November 28, 2007

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Mr. Sherwood Girion
Deputy Commissioner
Rate Regulation Branch
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013

RE: Variance Process – Request for Comments
Sent via Fax, Email and USPS

Dear Mr. Girion:

The members of the Personal Insurance Federation of California ("PIFC") appreciate this opportunity to offer comments and suggestions regarding the variances associated with the Prior Approval Regulations (California Code of Regulations, Title 10, Section 2644.27(f)). The Prior Approval Regulations are among the most important regulations implementing Proposition 103 because they govern the average rates that insurers may offer in the marketplace.

Since the present version of the Prior Approval Regulations became effective in April, 2007, we have seen clear evidence that a negative regulatory environment can, and does, adversely impact the competitive environment in California. By any objective measure, the revised Prior Approval Regulations have stifled innovation and denied California policyholders the benefits of robust price competition. California can, and should, do better.

The Revised Prior Approval Regulations Lead to Arbitrary Rate Indications

The revised Prior Approval Regulations are a major departure from many years of workable rate regulation, with several arbitrary inputs as well as elements of political rate suppression. The prior system empowered CDI rate staff to use judgment and expertise; the new system employs a rigid formula that elevates consistency above the need for accurate rate review.

While the new rate-making formula may be administratively convenient for the CDI, it will often produce rate indications significantly different from the real world. Sometimes the differences would result in rate suppression, but other times the differences would allow significantly higher rates than needed by an insurer. Either way, there is little insurer confidence in the new rate-making formula because it will most often lead to arbitrary rate indications.

An Arbitrary Prior Approval Formula Will Reduce Price Competition

Because the new Prior Approval Regulations produce arbitrary rates, insurers appear to be hesitant to participate in the new prior approval system. When the new formula produces too large of a rate *decrease* indication, it has the effect of forcing carriers to operate at the margin which then leads over time to solvency concerns. This is an example of where the public is harmed by the regulatory environment because the purpose of insurance is to provide coverage in the event of losses but in order to accomplish that task, carriers must have the necessary financial capacity to do so. For example, carriers are poised to be able to respond to the losses in the recent Southern California wildfires because of adequate capitalization, but, this result could have been vastly different if the new regulation had been applied.

When the new formula produces too large of a rate *increase* indication, then the CDI will be unable to stop an insurer from increasing its rates beyond its actual rate need. While a price competitive insurance market would certainly keep padded rates in check, there is little indication that the new prior approval system has produced vigorous price competition. This is another example of where the public is harmed by the regulatory environment.

In either case, the new prior approval system discourages new rate filings, creates disincentives to price competition and locks in present competitive advantages. While the market leaders like their position, they would much prefer the ability to compete and grow in a regulatory environment that allows fair and flexible pricing.

The Rate Review Process in California is Broken

The experience of the last six months shows that the new Prior Approval Regulations have damaged the insurance marketplace. There has been a sizable decrease in the number of prior approval filings, even after adjusting for the increased number of filings in 2006 to implement the auto rating factor regulations.

The likely new reality is that carriers will avoid the prior approval process until absolutely necessary (i.e., when they have an urgent rate need and are forced to make a rate filing). The CDI needs a better system that encourages rate applications and price competition, instead of the present system in which an insurer waits until there are few other alternatives and must (with great hesitation) subject itself to CDI rate review.

The "Variance" Process is an Inadequate Remedy for a Broken System

CDI staff has sought to reassure the insurance market that the new prior approval system can be flexible through various safety valves. The new Prior Approval Regulations allow an insurer to file a rate change request using the rigid formula and then seek a "variance" from the ordinary rules to cure any problems that arise. However, there are many problems with this approach.

First, under the revised Prior Approval Regulations, rate analysts are not permitted to use their judgment to grant variance requests. Instead, all variance requests must go through a "variance committee," with the guarantee of a substantial delay while the committee deliberates about the appropriateness of granting a variance. Several of the committee participants are outside of the Rate Regulation Division and have no day-to-

day experience reviewing rate applications – adding significant non-actuarial bias into the rate-making process. Additionally, our understanding is that the variance committee will add, at a minimum, one month to the rate review process.

Second, with each request for a variance from the formula-driven rate indication, paid "intervenor" groups will allege that insurers are seeking special treatment and "inflated rates," instead of mere rate adequacy. They will urge the CDI not to "cave in" to pressure from insurers – when in reality insurers simply want an opportunity to obtain fair rates under fair rules in a timely manner.

In this environment, it should come as little surprise that the insurance marketplace has not embraced the variance process. There is no indication that the variance process is workable.

We Need to Fix the Ratemaking Formula so that Variances are the Exception, Not the Rule

Rather than simply hope that the current negative situation will improve by bringing additional clarity to the variances, why not fix the aspects of the Prior Approval Regulations that we all know are broken? We respectfully submit that the CDI should focus, first, on fixing the prior approval formula and, second, on adding clarity to the standards for obtaining variances.

Under the new system, when insurers do file rate applications, it is highly likely that the CDI will see the same variances over and over because certain of the underlying formula components need to be fixed. Rather than force insurers into the cumbersome variance process, we ask the CDI to reserve the work of the "variance committee" for exceptional circumstances. It is likely that the CDI's regulations could regain credibility by fixing the glaring flaws with the (1) trend, (2) loss development, (3) efficiency factor and (4) rate of return components.

We hope the CDI will fix the Prior Approval Regulations and allow the experienced CDI rate analysts to do their jobs. There is a great need to eliminate our new cumbersome, confusing system where a handful of people on a "variance committee" will act as a bottleneck and impede the creation of a fair and flexible rate-making environment.

Suggestions for Improvement

While we will respond productively to the CDI's request for input on how to clarify the existing variance standards, we believe it is much more important to fix the underlying components to the rate-making formula. As requested, below are suggestions to clarify the standards for granting or denying variance requests. In addition, we have also identified selected components of the Prior Approval formula that lead to inaccurate rate indications and which should be modified. We respectfully request that the CDI consider both sets of changes which we believe would facilitate our mutual interest in stimulating price competition.

Suggestions to Modify the Variances

1. Section 2644.27(f)(1): We request deletion of the final sentence in Section 2644.27(f)(1), as follows:

(1) That the insurer will alter its mix of business in the rating period from the mix in the recorded period in a manner that affects the maximum and minimum permitted earned premium. Any such representation by the insurer shall specify the precise changes in business operations, shall be supported by a statement of an authorized official of the insurer indicating the manner in which the insurer plans to implement the change, and shall include such substantiating information as the Commissioner may require, including but not limited to specification of changes in the insurer's marketing program and relevant market research. ~~Such representation shall be accompanied by the stipulation by the insurer to refund to consumers in a subsequent rate case if the change fails to materialize.~~

- *Justification for Change:* The current variance for plans to alter a carrier's mix of business contains an unfair penalty that makes the variance too risky of a proposition. The current variance already requires significant planning and justification. If plans fail, it is unfair to expect an insurer to refund premiums after legitimate, albeit ineffective, marketing expenses. The variance would require an insurer to subject itself to rate inadequacy when, to the contrary, an insurer needs to be able to rely upon an approved filed rate. The current variance requires perfection in prospective rate-making that simply does not exist in the world, and which the CDI certainly would not demand of itself.

2. Section 2644.27(f)(2): We request modification of Section 2644.27(f)(2), as follows:

> (2) That the insurer should be allowed to recover additional costs for bona fide loss-prevention and loss-reduction activities provided the insurer can demonstrate~~ loss reductions commensurate with the increased expenditures~~ increased expenditures on loss-prevention and loss-reduction activities.

- *Justification for Change:* The current variance for loss-prevention and loss-reduction activities requires a level of proof that is unreasonable in prospective rate-making. The variance should focus upon actual expenditures as a justification for higher rates, instead of requiring a carrier to concoct a demonstration of the efficacy of the projected expenditures. Further, the current variance places the CDI variance committee in the position of substituting its business judgment for an insurer's, allowing the CDI to deny loss-prevention expenditures if it does not believe the expenditures will yield acceptable results. This cannot be the best use of CDI resources and certainly will not improve upon the loss-prevention and loss-reduction activities of trained insurer personnel.

3. Section 2644.27(f)(3): We request modification of Section 2644.27(f)(3), as follows:

> (3) That the insurer should be allowed a higher ~~or lower~~ efficiency standard due to:

- *Justification for Change:* There is no need for a variance to lower the efficiency standard. An insurer can offer lower-than-maximum rates without using a variance~~.~~

(A) ~~higher or lower quality of service, as demonstrated by objective measures of consumer satisfaction;~~ above industry average or significantly improving quality of customer service as demonstrated by any objective measures of consumer satisfaction ; justified complaint ratios lower than the industry average; or demonstrable expenditures in activities intended to improve customer service; or

- *Justification for Change:* The current variance for the efficiency standard should provide an incentive not only for those who seek additional expenses to improve their service levels, but also for industry service leaders to maintain their existing service levels. Also, the current variance requires an insurer to first demonstrate outstanding service in order to justify a variance for increased rates, rather than focusing upon actual expenditures to lead to increased service levels. Variances should lead to rate adequacy, not require an insurer to "roll the dice" on increased expenses and hope that it can obtain rate adequacy at a later date.

(B) Demonstrably superior ~~or inferior~~ service to underserved communities, as defined in section 2646.6; or

- *Justification for Change:* Reference to "inferior" service would only make sense if an insurer would be seeking a variance to "lower" its efficiency standard. This reference is unnecessary. An insurer can offer lower-than-maximum rates without using a variance.

(C) Significantly smaller ~~or larger than average policy size.~~ than average premium per policy than other carriers selling similar product lines through similar distribution channels.

- *Justification for Change:* The current variance related to average policy size could be tightened with the above change.

4. Section 2644.27(f)(4): We request modification of Section 2644.27(f)(4), as follows:

(4) That the insurer should be allowed a higher ~~or lower~~ return on equity due to higher ~~or lower~~ financial investment in underserved communities, as defined in section 2646.6.

- *Justification for Change:* This reference is not needed. The insurer would not seek a lower return related to its investment in underserved communities, but rather the variance would be based upon higher investments in underserved communities.

5. Section 2644.27(f)(5): We request modification of Section 2644.27(f)(5), as follows:

(5) That the insurer should be authorized a rate of return

different from the rate of return determined pursuant to section 2644.16 on the ground that the insurer writes at least 90% of its direct premium in one line or in California ~~and~~ or its mix of business presents investment risks different from the risks that are typical of the line as a whole.

- *Justification for Change:* This change adds flexibility to the variance system while maintaining ascertainable standards.

6. Section 2644.27(f)(9): We request modification of Section 2644.27(f)(9), as follows:

> 9) That the loss development formula in section 2644.6 loes not produce an actuarially sound result because
>
> A) There is not enough data to be credible;
>
> (B) There are not enough years of data to fully calculate the development to ultimate;
>
> (C) There are changes in the insurer's reserving or claims closing practices that significantly affect the data; or
>
> (D) There are changes in coverage or other policy terms that significantly affect the data;
>
> (E) There are changes in the law that significantly affect the data; or
>
> (F) It can be shown that the alternate selected loss development factors are reasonable in accordance with standards of practice as set forth by the Actuarial Standards Board.

- *Justification for Change:* The current formula for loss development contains an arbitrary 3-year provision that should be deleted. In the absence of such a deletion, rate applicants should be able to apply for a variance using alternate loss development factors based upon solid actuarial evidence.

7. Section 2644.27(f)(10): We request modification of Section 2644.27(f)(10), as follows:

> (10) That the trend formula in section 2644.7 does not produce an actuarially sound result because
>
> (A) There is a significant increase or decrease in the amount of business written or significant changes in the mix of business;
>
> (B) There is a significant change in the law affecting the

frequency or severity of claims;

(C) It can be shown that ~~trends calculated over at least a 10-year period are more reliable prospectively;~~ the alternate selected trend factors are reasonable in accordance with the standards of practice as set forth by the Actuarial Standards Board

- *Justification for Change:* The current formula for loss and premium trend contains an arbitrary 12-quarter provision that should be deleted. In the absence of such a deletion, rate applicants should be able to apply for a variance using alternate trend factors based upon solid actuarial evidence.

Suggestions to Modify the Prior Approval Formula

More important than the above suggestions to modify variance approval criteria is the need to improve the underlying components of the rate-making formula.

1. Section 2644.6: We request modification of Section 2644.6, as follows:

"Loss development" is the process by which reported losses are adjusted for anticipated payout patterns. Loss development shall be presented as a loss-development triangle, ~~based on the~~ and display dollar-weighted average of the ratios of losses for the ~~three~~ most recent accident-years, policy-years or report-years available for a reporting interval. The insurer shall demonstrate that its selected loss development factors are actuarially reasonable in accordance with standards of practice as set forth by the Actuarial Standards Board. Filings shall contain both paid losses and case-specific reserves, stated separately. Loss development shall employ either paid losses or the sum of paid losses and case-specific reserves. The insurer shall submit both the factors and ultimate losses for both paid and incurred loss development reported claims and the paid claims calculations, and shall demonstrate that its selection is the most actuarially reasonable. Loss development data shall exclude catastrophes. Where the loss development factors within a given line significantly vary by subline, by size of loss, or by coverage, separate loss development factors shall be calculated in accordance with that evidence.

- *Justification for Change:* This proposed change to permit alternate loss development factors would recognize the need for an actuary's knowledge and judgment, while adhering to specific recognized standards, resulting in a more complete analysis and prediction of future loss experience. This proposed change would also permit the CDI rate analysts to provide meaningful input into the rate-making process.

2. Section 2644.7(a): We request modification of Section 2644.7(a), as follows:

"Loss trend" and "premium trend" is the process by which forces not reflected in historical loss and premium data are expected to affect losses and premiums in the rating period.

(a) Trend factors shall be based on the exponential curve of best fit. Premium and loss trend factors shall be developed using the insurer's company-specific

~~most recent twelve quarters of rolling calendar year~~ data excluding catastrophe~~s~~ losses. Frequency trend shall be calculated as reported or closed claims divided by exposures. Severity trend shall be calculated on paid losses divided by closed claims or total paid losses, including partial payments in previous calendar years, on closed claims divided by closed claims. The insurer shall submit the frequency and severity calculations on both bases~~, and~~ . The insurer shall demonstrate that its ~~selection is the most~~ selected trend factors are actuarially reasonable in accordance with the standards of practice as set forth by the Actuarial Standards Board. Premium trend factors shall be developed using company-specific premium per exposure data.

- *Justification for Change:* This proposed change recognizes that twelve quarters is an arbitrary period that may not serve as the most accurate indicator of loss and premium trend. The existing language acknowledges forces *not* reflected in the historical loss and premium data will affect losses and premiums in the rating period. Allowing for actuarial knowledge and judgment, while adhering to specific recognized standards, should result in more accurate rates, and also permit the CDI rate analysts to provide meaningful input into the rate-making process.

3. Section 2644.12: We request modification of Section 2644.12(c) and (d), as follows:

(c) ~~The efficiency standard~~ Expense ratios for each insurer shall be calculated ~~as the arithmetic average of~~ using the latest three years for which data are available.

(d) In each category, the efficiency standard shall be set at the weighted ~~mean~~ 80th percentile (weighted by earned premium in California) expense ratio of insurers in that category. In calculating the~~ average~~ efficiency standard, the Commissioner may exclude insurers for which reliable data are not readily available.

- *Justification for Change:* This proposed change would calculate the efficiency standard based upon an industry percentile rather than an industry average. While industry-wide averages may serve as useful benchmarks, we believe that it is inappropriate to use the average expense ratio to determine default expenses for an individual company. Simply having an expense level that exceeds the average does not mean that a company is "inefficient." Averages and mean, by definition, will result in a significantly large number of requests for a variance. Moving to the 80th percentile will decrease the incentive to file variances for most companies.

4. Section 2644.16: We request modification of Section 2644.16, as follows:

(a) The maximum permitted after-tax rate of return means the risk-free rate, as defined in section 2644.20(d**),** plus ~~6%~~ 8%.

- *Justification for Change:* There is an inconsistency in the regulations regarding the maximum permitted rate of return for companies in Section 2644.16 and the rate of return that insurers must assume they are receiving on common stocks in their investment portfolios as in 2644.20 (c)(4). The maximum permitted rate of return for companies is the risk free yield rate plus 6%, while companies must assume that the

return on their investments in common stocks is the same yield rate plus 8%. The discrepancy wrongly assumes insurance is less risky than the average industry. The maximum permitted rate of return should be changed to match the presumed return on common stocks.

5. Section 2644.17(b): We request modification of Section 2644.17(b), as follows:

> (b) The Commissioner shall calculate industry-wide leverage factors for each insurance line annually, within 45 days of the publication of the necessary source data. The factors shall be calculated using the consolidated underwriting and investment exhibit as published in Best's Aggregates and Averages. The allocation of the commercial multiple peril data to liability and non-liability and the allocation of the automobile physical damage data to private passenger and commercial shall be done using data from the Exhibit of Premiums and losses (Statutory Page 14 Data) as published in Best's Aggregates and Averages. For medical malpractice, other liability and product liability, there shall be separate leverage factors for claims-made and occurrence. Total national industry surplus shall be allocated to lines of business in proportion to the national industry-wide unearned premium, loss and loss adjustment expense reserves. The leverage factor for each line of business shall be the national premium divided by the allocated surplus.
>
> Notwithstanding the result of the calculation, the maximum leverage factor for earthquake shall be 1.0. For other lines of business subject to catastrophes, mass torts and other unusual events, the Commissioner shall modify the leverage factors where he finds that they do not provide a reliable estimate of future risk, pursuant to section 2646.3. Given the uncertainties of insuring low-frequency, yet potentially high-severity events, for these lines of business the insurer may select an alternative leverage ratio and demonstrate that it is actuarially reasonable in accordance with standards of practice as set forth by the Actuarial Standards Board.

- *Justification for Change:* Catastrophes are potentially solvency threatening events whose frequency and large variation in severity make them difficult to recognize in projecting future costs for ratemaking purposes. Insurers should have flexibility to select a leverage ratio commensurate with the risk exposure and demonstrate its appropriateness. Alternatively, a rate of return could be selected that reflects riskiness of the insured peril.

6. Section 2644.25(e): We request modification of Section 2544.25(e) as follows:

> ~~(e) There will be no allowance for reinsurance between affiliated entities as set forth in Schedule Y of the Annual Statement.~~

- *Justification for Change*: Under current California regulations, inclusion of an insurance company's net cost of reinsurance is permitted only for reinsurance purchased from external (third) parties. For companies that purchase a portion of its catastrophe reinsurance from an affiliated company, the result of this regulation is financially penalizing. However, it should be noted that policyholders may benefit by a company's

purchase of catastrophe reinsurance through an affiliate rather than the external market. An affiliate may have a lower cost of capital, thereby allowing a lower rate for providing catastrophe reinsurance coverage than the rate required by the external market. This lower rate enables the company to purchase its catastrophe reinsurance (i.e., its financial protection) for less cost, making it a financially stronger entity, more able to protect its policyholders in the event of a significant loss.

PIFC looks forward to continued dialogue with the CDI on improving the Prior Approval Regulations, including both the underlying components to the rate-making formula, as well as the variance standards.

Thank you for your consideration of these comments. If you have any questions, please do not hesitate to contact Kimberley Dellinger at (916) 442-6646.

Sincerely,

Kimberley Dellinger
General Counsel

cc: Lara Sweat, Esq.
Rex Frazier