**STATE OF CALIFORNIA**
**DEPARTMENT OF INSURANCE**
**45 Fremont Street, 24th Floor**
**San Francisco, California 94105**

# NOTICE OF PROPOSED ACTION AND NOTICE OF PUBLIC HEARING

## INDIVIDUAL DISABILITY POLICY LOSS RATIO REGULATIONS

**RH-06092236**
**July 21, 2006**

## SUBJECT OF HEARING:

Notice is hereby given that a public hearing will be held regarding the adoption of amendments to California Code of Regulations ("CCR") Title 10, Chapter 5, Subchapter 2, Article 1.9 ("Standards for Determining Whether Benefits of an Individual Hospital, Medical or Surgical Policy Are Unreasonable In Relation to the Premium Charged Pursuant to Subdivision (c) of Section 10293"), sections 2222.10, 2222.11, 2222.12, 2222.13, 2222.14, 2222.15, 2222.16, 2222.17, and 2222.19. The proposed regulation will significantly increase the loss ratio requirement for individual hospital, medical or surgical policies, describe the actuarial method by which the loss ratio is to be calculated, provide that the new loss ratio will apply to new policies and to existing policies on rate revision, include mass-marketed policies, delete an obsolete preliminary screening procedure and an obsolete table of credibility factors, and make other, non-substantive, changes.

## HEARING DATE AND LOCATION:

Notice is hereby given that a public hearing will be held to permit all interested persons the opportunity to present statements or arguments, orally or in writing, with respect to the proposed regulations as follows:

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| **Date and time:** | **September 19, 2006**<br>**10:00 am*** |
| **Location:** | **Department of Insurance Hearing Room**<br>**45 Fremont Street, 22nd Floor**<br>**San Francisco, CA 94105** |

*The hearing will continue on the date noted until all testimony has been completed or 5:00 p.m., whichever is earlier.

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**PRESENTATION OF WRITTEN AND/OR ORAL COMMENTS:**

All persons are invited to present oral and/or written comments at the scheduled public hearing. Written comments should be addressed to the contact person, listed below under the heading "Contact Persons." Questions regarding procedure, the hearing, comments, or the substance of the proposed action should be also addressed to the contact person listed below.

**DEADLINE FOR WRITTEN COMMENTS:**

All persons are invited to submit written comments on the proposed regulations during the public comment period. **The public comment period will end at 5:00 p.m. on September 19, 2006.** All written comments, whether submitted at the hearing, or by U.S. mail, or by e-mail or facsimile, must be received by the Insurance Commissioner, c/o the contact person at the address listed below, no later than **5:00 p.m. on September 19, 2006.** Any written materials received after that time will not be considered.

**COMMENTS TRANSMITTED BY E-MAIL OR FACSIMILE:**

The Commissioner will accept written comments transmitted by e-mail provided they are sent to the following e-mail address: HinzeB@insurance.ca.gov. The Commissioner will also accept written comments transmitted by facsimile provided they are sent to the attention of the contact person at the following facsimile number: (415) 904-5896. **Comments sent to other e-mail addresses or other facsimile numbers will not be accepted. Comments sent by e-mail or facsimile are subject to the 5:00 p.m. September 19, 2006 deadline for written comments set forth above.**

**AUTHORITY AND REFERENCE:**

Authority:

The Insurance Commissioner proposes the adoption of amendments to California Code of Regulations ("CCR") Title 10, Chapter 5, Subchapter 2, Article 1.9 ("Standards for Determining Whether Benefits of an Individual Hospital, Medical or Surgical Policy Are Unreasonable In Relation to the Premium Charged Pursuant to Subdivision (c) of Section 10293"), sections 2222.10, 2222.11, 2222.12, 2222.13, 2222.14, 2222.15, 2222.16, 2222.17, and 2222.19, pursuant to the authority vested in him by section 10293 of the California Insurance Code.

Reference:

The Commissioner's decision on the proposed amendments will implement, interpret, and make specific the provisions of Insurance Code section 10293.

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## INFORMATIVE DIGEST

POLICY STATEMENT OVERVIEW

### 1) Purchasers of individual hospital, medical or surgical policies lack expertise and market power

One of the most significant factors facing purchasers of individual hospital, medical or surgical insurance is the disparity in expertise and market power between the purchaser and the insurer. While large purchasers of group health insurance have expertise in judging the level of benefit, and market power in negotiating benefits, small groups and individuals lack such expertise and market power. In part as a result of this disparity, the market for individual insurance does not function at full efficiency. This disparity in market knowledge and market power accounts, in part, for the fact that the amount of premium remaining after benefits and expenses is significantly higher for individual hospital, medical or surgical insurance, as compared to group health insurance.

### 2) Purchasers of individual hospital, medical or surgical policies bear an increasing economic burden

Consumers who purchase individual hospital, medical or surgical insurance policies face a growing economic burden, as both premium costs and out-of-pocket expenses have significantly increased. This economic burden is consistent with larger trends in health care costs. In the past decades, health care spending in the United States has outpaced the general rate of inflation. Nationally, the amount spent per person on health care increased 74 percent between 1994 and 2004. In addition to the increase in health care costs, the nature of the expenses has changed over the past 20 years, shifting to areas for which the individual hospital, medical or surgical insurance policyholder often must pay a significant portion of the expense. Between 1984 and 2004, the amounts paid for prescription drugs, as a percentage of national health expenditures, increased from 4.9% to 10.0%. From 2001 through 2004, the average annual growth rate in national health care expenditures was 8.4 percent. In the California individual hospital, medical or surgical insurance market, premiums rose almost 40 percent between 1997 and 2002, in contrast to an approximately 12 percent rise in the prices of other goods and services, as measured by the Consumer Price Index, over the same period.

### 3) Purchasers of individual hospital, medical or surgical policies are a vulnerable population

While this environment of rising costs poses challenges for purchasers of individual hospital, medical or surgical insurance, additional factors make these purchasers particularly vulnerable. First, the individual hospital, medical or surgical insurance market is the last resort for many; California has a higher rate of persons without insurance and lower rates of employer-sponsored coverage than does the nation as a whole. In addition, the need for individual hospital, medical or surgical insurance has been increasing due to corporate downsizing. Those who are not fortunate enough to receive insurance through their workplace and are not eligible for public programs must attempt to obtain coverage in the individual market. Once covered by individual insurance, many consumers rely on maintaining that coverage for years. In California, the individual insurance market is an important source of long-term hospital, medical or surgical insurance coverage for a sizable fraction of those who purchase it.

A second factor that confronts purchasers of individual hospital, medical or surgical insurance policies is the fact that products in the individual market are difficult to qualify for because they are carefully underwritten to manage risk. A third factor is the rapidly increasing cost of individual insurance. High premiums and the low incomes of many of the potential purchasers of individual insurance makes affordability a particular concern. The increasing expense of individual hospital, medical or surgical insurance reduces affordability, which in turn reduces availability for consumers who might otherwise be forced to go without vital hospital, medical or surgical insurance coverage. Also, inadequate benefits in individual insurance coverage can be a major source of underinsurance, which affects 13-20 percent of the privately insured. On average, coverage in the individual hospital, medical or surgical insurance market is less complete than coverage in the group market. Thus, purchasers of individual hospital, medical or surgical insurance are faced with rapidly increasing health care costs in general, as well as even more rapidly increasing premiums for individual coverage. Because they have no realistic alternative to individual coverage, such persons are at risk of being priced out of the individual insurance market, and joining the large number of uninsured Californians.

**4) Conclusion**

Over forty years ago, the Legislature recognized that the market for individual hospital, medical or surgical insurance would have to be supported by regulation in order to ensure that policyholders received a reasonable return in benefit for their premium dollar. This regulation increases the efficiency of the market for individual hospital, medical or surgical insurance. The statutory basis for this regulation, Insurance Code section 10293 (discussed below), provides that approval for a policy may be withdrawn if the benefits provided are unreasonable in relation to the premium charged. Since 1962, the standard for the reasonableness of the relationship between benefits provided and premium charged for most policies has been a minimum 50 percent loss ratio (calculated by dividing the benefits provided by the amount of premium charged). However the dramatic transformation of the health care market over the ensuing 44 years has made the 50 percent loss ratio an inadequate standard. Premiums have increased to the point where individual hospital, medical or surgical insurance has become a heavy economic burden even for those who pass medical underwriting. Increasing out-of-pocket expenses for copays, deductibles, and uncovered care add to this burden. In addition, the purchasers of individual hospital, medical or surgical policies often have no alternative, and lack expertise and market power. Because of these factors, the legislative mandate of a reasonable relationship between premium charged and benefits received requires that the loss ratio requirement be raised in order to support the individual hospital, medical or surgical insurance market and ensure that these consumers obtain fair value for their hospital, medical or surgical insurance dollars.

SUMMARY OF EXISTING LAW; EFFECT OF PROPOSED ACTION

**Summary of Existing Law:**

Insurance Code section 10293, originally enacted during the 1961 legislative session and as subsequently amended, requires, among other provisions, that the Insurance Commissioner withdraw approval of individual or mass-marketed policies of disability insurance “if after consideration of all

relevant factors the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged." The same Insurance Code section also required that the Insurance Commissioner promulgate "such reasonable rules and regulations…as are necessary to establish the standard or standards by which the commissioner shall withdraw approval of any such policy." As a result, on November 30, 1962, the Insurance Commissioner ordered that a new Article 1.9, consisting of sections 2222.10 to 2222.19, be added to the California Administrative Code. This article adopted a "loss ratio" as the means to determine whether the benefits provided by a policy were reasonable in relation to the premium charged. A loss ratio is a measure used by the actuarial profession to evaluate the reasonableness of the benefits provided by a hospital, medical or surgical policy. Here, the "loss ratio" is the ratio of incurred claims to earned premium over the lifetime of a block of insurance business.

As adopted in 1962, section 2222.12, "Standards of Reasonability," provided standards of reasonableness for the ratio of benefits to premium charged in hospital, medical, and surgical policies. These standards were a loss ratio of not less that 50 percent (for policies with annual premiums in excess of $7.50 per person), and 35 percent (for policies with annual premiums below $7.50 per person). Article 1.9 was subsequently amended in March 1978 to add a minimum loss ratio of 55 percent for Medicare supplement policies. In January 1983, Article 1.9 was further amended to set a revised loss ratio of 60 percent for Medicare supplement policies. However, the loss ratio standard for non-Medicare supplement individual group policies has remained at 50 percent for forty-four years.

The authority for the existing law, and for each of the proposed amendments, is Insurance Code section 10293. The reference is 10293.

**Effect of Proposed Action:**

The specific proposed amendments and their effect are discussed below.

Section 2222.10. Applicability.

The amendment deletes the obsolete 1962 operative date for the regulation, and instead makes the amended regulation applicable to new hospital, medical or surgical policies delivered or issued on or after July 1, 2007. The proposed amendment to section 2222.10 also provides that the increased loss ratio established by this amended regulation will apply to existing policies subject to a rate revision effective on or after July 1, 2007.

Section 2222.11. Definitions.

Subdivision (a):

The existing subdivision provided a definition of the term "hospital, medical, or surgical policy." This definitional subdivision was included as a part of the original regulation when it first went into effect in 1962.

The purpose of the proposed amendment to this section is to incorporate Insurance Code section 106, which was amended in 2001 to provide a definition of “health insurance,” into the definition of a "hospital, medical or surgical policy." Similarly, in 1981 Insurance Code section 10293 was amended to include mass-marketed policies within the category of policies covered by that section. The proposed amendment incorporates the 1981 revision of section 10293 into the definition of "hospital, medical or surgical policy."

New subdivision (f):

The existing regulation was applicable to policies issued after July 1962, but did not apply to policies in force as of that effective date.

The proposed amended regulation includes a provision that the increased loss ratio requirement will apply to existing policies upon rate revision (as well as to new policies) after the proposed effective date, July 1, 2007. Subdivision (f) provides a definition of “rate revision.” The definition provides that a “rate revision” occurs when premium rates change.

New subdivision (g):

The existing regulation, at 2222.12, describes the loss ratio calculation, but does not do so using current actuarial terminology.

The definition provided in this new subdivision (g) specifies the factors included in the calculation of a lifetime anticipated loss ratio, and the method of calculation, using current actuarial terminology.

Section 2222.12. Minimum Loss Ratio Standards

As described above under “Summary of Existing Law,” the existing regulation provides for a minimum loss ratio of 50% for individual hospital, medical, or surgical policies with annual premiums in excess of $7.50 per person, as well as other loss ratios for policies with lower annual premiums, and for Medicare supplement policies.

The proposed amended regulation changes the minimum loss ratio level at which non-Medicare-supplement hospital, medical, or surgical policies will be deemed to be reasonable from 50 percent to 70 percent.

The proposed amended regulation clarifies that the minimum loss ratio of 70 percent is calculated as a “lifetime anticipated” loss ratio. A “lifetime anticipated” loss ratio considers both the actual and anticipated experience (including incurred claims, changes in reserves, taxes and commission, administrative expenses, and gross margin) over the anticipated lifetime of an insurance product in a way that takes into account random annual fluctuations in earnings and claims, as well as the fact that loss ratios during the early years of a policy are expected to be lower than loss ratios during the policy’s later years. The lifetime loss ratio incorporates both the historical and anticipated performance of a given policy, and so provides the fairest picture of the design of the insurance policy in terms of how well it will deliver benefits to the consumer.

Further, in order to confer this reasonable level of benefit on both new policyholders and current policyholders (who often have no other realistic coverage options), the proposed regulation applies the 70 percent loss ratio requirement to new policies, and also to existing policies that file for rate revision. The proposed amended regulation requires that, upon the filing of a rate revision, the policy must demonstrate both a 70 percent lifetime loss ratio for the entire life of the product, as well as a 70 percent loss ratio for the period for which the amended rates are computed.

The proposed regulation deletes the provision of the 1962 regulation that provided for a 35 percent loss ratio for policies with an annual premium of less than $7.50 per person. There are no longer any policies available at that premium rate, and so this provision is now surplus.

The proposed regulation also modifies the reference to loss ratios for policies designed to supplement Medicare. This provision was added in 1978, and amended in 1983, on both occasions specifying a specific loss ratio amount. In 2000, Insurance Code section 10192.14 was enacted, specifying a loss ratio amount for policies designed to supplement Medicare. The proposed amendment of the regulation incorporates Insurance Code section 10192.14(a)(1)(A) by reference, rather than stating a loss ratio amount. The effect of this amendment will be that the regulation will automatically incorporate any change in the loss ratio amount without need for further revision, should Insurance Code section 10192.14 be amended.

The proposed regulation changes the title of the section to "Minimum Loss Ratio Standards" in order to achieve improved clarity and specificity.

Section 2222.13: Preliminary Screening Procedure.

Insurance Code section 900 provides that insurers must file an annual statement with the department. The existing regulation provides for a preliminary screening of policies based on national data obtained from this annual statement (specifically, the accident and health policy experience exhibit of the annual statement blank promulgated by the National Association of Insurance Commissioners ["NAIC"]). However, effective as of 2007 for reports reflecting 2006 data, this NAIC experience exhibit will change from requiring that data be reported based on policy forms to, instead, requiring that data be reported based on type of business. Therefore, the experience exhibit will no longer contain the information needed for the implementation of the existing preliminary screening procedure described by existing section 2222.13. Thus, the proposed amended regulation deletes this entire section.

Section 2222.14: Credibility Factors.

Credibility factors are an actuarial means of determining whether deviation from a standard may be due to chance variation; for example, an insurance product in which relatively few policies have been sold would ordinarily be expected to show more deviation due to chance variation than would an insurance product with a large number of outstanding policies. The existing credibility factor provision dates back to 1962, and is based solely on premium volume figures that are outdated. The proposed amended provision provides that the commissioner may consider a broader set of credibility factors, not merely limited to premium volume, in recognizing deviations due to chance variation.

Section 2222.15. Communication to Insurer.

The proposed changes to this section involve a minor punctuation change that does not alter the substantive meaning of the section. The proposed change is to add a comma after "2222.17" in the introductory clause, as follows: "Prior to taking any action under Section 2222.17, the commissioner will…"

Section 2222.16. Consideration of Relevant Factors.

The proposed changes to this section involve deleting the provision regarding "policies issued on an industrial debit basis" as such policies are no longer issued, so these provisions are now superfluous.

Section 2222.17. Notice to Insurer.

The proposed amendments to this section are to enhance readability and clarity, and to substitute gender-neutral terms, and do not represent a substantive change from the existing regulation, as follows: The existing text:

> "He shall further advise the insurer that unless within 31 days from the date thereof the insurer has committed itself in writing to the commissioner that it will, within 90 days thereafter, voluntarily either cease further issuance of the policy form or increase benefits under the policy in relation to premiums charged therefor sufficiently that they are reasonable in relation to such premiums, then the commissioner will thereafter, at his discretion, commence proceedings for the withdrawal of authorization of the form after notice and hearing as provided by law. At any time after expiration of said 31 days so specified, and if the insurer has not so committed itself to discontinue issuing the policy or increase benefits under the policy in relation to premiums charged, the commissioner may commence proceedings as provided by law for withdrawal of the authorization of the policy form,"

is replaced by

> "The commissioner shall also advise the insurer that the commissioner will, at the commissioner's discretion, commence proceedings for withdrawal of authorization of the form after notice and hearing as provided by law unless, within 31 days from the date of the notification, the insurer commits itself in writing to the commissioner that it will, within 90 days, voluntarily either (1) cease further issuance of the policy form or (2) increase benefits under the policy in relation to the premiums charged in an amount sufficient to bring the policy into compliance with the minimum loss ratio standards provided for in section 2222.12. If the insurer does not commit itself, within 31 days from the date of the notification, to discontinue issuing the policy or increase benefits under the policy in relation to premiums charged, the commissioner may commence proceedings at any time as provided by

law for withdrawal of the authorization of the policy form."

Section 2222.19. Filing Experience Data

The proposed changes to this section delete obsolete references to policies with annual premiums of $7.50 or less, and policies issued on the industrial debit basis, as such policies are no longer sold. The subdivisions are also re-numbered to conform to this change. Also, the phrase "pursuant to footnote (5) of the accident and health policy exhibit" is deleted, as the referenced exhibit no longer has a footnote 5.

**COMPARABLE FEDERAL LAW:**

There are no existing federal regulations or statutes comparable to the proposed regulations.

**MANDATES ON LOCAL AGENCIES OR SCHOOL DISTRICTS:**

The proposed regulations do not impose any mandate on local agencies or school districts. There are no costs to local agencies or school districts for which Part 7 (commencing with section 17500) of Division 4 of the Government Code would require reimbursement.

**FISCAL IMPACT (COST OR SAVINGS TO ANY STATE OR LOCAL AGENCY OR SCHOOL DISTRICT OR IN FEDERAL FUNDING):**

The Commissioner has determined that the proposed regulations will result in no cost or savings to any state agency, no cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code, no other nondiscretionary cost or savings imposed on local agencies, and no cost or savings in federal funding to the State.

**EFFECT ON HOUSING COSTS:**

The matters proposed herein will have no significant effect on housing costs.

**SIGNIFICANT STATEWIDE ADVERSE ECONOMIC IMPACT DIRECTLY AFFECTING BUSINESS, INCLUDING ABILITY TO COMPETE:**

The Commissioner has made an initial determination that the proposed regulations may have a significant, statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states. The types of businesses that may be affected are insurance companies.

The Commissioner has not considered other proposed alternatives that would lessen any adverse economic impact on business and invites interested parties to submit proposals. Submissions may include the following considerations:

(i) The establishment of differing compliance or reporting requirements or timetables that take into account the resources available to businesses;

(ii) Consolidation or simplification of compliance and reporting requirements for businesses;
(iii) The use of performance standards rather than prescriptive standards;
(iv) Exemption or partial exemption from the regulatory requirements for businesses.

**ASSESSMENT REGARDING EFFECT ON JOBS AND BUSINESSES IN CALIFORNIA:**

The Commissioner is required to assess any impact the regulations may have on the creation or elimination of jobs within the State of California, the creation of new businesses or the elimination of existing businesses within the State of California, and the expansion of businesses currently doing business within the State. The Commissioner does not foresee that the proposed regulations will have an impact on any of the above but invites interested parties to comment on this issue.

**COST IMPACTS ON REPRESENTATIVE PERSON OR BUSINESS:**

The Commissioner is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

**BUSINESS REPORT, FINDING OF NECESSITY:**

This proposed amended regulation continues an existing reporting requirement. The Commissioner has found that it is necessary for the health, safety, or welfare of the people of the state that the regulation apply to businesses. (Government Code sec. 11346.3(c).)

**IMPACT ON SMALL BUSINESS:**

The proposed regulations directly affect insurers. Pursuant to Government Code section 11342.610(b)(2), insurers are not small businesses. Implementation of an increased loss ratio requirement may, however, benefit small businesses, as the requirement that premiums bear a closer relationship to benefits may result in lower premiums.

**ALTERNATIVES:**

The Commissioner must determine that no reasonable alternative considered by the Commissioner or that has otherwise been identified and brought to the attention of the Commissioner would be more effective in carrying out the purposes for which the regulations are proposed or would be as effective as and less burdensome to affected private persons than the proposed regulations. The Commissioner invites public comment on alternatives to the regulations.

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**CONTACT PERSONS:**

Written comments should be addressed to the contact person:

Bruce Hinze, Staff Counsel
California Department of Insurance
45 Fremont Street, 23rd Floor
San Francisco, CA 94105
Telephone: (415) 538-4392

Questions regarding procedure, the hearing, comments, or the substance of the proposed action should be addressed to the contact person listed above. If he is unavailable, inquiries may be addressed to the backup contact person:

Nancy Hom, Staff Counsel III
California Department of Insurance
45 Fremont Street, 24th Floor
San Francisco, CA 94105
Telephone: (415) 538-4144

**AVAILABILITY OF EXPRESS TERMS (TEXT OF REGULATIONS) , INITIAL STATEMENT OF REASONS, AND RULEMAKING FILE:**

A copy of the express terms of the proposed amendments to the regulation is available, and will be made available for inspection and copying upon request to the contact person listed above.

The Department has prepared an Initial Statement of Reasons that sets forth the reasons for the proposed regulations. The Initial Statement of Reasons will be made available for inspection and copying upon request to the contact person listed above.

The rulemaking file for this proceeding, which includes a copy of the express terms of the proposed amendments to the regulation, the Initial Statement of Reasons, all the information upon which the proposed action is based, and any supplemental information, including any reports, documentation and other materials related to the proposed action, is available for inspection and copying at 45 Fremont Street, 24th Floor, San Francisco, California 94105, between the hours of 9:00 a.m. and 4:30 p.m., Monday through Friday by prior appointment with the contact person listed above.

**15-DAY AVAILABILITY OF CHANGED OR MODIFIED TEXT:**

If the regulations adopted by the Department differ from those which have originally been made available but are sufficiently related to the action proposed, the full text of the regulation changed pursuant to Government Code section 11346.8 will be available to the public for at least 15 days prior to the date of adoption. Interested persons should request a copy of these regulations prior to adoption from the contact person listed above.

## FINAL STATEMENT OF REASONS

Upon request, the Final Statement of Reasons will be made available for inspection and copying once it has been prepared. Requests for the Final Statement of Reasons should be directed to the contact person listed above.

## WEBSITE POSTINGS:

Documents concerning this proceeding will be available on the Department's website. The documents will include the proposed regulations, the Notice of Hearing and Informative Digest, the Initial Statement of Reasons, and, when it has been prepared, the Final Statement of Reasons. To access documents concerning this proceeding, go to http://www.insurance.ca.gov. Find the link "QUICK LINKS" in blue on the left of the screen. Click on the arrow next to "QUICK LINKS," then click on "Legal Information" in the drop-down menu. In the "Legal Information" screen, click on the "Proposed Regulations" link in the center of the screen. A new screen will open titled "Search or Browse for Documents for Proposed Regulations." In the search field under "How to Search" enter 'RH06092236' (the Department's regulation file number for these amended regulations), and click "submit."

## AUTOMATIC MAILING:

A copy of the proposed regulations and this Notice (including the Informative Digest, which contains the general substance of the proposed regulations) will automatically be sent to all persons on the Insurance Commissioner's mailing list.

## ACCESS TO HEARING ROOMS:

The facilities to be used for the public hearing are accessible to persons with mobility impairments. Persons with sight or hearing impairments are requested to notify the contact person(s) for the hearing in order to make special arrangements, if necessary.

## ADVOCACY OR WITNESS FEES:

Persons or groups representing the interests of consumers may be entitled to reasonable advocacy fees, witness fees, and other reasonable expenses, in accordance with the provisions of Title 10 of the California Code of Regulations, in connection with their participation in this matter. Interested persons should contact the Office of the Public Advisor at the following address to inquire about the appropriate procedures:

California Department of Insurance
Office of the Public Advisor
300 Capitol Mall, 17th Floor
Sacramento, CA 95814
(916) 492-3559

A copy of any written materials submitted to the Public Advisor regarding this rulemaking must also be submitted to the contact person for this hearing. Please contact the Office of the Public Advisor for further information.

Dated: July 21, 2006

JOHN GARAMENDI
Insurance Commissioner

By:_____/s/_____
Mansour Salahu-Din
Assistant Chief Counsel