COMMENTS ON CONTEMPLATED REVISIONS TO REGULATIONS GOVERNING PRIOR APPROVAL

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

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TABLE OF CONTENTS

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) and the Personal Insurance Federation of California (PIFC) to provide actuarial consulting services and comments on the contemplated revisions to the prior approval regulations.

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 became 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 for numerous insurers.

Revised prior approval regulations were put into effect in April 2007 with additional revisions in May 2008. I participated in each of the prior approval regulations workshops that led to the revised regulations.

The first section addresses the potential amendments provided in the CDI Notice. The second section discusses additional areas that continue to be of concern.

Comments on Potential Amendments

§2644.12 Efficiency Standard

We appreciate the CDI's willingness to consider potential changes to the efficiency standard. However, we continue to encourage the CDI to consider all of the costs associated with the transfer of risk for the individual insurer when reviewing rates to determine that they are not excessive or inadequate. The often-quoted CAS Statement of Principles in Regarding Property & Casualty Ratemaking Insurance Ratemaking, Principle 2, states that a rate provides for all costs associated with the transfer of risk so that the insurance system is financially sound. Simple averages and standard deviations above or below do not necessarily represent all the costs associated with the transfer of risk, nor can they be, save coincidence, a measure of efficiency. The CDI has an experienced and capable staff that can review the historic and projected expenses for each insurer making a rate filing application. Additionally, the exclusion of specific expenses contained in the current regulations, including a cap on executive compensation, provide a level of protection.

The pitfalls of using the efficiency standard include the following:

Lagging Indicator of Expenses. Ratemaking is prospective and should be based on an estimate of future costs. However, the efficiency standard is, by definition, a lagging indicator. For example, the denominator of the ratio responds slowly to increasing and decreasing rate levels. To the extent that certain expenses are fixed, the projected percentage of fixed expense to premium will drop as premium increases. Thus, when rates are rising the CDI's efficiency standard may project too much expense. Conversely, when rates decrease, the projected percentage of fixed expense to premium increases and the CDI's efficiency standard may project too little expense on an overall basis. At the individual insurer level the expense allocation may be incorrect by even greater amounts.

Because the ratio is based on historical data which predates the projected period from 18 months to over three years, it may also be slow to respond to increasing costs. For example, in the numerator of the ratio, a significant portion of an insurer's expense is payroll. Annual, modest cost of living adjustments are not reflected in the expense ratio except on a retrospective basis.

Fails to Distinguish Service Levels. There is no basis for the regulatory assumption that expenses above the designated level represent inefficient expenditures nor has there been any support presented 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. While variance 2644.27 (f) (2) (A) does allow relief from the efficiency standard for higher quality service levels, deletion of this variance is proposed. This will be discussed below.

Insurers distinguish themselves on service based such things as claims handling, policy service and broad agency distribution. Some insurers have 24/7 claims reporting, in-person service, drive-through and mobile response units to adjust claims: others do not. Some insurers have multi-lingual staff, 24-hour policy service or dedicated risk managers: others do not. However, all insurers are grouped together based on their predominant marketing method and it is assumed that each insurer in the group provides the same level of service. These expense limitations may ultimately result in a reduction in the range of products and services available to consumers and potentially raise rates. For example, an insurer could lower expenses by maintaining a fairly skeletal claims, policy services or agency force, and just pay the claims as they came in. In this case, losses would be higher, contributing to a higher overall rate. As another example, an insurer providing insurance products through a broader agency distribution than the average insurer requires the presence of a robust underwriting and validation functions, which in turns requires larger than average service expenditures. In this case, the regulatory expense cap provides a clear disincentive to widely distribute the insurance products. The regulations should encourage innovation and broad distribution rather than

penalizing reasonable insurer expenditures to streamline service and provide consumers with the widest variety of options as possible.

Fails to Distinguish Products with the Annual Statement Line. As we have noted in prior comments, the insurance products within an annual statement line are diverse. The Department has added language to potentially address the annual statement lines that mix commercial and personal lines of insurance. However, there is no current remedy for those insurance products with expense structures that are different than the majority of the annual statement line absent a generic determinations hearing.

The CDI's current potential amendment does address, to some extent, the concerns above. Allowing an expense cap value greater than the average is superior to the current system for some insurers as it is better suited to reflect the diversity of insurer operations. For other insurers, the proposal removes the current regulatory benefit of operating below the efficiency standard. The potential changes are clearly not uniformly beneficial to insurance companies.

While we continue to believe that the most efficient and accurate method to review rates is to review individual company expense projections, we understand the CDI's desire to use expense standards. A number of persons reading the section have found it less than clear as to how the calculation of the minimum and maximum efficiency standard will be performed. Additionally it is not clear what efficiency standard applies in the instance that an insurer's expense ratio is above or below the maximum and minimum efficiency standard ratios. Below is proposed language for the efficiency standard. Following the proposed language is a brief explanation of the proposed changes.

§2644.12 Efficiency Standards

(c) ~~The maximum efficiency standard shall be calculated as one standard deviation above the arithmetic average of the latest three years for which data are available. The minimum efficiency standard shall be calculated as one standard deviation below the arithmetic average of the latest three years for which data are available. In any rate application in which the insurer's expense ratio is above the minimum efficiency standard~~

~~and below the maximum efficiency standard, the insurer's actual expense ratio shall be employed in place of the efficiency standard.~~ In each category, an annual average expense ratio shall be calculated based upon the weighted mean (weighted by earned premium in California) expense ratio of insurers in that category for each of the three most recent years for which data is available. An annual standard deviation of the expense ratios shall also be calculated for each of the three most recent years based on the insurers' expense ratios in each category. In calculating the averages and standard deviations, the Commissioner may exclude insurers for which reliable data are not readily available as described in section (g).

(d) The efficiency standard for each category shall be calculated as the arithmetic average of the three annual average expense ratios calculated in section (c). The maximum efficiency standard shall be calculated as one average standard deviation above the arithmetic average where the average standard deviation is calculated as the arithmetic average of the three annual standard deviations calculated in section (c) above. The minimum efficiency standard shall be calculated as one standard deviation below the arithmetic average of the three annual average expense levels calculated in section (c). In any rate application in which the insurer's projected expense ratio is above the minimum efficiency standard and below the maximum efficiency standard, the insurer's projected expense ratio shall be employed in place of the efficiency standard.

~~(d)~~ (e) For farmowners, the maximum and minimum efficiency standard for captive insurers shall be based upon the average for all distribution systems combined.

~~(e)~~ (f) For earthquake, the maximum and minimum efficiency standard shall exclude adjusting and other expenses. Adjusting and other expenses shall be added to defense and cost containment expenses.

~~(f)~~ (g) For burglary and theft, all distribution systems shall be combined, and a five-year average shall be used.

~~(g) In each category, the maximum and minimum efficiency standard shall be based upon the weighted mean (weighted by earned premium in California) expense ratio of insurers in that category. In calculating the average, the Commissioner may exclude insurers for which reliable data are not readily available.~~

(h) All data shall be taken from the National Association of Insurance Commissioners database of the statutory annual statement state page and of the Insurance Expense Exhibit, Part III.

(i) A company's data shall be included in the calculation only if

(1) The company is licensed in California;
(2) The company's California direct earned premium is greater than zero;
(3) The company's countrywide direct earned premium is greater than zero;
(4) ~~The company's countrywide direct losses incurred us greater than zero~~ The company's California direct written premium is greater than zero; and

(5) The company's ratio of underwriting expenses to earned premium is greater than zero and less than 65%.

Subpart (c) begins the definition of the efficiency standard calculation. It replaces section (g) of the current regulations and clarifies that the calculation of the weighted average annual expense ratio is an interim calculation in deriving the efficiency standard, rather than defining it as the efficiency standard.

Subpart (d) completes the definition of the efficiency standard and the minimum and maximum efficiency standards. It preserves most of the language of the potentially new section (c) including the proposal to remove the benefit to insurers whose expenses are below the current efficiency standards. However, we are proposing language that would allow the insurer that falls within the range of the efficiency standard to use projected expenses. As noted above, ratemaking is prospective and expense provisions should reflect the conditions expected at the time the rates are expected to be in effect and should include all the expenses expected to be incurred in the transfer of risk. Thus to the extent an insurer's projected expenses fall within the allowable range of the minimum and maximum efficiency standards, they should be allowed to use projected expenses. This will improve the accuracy of the rate review process.

Subpart (i) The only change is to propose an additional check on the data entering the calculations as there are several entries in the current efficiency standard calculation where the written premium is negative. While these entries also have low earned premium and thus, do not have much impact on the calculation of an annual weighted average efficiency standard, including them makes little sense.

§2644.16. Rate of Return

The revision under consideration is to remove Subsection (c) which allows the Commissioner the latitude to increase or decrease the otherwise calculated maximum rate of return by 2%. Subsection (c) was added in May 2008.

An approach similar to what is proposed for the efficiency standard could be employed for the rate of return, whereby the average risk premium is calculated in the same manner as what underlies the current calculation and the standard deviation is calculated over a specified group of insurers. Following is the proposed language:

§2644.16. Rate of Return

~~(a) The maximum permitted after-tax rate of return means the risk-free rate, as defined in section 2644.20(d), plus 6%.~~

~~(c) The Commissioner may increase or decrease the maximum permitted after-tax rate of return by not more than 2% if he finds financial market conditions to be such that the difference between the risk-free rate and the cost of capital is significantly different from its historical average.~~

(a) The maximum permitted after-tax rate of return means the risk-free rate as defined in section 2644.20(d), plus the risk premium for property and casualty insurance companies as defined in section 2644.16(c), plus one standard deviation in the property and casualty insurance risk premium as defined in section 2644.16(d).

(c) The risk premium for property and casualty insurance companies shall be 4.5%.

(d) The standard deviation in property and casualty insurance risk premium shall be calculated as an arithmetic average over the past 15 years of the yearly standard deviation in risk premiums earned by the 50 largest publicly traded property and casualty insurance companies in each of those years. The 50 largest publicly traded property and casualty insurance companies will be determined based on their most recent market capitalization and shall be a static group for the entire period. The risk premium of these companies used in the standard deviation calculation for each year shall be their GAAP return on average equity less the risk free rate for the year in question as defined in section 2644.20(d). In years where the 1-month constant maturity US Treasury bill was not in existence, the 3-month constant maturity US Treasury bill yield shall be used.

Subpart (a) establishes that the maximum rate of return is the sum of the risk-free rate, the average risk premium for property & casualty (P & C) insurers and one standard deviation around the average risk premium.

Subpart (c) effectively adopts the average risk premium that the CDI calculated using P & C insurers.

Subpart (d) specifies the calculation for the standard deviation. It appears that in establishing the 6% risk premium, the CDI relied upon the P & C risk premium for the past 29 years and provided an additional 1.5 points to recognize the uncertainty around

the risk premium calculation and to give meaning to a "maximum" rate of return. However, there was no support or justification provided in support of the 1.5 additional points. Subpart (d) provides a specific calculation for this provision.

Following the methodology outlined above, the standard deviation in P & C company risk premium is 8.0% and the maximum permitted rate of return, based on the current risk free rates is approximately 15.0%. The regulations specifically state that the maximum profit shall represent yields on investments in other enterprises presenting risks to investors comparable to property and casualty insurance. The CDI previously compiled, and provided in the rulemaking file, rates of return for selected industries showing that diversified financial companies and commercial banks had average rates of return of 15.5% and 14.0%, respectively for the 1976-2004 time period.[1] Thus, the resulting maximum rate of return is consistent with the average rates of return for financial companies.

§2644.27. Variance request

The first revision being considered for the variance request section is to delete Subsection 2644.27 (f) (2) (A) which provides relief from the efficiency standard when an insurer can demonstrate a higher quality of service. This particular variance provides flexibility to the insurer that expends more than average on customer service. Even if the efficiency standard is widened to include one standard deviation above the average expense level, an insurer investing in quality service may not be able to reflect its projected costs in the rate. As a variance, the CDI has the right to review the support provided and make an individual determination as to whether the claimed higher quality of service is worthy of relief from the efficiency standard. We believe this variance should be retained.

The second change is to reinstate the variance for higher investments in the underserved communities. We agree with the reinstatement. As we have stated previously, investments in the underserved communities should be encouraged; moreover, the

[1] This information was provided in the file named ROR2004.xls which also showed rates of returns for Utilities and major California Utilities of 11.5% and 12.4%.

investments and support made by insurers for research should also be encouraged and recognized to the extent it exceeds an average participation level.

The third change is to revise the constitutional variance, Subsection (f) (10), to consider the effect on California operations only, rather than the entirety of the insurer's operations.[2] While this is an improvement, it still creates cross-line subsidies that are unfair to policyholders and conflict with actuarial standards. Additionally, it is in direct conflict with the original proponents of Proposition 103 and the early drafters of these regulations. J. Robert Hunter who was a key witness for the CDI during the rollback phase stated the following in regards to the pre-April 2007 regulations:

> "For rollbacks, I interpret CalFarm as testing the constitutionality by looking at the return of the whole insurer group, or a whole company where there is no group…This may result in cross-subsidies…CalFarm and Proposition 103 appear to call for the continuation of cross-subsidies in the rollback phase. However, in the prior approval phase, it is important not to create cross-subsidies between insurers in the group or between lines within a company, except where they serve a specific objective of the Commissioner.[3] (Emphasis contained in the original)

J. Robert Hunter's conclusion is in line with the proposition that both *Cal Farm* and *20th Century* were addressing solely the rollback, which was retrospective in its application to insurers. Therefore, arguably, application of the "regulated firm as an enterprise" concept would not be the same for prospective rate making.

Below is proposed language for this section:

(10) That the maximum permitted earned premium would be confiscatory as applied. This is the constitutionally mandated variance articulated in 20th Century v. Garamendi (1994) 8 Cal.4th 216 which is an end result test applied to the enterprise as a whole. *For purposes of this subdivision "enterprise as a whole" means the insurer's* California *operations in* the line ~~*all lines*~~ *of insurance which* is under review ~~*are*~~ *subject to this Article* ~~*and which are conducted in California*~~. Use of this variance requires a hearing pursuant to 2646.4.

[2] We believe that to be the intent of the proposed change, although placing "California" in front of "insurer's operations" would clarify the section.
[3] Excerpts from Proposition 103 Testimony (Statement), J. Robert Hunter, CAS Forum 1999, p. 357.

§2644.29. Implementation of Rate Changes

This potentially new section allows the Commissioner to require approved rate changes in excess of 15% be implemented over a period of not more than two years.

The regulations allow an insurer to charge a rate that falls between the minimum and maximum permitted earned premium. This section creates an arbitrary cap on the amount of rate that might be implemented in any single year even if the insurer has satisfied the maximum permitted earned premium criteria. The section serves no useful purpose and limits both the Commissioner's and the insurers' flexibility in implementing rate changes in a manner that is favorable to consumers.

§2644.51. Reduction of Approved Rates

This newly proposed Section establishes an expedited means for an insurer to file and receive approval for overall rate decreases. We are in support of a streamlined approval process for all filings. Ideally, expediting the review of rate decreases will allow the Department to free up resources to review other rate applications which should result in an overall reduction in the review period and goes directly to the stated intention of the contemplated revisions – to improve efficiency. There are, however, several considerations that should to be addressed in the current proposal.

The proposed deemer is 60 days after the complete application is received by the Commissioner. First, a complete application is defined elsewhere by regulation §2648.4 to include the numerous schedules contained in the CDI prior approval rate application. Thus, it should be clear what information is needed for a complete Application to Reduce Rates as opposed to any other complete rate application. Second, the date of receipt has been defined elsewhere by regulation §2648.2 as the date the filing is received by the Rate Filing Bureau in San Francisco. This date may precede the Public Notice date by as much as 24 days and may be more restrictive as to the amount of time allowed for the file review than was intended. While not wishing to prolong the review period, it may be

prudent to start the countdown for the expedited review beginning at the Public Notice date.

For private passenger auto, the proposed section only works when a uniform rate reduction is proposed. Any changes in rating categories or relativities necessarily require a class plan filing which is subject to a longer 90-day review period. Unless the CDI is also willing to consider an expedited review of the class plan application, this section will be of limited use to auto insurers in receiving expedited approvals for rate reductions. We suggest that a class plan application that accompanies an Application to Reduce Rates also be subject to the expedited review period.

We also encourage the CDI to allow form changes that represent decreases (or have no rate impact) to also qualify for expedited review.

Section (a) allows the application to reduce rates to be deemed approved in 60 days. Section (b) requires a finding by the Commissioner that the rate reduction will not cause the insurer's financial condition to present an undue risk to its solvency or otherwise be in violation of the law. It appears that the approval of an application to reduce rates is a two-pronged approval, requiring an affirmative finding by the Commissioner which may unintentionally delay the approval process. Therefore, we propose the following language for sections (a) and (b) which provides an approval if the Commissioner does not find an undue risk of insolvency.

(a) Notwithstanding Article 4 of this subchapter, any insurer desiring to reduce an approved rate may do so by filing an Application to Reduce Rates, on a form established by the Commissioner. The Application to Reduce Rates shall include all the information required for a complete rate application by section 1861.05 of the Insurance Code. An Application to Reduce Rates shall be deemed approved, as submitted, 60 days after public notice ~~complete application is received by the Commissioner~~ unless the Commissioner within those 60 days orders a hearing on the application pursuant to section 1861.05 of the Insurance Code or finds that the rate will cause the insurer's financial condition to present an undue risk to its solvency and will otherwise be in violation of the law.

(b) A rate reduction pursuant to this section may be made only on the basis of the insurer's certification~~, and the Commissioner's finding,~~ that the rate will not cause the insurer's

financial condition to present an undue risk to its solvency and will not otherwise be in violation of the law.

Finally there is some concern that section (c) could be used to retrospectively require further premium reductions in the event the Commissioner were to find, following a proceeding against an insurer's use of a reduced rate, that the rate could have been reduced more. We propose the following amendment to section (c):

(c) Nothing in this section shall restrict the Commissioner's authority to initiate a proceeding against an insurer's use of a rate that is excessive, inadequate, or unfairly discriminatory in violation of 1861.05 of the Insurance Code. <u>The Commissioner's Decision as a result of the proceeding will be applied to policies written after the date of the Decision.</u>

Additional Revisions for Consideration

§2642.6 Recorded Period

The regulations are premised on the notion that the historical data, when adjusted for loss development, trend and catastrophes, represent a reasonable expectation for future loss levels. However, there are instances where changes in law or the insurance or economic environment may render historic data less relevant and not predictive of future loss levels. For example, Proposition 213 was implemented in 1997 with an expectation of future reductions in liability losses, but the losses would be present in the three-year historical data set preceding the law change. As a law change this type of change might be allowed as a variance under trend or loss development. However, neither variance addresses the basic adjustment to the historical losses. Another example, currently under consideration, is the application of sales tax to motor vehicle repairs which would have an immediate, substantial increase to future losses, not reflected in the historical data. We suggest the following additional language for §2642.6.

<u>(b) If the historical experience no longer provides a reasonable starting point for ratemaking due to changes in law, policy terms, coverage, mix of business, economic or judicial environment, the historical data shall be adjusted. This adjustment may be made in addition to the adjustments for loss development and trend.</u>

The CDI may also consider allowing the option of using historical and prospective trends under Section 2644.7 or as an additional variance under 2644.12 (f) (8).

§2644.4. Projected Losses

We continue to recommend that the regulation be sufficiently flexible so as to permit the use of other models such as wildfire, wind/hail and terrorism without additional rulemaking required. An insurer wishing to employ emerging technology to better price its risks should not be denied an opportunity to prove the appropriateness of a complex catastrophe models and pay for this review process.

We suggest the following language for this section:

> (d) For the earthquake line of business and for the fire following earthquake exposure in other lines, projected losses and defense and cost containment expenses may be based on complex catastrophe models using geological and structural engineering science and insurance claim expertise. Projected losses and defense and cost containment expenses for other catastrophes may also be based on complex catastrophe models using appropriate scientific, engineering and claims information and expertise. The use of such models shall conform to the standards of practice as set forth by the Actuarial Standards Board and the applicant shall have the burden of proving, by a preponderance of the evidence, ~~that the model is based on the best available scientific information for assessing earthquake frequency, severity, damage and loss,~~ that the model is based upon the best available scientific information pertinent to the field, according to the standards accepted in that field and that the projected losses derived from the model meet all applicable statutory standards.

§2644.17 Leverage Factor and Surplus

Insurers are capitalized at different levels due to such things as the lines and states in which they conduct business, their corporate structure and their desired rating level. Currently there is no recognition in the regulations for insurers that hold capital above that imputed by the leverage ratio except for the limited variance allowed in §2644.27(f) (3).

The industry-wide calculation assumes that each insurer is identically diversified and should be identically capitalized. Ratings agencies such as AM Best and Moody's

specifically consider line and state level diversification in their financial ratings. For example, Moody's financial metrics for an individual insurer as to product focus and diversification are, for a Baa rating, that no single state generates more than 40% of total net written premium and there are two distinct lines of business each generating at least 10% of total net written premium. In order to improve the accuracy of the rate review process we recommend that additional variances be available for the leverage factor. For example, we suggest that the CDI consider a variance that allows consideration of the insurer's targeted rating level.

§2644.20. Projected Yield

Section 2644.20 (4) (B) assumes that capital gains will be realized when there is, of course, no guarantee that this will be the case for the industry as a whole in any given year or for individual insurers. Prior versions of the regulations reviewed the long-term average realized capital gains of the insurer as the estimate of future realized capital gains. We suggest a return to the prior methodology. The information is publicly available, reported in the insurer's Annual Statement, easily verified by the CDI and will increase the accuracy of the rate review process.

§2644.25. Reinsurance

While we continue to urge the CDI to consider reinsurance costs for any line where it represents a cost of the transfer of risk, at a minimum the regulations should allow reinsurance costs in lines of insurance that are subject to low frequency, high severity events. For example, umbrella and property insurance should be added as they are subject to low frequency and high severity events. Reinsurance, combined with adequate surplus levels, is necessary to protect insurer solvency and increase the likelihood that insurers can meet their obligations to policyholders in the face of large losses.

Insurers offering higher increased limits often reinsure a substantial portion or all of the additional limits through treaty excess of loss arrangements. Allowing the costs

associated with obtaining the reinsurance will encourage insurers to offer the higher limits and increase consumer choice.

Transactions with affiliates should be allowed, subject to the same criteria as other reinsurance agreements, that is, that the agreement with the affiliate is a good faith, arms-length transaction at fair market value. In some cases affiliates can provide reinsurance at rates that are more favorable; the regulation creates the incentive to move away from such agreements and may increase costs to consumers.

§2644.27 (f) (3) Variance Request

As we have previously noted, §2644.27(f) (3) could be improved to allow three distinct ways to qualify for a variance. The variance could be extended to insurers that write at least 90% of its direct premium in one line or write 90% of its business in California or when the insurer's mix of business presents an atypical risk. In essence, we recommend the "and" before the last clause in the subsection be changed to "or."

§2644.27 (f) (5) Variance Request

This variance provides relief from the efficiency standard for a line of insurance in which the insurer has never recorded over $1 million in earned premium annually. We propose that this variance be expanded to provide meaningful relief to insurers who are making a substantial investment to offer a new product or to increase their market share. The following language is offered to put forth this idea:

(5) That the insurer should be granted relief from operation of the efficiency standard for the following:

(A) a line of insurance <u>or a new product within a line of insurance</u> in which the insurer has never previously written over $ 1 million in earned premiums annually and in which the insurer has made or is making a substantial investment in order to enter the market. Any such request shall be accompanied by a proposed amortization schedule to distribute the start-up investment.

<u>(B) a line of insurance or a new product within a line of insurance in which the insurer has grown at an average annual rate in excess of one standard deviation above the industry mean growth rate for the line of insurance for at least two of the most recent periods over which the efficiency standard has been calculated.</u>

§2644.27. Variance Request

As we have noted in prior comments, reviewing the rate process component by component without a review of the final result can result in a rate that is biased too low or too high. The confiscation variance does consider the final result but it provides relief only at the lowest end of the spectrum. We propose an additional variance that considers the final result before the rate falls to the confiscation. Under the proposed variance the insurer would present their internal ratemaking calculations and the template rate indication. A variance would be allowed when the difference between the insurer's own rate calculation and the CDI rate review calculation exceeded a certain percent or a certain number of percentage points. The insurer would then detail in their variance request the elements that cause the difference and support for their alternate calculation. To the extent the difference was created by elements that the CDI believes are common to all insurers in a line, the CDI could, of course, deny the variance. Where the CDI recognizes the by-line approach may not apply well to a particular insurer's product they could approve the variance.

Alternately, the CDI could allow an insurer whose projected expenses exceed the maximum efficiency standard by a certain amount, e.g., 5 percentage points, to present support for the difference. As we have noted above there are a number of reasons why the efficiency standard may not encompass the best estimate of future expenses. To the extent the CDI agreed with the insurer projections, relief from the efficiency standard could be granted.