STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
300 Capitol Mall, 17th Floor
Sacramento, CA 95814

TEXT OF REGULATION

NET COST OF REINSURANCE AND RATEMAKING

December 27, 2024 **REG-2024-00016**

Title 10. Investment
Chapter 5. Insurance Commissioner
Subchapter 4.8. Review of Rates

Article 2. Definitions

Amend Section 2642.7. Lines of Insurance

(a) Wherever in this subchapter insurance is required to be classified by line, the classification shall be into one of the following categories:

(1) Fire

(2) Allied Lines

(3) Farmowners multiple peril

(4) Homeowners multiple peril

(5) Commercial multiple peril liability

(6) Commercial multiple peril non-liability

(7) Inland marine

(8) Medical malpractice

(9) Earthquake

(10) Other liability

(11) Products liability

(12) Private passenger automobile liability

(13) Private passenger automobile physical damage

(14) Commercial automobile liability

(15) Commercial automobile physical damage

(16) Aircraft

(17) Fidelity

(18) Surety

(19) Burglary and theft

(20) Boiler and machinery~~.~~

(21) Flood.

(b) For purposes of this subchapter, mechanical breakdown and similar insurance covering loss caused by the failure or malfunction of a component or system of a motor vehicle, as described in California Insurance Code Section 116(c), shall be classified as other liability occurrence.

(c) Any insurer or the Commissioner may disaggregate any of the foregoing lines, except homeowners multiple peril, private passenger automobile liability, and private passenger automobile physical damage, into two subcategories, "commodity" and "specialty." 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.

(d) Specialty insurance shall include:

(1) Any single policy having an annual premium over $75,000;

(2) Any policy having a deductible or self-insured retention of $100,000 or more;

(3) Any excess property, excess liability, or umbrella policy, where none of the underlying policies include private passenger automobile liability, private passenger automobile physical damage, or homeowners coverage, or where the underlying policy is written by an unaffiliated insurer and covers at least the first $500,000 in losses;

(4) All policies for

(A) nuclear risks,

(B) pollution legal liability,

(C) product-tampering, product impairment, or product recall,

(D) kidnap and ransom,

(E) political risks,

(F) directors' and officers' liability,

(G) boiler and machinery insurance,

(H) fidelity insurance,

(I) mortgage guaranty insurance,

(J) employer liability under the United States Longshoremen's and Harbor Workers' Compensation Act (33 U.S.C. section 901 et seq.), the Jones Act (46 U.S.C. section 688), the Federal Employer Liability Act (45 U.S.C. section 51 et. seq.), or any similar statute,

(K) excess employer's liability over workers' compensation insurance,

(L) differences in conditions coverage,

(M) surety,

(N) credit, and

(O) aviation.

(e) Commodity insurance shall include all policies in the line that are not defined in this section as specialty.

NOTE : Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805.

Article 4. Determination of Reasonable Rates

Amend Section 2644.16. Rate of Return

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

(b) The minimum permitted after-tax rate of return shall be -6%, which the Commissioner finds is high enough to prevent any undue risk of insolvency and to prevent injury to competition through predatory pricing.

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

(d) Notwithstanding subdivision (c), the Commissioner shall permit consideration for the cost or benefits of reinsurance according to subdivision (b) of 2644.25.1.

NOTE : Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805.

Amend: Section 2644.25. Reinsurance

(a) For all lines and sublines except for those listed in the next subparagraph, and the catastrophe perils within the property lines listed in subdivision (b) of section 2644.25.1, ratemaking shall be on a direct basis, with no consideration for the cost or benefits of reinsurance.

(b) For earthquake and for medical malpractice facultative reinsurance with attachment points above one million dollars, the maximum permitted earned premium is calculated as follows:

The sum of

(1) the quotient of

(A) the difference of

(i) the product of

a. the projected losses, as defined in section 2644.4, plus the projected defense and cost containment expense, as defined in section 2644.8, minus the projected reinsurance recoverables, as defined in section 2644.26,

b. multiplied by 1 minus the fixed investment income factor, as defined in section 2644.19(a),

(ii) minus the projected ancillary income, as defined in section 2644.13,

(B) divided by the sum of

(i) 1.0,

(ii) minus the efficiency standard, as defined in section 2644.12,

(iii) minus the maximum profit factor, as defined in section 2644.15,

(iv) plus the variable investment income factor, as defined in section 2644.19(b).

(2) plus the quotient of

(A) the reinsurance premium, net of ceding and contingent commissions,

(B) divided by the difference of

(i) 1.0,

(ii) minus the variable expense factor, as defined in section 2644.14.

Stated as a formula:

Max permitted EP=

(losses + DCCE - recoverables) x (1- fixed invest income factor) - ancil inc.

+

reins premium

1 - eff std - profit factor + var invest inc factor

1-var exp factor

(c) For the calculation of fixed investment income factor, the numerator and denominator of the loss reserves ratio shall be adjusted for projected reinsurance recoverables, and for the variable investment income factor, the numerator and denominator of the unearned premium reserve ratio shall be adjusted to reflect the cash flows of the unearned reinsurance premium.

(d) Reinsurance costs shall be allowed for ratemaking purposes as set forth in this section only if: (1) the reinsurance agreement was entered into in good faith in an arms-length transaction and at fair market value for the coverage provided, and (2) the reinsurance meets the statement credit requirements of Sections 2303 through 2303.25.

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

(f) Copies of the reinsurance agreements shall be submitted with the filing.

(g) For the purposes of this section and section 2644.26, reinsurance shall include other risk financing mechanisms, such as catastrophe bonds.

(h) For the earthquake line, if at least 30% of the requested rate results from the cost of reinsurance, and a consumer or the consumer's representative requests a hearing within 45 days of public notice, the Commissioner shall hold a hearing on the issue of the reasonableness of the reinsurance costs, as defined in section (d), and whether some or all of those costs shall be reflected in the proposed rate change. An insurer's rate application shall indicate whether at least 30% of the requested rate results from the cost of reinsurance.

(i) For the medical malpractice line, if at least 30% of the requested rate is attributable to the cost of facultative reinsurance with attachment points above one million dollars, and a consumer or a consumer's representative requests a hearing within 45 days of public notice, the Commissioner shall hold a hearing on the issue of the reasonableness of the reinsurance costs, as defined in section (d), and whether some or all of those costs shall be reflected in the proposed rate change. An insurer's rate application shall indicate whether at least 30% of the requested rate results from the cost of reinsurance.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805.

Adopt: Section 2644.25.1. Reinsurance for Property Catastrophe Perils

(a) Ratemaking shall be on a direct basis, with no consideration for the cost or benefits of reinsurance, except for the lines listed in section 2644.25, and the catastrophe perils within the property lines listed in subdivision (b).

(b) For the catastrophe perils of flood, fire following earthquake, and wildfire exposure for commercial property insurance and "qualifying residential property insurance," as that is defined in section 2644.4.8, within the property lines of fire, allied lines, private flood, homeowners, farm owners, and commercial non-liability, the maximum permitted earned premium is calculated as described in subpart (1). Additionally, for an insurer that thus

complies with section 2644.4.8 with respect to such "qualifying residential property insurance," the maximum permitted earned premium is calculated as described in subpart (1) for wildfire exposure covered under a renter's insurance policy, an HO-6 policy, or the equivalent of an HO-6 policy.

(1) the quotient of

(A) the sum of

(i) a. projected losses, as defined in section 2644.4,

b. plus projected defense and cost containment expenses, as defined in section 2644.8,

(ii) multiplied by 1 minus the fixed investment income factor as defined in section 2644.19(a),

(B) minus projected ancillary income, as defined in section 2644.13,

(2) divided by the maximum denominator, as defined in section 2644.25.1(d),

(3) plus the quotient of

(A) the Standard NCOR as defined in section 2644.25.2(j),

(B) divided by 1 minus the variable expense factor, as defined in section 2644.14.

Stated as a formula:

$$\underline{Max\ Permitted\ EP} = \frac{(losses\ +\ DCCE)\ x\ (1 -\ fixed\ invest\ inc\ factor)\ -\ ancil\ income}{max\ denom} + \frac{standard\ net\ cost\ of\ reinsurance}{1 - var\ exp\ factor}$$

(4) The maximum denominator means:

(A) 1.0,

(B) minus the efficiency standard, as defined in section 2644.12,

(C) minus the maximum profit factor, as defined in section 2644.15,

(D) plus the variable investment income factor, as defined in section 2644.19(b).

Stated as a formula:

$$Max\ denom = 1 - \text{eff std} - \text{profit factor} + \text{var invest inc factor}$$

(c) The cost or benefits of reinsurance shall be allowed for ratemaking purposes as set forth in this section only if the insurer complies with the insurer commitments defined in section 2644.25.3.

NOTE: Authority cited: Sections 1861.01, and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01, and 1861.05, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805.

Adopt Section 2644.25.2. Standard Net Cost of Reinsurance

(a) The Commissioner shall calculate the Standard Net Cost of Reinsurance (Standard NCOR) parameters from time to time as conditions warrant, and when updated source data is available. Data and information used to calculate the Standard NCOR shall prioritize the following:

(1) Information that represents the diversity and scope of insurance companies operating in California.

(2) Data that is most relevant to the current market conditions.

(3) Data and information that support the most actuarially sound parameters.

(4) Comprehensive data that is available, reliable, and reduces long-term volatility in the Standard NCOR methodology.

(b) The Standard NCOR parameters shall be expressed as permitted return multiples for specific loss probability layers, which represent the net cost for a reasonably efficient insurer to purchase reinsurance coverage or hold additional capital for exposure to the occurrence of catastrophic property loss, or both.

(1) Loss probability layers represent the coverage ranges within reinsurance contracts, where the reinsurer typically provides coverage for losses exceeding a certain dollar threshold up to a given dollar limit. The dollar thresholds and limits of these individual reinsurance coverage layers correspond to specific probabilities of loss, which can be used to aggregate and compare data across reinsurance contracts of varying sizes with different underlying risks.

(c) The Standard NCOR parameters shall be set separately for insurer/coverage groups.

(1) Insurer/coverage groups shall be assigned based upon objectively measurable or observable characteristics of the insurer and/or the coverage provided by the insurer to its policyholders for the catastrophe perils within property lines listed in subdivision (b) of section 2644.25.1.

(2) The Commissioner shall establish no less than three insurer/coverage groups, and may establish additional insurer/coverage groups based on the Commissioner's review and determination of updated and credible source data, to achieve a more actuarially sound result.

(d) In setting the insurer/coverage groups, the Commissioner shall determine whether adopting separate parameters for a given characteristic, or combination of characteristics, would produce a more actuarially sound result.

(1) If the Commissioner determines that adopting separate parameters for a given characteristic, or combination of characteristics, would produce a more actuarially sound result, the Commissioner shall set the parameters separately, pursuant to section 2646.3.

(A) Characteristics that may be relevant include, but are not limited to, insurer capital structure, amount of insurance being written based on premium or policy counts, percentage of insurance written in California, property line of business, and/or catastrophe peril.

(e) In determining whether a given characteristic, or combination of characteristics, would produce a more actuarially sound result, the Commissioner shall consider:

(1) The relationship with expected property catastrophe reinsurance costs;

(2) Common or standardized industry practices related to expected property catastrophe reinsurance costs;

(3) Limitations created by business practices and whether such limitations are likely to have a significant impact;

(4) The degree to which expected property catastrophe reinsurance costs vary within an insurer/coverage group (homogeneity);

(5) The size of an insurer/coverage group and its predictive value for expected property catastrophe reinsurance costs (credibility);

(6) The tradeoffs between practical and other relevant considerations (practicality); and

(7) The reasonableness of the results that proceed from their use.

(f) To determine the specific loss probability layers, the Commissioner shall consider:

(1) Common or standardized industry practices for both the purchase of property catastrophe reinsurance and the modeling of loss return periods;

(2) The homogeneity of return multiples by layer;

(3) The credibility of return multiple data by layer;

(4) The practicality of the number of layers; and

(5) The reasonableness of the results that proceed from their use.

(g) For each specific loss probability layer, the permitted return multiple shall be the average return multiple over the layer, calculated as the definite integral from the starting loss probability to the ending loss probability of a curve of best fit on return multiples by loss probability from the source data, as defined in section (i) of this section, divided by the length of the integration interval.

(1) In calculating curves of best fit, the Commissioner may exclude insurers and/or reinsurance coverage layers for which reliable data are not readily available in the source data.

(2) The Commissioner may consider, but is not limited to the consideration of, the currentness, consistency, reasonability, sufficiency, and any known limitations of the data when determining its reliability.

(h) Since the net cost for a reasonably efficient insurer to purchase reinsurance coverage and/or hold additional capital for exposure to the occurrence of catastrophic property loss may vary by the combination of catastrophe perils and/or property lines covered in California, where multiple catastrophe perils and/or property lines are covered in California, the Commissioner shall set both the level of detail at which the Standard NCOR parameters shall apply and the methodology by which the results are combined.

(1) Level of detail and methodology

(A) In setting the level of detail at which the Standard NCOR parameters shall apply and the methodology by which the results are combined, the Commissioner shall determine whether adopting a given treatment would produce a more actuarially sound result.

(B) The Commissioner shall consider, but is not limited to the consideration of, the following methodologies when determining whether a given treatment will produce a more actuarially sound result:

(i) Applying the Standard NCOR parameters to each catastrophe peril and/or property line in California individually, with or without covariance adjustments;

(ii) Applying the parameters to all catastrophe perils and property lines combined and allocating the results to individual catastrophe perils and property lines; or

(iii) A combination of (i) and (ii).

(2) If the Commissioner determines that a given treatment would produce a more actuarially sound result, the Commissioner shall adopt such treatment, pursuant to section 2646.3.

(i) Data used in subdivisions (a) through (h) of this section shall be derived from data available to the California Department of Insurance, including from data calls that the California Department of Insurance conducts relating to reinsurance strategies and placement, and/or publicly available data, whatever would produce the most actuarially sound result. If the Commissioner determines that the use of publicly available data alone would produce the most actuarially sound result, the Commissioner shall use such data, pursuant to section 2646.3.

(1) Any data derived from data calls shall only be released to the public in the aggregate so that no individual insurer experience is revealed.

(j) If an insurer complies with the commitments defined in section 2644.25.3, the insurer may file its complete rate application, made pursuant to section 2648.4, using the Standard NCOR parameters for its insurer/coverage group(s) for the catastrophe perils within property lines listed in subdivision (b) of section 2644.25.1.

(1) The permitted return multiples shall be applied to the expected losses generated from one or a combination of catastrophe models for the specific loss probability layers, at the level of detail set by the Commissioner.

(A) The expected losses may be adjusted to include a provision for defense and cost containment expenses (DCCE), either by applying a historical ratio of noncatastrophe DCCE to noncatastrophe loss or by applying a historical ratio of catastrophe DCCE to catastrophe loss.

(2) The results for multiple catastrophe perils and/or property lines covered in California shall be combined according to the methodology set by the Commissioner, where applicable.

(k) It is expected that in an insurer's complete rate application, made pursuant to section 2648.4, any catastrophe model(s) used for subdivision (j) of this section shall be consistent with the catastrophe model(s) used for subdivisions (a) through (c) of section 2644.4.5.

(1) The use of catastrophe models shall comply with the requirements set forth in subdivisions (d) through (f) of section 2644.4.5, and the inclusion of any required

model information in the complete rate application proceeding shall make such information public information.

Adopt Section 2644.25.3. Distressed Areas; Insurer Commitments for NCOR.

An insurer that opts to make, fulfill, and document the fulfillment of its insurer commitments in the manner specified in this section 2644.25.3 may consider the cost or benefits of reinsurance as permitted by subdivision (b) of section 2644.25.1.

The term "qualifying residential property insurance," for purposes of this section 2644.25.3, is as defined in section 2644.4.8.

(a) Distressed areas, and properties insured by FAIR Plan policies, that are to be used in insurer commitments for the purposes of this section 2644.25.3 are as defined in subdivision (a) of section 2644.4.8.

(b) Statewide market share calculations for the purposes of this section 2644.25.3 will be determined as described in subdivision (b) of section 2644.4.8.

(c) An insurer shall, as part of a complete rate application filing made pursuant to section 2648.4, submit an insurer commitment as set forth in subdivision (d), (e) and/or (j) of this section.

(d) Insurer commitments with respect to qualifying residential property insurance.

The insurer shall commit in writing to achieving no later than two years (730 days) after the approval of its rate filing (the insurer's "performance date" hereinafter), or maintaining, and then subsequently maintaining, the insurer's earned exposure commitment in the distressed areas of the state as follows:

(1) Eighty-five percent standard.

(A) The insurer shall commit to write in distressed areas a number of policies that is no less than the product of (1) the insurer's statewide market share, as calculated pursuant to subdivision (b)(1) of section 2644.4.8, (2) 0.85, and (3) the total number of statewide distressed areas earned exposures pursuant to subdivision (b)(2) of section 2644.4.8; or

(B) In the event the insurer already meets or exceeds the eighty-five percent standard set forth above in subdivision (d)(1)(A) of this section at the time of its rate application, the insurer shall commit to maintaining at least the

same number of earned exposures in the distressed areas as it reported in the rate application filing pursuant to subdivision (c) of this section.

(2) Five percent increment.

After the approval of its rate filing (the insurer's "performance date" hereinafter), the insurer may instead commit to writing additional policies as specified in subdivision (d)(3) in the voluntary market inside the distressed areas of the state such that, on the performance date, the insurer has increased its number of earned exposures inside the distressed areas by at least the number of policies equal to five percent (5%) of its earned exposures in the distressed areas of the state within the most recent 12 month period used in its recorded period as submitted in the insurer's rate application pursuant to subdivision (c) of this section. Upon meeting the initial five percent (5%) increment, the insurer shall commit in writing in each subsequent two year (730 days) period to writing additional policies as specified in subdivision (d)(3) in the voluntary market inside the distressed areas of the state such that it continues to increase its number of earned exposures inside the distressed areas by at least the number of policies equal to an additional five percent (5%) of the insurer's earned exposures in the distressed areas of the state until it meets or exceeds the eighty-five percent standard set forth above in subdivision (d)(1)(A) of this section.

(3) In the event that one or more of the bulletins described in subdivision (a) of section 2644.4.8 that is or are referred to in an insurer's approved rate application pursuant to subdivision (c) of this section (the insurer's "starting bulletin or bulletins" hereinafter) have been updated since the time the application was filed, then the insurer may satisfy its insurer commitment according to the same procedures as subdivisions (d)(3)(A) and (d)(3)(B) of section 2644.4.8.

(4) The additional policies written in order to satisfy the requirement of subdivision (d) of this section shall include only the additional policies described in subdivision (d)(4) of section 2644.4.8.

(e) Insurer commitments with respect to commercial property insurance shall be made in the same manner as subdivision (f) of section 2644.4.8. Upon meeting the initial five percent (5%), as described in subdivision (f)(2) of section 2644.4.8, the insurer shall commit in writing in each subsequent two year (730 days) period to writing additional policies such that it insures, and maintains, additional properties in eligible ZIP codes whose total insurable value is, in the aggregate, at least equal to five percent (5%) of the sum of the total insurable value of its insured properties in all the eligible ZIP codes, taken as a whole, until it has made a total of three (3) five percent (5%) commitments in order to

consider the cost or benefits of reinsurance as permitted by subdivision (b) of section 2644.25.1.

(f) An insurer shall document the fulfilment and maintenance of its insurer commitment as described in subdivision (g) of section 2644.4.8, with the exception of the application of the subdivision (g)(3)(C).

(g) A modification of an insurer commitment shall be governed as described in subdivision (h)(1) of section 2644.4.8.

(h) If at any time an insurer fails to fulfill its insurer commitment, or within a period of two years after the approval of its original application, or at any point thereafter, fails to make reasonable progress toward timely fulfilling its insurer commitment, then the insurer shall immediately submit a new rate application renouncing its insurer commitment as described in subdivision (d) or (e) of this section. In this case, the new rate application shall not consider the costs or benefits of reinsurance as permitted by subdivision (b) of section 2644.25.1.

(i) An insurer that obtained approval to consider the cost or benefits of reinsurance in its original application shall file one of the attestations described in subdivision (i)(1) and (2) of section 2644.4.8 in every subsequent rate application.

(j) Any contrary provision of this section notwithstanding, if for any of the reasons stated in subdivision (j)(1) of section 2644.4.8, an insurer is unable, in good faith, to make a commitment as set forth in subdivisions (d) or (e) of this section, then an insurer may propose an alternative commitment in a complete rate application filing made pursuant to subdivision (c) of this section, as described in subdivision (j)(2) of section 2644.4.8.

(k) Nothing in this section shall be construed as limiting, in any way, an insurer's ability to offer qualifying residential property insurance or commercial property insurance in this state.

(*l*) If any provision or clause of this section or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of this section which can be given effect without the invalid provision or application. To this end, the provisions of this section are hereby declared to be severable.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805.

Amend Section 2644.27. Variance Request

(a) A request that the maximum permitted earned premium or minimum permitted earned premium should be adjusted is referred to as a "variance request."

(b) Requests for variances shall be filed with the Rate Regulation Branch, together with the insurer's complete rate application. All such variance requests shall specifically:

(i) identify each and every variance request;

(ii) identify the extent or amount of the variance requested and the applicable component of the ratemaking formula;

(iii) set forth the expected result or impact on the maximum and minimum permitted earned premium that the granting of the variance will have as compared to the expected result if the variance is denied; and

(iv) identify the facts and their source justifying the variance request and provide the documentation supporting the amount of the change to the component of the ratemaking formula.

(c) Requests for variances shall be filed at the same time as the insurer's complete rate application to which it applies or after the filing of the complete rate application and before any final determination regarding that application. Public notice of all variance requests shall be provided as set forth in Insurance Code sections 1861.05, subdivision (c), and 1861.06.

(d) A variance request shall be deemed approved sixty days after public notice unless:

(i) a consumer or a consumer's 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

(ii) the Commissioner on the Commissioner's own motion determines to hold a hearing.

(e) Variance requests shall be determined in conjunction with the related complete rate application or rate hearing thereon.

(f) The following are the valid bases for requesting a variance:

(1) That the insurer should be allowed relief from the efficiency standard for bona fide loss-prevention and loss-reduction activities as set forth below.

(A) The insurer meeting the qualifications set forth below may obtain an increase in the applicable efficiency standard by the amount of its "Allocated Costs" for its Special Investigations Unit ("SIU") expense for the most recent year. The term SIU as used in this section has the same

meaning as that term has in Section 2698.30, subdivision (p). The term "Allocated Costs" means those costs set forth in subsection (iii) and attributable to investigations of claims made on the line of insurance subject to Insurance Code section 1861.05, subdivision (b) for which the variance is sought.

(i) An insurer may recover its "Allocated Costs" for its SIU expenses only in its approved rate filing for the line of insurance affected by the SIU investigation costs.

(ii) Affiliated insurers who utilize the same SIU unit may recover the portion of their "Allocated Costs" for their SIU expenses attributable to investigations of claims made on the line of insurance in the rate application only in one approved rate application for the line affected by the Allocated SIU costs. The term "Affiliated Insurers" has the same meaning as that term has in Insurance Code section 1215.

(iii) The only recoverable SIU expenses are those expended for investigators whose sole duties are investigation of insurance fraud, software dedicated solely to analysis of data for indications of insurance fraud, training of employees whose sole duty is the investigation of fraud and equipment to be used solely by the insurer's SIU. The recoverable expenses do not include the costs of employing or other costs for adjustors or underwriters.

(iv) The only recoverable SIU expenses are for SIU's dedicated to investigation of insurance fraud within the State of California or for the portion of an SIU's operations within California. The burden of demonstrating the amount of SIU expenses, and that those expenses are for the investigation of insurance fraud within the State of California, is the insurer's.

(v) An insurer may recover the "Allocated Costs" of retaining an independent contractor to perform SIU services as described in sub-paragraph (iii). The variance shall be calculated by multiplying the fees paid for the independent agency with whom the insurer contracts by the percentage of referrals of claims made on the line of insurance for which the rate application and variance application are made and that the contracted agency investigates in California on behalf of the insurer seeking the variance.

(vi) No expense that is included within the Defense and Cost Containment Expense portion of an insurer's complete rate

application can be included in whole or in part as the basis for a variance based on SIU expenses. The terms "Defense and Cost Containment Expense" or "DCCE" when used with regard to any variance have the same meaning as those terms have in Section 2644.23, subdivision (c).

(vii) An insurer that asserts that payments to: (1) an independent contractor; or (2) an SIU owned by an Affiliated Insurer; or (3) an SIU independent of an insurer, but which is owned directly or indirectly, in whole or part by the insurer applying for a variance or by an Affiliated Insurer, shall in its variance request, provide the Department of Insurance with documentation showing the costs of investigation for the purported "Allocated Costs" claimed in the variance request. The payments constituting the basis for the variance must be bona fide payments for investigation of individual cases of suspected insurance fraud. It shall be the burden of the insurer to demonstrate that the costs are bona fide costs for investigation of insurance fraud in the State of California.

(B) An insurer meeting the qualifications set forth below will be allowed to recover its expenses for the most recent year for dedicated loss prevention programs such as brush clearance, driver education, risk management, hazard mitigation or accident prevention. Loss prevention expenses do not include SIU expenses under subsection (A).

(i) An insurer may recover its "Allocated Costs" for its loss prevention expenses only in its approved rate for the line of insurance affected by the loss prevention expenses.

(ii) The insurer must provide documentation detailing the loss prevention program, what additional costs are being incurred and what losses are being prevented.

(iii) Recoverable loss prevention expenses are those expended for employees whose duties are loss prevention, software dedicated to loss prevention, and equipment to be used for loss prevention. Recoverable loss prevention expenses do not include the routine and customary costs of marketing or employing underwriters or adjusters.

(iv) The only loss prevention expenses recoverable are for loss prevention programs dedicated to loss prevention in the State of California or for the portion of the program within California. The burden of demonstrating the amount of loss prevention costs, and that those costs are expended for loss prevention in the State of California, is on the insurer.

(2) That the insurer should be allowed relief from the efficiency standard due to any or all of the following:

(A) Higher quality of service, as demonstrated by objective measures of consumer satisfaction; or

(B) Demonstrated superior service to underserved communities, as defined in Section 2646.6; or

(C) Significantly smaller or larger than average California policy premium, including any applicable fees. These fees include but are not limited to: policy fees, installment fees, endorsement fees, inspection fees, cancellation fees, reinstatement fees, late fees, SR-22, and other similar charges.

(3) That the insurer should be authorized leverage factor different from the leverage factor determined pursuant to Section 2644.17 on the basis that the insurer either writes at least 90% of its direct earned premium in one line or writes at least 90% of its direct earned premium in California and its mix of business presents investment risks different from the risks that are typical of the line as a whole. The leverage factor shall be adjusted by multiplying it by 0.85. The surplus ratio in Section 2644.22 shall likewise be divided by 0.85. If an insurer writes at least 90% of its direct earned premium in one line and writes at least 90% of its direct earned premium in California, the insurer will only be authorized one leverage factor adjustment of 0.85.

(4) That the insurer should be granted relief from operation of the efficiency standard for a line of insurance in which the insurer has never previously written over $1 million in earned premiums annually and in which the insurer has made or is making a substantial investment in order to enter the market. Any such request shall be accompanied by a proposed amortization schedule to distribute the start-up investment.

(5) That the minimum permitted earned premium should be lowered on the basis of the insurer's certification, and the Commissioner's finding, that the rate will not cause the insurer's financial condition to present an undue risk to its solvency and will not otherwise be in violation of the law.

(6) That the insurer's financial condition is such that its maximum permitted earned premium should be increased in order to protect the insurer's solvency. Any application for authorization under this subsection shall include:

(A) A showing of the insurer's condition, based on generally accepted standards such as the National Association of Insurance Commissioners' Insurance Regulatory Information System;

(B) A plan to restore the financial condition;

(C) A showing that, consistent with the claimed condition, the insurer has reduced or foregone dividends to stockholders or policyholders; and

(D) A plan to reduce rates once the insurer's condition is restored, in order to compensate consumers for excessive charges.

(7) That the insurer should be granted relief from using its in-force business as specified in subdivision (e) of Section 2644.4.5 because the insurer's in-force exposures do not reflect the insurer's prospective exposure to risk, such that the modeled catastrophe adjustment in subdivision (a) of Section 2644.5 does not produce the most actuarially sound result.

(8) That the loss development formula in Section 2644.6 does not produce an actuarially sound result because

(A) There is not enough data to be credible;

(B) There are not enough years of data to fully calculate the development to ultimate;

(C) There are changes in the insurer's reserving or claims closing practices that significantly affect the data;

(D) There are changes in coverage or other policy terms that significantly affect the data;

(E) There are changes in the law that significantly affect the data; or

(F) There is a significant increase or decrease in the amount of business written or significant changes in the mix of business.

(9) That the trend formula in Section 2644.7 does not produce the most actuarially sound result because

(A) There is a significant increase or decrease in the amount of business written or significant changes in the mix of business;

(B) There are not enough years of data to calculate the trend factor;

(C) There is a significant change in the law affecting the frequency or severity of claims;

(D) It can be shown that a trend calculated over a period of at least 4 quarters other than a period permitted pursuant to Section 2644.7, subdivision (b) is more reliable prospectively;

(E) There are changes in the insurer's claims closing practices that significantly affect the data; or

(F) There are changes in coverage or other policy terms that significantly affect the data.

(10) That the maximum permitted earned premium would be confiscatory as applied. This is the constitutionally mandated variance articulated in 20th Century v. Garamendi (1994) 8 Cal.4th 216 which is an end result test applied to the enterprise as a whole. Use of this variance requires a hearing pursuant to 2646.4.

(11) That the Standard NCOR, as defined in section 2644.25.2(j), does not accurately reflect the company's actual reinsurance costs, and does not produce an actuarially sound result.

(A) Any such request for variance shall be accompanied by a proposed net cost of reinsurance provision that is calculated based on the insurer's executed reinsurance agreements with supporting documentation, including but not limited to, complete copies of the reinsurance agreements with signatures and no redactions.

(B) Reinsurance agreements shall be allowed in the proposed net cost of reinsurance provision calculation only if: (1) the reinsurance agreement was entered into in good faith in an arms-length transaction and at fair market value for the coverage provided, and (2) the reinsurance meets the statement credit requirements of sections 2303 through 2303.25.

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

(g) If there is more than one actuarial analysis of a variance, each of which is based on reliable data and utilizes methods which are shown by qualified expert evidence to be generally accepted as sound by the actuarial community and the appropriate methods for the particular variance, then the variance shall be granted, denied or calculated utilizing the actuarial proposition that results in the soundest actuarial result.

(h) Notwithstanding any other section of these regulations, the aggregate total adjustment to the efficiency standard for all variances combined shall not exceed the difference between the insurer's most recent year total expense ratio excluding defense and cost containment expenses and the efficiency standard.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805.