COMMENTS ON PROPOSED CHANGES TO THE PRIOR APPROVAL REGULATIONS SET FORTH IN TITLE 10, CALIFORNIA CODE OF REGULATIONS, SUBCHAPTER 4.8 SECTIONS 2642.6 – 2644.27

REG-2007-00046

Made on behalf of the Personal Insurance Federation of California ("PIFC"), the Association of California Insurance Companies ("ACIC") and the American Insurance Association ("AIA")

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Introduction

My name is Shawna Ackerman and I am a principal and consulting actuary of Pinnacle Actuarial Resources, Inc., (Pinnacle). My business address is 50 California Street, San Francisco, California 94111. My firm has been retained by the Association of California Insurance Companies (ACIC), Personal Insurance Federation of California (PIFC) and the American Insurance Association (AIA) to provide actuarial consulting services and comments on the proposed changes to the prior approval regulations REG-2007-00046.

I am a Fellow of the Casualty Actuarial Society ("CAS") and a member of the American Academy of Actuaries. I am experienced in matters of insurance ratemaking, including working for the California Department of Insurance ("Department" or "CDI") for eight years from September 1989 to February 1998. My positions at the Department included Insurance Rate Analyst, Associate Insurance Rate Analyst, Associate Casualty Actuary and Senior Casualty Actuary, all of which I served in the Rate Regulation Division. As an Insurance Rate Analyst, I was responsible for reviewing insurer rate filings for all lines of property and casualty insurance subject to California's Proposition 103 (Cal. Ins. Code §1861.01 *et seq.*) When I was promoted to Associate Insurance Rate Analyst I was assigned to the Deputy Commissioner of Rate Regulation to assist with special projects including assisting in the drafting of regulations necessary to implement Proposition 103, including the rollback and prior approval regulations. When I attained my Associate designation from the CAS and was promoted to Associate Casualty Actuary in 1994, I also become responsible for representing the Department in rate and rollback hearings as an expert witness. I left the CDI as a Senior Casualty Actuary in 1998. Since 1998, I have been a consulting actuary and have continued working on projects involving ratemaking and loss reserving. A true and correct copy of my curriculum vitae is attached as Exhibit 1.

In 2006, the California Department of Insurance ("CDI" or "Department") held three workshops to discuss proposed changes to the Department's existing prior approval regulations as well as a regulatory hearing. Revised regulations were put into effect in April 2007 and insurers have been filing under the new regulations for approximately one

year. I participated in each of the prior approval regulations workshops that led to the April 2007 regulations.

The key concerns to the regulations continue to be trend, efficiency standards, the variance process and the criteria by which the CDI will select individual components of the ratemaking process, that is the "most actuarially sound" criteria that appears throughout the regulations.

Below are comments on specific sections of the proposed regulatory text.

Comments on Proposed Changes

§2642.6 Recorded Period

The proposed amendment is to allow a maximum of six years of experience to reach 25% credibility. Previously the regulations would allow up to ten years of experience to be considered. The Department's Statement of Reasons for the April 2007 prior approval regulatory changes supported a ten year period noting that the selection was made based on the CDI's experience gained over the course of the years. Here, there is no information provided as to why six years is a preferable cut-off point to ten years or what additional experience the CDI may have gained in the 11 months between the time the revised regulations went into effect and the additional proposed changes were set forth.

The number of filings that will be impacted by this change are likely few given the constraints on when the CDI will allow the additional years to be considered. Nevertheless, the ten year period is preferable as it provides an opportunity to consider closer to a full market cycle.

The proposed subsection continues to ignore that additional years of experience is an actuarially reasonable source of complementary data and may be more appropriate than the complement provided in 2644.23 (d) which is essentially a net trended permissible losses and DCCE. Additionally, it is commonplace to use longer experience periods (i.e.,

recorded periods) for homeowners insurance and for commercial liability lines where five years is common.

§2642.7. Lines of Insurance

Subsection (a) (18) adds Surety as a line of business that will be subject to these regulations. Subsection (d) then specifies that surety will be treated as a specialty line along with credit and aviation. .

The key benefit of specialty line status in the regulation is the ability to tender rate development based on accepted actuarial methods rather than the proscribed methodologies for such rate components as loss development and trend. However, the requirement that the rates will be approved or disapproved based on "the most sound actuarial method" in Section 2642.7 (c) is unclear. This phrase appears in numerous places throughout the proposed changes to the regulations. There exists no one "most sound actuarial method" for ratemaking. According to the CAS Statement of Principles Regarding Property and Casualty Insurance Ratemaking, "A number of ratemaking methodologies have been established by precedents or common usage within the actuarial profession." An insurer should only be required to demonstrate that it is using sound and reasonable actuarial methodologies, not that those methodologies are the "most sound."

Ratemaking is prospective in nature, projecting the costs of events yet to occur. Thus, there will necessarily exist a range of reasonable choices, not a single "most actuarially sound" choice.

The specialty insurance subcategories also recognize that certain programs of insurance will not fare well with the specified formulaic approaches, nor will industry average data capture the difference in expense levels and risk.

Setting aside the above-noted concern regarding the "most sound" aspect of the review standards for specialty lines, the addition of aviation as a specialty line is an improvement. Additionally, if the specialty status does in fact allow surety and credit and the other designated products to be developed and reviewed based on accepted actuarial

principles, guidelines and literature then the inclusion of credit and surety in these regulations should allow insurers to continue to make their rates in a manner consistent with current practices. However, while the rate filing instructions recognize the unique approval process conferred on specialty products in one instance (see page 3, Filing Types), the exhibits designated as required do not. For example, Page 7 - Ratemaking Data is required for all file types with rate impact, yet there is no place on this exhibit for the specialty insurer to display their own expenses. This data then feeds into the Rate Template where the efficiency standard, leverage factors, reserves factors and other CDI calculated components are applied. The concern with the addition of credit and surety is quite simply that the Rate Template will be applied in the review process. Reading the regulation it appears that the maximum and minimum permitted earned premium formula do not apply to specialty lines; page 3 of the Filing Instructions clearly supports this interpretation. The CDI's internal process may very well allow for a review of specialty lines that is separate from the ratemaking template, but it is less than clear how the benefits of specialty status are actually being conferred on these products. In particular, the rate template contains an efficiency standard, leverage factor and reserve ratio for surety. Why is this necessary if surety has specialty status?

There are numerous other commercial lines of insurance that would benefit from the specialty line status. In particular, all of the commercial lines insurance that report under annual statement lines that have diverse products and/or combine commercial with personal lines experience would benefit from specialty status. For example, the Fire annual statement line includes personal and commercial risks and includes everything from a small residential dwelling risk to a large office building. This diversity in many of the annual statement line groupings renders inappropriate and ineffective the application of all the standards that the CDI calculates based on the data from these annual statement lines.

§2644.4. Projected Losses

While there is no proposed change to this section, we wish to reiterate our prior request that the regulation allow consideration of other catastrophe models that have been

developed or are currently in the process of development for other perils. Examples of these include brush fire and wind/hail. Additionally terrorism insurance loss models have been developed for pricing. The proposed regulations are not sufficiently flexible so as to permit the use of other models for other types of loss, nor is there any apparent allowance via a variance to include such models.

§2644.6. Loss Development

This section also requires that the insurers' ratemaking selection is the "most actuarially sound." As noted above, the "most actuarially sound" criterion puts unknown hurdles before the insurers as how they are to demonstrate that a sound actuarial method or selection is the "most sound" one. Given this section still allows two choices for loss development, incurred or paid based on the dollar-weighted average for the three most recent accident- years, it is not clear how an insurer can demonstrate that one of the two prescribed methods is the most actuarially sound. The actuarial principles clearly recognize that the loss development and loss reserve estimation exercise is not an either / or exercise. The CAS Statement of Principles Regarding Property and Casualty Loss and Loss Adjustment Expense Reserves, Principle 4 states the following:

> The most appropriate reserve within a range of actuarially sound estimates depends on both the relative likelihood of estimates within the range and the financial reporting context in which the reserve will be presented.

In other words, it is quite possible that neither the paid or incurred method is the "most actuarially sound." The most appropriate estimate may be a weighted average of the incurred and paid methods in some cases.

This section also introduces a clear requirement for insurer claims data. If the loss development selection is limited to either paid loss development or incurred loss development, what additional information is gleaned from claims development data?

§2644.7. Loss and Premium Trend

The formulaic approach of trending 12, 24 or 40 rolling quarters of data which is proposed for frequency and severity will fail to capture turning points in the trend data. The April 2007 regulations considered only 12 quarters of rolling data at this point. Adding the longer periods of time to review of does not address the issue of turning points in the trend data. While there are several variances allowed for trend they are too restrictive to capture a general turn in the trend data. Only in the instance where the insurer can identify the cause of the change in trend might a variance be allowed. A more reasonable, appropriate and responsive approach would be to allow insurers and the Commissioner to consider historical and prospective trends. For example, the historical trend could be based on the most recent 12 quarters of data (or possibly some longer time period if it is appropriate) whereas the prospective trend could be based on the most recent four, six or eight quarters of data. This approach was reviewed and allowed prior to the April 2007 regulations. The CDI has both the staff and the expertise to review this methodology.

If consideration can be given to shorter time periods for trend, then the credibility criteria specified for private passenger auto and homeowners insurance will need to be revisited lest it effectively dampen or "undo" the responsiveness gained in looking at shorter time frames.

The added requirement for the additional quarters of data fails to recognize or address those situations where the filer does not have the data. Not every insurer has 40 quarters of trend data.

Limiting the trending methodology to the exponential curve of best fit ignores current actuarial practices and limits both the insurers and the CDI. For example, the WCIRB uses a Double Exponential Smoothing method and a host of other methods to project loss costs. It is unreasonable to think that only an exponential fit is appropriate.

This section also uses the criteria "most actuarially sound" both in subsection (a) and in the newly added subsection (d). This direction lacks clarity as there is no definition of a "most actuarially sound" trend in actuarial principles or standards of practice. The key place in which the term "actuarially sound" is defined is the aforementioned CAS Statement of Principles which defines this term in the context of the resulting rate, not the individual component decisions that are part of the ratemaking process. Requiring "the most actuarially sound" method at each step is inconsistent with the very meaning of the term "actuarially sound" as defined by the CAS and its generally accepted definition in multiple jurisdictions across the country.

§2644.8. Projected Defense and Cost Containment Expenses.

The alternate loss development methodology allowed for liability coverages in subsection (b) should be allowed for all coverages. In particular, a paid to paid methodology should be allowed for homeowners coverage where an insurer is unable to segregate the multiple perils.

This section also uses the criteria "most actuarially sound", and lacks clarity for that reason. While there is no explicit variance allowance for defense and cost containment expense (DCCE), there should be a variance allowance in order to maintain consistency between the developed losses and the developed DCCE.

§2644.12. Efficiency Standard

Subsection (b) adds some additional language to address the instance where an insurer uses more than one distribution system to sell insurance which is an increasingly common phenomenon, particularly in personal lines. A single distribution system may be associated with a single product with multiple distribution systems used within a line. Insurers set rates by product and make rate filings by product, not by line. The CDI, in calculating the average expense loads by annual statement line, can not appropriately reflect the different approaches to distribution of the product within the line. The CDI indicated in its comments and responses as part of the regulatory package for the April 2007 regulations that it would update its 1999 study of insurer distribution systems. To date there does not appear to have been any movement to update this report. Meanwhile

insurers are held to efficiency standards that do not, at a minimum, accurately reflect differences in distribution systems.

The Department added two documents related to the Efficiency Standard to the rulemaking file for the April 2007 regulations. However, neither of the documents remedies the complete lack of support for the premise that an average expense level is the boundary between an efficient insurer and an inefficient one. As the CDI indicated in their September 2006 regulatory package they did not rely on any empirical studies in proposing the adoption of the regulation. There is thus no basis and continues to be no basis for the regulatory assumption that expenses above the designated level are inefficient nor is there any support for the proposition that an average expense ratio reflects efficiency. Higher expenses could be due to more and better service, lower expenses could be due to inadequate service, including an inadequate claims force. The Department has no way of knowing whether an insurer's expenses are efficient, absent a study of some kind. The two documents added to the 2006 rulemaking file were simply a description of how the Department intends to calculate average expenses and do nothing to support the premise that the average is an appropriate measure of efficiency.

The rate filing instructions which were issued in conjunction with the April 2007 regulations designate specific fees separate from ancillary income. Certain insurers report their expenses on the Insurance Expense Exhibit (IEE) net of other income and thus the Department's calculated efficiency standard penalizes all insurers because the CDI rate indication formula assumes the expenses associated with installment payment plans, for example, are in the efficiency standard. Thos insurers that report expenses on the IEE net of this fee income are penalized even more.

§2644.23. Credibility Adjustment

The new section (b) adds clarity that for lines other than private passenger auto and homeowners that credibility can be applied in the ratemaking process. To the extent this was not clear in the prior regulations, this clarification is an improvement. However, once again, the phrase "most actuarially sound" is added to the criteria. As noted above

there is no single most actuarially sound method for any single component of the ratemaking process and thus this section lacks clarity. The phraseology is echoed again in section (g). As originally stated section (g) was preferable and recognized that an actuarially sound alternative is sufficient for complementary loss and defense and cost containment expenses.

§2644.24. Reinsurance

The restriction that reinsurance costs will only be considered for earthquake and medical malpractice facultative reinsurance continues to be in direct contradiction to actuarial ratemaking principles, which specify that consideration should be given to all costs associated with the insurance transaction and specifically states that the effect of reinsurance arrangements should be considered. We therefore recommend eliminating section (a) of the proposed regulation.

The reluctance to allow legitimate costs of risk transfer in the insurers' rates may be because reinsurance rates are not regulated. The absence of regulation of reinsurance rates does not differentiate that cost from any of the other costs of providing the insurance. Employee wages are not regulated, the price for facilities is not regulated, and prices for paper, pencils, computers and IT support are not regulated. Reinsurance is something the insurer must buy to provide the insurance. If reinsurance is necessary to provide a particular insurance coverage, then the cost of obtaining it should be included in the rates. If it is excluded the rates may be inadequate.

The CDI should clarify what it means and how it intends to apply section (f) as to the term "unauthorized reinsurers."

§2644.27. Variance request

The prior Section 2644.27 (f) (1) has been deleted. This particular variance provided sufficient flexibility to the insurer where the historical ratemaking data is not reasonably reflective of the rating period. This section as originally written clearly recognized the prospective nature of the ratemaking exercise. It also provided strict and adequate

controls allowing the CDI to revisit any granting of this variance. Thus it is unclear why the CDI sees the need to eliminate this particular variance. We believe it should be retained.

In general, the remaining changes to the variances more clearly define the circumstances in which the CDI will grant a variance, the proof that is required and the amount of the variance. To the extent this removes some uncertainty in the rate review process this would be an improvement. However, the would-be improvement comes at the expense of a restrictive system that does not appropriately reflect the dynamic nature of the insurance market and insurer innovations.

The new Section 2644.27 (f) (2) (A) stated reliance on the J.D. Power Ratings and creates an un-level playing field based on customer mix and distribution channel. Additionally J.D. Power Ratings are only available for a limited number of insurers. While additional external studies may be considered there is no allowance for internal studies conducted by the insurer which may provide objective measures of consumer satisfaction. Finally, the proposed changes provide no incentive for companies to invest in improving service if they are not currently "better than most." This is not good for consumers. The variance should also consider year over year improvement.

Similarly the new Section 2644.27 (f) (2) (B) should consider year over year improvements, providing incentive to insurers to increase their presence in underserved communities. Additionally, the wording in 2644.27 (f) (2) (B) which states the measure is the “number of policies sold” and that in 2644.27 (f) (2) (B) (ii) which states that the measure is “percentage of total earned exposures” is confusing. If the intent is to use the percentage then deleting the phrase, “as demonstrated by the number of policies sold in underserved communities” would make the intent more clear.

The addition to newly numbered Section 2644.27 (f) (2) (C) adds insurer fees to the policy premium. To the extent that the average California policy premium is calculated without consideration of fee income, the proposed change creates a mismatch in the

comparison. The Department should provide a source for average premium. To our knowledge the only source is the NAIC report; however this report states that the CDI provides the data.

The new Section 2644.27 (f) (2) (D) caps the adjustment to the efficiency standard at 2% each for superior customer service and superior service to the underserved communities. There is no basis provided for the cap. In light of the undeniable fact that the efficiency standard is nothing more than an average, there is no reason to limit the adjustment under these variances to 2% each. If it costs more than 2 points on the efficiency standard to provide superior customer service then the full amount of the expenses should be allowed.

The proposed deletion of Section 2644.27 (f) (4) should be reconsidered. Investment in the underserved communities should be encouraged. Moreover the investments and support made by insurers for research should also be encouraged and recognized to the extent it exceeds an average participation level.

The newly numbered Section 2644.27 (f) (3) should be rewritten to allow so that it is clear that there are three distinct ways to qualify for a variance under this subsection. The variance should be allowed when an insurer writes at least 90% of its direct premium in one line or writes 90% of its business in California or when the insurer's mix of business presents an atypical risk. In essence, the "and" before the last clause in the subsection should be changed to "or." Additionally, adjusting the leverage factor as contemplated is an unnecessarily rigid approach. The suggested approach would be to adjust based on the insurer's actual projected yield, and that approach would recognize the differences in the investment portfolio necessary to compensate for the increased risks for the mono-line or mono-state company. If, for example, the company is mono-line and focused on a line of insurance subject to catastrophes, then the insurer must maintain a relatively liquid portfolio in order to have the capacity to quickly liquidate investments and pay claims. This impact is accentuated if the company is mono-state as well as mono-line.

The variance for loss development (newly numbered Section 2644.27 (f) (7)) should make allowances for other changes that affect the data used in the loss development process. We recommend that subsection (E) be revised to read "There are changes in the law or other relevant changes that significantly affect the data."

Similarly the variance for trend (newly numbered Section 2644.27 (f) (8)) should make allowances for other changes that affect the data. Subsection (C) should provide: "There is a significant change in law or other relevant changes affecting the past or prospective frequency or severity of claims."

Section 2644.27 (f) (8) (D) should be changed to "It can be shown that a trend other than 12 quarters is more reliable prospectively." This would allow consideration of shorter trend periods to be considered and is consistent with our earlier comments regarding a historical / prospective trending approach.

The new Section 2644.27 (g) again adds the requirement that the "soundest actuarial result" be utilized or selected. Throughout the regulation, this notion that a "soundest" or "most sound" actuarial method can be identified fails to recognize that actuaries routinely look at a variety of methods and select one that is within a reasonable range. Here, again it appears the CDI is requiring a selection between two or more possible answers and not recognizing that an appropriate selection may be an average or within the range of the methods or analysis presented. This section should be deleted as the criteria lacks clarity and does not appropriately reflect the ratemaking process which is by its nature an estimation process that will result in a range of reasonable choices.

The new Section 2644.27 (h) penalizes efficient companies that are below the efficiency standard for investments that they make in loss prevention, loss reduction, superior service and superior service to underserved communities. For example, if an insurer has demonstrated excellence in operating below the efficiency standard and is also investing in these other variance areas why should they not be allowed to recoup these costs? Consumer interests are better served if the most efficient companies are given incentive

to continue to invest in these activities. At a minimum, in order to appropriately recognize the prospective nature of ratemaking the comparison should be against the insurer's projected expenses rather than the most recent year expense ratio.

§2646.4. Hearings on Individual Insurers' Rates

The newly added Subsection (d) requires that if, after a hearing has been noticed, the risk-free rate has changed by more than two percent then the risk-free rate used in the calculation of the minimum and maximum permitted earned premium will be updated. Since the inception of the April 2007 regulations the CDI has routinely updated the rate of the return along with the investment yields and the template formulas themselves. If the purpose of this additional section is to allow the rate review process to be more current then the limitation on adjusting only the risk-free rate falls short. During the course of the rate hearing additional data supporting the ratemaking process may become available such as additional quarters of trend or changes in any of the CDI calculated rate factors. What is gained by limiting the update to a single element of the ratemaking formula other than an inherently inconsistent maximum permitted earned premium? It is difficult to manage the rate filing process with the numerous updates to the template exhibits.