STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

NATIONAL STATES INSURANCE COMPANY,	)	
Petitioner,	)	
vs.	)	Case No. 05-3595
OFFICE OF INSURANCE REGULATION,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to Notice, a final hearing was held in this matter before Administrative Law Judge Diane Cleavinger of the Division of Administrative Hearings on March 8, 2006, in Tallahassee, Florida.

APPEARANCES

For Petitioner: Cynthia S. Tunnicliff, Esquire
Brian A. Newman, Esquire,
Pennington, Moore, Wilkinson,
Bell and Dunbar, P.A.
215 South Monroe Street, Second Floor
Tallahassee, Florida 32302-2095

For Respondent: James H. Harris, Esquire
Office of Insurance Regulation
200 East Gaines Street
612 Larson Building, Room 645A-5
Tallahassee, Florida 32399

STATEMENT OF THE ISSUE

Whether National States Insurance Company should be granted a rate increase for its four home health care policy forms HNF-1, HHF-3, HNC-1, and HHC-1 (HHC policies).

PRELIMINARY STATEMENT

Petitioner filed a Petition for Formal Hearing with the Respondent seeking a 53 percent rate increase for its HHC policies. However, the Department found that the original Petition did not allege any disputed issues of material fact and declined to forward the original Petition to the Division of Administrative Hearings. Thereafter, Petitioner filed an Amended Petition for Formal Hearing, again seeking a rate increase for its HHC policies and challenging Respondent's failure to forward the original Petition. Respondent referred the Amended Petition to the Division of Administrative Hearings, thereby making moot the issue of forwarding the original Petition in this case.

At the hearing, Petitioner presented the testimony of actuaries, Karl Volkmar and Rex Durrington. Petitioner also offered three exhibits into evidence. Respondent offered seven exhibits into evidence, and presented the testimony of actuaries Daniel Keating and Robert Yee.

After the hearing, Petitioner filed a Proposed Recommended Order on April 12, 2006. Likewise, Respondent filed a Proposed Recommended Order on April 12, 2006.

FINDINGS OF FACT

1. Petitioner, National States Insurance Company (National States) is licensed in the State of Florida to sell health insurance, including home health care policies without nursing home care and policies that combine home health care and nursing home care (PAL policies). The two types of policies are not the same, but overlap somewhat when both types of care are combined in PAL policies. Generally, in Florida, HHC policies have had higher claims and worse profitability than HHC policies in other states.

2. Respondent, the Office of Insurance Regulation (OIR), is a sub-unit of an agency of the State of Florida. Respondent is charged with the responsibility for, among other things, the review and approval of health insurance rate increases for health insurance policy forms used in Florida. See § 627.410, Fla. Stat.

3. No "basic insurance policy" may be delivered in Florida unless the "form" has first been approved by the Department. § 627.410(1), Fla. Stat.

4. Section 627.410(6), Florida Statutes, additionally requires that a copy of the applicable rating manual or rating

schedule included as part of an insurance policy form must be filed with the Department for approval before any "health insurance policy form" is delivered in Florida.

5. Pursuant to Section 627.410(7)(a), Florida Statutes, insurers required to file rating manuals or rating schedules pursuant to Section 627.410(6), Florida Statutes, must make an "annual filing" with the Department.

6. The "annual filing" requirement of Section 627.410(7)(a), Florida Statutes, may be satisfied in two ways:

a. A "rate filing prepared by an actuary which contains documentation demonstrating the reasonableness of benefits in relation to premiums charged in accordance with the applicable rating laws and rules promulgated by the department." § 627.410(7)(b)1., Fla. Stat.; or

b. "If no rate change is proposed, a filing which consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with applicable laws and rules promulgated by the department." § 627.410(7)(b)2., Fla. Stat.

7. In this case, National States filed a request for a 53 percent rate increase for several of its Limited Benefit Home Nursing Policy forms, HNF-1, HNF-3, HNC-1 and HHC-1 (HHC policies), on May 31, 2005.

8. The HHC polices, involved in the rate request, are individual polices written on a guaranteed renewable basis. The amount of the premium is not guaranteed. These policies pay benefits for home nursing care on an expense-incurred basis up to the daily maximum specified in the policies for periods of 12, 24 or 36 months for the HNF-1 and HNF-3 policies; 12, 24, 36, 48 or 60 months for the HHC-1 policy; and 12 or 24 months for the HNC-1 policy. The policies do not provide benefits for nursing home care.

9. Policies under these forms are not currently sold in Florida. The HHC-1 plan was sold through February 28, 2003; the HNF-1 plan was discontinued on April 1, 1994; the HNC-1 plan was discontinued in 1991 and the HNF-3 plan was discontinued on June 30, 1999. There are 4,361 Florida policies remaining in force that would be affected by the rate increase requested by National States.

10. Dan Keating was the actuary assigned by Respondent to review the requested rate increase. On June 8, 2005, and on June 15, 2005, Respondent requested revised calculations of earned premiums to reflect the impact of prior rate increases in all calendar years. It also requested one exhibit reflecting historical experience, current premiums and projected future experience assuming no rate increase. National States responded to these requests. The June 15, 2005, letter also requested an

explanation of a report given by a National States' actuary to the Missouri Department of Insurance in a confidential proceeding regarding the company's original pricing assumptions for the policies. The deadline for review was extended to July 15, 2005.

11. Twenty-two days before the review deadline, Respondent determined that the requested increase would be disapproved. In a letter to National States dated June 24, 2005, Respondent stated three reasons for disapproval of the HHC filing:

> (1) the company has failed to demonstrate that the proposed rates are reasonable in relation to the benefits provided in that the data supplied by the company does not justify the rate increase requested. As required by Florida Administrative Code Rule 690-149.005(2)(b)1 the rate increase is subject to both a future and a lifetime A/E ratio test. The starting point for the future projected experience is based on the combined data over the period used to determine credibility of the data, as defined in Florida Administrative Code Rule 690-149.0025(6) not just the last experience period;
>
> (2) the company has used inconsistent methods in calculating the expected loss ratio used to compare with actual experience in determining the reasonableness of the rates. The expected loss ratio is based on the durational loss ratio table provided by the company at the time the policy is originally approved and the historical distribution of business. However, each exhibit provided by the company reflected different expected loss ratios for the same block of business; and
>
> (3) the company failed to adequately respond to the Office's request for additional information regarding the original pricing assumptions used for this long-term care policy form, as required by Florida Administrative Code Rule 690-149.

However, post-disapproval, information on the original pricing assumptions requested by Respondent were given to Respondent. The original pricing assumptions were shown not to have changed and not to be relevant to the issues involved in this case. For the same reason, questions regarding the Missouri hearing regarding the original pricing information on these policies were irrelevant to the issues involved in this case. At the formal hearing, Respondent affirmed the above facts. Moreover, the original pricing assumptions were given to Respondent's predecessor when the initial approval of these forms was made and was presumably available to the Respondent in its own records. Failure to provide information that the Respondent already has cannot, on these facts, form a basis for disapproval of National States rate request. Therefore, the third basis for disapproval of Petitioner's rate request is essentially moot.

12. The first ground for disapproving the requested rate increase involves the "credibility" of the data used by National States in its rate filling. "Credibility" is a term of art in ratemaking that refers to how much weight or reliance an insurer can place on historical data to make projections about the future. The goal for a credibility standard is to generally require that the historical data being used, such as the amount and number of claims, cover a sufficient period of time and is

in sufficient numbers to form a basis to reliably predict the ratio of “actual projected” claims to “expected” claims (A/E ratio). In short, how far back in time an insurer must go to gather enough claims to reliably predict the number of claims it expects in the future. The A/E ratio is used to determine if a premium rate increase is needed. If the ratio is greater than one and based on credible data then a rate increase is indicated.

13. The Respondent has developed various rules defining credibility. See Fla. R. Civil Proc. 69O-149.006(3) and 69O-149.0025(6). The rules are, in part, based on studies done by actuarial professional organizations to determine when historical insurance data reliably predicts future rates and various claims characteristics of specific types of policies. Indeed, expert testimony indicated that, generally, a minimum of 1082 claims would be necessary to establish credibility for long-term care type policies, including HHC-type policies. All the parties agree that the credibility rules apply to National States rate filing.

14. Florida Administrative Code Rule 69O-149.006(6) states:

> (6) Credible Data:
>
> (a) Except as provided in paragraph (b), if a policy form has 2000 or more expected policies in force, then full (100 percent) credibility is given to the

> experience; if fewer than 500 policies are in force, then 0 percent credibility is given.
>
> (b)1. For policy forms with low expected claims frequency, such as accident and long term care, at least 1000 claims, over a period not exceed the most recent 5-year period, shall be assigned 100 percent credibility; 200 claims shall be assigned 0 percent credibility.

The practical difference between the above sections is that each section defines the period of time that an insurer must go back in order to rely on its claims data. In this case, the parties disagree over which credibility rule applies; and therefore, over the length of the time period that should be included in the rate filing. Respondent treated the HHC policies as low expected claims frequency policies and applied the credibility rule contained in Subsection (b)1. The application of that subsection resulted in 1260 claims from 2003 through the first quarter of 2005 being included in the Respondent's calculations. The evidence did not demonstrate the reason the Respondent used more than 1000 claims in its calculations. However, there was no evidence that the additional numbers had a significant impact on the amount of any rate increase. On the other hand, National States claims that these policies are not low expected claims frequency policies and applied Subsection (a). The application of Subsection (a) resulted in only 63 claims in the first quarter of 2005 being included its calculations. This is a very

small sample given the numbers contained in the credibility rules.

15. The evidence showed that National States has more than 2000 policies in force and that it has at least 1000 claims during the most recent five-year period. The question is whether the HHC policies are low expected claims frequency policies. The rules do not define the term “low expected claims frequency.” The actual experience of the HHC policies by National States is that the number of claims has been neither high or low, but in the mid-range level. The experts disagreed over whether these policies were low expected claims frequency policies. The better expert evidence showed that HHC policies are generally considered to be low expected claims frequency policies. Additionally, National States in another filing represented the HHC-1 form as having the same low frequency assumptions as the home health care component of PAL combination policies. Finally, Respondent has interpreted the term to refer to the expectations at the time the policy is originally priced. The later-acquired actual experience of the company is not relevant to the determination of whether these HHC policies are low expected claims frequency policies. In short, the original frequency expectations do not change over time based on actual experience. The use of the word “expected” in the phrase supports Respondent’s interpretation of the language of its rule

and such an interpretation is reasonable given the language of the rule and the rationale behind such credibility standards. Therefore, the appropriate credibility standard for these HHC policies is that found in Subsection (b)1.

16. When the correct credibility rule is applied, National States would be entitled to a minimum rate increase of 38.2 percent using Respondent's methodology.

17. The second ground for disapproving the requested rate increase was inconsistency in the methods used in calculating the expected loss ratios used to compare with actual historical data. The inconsistent methods occurred when National States' actuary used an incorrect calculation in his initial filing and then twice attempted to correct that error, at Respondent's request, with amended spreadsheets. The inconsistent calculations involved the method of calculating expected loss ratios for National States. As indicated in Respondent's letter, the expected loss ratio is based on the durational loss ratio table provided by the company at the time the policy is originally approved and the historical distribution of business.

18. The durational loss ratio, or durational loss ratio curve, is established by the company at the time a policy is first approved and reflects the expected increases in losses over the life of a product based on the price of the product when it is first used. In its simplest form, the graph of this

data over time generates a mathematical curve. Likewise, actual historical data based on an insurance product's claims versus price over the years generates a curve that can be projected forward into the future. If these two curves match there is no need for a price increase to cover future claims. If these two curves do not match then the price of the insurance product needs to be adjusted either up or down. It is the difference or gap between these two curves that is important.

19. In the filing made by National States, three separate spreadsheets were submitted on three separate occasions. These spreadsheets are stamped pages 16 (initial spreadsheet), 37 (first amended spreadsheet) and 41 (second amended spreadsheet) of Petitioner's Exhibit 1. The amended spreadsheets were submitted because Mr. Keating requested that National States submit such data on a "current" or "constant" premium basis. The request was not completely understood by National States' actuary and, in his attempt to meet that request, he generated inconsistent spreadsheets that were incorrect in their calculations in that the ordinarily unchangeable durational loss ratio changed. In fact, the second amended spreadsheet was intended to correct the errors in the first amended spreadsheet. The third spreadsheet continued to contain errors, but those errors only involved the historical durational loss ratios and did not involve the future durational loss ratio projections.

The historical durational loss ratios in the third spreadsheet changed over time. The future durational loss ratio did not change over time. After the third attempted correction, Mr. Keating no longer trusted the figures being submitted by National States and suspected that they might be using a faulty model for calculating premiums. Use of a faulty model would call the entire rate filing into question. The analytical portions of National States' model were not available to Mr. Keating and he could not determine the basis for the differing spreadsheets as either a faulty model or incorrect calculations. However, the model had been used in the past to gain approval of other rate increases by National States. Mr. Keating prepared page 92 of Petitioner's Exhibit 1 based on the best interpretation he could give the National States' data and the information about National States that was available to him. Page 92 demonstrates that National States is entitled to a 38.2 percent rate increase for the HHC policies based on the calculations Mr. Keating used on data supplied by National States. In fact, all of the actuaries that reviewed this filing agreed that National States was entitled to at least a 38.2 percent rate increase.

20. At hearing, National States actuary admitted he made an error in his initial spreadsheet and in the first amended spreadsheet, in part, based on his interpretation of the

requests from Respondent. The second amended spreadsheet corrected the first two and generally reflected accurate data from National States. The evidence showed that the differing spreadsheets were not a result of the application of a faulty model, but were a progressive attempt with errors to meet the requirements of Respondent. Clearly, Mr. Keating had some suspicion as to the reasons for the inconsistent spreadsheets since he was able to use the data from the second amended spreadsheet along with data contained elsewhere in the rate filing to determine the amount the rate should increase based on that data. Given the evidence, the inconsistent spreadsheets are not a sufficient reason to justify denial of a rate increase. Petitioner's experts corroborate this analysis and agree that the increase calculated by Mr. Keating is the minimum increase that is appropriate in this case.

21. The differences among the experts regarding the amount of the rate increase result from whether "shock lapse" and "anti-selection" should be applied to National States' data. These terms generally describe the phenomenon of policy cancellation that occurs when premiums increase. In the health area, consumers who cancel policies when premiums increase tend to be healthier than those who elect to renew their policies. The result is increased losses for the remaining book of business. The phenomenon is recognized by professional

actuaries, but there is no agreement, in this case, on whether it should be applied to these HHC policies. Mr. Keating did not apply any factor for shock lapse and anti-selection. The Petitioner's actuary did apply a factor for shock lapse and anti-selection.

22. Petitioner's actuary developed the following rate indications using National States' data:

> Over 70% increase using the pool of claims developed under subsection (a) of the credibility rules in its original rate filing.
>
> Over 51% increase using the 1260 claims used by Mr. Keating and applying subsection (b)1. of the credibility rules.
>
> Over 58% increase using only 1000 claims and applying subsection (b)1. of the credibility rules.

23. There was very little testimony on how any shock lapse was developed to these HHC policies. Apart from the very vague and non-scientific "rule of thumb" for the factor related to shock lapse, there was no evidence showing that these policies would be currently subject to significant shock lapse by Petitioner's actuaries, that application of a shock lapse factor is appropriate for these policies or that some recognized method to quantify the shock lapse phenomenon was used.

24. Indeed, the evidence in this case indicates that shock lapse should not be applied in this rate filing. National States, who is most familiar with its own block of business, did

not claim or apply any shock lapse factor in its rate filing until the hearing in this matter and after the 38.2 percent increase had been calculated by Respondent. Additionally, since 1999 the premiums for these policies has increased 266 percent and policyholders have decreased from 16,352 in 1999 to 4,361 in the first quarter of 2005. Both these facts indicate that the shock lapse phenomenon has either been realized or is insignificant in regard to this rate filing and that the appropriate rate indicated for this filing is a 38.2 percent increase.

25. Finally, National States offered no proof demonstrating that Respondent maintained a non-rule policy regarding any requirements that original pricing assumptions be supplied with a rate filing. Indeed, the allegations were an insignificant part of this case for both parties, but the issue could not be resolved until evidence was taken. There was no evidence of frivolousness in the assertion of the claim. Therefore, even though insignificant, attorney’s fees are not warranted in this action and the portions of the Amended Petition in this action related to such non-rule policy should be dismissed.

CONCLUSIONS OF LAW

26. The Division of Administrative Hearings has jurisdiction over both the parties to and subject matter of this proceeding. §§ 120.569 and 120.57, Fla. Stat.

27. Section 627.410(6), Florida Statutes, provides:

> (6)(a) An insurer shall not deliver or issue for delivery or renew in this state any health insurance policy form until it has filed with the office a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the office applicable premium rates and any change in applicable premium rates. . . .
> (b) The commission may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates. . . .

28. Part I of Chapter 690-149, Florida Administrative Code, specifies the applicable rules for rate filings of health insurance policies and is applicable to the HHC policies involved in this action.

29. The grounds for disapproval of forms filed under Section 627.410 are provided in Section 627.411, Florida Statutes. In pertinent part, Section 627.411(1), Florida Statutes, provides that a form may be disapproved if the form:

> (a) Is in any respect in violation of, or does not comply with, this code.
>
> . . . .

> (e) Is for health insurance, and provides benefits which are unreasonable in relation to the premium charged, contains provisions which are unfair or inequitable or contrary to the public policy of this state or which encourage misrepresentation or which apply rating practices which result in premium escalations that are not viable for the policyholder market or result in unfair discrimination in sales practices.

30. The Department has adopted rules establishing general rate-filing procedures. Fla. Admin. Code Ch. 69O-149 (formerly Chapter 4-149). Florida Administrative Code Rule 69O-149.006 sets out the information an actuary must provide and the manner in which an actuary is to provide that information. The Department has also adopted rules providing the manner in which the reasonableness of benefits in relation to premiums will be determined. Fla. R. Civil Proc. 69O-149.005.

31. Florida Administrative Code Rule 690-149.005 specifies the basic test of "reasonableness of benefits in relation to premium rates”:

> (1) Benefits will be determined to be reasonable in relation to the premium rates charged if the premium schedule is not excessive, not inadequate and not unfairly discriminatory. In determining whether a premium schedule satisfies these requirements, the office will consider all items presented in the filing with special emphasis placed on the information included in the actuarial memorandum.
> (2) A premium schedule is not excessive if the following are true:

(b)1. For individual forms, and group policy forms other than annually rated group policy forms, approved on or after 2/1/94 or issue on or after 6/1/94, the Premium Schedule satisfies the following:

a. An Anticipated Loss Ratio test such that the present value of projected claims is not less than the present value of expected claims value of over the entire future lifetime of the form. This is equivalent to the present value of the future A/E ratio not being less than 1.0; and

b. The current lifetime loss ratio, as defined in subparagraph 690-149.006(3)(b)24., F.A.C., is not less than the initial filed loss ratio for the form as may be subsequently amended and approved pursuant to his rule chapter.

32. Florida Administrative Code Rule 690-149.0025(1) specifies:

(1)(a) Actual-to-Expected (A/E) ratio: The ratio of actual incurred claims under the policy form divided by expected claims. This is equivalent to the actual annual loss ratio divided by the applicable durational loss ratios of the approved durational loss ratio table.

(b) For projected periods, the A/E ratio is the ratio of the projected claims divided by the expected claims.

(c) Both the year-by-year pattern of the A/E ratios and the aggregate past, future, and lifetime ratios shall be presented.

33. The term "expected claims" is defined by Florida Administrative Code Rule 690-149.0025(10)(a):

(10) Expected Claims:

(a) The actual earned premium or, for projected periods the projected premium, times the applicable policy durational loss ratio from the approved durational loss ratio table which was in effect for the time period covered by the premiums.

34. Florida Administrative Code Rule 690-149.006(3)(b), 23b(II) establishes the manner in which the insurer displays and projects future period data when based on actual in force policy experience, as was done by National States in the instant HHC rate filing:

> 23. Experience on the Form (Past and Future Anticipated): This section shall display the actual experience on the form and that expected for the future.
> a. Past Experience: Experience from inception (or the last 3 years for annually rated group coverage's) shall be displayed, although, with proper interest adjustment, the experience for calendar years more than 10 years in the past may be combined. Excluding annually rated group policy forms, earned premiums, actual incurred and expected claims experience shall also be displayed, for each policy year or issue year, within the calendar year. The following information shall be displayed (A sample experience exhibit is illustrated in Appendix A, Illustrative Experience Exhibit (2/04), which is hereby incorporated by reference):
>
> (I) Year,
>
> (II) Earned premium,
>
> (III) Paid claims, for past periods only
>
> (IV) Change in claim liability and reserve, for past periods only. These reserves shall be updated to reflect actual

claim runoff as it develops.

(V) Incurred claims (=(III) + (IV)),

(VI) Incurred loss ratio (=(V)/(II)),

(VII) Expected loss ratio,

(VIII) Expected incurred claims,

(IX) Actual-to-expected claims (=(V)/(VIII)) or equivalency (=(VI)/(VII)),

(X) Earned premium on a manual rate basis for at least the past 5 calendar years or the experience period used for projection purposes for annually rated group products; i.e., removing the impact of adjustments to the approved rate manual due to underwriter adjustments, the impact of any rate limits, and experience rating. . . .

(XI) Earned premium on a current rate basis for at least the past 5 calendar years or the experience period used for projection purposes of annually rated group products. . . .

b. Future periods where the projected values are based on in force experience:

(I) The experience period used as the basis for determining projected values shall be clearly indicated.

(II) The experience period shall reflect the most current date available, generally the most recent 12 months for coverage subject to medical inflation or the period of time to determine credible data pursuant to subsection 690-149.0025(6), F.A.C.

(III) An exhibit showing the development of the expected claims and A/E ratio for the experience period shall be provided. (A sample exhibit demonstrating an expected development is illustrated in Appendix A).

(IV) The projected values shall represent the experience that the actuary fully expects to occur. In order for the proposed premium schedule or rate change to be reasonable, the underlying experience used as the basis of a projection must be reflective of the experience anticipated over the rating period. The office will consider how the following items are considered in evaluating the reasonableness of the projections and ultimate rates. In order to expedite the review process, the actuary is encouraged to provide information on how each of the following have or have not been addressed in the experience period data used as the basis for determining projected values, or otherwise addressed in the ratemaking process.

(A) Large nonrecurring claims;

(B) Seasonality of claims;

(C) Prior rate changes not fully realized:

(D) Rate limits, rate guarantees, and other rates not charged at the full manual rate level;

(E) Experience rating, if any:

(F) Reinsurance costs and recoveries for excess claims subject to non-proportional reinsurance;

(G) Coordination of benefits and subrogation;

(H) Benefit changes during the experience period or anticipated for the rating period;

(I) Operational changes during the experience period or anticipated for the rating period that will affect claim costs;

(J) Punitive damages, lobbying, or other

costs that are not policy benefits;

(K) Claim costs paid which exceed contract terms or provisions;

(L) Benefit payments triggered by the death of an insured, such as waiver of premium or spousal benefits;

(M) Risk charges for excess group conversion costs or other similar costs for transferring risk;

(N) The extent and justification of any claim administration expenses included in claim costs; and

(O) Other actuarial considerations that affect the determination of projected values.

(V) The method or formulas, including necessary assumptions and sample calculations, used in determining the projected values from the experience period used shall be provided.

(VI) Projection years shall include columns I, II, V, VI, VII, VIII and IX as indicated in sub-subparagraph 23.a. above.

(VIII) A summary of the historical and projected data shall be provided for all experience columns providing the accumulated past values, future values, and lifetime values both with and without interest and with and without the proposed rate change.

35. Because medical inflation or trend is already included in the HHC policies pricing assumptions, Florida Administrative Code Rule 690-149.006(3)(b), 23 requires National States to use "credible data" as defined by Florida Administrative Code Rule 690-149.0025(6) to determine the experience period on which a

projection of future values is to be based. Florida Administrative Code Rule 69O-149.006(6), states:

> (6) Credible Data:
>
> (a) Except as provided in paragraph (b), if a policy form has 2000 or more expected policies in force, then full (100 percent) credibility is given to the experience; if fewer than 500 policies are in force, then 0 percent credibility is given.
>
> (b)1. For policy forms with low expected claims frequency, such as accident and long term care, at least 1000 claims, over a period not exceed the most recent 5-year period, shall be assigned 100 percent credibility; 200 claims shall be assigned 0 percent credibility.

36. In this case, the evidence demonstrated that the data supplied by National States was sufficient to use in determining if a rate increase should be approved, even though the data contained some immaterial errors. The evidence also demonstrated that the HHC policies were forms with low expected claims frequency. Finally, the evidence did not demonstrate that any factor for shock lapse should be applied to this rate filing.

37. Florida Administrative Code Rules 690-149.006(3)(b), 23b(II) and 690.149.0025(6) require that National States project forward expected claims based on Subsection (b)1. of that Rule. By applying Subsection (b)1. of the credibility rules National States is entitled to a 38 percent rate increase.

38. Further, Respondent admitted that the original pricing assumptions for the HHC policies have remained unchanged. Therefore, the request for such information by Respondent and the issue of whether that information was timely provided by National States is moot in this de novo hearing and immaterial as to whether Petitioner should be granted a rate increase. See Beverly Enterprises-Florida, Inc. v. Department of health and Rehabilitative Services, 573 So. 2d 19 (Fla. 1st DCA 1990); Young v. Department of Community Affairs, 625 So. 2d 831 (Fla. 1993); and Hamilton County Board of County Commissioners v. Department of Environmental Regulation, 587 So. 2d 1378 (Fla. 1st DCA 1991). The issue would be different if National States had never supplied the requested information up to and through the hearing. However, the information was supplied. Given this lack of materiality, National States' rate request should not be disapproved on the basis that such immaterial information was not timely supplied, especially since such original rating assumptions had been previously provided when the HHC policies were initially approved.

39. Finally, in its Petition, National States alleged that Respondent's request for additional information, specifically OIR's request for original pricing assumptions, was an unadopted rule.

40. A "rule" is defined by Section 120.52(15), Florida Statutes:

> (15) "Rule" means each agency statement of general applicability that implements, interprets, or prescribes law or policy or describes the procedure or practice requirements of an agency and includes any form which imposes any requirement or solicits any information not specifically required by statute or by an existing rule.

In a proceeding to challenge an unadopted rule, Petitioner has the burden of going forward and of proving the allegations of the agency's use of an unadopted rule. See §§ 120.56(4)(b); 120.57(1)(e), Fla. Stat.; St. Johns River Water Management Dist. v. Consolidated-Tomoka Land Co., 717 So. 2d 72, 76 (Fla. 1st DCA 1998). However, National States failed to plead or offer any proof that OIR's request for the original pricing assumption was "an agency statement of general applicability."

41. In Dept. of Highway Safety and Motor Vehicles v. Schluter, 705 So. 2d 81 (Fla. 1st DCA 1997), an administrative law judge determined that six statements stipulated by the Department of Highway Safety and Motor Vehicles ("DHSMV") were "rules." However, it was also stipulated that the first three statements only were applied by DHSMV "in certain circumstances." The First District Court of Appeal reasoned:

> We agree with appellant that the first three of the six policies do not constitute rules. They cannot be considered statements of general applicability because the record

> establishes that each was to apply only under certain circumstances.

Having failed to meet its burden of coming forward with proof of "general applicability," National States' claim of non-rule policy should be dismissed.

42. Section 57.105, Florida Statutes, provides:

> (1) Upon the court's initiative or motion of any party, the court shall award a reasonable attorney's fee to be paid to the prevailing party in equal amounts by the losing party and the opposing party's attorney on any claim or defense at any time during a civil proceeding or action in which the court finds that the losing party or the losing party's attorney knew or should have known that a claim or defense when initially presented to the court or at any time before the trial:
>
> (a) Was not supported by the material facts necessary to establish the claim or defense; or
>
> (b) Would not be supported by the application of then-existing law to those material facts.
>
> * * *
>
> (3) At any time in any civil proceeding or action in which the moving party proves by a preponderance of the evidence that any action taken by the opposing party, including, but not limited to, the filing of any pleading or part thereof, the assertion of or response to any discovery demand, the assertion of any claim or defense, or the response to any request by any other party, was taken primarily for the purpose of unreasonable delay, the court shall award damages to the moving party for its reasonable expenses incurred in obtaining

> the order, which may include attorney's fees, and other loss resulting from the improper delay.
>
> (4) A motion by a party seeking sanctions under this section must be served but may not be filed with or presented to the court unless, within 21 days after service of the motion, the challenged paper, claim, defense, contention, allegation, or denial is not withdrawn or appropriately corrected.
>
> (5) In administrative proceedings under Chapter 120, an administrative law judge shall award a reasonable attorney's fee and damages to be paid to the prevailing party in equal amounts by the losing party and a losing party's attorney or qualified representative in the same manner and upon the same basis as provided in subsections (1)-(4).

43. "Attorney's Fees are awarded under Section 57.105 . . . where there is a total or absolute lack of justiciable issues of either law or fact, this being tantamount to a finding that the action is frivolous or completely untenable." Weatherby Assocs., Inc., v. Ballack, 783 So. 2d 1138, 1141 (Fla. 4th DCA 2001) (citing Muckenfuss v. Deltona Corp., 508 So. 2d 340, 341 (Fla. 1987); Broad & Cassel v. Newport Motel, Inc., 636 So. 2d 590 (Fla. 3rd DCA 1994) (citing Whitten v. Progressive Cas. Ins. Co., 410 So. 2d 501, 502 (Fla. 1982)).

44. The Florida Supreme Court recently explained in Forum v. Boca Burger, Inc., ____ So. 2d ____, 30 Fla. L. Weekly S539, 2005 WL 1574959, p. 8 (Fla. 2005), the 1999 revision changed the

standards governing fee awards under Section 57.105, Florida Statutes. Unlike the prior version, the current version of the statute does not apply only to an entire action, but now applies to any claims or defense. Moreover, an award of fees is not limited to situations in which there is a complete absence of justiciable issue of law or fact. Instead, under the revised standard, fees will be awarded if the party or its counsel knew or should have known the claim or defense asserted was not supported by the facts or an application of then-existing law. See also Read v. Taylor, 832 So. 2d 219 (Fla. 4th DCA 2002).

45. In this case, National States' claim of non-rule policy cannot be said to be without merit. There were assertions, but no evidence that the claim was totally frivolous or without merit. The claim was clearly not a significant part of this action. However, pending development of evidence, such allegations were a legitimate issue to be raised. Therefore, attorneys' fees and costs are not appropriate.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED:

That a rate increase of 38 percent be approved for National States and that the allegations regarding non-rule policy be dismissed.

DONE AND ENTERED this 7th day of July, 2006, in Tallahassee, Leon County, Florida.

DIANE CLEAVINGER
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 7th day of July, 2006.

COPIES FURNISHED:

James H. Harris, Esquire
Office of Insurance Regulation
200 East Gaines Street
612 Larson Building, Room 645A-5
Tallahassee, Florida 32399

Cynthia S. Tunnicliff, Esquire
Pennington, Moore, Wilkinson,
Bell and Dunbar, P.A.
215 South Monroe Street, Second Floor
Tallahassee, Florida 32302-2095

Kevin M. McCarty, Commissioner
Office of Insurance Regulation
Financial Services Commission
200 East Gaines Street
Tallahassee, Florida 32399-0305

Steve Parton, General Counsel
Office of Insurance Regulation
Financial Services Commission
200 East Gaines Street
Tallahassee, Florida 32399-0305

NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the final order in this case.