

**SUMMARY OF AND RESPONSE TO PUBLIC COMMENT RECEIVED PRIOR
TO OCTOBER 23, 2006, PUBLIC COMMENT DEADLINE**

In response to the October 5, 2006, Notice, the Department received comments from the following persons prior to the October 23, 2006, public comment deadline:

Shawna Ackerman on behalf of American Insurance Association, Association of California Insurance Companies, Personal Insurance Federation of California, dated October 23, 2006 (hereinafter "Ackerman")

J. David Cummins on behalf of American Insurance Association, Association of California Insurance Companies, Personal Insurance Federation of California, dated October 23, 2006 (hereinafter "Cummins")

Dianne Estrada and Stephen Underhill on behalf of Fireman's Fund, received October 20, 2006 (hereinafter "Estrada/Underhill")

Randall Farwell on behalf of Interinsurance Exchange of the Automobile Club, dated October 23, 2006, (hereinafter "Farwell")

Roxani M. Gillespie on behalf of 21st Century Insurance Company, dated October 23, 2006 (hereinafter "Gillespie")

James E. Masek, on behalf of Insurance Services Office, Inc. October 23, 2006 (hereinafter "Masek")

Pamela Pressley, on behalf of the Foundation for Taxpayer and Consumer Rights, dated October 23, 2006 (hereinafter "Pressley")

John Richmond on behalf of California State Automobile Association Inter-Insurance Bureau, dated October 23, 2006 (hereinafter "Richmond")

Richard J. Roth, Jr. on behalf of 21st Century Insurance Company, dated October 23, 2006 (hereinafter "Roth")

Hilary N. Rowen and Richard Derrig on behalf of The Doctors Company, Nationwide Mutual Insurance Company, Allied Insurance Company, Oregon Mutual Insurance Company, dated October 23, 2006 (hereinafter "Rowen/Derrig")

Allan I. Schwartz, AIS Risk Consultants, Inc., on behalf of the Foundation for Taxpayer and Consumer Rights, dated October 23, 2006 (hereinafter "Schwartz")

Russina Sgoureira, Ph.D., on behalf of Progressive West Insurance Company, dated October 23, 2006 (hereinafter "Sgoureira")

Timothy J. Shannon, on behalf of the California Association of Professional Liability Insurers, dated October 23, 2006 (hereinafter "Shannon")

Sherman Sitrin, on behalf of American International Group (AIG), dated October 23, 2006 (hereinafter "Sitrin")

Steven H. Weinstein, on behalf of American Insurance Association, Association of California Insurance Companies, Personal Insurance Federation of California, dated October 23, 2006 (hereinafter "Weinstein")

Introductory, Concluding, and/or General Remarks Not Specific to a Particular Section

Commentor: Ackerman, 2 - 3

Summary: The commentor begins by summarizing her background and the status of this rulemaking proceeding. The commentor indicates her CV is attached as Exhibit 1, but it was not attached to the comments submitted on October 23.

Response: Because this is not a comment specifically directed at the proposed revised regulation text, or the procedures used, a response is not required.

Commentor: Roth, page 1

Summary: The commentor begins with general background information about the focus of his comments.

Response: Because this is not a comment specifically directed at the proposed revised regulation text, or the procedures used, a response is not required.

Commentor: Weinstein, page 1 - 3

Summary: The comment begins with introductory remarks and historical background. The commentor continues to object to the proposed regulations because they create a formulaic, one-size-fits-all approach to ratemaking and are contrary to applicable law. The comment sets forth the background of those on whose behalf the comments are submitted.

Response: Because this is not a comment specifically directed at the proposed revised regulation text, or the procedures used, a response is not required. To the extent the

comment previews comments detailed later, responses are provided in connection with the more detailed comments summarized and responded to later in this document.

Commentor: Weinstein, page 3 - 4

Summary: The proposed regulations do not comply with the six standards set forth in Government Code Section 11349.1, specifically the necessity and authority standards. There is no need for state mandated uniform rates, arbitrary reduction of costs and expenses incurred by insurers, a one-size-fits-all formula, and rate of return cap. The Department has provided no data, analysis, or study in support of the regulations and no support for the October 5 changes. There is no basis for making the necessity determination, and the Commissioner does not have authority to order state made rates.

Response: Please see response to similar comments made by the commentor in connection with the September 13, 2006, public comment deadline and to similar comments made in connection with the October 5, 2006, changes to the proposed regulations.

Commentor: Weinstein, page 7 - 8

Summary: The revised regulations do not comply with the clarity standard and do not comply with the "adverse economic impact" standards.

Response: To the extent the comments are general in nature, detailed responses cannot be provided. To the extent the comments are intended as a summary of comments set forth in greater detail later in the document, the Commissioner will respond in detail herein in connection with the responses to the more detailed comments.

Commentor: Weinstein, page 10 - 11

Summary: An agency must give the public an opportunity to participate in a public hearing before a regulation is adopted. The Department is not holding a hearing on the October 5, 2006, regulation revision. This is contrary to the requirement that there must be a public hearing. The October 5 revision includes changes that are substantial and not solely grammatical. The changes to professional liability and rate of return are cited as examples. This violates section 11346.8(c).

Response: Pursuant to Government Code Section 11340.9(g), Chapter 3.5, governing Administrative Regulations and Rulemaking, does not apply to a regulation that establishes or fixes rates, prices, or tariffs. Therefore, pursuant to section 11340.9(g) and *20th Century*, Chapter 3.5, including section 11346.8(c), does not apply to this rulemaking. Nevertheless, the commentor's interpretation of section 11346.8(c) is plainly wrong. That section provides that no further public notice is required if a change is

nonsubstantial or solely grammatical nature. If the change is substantial, or not solely grammatical, 15 days' notice is required. Despite the fact that Chapter 3.5 does not apply to this rulemaking proceeding, the Department did provide an opportunity to comment on the October 5, 2006, revisions for a period of at least 15 days. No hearing is required.

Commentor: Farwell, page 3

Summary: The proposed changes will lead to artificial rate reductions and an inadequate rate level for the Exchange. The combination of the target rate of return and the leverage ratio formulas will produce an actual return inconsistent with the risk being assumed. The Exchange's business is highly concentrated in California, and therefore an exceptionally strong surplus is needed. Because the Exchange is efficiently managed, its rates are low. Forcing future rate adjustments based on actuarially unsound methodology will erode the capital available to sustain a healthy and competitive marketplace.

Response: To the extent the comments are general summaries of comments further described in the commentor's comments, the Commissioner is responding in connection with its response to the more detailed comments. To the extent the Exchange's business is concentrated in California, the Commissioner notes that a variance is provided in section 2644.27(f)(5) for a company writing at least 90% of its direct premium in California. An efficiently managed company benefits from the clarification set forth to the efficiency standard. The Commissioner has determined that the methodology set forth in these regulations is actuarially sound.

Commentor: Pressley, page 1.

Summary: Introductory comments.

Response: Because this portion of the comment is not specifically directed at the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary.

Commentor: Pressley, page 1.

Summary: Concluding remarks.

Response: Because this portion of the comment is not specifically directed at the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary.

Commentor: Schwartz, page 1.

Summary: Introductory comments.

Response: Because this portion of the comment is not specifically directed at the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary.

Commentor: Masek, page 1.

Summary: Introductory comments.

Response: Because this portion of the comment is not specifically directed at the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary.

Commentor: Masek, page 2.

Summary: Concluding comments.

Response: Because this portion of the comment is not specifically directed at the Commissioner's proposed revised regulations or to the procedures followed in proposing the revised regulations, no response is necessary.

Comments Submitted on Unchanged Portions of Regulations

To the extent comments were provided on unchanged portions of the regulations, a response is not required.

Commentor: Shannon, page 2

Summary: Due to the changes in 2642.7, it may be appropriate to revise the wording in section 2643.6(c) to specify Professional Liability or Error and Omissions as well as, or instead of, the specialty categories.

Response: The comment, presented *verbatim*, appears to suggest adding Professional Liability and or Error and Omissions to specialty lines. For the reasons set forth herein this comment is rejected. This section was not proposed for change in the October version of these regulations, and a response is therefore not required.

Commentor: Pressley, pages 2-3.

Summary: Reiteration of FTICR's objections to Sections 2644.25-.26 of the proposed regulations relating to inclusion of certain reinsurance costs.

Response: Because this comment relates to an unchanged portion of the regulations, a response is not required.

Commentor: Pressley, page 4

Summary: We continue to be opposed to eliminating the use of an individual company's fixed and variable expenses in the rate calculation and requiring the use of the efficiency standard in all instances. We believe that when a company's expenses fall below the industry-wide efficiency standard expenses, the use of the efficiency standard should not be mandated. To use the efficiency standard in all instances, even when a company's own expenses may be lower, will result in windfall profits to insurers and excessive rates for policyholders.

Response: This comment relates to an unchanged portion of the regulations, and a response is therefore not required. The original intent of the efficiency standard was to apply the efficiency standard to all companies, allowing a reward for more the more efficient than average company while not allowing inefficient companies to pass their inefficiencies onto policyholder in the form of higher premiums. The application of the efficiency standard as described has been the methodology used by CDI for many years in many hundreds of case-by-case adjudications. There has emerged no pattern of windfall profits and there are no indications that the application of the efficiency standard has precipitated a pattern of excessive rates.

Because insurance tends to be a cost-plus business, insurers have little incentive to avoid expenses that they can pass through to consumers. It is impossible for a regulatory agency to regulate price if one allows management complete freedom to spend money arbitrarily and excessively. Proposition 103 requires effective regulation of price. There is no constitutional right to protection of inefficiency.

Under Proposition 103, as modified by *Calfarm Insurance Co. v. Deukmejian* (1989) 48 Cal.3d 805, insurers are entitled to the opportunity to earn a fair and reasonable rate of return. Court decisions interpreting the "fair rate of return" standard make it clear that the opportunity to achieve a fair return must be provided only to those who conduct their operations in a reasonably efficient manner. *Greenleaf Finance Co. v. Small Loans Reg. Bd.* (1979) 385 N.E. 2d 1364. Thus, insurers may only pass on reasonable expenses to insurance consumers. The efficiency standard complies with this requirement.

Commentor: Pressley, page 4

Summary: See various comments previously submitted in connection with specific regulation sections, which are reiterated here.

Response: These comments are not related to revisions proposed on October 5, 2006. .

Commentor: Shannon, page 3 - 4

Summary: Due to the changes in 2642.7, it may be appropriate to revise the references to “medical malpractice” in this section and specifically in section (j) to reference “Professional Liability or Error and Omissions,” of which medical malpractice is a subcategory, instead.

Response: The Commissioner rejects this comment. For the reasons set forth elsewhere in this rulemaking file, the Commissioner has determined that he will consider reinsurance costs for specified medical malpractice, not for all professional liability.

Commentor: Shannon, page 3 - 4

Summary: Subsections (i) and (j) require a hearing upon the request of an intervenor. The Commissioner should have discretion as to whether to hold a hearing.

Response: These comments related to unchanged portions of the regulations. Subsections (i) and (j) are only applicable in the earthquake and medical malpractices lines where at least 30% of the requested rate results from the cost of reinsurance. The Commissioner has determined the 30% threshold is reasonable under the circumstances and will prevent misuse of this subsection. Coupled with the fact that these subsections apply only to earthquake and medical malpractice lines the Commissioner does not see any substantial procedural danger in allowing for a hearing upon request of an intervenor. It should be noted that the regulations were revised to allow for the recognition of reinsurance in response to comments from earthquake and medical malpractice insurers due to the unusual reliance upon reinsurance by insurers selling these two lines. Prior to the revision there was no specific recognition of reinsurance in any line in the regulations, though reinsurance costs were allowed following the Safeco prior approval hearing discussed elsewhere in this rulemaking file.

Commentor: Shannon, page 3 - 4

Summary: While allowing for the recognition of reinsurance is a step in the right direction the Commissioner should expand this such that the regulations take reinsurance into account for all lines. The requirements set forth in subsection (d) that the reinsurance transaction be recognized for ratemaking purposes where the reinsurance agreement was entered into in good faith in an arms-length transaction and at fair market value and that there be an acceptable transfer of risk, and the reinsurance must comply with all applicable Statutory Accounting Principles are unclear. Insurers have no way to know what is meant by these phrases and requirements. A safe harbor provision should be included that allow for the recognition all reinsurance transactions reported and attested to in any annual statement. Reinsurance among affiliates should be recognized.

Response: These comments relate to unchanged portions of the regulations and a response is therefore not required. See responses to similar comments elsewhere in this rulemaking file.

Commentor: Shannon, page 3 - 4

Summary: Insurers should not be required to submit a “reinsurance agreement” as many times there is no formal documentation.

Response: This is not a comment on a changed portion of the regulations. To the extent there are concerns that reinsurance agreements are confidential, the Department has dealt with similar concerns in connection with underwriting guidelines and catastrophe modeling, and can similarly address any confidentiality concerns regarding reinsurance agreements.

Commentor: Shannon, page 3 - 4

Summary: There is no explanation of the rationale behind choosing thirty percent at the threshold amount in subsection (j).

Response: Thirty percent strikes a reasonable balance between a reinsurance agreement which may have a relatively insignificant impact on the rate and the costs of a reinsurance agreement which an insurer seeks to include in the rates which has an impact on the requested rate of 30% or more. This is not a comment on a changed portion of the regulations.

Commentor: Shannon, page 3 - 4

Summary: The meaning of the term “rate” in subsection (j) is unclear. It is unclear whether it refers to a proportion of the rate change requested or the total rate.

Response: The language of the regulation is clear that it refers to the total rate. This is not a comment on a changed portion of the regulations.

§2642.4. Pure Premium.

Commentor: Ackerman, page 3

Summary: The commentor supports the Department's deletion of this section.

Response: Because the commentor supports the proposed change, a specific response is not required.

§2642.6. Recorded Period.

Commentor: Ackerman, page 3 – 4

Weinstein, page 8

Summary: The proposed change regarding the use of more than three years lacks clarity and is unclear. More years may be used only if the credibility of the three year data is less than 25%. Additional years are allowed only to bring the data set to 25% credibility. What complement is to be used for the remaining 75%? Section 2644.23(g) provides that the complement of credibility is the insurer's choice provided it is actuarially sound and reasonable in the circumstance. Section 2644.23(c) – (f) dictates the complement of credibility in the event the data is more than 25% and less than 100% credible. Is it the Department's intent to use a three-part credibility when the data is less than 25% credible, in which case credibility is applied to the base three year period, the first complement applied to additional years up to a total of 25% credibility and the remaining 75% is applied to the net trend? If so, it is unclear that is the intent. Proposed subsection (1) continues to ignore that additional years of experience is an actuarially reasonable source of complementary data and may be more appropriate than net trend. It is commonplace to use longer experience periods (i.e., recorded periods) for homeowners and commercial liability, where five years is common.

Credibility is used to promote rate stability. A large company with fully credible data in a single year may not wish to rely upon the shorter time frame because of the volatility of the rate indication. The new addition in subsection (2) would require the insurer to rely on the single year and may introduce more volatility in rates than is desirable.

Response: The regulation is clear. If adding additional years of experience does not result in 25% credibility, then the insurer is free to use any actuarially sound and reasonable complement. If adding additional years of experience does result in 25% credibility, then the complement shall be as defined in section 2644.23(d). There is no three-way credibility procedure if credibility is 25% or more. Comments about preferred additional alternatives do not address revisions proposed here and similar comments in response to the initial notice were responded to previously. If the data is 100% credible, then by definition volatility is not a problem. For all lines except for homeowners and private passenger auto, insurers are given flexibility to choose their full credibility standards.

Commentor: Farwell, page 2

Summary: The commentor supports allowing insurers with less than 25% data credibility to add additional years of experience. The commentor is concerned with the proposed change that would reduce the experience period for carriers with a larger

volume of data. A carrier will be required to use less than three years of experience if they have attained the full credibility standard mandated by the Department. Ratemaking must balance the competing concepts of responsiveness and stability. This rule will give too much weight to the former at the expense of the latter. The last sentence if (s) should be replaced with "In that case, the carrier shall select no more than three years experience and justify their selection." This will align the regulation with the Casualty Actuarial Society.

Response: If the data is 100% credible, then stability is adequately weighed, by definition. For all lines except for homeowners and private passenger auto, insurers are given flexibility to choose their full credibility standards.

Commentor: Sitrin, page 1.

Summary: As the credibility adjustment allows for the use of less than three years data where the data is fully credible a different number of years may be used to calculate the premium indication within a given line. For instance, the number of years of data required for private passenger auto liability may be one year, while the number of years required for uninsured motorist may be three or more years.

Response: The credibility adjustment is intended to apply to coverages within lines.

Commentor: Shannon, page 1.

Summary: The summary sets forth an outline of the requirement provided for in the section. The regulation allows for additional historical experience periods to be considered up until the total volume achieves at least 25% credibility or up to a maximum of three years. And the section allows for the use of less than three years if the data reaches 100% credibility.

Response: The comment is correct in that the proposed regulations provide that the recorded period shall be the most recent three years for which reliable data are available, unless the credibility of that experience is less than the value contained in section 2644.23(g). The threshold value contained in 2644.23(g) is credibility weight of 25%. In that case, additional years shall be added to the recorded period until sufficient years are used to reach the credibility standard set forth in section 2644.23(g). In no case shall the recorded period exceed ten years. Pursuant to 2644.23(g) if the credibility weight is less than 25%, after an addition 10 years of data, the applicant or the Commissioner may use an alternative complementary loss and defense and cost containment expense, provided that the alternative is actuarially sound and reasonable in the circumstance.

The proposed regulations also provide that the recorded period shall be the most recent three years for which reliable data are available, unless the data is fully credible with fewer than three years experience. In that case, only as many years as needed to be fully credible shall be used.

Commentor: Shannon, page 1.

Summary: It is presumed that the intent behind allowing the consideration of additional experience periods is to allow insurer to use its own data and lessen the need for the credibility adjustment set forth in proposed section 2644.23, which is referred to a “the complement of credibility.”

Response: While this comment may be more aptly responded to under the summary and response section relevant to section 2644.23, it is responded to here.

The change in the language allowing additional expense periods was made in response to numerous comments relating to the requirements as originally set forth in that section. The revisions to the language are designed to expand the circumstances under which an insurer may apply its own data to meet credibility standards. The new language is not intended to “lessen the need for” the credibility adjustment. In point of fact most insurers will have enough credible data to meet the section 2644.23(g) credibility threshold. The Department disagrees that section 2644.23(g) is too complicated to administer. The Department chose the procedure in section 2644.23(g) for its relative ease of administration, compared to the alternatives.

Commentor: Shannon, page 1.

Summary: The regulations should allow for as many additional expense periods (up to some reasonable maximum) as are required to reach 100% credibility. The section 2644.23(g) 25% credibility threshold is too low. Restricting additional years of data will distort results, especially in medical malpractice lines.

Response: The current regulations allow for the use of three years of data. There are no exceptions and there is no consideration of credibility. The proposed regulations also provide that the recorded period shall be the most recent three years for which reliable data are available, unless the data is fully credible with fewer than three years experience. In that case, only as many years as needed to be fully credible shall be used.

The proposed regulations allow for a number of different approaches under a variety of circumstances. Less than three years data may be allowed where that data is fully credible. More than three years and up to ten years may be allowed where the credibility of that experience is less than the 25% credibility weight threshold.

Most insurers will have enough credible data such that accounting for three years of credible data presents no problem.

The Commissioner has determined that in order for the application of the regulations to produce reasonably consistent results while allowing for a reasonable amount of flexibility, there must be some reasonable threshold before application of more than three years' of data is allowed. Having considered the competing interests the Commissioner has determined that the 25% credibility weight threshold is reasonable and appropriate. Allowing as many years data for the recorded period as any insurer would like would subsume the rule entirely.

Commentor: Shannon, page 1.

Summary: Allowing insurers to use less than three years data to establish credibility will lead to potentially unsound results. Specialty lines, such as medical malpractice, are subject to significant volatility from year to year and claims remain open for up to 24 months. In these cases an experience period of less than three years would be inappropriate.

Response: The application of less than three years data will only be allowed where the data is fully credible. The Commissioner disagrees that allowing for less than three years of data, where that data can be shown to be fully credible, will result in inappropriate results.

In those lines, like medical malpractice, where less than three years data would not be appropriate, less than three years data should not be used and would not be approved during the rate review process. Professional liability, including medical malpractice, is given flexibility in the loss development and trend calculations in sections 2644.6 and 2644.7, so there is ample room to allow for actuarial judgment to arrive at a reasonable ultimate loss estimate based on a shorter experience period.

Commentor: Shannon, page 1.

Summary: For private passenger auto and homeowners lines three years of experience may be reasonable.

Response: The Commissioner agrees with the comment.

Commentor: Shannon, page 1.

Summary: For specialty lines like medical malpractice three years of experience is probably not enough.

Response: The Commissioner agrees and that is why the regulation has been amended to allow for a longer recorded periods under certain circumstances.

§2642.7. Lines of Insurance.

Commentor: Richmond, page 1

Summary: The current regulations provide that loss and premium trends shall be developed using the exponential curve of best fit. However, no single method is appropriate for all situations. Aberrant results will appear from time to time. The Department has addressed this in the variance provision of section 2644.27(f)(10). However, the process chosen is not consistent with the prior approval statute. Under section 1861.05(c), intervenors have an absolute right to a hearing only when the rate change is greater than 7%. The variance regulation (2644.27(d)) grants an absolute right to an intervention no matter how minimal the issue under discussion and even if the impact on the insurer's rates is modest. The commentor therefore suggests that the variance standards of section 2644.27(f)(10) be incorporated into section 2644.7.

Response: Because these comments are directed at portions of the regulations which were unchanged in the October 5, 2006, version of the regulation text, a specific response is not required. However, the Department notes that variance requests are subject to the same intervention parameters applicable to a rate application. Section 2644.27(d) provides that a variance request shall be deemed approved sixty days after public notice unless a consumer or his or her representative requests a hearing within forty-five days of public notice and the Commissioner grants the hearing, or determines not to grant the hearing and issues written findings in support of that decision, or the Commissioner on his or her own motion determines to hold a hearing. Section 2644.27 (e) provides that variance requests shall be determined in conjunction with the related prior approval application. Therefore, with the exception of the section 2644.27(f)(11) variance, the Commissioner has discretion regarding whether to hold a hearing on a variance request unless the proposed rate adjustment exceeds 7% for personal lines or 15% for commercial lines, the standard provided in California Insurance Code Section 1861.05(c). Therefore, the Commissioner has not proposed changes to the regulation in response to this comment.

Commentor: Ackerman, page 4

Summary: The existing commercial multiple peril line is subdivided into liability and non-liability. Businessowners rates are often developed as an indivisible premium. Under which line will those policies be filed and reviewed? Will an insurer be required to split the indivisible premium into liability and non-liability? The regulations provide no guidance as to how businessowners will be reviewed.

Response: Companies should be able to split losses into liability and non-liability. Splitting losses is necessary to calculating actuarially sound rates. If losses can be split, then separate maximum permitted premiums can be calculated under these regulations. If companies are not able to split their earned premiums, they may compare them to the sum

of the maximum permitted liability premium and the maximum permitted non-liability premium.

Commentor: Ackerman, page 4

Weinstein, page 4

Summary: The current regulation considers professional liability or errors or omissions to be a specialty line. Therefore, currently medical malpractice is a specialty line. This version takes all professional liability out of specialty and considers it commodity. The key benefit of specialty line status is the ability to tender rate development based on actuarial methods rather than the proscribed methodologies for loss development and trend. It is unclear what additional studies the Department may have performed that led them to consider all professional liability as a commodity line.

Response: In the currently-proposed version of these regulations, section 2644.4(d) provides that for professional liability and errors and omissions coverage (which includes medical malpractice) the insurer shall, in lieu of the computations of projected losses specified in sections 2644.5 through 2644.7, tender an alternative computation of projected losses. Thus the regulations allow insurers the ability to tender rate development based on actuarial methods rather than the proscribed methodologies for loss development and trend. (Sections 2644.5 through 2644.7, the sections not applicable, set forth procedures relating to catastrophe adjustment, loss development, and loss trend.) The treatment of professional liability in the revised regulations is the same as the current treatment of professional liability.

Commentor: Ackerman, page 5

Weinstein, page 4

Summary: Use of "the most" in section 2642.7(c) is troubling because there is no one "most sound actuarial method." In accordance with actuarial principles, an insurer need only demonstrate that it is using a sound and reasonable actuarial methodology, not the most sound. This language lacks authority and consistency.

Response: The commentor is referring to language which provides that rates for specialty insurance shall be approved or disapproved using the most sound actuarial method, consistent with California law, in accordance with the Actuarial Standards of Practice, and relevant and accepted actuarial principles, guidelines, and literature.

The amendments proposed in the October 5, 2006, version of these regulations allow insurers significantly more flexibility in developing rates for specialty lines. Nevertheless, the Department must review and approve each specialty line rate

application and ensure that the proposed rates are neither excessive, inadequate, unfairly discriminatory, or otherwise in violation of law. The Department believes that it can best ensure that the proposed rates are appropriate if it reviews a rate application using the most sound actuarial method applicable for that application.

The commentor references actuarial principles which indicate that an insurer need only demonstrate that it is using a sound and reasonable actuarial methodology, not the most sound. However, actuarial principles must yield to applicable legal requirements. California Insurance Code Section 1861.05(b) provides that the applicant shall have the burden of proving that the requested rate change is justified. The Commissioner has therefore determined that, in some limited circumstances, including for specialty lines, the Commissioner shall review a rate using the most sound actuarial method. The language is intended to give the Commissioner the ability to prefer a more sound approach to a less sound one. Without this language, the Commissioner would be forced to accept a less sound method so long as it met a minimum threshold of soundness. It allows the Commissioner to select between two minimally sound methods where one is clearly preferable.

Commentor: Pressley, page 4.

Summary: No justification has been provided for the significant amendment at proposed subdivision (c) that appears to exempt specialty lines from the application of all aspects of the regulatory ratemaking formula. The existing regulations only allow a different methodology for projected losses for specialty lines (§2644.4(c)). We are opposed to this drastic change from the existing regulations, which already allow sufficient grounds for variances.

Response: The specialty lines insurance market is the segment of the insurance industry where the more difficult or unusual risks are written. Because specialty lines insureds tend to be more unusual or higher risk, much of the specialty lines market is characterized by a high degree of specialization. Insurers participating in this market have specialized expertise and experience in underwriting and rating insurance for a wide range of risks. These insurers usually work with brokers experienced in specialty lines insurance. Much of the product development comes from the broker community in their quest to protect the insureds.

Due to experience gained in many years of case-by-case determinations the Commissioner has determined there are logical and actuarially valid reasons for allowing insurer to disaggregate a line of insurance into commodity and specialty “categories.” Given the specialized nature of these products and the fact that they are sold by specialty lines brokers to very informed and sophisticated buyers, there is diminished necessity for the precise ratemaking formula set forth in these regulations. Given the unusual nature of

the risks, specialty lines are generally not as susceptible to standard ratemaking methodologies as are personal lines.

Commentor: Schwartz, page 1.

Summary: If the Department intends subsection (c) and sections 2644.6, 2644.7(a) and 2644.8(b) to have the same rate standard, it would be useful to have the same wording used in each section. Also, it might be helpful to have a definition of “most sound actuarial method” or “soundest actuarial method,” so that all the modifying words do not need to be included in each regulation section.

Response: The Commissioner has determined that a definition is unnecessary. Including the appropriate reference where applicable is sufficient.

Commentor: Schwartz, page 1.

Summary: The revised rate approval standard for specialty lines appears to exclude specialty lines from any aspect of the rate calculations set forth in the regulations (under current regulations, specialty lines only use a different method for projected losses). No explanation has been given by the Department as to why this drastic change in the regulatory procedures should be made, especially in view of the variance requests allowed under the proposed regulations.

Response: Please see response to similar comment made by Ms. Pressley above.

Commentor: Sitrin, page 1.

Summary: Professional liability / errors and omissions should be considered “specialty insurance” because of the unique and riskier nature of these coverages.

Response: The proposed revision to the regulations provides that professional liability and errors and omissions, including medical malpractice, lines are exempted from catastrophe adjustment, (2644.5) by loss development, (2644.6) and loss trend (2644.7). Professional liability and errors and omissions are not considered “specialty lines” as they are not highly specialized form of coverage and are more akin to personal lines than that those lines designated specialty. The Commissioner has determined that while certain aspects of these coverages justify some flexibility in the calculations of losses, consumer protection considerations are such that, as compared to true specialty lines, a higher degree of regulatory precision is required in the regulations.

Commentor: Shannon, page 1 - 2

Summary: Medical malpractice should be designated a specialty line because it had been previously, losses are high severity low frequency, and it is a long tail line.

Response: The proposed revision to the regulations provides that medical malpractice lines are exempted from catastrophe adjustment, (2644.5), loss development (2644.6), and loss trend (2644.7). Professional liability and errors and omissions are not considered “specialty lines” as they are not highly specialized form of coverage and are more akin to personal lines than that those lines designated specialty. Medical malpractice is afforded the same recognition in the proposed regulations as under the current regulations.

Commentor: Shannon, page 1 - 2

Summary: The regulations are unclear as to whether medical malpractice insurance would be considered a professional liability or errors and omissions coverage.

Response: Medical malpractice is considered professional liability insurance.

Commentor: Shannon, page 1 - 2

Summary: If medical malpractice insurance is not allowed specialty insurance status, medical malpractice insurers will be subject to inconsistent treatment when dealing with the financial services branch of the department and the rate regulation branch.

Response: The Commissioner does not believe any inconsistent treatment will result through application of these regulations. Treatment of medical malpractice insurers has, in general, not changed in the proposed regulations.

§2643.2. Rating Basis.

Commentor: Ackerman, page 5

Summary: The commentor agrees that this section should be deleted.

Response: Because the commentor supports the proposed change, a specific response is not required.

§2643.8. Factors Calculated by Commissioner.

No comments were received regarding this section.

§2644.4. Projected Losses.

Commentor: Ackerman, page 5

Weinstein, page 5, 10

Summary: Subsection (d) states that the Commissioner shall approve the projection if made in the most sound actuarial manner, not the most sound actuarial method as set forth in section 2642.7(c). "Manner" should be changed to "method." Additionally, use of "most" is troubling because it is unclear how an insurer can show its projections are the most sound and unclear how the Department will judge one projection to be more actuarially sound than another. The language lacks authority, necessity, and consistency.

Response: The Commissioner disagrees that the language is inconsistent. Method and manner are synonyms. Additionally, the Commissioner notes that the prior language refers to a projection having been made in a sound actuarial manner. The Commissioner is not proposing amendments to the prior language referencing "sound actuarial manner." As previously indicated, the Department must review and approve rate applications to ensure that the proposed rates are neither excessive, inadequate, unfairly discriminatory, or otherwise in violation of law. California Insurance Code Section 1861.05(b) provides that an applicant shall have the burden of proving that the requested rate change is justified and meets all applicable legal requirements. The Department believes that it can best ensure that the proposed rates are appropriate if, in connection with its review of a rate application, it determines that the projection was made in the most sound actuarial manner for that application.

Commentor: Pressley, page 4

Summary: Medical malpractice insurance should be subject to the same standards for computing projected losses as other lines pursuant to sections 2644.5-2644.7.

Response: While medical malpractice insurance may be amenable to standard ratemaking procedures, it is inherently a long-tail line, meaning claims made against the policy do not surface until many years after the event that forms the basis of the claim. As such, ratemaking in the medical malpractice line presents certain challenges. Given these unique challenges, the Commissioner has determined that allowing medical malpractice insurers the ability to use a methodology for adjusting losses other than those set forth in sections 2644.5 - 2644.7 is reasonable given the special characteristic of this line of insurance. This is the treatment which has been afforded to medical malpractice insurers.

Commentor: Pressley, page 4

Summary: If there is a need for adding a provision for death, disability and retirement coverage losses, then the regulation should specify, as did the prior draft, that for that

coverage only, an insurer may compute the projected losses using the most sound actuarial method in lieu of the computation required by sections 2644.5 - 2644.7.

Response: The Commissioner assumes the comment relates to projected DD&R losses. There is a need for a special provision for death, disability and retirement. As insurers are allowed to use methodologies for adjusting losses other than that set forth in sections 2644.5 through 2644.7 in setting rates for medical malpractice insurance, there is no need for the same exception to apply to death, disability, and retirement coverage. Death, disability, and retirement coverage is sold in conjunction with medical malpractice insurance, so death, disability, and retirement coverage is subject to the same exception. The CDI has proposed a change to the regulations to deal with this specific issue (see proposed regulation text Section 2644.4(d)). Introduced primarily as a marketing tool, death, disability and retirement coverage (“free tail coverage”) is becoming a standard feature of claims-made insurance policies and is increasingly being used in conjunction with the sale of medical malpractice and other forms of professional liability exposures.

Commentor: Schwartz, page 1.

Summary: The revised proposed regulation excludes professional liability along with errors and omissions coverage from the regulation procedure to calculate projected losses. Since the earlier version of the proposed regulation allowed for a loss provision for death, disability, and retirement coverage for policies that offered this, there would appear to be no reason to completely exclude professional liability along with errors and omissions coverage from the regulation procedure to calculate projected losses, especially given the fact that the CDI is proposing to allow variance requests for the loss development procedures on five different bases.

Response: Please see response to similar comment made by Ms. Pressley, above.

Commentor: Shannon, page 2 - 3

Summary: The revisions add flexibility and eliminate many concerns.

Response: Because the comment agrees with the regulations, a response is not required. The Commissioner agrees with the comment as to additional flexibility and also agrees the intent was to address many of the concerns voiced in comments received.

Commentor: Shannon, page 2 - 3

Summary: Some of the language contained in the revision may be problematic. The old language read, “which the Commissioner shall approve if he or she finds the projection to have been made in a sound actuarial manner.” The language now reads, “which the Commissioner shall approve if he or she finds the projection to have been

made in the most sound actuarial manner.” The language “the most sound actuarial manner” could be read to mean there is a specific approach the Commissioner has determined to be the “most sound.”

Response: The language is intended to give the Commissioner the ability to prefer a more sound approach to a less sound one. Without this language the Commissioner would be forced to accept a less sound method so long as it met a bare minimum threshold of soundness.

§2644.5. Catastrophe Adjustment.

Commentor: Ackerman, page 5

Weinstein, page 5

Summary: Deleting the requirement to use ISO data is an improvement. However, it is still unnecessary to specify the time period for homeowners multiple peril fire and private passenger auto physical damage. Specific alternative language is suggested.

Response: To the extent the comment supports changes made to the regulation, a response is not required. The Commissioner disagrees with the alternative language proposed by the commentor. The language which was included in the July version of these regulations (which was not proposed for change in the October 5, 2006, version) provides that the catastrophe adjustment shall reflect any changes between the insurer’s historical and prospective exposure to catastrophe due to a change in the mix of business. The commentor suggests that the language instead allow for a loading based on a multi-year, long-term average of catastrophe claims appropriately adjusted for changes or projected changes in exposure distribution. Because the suggested alternative language relates to an unchanged portion of the regulation text, a specific response is not required. However, the Commissioner notes that, like the language suggested by the commentor (reflecting changes or projected changes in exposure distribution), the currently-proposed language references changes in the mix of business. The Department is unsure why the commentor prefers a reference to exposure distribution rather than mix of business. However, because the comment relates to an unchanged portion of the regulations, the Department has not changed the regulation text in response to this comment.

The commentor indicates that it is unnecessary to specify the time period for homeowners multiple peril fire and private passenger automobile physical damage. The language of the regulation provides that the number of years over which the average shall be calculated shall be at least 20 years for homeowners multiple peril fire and at least 10 years for private passenger auto physical damage. The Commissioner has determined that a period of at least 20 years is necessary for homeowners because of the extreme severity and relative low frequency of wildfires and other catastrophes. The shorter

period of 10 years for auto physical damage is reasonable because of the relatively lower severity of catastrophes for this line. Although some changes were proposed to this section in the October 5 version of the regulations, the changes proposed do not relate to whether or not it is necessary to specify the time period for homeowners multiple peril fire and private passenger auto physical damage. Consequently, the Commissioner has not adopted these comments.

§2644.6. Loss Development.

Commentor: Ackerman, page 6

Weinstein, page 5, 10

Summary: This section provides that the selection must be the "most actuarially reasonable" even though section 2644.27(f)(9) refers to an "actuarially sound result". The terminology should be consistent and should be sound actuarial method. How does an insurer demonstrate the "most sound" actuarial method or manner? The language lacks authority, consistency, and necessity.

Response: California Insurance Code Section 1861.05(b) provides that an applicant shall have the burden of proving that the requested rate change is justified and meets all applicable legal requirements. Section 2644.6 allows the insurer flexibility in loss development. However, in keeping with the statutory standard, the Commissioner may only approve a rate change if he first determines that the applicant has met the burden of proving that the requested rate change is justified. In this instance, the Commissioner has determined that he can best do so if the most actuarially reasonable selection is used. The language here is not inconsistent with similar language elsewhere in the regulations. Here the selection must be the most actuarially reasonable. In section 2644.4(d), for example, the projection shall have been made in the most sound actuarial manner. There is no inconsistency and the regulations can be readily understood by those to whom they apply and other interested members of the public .

Commentor: Ackerman, page 6

Summary: The additional requirement for insurer data set forth in this section uses a number of undefined terms, such as "incurred" and "loss development factors." "Reported claims and the paid claims calculations" makes no sense. Is a comma missing? If so, is CDI now asking for claim count development in addition to paid and incurred loss development?

Response: The language used in this section involves standard actuarial terms, and a further definition in these regulations is unnecessary. The proposed regulation requires that the insurer submit both the factors and ultimate losses for both paid and incurred loss

development calculations. The Commissioner has determined not to further change the regulations in response to this comment.

Commentor: Farwell, page 2 - 3

Summary: The proposed changes still maintain narrow limitations that restrict the actuary from selecting more appropriate loss development methods based on review of the historical data. The first sentence currently shown in double underline should be revised to "The insurer shall submit both the factors and ultimate losses for both the paid and incurred loss development reported claims and paid claims calculations, with the option to include any other loss development methodologies consistent with the Standards of Practice of the Casualty Actuarial Society, and shall demonstrate that its selection is the most actuarially reasonable."

Response: The variance for loss development identifies several circumstances where other procedures may be used. In addition, the specification of methods in section 2644.6 does not apply to professional liability and specialty lines. The Commissioner has determined that these exceptions strike the proper balance between allowing flexibility and applying a single, consistent methodology for review.

Commentor: Masek, page 2

Summary: It does not make sense to look at paid loss development unless you plan to apply those factors to paid losses. In section 2644.6, it appears that incurred losses, not paid losses, are part of the calculation.

Response: The section requires that filings "contain both paid losses and case-specific reserves, stated separately." In addition the regulation requires that loss development "shall employ either paid losses or the sum of paid losses and case-specific reserves." This should be read to mean that while the insurer may choose one of these two approaches it must report both in order to show which is the most actuarially sound under the circumstances. For the paid losses piece, the insurer shall submit the factors and ultimate losses derived from paid loss development. For the incurred losses piece, the insurer shall submit the factors and ultimate losses derived from incurred loss development.

As to the use of the terms "reported claims and the paid claims calculations" those terms are used to refer to the incurred and paid data in the two separate calculations. There is no requirement that an "ultimate claim" methodology be used.

Commentor: Masek, page 2

Summary: There should be wording indicating that loss development must be considered only where it is material. There are some lines of business where loss development is so small it is immaterial (e.g., personal inland marine).

Response: Loss development is described as the process by which reported losses are adjusted for anticipated payout patterns. Thus, the anticipated payout patterns are recognized.

Commentor: Masek, page 2

Summary: The loss development section appears inconsistent since the third sentence of this section states that “Loss development shall employ either paid losses or the sum of paid losses and case-specific reserves,” yet the remainder of this section states that an insurer shall submit both paid and incurred. Thus, it is unclear if it is to be either paid or incurred, or must be both paid and incurred.

Response: The section requires that filings “contain both paid losses and case-specific reserves, stated separately.” In addition the regulation requires that loss development “shall employ either paid losses or the sum of paid losses and case-specific reserves.” This should be read to mean that while the insurer may choose one of these two approaches it must report both in order to show which is the most actuarially sound under the circumstances. For the paid losses piece, the insurer shall submit the factors and ultimate losses used for paid loss development. For the incurred losses piece, the insurer shall submit the factors and ultimate losses used for incurred loss development.

Commentor: Sitrin, page 1

Summary: The sentence: “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” raises problems. The sentence is unclear as to whether paid loss, incurred loss or ultimate claim methodologies be used.

Response: The section requires that filings “contain both paid losses and case-specific reserves, stated separately.” In addition the regulation requires that loss development “shall employ either paid losses or the sum of paid losses and case-specific reserves.” This should be read to mean that while the insurer may choose one of these two approaches it must report both in order to show which is the most actuarially sound under the circumstances. For the paid losses piece, the insurer shall submit the factors and ultimate losses derived from paid loss development. For the incurred losses piece, the insurer shall submit the factors and ultimate losses derived from incurred loss development.

As to the use of the terms "reported claims and the paid claims calculations" those terms are used to refer to the incurred and paid data in the two separate calculations. There is no requirement that an "ultimate claim" methodology be used.

Commentor: Sitrin, page 2

Summary: It is unclear whether the severity trend is to be calculated on paid losses divided by closed claims or whether severity should be calculated as total losses on closed claimed divided by the number of closed claims or whether there is a choice between the two?

Response: The regulations provide that severity trend shall be calculated in two ways, a paid losses calculations and a closed claims calculation. In the paid losses calculation, paid losses may be divided by closed claims or total paid losses. The paid losses calculation shall include partial payments in previous calendar years. The closed claims calculation is to be based on closed claims divided by closed claims. The insurer shall submit the severity calculations on both bases, and shall demonstrate that its selection is the most actuarially reasonable.

§2644.7. Loss and Premium Trend.

Commentor: Ackerman, page 6

Weinstein, page 5, 10

Summary: This section uses "most actuarially reasonable," which lacks clarity. The variance for trend in section 2644.17(f)(10) refers to an "actuarially sound result." "Sound actuarial method should be used consistently throughout. The language lacks consistency, authority and necessity.

Response: The Commissioner will review the application based upon whether the selection is the most actuarially reasonable for the reasons set forth elsewhere in this rulemaking file in response to similar comments on other portions of these regulations. The Commissioner has determined that this language is clear and consistent. This section requires that the insurer demonstrate that its selection is the most actuarially reasonable, which is language clearly understood by those affected by these regulations.

Commentor: Ackerman, page 6 - 7

Summary: The formulaic approach of trending 12 rolling quarters of data proposed for frequency and severity will fail to capture turning points in the trend data. The variances allowed for trend are too restrictive to capture a general turn in the data. Only

when the insurer can identify the cause of the change in trend might a variance be allowed.

Response: The variance for trend identifies several circumstances where other procedures may be used. In addition, the specification of methods in section 2644.7 does not apply to professional liability and specialty lines. The Commissioner has determined that these exceptions strike the proper balance between allowing flexibility and applying a single, consistent methodology for review. Insurers are to free select from 24 point, 12 point, 8 point, 6 point and 4 point fits. However, 12 quarters of rolling data is a widely accepted historical time frame to use in loss trending and that is the measure by which an insurer's trend calculations will be tested. The Commissioner incorporates herein by this reference his other responses set forth elsewhere in this rulemaking file.

Commentor: Ackerman, page 7

Summary: Subsection (c) specified that for private passenger auto other than motorcycle, the complement of credibility for loss trend shall be calculated using California Fast Track data. In that data, losses are usually uncapped, so the severity values could be distorted by large claims. ISO's number of paid claims and paid losses are potentially different than a company's paid closed claims and paid closed losses in regards to open claims with partial payments. For a loss where multiple partial payments are made before it is deemed closed, a company may not count this as a closed claim until it is closed, and would only account for the partial payments as a loss when all payments were made. ISO would count this loss as a paid claim when the first partial payment is made, and would classify the partial payments as paid losses as they were paid. The partial payments will create more distorting impact on auto liability claims.

Response: There are a sufficient number of claims in the ISO fast track data that the occasional large claim does not cause a material distortion. The issue of how ISO counts paid claims is not significant, since the paid claims are counted in the same way in each quarter and trend is only measuring a change from quarter to quarter, not an absolute value.

Commentor: Pressley, page 4.

Summary: We remain opposed to converting the loss trend into a company-specific factor, rather than maintaining an industry-wide standard that the Commissioner should be required to determine annually, and in conjunction with the adoption of final regulations in this proceeding.

Response: While it is true that the "generic" approach has been abandoned in relation to loss and premium trend, there still remains a standard methodology against which an insurer's trend calculations shall be tested.

The changes as described are being made due to the experience gained in many years of case-by-case determinations, in response to changes in the marketplace, and in response to comments and suggestion made during this rulemaking and /or in the previous workshops. The Commissioner has determined that this revision to the current regulation is reasonable, prudent and necessary. The specific purpose of deleting the generic determination of loss trend in favor of using company-specific data is to enhance flexibility, to ensure the characteristics of individual insurers are reasonably considered and achieve the most accurate results possible. However, a standardized methodology will provide for consistency in the ratemaking process.

Commentor: Schwartz, page 2

Summary: In the revised portion of subsection (a), the word “earned” should be included before “exposures” to distinguish that from other types of exposures (e.g., written).

Response: The Commissioner has determined the word “earned” is not required and that the language is clear as it is. Because of the context in which the word “exposures,” is used, that is in relation to trend, it is quite obvious the language is referring to earned exposures.

Commentor: Masek, pages 1-2.

Summary: Section 2644.7 subsection (a) and other sections of the regulation limiting development of factors to insurer specific data rather than “industry wide” are inconsistent with California law.

Response: The Commissioner disagrees. The proposed regulations abandon, for the most part, the “generic” approach in favor of company-specific data. Section 2644.7 is one example of this. To the extent the company data are not credible, substitute data may be used. Section (c) specifies that industry data shall be used for private passenger auto. After years of case-by-case determinations, and due to comments made in this rulemaking and previous workshops, the Commissioner has determined that accuracy is increased where the insurer uses its company-specific loss data. Nothing in this approach, or in these regulations, violates any California law as is made perfectly clear in the *20th Century* case.

Commentor: Masek, pages 1-2.

Summary: With respect to loss trend, the regulation gives companies the option of using either reported or closed claims for frequency but only closed claims for severity. Companies should have the option of choosing either for both frequency and severity.

From an actuarial standpoint, reported claims are more current and thus preferable over closed claims. For long tail liability lines, the problem is exacerbated.

Response: The proposed regulations provide that 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 shall demonstrate that its selection is the most actuarially reasonable. Using reported claims for severity is not appropriate for long-tail lines, as there would be an extreme mismatch between the payments in the numerator and the claims in the denominator in such a ratio.

Commentor: Masek, pages 1-2.

Summary: For ISO, the manner in which claim data is report to ISO does not identify if a claim is closed. If a loss is partly paid and partly outstanding, a claim count of one can be reported either with the paid loss transaction or the outstanding loss transaction but not both. If a company reports a paid loss with a claim count of one and then subsequent losses are paid on the same loss, these later records are recorded with a claim count of zero.

Response: Where closed claim data is not available and the only available data are for paid claims, the Commissioner will construe the language to allow for paid claims. Except for claims that have partial payments, a paid claim will always be a closed claim.

Commentor: Masek, pages 1-2.

Summary: From an actuarial standpoint, using just closed claim data doesn't give you the most current read on what is happening with claim cost or frequency. The loss trend section should specifically allow for the use of external data for trend purposes. That approach is currently used by ISO as well as individual companies for some lines of business.

Response: The Department's experience over the years is that, except for the occasional use of construction cost indices for property severities, using external data for trend has been extremely rare. Even for property severities, it has become more common to use actual claim data or to modify the construction cost indices by actual claim data. To the extent that a company's claim data is not fully credible, alternative data may be used.

Commentor: Masek, pages 1-2.

Summary: For premium trend, the use of a fitted historical average premium may be distorted by changing distributions in deductible, territory or class variables which are unlikely to occur in the future. As an example, if a company rewrites their book for Physical Damage to be at a higher deductible level, the change in average premium from one period to another will reflect a lowering of the average premium because of the greater discounts granted. Since this is most likely a short-term non-repeatable occurrence, the use of change in average premium will not correctly capture the appropriate premium trend for the future. Therefore, the option to use historical and projected exposure distributions of model year and symbol should be allowed as this will better capture the expected future premium changes.

Response: Proposed section 2644.27(f)(10) provides a variance where the trend formula in section 2644.7 does not produce an actuarially sound result because there is a significant increase or decrease in the amount of business written or significant changes in the mix of business or where there are changes in coverage or other policy terms that significantly affect the data. This variance was specifically designed to address the scenario described in the comment.

§2644.8. Projected Defense and Cost Containment Expenses.

Commentor: Ackerman, page 7

Weinstein, page 5, 10

Summary: This section uses the "most actuarially reasonable" language and therefore lacks clarity. The regulation lacks consistency. For consistency, the regulation should be changed to "sound actuarial method." There should be a variance allowance to maintain consistency between the developed losses and the developed DCC.

With the newly added language in section 2642.7(c), section 2644.8(c) is unnecessary and should be deleted.

Response: Please see response to similar comments elsewhere in this rulemaking file. As to section 2644.8(c), the Commissioner has determined that retaining this section makes specific the fact that an insurer may tender an alternative computation of DCCE for the specialty category.

Commentor: Weinstein, page 9 - 10

Summary: This section fails the consistency standard. It uses the "most actuarially reasonable" but fails to provide an explicit variance allowance for defense and cost containment expense. There should be such a variance to maintain consistency between the developed losses and the developed cost containment expense.

Response: The Commissioner incorporates herein by this reference his responses to similar comments elsewhere in this rulemaking file. As indicated elsewhere, the loss development and trend variances specifically refer to sections 2644.6 and 2644.7 and do not distinguish between loss and DCCE.

Commentor: Shannon, page 3

Summary: Due to the changes in section 2642.7 it may be appropriate to revise the wording in section (c) to specify Professional Liability or Error and Omissions instead of specialty categories. The current proposed wording creates an inconsistency with the application of section 2644.4

Response: The language to which the comment refers provides, "Where an insurer or the Commissioner elects to disaggregate a line of insurance into commodity and specialty categories pursuant to section 2642.7" The Commissioner sees no inconsistency between this language and the language contained in § 2642.7. To the extent this comment should be read to mean that Professional Liability or Error and Omissions should be treated as "specialty lines" the comment is rejected for the reasons stated herein.

§2644.12. Efficiency Standard.

Commentor: Gillespie, page 1 - 7

Summary: The commentor describes the efficiency standard provision. The passage of time has rendered this section, which was designed for rate rollbacks, obsolete and it should be eliminated. All insurers now use computerized systems and many use central customer service centers. AB 393 must be recognized. A brief history of the section is provided. Capping expenses reduces innovation and competition and harms policyholders. Use of an average forces the maximum down. Target market, rather than distribution system, drives costs. If CDI is to retain an efficiency standard, it should set a single standard for all insurers in a line of business and at the 80th percentile.

The captive and direct categories should be combined for the reasons set forth at pages 3 – 5 of the comments, including the fact that captive and direct writers cannot be distinguished based on "service". Rationales specific to 21st Century are set forth. Many direct writers target niche markets, allowing them to reduce expenses. The commentor believes that this change would be "nonsubstantial."

The direct writer category should be eliminated based on the small number of writers, as authorized by section 2644.12(b). The comment references charts attached to comments submitted by Richard Roth, which the Department will respond to in connection with Mr. Roth's comments.

CDI should establish a variance allowing an insurer to be placed in another marketing category and a variance based on the location of 75% or more of an insurer's employees/operations in a high-cost metropolitan area.

Response: The changes made to this section in the October 5, 2006, version of the regulations added the following language to subsection (b):

For an insurer using more than one distribution system, the efficiency standard shall consist of an average weighted by earned premium for each distribution system.

It also added the following language to the section:

(g) If a company's commission expense is less than zero, the negative amount shall be set to zero.

(h) If a company's California allocated other acquisition expense is less than zero, the negative amount shall be set to zero.

(i) If a company's California allocated general expense is less than zero, the negative amount shall be set to zero.

(j) If a company's tax, licenses and fees expense is less than zero, the negative amount shall be set to zero.

None of the comments summarized above relate to a changed portion of the regulation. Therefore, a response is not required. Most of the comments were made and responded to previously in this rulemaking file.

Commentor: Richmond, page 2

Summary: To avoid confiscatory results, the regulations should be revised so that the unique characteristics of individual insurer's business models, not just industry averages, are used to determine acceptable levels of expense. To do otherwise would impair the ability of insurers to seek innovative ways to serve insurance consumers.

Response: Existing regulation section 2644.12(d) provides that in each category, the efficiency standard shall be set at the weighted mean (weighted by earned premium) expense ratio of insurers in that category. In calculating the average, the Commissioner may exclude insurers for which reliable data are not readily available or which reflect anomalous conditions. The current regulations generally retain the same requirement. No changes were made to section 2644.12(d) in the October 5, 2006, version of the regulations. Therefore, this is not a comment on the October 5, 2006, regulation changes, and a detailed response is not required. The Department does note, however, that section

2644.27(f)(11) specifically allows a variance to avoid confiscation. Additional variances relate to efficiency or expenses, such as those set forth in sections 2644.27(f)(2), (3), and (6). The Commissioner has determined that these exceptions strike the proper balance between allowing flexibility and applying a single, consistent methodology fore review.

Commentor: Roth, page 1, 3

Summary: The distinction between types of marketing is a relic from the days before computers. Now policies can be purchased over the phone. Independent agents don't necessarily need to provide the extra service they used to. In 2002, Safeco launched a new automated underwriting initiative allowing agents to more efficiently quote and see [sic] policies. The distinction between direct writer and agent is disappearing. Some insurers market auto insurance through more than one basis.

Response: The existing regulations recognize three different distribution systems – independent agents and brokers, exclusive agents, and direct writers. The tri-modal system is not proposed for change in these regulations. Therefore, this comment is not directed at a portion of the regulations which has been changed, and a response is not required. To the extent the comment references insurers marketing through more than one basis, the revisions proposed to the regulations reflect that fact. These regulations have been in effect without problem for approximately 15 years.

Commentor: Roth, page 1 - 2

Summary: For automobile insurance, the real cost is in servicing the policy and in the difference between standard and non-standard policies. Most standard policyholders pay on time and always renew. Non-standard policyholders don't pay on time (causing frequent cancellations) and switch insurers frequently. The difference in retention impacts underwriting expenses. Non-standard auto has a 31.2% expense ratio. "Private passenger" auto (presumably standard policies) has a 21.5% expense ratio. The expense ratios for some direct writers may be low, not because they are direct writers but because they write standard or preferred risks.

Response: Please see response to Mr. Roth's comment above. This comment is directed at an unchanged portion of the regulation text and a response is therefore not required. These regulations have been in effect without problem for approximately 15 years.

Commentor: Roth, page 2

Summary: There is a significant difference in costs by geography. Rents and security precautions result in higher costs in the inner-city. In the suburbs, agents save expenses by selling an auto and homeowner's policy together.

Response: This comment is not directed at a portion of the regulations which is proposed for change. Therefore, a response is not required. This portion of the regulations has been in effect without problem for approximately 15 years.

Commentor: Roth, page 2

Summary: The data source CDI relies on doesn't report general and underwriting expenses specifically for California. In the NAIC Annual Statement, there is only one page for California specific data, with the rest of the Annual Statement showing only national data. The California specific page only shows California premiums, losses and loss expenses, commissions and state taxes. No general expenses are reported, because it is very difficult for any insurer to allocate general expenses by line by state, unless a somewhat arbitrary allocation method is chosen. For the efficiency standard, CDI allocates the countrywide general expenses to California in proportion to California premiums. This doesn't recognize the high cost of doing business in Los Angeles, San Francisco, and the rest of California. A comparison of a California company with a mid-western or southern company would be clearly unfair.

Response: The commentor is correct that certain expenses are allocated to California. The commentor alleges that the allocation method doesn't recognize the high cost of doing business in Los Angeles, San Francisco, and the rest of California. Section 2644.12(k) provides that countryside expenses for general and other acquisition expenses shall be allocated to California on the basis of direct earned premium. Countrywide expenses for adjusting and other expenses shall be allocated to California on the basis of direct incurred losses. There were no changes proposed to this language in the October 5, 2006, version of these regulations. Therefore, to the extent the comment is directed at this language, a specific response is not required. However, the Department notes that, to the extent costs are higher in California, premiums can also be expected to be higher. Therefore, the allocation recognizes any higher expenses. It is unclear why comparison of a California company with a mid-western or southern company would be clearly unfair.

As noted elsewhere in this rulemaking file, the *20th* Century court upheld the efficiency standard.

Commentor: Roth, page 2

Summary: 21st Century is the leading insurer in California in an attached exhibit, yet it is a minor player nationally. The result is that the efficiency standard allocates the national expense ratios of other named companies to 21st Century. In column 24, the national expense ratio for direct writers is 22.11%, yet 21st Century's primarily California expense ratio is 28.51%. This expense ratio compares favorably with the All Auto Insurers national average of 30.41%.

Response: Please see response to similar comments made elsewhere in this rulemaking file.

Commentor: Roth, page 2

Summary: The data source CDI relies on often contains inconsistent reporting. None of the other direct writers reported the California commission and brokerage expenses (column 7) the same way that 21st Century did, yet they are all in the same marketing category.

Response: The Commissioner has identified various screens for anomalous data. The Commissioner has also relied on the three-year average of all companies. Therefore, the Commissioner has determined that one unusual value for one company in one year that still falls within the ranges of all the screens will not cause a serious distortion in the calculated efficiency standard. As for inconsistent allocation between expense categories within and between companies, this is why the Commissioner originally decided to apply the efficiency standard to the sum of the expense categories rather than separately to each individual expense category.

Commentor: Roth, page 2

Summary: Some of the reporting is clearly incorrect. The line for USAA Group – All Lines has negative General Expenses in column 23, which is clearly incorrect. The NAIC Insurance Expense Exhibit should reconcile with the other schedules in the Annual Statement, yet this doesn't always happen.

Response: The Commissioner has identified various screens for anomalous data. The Commissioner has also relied on the three-year average of all companies. Therefore, the Commissioner has determined that one unusual value for one company in one year that still falls within the ranges of all the screens will not cause a serious distortion in the calculated efficiency standard. As for inconsistent allocation between expense categories within and between companies, this is why the Commissioner originally decided to apply the efficiency standard to the sum of the expense categories rather than separately to each individual expense category.

Commentor: Roth, page 3

Summary: The general expenses should be about the same for everyone, yet the general expenses for the direct writers show significant inconsistency in column 23.

Response: The Commissioner has identified various screens for anomalous data. The Commissioner has also relied on the three-year average of all companies. Therefore, the Commissioner has determined that one unusual value for one company in one year that

still falls within the ranges of all the screens will not cause a serious distortion in the calculated efficiency standard. As for inconsistent allocation between expense categories within and between companies, this is why the Commissioner originally decided to apply the efficiency standard to the sum of the expense categories rather than separately to each individual expense category.

Commentor: Roth, page 3

Summary: At the bottom of the exhibits, the commentor shows the results for GEICO General for 2000 – 2005. Even for a single well-established insurer, the expense ratios can vary significantly from year to year (column 24).

Response: The Commissioner has identified various screens for anomalous data. The Commissioner has also relied on the three-year average of all companies. Therefore, the Commissioner has determined that one unusual value for one company in one year that still falls within the ranges of all the screens will not cause a serious distortion in the calculated efficiency standard. As for inconsistent allocation between expense categories within and between companies, this is why the Commissioner originally decided to apply the efficiency standard to the sum of the expense categories rather than separately to each individual expense category.

Commentor: Roth, page 3

Summary: The proposed efficiency standard in the current draft is wrong in several respects. CDI has added "adjusting and other expenses" to the formula. The efficiency standard is keyed to the type of marketing the insurer uses. The adjusting and other expenses are claims settlement expenses, which do not relate to the type of marketing. The adjusting and other expenses are ratioed to the direct incurred losses. But since a large number of claims are closed without payment, it is wrong to relate these expenses to losses. They should relate to the reported claim count or earned premiums.

Response: The changes to the regulation merely update ULAE to AOE, to reflect the change in terminology used by the NAIC. USLE expenses have been contained in the efficiency standard since the regulations were first adopted approximately 15 years ago.

Commentor: Roth, page 3

Summary: The Efficiency Standard formula is with respect to direct earned premiums, but it should be with respect to Direct Written Premiums.

Response: Relating expenses to earned premium is appropriate when SAP surplus is used as the return basis. Relating expenses to written premium would lower the expenses allowed and would be unfair to the insurers.

Commentor: Roth, page 3

Summary: Instead of trying to micromanage the industry, CDI should specify one expense ratio for everyone at about the 80% percentile of expense ratios reported in Best's Aggregates & Averages.

Response: Use of averages was upheld by the Supreme Court in the *20th Century* case and for the reasons set forth elsewhere in this rulemaking file, the Commissioner has decided not to change that portion of the regulations.

Commentor: Roth, page 3

Summary: The reported expense amounts are only estimates, which change from year to year.

Response: Using a three-year average adequately addresses this concern.

Commentor: Roth, Exhibits 1, 2A., 2B., 3

Summary: The commentor attached the above-referenced exhibits to his comments.

Response: These exhibits relate to specific comments made by Mr. Roth and summarized above. The Commissioner incorporates herein by this reference his response to those comments.

Commentor: Ackerman, page 7 – 8

Weinstein, page 5, 8 - 9

Summary: The efficiency standard lacks consistency, authority and necessity. Subsection (b) adds additional language to address situations where insurers use more than one distribution system, which is increasingly common. Although a single distribution system may be associated with a single product, multiple distribution systems may be used within a line. Insurers set rates by product and make rate filings by product, not by line. It is unclear in which circumstance the Department will apply the weighted average. This lacks clarity and demonstrates another difficulty in calculating and applying an industry average cap on expenses.

Response: To the extent the comment is objecting to the efficiency standard in general, it is not a comment on a changed portion of the regulation text, and a response is not required. The existing regulation provides that the efficiency standard shall be set separately for each insurance line. Therefore, to the extent the comment is objecting to a by-line efficiency standard, this is a comment on an unchanged portion of the regulations, and a specific response is not required. The commentor indicates that it is unclear in

what circumstance the Department will apply the weighted average. However, the regulation clearly says that when an insurer uses more than one distribution system, the efficiency standard shall consist of a weighted average. It is not clear why the commentor believes this language is unclear and, because the Department believes the language is clear, this comment is rejected.

Commentor: Ackerman, page 8

Weinstein, page 5 - 6

Summary: The Department has added two documents to the rulemaking file related to the efficiency standard. Neither document remedies the lack of support for the premise that an average expense level is the boundary between an efficient insurer and an inefficient one. CDI has not relied on any empirical studies in proposing the adoption of the regulation. There is 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. There must be a study to determine whether an insurer's expenses are efficient. The documents added to the rulemaking file are simply a description and do not support the premise that the average is an appropriate measure of efficiency.

Response: The regulations have always used the average, as explained in the original rulemaking file and upheld by the Supreme Court in the *20th Century* case.

Commentor: Ackerman, page 8

Weinstein, page 6

Summary: Different regulations (section 2662.6(d)) allow an insurer to reflect in its rate all fees awarded as intervenor compensation. The efficiency standard will fail to make this allowance. A change should be made to this section to reflect the intervenor fee expense allowance.

Response: The regulations are not being changed in response to this comment. Section 2662.6(d) adequately addresses this situation, and recognizes that intervenor compensation is an expense that appropriately can be included in a rate application. That fact need not also be referenced in this section. Additionally, the Commissioner notes that this comment does not relate to a changed portion of this regulation and a specific response is therefore not required.

Commentor: Weinstein, page 9

Summary: The terms "most sound actuarial manner," "most actuarial sound method," "actuarial sound result," and "most actuarially reasonable" are used interchangeably, causing confusion and a lack of clarity. There exists no one "most sound actuarial method." A number of ratemaking methodologies have been established. An insurer need only be required to demonstrate that it is using sound and reasonable actuarial methodologies, not the "most sound."

Response: Please see response to other comments raising the same issue and responded to elsewhere in this rulemaking file. The Commissioner incorporates herein by this reference his response to those comments.

Commentor: Pressley, page 3

Summary: Even though Section 2643.8 has been amended to specify the process and values that shall be used if the Commissioner has not published the values within the specified time period, it is critical that the Commissioner set and publish these values at the same time he promulgates the final amendments to these regulations so that insurers, the Department and the public will have a complete set of regulations to review rate filings.

Response: All pertinent values will be published before the time the regulations are effective.

Commentor: Pressley, page 3

Summary: The regulations should also be amended to specify that any values that are updated by the Administrative Hearing Bureau during the course of an evidentiary hearing must be reviewed and approved or amended by the Commissioner.

Response: Under current law the Commissioner must reject, amend or adopt any proposed decision made by an ALJ in the Administrative Hearing Bureau. As such there is no need for the regulations to spell out this requirement.

Commentor: Schwartz, page 2

Summary: Presumably, section 2644.12, (g), (h), (i) and (j), limit an insurer's reported expenses as used in the calculation of the efficiency standard to be no less than \$0, were added to remove the impact of abnormal or unusually low values. In a similar manner, any high values that are abnormal or unusual should be limited, and including certain wording in various subsections would accomplish this goal.

Response: The original intent of the efficiency standard was to apply the efficiency standard to all companies, allowing a reward for more the more efficient than average company while not allowing inefficient companies from passing its inefficiencies on to

policyholder in the form of higher premiums. The application of the efficiency standard as described has been the methodology used by CDI for many years in many hundreds of case-by-case determinations. The regulations provide in (f)(5) that high values shall be excluded.

Commentor: Sitrin, page 2.

Summary: The 1999 data used for the tri-modal efficiency standard is stale and needs to be updated. Many companies have made changes to their distribution systems.

Response: The data will be updated.

Commentor: Sitrin, page 2-3.

Summary: There are certain exclusions relating to company data when it is less than zero. However, there is no provision in the regulations that allow for the exclusion of data if the sum of expenses appears to be anomalous or erroneous.

Response: The existing and proposed regulations provide that the Commissioner may exclude insurers for which reliable data are not readily available. The Commissioner has determined that this language addresses the commentor's concern regarding data which may be anomalous or erroneous, since such data would not be expected to be reliable

Commentor: Sitrin, page 3.

Summary: The efficiency standard provides for a separate efficiency standard “for insurers writing large and small amounts of business.” Insurers using direct marketing that sell a large amount of business have significant cost advantages over smaller insurer that sells smaller amounts of business and have to pay commissions. Once a direct marketer has the business the higher up-front costs are paid for by retention while insurers using agents must continue to pay commissions year after year. This is known as an “acquisition dynamic.” Where insurers within a group use different methods of distribution this problem becomes that much more pronounced. In determining whether an insurer is writing “large and small amounts of insurance” which would allow for exemption from the efficiency standard, what is large and small should be determined by the group’s premium rather than by the premium generated by companies within the group.

Response: As this comment is directed at unchanged portions of the regulation, a response is not required.

§2644.16. Rate of Return.

The summaries of and responses to comments regarding section 2644.16 are included at the end of this document.

§2644.17. Leverage Factor and Surplus.

Commentor: Richmond, page 2

Summary: The commentor supports the change from using the industry average by line over the past 30 years. However, the commentor continues to object that the leverage factor is calculated by line. Consequently, stock insurers are unfairly grouped with reciprocals and mutuals even though their respective risk tolerances are not equal because stock insurers have access to the capital markets. Stock insurers can therefore write at higher leverage factors. Leverage factors for stock insurers should be calculated separately from the leverage factors for reciprocal and mutual insurers.

Response: Because the commentor supports deletion of the 30-year historical average language, a response is not required. To the extent the commentor suggests that stock insurers should be allowed different leverage factors than reciprocal and mutual insurers, that comment relates to unchanged regulation language and a specific response is therefore not required. Another large mutual insurer, State Farm, commented that no distinction should be made among stock, mutual and reciprocal insurers.

Commentor: Farwell, page 1

Summary: The commentor agrees with the change from a 30-year average to an annual average. However, the continued use of the formula results in leverage ratios that do not reflect the risk assumed by the insurer. The Interinsurance Exchange is highly concentrated in California and requires an exceptionally strong surplus to protect insureds and assure it can meet its obligations. The Department should allow more flexibility to recognize the unique characteristics of individual insurers. An industry calculation should not be imposed. The numbers contemplated are far higher than the Exchange's actual leverage.

Response: To the extent the commentor supports the change, a response is not required. The fact that the leverage factor is an industry-wide number is a provision of the existing regulations and that provision of the regulation is not proposed for change in this rulemaking proceeding. Therefore, to the extent the commentor is commenting on an unchanged portion of the regulations, a specific response is not required. The variance set forth in section 2644.27(f)(5) does authorize granting an insurer a different rate of return if it writes at least 90% of its business in California, thus recognizing insurers whose business is concentrated in California.

Commentor: Estrada/Underhill, pages 1-3

Summary: An earthquake leverage ratio of one is almost identical to the current industry wide leverage ratio. However the earthquake line is much riskier than all lines combined so that an appropriate leverage ratio for earthquake would be less than one. The California earthquake authority has a premium to surplus ratio of .25 and A.M. Best only gives the CEA an A- rating. Both A.M. best and Standard & Poor's evaluate an insurance companies capital position relative to one in 250 year events which would require significant reinsurance utilization if the carrier is not allowed to price for capital beyond the 1.0 leverage ratio. That does not make good financial sense. Furthermore, there are significant constraints on obtaining adequate reinsurance coverage. We believe the Commissioner should have discretion to modify the leverage factors for earthquake and other lines of business subject to catastrophes, mass torts and other unusual events.

Response: This is not a comment on a changed portion of the regulation text. Therefore, a response is not required.

Commentor: Pressley, page 3

Schwartz, pages 3-4

Summary: Deleting the language “then multiplied by the ratio of the 30-year historical average total industry leverage divided by the total industry leverage in the most recent year” is unacceptable. The elimination of the 30-year adjustment period will substantially reduce the calculated leverage factor, which will cause a commensurate increase in the profit provision as a percent of premium included in the rates. This one change has the impact of allowing rates to increase by about 7%

Response: The 7% is overstated. Instead of the calculation provided by the commentor, the comparison should be between $.11/(1.54*(1-.35))$ and $.11/(1.12*(1-.35))$. This difference is only 4.1%. In addition, the commentor ignores that additional surplus generates additional investment income. Assuming a 6.5% yield, this difference is 1.6%. Thus the net increase in rates is only 2.5%.

Commentor: Pressley, page 3

Schwartz, pages 3-4.

Summary: The amount of the profit factor allowed under the revised regulations for medical malpractice occurrence insurance is larger than the portion of the premium attributable to losses, loss expenses and insurance company expenses combined. To avoid this situation, CDI should reinsert the wording that was removed in the revised proposed regulation text, or alternatively, change the regulation to use a minimum leverage factor irrespective of what the calculation otherwise indicates.

Response: As with the previous comment, the commentor ignores that additional surplus generates additional investment income. Assuming a 6.5% yield, that investment income is 21% of premium. Thus the total profit is 33.6% premium, not the 54.6% calculated by the commentor.

§2644.20. Projected Yield.

Commentor: Richmond, page 2

Summary: The regulation makes several references to using average bond yields as provided by Valu/Bond on Yahoo. This requirement is too limiting and impractical. The data referenced is simply a snapshot as of the day it is posted. Because there is no historical search capability, each insurer and the Department would have to download and archive the data daily to create a historical record. This could lead to disputes over what the past data actually was. The best approach would be to allow insurers to use any governmental or third-party source. Of a specific source is to be named in the regulation, it should be one which can provide reliable historical data, such as Bloomberg.

Response: Because these are not comments specifically directed to a changed portion of the regulation text, a specific response is not required. However, the Commissioner incorporates herein by this reference his response to similar comments elsewhere in this rulemaking file.

§2644.23. Credibility Adjustment.

No comments were received on this section.

§2644.27 Variance Request.

Commentor: Gillespie, page 2, 7 - 8

Summary: For the reasons set forth at pages 7 – 8, revise the variance in section 2644.27(f)(5) to allow relief for companies that are mono-line, mono-state *or* present a mix of business different from that typical of the line as a whole.

Response: Section 2644.27(f)(5) provides as grounds for requesting a variance the fact 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 its mix of business presents investment risks different from the risks that are typical of the line as a whole. That language was not changed in the October 5, 2006, version of the proposed regulations. Therefore, this is a comment on an unchanged portion of the regulations and a response is not required. The commentor also notes that an unusual mix of business may reflect the

fact that an insurer serves an underserved community. However, that variance is already reflected in section (f)(4).

Commentor: Ackerman, page 9

Summary: The commentor suggests a change to section 2644.27(f)(5).

The commentor also suggests that use of the term "policy size" in section 2644.27(f)(3)(C) lacks clarity because it is ambiguous. It could refer to number of policies in force or to per policy exposure.

Response: As to the proposed change to section 2644.27(f)(5), because this is not a comment on a changed section of the proposed regulations, a response is not required. As to the comment regarding the "policy size", the Department is not proposing a change to the proposed regulation text in response because that change was made in response to a comment made in connection with the July 18, 2006, proposed regulation text. Average policy size means premium per policy.

Commentor: Farwell, page 2

Summary: Concerns are expressed about the rigidity and limitations imposed by the proposed regulation. It should be amended to make the variance request part of the rate filing, not a separate item requiring separate notice and approval outside the rate filing.

Response: Variance requests are considered when rate filings are reviewed. Section 2644.27(e) provides that a variance request shall be determined in conjunction with the rate application in which it was submitted. Subsection (c) provides that requests for variances shall be filed at the same time as the prior approval application to which it applies or after the filing of the rate application and before any final determination regarding that application. While the Department anticipates that variance requests may be submitted at the same time as the rate application, the Department sees no reason not to allow insurers the flexibility to amend their rate applications while under review to add a request for variance. The Department believes this is one reason why this section is not rigid and limited. If an insurer does not originally request a variance, it need not withdraw and refile its rate application. It can amend its rate application to seek a variance. This is similar to other amendments to a rate application which are made during the course of review. However, unlike minor actuarial changes which may be made in response to questions posed by the Department's rate analysts, the Department believes that any requests for a variance should be open and transparent. An insurer seeking a variance should openly do so, not obscure that fact in the middle of a voluminous rate application. If a variance is requested after public notice is provided of the filing of a rate application, public notice shall be provided of the variance request so that interested members of the public can review the variance request if they choose to do

so. In keeping with the provisions of Proposition 103, interested members of the public should be informed that a variance has been requested. To the extent the comments relate to unchanged provisions of the October 5 regulation text, the Department is not required to provide a specific response.

Commentor: Pressley, pages 1, 2

Summary: Allowing additional variances for loss development, loss trend, and the application of the efficiency standard outside the context of a rate hearing will contravene two essential goals of Proposition 103 by allowing insurers to seek greater rate hikes and injecting the very element of arbitrariness into the rate review process that Proposition 103 sought to end. The current framework already allows for sufficient flexibility and actuarial judgment without providing for more exceptions that will ultimately swallow the rule of “a single, consistent methodology.” Moreover, no evidence in the record has been cited by the Department as to why further exceptions are necessary. For these reasons, the variance amendments contravene the standards of necessity and consistency with Proposition 103. Moreover, the inclusion of such vague and subjective language in proposed subdivisions (e)(9) and (e)(10) [note: the correct reference should be to (f)(9) and (10)] as “does not produce an actuarially sound result,” fails to provide sufficiently clear and understandable criteria.

Response: These variances were included in the July 2006 version of the proposed regulations which were the subject of the September 13, 2006, public hearing. Therefore, this comment is directed at an unchanged portion of the regulations, and a response is not required. The final portion of the comment appears to be directed to sections 2644.27(f)(9) and (10), not (e)(9) and (e)(10). This language has not been changed in the October version of these regulations. Therefore, this comment is directed at an unchanged portion of the regulations, and a response is not required.

Commentor: Sgourea, page 2 - 3

Summary: The new proposed variance language allows for an exemption from the efficiency standard due to significantly smaller or larger than average policy size. Policy premium should be the standard rather than policy size. The variance should be allowed for “significantly smaller or larger average premium or policy size.”

Response: Policy size and policy premium are synonymous as used in section 2644.27(f)(3).

§2644.50 Refiling of Approved Rates.

Commentor: Pressley, page 4-5

Summary: This provision is especially necessary at a time when homeowners and private passenger automobile insurers are reaping excessive profits and experiencing dismally low loss ratios. As we stated previously, FTCR recommends that the regulation specify that a rate application shall be filed by an insurer when its loss ratios fall below 65% for private passenger automobile insurance and 60% for homeowners insurance. A 90% triggering threshold for medical malpractice would be appropriate. The regulation should be amended to clarify that the Commissioner may order a company to file a rate application any time he has reason to believe that a company's rates are no longer in compliance with § 1861.05(a). The regulation should clarify that the insurer shall have the burden of proving that its rate "is justified and meets the requirements of this article [article 10]," including the requirement that no rate shall remain in effect which is excessive, inadequate and unfairly discriminatory as mandated by Section 1861.05(a).

Response: The only change proposed to this section in the October version of these regulations was the addition of authority cites to the Note following the regulation text. These comments do not relate to those changes. Therefore, a response is not required.

§ 2648.4. Complete Application.

No comments were received regarding this section.

Comments on Materials Added to Rulemaking File

Commentor: Ackerman, page 9

Summary: What remedies or opportunities will companies have to correct or validate the calculations that CDI will be required to perform each year.

Response: If an error is made in the calculations, the Department would expect to correct that error. The Department does not believe a formal process need be established in the regulations for that purpose.

Commentor: Ackerman, page 9 - 10

Summary: The use of Annual Statement data for the efficiency standard calculations seems to conflict with section 2643.6 which specifies that certain California data shall be submitted with a rate application and shall be used.

Response: Section 2643.6 provides that in certain circumstances, California data shall be used. The fact that that data may be capped by the efficiency standard in some instances is not inconsistent. The Commissioner rejects this comment.

Commentor: Ackerman, page 10

Summary: The assignment of marketing system is based on a 1999 survey, which should be updated. There should be some mechanism to routinely update the marketing system assignments.

Response: The Department agrees and will update the marketing system survey in advance of implementation of these regulations and on a routine basis thereafter.

Commentor: Ackerman, page 10

Summary: The Summary Worksheets shows the selected efficiency standard average by line of insurance. It is not clear why Surety and Financial Guaranty are listed in the summary, since neither line is subject to Insurance Code Sections 1861.01 – 1861.05. If financial guaranty is subject to these regulations, only one efficiency standard is listed for all distribution systems. The adoption of a single efficiency standard is subject to section 2646.3, generic determinations.

Response: Please see *Amwest Surety Insurance Company v. Wilson*, 11 Cal.4th 1243 (1995).

Commentor: Weinstein, page 14

Summary: The commentor joins in and incorporates the comments made by Ms. Ackerman regarding certain documents added to the rulemaking file.

Response: The Department incorporates as its response to the above comment the responses it made to the comments submitted by Ms. Ackerman.

Commentor: Weinstein, page 11

Summary: Documents were added to the rulemaking file but no explanation is given for why they have been added, what is their purpose or relevance, how or whether the Department is relying on them, what is the foundation, and who prepared them.

Response: The Department added these documents to the rulemaking file and solicited public comments on them in connection with earlier comments that certain calculations were not described.

Commentor: Weinstein, page 11 - 14

Summary: Adding the excerpt of the Massachusetts decision is egregious. The Department does not explain why it is being used or what specific regulation it supports or why an excerpt only has been filed. The documentation is incomplete and misleading. Massachusetts has a different statutory scheme in several enumerated respects. A brief summary of the proceeding is set forth. That record is different than this record.

Historically Massachusetts set the profit provision by applying mathematical models. The conclusions contained in that decision are based on the limited record then before the Massachusetts Commissioner, on data related to Massachusetts auto, on a model used in Massachusetts, and on a different statutory scheme. It should be disregarded and removed from the rulemaking file. There is a reference to the fact that interested parties are submitting the complete Massachusetts decision under separate cover. However, that document was never submitted.

Response: As indicated above, the complete Massachusetts decision was not submitted. Therefore, the Department is not providing a response to that portion of the comment. During the workshop, several commentators, representing both insurers and consumers, referred to the Massachusetts decision as a reasonable approach to calculating prospective yields using annual statement data and current market return. Consequently, the excerpt of the Massachusetts decision was added to the rulemaking file for the purposes of the yield calculation only.

Commentor: Sgoureira, page 3

Summary: The Massachusetts study is irrelevant as it involves different statutes and a different regulatory system.

Response: The Massachusetts study is being used for the limited purpose of supporting the calculation of the yield factor. The portion of the study relied upon is relevant to that calculation. The Commissioner has determined it is appropriate to rely on this study. In the workshops, several commentators pointed to the Massachusetts decision for the yield calculation.

§2644.16. Rate of Return.

Commentor: Cummins, October 20, 2006, pages 1 and 5, Weinstein, page 6

Summary: The regulation determining a maximum rate of return is inconsistent with modern financial theory and appears to be completely arbitrary and unsupported by data analysis. Maximum return should be based on an asset pricing model using market value data to conduct estimation. The choice of a risk premium of 6% by the Department appears to be completely arbitrary. It is based on no modern financial model and is not supported by data analysis.

Response: The Department in response to Dr. Cummins' earlier comments revised the regulation on rate of return so that it varies over time in response to financial conditions. The calculation involves both a risk-free rate and a risk premium. That is exactly what Dr. Cummins model uses to determine the rate of return, adding the risk-free rate and a

risk premium. Dr. Cummins takes issue with the fact that the Department looks at book returns rather than market returns and implicitly contends that book returns are of no use for a modern financial model. Dr. Cummins, in his September 13, 2006 comments, recommends, the Fama-French three-factor method over the CAPM model because the Fama French model uses three factors instead of CAPM's one. One of the additional two factors that Fama French uses that CAPM does not is a book value to market value ratio. The Department has long recognized that the use of market value in this manner is inappropriate and has relied on book returns. Incorporating market returns in the manner the commentators propose would be circular, since the authorized rate of return would itself affect market expectations and market returns. Furthermore, to the extent the insurer engages in businesses other than the regulated insurance, those unregulated enterprises are likely to affect the company's market returns. Also, a large fraction of the property-casualty insurance written is written by companies whose equity is not publicly traded, and which typically accept lower percentage returns than publicly traded companies tend to demand. In the long-run, a company's market returns ought to track its book returns, since the book returns are the source of profits to the shareholders, so there is no principled reason to grant insurers the premium over book returns these commentators seek. Also see next response. In response to the comments that the Department's method is unsupported by data analysis the Department would direct the commentators to the four documents introduced in the rulemaking file by the Department after the September 13 hearing under the heading "Rate of Return". These documents are discussed in more detail in subsequent responses.

Commentor: Cummins, October 20, 2006, pages 2-4, Weinstein page 6-7, 10

Summary: The regulation provides that the maximum rate of return shall be the risk-free rate plus 6%. Using the regulations' definition of risk-free rate with the assumption that the long-term bond yields as a 20 year maturity results in a 4.86% risk-free rate. The resulting maximum rate of return of 10.86% compensates insurers for the risk they bear and does not give them an adequate return under the comparable risk standard established in *Hope*. Market values rather than book value should be used. Books do not provide a sufficiently accurate indication of the value of an insurance company or other investments to be used in estimating the cost of capital.

Response: Most of the insurers have commented that the Department's maximum rate of return must comply with *Hope*. The California Supreme Court made it clear in *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216, that the *Hope* inquiry does not examine the rate-of-return in isolation and that the rate-of-return value itself is not of constitutional significance. In fact, if one looks at the factors the U.S. Supreme Court enunciated in *Hope*, it is clear that book values provide in some cases a *better* measure than market values. The three criteria that must be considered for a rate to be upheld by the court are: (1) that there be enough revenue not only for operating costs but also

capital costs (e.g. servicing debts and paying dividends); (2) that the return for the regulated entity should be commensurate with returns on investments in other enterprises having corresponding risks; and (3) that the returns should be sufficient to maintain the entity's credit and attract capital. To answer these questions it is much more helpful to look at the books rather than the stock price. For example under (1), to determine revenues one must look at the books. With respect to (2), it is reasonable to assume that in the long run book and market returns should converge. To comply with (3), among other things, the Department introduced into the rulemaking file a spreadsheet showing book rates of return on other like entities, such as life insurers and financial-services companies. And if the company is making a book return, there is no reason to doubt that it can maintain its credit rating and its ability to attract capital. Indeed, financial analysts, rating authorities, lenders, and others in the business of assessing credit risk carefully examine companies' books in making such assessments, including careful examination of book profit.

Commentor: Cummins, October 20, 2006, page 3-5

Summary: Rate of return estimates should be based on widely accepted and thoroughly tested financial pricing models based on market value data. Investors care only about the market value of an investment because the marketplace determines their ultimate return for the investment. Appropriate asset pricing models determine the fair rate of return by adding the risk-free return to a market risk premium that reflects the risk borne by the firm for which the cost of capital is being calculated. Market risk premium varies somewhat over time and generally is calculated as long-term averages of the risk premium actually realized in securities markets.

Response: The Department is employing the sum of the risk-free rate and a risk-premium, as the commentor recommends. It is, however, looking at book returns, rather than market returns, and rejects the comment recommending the contrary. The Department actually chose a risk premium approximately 1 1/2 points higher than indicated by the Department's analysis, both to recognize the uncertainty around this number as equally valid methods can produce different results and to take into account that the excessive rate is allowed to be somewhat above the average rate.

In *20th Century Insurance Co. v Garamendi* (1994) 8 Cal.4th 216 (repeatedly quoted by the insurers in their comments), the California Supreme Court case which applied the *Hope* standards to California insurance rate regulation, the Supreme Court noted at page 303 "determining rates of return is not an exact science, and indeed requires exercise of judgment." The decision went on to note that the two prior commissioners, Commissioner Gillespie and Commissioner Garamendi, arrived at different numbers but both numbers were reasonable. As noted in the documents provided with the 15 day Notice, there is additional, reasonable evidence that would support a rate of return of

9.44%. While that document shows that calculation supporting the Commissioner's choice of the risk premium, he actually adopted a risk premium 1 1/2 percent greater than that. This recognizes that selecting a rate of return number is not an exact science and in the exercise of reasonable discretion a number was selected from among the various estimates.

Commentor: Cummins, October 20, 2006, page 4-5

Summary: The commentor recommends that the Department use the Fama-French three-factor model for determining the fair rate of return for insurers writing property and liability insurance in California. In his September 12 report he opined that the fair rate of return for insurers writing property and liability insurance in California is 17.1% based on the Fama-French three-factor method, which, he contends, is a better predictor than CAPM.

Response: Using CAPM, the Department's adoption of that method as modified to use book returns, or the Fama French three factor method could all be considered reasonable choices upon which the rate of return could be calculated. Please see previous response.

Commentor: Cummins, October 20, 2006, pages 5-6

Summary: The Department should vary the risk-free rate based upon what line of insurance is being written. Short tailed lines, like auto collision, should have a shorter term risk-free rate, like the one or three-month treasury bill rate, while longer tailed lines, such as commercial liability, should have a risk-free rate that corresponds with what the payout period is for that line.

Response: The Commissioner has chosen to reflect the different levels of risk of different lines of insurance by modulating the recognized capital, in the leverage ratio. That is a satisfactory method that isolates all line-specific risk factors in a single variable for readier analysis.

Commentor: Weinstein, page 6

Summary: The Department's regulation rather than providing an appropriate standard for an excessive rate merely provides an artificial minimum nonconfiscatory standard which is not the standard in Insurance Code section 1861.05.

Response: The Department actually chose a risk premium approximately 1 1/2 points higher than indicated by the Department's data analysis both to recognize the uncertainty around this number as equally valid methods can produce different results and to take

into account that the excessive rate is allowed to be somewhat above the average rate. Furthermore, economic theory defines returns in excess of the company's cost of capital as "monopoly rents." The Commissioner interprets the term "excessive" in Insurance Code section 1861.05 and similar statutes to prohibit rates so high that they yield monopoly rents.

Commentor: Weinstein, page 7

Summary: Because making rates for the future, unlike what was done in rollbacks for a rate in the past, involves estimates and projections, uncertainty must be accounted for in the analysis. You need to allow for the potential for greater losses and expenses.

Response: The Commissioner rejects this comment. The regulations provide a return that fully compensates the insurer for its risk. The industry, setting rates prospectively, has earned a return lower than the return set in section 2644.16. While prospective ratemaking does, the Commissioner agrees, involve greater uncertainty than rollbacks, it is also true that the economic conditions in the rollback year required a higher return than current conditions, so the comparison to the authorized rate of return for the rollback year is inapposite. The prospective authorized rate of return provided in section 2644.16 is higher than the average returns, scaled for the risk-free rate. By comparison, the authorized rate of return in the rollback year was the first-quartile value for 10 historic years during which the risk-free rate was substantially above its current level.

Commentor: Sitrin, October 23, 2006, page 2

Summary: AIG agrees with the comments from ACIC. Regardless of the method chosen for determining the maximum rate of return, a provision should be included in the regulations for periodic review and, if necessary, revision.

Response: Please see responses above to ACIC's comments. The Department would point out that a regulation can be revised at any time. Furthermore, the insurers, or any interested member of the public, may file a Petition for Rulemaking with the Department at any time. But since rate of return varies, under the proposed regulation, with the risk-free rate, and since the risk-premium properly does not vary much from year to year, the commentor has failed to justify any revision not already available under the proposed regulations.

Commentor: Rowen/Derrig, October 23, 2006, page 1

Summary: The approximate 10.75% return generated by the Department's regulation is less than a percent above the minimum nonconfiscatory return of 10% in the rollback regulations.

Response: The rollback regulation was for the period 1989, the current regulations are devising rates for 2007 and beyond, almost 20 years later. As the insurers have pointed out, including this commentator, a rate of return varies significantly over time due to changes in the risk-free rate and other economic conditions. Indeed, the risk-free rate in 1989 was nearly double what it is today. Comparing the authorized rate of return going forward to the 1989 number is irrelevant.

Commentor: Rowen/Derrig, October 23, 2006, page 2, 5, 13

Summary: The minimum rate of return of -6% is too low. The document placed by the Department in the rulemaking filed to support this is bizarre. It shows that for the period from 1997 to 2004 for about 1000 companies the average rate of return necessary for the companies to maintain its surplus is 5.8%. Determining the rate of return necessary to maintain surplus is not appropriate for determining the minimum rate of return. The minimum rate of return should be zero.

Response: Part of the determination in what makes a rate inadequate is whether the insurer is losing surplus as a result. The data show that companies can successfully protect their surplus at a -6% rate of return. The commentators have failed to show why the Commissioner should not take that fact into account. Furthermore, a 0% minimum rate of return would restrict companies from salutary price-competition; while the degree of competition is legally irrelevant, under Insurance Code section 1861.05, to a determination of whether a rate is excessive or inadequate, the Commissioner can and should authorize a rate-level for inadequate rates that permits competitive pricing that does not otherwise harm the market or insurer solvency.

Commentor: Rowen/Derrig, page 10-11

Summary: The document placed by the Department in the rulemaking file entitled "Return on Equity of Appel's select and Derrig's Companies: 1996-2005 Data from S&P's 9/16/06 Report" does not support the Department's calculation for its maximum rate of return for the following reasons. The fact that the return on equity from 1996 to 2005 was 10.29% and for 2005 was 10.43% as shown by these exhibits is not relevant for the Department's choice of approximately 11% for three reasons. 1. Both sets of returns are ex-post returns which cannot serve as prospective returns. 2. The historic GAAP book returns are accounting returns and cannot be compared either to market returns for insurers or GAAP returns for other industries. 3. The choice of any return value other than a prospective market return would be inconsistent with the prospective projected yield rate in section 2466.20.

Response: Every methodology for setting an authorized rate of return, like investor expectations themselves, is informed by historic returns. Industry witnesses rely on the Ibbotson historical data to defend their recommended authorized rates of return. So it is not true that ex post returns are irrelevant. The proper relationship between retrospective and prospective returns is in recognition of prospective financial conditions, through use of the contemporaneous risk-free rate. These commentors also complain, as have several others representing the industry, about the use of book returns. The regulations set book revenue and appropriately are based on book returns. Reliance on market returns would be inappropriate because, inter alia, of circularity of such reliance and because in the long run market returns from a regulated business should equal book returns.

Commentor: Rowen/Derrig, pages 11-12

Summary: The document entitled "2004 Annual Rate of Return (ROR)" labeled Exhibit A introduced by the Department into the rulemaking file is irrelevant. Historical returns, whether SAP or GAAP, are not relevant to gauging the market returns which are required to determine the rate of return in section 2644.16.

Response: The Commissioner rejects this comment as fundamentally incorrect. The authorized rate of return is a function of the risk-free rate and the risk-premium. Virtually every commenter has employed historical data to derive the risk-premium going forward, as the Commissioner has in section 2644.16.

Commentor: Rowen/Derrig, page 12-13

Summary: The Excel spreadsheet entitled "Property and Casualty Risk Premium" introduced by the Department into the rulemaking file shows risk premiums from the Ibbotson Associates 2005 Yearbook averaged in the three ways that have been used in Massachusetts, 1926-2004, 1960-2004 and 1976-2004 which respectively show risk premiums from CAPM of, respectively, 7.81%, 5.94% and 6.94%. Using the three months June to August 2006 risk-free average of 5.04% would result in rates of return, respectively of 12.85%, 10.98% and 11.98%. It also shows a risk premium for the period of 1976 to 2004 using book returns and including unrealized capital gains of 4.41%. This does not support the Department's selection of 6% in section 2644.16(a). What would support the 6% has been abandoned in Massachusetts in recent years in favor of averaging 1926 to 2004 and the 1976 to 2004 periods.

Response: At best, the commentors' comments support these other choices as additional reasonable choices that could have been made by the Commissioner. The *20th Century Insurance Co. v Garamendi* decision, (1994) 8 Cal.4th 216 noted at page 303 that "determining rates of return is not an exact science, and indeed requires exercise of judgment." The decision went on to note that the two prior commissioners,

Commissioner Gillespie and Commissioner Garamendi, both arrived at different numbers but both numbers were reasonable. As noted in the documents provided with the 15 day Notice, there is additional, reasonable evidence that would support a rate of return of 9.44% yet the Commissioner chose approximately 11%.

Commentor: Rowen/Derrig, pages 2-3, 10-11

Summary: It is well established that the risk premium for the average risk investment is about 8%. This would result in a maximum rate of return of 12.75% rather than the approximate 10.75% generated by the Department's regulation. The risk premium of 6% would be appropriate only if the property-casualty insurers Beta is .75. However, it is well documented that property-casualty insurers are average risk investments which should have a beta of 1. The simple one factor calculated 60 month beta (.66) which would support an approximate 11% total return as selected by the Department has been shown in the Commons and Phillips study to be biased low.

Response: See previous response. As noted, the analysis of Value Line stocks has limited applicability to the property-casualty insurance industry, which has long experienced lower returns than the Value Line sample. The Commissioner has already rejected the objection to the use of book returns, which he has found to be appropriate to regulation of rates, and to the use of historic returns, which the commentor and many others use, albeit with a different methodology.

Commentor: Estrada/Underhill, October 23, 2006, page 4

Summary: Commentors recognize that the latest revision breaks up the rate of return into a risk-free component and a risk premium component of 6%. The 6% risk premium is based on an average for large-cap stock companies over the last 40 years. If 75 years were chosen instead, the risk premium would be 8%. Using the same 40 year period, the median risk premium is 9%. Going only to the 55th percentile gives a risk premium of 10%. The Department should choose some of the alternate numbers rather than the 6% in order to ensure that the California insurance marketplace attracts needed capital.

Response: The commentor may be correct that the Ibbotson data could justify a higher rate of return, but that does not render the Commissioner's selection of the 6% risk premium incorrect. As previously noted, analysis of the Value Line stock companies is not fully applicable to selection of a rate of return for insurers since the Value Line sample has, for many years, earned a higher historic return than the property-casualty insurance industry. For this and other reasons already stated, the Commissioner is persuaded that 6% is the appropriate risk premium.

Commentor: Farwell, October 23, 2006, page 2

Summary: Similar to the comments from Fireman's Fund the commentor proposes different periods than the 1976-2004 period, which would result in a higher risk premium. The selection of other periods, for example the past 10, 20 and 30 year periods, would produce risk loads of 9.1%, 8.4% and 7.7% respectively. Experience periods up to 60 to 80 years would produce risk loads in the range of 7.8% to 8.3%.

Response: The selection of 6% is not based principally on the observed risk premium from 1960 in particular but from the fact that the higher risk premia cited by the commentor are attributed to the Value Line sample of stock companies that, the Department has determined, have historically experienced higher risk-premia, on average, than the property-casualty insurance industry. More generally, selection of the historical period for risk-premium analysis calls for balancing the competing needs for a long-enough period for the analysis to be representative and robust but not so long that it reflects historic conditions no longer relevant to contemporary conditions. Some commentors favor using the historical record all the way back to 1926, but the Commissioner has concluded that economic conditions prevailing in 1926 are not sufficiently similar to current conditions to justify use of the data from that period. On the other hand, a period of, say, 10 years is too short, eliminating many years that are obviously relevant. The period back to 1960 is long enough to avoid over-emphasis of recent years without inclusion of data from periods of significantly different economic conditions.

Commentor: Sgourea, October 23, 2006, pages 1-2

Summary: The Department's selection of 10.86% as the maximum rate of return does not comply with the *Hope* case and the 17.1% calculated by Dr. Cummins should be chosen. Dr. Cummins' method should be chosen as it eliminates potential biases introduced by these accounting returns and use of a market-based model is in the best interests of California citizens preserving the economic incentive necessary to maintain a stable insurance market.

Response: See previous four responses.

Commentor: Sgourea, October 23, 2006, pages 1-2

Summary: The Department's proposal of a -6% rate of return as the minimum return would violate section 1861.05 (a) and would threaten an insurer's solvency or promote predatory pricing.

Response: The Department's regression in the rulemaking file shows that over the eight year period from 1997 to 2004 surplus could be maintained at an average -6% rate of return. The commenter has failed to proffer any basis for a different conclusion.

Commentor: Weinstein, pages 6 – 7, 10

Summary: The commentor references comments made by Dr. Cummins. The changes to this section are arbitrary, unauthorized, and unnecessary. They fail to reflect the distinction between rate rollbacks and prospective ratemaking. The section is inconsistent with modern financial economic principles, arbitrary, unsupported by data analysis, and conflicts with *Hope*.

Response: Please see responses to the comments made by Dr. Cummins and others on these issues elsewhere in this rulemaking file.

Commentor: Farwell, page 2

Summary: The fixed target rate of return has been changed to a variable target (risk free return plus 6%). The commentor supports the change in methodology, but the formula will produce a target value that is too low – currently 10.7%. The historical risk load varies depending on the time period selected, but the Department has chosen one of the lowest possible historical figures within the rates, the 1960 – 2004 period value of 6%. The most recent 10, 20, and 30 year periods produce risk loads of 9.1%, 8.4%, and 7.7% respectively. Experience periods of 60 – 80 years produce risk loads in the range of 7.8% to 8.3%. The risk load should be increased to 7.5%; 6% is too low.

Response: Please see response elsewhere in this rulemaking file.