked in an agency electronic database and form filings are defined as both policy forms (code PF) and endorsements (code EN). Processing of a form filing is completed on the date final action is taken on the filing. Final action is defined as receiving a final status code (includes approval, disapproval, rejection or withdrawal) as listed in the TRACK database status code table as PCFINAL. A form filed as a substitution for a prior approval is counted as a separate filing. The completion period to be used in determining a completed filing begins on the date the filing is received by TDI and ends on the date of final agency action related to the filing.
Method of Calculation:	The number of personal automobile and residential form filings whose processing by TDI is completed during the reporting period and within 60 days of receipt of the filing divided by the total number of personal automobile and residential form filings completed during the reporting period.
Data Limitations:	NONE
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

1.2.1. OP 1	**Number of Complaints Resolved**
Short Definition:	The number of written communications primarily expressing a grievance which have been resolved. (This definition of complaint comes from Texas Insurance Code Art. 21.21-2, Sec. 2 (b) (6).
Purpose/Importance:	To measure the number of written communications primarily expressing a grievance which have been resolved. This measure does not include complaints against HMOs.
Source/Collection of Data:	Complaints are tracked on the Complaint Inquiry System (CIS). The source of the data is the quarterly and annual CIS "Summary Work Measures Report". Complaints that are referred to other entities having primary responsibility for the subject are not included in this measure. This measure does not include complaints coded as HMO; these are reported in measure 1.2.1 OP 4, Number of complaints against HMOs resolved. The complaint is resolved when staff have closed the complaint on CIS. To close a complaint on CIS, staff must exhaust all actions deemed appropriate to resolve the complaint and have sent the complainant a letter explaining the final disposition of the complaint. Anonymous complaints will have a memo to file instead of a letter to the complainant.
Method of Calculation:	The sum of complaint records coded in CIS as either "F11" (justified complaint) or "F 20" (unjustified complaint) that at the time of closing are not linked to a legal or fraud case.
Data Limitations:	NONE
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

1.2.1. OP 2	**Number of Insurance Advertising Filings Reviewed**
Short Definition:	The number of reviews of insurance company and agent advertising and marketing materials to identify violations of insurance regulations in the areas of advertising requirements, unfair trade practices, and proper licensing.
Purpose/Importance:	To measure the number of insurance advertising filings reviewed.
Source/Collection of Data:	The source of the data is the monthly "Not-Required Closed Files" and "Required Closed Files" reports from the Advertisement Management System in Oracle. Such reviews are initiated by insurance companies and agents, consumer complaints and inquiries, sources within TDI, and referrals from other governmental entities. Reviews result in a determination of compliance or non-compliance for each reviewed advertisement. Non-compliance results in notice of non-compliance, request for voluntary discontinuance of the advertisement, or request for disciplinary action by Legal and Compliance.
Method of Calculation:	The number of reviews of insurance company and agent advertising and marketing materials to identify violations of insurance regulations in the areas of advertising requirements, unfair trade practices, and proper licensing.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.2.1. OP 3	**Dollar Amount Returned to Consumers Through Complaint Resolution**
Short Definition:	The total dollar amount of claim payments and premium refunds returned to the consumer through complaint resolution by TDI Consumer Protection.
Purpose/Importance:	To measure the dollar amount returned to consumers through complaint resolution.
Source/Collection of Data:	The claim payments and amounts of premium refund obtained through staff intervention are tracked in the Complaint Inquiry System (CIS). Claim payments amounts are the additional amount above what was originally offered to the consumer before TDI staff intervention. Premium refunds are amounts of premiums previously paid that are refunded as a result of TDI staff intervention.
Method of Calculation:	The total dollar amount of claim payments and premium refunds returned to the consumer through complaint resolution by TDI Consumer Protection.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.2.1 OP 4	**Number of Complaints Against HMOs Resolved**
Short Definition:	This measure monitors the total number of complaints against all HMOs performing commercial, CHIP, and ERS business during the reporting period upon which action has been taken or a determination is made that a violation did not occur.
Purpose/Importance:	To measure the number of resolved complaints against HMOs to ensure the agency's efforts on behalf of Texas consumers.
Source/Collection of Data:	The source of the data is the quarterly and annual Complaint Inquiry System (CIS) report. All verbal and written complaints are tracked on the agency CIS A case is closed when all avenues to resolve the complaint are exhausted, the case is referred to Legal for adjudication or no violation of statute is found. The complainant is sent a letter notifying them of the disposition of the case.
Method of Calculation:	Sum the total number of complaints against all HMOs performing commercial, CHIP, and ERS business during the reporting period upon which action has been taken or a determination is made that a violation did not occur.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.2.1. EF 1	**Average Response Time (in Days) to Complaints**
Short Definition:	The number of days from the date a complaint is received in writing at TDI to the date complaint action is concluded summed for all written complaints, divided by the number of complaint actions concluded. A complaint is a written communication primarily expressing a grievance. (This definition of a complaint comes from TIC Art. 21.21-2, Sec. 2 (b) 6).
Purpose/Importance:	To measure the average response time to complaints.
Source/Collection of Data:	The source of the data is the quarterly and annual CIS "Summary Work Measures Report". A complaint is a written communication primarily expressing a grievance. The date a complaint is received is the earliest date stamped by TDI staff on the written complaint. The date action is concluded is the date staff closed the complaint on CIS. The closure on CIS will be after staff have determined that they have exhausted actions they deem appropriate to resolve the complaint and have sent the complainant a letter explaining the final disposition of the complaint.
Method of Calculation:	The number of days from the date a complaint is received in writing at TDI to the date complaint action is concluded summed for all written complaints, divided by the number of complaint actions concluded. The denominator of this measure is "Number of Complaints Resolved." This measure excludes complaints coded as HMO; the average time or HMO complaints is reported in measure "Average time (days) for HMO complaint resolution".
Data Limitations:	Anonymous complaints will have a memo to file instead of a letter to the complainant. If a complaint is re-opened, the lapsed time between a closure date and a reopen date is not included in the calculation. If there is no date stamp, the date on the complainant's letter will be the starting date.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

1.2.1 EF 2	**Average response Time (in Days) for HMO Complaint Resolution**
Short Definition:	The average number of calendar days from the time all complaint investigation information is received until the complaint is closed on the Complaint Inquiry System (CIS) system summed for all HMO, CHIP, and ERS complaints, divided by the number of complaints resolved during the reporting period.
Purpose/Importance:	To measure the average response time to complaints.
Source/Collection of Data:	All complaints are entered into CIS by the HMO staff when received. The complaint processing time begins on the date that all documentation has been received. The complaint processing time ends when all avenues to resolve the complaint are exhausted, the case is referred to Legal for adjudication or no violation of statute is found. The complainant is sent a letter notifying him/her of the disposition of the case.
Method of Calculation:	This measure is calculated by summing the number of days to resolve all complaints divided by the number of complaints resolved during the reporting period.
Data Limitations:	NONE
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

1.2.2 OC 1	**Percent of Insurer Fraud Referrals to State and Federal Prosecutors Resulting in Legal Action**
Short Definition:	The percent of insurer fraud referrals to State and Federal Prosecutors such as district attorneys and United States attorneys resulting in legal action. **Insurer fraud** is a violation of a penal law and is committed or attempted while engaging in the business of insurance, or relating to an insurance transaction. **Legal action** includes the filing of a charging document (e.g., indictment, criminal complaint or information). A **case** is an investigation performed by the Fraud Program of TDI. **Referral** is a Fraud Program investigation of a penal law violation by a person or entity, concluded and submitted to a prosecutor.
Purpose/Importance:	To measure the percent of insurer fraud referrals resulting in legal action.
Source/Collection of Data:	The source of the data is the Fraud Program's case management system.
Method of Calculation:	The measure is calculated by dividing the number of "legal actions" taken against individuals or entities as a result of referrals submitted (numerator), by the total number of referrals submitted by the Fraud Program to prosecutors during the fiscal year (denominator). If a referral to a prosecutor results in multiple charging documents against one or more individuals or entities, each legal action taken by the prosecutor is counted in the numerator of this measure.
Data Limitations:	A single fraud case in which more than one individual or entity is investigated may result in more than one referral made to one or more prosecuting agencies on each individual or entity. In many instances, legal action will not be filed or reported during the same fiscal year the case was referred. Variance in the number of referrals and/or legal actions may result in calculation of a percentage that reflects the agency's performance over multiple fiscal years.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

1.2.2 OP 1	**Number of Enforcement Actions Concluded**
Short Definition:	The number of enforcement actions that are concluded against agents, companies or licensees for violations of the statute. This measure includes enforcement actions such as contested orders resulting from hearings at the State Office of Administrative Hearings, uncontested orders which are settled without a hearing and voluntary agreements between subject parties and the Texas Department of Insurance (TDI)--i.e., Assurance of Voluntary Compliance.
Purpose/Importance:	This measure monitors the number of enforcement actions concluded by the agency against certain entities in order to demonstrate the agency's efforts toward reducing unfair or illegal practices.
Source/Collection of Data:	The source of the data is TDI's Chief Clerk's database, the State Fire Marshal's database, and the Case Tracking System (CTS). The Chief Clerk's database contains the Commissioner's orders and the Fire Marshal's database contains the Fire Marshal's orders. Enforcement actions are coded as such in the CTS database.
Method of Calculation:	The sum of the number of TDI administrative oversight letters, Assurances of Voluntary Compliance received and affirmed by TDI, Commissioner's Orders issued for agent license revocations or suspensions, agent/company license denials and approvals, cease and desist orders, suspensions of writing by a company, conservation, supervision, assessment of monetary forfeitures, cancellation/revocation of an engineer's appointment as a qualified inspector and regulatory oversight due to a hazardous financial condition (1.32 orders) for the reporting period. Also included are State Fire Marshal orders issued for license suspension, revocation or denial, company registration suspension, revocation or denial, and the assessment of a monetary forfeiture. The enforcement action is considered "concluded" on the date an order is issued, an administrative letter is issued or an assurance of voluntary compliance is affirmed by TDI.
Data Limitations:	This measure includes contested orders resulting from hearings at the State Office of Administrative Hearings, uncontested orders which are settled without a hearing and voluntary agreements between subject parties and TDI—i. e., Assurances of Voluntary Compliance.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.2.2 OP 2	**Dollar Amount of Penalties Assessed for Unfair and Illegal Practices**
Short Definition:	The total amount of monetary forfeitures, fines, penalties, and/or interest assessed for unfair and illegal practices against companies, groups, agents and licensees as a result of final judgments, orders, or agreements when TDI initiated the enforcement process or in which TDI has opened a case file. Unfair and illegal practices are violations of statute by agents, companies and licensees.
Purpose/Importance:	To measure the dollar amount of penalties assessed for unfair and illegal practices.
Source/Collection of Data:	The source of the data is TDI's Chief Clerk's and State Fire Marshal's databases, the Fraud Program's case management system and the automated Case Tracking System (CTS). This number will be obtained from the orders report received from the Chief Clerk's and State Fire Marshal's office and compared to CTS. It will be stressed to staff the importance of entering into CTS judgments received from the Attorney General and District Attorney and agreements such as assurances of voluntary compliance. The input entry of "assessed" as well as collected penalties should be stressed although this is a measure of assessed penalties.
Method of Calculation:	The total amount of monetary forfeitures, fines, penalties, and/or interest assessed for unfair and illegal practices against companies, groups, agents and licensees as a result of final judgments, orders, or agreements when TDI initiated the enforcement process or in which TDI has opened a case file for the reporting period. Unfair and illegal practices are violations of statute by agents, companies and licensees.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.2.2 OP 3	**Dollar Amount of Restitution Assessed for Unfair and Illegal Practices**
Short Definition:	The total amount assessed in restitution for customers who are harmed by unfair and illegal practices of companies, groups, agents, and licensees as a result of final judgments, orders or agreements for unfair and illegal practices when TDI initiated the enforcement process or in which TDI has opened a case file. Unfair and illegal practices are violations of statute by agents, companies and licensees.
Purpose/Importance:	To measure the dollar amount of restitution assessed for unfair and illegal practices.
Source/Collection of Data:	The source of the data is TDI's Chief Clerk's database, the Fraud Program's case management system, State Fire Marshal's database and the automated Case Tracking System (CTS). This number will be obtained from the orders report received from the Chief Clerk's and State Fire Marshal's office and compared to CTS. It will be stressed to staff the importance of entering into CTS judgments received from the Attorney General and District Attorney and agreements such as assurances of voluntary compliance. The entry of "assessed" as well as "collected" restitution should be stressed although this is a measure of assessed restitution. An order could assess an undetermined or unknown amount of restitution whereby the entity is required to submit a report once restitution is determined and paid. In this case, the amount paid or collected would also be assessed.
Method of Calculation:	The total amount assessed in restitution for customers who are harmed by unfair and illegal practices of companies, groups, agents, and licensees as a result of final judgments, orders or agreements for unfair and illegal practices where TDI initiated the enforcement process or in which TDI has opened a case file for the reporting period. Unfair and illegal practices are violations of statute by agents, companies and licensees. In the case an order assesses an unknown amount; the amount is assessed in the month it is reported.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.2.2 OP 4	**Number of Contested Cases Closed**
Short Definition:	The number of closed cases in which a Notice of Hearing was formally issued.
Purpose/Importance:	To measure the number of contested cases closed. A "case" is a legal matter, issue, investigation or work performed or reviewed by the Legal or Fraud Division of the Texas Department of Insurance (TDI).
Source/Collection of Data:	The source of the data is the automated Case Tracking System (CTS). A case is closed when staff have determined that they have exhausted all actions deemed appropriate or have determined that no action should be taken. The closing date is the date of closure on the CTS system identified by status "C" (closed). A case can be initiated from an external or internal complaint or request. When a violation is not initially resolved by voluntary agreement, a hearing is scheduled with the State Office of Administrative Hearings and a Notice of Hearing is issued.
Method of Calculation:	A SQL Plus query is used to obtain the number of contested cases closed in which a Notice of Hearing was formally issued during the reporting period. The query will utilize a "case action" of "NOH" and status of "C" (closed).
Data Limitations:	A Commissioner's Order or Fire Marshal's Order may result from hearings at the State Office of Administrative Hearings or a voluntary agreement between subject parties and TDI (i.e., Assurances of Voluntary Compliance, Consent Order) may be obtained any time after issuance of a Notice of Hearing and would still be included in this measure. A single case can include multiple violations and/or have multiple complaints linked to the case. Multiple cases, because the Cases involve separate and distinct issues, may be initiated on the same person or entity.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.2.2 OP 5	**Number of Quality Assurance examinations conducted**
Short Definition:	This measure monitors all examinations conducted to determine compliance with statutes and regulations. These exams include but are not limited to triennial, service area expansion, service area modification, complaint, including restitution, certificate of authority and utilization reviews of HMOs, Exclusive Provider Organizations (EPOs) and affiliate entities. Exams may include on-site reviews and reviews of materials required to be submitted to the agency.
Purpose/Importance:	To measure the number of examinations conducted by the Quality Assurance (QA) Section to ensure compliance statutes and regulations to protect the citizens of Texas.
Source/Collection of Data:	The measure is calculated using work papers and data captured in the QA Exam database. The frequency of examinations ranges from one to three years and is mandated by statute for certain examinations; others are conducted on an as-needed basis. An examination is considered complete on the date the exam report is mailed and the completion date is entered in the QA Exam database.
Method of Calculation:	Sum the number of examinations conducted to determine compliance with statutes and regulations for the reporting period.
Data Limitations:	This measure does not include QA examinations that are 100 percent outsourced. Some exams included in this measure may be conducted jointly with the Financial program. However, the two programs have different scopes because the Financial exams relate to solvency and market conduct while the QA exams review health care services provided to enrollees and business practices to assure they are consistent with reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. Therefore, each program will include these joint exams in calculating the number of exams conducted.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.2.2 EF 1	**Average Cost Per Quality Assurance Examination Conducted**
Short Definition:	This measure monitors the average cost of expenditures by the Quality Assurance (QA) Section for the reporting period. These exams include but are not limited to, triennial, service area expansion, service area modification, complaints, including restitution, certificate of authority and utilization reviews of HMOs, Exclusive Provider Organizations (EPOs) and affiliate entities. Exams may include on-site reviews and reviews of materials required to be submitted to the agency.
Purpose/Importance:	To measure the average state cost per examination.
Source/Collection of Data:	Costs are calculated using work papers and from data captured in the QA Exam database. An examination is considered complete on the date the exam is completed in the QA Exam database. The denominator of this measure is "Number of HMO quality assurance examinations conducted." The frequency of some examinations is mandated by statute; others are conducted on an as-needed basis.
Method of Calculation:	All expenditures for QA examination activity for the reporting period divided by the number of examinations completed for the reporting period.
Data Limitations:	This measure does not include Quality Assurance examinations that are 100 percent outsourced. Some exams included in this measure may be conducted jointly with the Financial program. However, the two programs have different scopes because the Financial exams relate to solvency and market conduct while the QA exams review health care services provided to enrollees and business practices to assure they are consistent with reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. Therefore, each program will include these joint exams in calculating the number of exams conducted.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

1.2.2 EX 1	**Percent of Contested Cases Finalized Within 180 Days**
Short Definition:	The percent of Texas Department of Insurance (TDI) or State Fire Marshal contested cases finalized within 180 days.
Purpose/Importance:	To measure the percent of contested cases finalized within 180 days.
Source/Collection of Data:	The source of the data is the automated Case Tracking System (CTS). Contested cases are those in which a notice of hearing is formally issued. Determination for finalizing a contested case will be the date the Texas Department of Insurance issues notification that enforcement action is being taken, (Notice of Hearing date) to the date the case is closed on the CTS- identified by status "C" (closed). A "case" is a legal matter, issue, investigation or work performed or reviewed by the Legal or Fraud Division of TDI. A case can be initiated from an external or internal complaint or request. When a violation is not initially resolved by voluntary agreement, a hearing is scheduled with the State Office of Administrative Hearings and a Notice of Hearing is issued.
Method of Calculation:	The number of contested cases finalized within 180 days divided by the total number of contested cases closed for the reporting period.
Data Limitations:	A Commissioner's Order or State Fire Marshal's Office Order may result from hearings at the State Office of Administrative Hearings or a voluntary agreement between subject parties and TDI (i.e., Assurances of Voluntary Compliance, Consent Order). It may be obtained at any time after issuance of a Notice of Hearing and would still be included in this measure. A single case can include multiple violations and/or have multiple complaints linked to the case. Multiple cases, because the cases involve separate and distinct issues, may be initiated on the same person or entity. This measure is dependent on the performance of the State Office of Administrative Hearings, which is not under the control of TDI.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

1.2.3 OP 1	**Number of Referrals of Alleged Insurer Fraud to State and Federal Prosecutors**
Short Definition:	Number of referrals of alleged insurer fraud to appropriate authorities. **Insurer fraud** is a violation of a penal law and is committed or attempted while engaging in the business of insurance, or relating to an insurance transaction. **Legal action** includes the filing of a charging document (e.g., indictment, criminal complaint or information). A **case** is an investigation performed by the Fraud Program of TDI. **Referral** is a Fraud Program investigation of a penal law violation, a person or entity, concluded and submitted to a prosecutor.
Purpose/Importance:	To measure the number of referrals of alleged insurer fraud to appropriate state and federal prosecutors by TDI.
Source/Collection of Data:	The source of the data is the Fraud Program's case management system. A case can be initiated from an external or internal report of fraud or request.
Method of Calculation:	The number of subjects and/or entities associated with fraud cases that are referred for legal action to the prosecutors which allege insurer fraud as defined in this measure for the reporting period.
Data Limitations:	A case that may identify more than one individual or entity will count each individual or entity referred as a separate referral. Referrals made to multiple prosecuting agencies from the same case will be counted independently as additional referrals. Separate cases that involve the same party will be counted as separate referrals.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.2.3 EF 1	**Average Number of Days per Insurer Fraud Enforcement Case Referred**
Short Definition:	The average number of days from the date the insurer fraud enforcement case is opened to its referral to prosecutors. **Insurer fraud** is a violation of a penal law and is committed or attempted while engaging in the business of insurance, or relating to an insurance transaction. A **case** is an investigation performed by the Fraud Program of TDI. **Referral** is a Fraud Program investigation of a penal law violation by a person or entity, concluded and submitted to a prosecutor.
Purpose/Importance:	To measure the average number of days from the date the insurer fraud case is opened by TDI to its referral.
Source/Collection of Data:	An insurer fraud enforcement case begins on the date the case is opened. The average number of days completed will be obtained from a query of the Fraud Program's case management system calculating the number of days from the date a case is opened to the date a case is first referred and concluded. If more than one referral is made from a single fraud case, each individual or entity will count as a separate referral. When multiple referrals are made, the query will only select the date the case is first referred and concluded.
Method of Calculation:	This measure is calculated by dividing the total number of days for each insurer fraud case referred by the total number of insurer fraud cases referred during the reporting period. A case is concluded upon the date of the first referral to a prosecutor. Cases closed and not referred are not counted in this measure.
Data Limitations:	A single fraud case, in which more than one person or entity are investigated, may result in more than one referral made to one or more prosecuting agencies on each individual or entity.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

1.2.3 EX 1	**Estimated Dollar Amount (in Millions) of Insurer Fraud Referred**
Short Definition:	The dollar amount of fraud identified, following submission to a prosecutor such as a district attorney or a United States attorney by TDI in connection with suspected insurer fraud. **Insurer fraud** is a violation of a penal law and is committed or attempted while engaging in the business of insurance, or relating to an insurance transaction. A **case** is an investigation performed by the Fraud Program of TDI. **Referral** is a Fraud Program investigation of a penal law violation by a person or entity, concluded and submitted to a prosecutor.
Purpose/Importance:	To measure the estimated dollar amount of insurer fraud referred.
Source/Collection of Data:	The source of the data is obtained from a Fraud Program referral report to a prosecutor, generated from the Fraud Program case management system. A case can be initiated from an external or internal report of fraud or request.
Method of Calculation:	The dollar amount of fraud referred will be calculated and recorded in the initial referral report to law enforcement and included in the Fraud Program case management system during the reporting period.
Data Limitations:	The dollar amount of fraud referred is limited to the total amount of fraud committed in conjunction with a scheme or continuing course of conduct for all parties involved in a case.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.2.3 EX 2	**Number of Reports of Insurer Fraud Received**
Short Definition:	Number of reports of insurer fraud received.
Purpose/Importance:	To measure the number of reports of insurer fraud received by the Texas Department of Insurance.
Source/Collection of Data:	The source of the data is the Fraud Program's case management system. The number of written or electronic communications received by the Fraud Program alleging insurer fraud during the report period. All reports of insurer fraud from any source will be entered into the Fraud Program's case management system and the total will be calculated by a query on that system. **Insurer fraud** is a violation of a penal law and is committed or attempted while engaging in the business of insurance, or relating to an insurance transaction.
Method of Calculation:	The number of written or electronic communications received by the Fraud Program alleging insurer fraud during the report period.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

1.2.4. OC 2	**Percent of Licensees Who Renew Online**
Short Definition:	The number of agent licenses renewed on-line divided by the total number of agent licenses renewed.
Purpose/Importance:	To track the percentage of agent licenses that are renewed on-line.
Source/Collection of Data:	An agent license is renewed when the license's renewal invoice is paid in the agent license database. "Agent license" includes the following license types: Adjuster, County Mutual, General Lines, Insurance Service Representative, Life and Health Insurance Counselor, Life Insurance not to exceed $15, 000, Limited Lines, Managing General Agent, Pre-Need, Public Insurance Adjuster, Reinsurance Broker, Reinsurance Manager, Risk Manager, Surplus Lines, and Specialty. The "agent license invoices renewed on-line" are the invoices for which the licensee or the licensee's representative submits payment electronically through a third-party system, including, but not limited to, TexasOnline, Sircon, and the National Insurance Producer Registry. The "total number of agent license invoices renewed" are invoices that are renewed on-line plus all renewals that are paid by cash, check or money order.
Method of Calculation:	The number of agent license invoices renewed on-line during the reporting period divided by the total number of agent license invoices renewed during the reporting period.
Data Limitations:	An agent my hold more than one license at the agency; therefore, for this measure, individual licenses are counted instead of the licensee to better reflect accurate activity at the agency.
Calculation Type:	Non-Cumulative
New Measure:	No
Desired Performance:	Higher than Target

2.1.1 OC 1	**Percent of statutorily mandated examinations completed within 18 months**
Short Definition:	The percent of statutorily mandated examinations completed within 18 months of the start date of the examination calculated as of fiscal year end.
Purpose/Importance:	To gauge whether TDI is completing statutorily mandated examinations in a timely manner.
Source/Collection of Data:	Receipt of the examination report at TDI headquarters signifies the completion of the on-site examination. The received reports are logged and tracked in a database. On-site examinations are conducted at the location of a company's books and records.
Method of Calculation:	The number of companies examined in a fiscal year will be calculated by determining the total of all on-site comprehensive examination reports of entities subject to statutorily mandated examinations that are received in Austin during the fiscal year. The completion date is the date the examination report is received in Austin. The as of date is the date of the financial statement that is being examined. The 18-month time period is calculated by determining the time difference between the as of date and the completion date. The number of statutorily mandated examinations completed during the fiscal year, that were completed within 18 months of the as of date is divided by the total number of statutorily mandated examinations completed during the fiscal year.
Data Limitations:	Factors outside the control of Financial could affect the completion of examinations, such as company cooperation and unexpected/unforeseen circumstances and issues that may develop on any given exam. The examination schedule is adjusted throughout the fiscal year to add newly incorporated companies; to remove or postpone companies that merged, dissolved, underwent significant restructuring or reorganization, or otherwise had alternative regulatory intervention strategies employed to address solvency concerns. A comprehensive examination reviews a company's overall financial condition as well as its conduct of business and its compliance with the laws of Texas, and is required to be conducted at intervals generally mandated by Article 1.15 of the Texas Insurance Code. This measure includes outsourced on-site comprehensive examinations.
Calculation Type:	Non-cumulative
New Measure:	Yes
Desired Performance:	Higher than Target

2.1.1 OC 2	**Percent of Identified Companies Reviewed**
Short Definition:	The percent of financial reviews of annual statements filed by companies identified as Texas domestic companies, or foreign companies writing a certain level of Texas premium, with potential solvency concerns, calculated as of fiscal-year end.
Purpose/Importance:	To ensure identified companies have all been reviewed for financial regulatory problems.
Source/Collection of Data:	The number of identified companies is established by June 1 of each fiscal year, based on TDI's priority system. The number of identified companies is evidenced by a report of Texas and Foreign+ Priority Companies. Foreign+ is defined as foreign Life insurance companies writing more than an amount determined annually in Texas premium in the preceding calendar year and foreign Property/Casualty companies writing more than an amount determined annually in Texas premium in the preceding calendar year. The number of financial reviews are those conducted between March 1 and August 31. Financial reviews conducted are evidenced by a report entitled Annual Reviews Completed on Priority Companies generated as of fiscal year-end from Financial Tracking system.
Method of Calculation:	The number of financial reviews of annual statements filed by companies identified as Texas domestic companies, or foreign companies writing a certain level of Texas premium, with potential solvency concerns, divided by the total of such identified companies, calculated for the reporting period.
Data Limitations:	Domestic insurance companies are Texas-based entities chartered in Texas holding a Certificate of Authority, as tracked on the Company License mainframe system. Foreign companies are non-Texas-based entities chartered in other States or by a foreign government holding a Certificate of Authority, as tracked on the Company License mainframe system. Company types (and TDI company type numbers) subject to this measure will be Life and/or Health (01 and 02), Stipulated Premium (20), Non-Profit Group Hospital (55), Fire and/or Casualty, (03, 04, 05, 06, 07, 08, 09, and 10) Lloyds (12 and 13), Reciprocals (14 and 15), Domestic Risk Retention Groups (40), County Mutual (56), Fraternal (16 and 17), Title (18 and 19), and Health Maintenance Organization (28 and 29) companies.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

2.1.1 OC 3	**Special Deputy Receiver Receivership Asset Recovery Expenses, as a Percent of the Total Dollars Collected by Special Deputy Receivers**
Short Definition:	The percent of the total dollars collected by Special Deputy Receiver (SDRs) appointed by the Commissioner of the Texas Department of Insurance (TDI) that are used in converting receivership assets.
Purpose/Importance:	This measure tracks the workload of the SDRs as they convert receivership assets to cash. Monitoring receivership asset recovery is one of the most important components of receivership administration.
Source/Collection of Data:	The receivership recovery expenses are the expenses incurred to collect the funds as reported by the SDRs. The total dollars collected includes cash received by SDRs from: (1) sales of receivership assets, e.g., stocks bonds, real estate and debt instruments; (2) collection of company receivables, e.g., agents' balances and reinsurance; (3) recovery of statutory deposits; (4) recovery resulting from officer and director liability litigation; and (5) recovery from other lawsuits, e.g., asset recovery and professional malpractice. The total dollars collected represent only those funds collected by SDRs and deposited by SDRs in approved receivership bank accounts or receivership depository accounts with the Texas Treasury. All data comes from receivership financial statements that the SDRs file with the court monthly or quarterly and submit to the Receiver. This measure is tracked on a personal computer-based spreadsheet.
Method of Calculation:	The total dollar amount of receivership asset recovery expenses divided by the total dollars collected by SDRs appointed by the Commissioner of TDI as Receiver in converting receivership assets to cash during the reporting period.
Data Limitations:	Fluctuations from high to low in the asset recovery expenses as a percent of the total dollars collected is representative of the common cyclical trend of incurring the bulk of the asset recovery expenses prior to the collection of the assets. In addition, it is important to note that given the maturity of the assets that remain toward the end of a receivership, the collection effort becomes more difficult, and in some cases, more expensive.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

2.1.1 OC 4	**Average Number of Days from Company "At risk" Identification to the Date of Solvency-related Regulatory Action**
Short Definition:	The average number of days from the date a company is identified as "at risk" to the date the earliest solvency-related regulatory action is taken for the reporting period.
Purpose/Importance:	The purpose of this measure is to reflect the average number of days from the date a company is identified as "at risk" to the date the earliest solvency-related regulatory action is taken to minimize insolvencies.
Source/Collection of Data:	The data are tracked on the automated Case Tracking System (CTS). The "at risk" date is the date a referral is received in the Legal Program from the Financial Program. The solvency-related regulatory action date is the date an action is initiated administratively or a case is referred to the Attorney General. Solvency-related regulatory actions are defined as all orders based upon Article 1.32 of the Texas Insurance Code, administrative oversight letters from the Texas Department of Insurance, Commissioner orders for supervision or conservatorship and referrals to the Attorney General for receivership.
Method of Calculation:	The total number of days from the date a company is identified as "at risk" to the date the earliest solvency-related regulatory action is taken, summed for all such companies, divided by the number of solvency-related regulatory actions taken for the reporting period.
Data Limitations:	NONE
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

2.1.1 OC 5	**Percent of Insurers Meeting Statutory or Risk-Based Capital and Surplus Requirements**
Short Definition:	The percent of companies that meet risk based capital and surplus (RBC) requirements as set by the Commissioner in accordance with certain provisions of the Texas Insurance Code (TIC) and the Texas Administrative Code (TAC).
Purpose/Importance:	To measure the percent of insurers meeting statutory or risk-based capital and surplus requirements and to ensure that the companies maintain minimum capital and surplus requirements relative to the risk the company assumes as mandated by the TIC.
Source/Collection of Data:	These requirements will be calculated once a year and will be calculated on available NAIC data by applying the risk-based capital and surplus formulas adopted in 28 TAC Section 7.401. An insurer is considered to have met the RBC requirement if its actual capital and surplus, (including certain asset and interest reserves for life companies), is equal to or exceeds the required RBC as calculated applying the adopted formulas.
Method of Calculation:	The number of companies that meet risk based capital and surplus requirements as set by the Commissioner, divided by the total number of companies subject to these requirements for the reporting period.
Data Limitations:	The number of companies meeting RBC may vary from year to year because of reorganizations, changes in operations, changes in market conditions for business investments, social reform measures, etc.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

2.1.1 OC 6	**Percent of Companies Rehabilitated After Texas Department of Insurance Solvency-related Intervention**
Short Definition:	The percent of companies or agencies released from TDI solvency-related intervention, including ancillary supervisions or conservatorships. TDI solvency-related intervention is any administrative order such as supervision, conservatorship, Article 1.32 order, administrative oversight letter, or court-directed order, including court-directed rehabilitation. An entity is any licensed or domestic or unauthorized insurance company or agency as defined in TEX. INS. CODE ANN. Articles 1.10 and 21-28-A.
Purpose/Importance:	To measure the percent of companies rehabilitated after TDI solvency-related intervention. This measure represents the TDI philosophy of early intervention to attempt rehabilitation of companies as mandated by the Texas Insurance Code (TIC) Article 21.28-A.
Source/Collection of Data:	A release is defined as an official Commissioner's Order, an Administrative Oversight Letter, or a court order releasing the company or agency from solvency intervention under the following conditions: (1) released to company or agency management; (2) released for merger into another company or agency; (3) released as a result of sale to another entity; (4) released because the business was 100 percent assumptive reinsured by another company; or (5) the business of an agency is taken over by the underwriting insurance company of another agency. A referral is defined as the issuance of an official Commissioner's Order or letter for TDI solvency-related intervention, including ancillary supervision or conservatorship, and includes the count of TDI solvency related intervention in effect at the beginning of the fiscal year plus companies or agencies referred during the fiscal year.
Method of Calculation:	The number of companies or agencies released from TDI solvency-related intervention, including ancillary supervisions or conservatorships, divided by the number of companies or agencies referred to TDI solvency-related intervention for the reporting period.
Data Limitations:	The number of troubled companies referred for regulatory intervention is influenced by many economic and environmental influences.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

2.1.1 OP 1	**Number of Entities Receiving Texas Department of Insurance Solvency-related Intervention**
Short Definition:	The number of licensed or unauthorized insurance companies or agencies whose operations are placed under TDI solvency-related intervention for financial rehabilitation. TDI solvency-related intervention is any administrative order such as supervision, conservation, Article 1.32 order, administrative oversight letters, or any court-directed order, including court-directed rehabilitation. An entity is any licensed foreign or domestic or unauthorized insurance company or agency as defined in TEX. ANN. CODE Ann. Articles 1.10 and 21.28-A.
Purpose/Importance:	To measure the number of entities receiving TDI solvency-related intervention. This measure represents the TDI philosophy of early intervention to attempt rehabilitation of companies as mandated by the Texas Insurance Code (TIC) Article 21.28-A.
Source/Collection of Data:	This measure uses the number of referrals as the source for calculating this measure. A referral is defined as the issuance of an official Commissioner's Order or letter for TDI solvency-related intervention, including ancillary supervision or conservatorship, and includes the count of TDI solvency related intervention in effect at the beginning of the fiscal year plus companies or agencies referred during the fiscal year. The number of referrals is tracked in an Excel spreadsheet.
Method of Calculation:	Sum the total number of new companies or agencies placed under TDI solvency-related intervention during the reporting period.
Data Limitations:	The number of troubled companies referred for regulatory intervention is influenced by many economic and environmental influences.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Lower than target

2.1.1 OP 2	**Dollar Amount (in Millions) of Net Asset Recoveries Collected from Receivership Estates**
Short Definition:	The total dollars of net asset recoveries collected by Special Deputy Receivers (SDRs) appointed by the Commissioner of the Texas Department of Insurance (TDI) as Receiver (Receiver) in converting receivership assets to cash.
Purpose/Importance:	This measure tracks the workload and reports the cost-effectiveness as receivership assets are converted to cash.
Source/Collection of Data:	The amount reported includes cash received from: (1) the sale of receivership assets, e.g., stocks, bonds, real estate and debt instruments; (2) collection of company receivables, e.g., agents' balances and reinsurance; (3) recovery of statutory deposits; (4) recovery resulting from officer and director liability litigation; and (5) recovery from other lawsuits, e.g., asset recovery and professional malpractice suits. Reported recoveries represent only those funds collected and deposited in approved receivership bank accounts or receivership depository accounts with the Texas Treasury. The data comes from receivership financial statements SDRs file with the court monthly or quarterly and submit to the Receiver.
Method of Calculation:	Sum the total dollars collected by SDRs appointed by the Commissioner of TDI as Receiver in converting receivership assets to cash, less the expense incurred to collect the funds during the reporting period.
Data Limitations:	Fluctuations from high to low in the asset recovery expenses as a percent of the total dollars collected is representative of the common cyclical trend of incurring the bulk of the asset recovery expenses prior to the collection of assets such as reinsurance and retrospective premium, as well as assets tied to litigation (e.g., directors and officers litigation). In addition, it is important to note that given the maturity of the assets that remain toward the end of the receivership, the collection effort becomes more difficult, and in some cases, more expensive.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

2.1.1 OP 3	**Number of Holding Company Transactions Reviewed**
Short Definition:	The number of holding company transactions reviewed pursuant to Article 21.49-1 of the Texas Insurance Code. The number of transactions reviewed means the number of transactions closed or completed during a calendar month.
Purpose/Importance:	This measure tracks the number of holding company transactions reviewed pursuant to Article 21.49-1 of the Texas Insurance Code to ensure that transactions with affiliates and acquisitions of control of an insurer do not adversely affect the interest of policyholders and the public.
Source/Collection of Data:	The "Date closed/completed" will be evidenced by: a) for transactions requiring Commissioner's Orders: the date stamped on the Commissioner's Order; b) for stockholder dividends: the "date completed" on the "Notice of Dividend or Distribution Pursuant to 28 Texas Administrative Code Section 7.203(n)." form; c) for all other holding company transactions: the "date closed" on the "transaction closing request" form prepared by Texas Department of Insurance staff. The appropriate "date closed/completed" is entered onto the Oracle HC system (FMHC) by unit support staff, ultimately closing the transaction. Then a report entitled "Holding Company System Closed Transactions Report" is generated for each month indicating the number of reviews completed.
Method of Calculation:	The number of transactions reviewed means the number of transactions closed or completed during a calendar month as evidenced by the total number of "rows selected" on the 'Holding Company System Closed Transactions Report."
Data Limitations:	The number of reviews may vary with the number of transactions filed, which can be affected by changes in the economy.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than Target

2.1.1 OP 4	**Number of Actuarial Examinations Completed**
Short Definition:	The number of actuarial examinations of life and property and casualty companies completed by Financial Program actuaries which focus on the adequacy of reserves and other related actuarial items.
Purpose/Importance:	To measure the number of actuarial exams completed.
Source/Collection of Data:	These actuarial examinations are typically performed on domestic life and property and casualty companies every three to five years. The date of completed actuarial exam is the completion date entered by the examining actuary on the cover page of the actuarial examination report. Actuarial examinations are tracked on a computer application. Completed actuarial examinations are sent to TDI headquarters and entered in an ACCESS database. The original report is maintained in the Financial Program's company file and a copy is filed with the work papers.
Method of Calculation:	The sum of actuarial examinations of life and property and casualty companies that are completed during the reporting period.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

2.1.1 OP 5	**Number of On-Site Examinations Conducted**
Short Definition:	The number of on-site financial and market conduct examinations of insurance entities regulated by the Texas Department of Insurance (TDI).
Purpose/Importance:	The purpose/importance of this measure is to reflect program efforts to monitor the financial health and business practices of insurance entities.
Source/Collection of Data:	On-site examinations are conducted at the location of a company's books and records. An examination is considered complete upon receipt of the examiner's report at TDI headquarters. The measure is tracked manually.
Method of Calculation:	The sum of the number of on-site financial and market conduct examinations that are conducted by the department during the reporting period.
Data Limitations:	The frequency of such examinations ranges from one to five years and is mandated by statute for certain of these entities; others are examined on an as-needed basis. The measure does not include out-sourced examinations in which TDI staff did not directly participate.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

2.1.1 OP 6	**Number of Reviews of Annual and Interim Financial Statements Conducted**
Short Definition:	The number of financial reviews, i.e. analyses, physically conducted in any month by Financial Analysis staff on annual, quarterly, and monthly statements filed by licensed insurers.
Purpose/Importance:	To determine the financial condition of insurance companies, health maintenance organizations (HMOs) and other licensed insurance entities and initiate recommendations for regulatory actions as mandated by the Texas Insurance Code relating to the financial condition.
Source/Collection of Data:	The number of reviews will be evidenced by a report entitled "Annual and Interim Reviews Completed" generated for each month. The date completed on the form will be evidenced by the "Date Review Completed" indicated on a "Statement Analysis Tracking Sheet" which is filled out by the analyst at the close of each review and from which information is input into the Financial Tracking system.
Method of Calculation:	The "Annual and Interim Reviews Completed" report includes a total number of "rows selected", i.e., the total number of reviews completed during the month.
Data Limitations:	These are desk reviews performed at TDI and do not include any on-site examinations For purposes of this measure, licensed insurers(and their TDI company type numbers) are defined as Life and/or Health (01 and 02), Stipulated Premium (20) Non-Profit Group Hospital (55), Fire and/or Casualty (03, 04, 05, 06, 07, 08, 09, and 10), Mexican Casualty (11), Lloyds (12 and 13), Reciprocal (14 and 15), Domestic Risk Retention Group (40), County Mutual (56), Fraternal (16 and 17), Title (18 and 19), Health Maintenance Organization (28 and 29), Statewide Mutual Assessment (51) Local Mutual Aid (52), Local Mutual Burial (53), Exempt Association (54), Farm Mutual (57), Continuing Care Retirement Community (26 and 27), and Accredited Reinsurance (82) companies.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

2.1.1 EF 1	**Average State Cost per Examination**
Short Definition:	The average cost for on-site financial and market conduct examinations completed for the reporting period.
Purpose/Importance:	To report the average state cost per examination and to measure the cost-effectiveness of examinations.
Source/Collection of Data:	The numerator of this measure is all expenditures and encumbrances for the Examinations activity. The denominator of this measure is "Number of on-site examinations conducted." An examination is considered complete upon receipt of the examiner's report at TDI headquarters. The examination reports are on-site financial and market conduct examinations of insurance entities regulated by TDI. The frequency of such examinations ranges from one to five years and is mandated by statute for certain of these entities; others are examined on an as-needed basis. Examination costs are tracked in a database. The number of examinations is tracked in an Excel spreadsheet.
Method of Calculation:	All expenditures and encumbrances for the Examinations activity for the reporting period divided by the number of examinations completed for the reporting period.
Data Limitations:	Outsourced costs and reports are not included.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

2.1.1 EX 1	**Dollar Amount (in Millions) of Insurance Company Insolvencies**
Short Definition:	The dollar value of each insurance company or entity placed in receivership.
Purpose/Importance:	To report the financial impact of insurance company receiverships for the purposes of liquidation.
Source/Collection of Data:	The dollar amount of insolvencies is tracked in an Access database. The dollar value of insolvency of each insurance company or entity placed in receivership is summed at fiscal year end.
Method of Calculation:	The dollar value of insolvency of each insurance company or entity placed in receivership, as reported on the balance sheet prepared and submitted to the Texas District court by Texas Department of Insurance Financial staff at the time the temporary restraining order or other order initially placing an entity into receivership is issued for the reporting period. The dollar value of insolvency is tracked in an Access database.
Data Limitations:	This measure reports the financial impact of insurance company receiverships for the purposes of liquidation. Insurance company receiverships for the purposes of rehabilitation are not included in this measure. There are various external factors; such as company marketing and new product development, mismanagement, improper financial reporting, and federal government action (i.e., enactment of financial modernization legislation) which can significantly impact this measure.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Lower than target

2.1.1 EX 2	**Number of Estates Placed in Receivership**
Short Definition:	The number of estates placed in receivership by Texas District courts for liquidation during the fiscal year.
Purpose/Importance:	Allows the public to know how many companies/estates have been placed into receivership.
Source/Collection of Data:	An insolvent insurance company or entity placed into receivership is referred to as a receivership estate. The estate is all of the property of the insolvent entity. The number is obtained from the docketing reports supplied by receivership court that indicate the date of court action placing a company in receivership. This measure is tracked in an Excel database.
Method of Calculation:	Sum the total number of estates placed in receivership by Texas District courts for liquidation for the reporting period.
Data Limitations:	This measure reports the number of entities placed into receivership for the purpose of liquidation. Insurance company receiverships for the purpose of rehabilitation are not included in this measure. There are various external factors, such as company marketing and new product development, mismanagement, improper financial reporting, and federal government action (i.e., enactment of federal modernization legislation) which can significantly impact this measure.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Lower than target

2.1.1 EX 3	**Percent of Companies Subject to Statutorily Mandated Examinations During the Fiscal Year**
Short Definition:	The percent of entities subject to statutorily mandated examinations at certain intervals, pursuant to the Texas Insurance Code (Article 1.15, et al.), that were examined in the current fiscal year.
Purpose/Importance:	To report the percent of companies examined during the fiscal year.
Source/Collection of Data:	The total number of statutorily mandated on-site examinations completed during the fiscal year is tracked in and determined from a database. An examination reviews a company's overall financial condition as well as its conduct of business and its compliance with the laws of Texas, and is required to be conducted at intervals generally mandated by Article 1.15, Texas Insurance Code. The frequency of on-site examinations ranges from one to five years. The measure includes outsourced on-site examinations. Receipt of the examination report in Austin signifies the completion of the on-site examination. The received reports are logged and tracked in an Excel database. The total number of entities subject to mandatory on-site examination intervals is tracked in and determined from an Excel database.
Method of Calculation:	The total of all entities subject to statutorily mandated examinations at certain intervals, pursuant to the Texas Insurance Code (Article 1.15, et. al.), that were examined in the current fiscal year divided by the total number of entities subject to mandatory on-site examination intervals as of August 31 for the reporting period.
Data Limitations:	The total number of entities subject to mandatory on-site examination intervals is adjusted throughout the fiscal year to add newly incorporated companies and to remove companies that merged or dissolved.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Target

3.1.1 OC 1	**Percent of Insurers Providing Adequate Loss Control Programs**
Short Definition:	The percent of companies receiving "adequate" ratings for loss control programs by the Texas Department of Insurance during the reporting period.
Purpose/Importance:	To measure the percent of insurers providing adequate loss control programs.
Source/Collection of Data:	An evaluation is considered completed when the company is given an adequate or inadequate rating and notification of such. Evaluations may be conducted on-site by the Texas Department of Insurance (TDI) safety services inspectors or desk audits may be conducted TDI. Companies with low premium volume may be evaluated by a TDI desk-top review of materials submitted by mail. Evaluations are conducted in accordance with the Texas Administrative Code sections 5.301 - 5.303; 5.311; 5.1701-5.1703, 5.1711-5.1713; 5.1721-5.1723 and 5.1731, loss control programs. A review is made of records and procedures by which the appropriate loss control service for a policyholder is determined, worksheets completed on selected policyholders and other data. Evaluation results are tracked by a Loss Control Program computer database.
Method of Calculation:	The total number of companies receiving "adequate" ratings for loss control programs by the Texas Department of Insurance divided by the total number of company evaluations completed that received a rating.
Data Limitations:	NONE
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

3.1.1 OC 2	**Percent of Commercial Property Inspections That Meet Filed Rating Schedule Requirements**
Short Definition:	The percent of commercial property oversight inspections conducted on commercial buildings that meet industry filed rating schedules during the reporting period.
Purpose/Importance:	To measure the percent of Commercial Property inspections that meet industry filed fire rating schedules.
Source/Collection of Data:	The measure is calculated manually using the monthly activity report. The Insurance Code requires insurers to file a manual of rules and rating schedules for commercial property risks. Inspections are re-inspections or oversight inspections by TDI to determine if initial fire rating inspections by private entities are accurate or contain errors. A commercial building does not meet standards when TDI identifies an error in the loss costs analysis due to misapplication of filed rating schedules, inaccurate mathematical calculations, omission of pertinent rating information, or incorrect classification of occupancies. A commercial building meets standards when loss costs are properly developed and classified in accordance with company-filed commercial property rating schedules. TDI does not count an inspection as an error if it is within a tolerance of plus or minus five percent of the correct loss cost, due to the complexity and subjectivity of application of rating schedules.
Method of Calculation:	The number of commercial property oversight inspections conducted that meet industry filed fire rating schedules divided by the total number of Commercial Property oversight inspections completed during the reporting period.
Data Limitations:	NONE
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

3.1.1 OC 3	**Percent of Windstorm Inspections that Result in an "Approved" Status Code**
Short Definition:	The percent of physical windstorm inspections performed that received an "approved" status code.
Purpose/Importance:	To ensure compliance with the building code by measuring the percent of windstorm inspections that result in an "approved" status code.
Source/Collection of Data:	The total number of physical windstorm inspections conducted is the sum of the number approved, disapproved and incomplete. A windstorm inspection is documented by an inspection form, WPI-7 and is considered performed on the date the inspector completes the WPI-7 and enters the status on the inspection log. Pursuant to Article 21.49, Texas Insurance Code, windstorm inspections are performed in the Texas areas which are serviced by the Texas Windstorm Insurance Association (TWIA) for wind and hail insurance. The areas are designated by the Commissioner of Insurance. Inspections determine if structural elements are in accordance with the Department of Insurance (TDI) windstorm construction guidelines as approved by administrative rule. The number of physical inspections performed is determined from a monthly report prepared by the windstorm activity from an automated system. The denominator for this measure is "Number of Windstorm Inspections Completed."
Method of Calculation:	The number of physical inspections performed receiving an "approved" ("A") status code divided by the total number of physical windstorm inspections performed for the reporting period. Each physical inspection is coded as A = Approved, D = Disapproved or I = Incomplete. Inspections requested but not performed are coded as SC = Site Cancel and C = Cancel. Site Cancel and Cancel will not be used in the calculation of this measure. The denominator for this measure is "Number of Windstorm Inspections Completed."
Data Limitations:	NONE
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

3.1.1 OP 1	**Number of Windstorm Inspections Completed**
Short Definition:	The number of inspections conducted by TDI of property for windstorm code compliance. A windstorm inspection is a physical inspection by a TDI windstorm inspector of a structure for compliance with Article 21.49, Texas Insurance Code, to determine if the structural elements are in accordance with the TDI Windstorm Construction Guidelines as approved by Administrative Rule.
Purpose/Importance:	To measure the number of windstorm inspections completed.
Source/Collection of Data:	A windstorm inspection is considered completed when documented on a WPI-7 inspection form and the status is entered on the inspection log. An inspection is conducted at either (1) a new commercial or residential structure which include requested inspections of foundation, rough framing, final framing, and mechanical, if applicable or (2) an existing commercial or residential structure that must have re-roofing or remodeling work inspected to maintain eligibility. Inspections are completed in accordance with Article 21.49, Texas Insurance Code, in the Texas areas which are serviced by the Texas Windstorm Insurance Association (TWIA) for wind and hail insurance. The areas are designated by the Commissioner of Insurance. A scheduled inspection that is canceled prior to the physical inspection is not counted as an inspection performed. The windstorm inspections are entered into a database and the number of inspections is calculated monthly.
Method of Calculation:	The number of inspections conducted by TDI of property for windstorm code compliance during the reporting period.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

3.1.1 OP 2	**Number of Inspections of Insurer Loss Control Programs Completed**
Short Definition:	The number of evaluations conducted of the loss control programs required of insurance companies for their policyholders. Evaluations may be conducted on-site by the Texas Department of Insurance (TDI) safety services inspectors or may be conducted at TDI with appropriate company program documentation submitted by the insurance company representatives.
Purpose/Importance:	To measure the number of inspections of insurer loss control programs completed.
Source/Collection of Data:	Evaluations are conducted in accordance with the Texas Administrative Code sections 5.301-5.303; 5.311; 5.1701-5.1703; 5.1711-5.1713; 5.1721-5.1723 and 5.1731, which includes loss control programs. Evaluation results are tracked by a computer database which quantifies the total number of loss control programs evaluated, the number of evaluations with adequate ratings, and the number of evaluations with inadequate ratings. An evaluation is completed when TDI notifies the company in writing of an adequate or inadequate rating and the basis for that determination.
Method of Calculation:	The number of evaluations conducted of the loss control programs required of insurance companies for their policyholders.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

3.1.1 OP 3	**Number of Commercial Property Oversight Inspections Completed**
Short Definition:	The number of Commercial Property oversight inspections conducted by TDI to determine the accuracy of Commercial Property rating inspections performed by private entities.
Purpose/Importance:	To measure the number of Commercial Property oversight inspections completed to assure that accurate loss costs are developed and that structures are properly classified in accordance with industry filed building rating schedules.
Source/Collection of Data:	A Commercial Property oversight inspection is conducted by TDI after independent inspections by private entities to assure that accurate loss costs are developed and that structures are properly classified in accordance with industry filed building rating schedules. An oversight inspection is an inspection by a TDI Oversight Inspector of a commercial or a public building. The number of Commercial Property oversight inspections is based on a manual count of oversight inspections recorded in the inspection log maintained by the oversight inspection staff. The number of Commercial Property oversight inspections is counted manually.
Method of Calculation:	The number of oversight inspections conducted by TDI of commercial property to assure that accurate loss costs are developed for fire rating.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

3.1.1 EF 1	**Average Cost Per Windstorm Inspection**
Short Definition:	Total inspection-related funds expended for the Windstorm Activity divided by the number of windstorm physical inspections and requested inspections for the reporting period.
Purpose/Importance:	To measure the average cost per windstorm inspection.
Source/Collection of Data:	Expenditures are calculated by using the Financial Accounting System (General Ledger) Budget Status Detail Report and excel spreadsheets for travel voucher expenses not yet processed and overtime earned but not yet paid. A physical inspection is considered performed on the date the inspector completes the WPI-7 form and enters A=Approved, D=Disapproved or I=Incomplete status code on the inspection log. A requested inspection is considered performed on the date the inspector completes the WPI-7 form and enters an SC=Site Cancel or C= Cancel status code on the inspection log. The Windstorm Activity queries an Oracle database at the end of the reporting period and calculates the total number of inspections performed and requested.
Method of Calculation:	Total inspection-related funds expended by the Windstorm Activity divided by the number of windstorm physical inspections and requested inspections for the reporting period.
Data Limitations:	NONE
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

3.1.2 OC 4	**Percent of Consumer and Provider Fraud Referrals to State or Federal Prosecutors Resulting in Legal Action**
Short Definition:	Percent of consumer/provider fraud referrals to state or federal prosecutors such as district attorneys or United States attorneys resulting in legal action. **Claim fraud** is an act by a consumer or provider that is a violation of any penal law and: a) is committed or attempted as a part of or in support of an insurance transaction; or b) is part of an attempt to defraud an insurer. A **consumer (claimant**) is an insured, beneficiary, third party, or representative who has filed a claim and has received or is expecting payment or reimbursement from a claim. A "**provider"** is a person or entity providing goods or services for which reimbursement is sought under a policy of insurance. **Legal action** includes the filing of a charging document (e.g., indictment, criminal complaint or information). A **case** is an investigation performed by the Fraud Program of TDI. **Referral** is a Fraud Program investigation of a penal law violation by a person or entity, concluded and submitted to a prosecutor.
Purpose/Importance:	To measure the percent of consumer/provider referrals resulting in legal action.
Source/Collection of Data:	The source of data is the Fraud Program's case management system.
Method of Calculation:	The measure is calculated by dividing the number of "legal actions" taken against individuals or entities as a result of referrals submitted (numerator), by the total number of referrals submitted by the Fraud Program to prosecutors during the fiscal year (denominator). If a referral to a prosecutor results in multiple charging documents against one or more individuals or entities, each legal action taken by the prosecutor is counted in the numerator of this measure.
Data Limitations:	This measure does not include workers' compensation insurance fraud. A single fraud case, in which more than one individual or entity are investigated, may result in more than one referral made to one or more prosecutors on each individual or entity. A case can be initiated from an external or internal report of fraud or request. In many instances Legal Action will not be filed during the same fiscal year the Case was referred. Variance in the number of Referrals and/or Legal Actions may result in calculation of a percentage that reflects the agency's performance over multiple fiscal years.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

3.1.2 OP 1	**Number of Referrals of Alleged Consumer and Provider Fraud to State and Federal Prosecutors**
Short Definition:	The number of referrals of alleged consumer/provider fraud to appropriate authorities. **Claim fraud** is an act by a consumer or provider that is a violation of any penal law and: a) is committed or attempted as a part of or in support of an insurance transaction; or b) is part of an attempt to defraud an insurer. A **consumer (claimant**) is an insured, beneficiary, third party, or representative who has filed a claim and has received or is expecting payment or reimbursement from a claim. A "**provider"** is a person or entity providing goods or services for which reimbursement is sought under a policy of insurance. **Legal action** includes the filing of a charging document (e.g., indictment, criminal complaint or information). **Referral** is a Fraud Program investigation of a penal law violation by a person or entity, concluded and submitted to a prosecutor. A **case** is an investigation performed by the Fraud Program of TDI.
Purpose/Importance:	To measure the number of referrals of alleged consumer and provider fraud to appropriate State and Federal Prosecutors by TDI.
Source/Collection of Data:	The source of the data is the Fraud Program's case management system. A case can be initiated from an external or internal report of fraud or request.
Method of Calculation:	The number of subjects and/or entities associated with fraud cases that are referred for legal action to prosecutors which allege consumer & provider fraud (claim fraud) during the reporting period.
Data Limitations:	This measure does not include workers' compensation insurance fraud. A case that may identify more than one individual or entity will count each individual or entity referred as a separate referral. Referrals made to multiple prosecuting agencies from the same case will be counted independently as additional referrals. Separate cases that involve the same party will be counted as separate referrals.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

3.1.2 EF 1	**Average Number of Days per Consumer or Provider Fraud Enforcement Case Referred**
Short Definition:	The average number of days from the date the consumer and provider fraud enforcement case is opened to its referral to prosecutors. A **consumer (claimant**) is an insured, beneficiary, third party, or representative who has filed a claim and has received or is expecting payment or reimbursement from a claim. A "**provider"** is a person or entity providing goods or services for which reimbursement is sought under a policy of insurance. **Claim fraud** is an act by a consumer or provider that is a violation of any penal law and: a) is committed or attempted as a part of or in support of an insurance transaction; or b) is part of an attempt to defraud an insurer. A **case** is an investigation performed by the Fraud Program of TDI. **Referral** is a Fraud Program investigation of a penal law violation by a person or entity, concluded and submitted to a prosecutor.
Purpose/Importance:	To measure the average number of days from the date the consumer or provider fraud case is opened at TDI to its referral to prosecutors.
Source/Collection of Data:	A consumer and provider enforcement case, initiated from a complaint, begins on the date the case is opened. The average number of days to completion will be obtained from a query of the Fraud Program's case management system calculating the number of days from the date a case is opened to the date a case is first referred and concluded.
Method of Calculation:	The measure is calculated by dividing the total number of days for each consumer and provider fraud case referred by the total number of consumer and provider fraud cases referred during the reporting period. A case can be initiated from an external or internal report of fraud or request. A case is concluded for the purpose of this measure upon the date of the first referral, as evidenced by a letter from the case owner to a prosecutor, in which the case is described.
Data Limitations:	This measure does not include workers' compensation insurance fraud. A single Fraud Program case, in which more than one person or entity is investigated may result in more than one referral made to one or more prosecuting agencies on each individual or entity. If more than one referral is made from a single fraud case, each individual or entity will count as a separate referral. Cases closed and not referred are not counted in this measure.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

3.1.2 EX 1	**Number of Reports of Consumer and Provider Fraud Received**
Short Definition:	The number of reports of consumer/provider fraud received at the Texas Department of Insurance (TDI). **Claim fraud** is an act by a consumer or provider that is a violation of any penal law and: a) is committed or attempted as a part of or in support of an insurance transaction; or b) is part of an attempt to defraud an insurer. A **consumer (claimant**) is an insured, beneficiary, third party, or representative who has filed a claim and has received or is expecting payment or reimbursement from a claim. A "**provider"** is a person or entity providing goods or services for which reimbursement is sought under a policy of insurance.
Purpose/Importance:	To measure the number of reports of consumer and provider fraud received.
Source/Collection of Data:	The source of the data is the Fraud Program's case management system. The number of written or electronic communications received by the Fraud Program alleging consumer or provider fraud during the report period. All reports of consumer and provider fraud from any source will be entered into the Fraud Program's case management system and the total will be calculated by a query on that system.
Method of Calculation:	The number of written or electronic communications received by the Fraud Program alleging consumer or provider fraud during the reporting period.
Data Limitations:	This measure does not include workers' compensation insurance fraud.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

3.1.2 EX 2	**Estimated Dollar Amount (in Millions) of Consumer and Provider Fraud Referred**
Short Definition:	The dollar amount of fraud identified within the referral report, following submission to a prosecutor by the Texas Department of Insurance (TDI) in connection with suspected consumer/provider fraud. A **consumer (claimant**) is an insured, beneficiary, third party, or representative who has filed a claim and has received or is expecting payment or reimbursement from a claim. A "**provider"** is a person or entity providing goods or services for which reimbursement is sought under a policy of insurance. **Claim fraud** is an act by a consumer or provider that is a violation of any penal law and: a) is committed or attempted as a part of or in support of an insurance transaction; or b) is part of an attempt to defraud an insurer. A **case** is an investigation performed by the Fraud Program of TDI. **Referral** is a Fraud Program investigation of a penal law violation by a person or entity, concluded and submitted to a prosecutor.
Purpose/Importance:	To measure the estimated dollar amount of consumer and provider fraud referred.
Source/Collection of Data:	The source of the data is obtained from a Fraud Program referral report to a prosecutor, generated from the Fraud Program case management system.
Method of Calculation:	The sum of the dollar amount of fraud referred will be calculated and recorded in the initial referral report to law enforcement and included in the Fraud Program case management system for the reporting period. A case can be initiated from an external or internal report of fraud or request.
Data Limitations:	This measure does not include workers' compensation insurance fraud. The dollar amount of fraud referred is limited to the total amount of fraud committed in conjunction with a scheme or continuing course of conduct for all parties involved in a case.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

3.1.3 OC 5	**Percent of Workers' Compensation Insurance Fraud Referrals to State or Federal Prosecutors Resulting in Legal Action**
Short Definition:	Percent of workers' compensation insurance fraud referrals to state or federal prosecutors such as district attorneys or United States attorneys resulting in legal action**. Workers' compensation insurance fraud** occurs when a person with intent to defraud or deceive an insurer in support of a claim or application for an insurance policy, prepares or causes to be prepared a statement that contains false or misleading material information and is presented to an insurer or presents or causes to be presented to an insurer, a statement that the person knows contains false or misleading material information. **Legal action** includes the filing of a charging document (e.g., indictment, criminal complaint or information). A **case** is an investigation performed by the Fraud Program of TDI. **Referral** is a Fraud Program investigation of a penal law violation by a person or entity, concluded and submitted to a prosecutor.
Purpose/Importance:	To measure the percent of workers' compensation insurance fraud referrals resulting in legal action.
Source/Collection of Data:	The source of data is the Fraud Program's case management system.
Method of Calculation:	The measure is calculated by dividing the number of "legal actions" taken against individuals or entities as a result of referrals submitted (numerator), by the total number of referrals submitted by the Fraud Program to prosecutors during the fiscal year (denominator). If a referral to a prosecutor results in multiple charging documents against one or more individuals or entities, each legal action taken by the prosecutor is counted in the numerator of this measure.
Data Limitations:	This measure relates to workers' compensation insurance fraud. A single fraud case, in which more than one individual or entity are investigated, may result in more than one referral being made to one or more prosecutors on each individual or entity. A case can be initiated from an external or internal report of fraud or request. In many instances Legal Action will not be filed during the same fiscal year the case was referred. Variance in the number of Referrals and/or Legal Actions may result in calculation of a percentage that reflects the agency's performance over multiple fiscal years.
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than target

3.1.3 OP 1	**Number of referrals of alleged fraud relating to workers' compensation insurance to state or federal prosecutors**
Short Definition:	The number of referrals of alleged fraud relating to workers' compensation insurance to appropriate authorities. **Workers' compensation insurance fraud** occurs when a person with intent to defraud or deceive an insurer in support of a claim or application for an insurance policy, prepares or causes to be prepared a statement that contains false or misleading material information and is presented to an insurer or presents or causes to be presented to an insurer, a statement that the person knows contains false or misleading material information. **Legal action** includes the filing of a charging document (e.g., indictment, criminal complaint or information). **Referral** is a Fraud Program investigation of a penal law violation by a person or entity, concluded and submitted to a prosecutor. A **case** is an investigation performed by the Fraud Program of TDI.
Purpose/Importance:	To measure the number of referrals of alleged fraud relating to workers' compensation insurance to State or Federal Prosecutors by TDI.
Source/Collection of Data:	The source of the data is the Fraud Program's case management system. A case can be initiated from an external or internal report of fraud or request.
Method of Calculation:	The number of subjects and/or entities associated with fraud cases that are referred for legal action to prosecutors which allege workers' compensation insurance fraud.
Data Limitations:	This measure relates to workers' compensation fraud. A case that may identify more than one individual or entity will count each individual or entity referred as a separate referral. Referrals made to multiple prosecuting agencies from the same case will be counted independently as additional referrals. Separate cases that involve the same party will be counted as separate referrals.
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than target

3.1.3 EF 1	**Average number of days per workers' compensation insurance fraud enforcement case referred**
Short Definition:	The average number of days from the date the workers' compensation insurance fraud enforcement case is opened to its referral to prosecutors. **Workers' compensation insurance fraud** occurs when a person with intent to defraud or deceive an insurer in support of a claim or application for an insurance policy, prepares or causes to be prepared a statement that contains false or misleading material information and is presented to an insurer or presents or causes to be presented to an insurer, a statement that the person knows contains false or misleading material information. A **case** is an investigation performed by the Fraud Program of TDI. **Referral** is a Fraud Program investigation of a penal law violation by a person or entity, concluded and submitted to a prosecutor.
Purpose/Importance:	To measure the average number of days from the date the workers' compensation insurance fraud case is opened at TDI to its referral to prosecutors.
Source/Collection of Data:	A workers' compensation insurance fraud enforcement case, initiated from a complaint, begins on the date the case is opened. The average number of days to completion will be obtained from a query of the Fraud Program's case management system calculating the number of days from the date a case is opened to the date a case is first referred and concluded.
Method of Calculation:	The measure is calculated by dividing the total number of days for each workers' compensation insurance fraud case referred by the total number of workers' compensation insurance fraud cases referred during the reporting period. A case can be initiated from an external or internal report of fraud or request. A case is concluded for the purpose of this measure upon the date of the first referral, as evidenced by a letter from the case owner to a prosecutor, in which the case is described.
Data Limitations:	This measure relates to workers' compensation insurance fraud. A single Fraud Program case, in which more than one person or entity is investigated may result in more than one referral made to one or more prosecuting agencies on each individual or entity. If more than one referral is made from a single fraud case, each individual or entity will count as a separate referral. Cases closed and not referred are not counted.
Calculation Type:	Non-cumulative
New Measure:	Yes
Desired Performance:	Lower than target

3.1.3 EX 1	**Number of reports of workers' compensation insurance fraud received**
Short Definition:	The number of reports of workers' compensation insurance fraud received at the Texas Department of Insurance (TDI). **Workers' compensation insurance fraud** occurs when a person with intent to defraud or deceive an insurer in support of a claim or application for an insurance policy, prepares or causes to be prepared a statement that contains false or misleading material information and is presented to an insurer or presents or causes to be presented to an insurer, a statement that the person knows contains false or misleading material information.
Purpose/Importance:	To measure the number of reports of workers' compensation insurance fraud received.
Source/Collection of Data:	The source of the data is the Fraud Program's case management system. The number of written or electronic communications received by the Fraud Program alleging workers' compensation insurance fraud during the report period. All reports of workers' compensation insurance fraud from any source will be entered into the Fraud Program's case management system and the total will be calculated by a query on that system.
Method of Calculation:	The number of written or electronic communications received by the Fraud Program alleging workers' compensation insurance fraud during the reporting period.
Data Limitations:	This measure relates to workers' compensation insurance fraud.
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than target

3.1.3 EX 2	**Estimated dollar amount (in millions) of workers' compensation insurance fraud referred**
Short Definition:	The dollar amount of fraud identified within the referral report, following submission to a prosecutor by the Texas Department of Insurance (TDI) in connection with suspected workers' compensation insurance fraud. **Workers' compensation insurance fraud** occurs when a person with intent to defraud or deceive an insurer in support of a claim or application for an insurance policy, prepares or causes to be prepared a statement that contains false or misleading material information and is presented to an insurer or presents or causes to be presented to an insurer, a statement that the person knows contains false or misleading material information. A case is an investigation performed by the Fraud Program of TDI. **Referral** is a Fraud Program investigation of a penal law violation by a person or entity, concluded and submitted to a prosecutor.
Purpose/Importance:	To measure the estimated dollar amount of workers' compensation insurance fraud referred.
Source/Collection of Data:	The source of the data is obtained from a Fraud Program referral report to a prosecutor, generated from the Fraud Program case management system.
Method of Calculation:	The sum of the dollar amount of fraud referred will be calculated and recorded in the initial referral report to law enforcement and included in the Fraud Program case management system. A case can be initiated from an external or internal report of fraud or request during the reporting period.
Data Limitations:	This measure relates to workers' compensation insurance fraud. The dollar amount of fraud referred is limited to the total amount of fraud committed in conjunction with a scheme or continuing course of conduct for all parties involved in a case.
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than target

4.1.1 OC 1	**Percent of State Fire Marshal's Office Criminal Referrals Resulting in Enforcement/Legal Action**
Short Definition:	The percent of criminal referrals, which are submitted as a result of fire investigations that lead to an enforcement or a legal action.
Purpose/Importance:	To reflect agency efforts in criminal referrals for enforcement or legal action of fire-related investigations.
Source/Collection of Data:	The source of the data is collected in official fire investigation reports completed by field investigators. These reports are reviewed and verified through proper documentation by division supervisors, then entered and stored on the SFMO Fire/Arson Investigation Section (FAIS) Case Management System. A "referral" indicates a single suspect, no matter how many potential offenses are recommended to the prosecutor. "Enforcement/legal action" includes the filing of a charging instrument (e.g., indictment or information) or an adjudication rendered by the court system (federal, state, county, juvenile) during the criminal process. For this measure, a SFMO criminal investigation is initiated when, during a fire investigation (known as a "case"), evidence of criminal activity has been discovered.
Method of Calculation:	This measure represents the percentage of criminal referrals resulting from a fire investigation that lead to an enforcement or a legal action. This measure is calculated by dividing the total "Number of SFMO criminal referrals resulting in enforcement/legal action" during the current fiscal year (numerator), by the total "Number of criminal referrals for prosecution" and the number of referrals in effect at the beginning of the fiscal year (denominator). At the end of each fiscal year, those cases which have been referred, that have not resulted in legal action will be carried over to the next fiscal year, with the exception of those cases that have been closed due to lack of action by the prosecuting agency.
Data Limitations:	NONE
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

4.1.1 OC 2	**Percent of Registrations, Licenses, and Permits Issued, After Receipt of a Completed Application, Within 20 Days to Fire Alarm, Fire Extinguisher, Fire Sprinkler, and Fireworks Firms, Individuals, and Other Regulated Entities**
Short Definition:	Percent of Registrations, Licenses, and Permits Issued, After Receipt of a Completed Application, to Fire Alarm, Fire Extinguisher, Fire Sprinkler, and Fireworks Firms, Individuals and Other Regulated Entities.
Purpose/Importance:	To track efficiencies in the issuance of registrations, licenses and permits.
Source/Collection of Data:	Both initial and renewal certificates of registration, licenses, and permits are issued to firms, individuals, and other entities, upon request, after the applicant provides all the requirements of Articles 5.43-1, 5.43-2, and 5.43-3; of the Texas Insurance Code and The Occupations Code, Title 13, Subtitle D, Chapter 2154. The dates from receipt of a completed application, as determined by the date of the Texas Department of Insurance Division Cash receipt Report for correspondence including fees or by the State Fire Marshal's office "received" date stamp on correspondence without fees, to the issuance of the registration, license or permit, as signified by the date printed on the registration, license or permit, or the date fireworks permit booklets are picked up or mailed, are entered into a database located on the agency's computer network.
Method of Calculation:	The percent is calculated as the number of registrations, licenses, and permits issued within 20 days or less divided by the total number of registrations, licenses, and permits issued within the reporting period.
Data Limitations:	NONE
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

4.1.1 OP 1	**Number of individuals attending fire prevention and fire safety presentations coordinated by the State Fire Marshal's Office**
Short Definition:	The sum of all individuals attending presentations coordinated by the State Fire Marshal's Office (SFMO).
Purpose/Importance:	To track the number of individuals attending presentations coordinated by the SFMO.
Source/Collection of Data:	The source of the data comes from the public presentation report forms, logs and the public education booth exhibition log. Only individuals external to the SFMO will be counted. Individuals will be counted only once when attending presentations consisting of multiple sessions. A presentation is any event coordinated by the SFMO that educates and/or informs external customers on ways to protect their lives and property from fire and fire-related hazards using one or more of the following methods of communication: speeches, training, exhibits, seminars, teleconferences, and/or TV, radio and print interviews.
Method of Calculation:	The sum of all individuals attending presentations coordinated by the SFMO during the reporting period. The totals of all forms, logs and all public education booth exhibitions with dates on or between the first and last day of the month are added.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than Target

4.1.1 OP 2	**Number of Fire Investigations Completed**
Short Definition:	This number represents the total number of fire investigations completed.
Purpose/Importance:	To reflect the agency's efforts in investigating fires.
Source/Collection of Data:	The source of the data is collected in official fire investigation reports and stored on the SFMO (FAIS) Case Management System. A fire investigation includes all cases investigated whether the cause is incendiary, accidental or undetermined. A "Case" is initiated when a request for a fire investigation has been received and a "Case Number" has been assigned. An "accidental or undetermined" case is considered "completed" upon a supervisory approval of the report containing the cause and origin determination. An arson (incendiary) case, which is considered a criminal investigation, is considered completed when referred for prosecution. Field investigators refer cases for prosecution to prosecuting agencies (federal, state, county, juvenile, etc.) and document their activities in fire investigation reports. Assistance to other law enforcement entities in investigating fires are not included in this measure.
Method of Calculation:	Sum the number of fire investigations completed. The total number of completed investigations will be obtained by conducting a query of the database. The date the supervisor approves the fire investigation report is considered the "completed date." The completed date is entered into the case management system.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

4.1.1 OP 3	**Number of Samples Analyzed in the Arson Lab**
Short Definition:	The total number of items (samples) analyzed as evidence by the Forensic Arson Laboratory.
Purpose/Importance:	To track the number of samples submitted to the Arson Lab to be analyzed for the presence of accelerants.
Source/Collection of Data:	The data is stored in the laboratory database on the agency's network. The "final report" is generated after the analysis is complete and the final results of a case submission are entered into the database. Each sample (item) from a submission is counted as a separate item. Evidence samples are received from the agency's fire and arson investigators, and from other fire service and law enforcement agencies throughout the state.
Method of Calculation:	Sum the total number of items (samples) analyzed as evidence by the Forensic Arson Laboratory in a month. Calculation of this sample total is based on the date of the final report.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

4.1.1 OP 4	**Number of State Fire Marshal's Office Criminal Referrals to Prosecution**
Short Definition:	This number represents the total number of criminal referrals to a prosecuting agency (Federal, State or Local) for legal action resulting from an SFMO fire investigation.
Purpose/Importance:	To reflect agency efforts toward referring fire-related criminal activities to a prosecuting agency (Federal, State or Local) for legal action.
Source/Collection of Data:	The source of the data is collected in official fire investigation reports completed by field investigators. For this measure, a SFMO criminal investigation is initiated when, during a fire investigation (known as a "case"), evidence of criminal activity is discovered. A "case" is initiated when a request for a fire investigation has been received and a "case number" has been assigned. A single case can result in the referral of multiple suspects. The total number of referrals will be obtained by querying the database.
Method of Calculation:	Sum the total number of criminal referrals to a prosecuting agency (Federal, State or Local) for legal action.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

4.1.1 OP 5	**Number of Registrations, Licenses, and Permits Issued to Fire Alarm, Fire Extinguisher, Fire Sprinkler and Fireworks Firms, Individuals and Other Regulated Entities**
Short Definition:	Number of Registrations, Licenses, and Permits Issued to Fire Alarm, Fire Extinguisher, Fire Sprinkler and Fireworks Firms, Individuals and Other Regulated Entities.
Purpose/Importance:	To track the number of licenses issued to firms and individuals in the alarm, extinguisher, sprinkler and fireworks industries.
Source/Collection of Data:	Both initial and renewal certificates of registration, licenses, and permits are issued to firms, individuals, and other entities in accordance with Articles 5.43-1, 5.43-2, and 5.43-3, of the Texas Insurance Code and The Occupations Code, Title 13, Subtitle D, Chapter 2154. The date of issuance or renewal, as signified by the date printed on the registration, license or permit or the date fireworks permit booklets are picked up or mailed, is recorded in a database located on the agency's computer network.
Method of Calculation:	The number of each type of registration, license, and permit, issued or renewed, is totaled from the information in the database for the reporting period.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

4.1.1 OP 6	**Number of Licensing Investigations or Inspections Conducted**
Short Definition:	This is the number of licensing investigations or inspections conducted to determine possible violations by fire extinguisher, fire alarm, fire sprinkler, and fireworks firms and individuals regulated and licensed under Article 5.43-1, 5.43-2, and 5.43-3, of the Texas Insurance Code and The Occupations Code, Title 13, Subtitle D, Chapter 2154.
Purpose/Importance:	To track the number of investigations of complaints and inspections of licensed entities.
Source/Collection of Data:	The date on the completed report is entered into a database on the agency's computerized network. Investigations are individually quantified by each investigated firm or individual and inspections are quantified by each physical location. Each investigation and inspection is assigned a specific case number. After the investigation/inspection is conducted, the investigator files a report.
Method of Calculation:	This is the number of licensing investigations or inspections conducted to determine possible violations by fire extinguisher, fire alarm, fire sprinkler, and fireworks firms and individuals regulated and licensed under Article 5.43-1, 5.43-2, and 5.43-3; of the Texas Insurance Code and The Occupations Code, Title 13, Subtitle D, Chapter 2154. The number of licensing investigations and inspections is calculated from the sum of case numbers on the database for the reporting period.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

4.1.1 OP 7	**Number of Buildings Inspected or Reinspected for Fire Safety Hazards**
Short Definition:	The number of buildings in which a physical survey of the structure is completed and recommendations for correction of hazardous conditions have been made, if noted, including all subsequent surveys for compliance with recommendations.
Purpose/Importance:	To track the number of buildings inspected, on an annual basis, for the protection of building occupants.
Source/Collection of Data:	The data is collected from reports submitted by the inspector and recorded in the agency database. A building is defined as an identifiable structure with fire or space separation containing its own exit facilities and includes inspections of retail service stations. An inspection is completed when the physical survey is conducted and documented on the inspection report. The date of inspection is recorded in the inspection report.
Method of Calculation:	The number of buildings in which a physical survey of the structure is completed and recommendations for correction of hazardous conditions have been made, if noted, including all subsequent surveys for compliance with recommendations.
Data Limitations:	NONE
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

4.1.1 OP 8	**Number of communities or community partners accepting a SFMO fire prevention program or initiative**
Short Definition:	The number of Communities or community partners accepting a SFMO fire prevention program or initiative.
Purpose/Importance:	To track fire prevention programs to communities and enable SFMO partners to provide sustainable services to help local communities and organizations protect lives and property.
Source/Collection of Data:	The source of the data is completed SFMO fire prevention program and initiative project reports. A report is considered completed when accepted by the State Fire Marshal. In this measure, "communities" and "community partners" means the geographic or demographic entity or organization that accepts the SFMO's prevention program or initiative. "Accepting" includes delivery of programs, facilitation of program implementation, establishment of fire prevention educational initiatives, conducting fire safety consultancy evaluations, and delivery of other substantial community fire prevention assistance.
Method of Calculation:	Count the number of communities and community partners accepting SFMO fire prevention programs or initiatives. The total number of communities and community partners involved in completed programs will be obtained by counting approved project reports at the end of the reporting period. The date the State Fire Marshal approves the report is considered the "completed date."
Data Limitations:	This measure will focus only on substantial fire prevention programs and initiatives. A community may be counted each time a separate SFMO program is accepted by that community.
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than Target

4.1.1 EF 1	**Average Cost per Fire Safety Inspection**
Short Definition:	The average cost per fire safety inspection calculated during the reporting period.
Purpose/Importance:	To track efficiencies of agency staff in conducting fire safety inspections.
Source/Collection of Data:	These costs are salary, longevity, professional fees, consumable supplies, postage, rent, telephone, utilities, travel, fuel and lubricants and other operating expenses as reported on the monthly DFAS report. The number of inspections is derived from data stored in the database system on TDI's computerized network.
Method of Calculation:	The average cost per fire safety inspection is calculated by dividing the total associated costs by the total number of inspections conducted.
Data Limitations:	NONE
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

4.1.1 EF 2	**Average Time to Complete Fire Investigations**
Short Definition:	This number represents the average number of days from the date a fire investigation is initiated until the date the fire investigation is completed.
Purpose/Importance:	To determine efficiencies of agency personnel in conducting fire investigations.
Source/Collection of Data:	A fire investigation includes all cases investigated whether the cause is "arson (incendiary)", "accidental" or "undetermined". The "average time to complete fire investigations" will be obtained by conducting a query giving the date of investigation and completion date of each investigation completed within the reporting period. Assistance to other law enforcement entities in investigating fires are not included in this measure.
Method of Calculation:	The date of investigation will be subtracted from the completion date; the number of days will then be totaled, then divided by the total investigations completed. This will reveal the average time to complete a fire investigation. A "Case" is considered initiated when a request for a fire investigation has been received and a "Case Number" has been issued. "Completed" refers to the approval of the report containing the cause and origin determination resulting from the fire investigation." The date the supervisor indicates approval of the report is the date the investigation is completed. An arson (incendiary) case, also a criminal investigation, is considered completed when referred for prosecution. Field investigators refer cases for prosecution to prosecuting agencies (federal, state, county, juvenile, etc.) and document their activities in fire investigation reports. The completion date is then entered into the FAIS in the case management system.
Data Limitations:	NONE
Calculation Type:	Non-cumulative
New Measure:	No
Desired	Lower than target

5.1.1 OC 1	**Statewide Incidence Rate of Injuries and Illnesses per 100 Full-time Employees**
Short Definition:	This measure reflects the injury and illness rate for the state of Texas as developed by the U. S. Bureau of Labor Statistics.
Purpose/Importance:	This measure, in conjunction with the National Incidence Rate of Injuries and Illnesses, provides a comparison of the Texas injury and illness rate to the National injury and illness rate.
Source/Collection of Data:	Data comes from the Annual Survey of Occupational Injuries and Illnesses, which uses a stratified sample of private sector establishments by industry and size class to develop reliable estimates of occupational injury and illness rates in Texas. This is determined by using OSHA (Occupational Safety & Health Administration) standards for record-keeping and injury reporting. Data is collected by the Division of Workers' Compensation (DWC) and is entered into terminals which are linked to the Bureau Of Labor Statistics. Rates are developed by the Bureau of Labor Statistics on a calendar year basis. The incidence rate is based on the preceding calendar year.
Method of Calculation:	The measure is calculated as (N/EH)x200,000. The numerator is the total number of recordable injuries and illnesses ("N") in the year. The denominator is the total number of hours ("EH") worked by all employees in the year. The multiplier (200,000) expresses the ratio as a rate equivalent to 100 full-time employees working 40 hour weeks 50 weeks per year, or 200,000 hours. Calculation is completed by BLS and reported result is used for performance measure.
Data Limitations:	Data is dependent on the Bureau of Labor Statistics, since BLS produces all calculations based on surveyed data collected by DWC. The performance reported on a fiscal year basis is the most recently reported incidence rate. Because the incidence rate is calculated on a calendar year basis and almost one year after the close of the calendar year, the reported performance is almost two years old (e.g., CY 2004 performance will be reported in FY 2006). Because of changes to OSHA record keeping for data collected for CY 2002 (and subsequent years), and the BLS switch from Standard Industrial Classification (SIC) codes to North American Industry Classification System (NAICS) for data collected for CY 2003 (and subsequent years), the injury rates reported in FY 2006-FY 2007 and subsequent biennia cannot be directly compared to any year prior to FY 2005.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

5.1.1 OC 2	**Percentage Change in the Injury Rate for Employers Provided Consultations and Inspection Services**
Short Definition:	This measure represents the percentage the injury rate changed in the twelve month period following the provision of a service or regulatory action when compared to the twelve month period prior to the service or regulatory action. These services or regulatory actions are provided through programs such as the OSHCON, Rejected Risk, and Accident Prevention Services (policyholder inspections), and any similar programs operated through additional federal grants. Injury rates include injuries and job related illnesses with one or more lost workdays, and are collected for both twelve month periods for comparison.
Purpose/Importance:	This measure shows the progress of employers in reducing injuries by comparing the average injury rate for the twelve months prior to the time employers receive services or regulatory actions to the average injury rate for the twelve months following the service or regulatory action.
Source/Collection of Data:	Data is documented on various worksheets and maintained in automated applications.
Method of Calculation:	Injury Rate: The injury rate is calculated by the formula (injuries / employees) *100. For the OSHCON consultations, the numerator is the number of recordable job-related injury and illness cases from OSHA 300 Log during a 12-month period. For the policyholder and Rejected Risk inspections, the numerator is the number of workers' compensation claims during a 12-month period. The denominator is the highest number of workers employed by the employer during any month during a 12-month period. An injury rate is calculated before and after the intervention. Percentage change in the injury rate: The percentage change is calculated by the formula: [(post-intervention injury rate - pre-intervention injury rate) / pre-intervention injury rate] * 100. The numerator is the difference between the post-intervention injury rate and the pre-intervention injury rate. The denominator is the pre-intervention injury rate.
Data Limitations:	None
Calculation Type:	Non-cumulative
New Measure:	Yes
Desired Performance:	Lower than target

5.1.1 OP 1	**Number of Consultations and Inspections Provided to Employers**
Short Definition:	This measure shows the number of consultations and inspections provided to employers.
Purpose/Importance:	These services or regulatory actions are provided through programs such as the OSHCON, Rejected Risk, and Accident Prevention Services (policyholder inspections), and any similar programs operated through additional federal grants.
Source/Collection of Data:	Data is maintained on automated applications.
Method of Calculation:	The measure is calculated by adding the number of consultations and inspections accomplished for the reporting period.
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than target

5.1.1 OP 2	**Number of Texas Employers Receiving Safety Educational Products/Services**
Short Definition:	This measure is the total number of Texas employers receiving safety education and training products and services and the number of academic institutions incorporating safety and health educational programs into their curriculum. Safety products include hard copies of publications; informational brochures; and verified viewing of videotapes and DVDs. Safety services include on-site needs assessments, participation in seminars, workshops, and training events. Educational curriculum includes health and safety print materials, television programs produced, lesson plans, and student activities and programs.
Purpose/Importance:	The measure reports the number of Texas employers and educational institutions receiving safety and health products and services.
Source/Collection of Data:	Data is maintained on PC automated systems and on paper documents.
Method of Calculation:	The measure is calculated by adding the number of the Texas employers and academic institutions receiving products and services during the reporting period. For the purposes of this measure, employer counts are unique (i.e., any employer who receives more than one product or service is counted only once).
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

5.1.1 OP 3	**Number of Texas Employees Receiving Safety Educational Products/Services**
Short Definition:	This measure is the total number of Texas employees receiving safety education and training products and services. Safety products include hard copies of publications; informational brochures; and verified viewing of videotapes and DVDs. Safety services include on-site needs assessments, and participation in seminars, workshops, and training events.
Purpose/Importance:	The measure reports the number of Texas employees receiving safety and health products and services.
Source/Collection of Data:	Data is maintained on PC automated systems and on paper documents.
Method of Calculation:	The measure is calculated by adding the number of Texas employees that receive informational publications, and brochures, and those who view videotapes as reported by employers requesting those publications, brochures and videos during the reporting period. Added to this is the number of Texas employees participating in on-site needs assessments, seminars, workshops, and training events.
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

5.1.1 EF 1	**Average Cost Per Consultation and Inspection**
Short Definition:	This measure shows the average cost for providing consultations and inspections. Direct costs and all indirect costs applicable to the programs are included in the total.
Purpose/Importance:	The measure provides the average costs of consultations and inspections. These services or regulatory actions are provided through programs such as the OSHCON, Rejected Risk, and Accident Prevention Services (policyholder inspections), and any similar programs operated through additional federal grants.
Source/Collection of Data:	The costs associated with providing consultation and inspection services are based upon all direct and indirect costs associated with providing those services. Direct costs include the total cost of supporting the program to perform its functions. Indirect costs are a proportionate share of TDI, DWC indirect administrative costs. The number of consultations and inspections are totaled.
Method of Calculation:	The measure is calculated by dividing the total costs associated with the consultations and inspections by the total number of consultations and inspections for the reporting period. The denominator for this measure is the output measure "Number of Consultations and Inspections" conducted during the reporting period. Expenditures are calculated by using the Financial Accounting System (General Ledger) Budget Status Detail Report and an excel spreadsheet for travel voucher expenses not yet processed. Fringe is included in figuring the costs for OSHCON consultations (federal funds) for purposes of reimbursement by the third party source. Fringe is not included in figuring the Rejected Risk and Accident Prevention Services policyholder inspections because fringe benefits are not appropriated to the agency in the appropriations bill.
Data Limitations:	Because they are specifically appropriated in the OSHCON grant, fringe benefit costs, such as OASDI/Medicare, state retirement contributions, benefit replacement pay, salary increases, and medical benefits are included in the indirect costs for the OSHCON program. The same costs for the other programs are not included.
Calculation Type:	Non-cumulative
New Measure:	Yes
Desired Performance:	Lower than target

5.2.1 OC 1	**Percent of Temporary Income Benefit (TIB)s Recipients Returning to Work Within 90 Days of Injury (Based on TIBs Duration)**
Short Definition:	This measure identifies the percentage of injured employees who received temporary income benefits and returned to work within 90 days of the date of injury.
Purpose/Importance:	The purpose of this measure is to identify the percentage of injured employees who received temporary income benefits (TIBs) and returned to work within 90 days of injury.
Source/Collection of Data:	**This data is maintained in automated databases.**
Method of Calculation:	The numerator is the total number of claims in which TIBs stopped within 90 days after the date of injury for the reporting period. The denominator is the number of claims in which TIBs were paid for the reporting period. Twelve months of data, based on the date of injury, are used in the calculation. The data is lagged three months from the reporting month.
Data Limitations:	***The date TIBs stopped is used as a proxy for return-to-work.***
Calculation Type:	Non-cumulative
New Measure:	Yes
Desired Performance:	Higher than target

5.2.1 OP 1	**Number of Persons Receiving Return-to-Work Training**
Short Definition:	This measure identifies the number of persons receiving return-to-work training provided by the Division.
Purpose/Importance:	The purpose of this measure is to identify the number of persons receiving return-to-work training products and services that will aid in returning people to the workforce who have been injured on the job. Return-to-work training provides education and information to employers and others regarding effective tools for managing disability associated with work-related illness or injuries. The training products and services include presentations, seminars, publications and on-site visits to system participants.
Source/Collection of Data:	This data is maintained in agency automated databases and paper documents.
Method of Calculation:	This measure is manually calculated by summing the number of persons that received return-to-work training products and services during the reporting period, who attended seminars and presentations, received hard copy publications, and were assisted through on-site visits.
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than target

5.2.1 OP 2	**Number of Workers' Compensation Income Benefit Recipients Referred to the Department of Assistive and Rehabilitative Services**
Short Definition:	This measure identifies the number of persons referred to the Department of Assistive & Rehabilitative Services (DARS) by the Division of Workers Compensation (DWC). The DWC refers injured employees to DARS if the injured employee is identified as meeting at least one of the criteria of rule 136.1(a), such as having or likely to have an amputation of an arm or leg, a permanent spinal cord injury, a head injury, a heart attack or heart disease, an occupational disease, etc., or are eligible to receive supplemental income benefits (Rule 130.102).
Purpose/Importance:	The purpose of this measure is to identify the number of injured employees referred to DARS for training/education to assist them in returning to the workforce.
Source/Collection of Data:	This data is maintained in automated databases.
Method of Calculation:	This measure is calculated by adding all referrals to DARS from DWC staff during the reporting period.
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than target

5.2.1 EF 1	**Average Number of Participants per Return-to-Work Seminar**
Short Definition:	This measure identifies the average number of participants per return-to-work seminar.
Purpose/Importance:	The purpose of this measure is to monitor the effectiveness and efficiency of providing return-to-work information to system participants through seminars.
Source/Collection of Data:	Data is maintained on paper documents.
Method of Calculation:	This measure is calculated by dividing the total number of return-to-work seminar participants by the total number of seminars conducted during the reporting period. The numerator is calculated by summing the number of return-to-work seminar participants that attended seminars. The denominator is calculated by summing the total number of return-to-work seminars conducted during the reporting period.
Data Limitations:	None
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

6.1.1 OC 1	**Percentage of Medical Bills Processed Timely**
Short Definition:	This measure indicates the percentage of medical bills timely processed by insurance carriers. Medical bills are to be processed within forty-five days from receipt of a complete medical bill.
Purpose/Importance:	The purpose of this measure is to indicate the timely processing of medical bills by the insurance carrier.
Source/Collection of Data:	The Division receives medical billing information used in the calculation electronically from carriers. Data is maintained in agency automated systems.
Method of Calculation:	The numerator is calculated by adding the number of medical bills processed timely for the reporting period. The denominator is the number of medical bills processed by the insurance carriers for the reporting period. Twelve months of data are used in the calculation. The data is lagged one month from the reporting period.
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than target

6.1.1 OP 1	**Number of Quality of Care Reviews of Health Care Providers, Insurance Carriers and Independent Review Organization's (IRO's) Completed**
Short Definition:	This measure indicates the number of quality of care reviews completed on health care providers, insurance carriers and independent review organizations (IRO's) during the reporting period. A quality of care review is defined as a review of clinical evaluations, recommendations, treatment decisions, and clinical outcomes relating to health care. Quality of Care reviews are conducted on health care providers who provide care or evaluations in the workers' compensation system (other than in a peer-review or utilization review capacity). Quality of Care reviews can be conducted on insurance carriers or on individual providers working at the direction of or in the employ of a carrier(s). Quality of Care reviews can be conducted on IRO's working on network and non-network disputed claims. A review uses random or non-random sample methodology or census and may be directed towards a specific entity or the system as a whole. Completion of a review is the date the final report is issued.
Purpose/Importance:	The Division is charged with monitoring the quality of healthcare in the workers' compensation system. This measure reflects one of the principle methods by which the Division fulfills this requirement.
Source/Collection of Data:	Information is entered and maintained in a database.
Method of Calculation:	This measure is calculated by adding the number of final reports issued during the reporting period for all quality of care reviews conducted on health care providers, insurance carriers and IROs.
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than target

6.1.1 OP 2	**Number of System Participants Who Received Medical Benefit Training**
Short Definition:	This measure identifies the number of verified system participants that receive medical benefit training. Types of training include seminars, hard copy training publications, and web-based training providing up-to-date information regarding medical issues in workers' compensation such as preauthorization, impairment rating, and medical dispute resolution, etc.
Purpose/Importance:	The purpose of this measure is to identify the number of system participants who receive training on medical issues. It is assumed that people who have current information and understanding of processes will have fewer problems and questions.
Source/Collection of Data:	Data are maintained in agency automated systems, manual logs of publications sold, and paper attendance roster documents.
Method of Calculation:	This measure is manually calculated by summing the number of certificates issued to and confirmations/evaluations received from system participants that have received medical benefit web-based training or purchased a hard copy training publication, and the number of system participants that attended a seminar during the reporting period. A certificate is only issued to system participants who have completed the entire web-based training, and a confirmation/evaluation is only received from system participants who have taken web-based training or purchased a hard copy training publication.
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

6.1.1 EF 1	**Average Number of Days to Complete Quality of Care Reviews of Health Care Providers, Insurance Carriers, and Independent Review Organizations**
Short Definition:	This measure is defined as the average number of days to complete a quality of care review of a health care providers, insurance carriers and independent review organizations (IRO's).
Purpose/Importance:	This indicates the efficiency of the quality of care review process by measuring the length of time for a quality of care review to be completed.
Source/Collection of Data:	Information is entered and maintained in a database.
Method of Calculation:	This measure is calculated by dividing total days by reviews completed. The numerator is the total number of days to complete all reviews whose final report was issued during the reporting period. The denominator is the number of reviews completed during the reporting period. Total days for a review, includes the time between the start of the record review and the issuance of the final report.
Data Limitations:	None
Calculation Type:	Non-cumulative
New Measure:	Yes
Desired Performance:	Lower than target

6.2.1 OC 1	**Dollar Amount Returned to Workers' Compensation System Participants Through Complaint Resolution**
Short Definition:	This measure indicates the dollar amount returned to system participants due to non-compliance with the Texas Labor Code or Division Rules as a result of complaint resolution by the Compliance and Regulation program area of the Division of Workers' Compensation. Dollar amounts are the amount above what was originally offered to the participant before Compliance and Regulation intervention.
Purpose/Importance:	The purpose of this measure is to track the success of the Division's intervention in resolving issues regarding compliance.
Source/Collection of Data:	The data is entered and maintained in a Compliance and Regulation database.
Method of Calculation:	The sum of the dollar amount remitted to system participant(s) as a result of a complaint resolved during the reporting period by the Compliance and Regulation program area of the Division.
Data Limitations:	Complaints included in this measure are received, tracked, and resolved by the Compliance and Regulation program of the Division of Workers' Compensation. Complaints received and resolved through other program areas are not included in this measure.
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than target

6.2.1 OC 2	**Average Number of Days for the Required Initial Benefit Payment to be Issued after Benefits Begin to Accrue**
Short Definition:	This measure indicates the average number of days from the eighth day of disability (i.e., the benefit eligibility/accrual date) to the date the required initial temporary income benefit (TIBs) payment is issued to injured workers.
Purpose/Importance:	This measure provides an indication of the length of time for the initial temporary income benefit payments to be issued once a worker is eligible for temporary income benefits.
Source/Collection of Data:	The information used in this calculation is received by the DWC either via paper DWC Form-1 or DWC Form-21 form or electronically from the EDI I48 or A49. Paper documents submitted by the carriers are data entered by DWC staff. EDI information is submitted electronically by the carriers and DWC only transfers the data electronically to the automated system. Data is maintained in agency automated systems.
Method of Calculation:	The numerator is calculated by adding the number of days from the eighth day of disability to the date the required initial temporary income benefit payment is issued for the reporting period. The denominator is the total number of eligible indemnity claims for the reporting period. Twelve months of data, based on the date of injury, are used in the calculation. The data is lagged one month from the reporting month.
Data Limitations:	DWC does not capture the accrual date. "A1from" field captured through EDI A49 or the DWC Form-21, which is the first day of the benefit period, is used as a proxy accrual date. This measure is dependent on the provision of accurate data being submitted by insurance carriers.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

6.2.1 OC 3	**Percentage of First Benefit Payment Timely Made by Insurance Carriers**
Short Definition:	This measure indicates the timely initiation of temporary income benefit payments to injured workers by insurance carriers. Insurance carriers are allowed fifteen days from the notice of injury to initiate payment or dispute benefits. Benefits are to be delivered to the injured worker within seven days of the eighth day of disability (the benefit eligibility date).
Purpose/Importance:	The purpose of this measure is to indicate whether the insurance carriers timely initiated temporary income benefit payments.
Source/Collection of Data:	The information used in the calculation is received by the Division either via paper DWC Form-1 or DWC Form-21 forms or electronically from the EDI 148 or A49. Paper documents submitted by the carriers are data entered or imaged by Division staff. EDI information is submitted electronically by the carriers and the Division only transfers the data electronically to the Division's automated system. Data is maintained in agency automated systems.
Method of Calculation:	The numerator is calculated by adding the number of initial temporary income benefits payments made timely for the reporting period. The denominator is the total number of eligible paid indemnity claims in the period for the reporting period. Twelve months of data are used in the calculation. The data is lagged one month from the reporting period.
Data Limitations:	The Division does not capture the date that benefits begin to accrue or the eighth day of disability. The Division uses the "A1from" field captured through EDI A49 or the DWC Form-21, which is the first day of the benefit period, as a proxy accrual date. This measure is dependent on the provision of accurate data being submitted by insurance carriers.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

6.2.1 OP 1	**Number of Complaints Completed Involving Workers' Compensation System Participants**
Short Definition:	This measure indicates the number of complaints completed involving workers' compensation system participants. A complaint is defined as a case review of a specific allegation of a violation of the statute or rules received from internal or external sources. Included in this measure are reviews completed as part of administrative fraud investigations. A completed review is defined as when enforcement action is taken or when enforcement action is deemed not warranted based on facts or available evidence.
Purpose/Importance:	The Division is charged with monitoring system participants for compliance with the statute and rules. The Division receives complaints from the public. This measure indicates the number of these complaints completed.
Source/Collection of Data:	Information is entered and maintained in agency automated systems.
Method of Calculation:	This measure is calculated by adding the number of complaints completed in the reporting period.
Data Limitations:	This measure only includes complaints pertaining to the workers' compensation system and only those filed as an allegation of a violation of the statute and/or rules.
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than target

6.2.1 OP 2	**Number of Performance Reviews Completed**
Short Definition:	This measure indicates the number of performance reviews conducted involving workers' compensation records and claim files. A performance review is defined as a review of the compliance of one or more duties specified by statute or rule. A review uses random or non-random sample methodology or census and may be directed towards a specific entity or the system as a whole. Completion of a performance review is the date the final report is issued.
Purpose/Importance:	The Division is charged with monitoring and reviewing the records of insurance carriers, employers, health care providers, and other system participants. This measure provides the number of performance reviews completed involving these system participants.
Source/Collection of Data:	Information is entered and maintained in an audit database.
Method of Calculation:	This measure is calculated by adding the number of performance reviews conducted with a final report issued during the reporting period.
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

6.2.1 EF 1	**Average Days to Complete a Complaint Involving Workers' Compensation System Participants**
Short Definition:	This measure indicates the efficiency of the workers' compensation complaint process.
Purpose/Importance:	The purpose of this measure is to indicate the length of time for a workers' compensation complaint to be completed.
Source/Collection of Data:	Information is entered and maintained in agency automated systems.
Method of Calculation:	The numerator is calculated by adding the number of days from receipt of the complaint to the conclusion of the complaint during the reporting period. The denominator is the total "Number of Complaints Involving Workers' Compensation System Participants" during the reporting period.
Data Limitations:	This measure only includes the average days to complete complaints pertaining to the workers' compensation system and only those filed as an allegation of a violation of the statute and/or rules.
Calculation Type:	Non-cumulative
New Measure:	Yes
Desired Performance:	Lower than target

6.2.1 EF 2	**Average Number of Days to Complete a Performance Review**
Short Definition:	This measure indicates the efficiency of the performance review process.
Purpose/Importance:	The purpose of this measure is to indicate the length of time for a performance review to be completed.
Source/Collection of Data:	Information is entered and maintained in a performance review database.
Method of Calculation:	The numerator is calculated by totaling the number of days between the start of the record reviews to issuance of the final performance review reports during the reporting period. The denominator is the "Number of Performance Reviews Completed" during the reporting period.
Data Limitations:	None.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

6.2.1 EX 1	**Total Number of Administrative Remedies Issued for Violations**
Short Definition:	This measure indicates the total number of violation notices and warning and education letters issued by the Divisions' Compliance and Regulation program for administrative violations, including violation notices and warnings issued resulting from fraud investigations.
Purpose/Importance:	The purpose of this measure is to address the extent to which the outcome of complaint reviews (including referrals resulting from data mining) and performance reviews resulted in the issuance of notices of administrative violation and warnings and education letters due to non-compliance with the statute and/or rules.
Source/Collection of Data:	Information is entered and maintained in agency automated systems.
Method of Calculation:	This measure is calculated by adding the number of violation notices and warnings letters issued during the reporting month. The number of violation notices withdrawn during the reporting month is subtracted from the number of violation notices and warning letters issued for the reporting month irrespective of the month in which they were originally issued. Therefore, it may be possible for a negative number to be reported as the number of violation notices and warnings and education letters issued for the month.
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than target

6.3.1 OC 1	**Percentage of Documents Received and Maintained Electronically by the Division**
Short Definition:	This measure reflects the percent of high volume forms that are eligible for electronic submission, excluding medical payments that are received by the Division electronically.
Purpose/Importance:	The purpose of the measure is to monitor the agency's efforts in maintaining injury information electronically rather than on paper. This is consistent with direction provided by the Legislature.
Source/Collection of Data:	Documents are received from insurance carriers, employers, employees, health care providers, and other participants in the workers' compensation system. Data are maintained in agency automated systems.
Method of Calculation:	The numerator is the number of eligible documents received or maintained electronically for the reporting period. The denominator is the total number of high volume documents eligible for electronic transmission (148, A49, DWC Form-1, 5, 20, 21, 32, 45, 60, 69, 81-84, and 152) for the reporting period. Eligible documents are identified based upon the agency's ability to receive the records electronically. For projection purposes, the documents eligible for electronic transmission are the following: DWC Form -1 (initial report of injury), DWC Form -21 (subsequent report of injury), DWC Form -32 (Request for Designated Doctor), DWC Form -45 (Request for a Benefit Review Conference), DWC Form -60 (Medical Dispute Resolution Request), DWC Form -69 (Report of Medical Evaluation), DWC Form -5, DWC Form -20, and DWC Form -81-84 (insurance coverage documents), and DWC Form -152 (attorney fee application).
Data Limitations:	Data is limited by parties that do not report injury information electronically, and therefore, can not be counted in the measure.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Higher than target

6.3.1 OP 1	**Number of Documents Received and Maintained Electronically by the Division**
Short Definition:	This measure reflects the number of high volume forms, excluding medical payments that are received by the Division electronically.
Purpose/Importance:	The purpose of the measure is to monitor the agency's efforts in maintaining injury information electronically rather than on paper.
Source/Collection of Data:	Documents are received from insurance carriers, employers, employees and healthcare providers, and other participants in the workers' compensation system. Data is maintained in agency automated systems.
Method of Calculation:	This measure is calculated by adding all high volume documents received or maintained electronically for the reporting period. For projection purposes, the documents eligible for electronic transmission are the following: DWC Form-1 (initial report of injury), DWC Form -21 (subsequent report of injury), DWC Form -32 (Request for Designated Doctor), DWC Form -45 (Request for a Benefit Review Conference), DWC Form -60 (Medical Dispute Resolution Request), DWC Form -69 (Report of Medical Evaluation), DWC Form -5, DWC Form -20, and DWC Form -81-84 (insurance coverage documents), and DWC Form -152 (attorney fee application).
Data Limitations:	Data is limited by external parties that do not report injury information electronically, therefore can not be counted in the measure.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Higher than target

6.3.1 OP 2	**Number of Reportable Injury Records Created**
Short Definition:	This measure includes all injury records created based on a report of injury resulting in one day or greater of lost time, occupational diseases and fatalities.
Purpose/Importance:	The purpose of this measure is to reflect the number of injuries/illnesses required to be reported to the Division during a reporting period (409.005, Labor Code).
Source/Collection of Data:	Reports of injury are received from insurance carriers, employees, and healthcare providers. This measure applies only to injuries which occurred on or after January 1, 1991, for which claims were established in the current year. Data are maintained in agency automated systems.
Method of Calculation:	The measure is calculated by adding the total number of indemnity injury records created and the total number of reportable injury records created during the reporting period. An indemnity injury record is created for cases in which the injury resulted in: benefit payments being paid. A reportable injury record is created for cases in which the injury resulted in one day or greater lost time, occupational diseases, and fatalities. If a reportable injury has resulted in benefit payments, it is counted as an indemnity injury record.
Data Limitations:	This measure does not necessarily reflect the number of injuries occurring in a given year. The measure represents records created based on reports of injury, and an injury may be reported in a different year from the year of injury. Prior to September 2004, all injury records created were included in this measure regardless of whether one day of lost time or income benefits were paid. Since that time, the measure only includes injury records for which there is at least one day of lost time, income benefits have been paid, occupational diseases, and fatalities.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Lower than target

6.3.1 OP 3	**Number of Injury Records in Which Indemnity Benefits Are Initiated**
Short Definition:	This measure is the total number of injury records in which indemnity benefits are initiated.
Purpose/Importance:	The purpose of this measure is to reflect the number of indemnity payments initiated during the reporting period.
Source/Collection of Data:	Reports of indemnity payments initiated are received from insurance carriers. This measure applies only to injuries, which occurred on or after January 1, 1991. Data is maintained in agency automated systems.
Method of Calculation:	This measure is calculated by adding the number of records in which indemnity payments are initiated during the reporting period. Data is lagged one month from the reporting period since carriers are required to report payments to the Division within 7 days of the payment.
Data Limitations:	This measure is dependent on receiving information from the carrier in a timely manner.
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Lower than target

6.3.1 OP 4	**Number of Workers' Compensation Educational Publications Provided to System Participants in an Electronic Format**
Short Definition:	This measure reflects the number of system participants that receive workers' compensation information on their rights and responsibilities (102.021(b)(8), Labor Code) and educational efforts relating to workplace safety, return-to-work, and health care provider issues in an electronic format.
Purpose/Importance:	The purpose of this measure is to monitor the Division's efforts to provide educational material to system participants.
Source/Collection of Data:	Employee and Employer Rights and Responsibilities, fact sheets, medical benefit, safety, and return-to-work publications are available on the Division's web site. The number of hits to the documents is obtained from logs generated by the web server. Data on email newsletters is obtained from Mailloop activity logs that track email distribution. Electronic publications sent as email attachments by Resource Center staff are logged in electronic files.
Method of Calculation:	The sum of the number of: (1) hits on the Employee and Employer Rights and Responsibilities, fact sheets, newsletters, medical benefit, safety, and return-to-work publications on the website; (2) email newsletters distributed; and (3) publications sent as email attachments for the reporting period.
Data Limitations:	The count of the number of hits cannot accurately reflect the extent of public use of the information once it is distributed; however, it is assumed that people who have current information and understanding of processes will have fewer problems and questions.
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than target

6.3.1 EF 1	**Average Number of Days to Create Reportable Injury Records**
Short Definition:	This measure calculates the average number of days to create records for injuries required to be reported (409.005, Labor Code) to the Division.
Purpose/Importance:	This measure represents the average number of elapsed business days between receipt date of DWC forms that create an injury record and the date the injury record is created. The measure is an indicator of customer service and workers' compensation system performance.
Source/Collection of Data:	Reports of injury are received from insurance carriers, employees, and healthcare providers. This measure includes all injury records created resulting in one day or greater of lost time, occupational diseases and fatalities (reportable injuries), and injury records created in which the injury resulted in benefit payments being paid (indemnity records). This measure applies only to injuries, which occurred on or after January 1, 1991, for which claims were established in the current year. The date of the receipt of the form is determined by the date stamp affixed to the forms by the Division of Workers' Compensation (DWC) central office mail room or by each DWC field office. The date received generated by facsimiles will be used in place of date stamps. Records submitted via Electronic Data Interchange (EDI) will have the date received electronically recorded by the DWC automated data system. Data are maintained in agency automated systems.
Method of Calculation:	The numerator is the total number of days to create reportable injury and indemnity records for the reporting period. The denominator is the total number of reportable injury and indemnity records created for the reporting period.
Data Limitations:	Prior to September 2004, all injury records created were included in this measure regardless of whether one day of lost time or income benefits were paid. Since that time, the measure only includes injury records for which there is at least one day of lost time, income benefits have been paid, occupational diseases, and fatalities.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

6.4.1 OC 1	**Percentage of Market Share of Certified Self-Insurance to the Total Workers' Compensation Insurance Market**
Short Definition:	This measure indicates certified self-insured employers' market share of the total workers' compensation insurance market.
Purpose/Importance:	This measure serves as a reflection of changes in the workers' compensation insurance market. The portion of the market share represented by certified self-insured is related to the cost and availability of workers' compensation insurance in the commercial market. Self-insurance provides an alternative to purchasing commercial insurance for qualifying companies, and the program acts to moderate insurance rates in a competitive insurance market.
Source/Collection of Data:	Data on estimated manual premiums for certified self-insurers is maintained by the Division of Workers' Compensation (DWC) in spreadsheets. Data reflecting the total workers' compensation insurance market is maintained and reported by the Texas Department of Insurance in its *Quarterly Legislative Report on Market Conditions*.
Method of Calculation:	The numerator is the total amount of statutorily estimated manual premium as maintained by the Division for active certified self-insurers for the reporting period. The denominator is the direct written premiums for the voluntary workers' compensation market as published quarterly by the Texas Department of Insurance for the reporting period.
Data Limitations:	The measure excludes public self-insured entities from the amount used to represent the total workers' compensation insurance market. Data for those entities is not collected and maintained regarding the estimated premiums attributable to them.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

6.4.1 OP 1	**Number of Active Certified Self-Insured Employers**
Short Definition:	The measure represents the number of current self-insured employers in the reporting period.
Purpose/Importance:	The measure reports certification activity for initial and renewal applicants and their subsidiaries.
Source/Collection of Data:	The DWC's Self-Insurance Regulation maintains the data in spreadsheets.
Method of Calculation:	This measure is calculated by adding the number of current companies and their subsidiaries certified to self-insure as of the reporting period.
Data Limitations:	The measure reports only certification activity and does not reflect work related to applicants that withdraw or are rejected. In the self-insurance program, certificates of authority are issued at the parent level of the applicant's corporate structure in order to minimize unnecessary duplication of effort and to streamline the application and renewal process. Depending upon an applicant's corporate structure, a certificate of authority may cover one company or a parent with many subsidiaries.
Calculation Type:	Non-cumulative
New Measure:	Yes
Desired Performance:	Higher than target

6.4.1 EF 1	**Average Cost per Certified Self-Insured Certificate Holder**
Short Definition:	This measure indicates the average cost per active certified company holding the certificate of authority in the self-insurance program. Direct costs and all indirect costs applicable to the program are included in the total cost.
Purpose/Importance:	The measure provides an average cost to regulate an active company in the program. It is important to note that all costs for the self-insurance program are billed to and are paid by the companies that participate in the self-insurance program through the Self-Insurance Regulatory Fee. The proceeds of the Regulatory Fee are deposited with the Comptrollers' office as un-appropriated funds.
Source/Collection of Data:	The costs included in the Regulatory Fee are based upon all direct and indirect costs associated with the program in order for the state to fully recover any costs expended on this program. Indirect costs include a proportionate program share of DWC indirect administrative costs and matching payroll and retirement costs such as OASDI/Medicare, state retirement contribution, state insurance contribution, Benefit Replacement Pay, and salary increases. For consistency purposes, the same methodology used to determine the Regulatory Fee is used to determine costs for reporting this average cost measure. Cost figures used in determining the average cost are based on accounting system.
Method of Calculation:	The numerator is the total cost associated with administering the self-insurance program for the reporting period. The denominator is the number of current certified self-insurer certificate holders. The number used for the denominator is the amount of active certifications issued and subtracting any withdrawals made after certification for the reporting.
Data Limitations:	In the self-insurance program, certificates of authority are issued at the parent level of the applicant's corporate structure in order to minimize unnecessary duplication of effort and to streamline the application and renewal process. Depending upon an applicant's corporate structure, a certificate of authority may cover one company or a parent with many subsidiaries.
Calculation Type:	Non-cumulative
New Measure:	Yes
Desired Performance:	Lower than target

6.5.1 OC 1	**Percentage of Indemnity Disputes Resolved Prior to a Benefit Review Conference**
Short Definition:	The measure reflects the percentage of indemnity disputes resolved prior to a Benefit Review Conference. A dispute is considered resolved when it will not advance to dispute resolution proceedings. Disputes considered "resolved prior to a BRC" include disputes in which: the parties reach an agreement; or, due to the dispute, a designated doctor appointment is set.
Purpose/Importance:	The purpose of this measure is to monitor the Division's effectiveness in resolving disputes at the lowest level prior to benefit dispute proceedings. Indemnity disputes are identified by Division staff in communication with unrepresented claimants or by a party filing a "request for a BRC." Each dispute may consist of up to 6 issues. Issues include coverage, compensability, average weekly wage, disability, impairment rating, and maximum medical improvement, etc.
Source/Collection of Data:	Disputes are identified and are resolved by Claims Services staff within 19 days of receiving the dispute or a BRC was set to be held, but was resolved prior to holding the proceeding. Data are entered and maintained in agency automated applications.
Method of Calculation:	The numerator (Total Number of Indemnity Disputes Resolved Prior to a BRC) is calculated by adding the number of indemnity disputes in which the parties reach an agreement; or, due to the dispute, a designated doctor appointment is set during the reporting period. The denominator (Total Number of Indemnity Disputes Concluded) is calculated in the following way: The number of indemnity disputes resolved prior to a Benefit Review Conference (BRC) plus the number of indemnity disputes concluded in BRCs during the reporting period.
Data Limitations:	Indemnity disputes denied by the Division because the parties are not ready to proceed and indemnity disputes withdrawn before agreement is reached or a determination is made to proceed to BRC are not included in this measure. Disputes over recommendations for spinal surgery, and legal expenses associated with a dispute are set for a CCH, and bypass the BRC proceeding level and are not included in the denominator.
Calculation Type:	Non-cumulative
New Measure:	Yes
Desired Performance:	Higher than target

6.5.1 OC 2	**Percentage of Indemnity Disputes Resolved in Dispute Resolution Proceedings**
Short Definition:	This measure reflects the percent of indemnity disputes resolved in dispute resolution proceedings. This measure involves indemnity disputes resolved at Benefit Review Conferences (BRCs), Contested Case Hearings (CCHs) and through appeals panel decisions. Indemnity disputes are identified by Division staff in communication with unrepresented claimants or by a party filing a "request for a BRC." Each dispute may consist of up to 6 issues. Issues include coverage, compensability, average weekly wage, disability, impairment rating, maximum medical improvement. An indemnity dispute is considered resolved when it is not appealed for judicial review.
Purpose/Importance:	The purpose of this measure is to monitor the Division's effectiveness in resolving disputes relating to indemnity issues in the dispute resolution system.
Source/Collection of Data:	Data is maintained in agency automated applications.
Method of Calculation:	The numerator is calculated in the following way: The sum of indemnity disputes resolved at a BRC, CCH and at Appeal, which is calculated as the number of concluded BRCs minus the number of requests for judicial review during the reporting period. The denominator (Total Number of Indemnity Disputes Concluded) is calculated in the following way: The number of indemnity disputes resolved prior to a Benefit Review Conference (BRC) plus the number of indemnity disputes concluded in BRCs during the reporting period.
Data Limitations:	This measure estimates resolution rates rather than tracking each dispute to conclusion. Disputes denied by the Division because the parties are not ready to proceed and disputes withdrawn before agreement is reached or a determination is made to proceed to BRC are not included in this measure. Disputes over recommendations for spinal surgery, and legal expenses associated with a dispute are set for a CCH, and bypass the BRC proceeding level and are not included in the denominator.
Calculation Type:	Non-cumulative
New Measure:	Yes
Desired Performance:	Lower than target

6.5.1 OC 3	**Average Number of Days to Resolve Indemnity Disputes Through Dispute Resolution Proceedings**
Short Definition:	This measure shows the average time to conclude disputes through the Division's dispute resolution processes (Benefit Review Conference, Contested Case Hearing and Appeal).
Purpose/Importance:	Disputes are resolved at various levels, some are quickly resolved and some may go through the highest levels of resolution. This measure gives an accurate indication of the average time to resolve all disputes regardless of the level reached.
Source/Collection of Data:	Data is maintained in agency automated applications.
Method of Calculation:	The numerator is calculated by adding the days between the first notification of a dispute and the conclusion of the highest level of resolution for each dispute resolved during the reporting period. The final conclusion date may be the date the parties last met in a proceeding if the dispute is withdrawn or the parties reach an agreement; or the date the decision and order or appeals panel determination is mailed to the parties. The highest level of dispute resolution is determined by the point at which no further appeal was pursued to conclusion. The denominator is the total number of indemnity disputes concluded in the dispute resolution process during the reporting period, which is the Number of Indemnity Disputes Concluded in BRCs.
Data Limitations:	Disputes denied by the Division because the parties are not ready to proceed and disputes withdrawn before agreement is reached or a determination is made to proceed to BRC are not included in this measure.
Calculation Type:	Non-cumulative
New Measure:	Yes
Desired Performance:	Lower than target

6.5.1 OC 4	**Percentage of Medical Fee Disputes Resolved by Agency Decision**
Short Definition:	This measure reflects the percentage of medical fee disputes resolved by agency decision. Medical fee dispute decisions are issued when the dispute is reviewed and results in a decision. A decision is defined as the document used to formally communicate to disputing parties the outcome that may or may not require additional reimbursement for medical services. The measure does not include medical fee disputes (1) that are withdrawn by the parties, or (2) for which a determination is made that the Division does not have jurisdiction to resolve the dispute prior to being assigned to a Medical Dispute Resolution Officer for review.
Purpose/Importance:	The purpose of this measure is to monitor the Division's efforts in resolving medical fee disputes.
Source/Collection of Data:	Data is maintained in agency automated systems.
Method of Calculation:	The numerator is calculated by subtracting the number of medical fee disputes that are appealed to district court from the total number of medical fee disputes concluded during the reporting period. The denominator is the total number of medical fee disputes for which a decision is issued during the reporting period. Concluded disputes are defined as disputes in which a decision has been made.
Data Limitations:	The Division receives copies of petitions for judicial review; however, since there is no penalty for not sending a copy of the petition to the agency, even though it is required by law, some plaintiffs may not send one. The Division has no way of verifying that all appeals to district court have been filed with the Division.
Calculation Type:	Non-cumulative
New Measure:	Yes
Desired Performance:	Higher than target

6.5.1 OP 1	**Number of Indemnity Disputes Concluded in Benefit Review Conference**
Short Definition:	This measure reflects the number of indemnity disputes concluded in a benefit review conference (BRC) whereby the dispute is resolved or is referred to the next level of dispute resolution. Disputes are considered resolved when the parties: withdraw the dispute; reach an agreement; or do not pursue the dispute within 90 days of ending the BRC session.
Purpose/Importance:	The measure indicates the number of BRCs that are actually held and concluded for the purpose of resolving indemnity disputes that have been identified but not resolved by more informal means.
Source/Collection of Data:	Data is reported in the agency automated applications.
Method of Calculation:	The measure is calculated by adding the number of indemnity disputes resolved at BRC and the number of disputes referred to the next level of dispute resolution during the reporting period.
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Lower than target

6.5.1 OP 2	**Number of Indemnity Disputes Concluded in Contested Case Hearings**
Short Definition:	The measure is the number of indemnity contested case hearings (CCHs) held and concluded whereby a decision is rendered.
Purpose/Importance:	The measure indicates the number of CCHs that are actually held and concluded because an indemnity dispute has not been resolved by more informal means.
Source/Collection of Data:	Data is reported in the Division automated applications.
Method of Calculation:	The measure is calculated by adding the number of CCHs held and concluded in the reporting period.
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Lower than target

6.5.1 OP 3	**Number of Medical Fee Disputes Resolved Prior to a Decision**
Short Definition:	This measure represents the number of medical fee disputes resolved prior to a decision. Medical fee disputes are resolved prior to a decision when the dispute is withdrawn by the requestor.
Purpose/Importance:	The purpose of this measure is to monitor the agency's effectiveness in resolving medical fee disputes prior to a decision, which is the lowest possible level.
Source/Collection of Data:	Data is maintained in agency automated systems.
Method of Calculation:	The number is calculated by adding the number of medical fee disputes that are withdrawn by the requestor during the reporting period.
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than target

6.5.1 OP 4	**Number of Medical Fee Dispute Decisions Issued**
Short Definition:	This measure represents the number of medical fee dispute decisions issued. Medical fee dispute decisions are issued when the dispute is reviewed and results in a decision. A decision is defined as the document used to formally communicate to disputing parties the outcome that may or may not require additional reimbursement for medical services.
Purpose/Importance:	The purpose of this measure is to monitor the agency's effectiveness in resolving medical fee disputes.
Source/Collection of Data:	Data is maintained in agency automated systems.
Method of Calculation:	The number is calculated by adding the number of medical fee dispute decisions that are issued during the reporting period. The measure does not include medical fee disputes (1) that are withdrawn by the parties, or (2) for which a determination is made that the Division does not have jurisdiction to resolve the dispute prior to being assigned to a Medical Dispute Resolution Officer for review.
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Higher than target

6.5.1 EF 1	**Average Number of Days From the Request for Benefit Review Conference to the Conclusion of the Benefit Review Conference**
Short Definition:	This measure reflects the average number of days from the request for a BRC to its conclusion. A BRC is considered concluded when either resolution results or a report refers the dispute to the next level of dispute resolution (CCH). Disputes are considered "resolved at a BRC" when the parties: withdraw the dispute; reach an agreement; or do not pursue the dispute within 90 days of ending a BRC session.
Purpose/Importance:	The purpose of this measure is to monitor the efficiency of the BRC process.
Source/Collection of Data:	Data is maintained in agency automated applications.
Method of Calculation:	The numerator is calculated by adding the total number of days from the BRC request date to the date the BRC is concluded during the reporting period. The denominator is the Number of Indemnity Disputes Concluded in BRCs during the reporting period.
Data Limitations:	None
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

6.5.1 EF 2	**Average Number of Days From the Request for a Contested Case Hearing to the Distribution of the Decision**
Short Definition:	The measure reflects the average number of days from the request for a CCH to the distribution of the decision.
Purpose/Importance:	The purpose of this measure is to monitor the efficiency of the Contested Case Hearing (CCH) process.
Source/Collection of Data:	Data is maintained in agency automated applications.
Method of Calculation:	The numerator is calculated by adding the total number of days between the CCH request date to the date the CCH decision is distributed during the reporting period. The denominator is Number of Indemnity Disputes Concluded in CCHs during the reporting period.
Data Limitations:	None
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than target

6.5.1 EF 3	**Average Number of Days from Receipt of the Medical Fee Dispute to Date Decision Issued**
Short Definition:	This measure represents the average days from receipt of the fee dispute to the date the decision is issued. Medical fee dispute decisions are issued when the dispute is reviewed and results in a decision. A decision is defined as the document used to formally communicate to disputing parties the outcome that may or may not require additional reimbursement for medical services. Fee disputes identified as non-jurisdictional, upon receipt of the dispute, prior to review by a MDRO, and disputes withdrawn are not included in this measure.
Purpose/Importance:	The purpose of this measure is to indicate the length of time for a medical fee dispute decision to be issued. Medical fee dispute decisions are issued when the dispute is reviewed and results in a Findings and Decision.
Source/Collection of Data:	Data is maintained in agency automated systems.
Method of Calculation:	The numerator is calculated by adding the cumulative number of the days from receipt of the medical fee dispute to the date the decision is issued within the reporting period. The denominator is calculated by adding the total number of medical fee dispute decisions issued within the reporting period.
Data Limitations:	For medical fee disputes, the respondent has 14 days to respond to the request for medical dispute resolution. After the respondent provides a response to the initial request, both parties are then provided with an additional 14 days to submit all documentation necessary to resolve the fee issues.
Calculation Type:	Non-Cumulative
New Measure:	Yes
Desired Performance:	Lower than target

6.5.1 EX 1	**Number of Indemnity Disputes Received by the Division**
Short Definition:	This is a measure of the number of indemnity disputes received during a reporting period. Indemnity disputes are identified by the Division staff in communication with unrepresented claimants or by a party filing a "request for a BRC." Each dispute may consist of up to 6 issues. Issues include issues such as coverage, compensability, average weekly wage, disability, impairment rating, maximum medical improvement, disputes over recommendations for spinal surgery, and legal expenses associated with a dispute.
Purpose/Importance:	This measure reflects whether the volume of indemnity disputes is increasing, decreasing, or remaining constant.
Source/Collection of Data:	The data is maintained in agency automated applications.
Method of Calculation:	The measure is calculated by adding the number of indemnity disputes received and identified in the Dispute Resolution Information System during the reporting period.
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Lower than target

6.5.1 EX 2	**Number of Medical Fee Disputes Received by the Division**
Short Definition:	This measure reflects the number of requests for medical fee dispute resolution received during the reporting period. Medical fee disputes are considered received when a written request is entered into the system. All requests for medical disputes are included in this measure, including valid medical fee disputes and disputes identified as non-jurisdictional.
Purpose/Importance:	This measure provides a reflection of changing trends in the volume of requests for medical dispute resolution received by the Division.
Source/Collection of Data:	The data are maintained in the agency automated systems.
Method of Calculation:	The measure is calculated by adding the total number of requests for medical fee dispute resolution received by the Division during the reporting period.
Data Limitations:	None
Calculation Type:	Cumulative
New Measure:	Yes
Desired Performance:	Lower than target

6.6.1 OC 1	**Total Payments Made Out of the Subsequent Injury Fund For Lifetime Income Benefits and Reimbursements to Insurance Carriers**
Short Definition:	This measure represents Subsequent Injury Fund (SIF) payments to injured workers eligible for lifetime income benefits (LIBs) and reimbursements to insurance carriers for benefits that have been paid but have been determined to be reimbursable by the SIF.
Purpose/Importance:	This measure reflects the obligations of the SIF in making payments to injured workers and to insurance carriers and in monitoring the SIF's financial status to meet those obligations.
Source/Collection of Data:	SIF data is collected and maintained in the agency accounting system.
Method of Calculation:	The measure is calculated by summing the payments made by the SIF: 1) to injured workers for LIBs, and 2) to insurance carriers for benefits that have determined to be reimbursable by the SIF administrator in accordance with the Workers' Compensation Act and Rules during the reporting period.
Data Limitations:	Requests for reimbursement for benefits that have been paid as a result of a Division order or decision that has been reversed or modified are paid the quarter following the quarter in which the requests were received. All requests for reimbursement for benefits paid as a result of multiple employment or pharmaceuticals for the first seven days after an injury are reimbursed in the fiscal year following the year in which the requests were received by the SIF. The measure does not include payments made from the SIF for reimbursing death benefits prematurely paid to the SIF by insurance carriers.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Lower than projected

6.6.1 OP 1	**Number of Injured Workers Receiving Lifetime Income Benefit (LIBs) Payments Through the SIF**
Short Definition:	This measure tracks the number of injured workers who meet the eligibility requirements set by statute for lifetime income benefits and are receiving payment of those benefits through the Subsequent Injury Fund.
Purpose/Importance:	The purpose of this measure is to identify the long-term obligations of the SIF because these benefits must be paid for the life of the injured worker. SIF is statutorily obligated to pay LIBs to injured workers who sustain a subsequent compensable injury that, with the effects of a previous injury, results in eligibility of LIBs.
Source/Collection of Data:	SIF data is collected and maintained in the agency's accounting system.
Method of Calculation:	The measure is calculated by summing the number of injured workers receiving LIBs payments from the SIF during the reporting period.
Data Limitations:	Attorneys, spouses, or children receiving a portion of a LIBs payment are not included in the measure.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than projected

6.6.1 OP 2	**Number of Requests for Reimbursement for Overpayment of Benefits Processed**
Short Definition:	This measure tracks the number of determinations made by the SIF on completed requests received from insurance carriers for reimbursement of benefits that they have paid as a result of a Division order or decision that has been reversed or modified by a subsequent order or decision by the Division or a court.
Purpose/Importance:	The SIF is statutorily obligated to reimburse insurance carriers who have paid benefits based on a Division order or decision that is ultimately reversed or modified by a subsequent order or decision.
Source/Collection of Data:	SIF data is collected and maintained in the SIF database.
Method of Calculation:	The measure is calculated by summing the number of reimbursement requests reviewed for which a determination is issued during the reporting period.
Data Limitations:	Incomplete requests for reimbursement are not included in this measure.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Lower then projected

6.6.1 OP 3	**Number of Requests Filed for Reimbursement of Multiple Employment Benefits Paid**
Short Definition:	The measure reflects the number of requests the SIF receives from insurance carriers for the reimbursement of benefits paid to injured workers who held multiple jobs prior to their injury.
Purpose/Importance:	Reimbursement of the portion of income benefits paid by insurance carriers to injured workers for lost income from a job other than the one at which the injury occurred was added to the SIF's obligations during the 77th Legislative Session. This measure assists in tracking the frequency with which the SIF is asked to reimburse for multiple employment benefits and in identifying trends in that type of reimbursement.
Source/Collection of Data:	SIF data is collected and maintained in the SIF database.
Method of Calculation:	The measure is calculated by summing the number of complete requests filed by insurance carriers for reimbursement of benefits paid to injured workers who held multiple jobs prior to an injury and received benefits based on the lost income of the multiple jobs during the reporting period.
Data Limitations:	Requests for reimbursement of multiple employment benefits are reimbursed annually in the fiscal year following the year in which the requests were received.
Calculation Type:	Cumulative
New Measure:	No
Desired Performance:	Lower than target

6.6.1 EF 1	**Average Days from Close of Quarter to Payment of Requests for Reimbursement that are Approved**
Short Definition:	The measure reflects the average length of time required to review and make determinations on requests for reimbursement to insurance carriers for income benefits that were paid.
Purpose/Importance:	The measure shows how long an insurance carrier waits after the close of a quarter to be reimbursed for overpaid benefits.
Source/Collection of Data:	SIF data is collected and maintained in the agency's accounting system and in the SIF administrator's database.
Method of Calculation:	The measure is calculated for all reimbursement requests approved by the SIF administrator based on requests filed in the preceding quarter(s). The measure is calculated by dividing the total number of days from the start of a quarter to the paid date for each approved reimbursement request by the total number of reimbursement requests approved in that quarter for the reporting period. For reimbursements of benefits based on overpayment of benefits due to reversed or modified orders/decisions, the number of days for each approved request is calculated as the difference between the paid date shown on the accounting reports and the first day of each quarter. For reimbursements of multiple employment and pharmaceutical benefits paid for the first seven days after an injury, the number of days for each approved request is calculated as the difference between the paid date shown on the accounting reports and the first day of the fiscal year.
Data Limitations:	Reimbursements in each quarter are based on requests filed by insurance carriers in previous quarter(s). Multiple employment and pharmaceutical reimbursements are made annually; therefore, activity relating to that type of reimbursement will only be reflected in the first quarter of each fiscal year. This measure does not include reimbursed death benefits or settlements.
Calculation Type:	Non-cumulative
New Measure:	No
Desired Performance:	Lower than projected

APPENDIX G

Five-Year Outcome Projections

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Fiscal Year 2007 - 2011 Projected Outcomes*

Measure Code	Measure Description	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
1.1.2 oc 1	Percent of company licenses completed within 60 days	98%	98%	98%	98%	98%
1.1.2 oc 2	(Key) Percent of agent license filings completed within 15 days	96%	96%	96%	96%	96%
1.1.2 oc 3	(Key) Percent of statutory rate and form filings completed within 90 days	87%	87%	87%	87%	87%
1.1.3 oc 4	(Key) Number of autos in underserved markets with voluntary coverage	69%	69%	69%	69%	69%
1.1.3 oc 6	(Key) Percent of personal auto and residential property form filings completed within 60 days	95%	95%	95%	95%	95%
1.2.2 oc 1	Percent of insurer fraud referrals to state and federal prosecutors resulting in legal action	55%	55%	55%	55%	55%
1.2.4 oc 1	(Key) Percent of licensees who renew online	55%	55%	55%	55%	55%
2.1.1 oc 1	(Key) Percent of statutorily mandated examinations completed within 18 months	97%	97%	97%	97%	97%
2.1.1 oc 2	Percent of identified companies reviewed	97%	97%	97%	97%	97%
2.1.1 oc 3	(Key) Special Deputy Receiver receivership asset recovery expenses as a percent of the total dollars collected by Special Deputy Receivers	15%	15%	15%	15%	15%
2.1.1 oc 4	(Key) Average number of days from company "at risk" identification to the date of solvency-related regulatory action	31	31	31	31	31
2.1.1 oc 5	Percent of insurers meeting statutory or risk-based capital and surplus requirements	97%	97%	97%	97%	97%

*The targets presented in this plan reflect current level funding. The FY 2008-2009 LAR instructions require agencies to submit their baseline request at a ten percent reduction level. The agency's LAR will reflect the necessary adjustments to performance targets based on the ten percent reduction.

Fiscal Year 2007 - 2011 Projected Outcomes*

Measure Code	Measure Description	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
2.1.1 oc 6	(Key) Percent of companies rehabilitated after Texas Department of Insurance solvency-related intervention	18%	18%	18%	18%	18%
3.1.1 oc 1	Percent of insurers providing adequate loss control programs	93%	93%	93%	93%	93%
3.1.1 oc 2	(Key) Percent of Commercial Property inspections that meet filed rating schedule requirements	85%	85%	85%	85%	85%
3.1.1 oc 3	(Key) Percent of windstorm inspections that result in an "approved" status code	35%	35%	35%	35%	35%
3.1.2 oc 4	Percent of consumer and provider fraud referrals to state and federal prosecutors resulting in legal action	55%	55%	55%	55%	55%
3.1.3 oc 1	(New) Percent of consumer and provider Workers' Compensation Insurance fraud referrals to state and federal prosecutors resulting in legal action	55%	55%	55%	55%	55%
4.1.1 oc 1	(Key) Percent of State Fire Marshal's Office criminal referrals resulting in enforcement/legal action	79%	79%	79%	79%	79%
4.1.1 oc 2	(Key) Percent of registrations, licenses, and permits issued, after receipt of a completed application, within 20 days to fire alarm, fire extinguisher, fire sprinkler, and fireworks firms, individuals, and other regulated entities	99%	99%	99%	99%	99%
5.1.1 oc 1	(Key) Statewide incidence rate of injuries and illnesses per 100 full-time employees	3.9	3.9	3.9	3.9	3.9
5.1.1 oc 2	(New) Percentage change in the injury rate for employers provided consultations and inspection services	20%	20%	20%	20%	20%
5.2.1 oc 1	(New) Percent of Temporary Income Benefit recipients returning to work within 90 days of injury (based on TIBs duration)	53%	56%	58%	60%	62%

*The targets presented in this plan reflect current level funding. The FY 2008-2009 LAR instructions require agencies to submit their baseline request at a ten percent reduction level. The agency's LAR will reflect the necessary adjustments to performance targets based on the ten percent reduction.

Fiscal Year 2007 - 2011 Projected Outcomes*

Measure Code	Measure Description	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
6.1.1 oc 1	(New) Percentage of medical bills processed timely	94%	95%	95%	95%	95%
6.2.1 oc 1	(New) Dollar amount returned to workers' compensation system participants through complaint resolution	$525,000	$500,000	$475,000	$450,000	$425,000
6.2.1 oc 2	(Key) Average number of days for the required initial benefit payment to be issued after benefits begin to accrue	7.1	7.1	7.1	7.1	7.1
6.2.1 oc 3	Percentage of first benefit payment timely made by insurance carriers	91%	92%	93%	94%	95%
6.3.1 oc 1	(Key) Percentage of documents received and maintained electronically by the division	70%	70%	70%	70%	70%
6.4.1 oc 1	Percentage of market share of Certified Self-Insurance to the Total Workers' Compensation Insurance market	10%	10%	10%	10%	10%
6.5.1 oc 1	(New) Percentage of indemnity disputes resolved prior to a benefit review conference	41.5	42	43	44	45
6.5.1 oc 2	(New) Percentage of indemnity disputes resolved in dispute resolution	57	56	55	54	53
6.5.1 oc 3	(New) Average number of days to resolve indemnity disputes through dispute resolution proceedings	117	116	115	114	113
6.5.1 oc 4	(New) Average number of days to resolve indemnity disputes through dispute resolution proceedings	95%	95%	95%	95%	95%
6.6.1 oc 1	Total payments made out of the subsequent injury fund for lifetime income benefits and reimbursements to insurance carriers	$2,851,000	$3,373,000	$3,654,500	$3,987,000	$4,385,500

*The targets presented in this plan reflect current level funding. The FY 2008-2009 LAR instructions require agencies to submit their baseline request at a ten percent reduction level. The agency's LAR will reflect the necessary adjustments to performance targets based on the ten percent reduction.

APPENDIX H

Survey of Organizational Excellence

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TDI recognizes that high employee satisfaction is critical to retaining and recruiting quality staff and in delivering the best customer service to the citizens of our state. Since 1994, TDI has participated every two years in the Survey of Organizational Excellence conducted by the University of Texas, School of Social Work. This survey measures five dimensions of the workplace including organizational features, accommodations, exchange of information, work group and personal aspects. The constructs are scored on a 500 point system. A score at or below 300 indicates an opportunity for growth, because employees view the area more negatively than positively. A score above 300 means the construct is viewed more positively by employees, and it is an area of strength for the agency. Some areas of strength for TDI include the strategic orientation, quality principles, physical environment, external communication, and job satisfaction.

The November 2005 survey was delayed until May 2006 due to the organizational changes that began in September 2005 as a result of HB 7. This organizational change increased the size of TDI by approximately 900 FTEs, doubling the size of the agency.

Sixty-seven percent of TDI employees completed the survey. This response is higher than the average for agencies in the same size category. TDI's overall response rate is slightly below the 2004 response rate of 69%.

The results showed a slight decrease in employee satisfaction from the 2004 results. This decrease was expected due to significant agency changes that have recently occurred; however it was important for agency management to know employees' attitudes about their work environment so that appropriate actions could be taken to address problem areas. In addition, the survey results are used as an assessment tool in the agency strategic plan and will continue to be used in the business planning process, both at the organizational level and the program area level. Program heads will receive a complete analysis of the agency-wide survey, along with results for their program areas and a comparison of satisfaction levels reported by field office staff to Austin staff, if applicable. They are encouraged to share the results with their managers and staff and to discuss ideas for continually improving employee satisfaction, agency processes and customer service. Agency-wide results are also shared with all employees.

Comparison of Survey Results

The chart below shows the last 10 years of results from the Survey of Organizational Excellence. In the 2006 survey, the scores for most constructs are slightly lower than in 2004 and 2002, but remain higher than scores from 1996-2000. The decrease in employee satisfaction in 2006 is likely attributed to the significant workload and changes created by the merger of TWCC with TDI. However, all constructs, with the exception of fair pay, continue to be viewed more positively than negatively by agency employees.

CONSTRUCT	1996	1998	2000	2002	2004	2006
Supervisor Effectiveness	**281**	**290**	**298**	**349**	**341**	**331**
Fairness	**300**	**306**	**318**	**371**	**362**	**349**
Team Effectiveness	**301**	**321**	**327**	**351**	**343**	**330**
Job Satisfaction	**331**	**340**	**350**	**374**	**375**	**355**
Diversity	**312**	**319**	**325**	**364**	**355**	**344**
Fair Pay	**301**	**301**	**286**	**258**	**243**	**223**
Adequacy of Physical Environment	**333**	**353**	**360**	**380**	**377**	**363**
Benefits	**367**	**373**	**366**	**374**	**350**	**350**
Employment Development	**331**	**335**	**343**	**371**	**365**	**347**
Change Oriented	**331**	**335**	**334**	**354**	**346**	**336**
Goal Oriented	**334**	**348**	**349**	**371**	**364**	**349**
Consistency (Holographic)	**303**	**319**	**323**	**358**	**350**	**338**
Strategic Orientation	**384**	**399**	**404**	**389**	**388**	**375**
Quality	**359**	**373**	**375**	**393**	**389**	**372**
Internal Communication	**302**	**320**	**330**	**341**	**335**	**322**
Availability of Information	**308**	**321**	**333**	**373**	**366**	**346**
External Communication	**347**	**365**	**375**	**380**	**375**	**361**
Time and Stress Management	**361**	**363**	**371**	**372**	**373**	**353**
Burnout	**310**	**328**	**331**	**373**	**367**	**354**
Empowerment	**285**	**299**	**309**	**364**	**357**	**348**

SUMMARY OF SURVEY BY CATEGORY
TDI 2006

Work Group		Organizational Features	
Supervisor Effectiveness	331	Change Oriented	336
Fairness	349	Goal Oriented	349
Team Effectiveness	330	Holographic (Consistency)	338
Diversity	344	Strategic Orientation	375
		Quality	372

Personal		Information	
Job Satisfaction	355	Internal Communication	322
Time and Stress Management	353	Availability of Information	346
Burnout	354	External Communication	361
Empowerment	348		

Accommodations	
Fair Pay	223
Physical Environment	363
Benefits	350
Employment Development	347

Human Resources, along with the Employee Ombudsman, will develop a plan to improve lower scoring constructs and continued improvement in all other construct areas. Human Resources continually work with areas to offer information and suggestions for maintaining high employee satisfaction levels and for improvement in survey dimensions where opportunities for growth are indicated.