Prior Approval Rate Application Filing Instructions

State of California
Department of Insurance

I. Introduction

Every insurer wishing to introduce new, or change existing, rules, rates or forms, or to introduce a new program, must complete a **Prior Approval Rate Application** ("Application"), an **Affidavit** and, if applicable, a **Prior Approval Rate Template** ("Rate Template") and a **Standard Exhibits Template**, in compliance with Title 10, Chapter 5, Subchapter 4.8 of the California Code of Regulations (CCR) and file it with the Commissioner.

The Application must include all data referred to in §1861.05(b) of the California Insurance Code (CIC), a justification of the rate and a showing that the rate meets the applicable requirements of CIC §1861.01 through §1861.16, CCR §2641.1 through §2644.28, §2648.4 and any other detailed supporting statistics and information as the Commissioner may require.

All Applications must be submitted via the National Association of Insurance Commissioners (NAIC) System for Electronic Rate and Form Filing (SERFF). Acknowledgment of filings is provided automatically through SERFF.

Important note: Refer to the California Department of Insurance ("Department") website for the most current Application, Affidavit, Rate Template, Standard Exhibits Template and prior approval factors.

Do not submit any fee with this Application. Each insurer will be billed an administrative fee.

This Application applies only to new program, rate, coverage form, rule, transferred and program withdrawal filings for prior approval (Proposition 103) lines of business. Separate Applications for Class Plans, Advisory Organizations, Credit, Financial Guaranty, Title, and Workers' Compensation, including Excess Workers Compensation, are available.

All rate filings require the completion of the Prior Approval Rate Application (PriorAppRateAPL.xlsm), the Prior Approval Rate Template (Prior AppRateTl.xlsm) and the Standard Exhibits Template (StdExhTl.xlsm), submitted in both Excel and PDF format.

In order to populate those spreadsheets, macros must be enabled in Excel. In addition to the Application and Templates, insurers must submit Exhibits 2, 3, 4, 6, 9, 10, 11, 12, 14, 15, 19, 20 and 21 in both working Excel (with formulas intact) and PDF (with searchable text) format.

The Commissioner may at any time take any action allowed by law if the Commissioner determines that any eligibility guidelines, forms or procedures for application of rates, or any other portions of a current or prior Application conflict with any applicable laws or regulations.

II. General Filing Information

A. Application

Insurers must submit a completed Application for all new programs and changes to existing rates, forms and rules (rating and eligibility). The insurer shall indicate the amount of the overall rate impact, if any. Each insurer must indicate the type of filing submitted for review and provide the corresponding Application pages plus exhibits according to the requirements shown on Application Page 3 (Filing Type and Checklist).

Insurers must submit a rate filing Application with full rate support for any changes in rates, rating factors, rating and eligibility guidelines or contract language that affect the rate or cost of coverage to any insured due to the broadening or restricting of coverage. "Full rate support" means all exhibits and information as identified on Page 3 of the Application supporting a filing with rate impact, whether resulting from rate, rule, form or eligibility guideline changes.

The overall proposed rate impact shall be measured by changes in the adjusted earned premium and displayed on Application Page 4 (Proposed Impact).

For all filings without rate impact, insurers must submit a rule or form filing. An Application with full rate support may subsequently be required at the discretion of the Department.

Changes to rating manuals and eligibility guidelines may have a rate impact. It is the insurer's responsibility to identify any rate impact resulting from such proposed changes. If proposed changes may impact the insurer's rates, the insurer is required to submit a complete rate application in support of the proposed changes. If an insurer maintains that there is no rate impact resulting from proposed changes to rating manual or eligibility guidelines, the insurer is required to submit the proposed changes as part of a rule or form filing at least 90 days prior to the proposed effective date of the changes, in order for the Department to review the proposed changes for possible rate impact. The Department retains discretion to require the insurer to file a complete rate application in support of the proposed changes. The insurer shall not take any action to implement the proposed changes until or unless the Department confirms there is no rate impact.

Frequently, the Department requests rate applicants to waive the "deemed approved" dates set forth in Insurance Code section 1861.05(c). The purpose of these requests is to allow the Department sufficient time to fully review and analyze Applications to ensure their compliance with Proposition 103's mandate that "[n]o rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this chapter." (Ins. Code, § 1861.05(a).) While the applicant retains the legal right to deny the request, the applicant shall understand that failure to waive the "deemed approved" dates when requested, or revocation of the applicant's existing waiver during the rate review

process, may require the Department, as a matter of legal compliance, to issue a notice of hearing. This notice of hearing is necessary to ensure that the Department is able to complete its comprehensive analysis of the requested rates, and that the rates that are ultimately approved are not excessive, inadequate, unfairly discriminatory, or otherwise in violation of California insurance law.

Changes to declaration pages, insurance application forms and installment payment plans *without a fee* do not require filings. Installment payment plans that *include fees* are subject to the prior approval filing requirements.

B. Affidavit

Insurers must submit an Affidavit with the signature of an authorized representative of the insurer, declaring under penalty of perjury that the information contained in the filing is true, complete and correct, and that price optimization methods or models have not been used in the development of the final rates for any segment of the filed rating plan. Price optimization is defined as any method of taking into account an individual's or a class's willingness to pay a higher premium relative to other individuals or classes. Only digital signatures created using Adobe Sign will be accepted. The company tracking number stated on the Affidavit should be the same as the company tracking number used in SERFF.

C. Filing by Line of Insurance

Filings shall be made *per line of insurance as outlined in CCR* §*2642.7* or those defined in NAIC's Uniform Property Casualty Product Coding Matrix. Select a Line Type (Personal/Commercial) and General Line of Insurance from the pull-down menu on Application Page 1 (General). It is also necessary to select a Detailed Line Description(s) from the pull-down menu on Rate Template Page 1 (General) and Standard Exhibits Template Page 1 (General), if applicable. Note that these line descriptions may differ, in some cases, from the Uniform Product Coding Matrix Type of Insurance used in SERFF.

Refer to the Instructions sheets for the Application, the Rate Template and the Standard Exhibits Template.

The rates, rules and forms for the same line of insurance may be combined in one Application. Commercial auto liability and physical damage ***must*** be combined in one Application, with separate Ratemaking Data and Rate Calculation pages in the Rate Template for liability and physical damage coverages. For private passenger auto, refer to Section IV for instructions.

D. Program Filings

Filings per line of insurance may be made for individual programs within the line (e.g., commercial automobile auto dealers). The filing must contain the rules, rates and forms for each coverage and include all supporting documentation.

Note on travel insurance programs: Travel insurance programs as defined in CIC §1753(c)(1) incorporate insurance coverages that are categorized under both Property & Casualty and Life & Health insurance. California law has different procedures for policy and rate review for these two categories. Therefore, Applications requesting approval of travel insurance policies and rates must be submitted separately to the Rate Regulation Branch for property and casualty rates, rules, and forms, and to the Policy Approval Bureau for sickness, accident, disability, or death, occurring during travel. Once the SERFF filing numbers are assigned, each should be cross-referenced in the filings submitted to each respective Bureau/Branch.

E. Proposed Rate Manual Pages

For all rate, rule or transferred program filings the following items must accompany the Application:

- A clean copy of the current rate manual pages.
- A marked-up copy of the proposed rate manual pages. In the revised pages, underline any additions to, and use brackets ([ ]) to identify any deletions from, the current pages.
- A clean copy of the complete proposed rate manual and eligibility guideline pages. .

A rate manual must include **any and all** criteria, guidelines, systems, manuals, models and algorithms used or relied upon to determine the rate, rating rules and coverages for any particular applicant or insured, including optional coverage rates and rules.

Submit all items above in PDF (with searchable text) format.

F. Eligibility Guidelines

For all rate, rule or transferred program filings the following items must accompany the Application:

- A clean copy of the current eligibility guidelines pages.
- A marked-up copy of the proposed eligibility guidelines pages. In the revised pages, underline any additions to, and use brackets ([ ]) to identify any deletions from, the current pages.
- A clean copy of the complete proposed rate manual and eligibility guideline pages.

An eligibility guideline must include any method or set of standards, parameters, rules, requirements or procedures that is used in the determination of whether to accept, examine, inspect, cancel, non-renew, or re-underwrite a risk, or to modify an applicant's or insured's coverage or coverage options including any and all criteria, guidelines, systems, manuals, models and algorithms an insurer uses to reduce, increase, or restrict the number of policies written or renewed, or restrict the coverages offered, in specific geographic areas such as ZIP codes, counties, or territories, for any reason, including over-concentration.

Eligibility guidelines provided to the Commissioner in connection with an Application for approval of property and casualty rates pursuant to Insurance Code section 1861.05 must be available for public inspection pursuant to Insurance Code section 1861.07.

Submit all items above in PDF (with searchable text) format.

G. Model Checklist

For any rate or rule filings involving an allowable model, insurers must submit a completed model checklist as posted on the Department's public website and on SERFF. Insurers that use a model in any form, manner, or capacity, must describe such use, along with details about the features of the model, in the filing memorandum. The model itself is not required to be filed.

H. Questionnaire for Homeowners or Residential Property

For rate or rule filings for homeowners or residential property lines of business, insurers must submit a completed questionnaire as posted on the Department's public website and on SERFF. This questionnaire requests additional detailed information on block non-renewals and new business restrictions, wildfire rating issues, customer dislocation and the California FAIR Plan Clearinghouse Program. Failure to provide thorough and clear responses prohibits the Department from accomplishing its duties and thereby halts or impedes review of the submitted filing in a timely manner.

I. Submitting an Application with More Than Ten Coverages/Forms/Programs

The current Application, Rate Template and Standard Exhibits Templates allow for ten

coverages/forms/programs. If there are more than ten coverages/forms/programs, consider combining smaller coverages/forms/programs if the aggregated impact on the overall rate is not material and/or if the aggregated data has insufficient credibility upon which to base a rate decision.

In the case where more than ten coverages/forms/programs are still required:

- **Application** - provide one Application file with supplemental exhibits in lieu of Application Page 4 and Application Page 5. In the Filing Memorandum, identify the supplemental exhibit where this information is shown.
- **Rate Template** - consider combining similar low-volume coverages/forms/programs if appropriate in order to provide one Rate Template file. If this is not possible, provide multiple Rate Template files, and include a supplemental exhibit that contains the rate request by coverage/form/program and in total for all coverages/forms/programs (as per the summary table on Rate Template Page 2).
- **Standard Exhibits Template** - submit multiple Standard Exhibit files.

J. Withdrawal of Pending Filings

An insurer wishing to withdraw its pending filing may submit a request to withdraw the filing via a SERFF filing note. The request to withdraw will be evaluated by the file reviewer. Additional questions from the file reviewer may be necessary to ensure that withdrawal is appropriate and that the existing rates in effect are not excessive, inadequate or unfairly discriminatory. If the pending filing is subject to intervention, the insurer shall also forward the request for withdrawal to the Department and the intervenor(s) via email.

III. Filing Information by Filing Type

A. Filing Types

The Application applies to the following various types of filings: New Programs, Rates (including Variance Requests), Coverage Forms, Rules, Transferred Programs and Withdrawals. Refer to Application Page 3 for specific information regarding the filing documents to be submitted for each type of filing.

For most lines of insurance, the regulations prescribe a particular formula and factors to determine the maximum and minimum permitted earned premium. An exception exists for specialty insurance, where the primary requirement is that the most actuarial sound method be used. Both a Rate Template and a Standard Exhibits Template subject to all prior approval ratemaking requirements must also be submitted with each specialty filing. Types of specialty insurance include policies with a premium over $75,000 or a deductible over $100,000. For a complete definition of specialty insurance, refer to CCR §2642.7(d).

B. Variance Requests

The Application provides for the submission of variance requests. A variance is a request to adjust the maximum or minimum permitted earned premium.

Requests for variance may be submitted at the same time as the prior approval Application to which it applies or after the filing of the same. All requests for variance must identify and support the bases for the variance in accordance with CCR §2644.27, Variance Request. When a variance is requested, Application Page 11 (Variance Request) and Exhibit 13 must be completed. Refer to CCR §2644.27 for information on the allowable bases for variance requests and the documentation required to support those requests. Filings requesting a variance must include one Rate Template excluding the variance and one Rate Template including the variance. A filing with multiple variances must include one Rate Template for each individual variance as well as the *combined impact* of all variances.

C. New Programs

A new program is a completely new product with no existing rate manual, rules manual, policy forms, eligibility guidelines, nor policyholders. A new program is one that has not been previously written by any insurer, including an affiliated insurer who is a member of the same insurance group, or an unaffiliated insurer. A new program therefore does not have any prior program experience upon which to rely for rate development.

In order for a completed Application to qualify for submission as a new program, there must be no current book of business nor policyholders that will be rolled into, renewed into, or transferred into the program (see D. Transferred Program below). As a result, a new program Application requires at least one year of projections.

A new program differs from a rule filing in that a rule filing is intended to add, delete, or limit specific coverages to an ***existing*** program. A new program differs from a transferred program in that a transferred program represents any program that currently exists, whether written by an affiliated insurer or unaffiliated insurer, and is being moved to or assumed by another insurer.

A new program Application must contain ***all*** rates, rating rules, forms, and eligibility guidelines that pertain to the program. This requirement includes submitting all advisory organization manuals and forms being adopted. This requirement also includes the submission of mutually exclusive eligibility guidelines if the insurer also writes a similar program.

For new program Applications, enter the following ***projected*** annual data reflecting a mature book of business in the New Program column of Page 6 (Ratemaking Data) of the Rate Template for each coverage, form or program included in the filing: (1) written premium, (5) miscellaneous fees and other charges, (6) earned exposures, (7) losses, (8) DCCE and (15) ancillary income. Data for Page 6, lines 16, 17 and 18 in the Rate Template will be automatically populated from Pages 3 (YieldFIT) and 4 (Excluded Exp) of the same template. Earned premium is equal to written premium.

For earthquake and certain medical malpractice lines where the insurer elects to include consideration for the cost of reinsurance, enter the direct commission rate, reinsurance premium and reinsurance recoverable corresponding to the line. Rows for this information are hidden at the bottom of Page 6 of the Rate Template for each coverage, form or program unless "Earthquake w/consideration for cost of reinsurance" or one of the "Medical Malpractice" options indicating "incl. reinsurance costs" is selected as the Detailed Line Description from the pull-down menus on Page 1 of the Rate Template.

It is ***not*** necessary to enter the following data for new program Applications: prior effective date; (2) earned premium (as it is equal to written premium), (3) premium adjustment factor, (4) premium trend factor, (9) loss development factor, (10) DCCE development factor, (11) loss trend factor, (12) DCCE trend factor, (13) catastrophe adjustment factor or (14) credibility factor.

NOTE 1: If an insurer intends to replace or update an existing program where current policyholders are to be renewed or offered renewal into a "replacement" program written by that same insurer, the Filing Type for this Application must be identified as a rate filing and not as a new program filing. Separate requirements apply to the Private Passenger Automobile line of insurance.

NOTE 2: If an insurer(s) within an insurer group intends to replace or update an existing program where current policyholders are to be renewed or offered renewal into a "replacement" program written by an affiliate insurer(s) within the same insurer group, the Filing Type for this Application for the affiliate insurer(s) to start writing the "replacement" program must be identified as a transferred program filing and not as a new program filing. The insurer(s) that will no longer be writing the existing program, with limited exceptions, must submit a rule filing to withdraw the existing program. Separate requirements apply to the Private Passenger Automobile line of insurance.

D. Transferred Program

A transferred program is a program or product that currently is being written by an insurer(s) and where the current book of business or policyholders are going to be rolled to, renewed with, or transferred to a different insurer(s), regardless of whether or not there is an affiliation between the insurer(s) currently writing the existing program and the insurer(s) that will take over writing the program. A transferred program has an existing rate manual, rules manual, policy forms and endorsements, disclosure notices, eligibility guidelines, and policyholders such that a transferred program will have its own program experience to rely upon for ratemaking purposes, even if that experience occurred with a different insurer.

A transferred program Application must contain ***all*** rates, rating rules, forms, and eligibility guidelines that pertain to the program. This requirement includes submitting all advisory organization manuals and forms being adopted. This requirement also includes the submission of mutually exclusive eligibility guidelines if the insurer also writes a similar program.

Since a transferred program has its own program experience to rely upon for ratemaking purposes, even if that experience occurred with a different insurer, the Application must be submitted with the same supporting documentation, rate template, and exhibits as a rate filing. A transferred program cannot be submitted as a new program.

NOTE 1: If an insurer(s) within an insurer group intends to replace or update an existing program where current policyholders are to be renewed or offered renewal into a "replacement" program written by an affiliate insurer(s) within the same insurer group, the Filing Type for this Application for the affiliate insurer(s) to start writing the "replacement" program must be identified as a transferred program filing and not as a new program filing. The insurer(s) that will no longer be writing the existing program, with limited exceptions, must submit a rule filing to withdraw the existing program. Separate requirements apply to the Private Passenger Automobile line of insurance.

E. Rates

Any insurer proposing to change their base rates, rating factors and/or rate classification relativities must file a complete Application.

In addition, supplemental rating plans that impact the rating process in a program must be filed with the Department using the Application. These supplemental rating plans include, but are not limited to, merit rating plans, experience rating plans, loss rating plans, composite and retrospective rating plans, and expense rating plans.

The rating rules shown in the insurer's rate manual must include a rating algorithm (also known as premium determination rule) and a rating sample that illustrates how the premium determination rules apply using the rates and relativities proposed within the filing. Additional rating samples may subsequently be required at the discretion of the Department. These additional rating samples could be submitted as a supplementary exhibit(s) and are not required to be a part of the rate manual. Refer to section III. G. Rating Rules and Eligibility Guidelines for further clarification.

Eligibility guidelines must be submitted in PDF (with searchable text) format with ***all*** rate filings, regardless of line of business. Eligibility guidelines are reviewed only insofar as they relate to rates contained in the filing or currently on file with the Department. Eligibility guideline changes that may have an impact on the rates must be submitted in a rule filing for prior approval. It is the insurer's responsibility to identify any rate impact resulting from

guideline changes. The Department retains discretion to require the insurer to file a complete rate application in support of the proposed changes.

F. Forms

Application Page 9 (Forms) must be completed for new, replacement or withdrawn forms. This requirement includes submitting all Advisory Organization forms being adopted.

- For new forms, the new form must be submitted.
- For replacement forms, insurers must submit the following:
    - A clean copy of the current form.
    - A marked-up copy of the current form. In the revised forms, underline any additions to and use brackets ([ ]) to identify any deletions from the current forms.
    - A clean copy of the proposed form.
- For withdrawn forms, the withdrawn form must be submitted.

Submit items above in PDF (with searchable text) format.

Provide a brief explanation of each form revision in the Filing Memorandum. A detailed explanation should be provided in Page 9 of the Application. If additional space is needed the insurer may submit a supplemental exhibit.

If a form has a corresponding rule, the form and the rule must be submitted together.

Upon approval of any changes to basic policy contracts or mandatory forms for homeowners, renters or condominiums, insurers must upload the revised forms and update the relevant summary language in the Homeowners Coverage Comparison Tool posted on the Department's public website.

G. Rating Rules and Eligibility Guidelines

When insurers seek to revise rating rules and eligibility guidelines, the following items must accompany the Application:

- A clean copy of the current rating rules and eligibility guidelines.
- A marked-up copy of the current rating rules and eligibility guidelines. In the marked up copy, identify changes from the current rules and guidelines by underlining additions and putting deletions in brackets ([ ]).
- A clean copy of the ***complete*** proposed rating rules and eligibility guidelines.

Submit items above in PDF (with searchable text) format.

Changes to eligibility guidelines are required to be filed at least 90 days prior to the proposed effective date of the changes, in order for the Department to review the proposed changes for possible rate impact.

The rating rules shown in the insurer's rate manual must include a rating algorithm (also known as premium determination rule) and a rating sample that illustrates how the premium determination rules apply using the rates and relativities proposed within the filing. The number of rating algorithms and rating samples required to be displayed in the rate manual is dependent upon the number of different delineations (coverages, policy types, perils, programs, industries, etc.) represented within the particular rate manual. In the event that the number of delineations exceeds 10, then the insurer may limit the number to the largest 10 delineations as measured by premium volume. The rating algorithm and rating sample should include all rating and premium items that are used in the calculation of the overall premium to be paid by an individual policyholder. These items include any premiums or charges associated with optional endorsements or fixed expenses.

The rating algorithm and rating sample should be submitted in pdf. A separate copy of the rating algorithm and rating sample should be submitted in excel. The excel document should be unprotected with formulas intact.

The rating algorithm and associated rating sample should identify for each step of the calculation:

1. Provide a summary of the risk profile
2. Step number
3. Operation applied (×, +, -, etc.)
4. Rounding rule
5. Rate manual page reference for applicable rate or rating relativity
6. Rate or rating relativity (for rating sample only)
7. Calculation
8. Item description for each premium calculation step
9. Total premium

Rating Sample for Illustrative Purposes	
Basic Annual Premium	
Risk Profile	HO3 policy within zip code 90623. Coverage A amount of $100,000. See Item Description for details of the Risk Profile.

Step	Operation	Rounding	Rate Manual Reference	Factor	Calculation	Item Description
1			Pg. 1 – Rule 1.1	6.71		Base Rate (per 1,000 of coverage A limit)
2	x	2 decimals	Pg. 8 – Rule 5.2	1.00	671.00	Coverage A Factor (amount 100,000)
3	x	2 decimals	Pg. 4 – Rule 3.1	1.20	805.20	ZIP Code Factor (90623)
4	**=**	nearest whole dollar			**805**	**Basic Annual Premium**

Credits/Surcharge - Multiplicative						
Step	**Operation**	**Rounding**	**Rate Manual Reference**	**Factor**	**Calculation**	**Item Description**
5	x	2 decimals	Pg. 9 – Rule 5.3	0.95	764.75	Fire or Smoke Alarm Protective Devices
	x	2 decimals	Pg. 9 – Rule 5.5 – Modeled Relativity	1.15	879.46	Age of Home (40 years)
	x	2 decimals	Pg. 9 – Rule 5.6	0.90	791.51	Protection Class (1)
	x	2 decimals	Pg. 10 – Rule 5.7	1.00		Construction Type (if credit) (Masonry)
	x	2 decimals	Pg. 10 – Rule 5.9	0.95	751.93	Multi-Policy Discount (home + auto)
	x	2 decimals	Pg. 10 – Rule 6.0	1.00		Seasonal/Secondary Home (No)
	x	2 decimals	Pg. 11 – Rule 6.2	0.97	729.37	Claims Free (3 years)
6	**=**	nearest whole dollar			**-76**	**Total of Credits/Surcharge**

Optional Coverages – Multiplicative (multiply each by the Basic Annual Premium)						
Step	**Operation**	**Rounding**	**Rate Manual Reference**	**Factor**	**Calculation**	**Item Description**
7	+	2 decimals	Pg. 12 – Rule 7.0	0.30	241.50	Optional Special Limit for Water Damage
	+	2 decimals	Pg. 12 – Rule 7.1	0.25	201.25	Water Back-Up
8	**=**	nearest whole dollar			**443**	**Total Optional Coverages - Multiplicative**

Optional Coverages – Flat Dollar						
Step	**Operation**	**Rounding**	**Rate Manual Reference**	**Factor**	**Calculation**	**Item Description**
9	+	nearest whole dollar	Pg. 12 – Rule 7.0	$100	100	Animal Liability – Optional Limits
	+	nearest whole dollar	Pg. 12 – Rule 7.1	$50	50	Additional Insured
10	**=**	nearest whole dollar			**150**	**Total Optional Coverages – Flat Dollar**

Total Policy Premium						
Step	**Operation**	**Rounding**	**Rate Manual Reference**	**Factor**	**Calculation**	**Item Description**
11	**+**	nearest whole dollar			805	Basic Annual Premium
12	**+**	nearest whole dollar			-76	Total Credits/Surcharges

13	**+**	nearest whole dollar			443	Total Optional Coverages - Multiplicative
14	**+**	nearest whole dollar			150	Total Optional Coverages - Flat Dollar
15	**+**	nearest whole dollar	Pg. 13 – Rule 8.0	$50	50	Policy Fee (Renewal)
16	**+**	nearest whole dollar	Pg. 13 – Rule 8.1	$25	100	Installment Fee (4 installments)
17	**=**	nearest whole dollar			**1,472**	**Total Policy Premium**

In addition, the Commissioner requires that a ***complete*** copy of the eligibility guidelines must be provided with ***all rate filings when initially submitted***, regardless of line of business, whether or not a change to those guidelines is being proposed. Furthermore, guideline changes that may have an impact on rates must also be submitted in a rule filing for prior approval. It is the insurer's responsibility to identify any rate impact from underwriting guideline changes. The Department retains discretion to require the insurer to file a complete rate application in support of the proposed changes

Further, Application Page 10 (Rules) must be completed, and the overall rate impact must be justified. Mutually exclusive underwriting guidelines must be provided for programs with rating tiers.

Any changes to fees or other charges identified on Application Page 8 (Miscellaneous Fees) require a rule filing. The overall rate impact of such changes to the current book of business must be included in Exhibit 18.

H. General Examples Demonstrating the Appropriate Filing Type

CURRENT		PROPOSED	PATH FROM CURRENT TO PROPOSED
GROUP A Company A Writes *Widget+* Program GROUP B Company A Does not write any widget program	MGA moves *Widget+* Program	GROUP A Company A Does not write *Widget+* Program GROUP B Company A Writes Widget+ Program	GROUP A Company A File Type: **Rule (Withdrawn Program)** GROUP B Company A File Type: **Transferred Program**

CURRENT		PROPOSED	PATH FROM CURRENT TO PROPOSED
GROUP A Company A Writes *Widget+* Program GROUP B Company A Writes a generic widget program	MGA moves *Widget+* Program	GROUP A Company A Does not write *Widget+* Program GROUP B Company A Revamps generic widget	GROUP A Company A File Type: **Rule (Withdrawn Program)** GROUP B Company A File Type: **Rate**

	program into Widget+ Program; rolls all policyholders	

CURRENT	PROPOSED	PATH FROM CURRENT TO PROPOSED
GROUP A Company A No widget program exists anywhere	GROUP A Company A New widget program	GROUP A Company A File Type: **New Program**

CURRENT	PROPOSED	PATH FROM CURRENT TO PROPOSED
GROUP A Company A Writes a widget program	GROUP A Company A Changes existing widget program rates	GROUP A Company A File Type: **Rate**

CURRENT	PROPOSED	PATH FROM CURRENT TO PROPOSED
GROUP A Company A Writes a widget program	GROUP A Company A Replace existing legacy widget program with replacement/updated widget program called *Widget+* and rolls legacy policyholders into new *Widget+* program	GROUP A Company A File Type: **Rate**

CURRENT	PROPOSED	PATH FROM CURRENT TO PROPOSED
GROUP A Company A Writes a widget program Company B Does not write a widget program	GROUP A Company A Does not write a widget program Company B Writes a revamped Company A widget program; Company A policyholders offered renewal here	GROUP A Company A File Type: **Rule (Withdrawn Program)** Company B File Type: **Transferred Program**

CURRENT	PROPOSED	PATH FROM CURRENT TO PROPOSED
GROUP A Company A Writes a widget program Company B Does not write a widget program	GROUP A Company A Revises to a Preferred Widget program; 70% of policyholders rolled here Company B Writes a Standard Widget program; 30% of policyholders rolled here	GROUP A Company A File Type: **Rate** Company B File Type: **Transferred Program**

IV. Private Passenger Auto

In addition to the prior approval rate filing needed to support the rate level, private passenger auto programs may require the submission of a class plan. The **Class Plan Application** must indicate the rating factors to be applied, the relativities for each rating factor, the base rate, the good driver discount plan and the statistical analysis used to determine the classification variables in accordance with CCR Title 10, Chapter 5, Subchapter 4.7. Rate changes that do not involve changes to the rating factors do not require a Class Plan Application. Refer to the Class Plan Application and instructions for detailed information. (Note: Filings for vehicle symbols must be completed on the Class Plan Application per CCR §2632.3(b)).

When submitting an Application for a rate change or new program in private passenger auto, include all coverages that comprise the private passenger auto liability and auto physical damage lines in the Rate Template. Page 6 of the Rate Template must be completed for each coverage (i.e., bodily injury liability, property damage liability, medical payments, uninsured motorist, comprehensive, collision and any miscellaneous coverages). Data must be provided for each coverage offered, even if no change in the rate for that coverage is proposed. Additionally, Page 4 of the Application must include **all** coverages in the filed line, including any miscellaneous coverages (e.g., towing, rental reimbursement, etc.).

Application Pages 5, 6, and 7 (Reconciliation, Program Detail, and Statutory Data, respectively) may be submitted separately for liability and physical damage or on a combined basis.

Assigned risk data must be excluded from Page 7 of the Rate Template, but included as a separate line on Page 5 of the Application. Rating tiers are *disallowed* in private passenger auto. However, insurers may have more than one private passenger auto program with different rates *if* the programs include significant and relevant coverage differences. If an insurer has more than one program with different rates, the insurer must describe, in detail, the significant and relevant coverage differences by coverage and fully support the rate differentials between the programs. Every insurer offering multiple programs with different coverages must offer **all** such programs to **all** eligible applicants. The use of different marketing systems or types of insurance producers does not affect this requirement.

The following points are intended to provide direction in the filing of group programs pursuant to the authority of CIC §1861.12 and multiple programs offering coverage differences:

- Filings may be made on an individual program basis or on an all-program combined basis. If an all-program combined filing is made, a calculation reflecting each program's premium and loss ratio history shall be included in Exhibit 14 to justify each individual program's rate level relative to the insurer's aggregate private passenger auto rate level.
- In most cases, when individual private passenger auto programs are submitted, the aggregate all-program combined premium and loss trend and loss development data will be used. Exceptions may occur in situations such as where limits and deductibles differ significantly among programs, where separate claim adjusting staffs are used, or where the amount of data in a program significantly exceeds the published full credibility standard. Trend credibility is defined in CCR §2644.7. This list is not intended to be exhaustive.

Insurers must submit electronically through SERFF a complete California private passenger auto rate manual which contains all current rates, rating factors and rating rules including any changes in rates, rating factors and/or rating rules, and the final effective date associated with those changes, before approval of the filing will be issued.

Collector vehicles may be filed under the Inland Marine line of business if the following conditions are met:

a. The vehicle is not licensed for use on public highways; and
b. The vehicle is transported as property (for instance, on flatbed trucks), not driven.

V. Filing Memorandum

A Filing Memorandum must be attached to each filing and must include the following:

- a clear statement of the purpose of the filing
- a summary of all proposed changes
- the underlying assumptions relied on for the changes
- a detailed explanation of and support for each selection including a demonstration of why the selections and methodologies for calculating the premium trend, loss trend loss development and catastrophe adjustment factors are the most actuarially sound as defined by CCR §2642.8
- any adjustments/modifications to the data
- any credibility standard used together with justification for its use
- any appropriate additional explanation regarding included exhibits.

The filing memorandum must also comment on any model that has been used in any form, manner, or capacity in support of, or in conjunction with the filing, including details about the features and use of the model. Refer to section "II. G. Model Checklist".

Unless the final approval letter explicitly states otherwise, any proposed changes not addressed within the filing memorandum are not approved.

VI. Completing the Application, Rate Template, Standard Exhibits Template and Required Exhibits

A. Completing the Rate Application

The following information explains the pages of the Application required as part of a prior approval filing. A complete Application is required in accordance with the provisions set forth in CIC §1861.05(b) and CCR §2648.1 through §2648.4. Excel sheets with blue-colored tabs require insurer input. Areas for insurer input on each sheet are generally formatted in blue font text and/or light blue outlined boxes. Pages that are not applicable to the line of business or Application in question will be hidden based on insurer input on Page 1 of the Application.

Application Page 1 - General Information

Every insurer wishing to make a filing must complete Page 1 of the Application. This page specifies certain general filing characteristics, including, but not limited to, the line of insurance, subline and program for which the filing is being submitted, as well as company specific information.

Each insurer writing private passenger auto must indicate whether they are operating under a Super Group corporate structure as defined in CIC §1861.16(c). Super Groups are insurers that have common ownership but whose California operations are separate per CIC §1861.16(c). If CIC §1861.16(c) applies to an insurer group, Exhibit 17, Super Group Corporate Structure Verification Exhibit, must also be completed. Each Super Group insurer that issues a policy, as defined in CIC §660(a), must provide Exhibit 17 as part of a rate filing to verify compliance with CIC §1861.16(c).

Application Page 2 - Insurer Group Information

This page applies to affiliated companies within an insurer group, and is hidden from view unless the filing includes group data, as indicated on Page 1 of the Application. Page 2 must be completed when a group filing is submitted. Each company to which the Application applies must be identified on this page.

A single Application for an insurer group may be submitted for all filing types if each company within a group uses the same rates, forms and/or rules (rating and underwriting) and the submission includes group data. If there are different loss cost multipliers, tiering factors or any other factors that result in an insured being charged different premiums between the companies then the companies must file separate rate applications.

For each individual company to which the Application applies, provide the proposed rate change. The proposed impact for each individual company should be based on that company's premium distribution by Coverage/Form/Program, and will not necessarily equal the total rate impact shown on Application Page 4. The underlying support should be provided in Exhibit 14 - Rate Distribution. See section VII. D. Required Exhibits for further information.

Application Page 3 - Filing Type and Checklist

Each insurer must identify the type of filing in the Filing Type section on Page 3 of the Application. The various broad types of filing submissions are: New Program, transferred program, Rates, Variance Request, Coverage Forms and Rules and Eligibility Guidelines. Each filing type is set to no ("N") as default. The insurer should mark yes ("Y") to each question that applies to the filing. More than one filing type can apply to a single filing. Note that changes to rule(s) include the introduction of new rule(s) and changes to existing rule(s). Form change(s) include the introduction of new forms, withdrawal of old form(s) and/or replacement of old form(s).
The Filing Checklist section on Page 3 of the Application is provided to ensure that all necessary documents and exhibits are included in the submission, according to the filing purpose and type(s) of filing. The insurer should use this checklist to indicate submission of all items listed in the checklist in the format(s) required (either PDF or Excel and PDF). If a warning message appears in the Filing Checklist section, the Filing Type is invalid and the insurer should ensure a valid Filing Type is selected prior to submitting the filing.

Application Page 4 - Impact of Proposed Changes

Page 4 of the Application must be completed for every filing identified as having a rate impact. The earned premium must include all income derived from miscellaneous fees and other charges (refer to the instructions for completing Exhibit 6 for more detailed information).

The adjusted earned premium is the historical earned premium for the most recent year adjusted to the current rate level and trended to the average earned date of the proposed rating period.

This page must include all coverages or forms contained in the line of business being filed. Thus, for example, a private passenger auto filing must include all coverages, including

miscellaneous liability or physical damage coverages that are reported in their respective lines of business, even if the insurer proposes no change to rates for those coverages.

Application Page 5 - Reconciliation of Direct Earned Premium Data

In Page 5 of the Application, the insurer must provide calendar year direct earned premium data and itemize the data for each program until all data is reconciled to the corresponding Annual Statement line of insurance (Statutory Page 14).

This page requires insurers to itemize each Coverage/Form/Program until all data is reconciled to the corresponding annual statement line of insurance. The level of granularity of this page should be consistent with the number of Ratemaking Data sheets in the Rate Template and any other Coverages/Forms/Programs that roll up to the annual statement line of insurance, once aggregated.

File numbers are not required for residual market data. Auto liability and physical damage data may be shown together on the same page. If the data does not reconcile exactly to the Statutory Page 14 data a detailed explanation must be provided of why it does not reconcile.

Application Page 6 - Program Detail

Any insurer submitting a filing for a subset of their entire line of business (for instance, HO-3 only, Businessowners only, Auto Dealers only, etc.) must complete Page 6 of the Application by providing premium, loss and DCCE information for the entire line of business as shown in that insurer's Annual Statement as well as for each separate form/program that comprises the insurer's line of business. If the Application to be submitted is a group filing, the insurer must populate this page for the group.

Application Page 7 - Additional Calendar Year Data Required by Statute

Data requested on Page 7 of the Application must be provided for the most recent calendar year. The data provided must correspond to the program to which it applies and need not necessarily reflect the total Annual Statement line of insurance data.

Auto liability and physical damage data may be shown separately or on a combined basis.

Application Page 8 - Miscellaneous Fees and Other Charges

Page 8 of the Application requires that each insurer disclose all fees and the amounts charged to individual policies for new and renewal business. These fees and charges may be categorized as miscellaneous fees and other charges or ancillary income.

Miscellaneous fees include but are not limited to: policy fees, installment fees (usually expressed as a dollar amount), fixed expense fees, endorsement fees, inspection fees,

cancellation fees, reinstatement fees, late fees, SR-22 fees and any other similar fees. All such fees are added to earned premium for ratemaking purposes and the miscellaneous fees for each year of the recorded period must be included on Page 6 of the Rate Template, line 5 (miscellaneous fees and other charges). These data must be itemized and appropriately adjusted (e.g. on-leveled) in Exhibit 6, Miscellaneous Fees and Other Charges.

Components of ancillary income include but are not limited to: non-sufficient funds (NSF) fees, membership dues, premium finance revenues and installment finance charges (usually expressed as a percentage). Ancillary income shall be reported on Page 6 of the Rate Template, line 15. These data must be itemized and supported in Exhibit 11, Ancillary Income.

Application Page 9 - Forms

Page 9 of the Application requires that each insurer identify each form by title and form number, type and source of the form, and by the applicable rule or page number. The insurer must indicate whether this is a new, replacement or withdrawn form and indicate whether the form broadens or restricts coverage

The insurer must also provide additional detailed information explaining the changes for each form being proposed in the space provided on this page. If additional space is needed the insurer may submit a supplemental exhibit. If a rate or premium is specifically charged for the form, the insurer must provide additional justification of that factor or charge on this page.

Insurers must declare and explain whether the proposed form changes have a rate impact and assess the value of the coverage change if a rate is not specifically charged for the form.

Forms that restrict, exclude or delete coverage require consideration of a rate offset/credit. Provide the amount of prior incurred losses, if any, associated with the impacted coverage. If the form proposes to restrict or exclude coverage, the proposed rate for the remaining coverages must be justified.

The insurer must include any relevant rule(s) or manual page number(s). For forms that the insurer requires to be attached to some policies, the insurer must include a reference to the accompanying rule specifying when the form will attach.

Page 9 of the Application is also required for new program filings.

Application Page 10 - Rules and Eligibility Guidelines

Page 10 of the Application must be completed for all rule change filings. In addition to providing an explanation and a copy of the rule, justification of the rate impact to the current book of business must be provided. Exhibit 18, Rules and Eligibility Guidelines, must be used to provide the necessary information. The current, proposed and “marked-up” copy of the

rate manual along with the current, proposed and “marked-up” copy of the eligibility guidelines must be included.

Application Page 11 - Variance Request

Page 11 of the Application is hidden from view unless the filing includes a request for variance, as indicated on Page 1 of the Application. This page must be completed when requesting a variance. Enter the minimum and maximum permitted rate change for the Application without variance. Then, for each variance request, select the basis of the variance from the pull-down menu. A synopsis corresponding to that basis as specified by CCR §2644.27(f) will appear below the selection. Enter the minimum and maximum permitted rate changes associated with each variance. In instances when multiple variances regarding the same ratemaking component are requested but cannot be separately quantified (e.g., 8A and 8D), enter the minimum and maximum permitted rate changes associated with the combined effect of those variances for each variance included in the combination. At the bottom of Page 11, enter the minimum and maximum permitted rate changes for all variances combined.

If there are not enough years of data to calculate the loss development to ultimate or trend factors, thereby requiring the application of variance 7B or 8B, the insurer need not enter a minimum and maximum permitted rate change for the no-variance Rate Template. In these cases, a Rate Template without variance is not required.

Exhibit 13, Variance Request, must be completed, along with Page 11 of the Application, for every variance filing, whether filed together with the Application to which it applies or after the same. When a variance filing is submitted, the filing must provide substantial, detailed support and justification for each variance request in accordance with CCR §2644.27 (b). In addition, each variance filing must include:

- A Rate Template that shows the minimum and maximum permitted rate changes excluding variance(s), with the exception as noted above;
- A Rate Template that shows the minimum and maximum permitted rate change for each variance request. If multiple variances are requested, multiple, separate Rate Templates must be provided. Each Rate Template should clearly identify the corresponding variance to which it applies; and
- A Rate Template that shows the cumulative minimum and maximum permitted rate changes for all variances combined.

Final decisions regarding variances will be made by the Department, or by administrative hearing. In determining whether an insurer qualifies for a variance under CCR §2644.27 (f) (2) (A) for "Higher quality of service, as demonstrated by objective measures of consumer satisfaction,” the Department may consider multiple sources of objective data. These sources

may include surveys by reputable nongovernmental organizations such as Consumers Union and J.D. Powers, designed to objectively measure the relative quality of service provided by multiple insurers in the relevant line of business. The Department may also consider governmental sources of objective data including, but not limited to, the Department's own consumer complaint records.

Application Page 12 - Model Disclosure

Page 12 of the Application must be completed when a model or models were used in the development of the filed program. Insurers must indicate the number of models used in the development of this program on Page 1 of the Application. A separate Application Page 12 must be filled out for each model. The current Application allows for up to ten model pages to be submitted. If the insurer uses more than ten models, additional supplementary exhibits should be provided containing all of the information requested on Application Page 12.

If the insurer is using a vendor model, the "Model Name/ Model Version" field must include the full name of the vendor model and include the version number of the model used.

There are four types of model submissions that must be filed on Application Page 12:

- **New/initial:**

  Any model that has not been used for the program before.

- **Revision to Existing Model:**

  An in-house developed model, where the insurer has filed to use the model for the program before, and the insurer is changing the structure of this existing model. Changes to the structure of the model include, but are not limited to, inclusion/removal of rating variables, and/or changes to the categories/boundaries that each rating variable may have. Structural changes to the model can take many forms, and include any change to the model that does not involve a change solely to the underlying data.

  A vendor model where the insurer is either (1) using a more up to date model version of a model that has been used in the previously approved rating plan or (2) using an alternative model to a model that has been used in the previously approved rating plan. If an alternative model is being used, the insurer should provide an explanation for the model change in the filing memorandum.

- **Refresh of Data to Existing Model:**

  An in-house developed model, where the insurer re-runs an existing model using more current data for the purpose of updating the rating relativities of the existing rating plan, without any change to the structure of the model.

A vendor model where the insurer is using the same model version as used in the previously approved rating plan and updating the input data. If the latest model version is not being used the insurer should provide an explanation for not updating the model version in the filing memorandum.

- **No revision**:

  An in-house developed model, where the insurer has a previously approved rating plan based on a model, and no changes are being made to the structure of that model or the relativities based on that model in the current filing.

  A vendor model where the insurer used the same version number in the previously approved rating plan and is not updating the input data.

  For all model submission types listed directly above except a new/initial model, the insurer must provide the applicable CDI and the SERFF file numbers for the existing model on Application Page 12, and include reference to these file numbers in Exhibit 1. Refer to "Section VII. D. Required Exhibits, Exhibit 1 - Filing History" for further details.

B. Completing the Rate Template

The following information explains the pages of the Rate Template required for all filing types with rate impact. Excel sheets with blue-colored tabs require insurer input. Areas for insurer input on each sheet are generally formatted in blue font text and/or light blue outlined boxes. Pages and rows of data that are not applicable to the line of business or Application in question will be hidden based on insurer input on Page 1 of the Rate Template. *[Note: To generate a valid CHANGE_AT_MIN and CHANGE_AT_MAX, all errors must be resolved on all pages of the Rate Template. Any error message left unresolved will prevent the calculation of CHANGE_AT_MIN and CHANGE_AT_MAX for each coverage, form or program included in the Rate Template. Instead, each Rate Calculation page will display "Error."]*

Rate Template Page 1 - General Information

This page specifies certain general filing characteristics common to all coverages, forms or programs contained in the Application, including, but not limited to:

- Company (or group);
- The line of insurance;
- The percentage volume of each marketing system used in the line of business, based on earned premium;
- The proposed effective date of the proposed rates;
- An indicator identifying the filing type as a new program, if applicable;

- An indicator identifying the inclusion of an LCM calculation in the Application, if applicable; [Note: LCM Calculation sheets for each coverage, form or program will remain hidden unless this box is checked.]
- The data aggregation method used in the ratemaking process (accident year, report year, or policy year);
- The most recent year of data included in the experience period (in YYYYQ format); and
- Variance request, if any. [Identify all variances being requested by number, separated by commas. Separately identify the request for Variance #3 from the pulldown menu.]

In addition, this page requires the identification of each coverage, form or program included in the Rate Template and its corresponding Detailed Line Description, proposed impact and prior effective date. The Rate Template accommodates 10 coverages, forms or programs. For Rate Templates with less than 10 coverages, forms or programs, the unused boxes must be left blank.

Pages for ratemaking data input and rate change calculations remain hidden unless coverages, forms or programs are entered in this page.

Rate Template Page 2 - Summary

This page provides a summary of the minimum and maximum permitted earned premium and associated rate change for the filed line and coverages, forms, or programs using the data input by the insurer in subsequent pages of this Rate Template. The summary also provides the average earned premium per exposure and loss and DCCE ratio by coverage, form or program. In addition, this page requires the insurer to input the latest year's combined total earned exposures (or projected exposures for new programs).

Rate Template Page 3 - Projected Yield and Federal Income Tax Rate on Investment Income

Page 3 of the Rate Template provides the calculation of the projected yield and the federal income tax rate on investment income, as specified in CCR §2644.20 and §2644.18. The results of that calculation feed directly to lines 17 and 18 of Page 6 of the Rate Template.

When calculating the weighted average yield: 1) the weights used shall be based on the insurer's most recent Consolidated[1] (Combined) Statutory Annual Statement ***for the insurer group***, and 2) the yields for each asset class shall be based on the average of the most recent three complete calendar months available as of the date of the filing. These yields by asset

[1] The *Official NAIC Annual Statement Instructions for the 2019 Reporting Year – Property/Casualty* (September 2014), 601 states "wherever the word 'combined' appears in the blank, it should be construed to mean consolidated or combined."

class are pre-populated in the Rate Template from an internal Department file. To ensure the latest yield/rate of return information is used in the Rate Template at the time of filing submission, navigate to the "Data" menu of the Excel ribbon, click on "Edit Links" and then click on "Open Source." Opening of this source will automatically update the links to the most recent yield and rate of return figures.

Rate Template Page 4 - Excluded Expense Ratio

Page 4 of the Rate Template provides the calculation of the excluded expense ratio for the ***insurer group***. The definition of "insurer group" must be consistent with that used in the calculation of the projected yield and the federal income tax rate on investment income.

For the most recent three calendar years, provide the insurer group's countrywide direct earned premium for all lines subject to Proposition 103. Also provide the countrywide direct earned premium for all remaining lines. The total of these two direct earned premium aggregations must reconcile to the direct earned premium as provided in the Insurance Expense Exhibit, Part III Supplement of the Consolidated (Combined) Statutory Annual Statement for the insurer group.

Pursuant to CCR §2644.10, certain expenses are not permitted to be included for ratemaking purposes. Provide the expenses for each of the categories below for the most recent three calendar years:

- Political contributions and lobbying;
- Total executive compensation (cash & salary and bonus shown separately) for the five highest-paid policymaking positions;
- Bad faith judgments and associated defense and cost containment;
- All costs attendant to the unsuccessful defense of discrimination claims;
- Fines and penalties;
- Institutional and Non-Institutional advertising expenses, and;
- All payments to affiliates that exceed fair market rate.

"Institutional advertising" is advertising not aimed at obtaining business for a specific insurer and not providing consumers with information pertinent to the decision whether to buy the insurer's product. For purposes of reporting advertising expenses in this application, if a particular advertisement is not aimed at obtaining business for a specific insurer, the advertisement should be considered Institutional advertising. Similarly, if a particular advertisement does not provide consumers with information pertinent to the decision whether to buy the insurer's product, the advertisement should also be considered Institutional advertising. "Non-Institutional advertising" refers to all advertising that is not Institutional advertising. For each calendar year, identify the total amount spent on

Institutional advertising and the total amount spent on Non-Institutional advertising. The sum of the Institutional and Non-Institutional advertising expenses must be equal the total advertising expenses reported in the Insurance Expense Exhibit, Part I Supplement of the Consolidated (Combined) Statutory Annual Statement for the insurer group.

Provide samples or realistic representations of all advertisements the company claims fall under the category of Non-Institutional advertising expenses. For example, if the company purchased Non-Institutional print advertisements, provide copies of the print advertisements; if the company purchased Non-Institutional online advertisements, provide a screen shot, a specimen image, a script, or a video clip, or a live electronic link to samples of each advertisement, and so forth for all Non-Institutional advertisements the company used during the previous three calendar years. It is not necessary to provide any samples or realistic representations of advertisements that the company claims fall under the category of Institutional advertising.

The efficiency standard will be reduced to reflect the disallowance of the excluded expenses for ratemaking purposes.

Rate Template Page 5 - CDI Parameters

This page displays the final prior approval factors for efficiency standard, leverage ratio, unearned premium reserves and loss reserves after adjustment for variance, if applicable, used in the calculation of the minimum and maximum permitted earned rate change for the coverages, forms or programs included in this Rate Template. Loss and DCCE information is also provided for purposes of completing the LCM Calculations, if applicable.

With reference to CCR §2644.16, Rate of Return, the decision to increase or decrease the rate of return is solely at the discretion of the Commissioner and not pursuant to an individual insurer's request. No insurer input is necessary for this page.

Rate Template Page 6 - Ratemaking Data

Page 6 of the Rate Template must be completed for all filing types with rate impact. A separate Page 6 is available for each coverage, form or program included in this Rate Template. *[Note, this page is hidden for each coverage unless a Detailed Line Description and associated coverage, form or program has been selected on Page 1 of the Rate Template.]* If more than three years of data is needed for credibility purposes for a particular coverage, form or program, expand the page in question to allow up to six years of data input.

This page requires that the insurer provide the following information specific to the coverage, form or program under rate review:

- Three years of data directly corresponding to the coverage, form or program under rate review, subject to regulations pertaining to credibility (CCR §2642.6 and §2644.23); *[Note, years may be on a fiscal year basis, but must end on a traditional quarter (i.e., March 31, June 30, September 30 or December 31).]*
- Trends (premium, loss and DCCE) expressed as an annual percentage, and entered in lines 4, 11 and 12 of the Projected column;
- For new programs, all data required as detailed in the instructions for new program filings, and entered in lines 1, 5, 6, 7, 8 and 15 of the new program column. Earned premium is equal to written premium;
- Data excluding that associated with residual markets;
- The change to the efficiency standard being proposed, if any, and the insurer's most recent year total actual expense ratio excluding DCCE, provided the appropriate variance is indicated; *[Note, the input area for the change to efficiency standard and insurer expense ratio is hidden on this page unless a variance impacting the efficiency standard (i.e., Variance 1A, 1B, 2A, 2B, 2C or 4) is indicated on Page 1 of the Rate Template.]*
- The direct commission rate on premiums subject to reinsurance agreements for earthquake and medical malpractice rate filings, if applicable; *[Note, the input area for direct commission rate, reinsurance premiums and reinsurance recoverable is hidden on this page unless "Earthquake w/consideration for cost of reinsurance" or one of the "Medical Malpractice" options indicating "incl. reinsurance costs" is selected as the Detailed Line Description from the pull-down menu on Page 1 of the Rate Template.]*
- Data ***in the recorded period*** ending no more than eight (8) months prior to the submission date of the filing. For instance, for a filing submitted on October 29th, 2020, the last year in the recorded period must be fiscal year ending March 31, 2020, or a more recent quarter-end. See reference chart below:

Month Filing Submitted	**8 Months Prior**	**Most Recent FY Ending Quarter**	**Most Recent FY Ending Quarter (YYYYQ format)**
Jan-2025	May-2024	Jun-2024	20242
Feb-2025	Jun-2024	Jun-2024	20242
Mar-2025	Jul-2024	Sep-2024	20243
Apr-2025	Aug-2024	Sep-2024	20243
May-2025	Sep-2024	Sep-2024	20243
Jun-2025	Oct-2024	Dec-2024	20244
Jul-2025	Nov-2024	Dec-2024	20244

Aug-2025	Dec-2024	Dec-2024	20244
Sep-2025	Jan-2025	Mar-2025	20251
Oct-2025	Feb-2025	Mar-2025	20251
Nov-2025	Mar-2025	Mar-2025	20251
Dec-2025	Apr-2025	Jun-2025	20252

Data for all rate filings is subject to the following requirements:

- Loss and DCCE development data may be evaluated on an annual period/annual development or quarterly period/quarterly development basis (see discussion under Section VI. C. for Standard Exhibits Template Page 3);
- Annual development triangles may be submitted as of 12 or 15 months of development (see discussion under Section VI. C. for Standard Exhibits Template Page 3); and
- The loss and DCCE data in the recorded period and the loss and DCCE development data must be consistent (i.e., ending the same year and quarter, and evaluated as of the same number of months).

The following chart provides additional examples of time periods acceptable for data in the recorded period, the trend exhibits and the (annual) loss development exhibits:

Ex	Recorded Period (YYYYQ); Eval as of	Trend Data	Devt Data	Eval as of (mos)	Acceptable to File?	Explanation
1	20244 12 mos[2]	20244	20244	12	Yes	Data for recorded period, trend, and development are all consistent.
2	20244 12 mos	20251	20244	12	Yes	Data for recorded period and development are consistent, trend data includes only one quarter past the end of the recorded period.
3	20244 12 mos	20251	20244	15	No	Data for recorded period and development are inconsistent (number of months at which losses are evaluated don't match).
4	20244 15 mos	20251	20244	15	Yes	Data for recorded period and development are consistent, data for development is evaluated at, and trend data is, only one quarter past recorded period.
5	20244 18 mos	20244	20244	18	No	Data for recorded period, trend and development are all consistent, but development data is evaluated more than one quarter past recorded period.
6	20251 12 mos	20251	20251	12	Yes	Same as Ex 1, except that a fiscal year is used.
7	20251 12 mos	20252	20251	12	Yes	Same as Ex 2, except that a fiscal year is used.
8	20251 12 mos	20252	20252	12	No	Data for recorded period and development are inconsistent (fiscal years don't match).
9	20251 15 mos	20252	20251	15	Yes	Same as Ex 4, except that a fiscal year is used.

[2] Evaluation at 12 months facilitates reconciliation of data between exhibits.

10	20251 6 mos	20251	20251	6	No	Data for recorded period, trend and development are all consistent, but development data is evaluated as of less than 12 months.

For companies opting for quarterly loss development, similar requirements apply, except that quarterly triangles may only be evaluated at 3, 6, 9, … months of development.

Treatment of Filings with Data in the Recorded Period Less than 25% Credible over Six Years

- For any filing for which data in the recorded period has less than 25% credibility, as defined in CCR §2644.23, over a maximum of six years, the insurer may use an alternative complementary loss and DCCE in lieu of the net trend method, provided the alternative is the most actuarially sound method. *[Note, CCR §2644.23 refers to credibility associated with the data in the recorded period only. Refer to CCR §2644.7 for information regarding credibility associated with loss trend.]*
- If alternative complementary loss and DCCE are used as specified by CCR §2644.23

(i), enter the credibility-weighted projected ultimate loss and DCCE on lines 7 and 8 of Page 6;

- Enter a factor of 1.00 for all loss and DCCE development, trend and catastrophe adjustment on lines 9 through 13;
- Enter 100% for credibility in line 14, and;
- Provide detailed data and calculations supporting the development of the credibility-weighted projected ultimate loss and DCCE within the corresponding exhibits.

Rate Template Page 7 - Rate Change Calculation

This page calculates the minimum and maximum permitted rate changes for the filed line and each coverage, form or program included in this Rate Template, using the data input by the insurer in previous pages of this same template. *[Note, this page is hidden for each coverage unless a Detailed Line Description and associated coverage, form or program has been selected on Page 1 of the Rate Template.]* No insurer input is necessary for this page unless the Rate Template reflects a variance request. In that event, select the applicable variance number from the pull-down menu at the top of this page.

Rate Template Page 8 - LCM Calculation

Page 8 of the Rate Template must be completed for those rate filing submissions where the filed line or coverage uses a Loss Cost Multiplier (LCM). *[Note, this page is hidden for each coverage unless the box to the right of "LCM Calculation(s) Included" is checked on Page 1 of the Rate Template.]* Examples include new or existing program rate filings that involve the

adoption of Advisory Organization loss costs, and existing program rate filings where the LCM is being revised. Refer to specific instructions for completing the LCM Calculation page in Section VIII.

C. Completing the Standard Exhibits Template

The following information explains the pages of the Standard Exhibits Template required for all filing types with rate impact. Excel sheets with blue-colored tabs require insurer input. Areas for insurer input on each sheet are generally formatted in blue font text and/or light blue outlined boxes.

Standard Exhibits Template Page 1 - General Information

This page specifies certain general filing characteristics common to all coverages, forms or programs contained in the Application, including, but not limited to:

- Company (or group);
- The line of insurance;
- The data aggregation method for loss & DCCE development (accident year, report year, policy year);
- The number of months of development for annual loss & DCCE development;
- The most recent year of data included in the trend, complement trend and development data (in YYYYQ format);
- The basis for premium trend (written or earned);
- Indicators to identify whether DCCE is included or excluded from the data; and
- An indicator to identify if the data in this Application reflects the current NAIC categorical split of LAE (DCCE/AOE). [Any Application reflecting a ALAE/ULAE split of LAE instead of DCCE/AOE is out of compliance with CCR §2644.8.]

In addition, this page requires the identification of each coverage, form or program included in the Standard Exhibits Template and its corresponding Detailed Line Description. The Standard Exhibits Template accommodates 10 coverages, forms or programs. For Standard Exhibits Templates with less than 10 coverages, forms or programs, the unused boxes must be left blank. Do not skip coverages.

Standard Exhibits Template Page 2 - Exhibit 5 – Premium Trend

Indicate how the premium trend factors on Page 6, line 4 of the Rate Template were developed by completing the Standard Exhibits Template. The premium trend factors shall be based on the exponential curve of best fit, using the most actuarially sound company

specific California rolling calendar year premium per exposure data for the most recent 8, 12, 16, 20 or 24 quarters. Premium trends shall not be credibility-weighted.

Display the exposure and premium data separately for each of the underlying 27 quarterly data points that, when compiled to rolling 4-quarter data, serve as the basis for the calculated annual premium trend. Specifically, the Standard Exhibits Template requires that the insurer provide:

- Quarterly company-specific California exposures, premium and on-level premium, whether written or earned, for 27 quarters;
- The calculated annual trend for each of the 8, 12, 16, 20 and 24 point data periods;
- The selected annual trend; and
- The trend period for the most recent year in the recorded period. The trend period used must extend from the average earned date (or written date, if written data is used) of the recorded year to the average earned (or written) date of the rating period. While a default trend period is reflected in the template, the calculation may be overwritten based on Company actual exposure distribution.

The Filing Memorandum must include:

- Justification of the trend period
- The type of exposure unit used to derive the average premium (e.g., earned house years, number of policies, earned car years, square footage, etc. The exposure and premium bases must match: if *earned* exposures are used, *earned* premium must also be used.
- An explanation of any significant shifts in the type or mix of business and its effect on the trend
- A demonstration of why the premium trend selections are the most actuarially sound.

The number of data points in the trend selection must be the same for the premium trend and the loss trend.

In accordance with CCR §2644.27(f)(8), a variance for premium trend may be requested if CCR §2644.7 does not produce an actuarially sound result.

Standard Exhibits Template Page 3 - Exhibit 7 – Loss and Defense and Cost Containment Expense (DCCE) Development

Pursuant to CCR §2644.6 and §2644.8, indicate how the loss and DCCE development factors shown on Page 6, lines 9 and 10 of the Rate Template were developed by completing Exhibit 7. Insurers must submit annual loss development triangles in the Standard Exhibits Template regardless of whether the insurer is developing losses on an annual or quarterly basis.

Insurers opting to develop losses on a quarterly basis must submit both annual development triangles in the Standard Exhibits Template and quarterly development triangles in the Supplemental Quarterly Development Template posted on the Department's website. The Supplemental Quarterly Development Template accommodates 5 coverages, forms or programs. If there are over five coverages/forms/programs, then additional Supplemental Quarterly Development Templates must be submitted. The coverages/forms/programs must be in the same order as in the Prior Approval Rate Template and Standard Exhibits Template. Exhibit 7, whether provided on an annual or quarterly basis, must include the **complete** claim count development and loss development triangles of company-specific California data that serve as the basis of the dollar-weighted average of the link ratios of losses for the three most recent accident years, policy years or report years available for a reporting interval.

Provide all non-catastrophe loss and DCCE amount and claim count data required by regulation in triangular format. Development triangles must be **complete**; i.e., they must be presented through the evaluation date and must include the entire interior of the triangle for **all** time periods provided. The Standard Exhibits Template provides an exhibit, Exhibit 7 - Annual, for annual periods/annual development. The Supplemental Quarterly Development Template provides an exhibit, Exhibit 7 - Quarterly, for quarterly periods/quarterly development. If annual periods are evaluated as of 15 months of development in Exhibit 7-Annual, the insurer must additionally submit the data as of three months of development. Note that triangles are required for paid loss & DCCE, paid loss, paid DCCE, incurred loss & DCCE, incurred loss, incurred DCCE (if tracked), reported claim counts[3], paid claim counts[4], closed with payment claim counts, and closed with no payment claim counts.

The Standard Exhibit Template only allows for ten years of development data. For filings where more than ten years of development is deemed to be required, insurers can provide this data in a supplemental exhibit. If the insurer requires more than ten years of loss development data, the loss development factors produced by the data in the supplemental exhibit may be used in the Rate Template.

Loss development shall employ either paid losses or incurred losses (the sum of paid losses and case-specific reserves). In accordance with CCR §2644.6, triangles for reported[3] and paid[4] claims shall also be submitted. The insurer shall submit both the factors and ultimate values for (1) the paid and incurred loss and (2) the reported and the paid claim count development calculations. Loss and claim count development data shall exclude catastrophes.

[3] Reported claim counts include counts for all claims submitted to the insurer, including counts for claims closed without payment.

[4] Paid claim counts include counts for both closed and open claims with payment.

DCCE may be evaluated in the same manner as losses, may be added to losses for loss development, or may be developed using ratios of DCCE to losses.

The Filing Memorandum must include:

- An explanation of why there are significant differences in the ultimate losses between the two development methodologies described in CCR §2644.6, including any impacts resulting from intended or unintended changes in claims closing practices or settlement rates.
- An explanation of unusually large losses and their effect on the ultimate loss calculation.
- A demonstration of why the loss development selections are the most actuarially sound.

In accordance with CCR §2644.27(f)(7), a variance for loss development may be requested if CCR §2644.6 does not produce an actuarially sound result.

Standard Exhibits Template Page 4 - Exhibit 8 – Loss and DCCE Trend

Pursuant to CCR §2644.7, provide support for the loss and DCCE trend factors on Page 6, lines 11 and 12 of the Rate Template by completing the Standard Exhibits Template.

The trend factors shall be based on the exponential curve of best fit, using the most actuarially sound company-specific California rolling calendar year data, excluding catastrophes, for the most recent 8, 12, 16, 20 or 24 quarters. The frequency trend shall be calculated using reported and closed claims divided by exposures. The severity trend shall be calculated on (1) paid losses on both open and closed claims divided by closed claims and (2) total paid losses, including partial payments in previous calendar years, on closed claims divided by closed claims. This latter basis of aggregating severity data matches the cohort of closed claims in a rolling calendar year with all payments and subrogation/salvage recoveries or other payment adjustments generated by that cohort of claims, regardless of transaction date. As an example, assume the following transactions for a particular claim:

- The claim is reported in 2nd Quarter 2019;
- A partial payment of $5,000 is made on that claim in 3rd Quarter 2019;
- A final payment of $10,000 is made and the claim is closed in 4th Quarter 2020.

The table below displays how the data for this claim would be aggregated under each frequency and each severity calculation method:

	Frequency Method 1	Frequency Method 2	Severity Method 1	Severity Method 2
Calendar Year	**# Reported Claims**	**# Closed Claims**[5]	**$ Paid Losses (on Open and Closed Claims)**	**$ Total Paid Losses (includes Partial Payments from Previous Calendar Years) on Closed Claims**
2024	1	0	5,000	0
2025	0	1	10,000	15,000

The exhibit must contain the frequency and severity calculations on all bases (two bases each for frequency and severity) and shall demonstrate that the selection is the most actuarially sound.

Display the exposure, claim count and loss data separately for each of the underlying 27 quarterly data points that, when compiled to rolling 4-quarter data, serve as the basis for the calculated annual frequency and severity trends. Specifically, the Standard Exhibits Template requires that the insurer provide:

- Quarterly company-specific California earned exposures, closed claims, reported claims, paid losses, and total paid losses on closed claims (including partial payments in prior calendar periods) for 27 quarters;
- For all complement data other than California Fast Track, quarterly complement earned exposures, closed claims, reported claims, paid losses, and total paid losses on closed claims (including partial payments in prior calendar periods) for 27 quarters;
- The calculated annual trend for each of the 8, 12, 16, 20 and 24 point data periods; • The selected annual trend; and
- The trend period for the most recent year in the recorded period. The trend period used must extend from the average date of loss of the recorded year to the average date of loss of the rating period. While a default trend period is reflected in the template, the calculation may be overwritten.

The Filing Memorandum must include:

- Justification of the trend period
- An explanation of why there are any significant differences in the annual trend between the paid and reported annual frequency trends.

[5] The number of closed claims is used as the denominator for *both* severity methods.

- An explanation of why there are any significant differences in the annual trend between the paid and total paid annual severity trends.
- An explanation of why there are any significant changes in frequency or severity trends for the different trend periods.
- An explanation of any significant shifts in the type or mix of business and its effect on the trend.
- An explanation of unusually large losses and their effect on the loss trend calculation.
- A demonstration of why the loss trend selections are the most actuarially sound.
- An explanation of why any complement of credibility for loss trend is the most actuarially sound.

The type of exposure must be the same for premium and loss trend (i.e., if car years are selected as the exposure unit for premium trend, car years must be selected as the exposure unit for loss trend).

The number of data points in the trend selection must be the same for the premium trend and the loss trend.

Refer to Section VII. D. (Exhibit 10) for requirements for loss trend credibility.

DCCE may be added to losses for trend. The insurer shall demonstrate that its selected methodology is the most actuarially sound.

In accordance with CCR §2644.27(f)(8), a variance for loss trend may be requested if CCR §2644.7 does not produce an actuarially sound result.

For the earthquake line of business and for the fire following earthquake exposure in other lines, the insurer may submit projected losses in accordance with CCR §2644.4 (e) rather than the Standards Exhibit Template.

For Standard Exhibits Template Page 2 - Exhibit 5 and Standard Exhibits Template Page 4 - Exhibit 8, exposure data should be entered as a blank cell if the insurer was not actively writing business and there were zero exposures written/earned in that quarter. Exposure data should be entered as a zero cell if the insurer was actively writing business but there were zero exposures written/earned in that quarter. Entering exposure data in this way ensures that the premium and loss trend calculations are performed correctly.

D. Required Exhibits

The following is a summary of exhibits that **must** accompany the Application to support the figures applied in Page 6 of the Rate Template. Indicate the appropriate exhibit number in the upper right-hand corner of the page. In addition, number the pages in each exhibit in

consecutive order. If the exhibit is not applicable, explain why. Exhibits 5, 7 and 8 must be completed using the Standard Exhibits Template. In addition, insurers must submit Exhibits 2, 3, 4, 6, 9, 10, 11, 12, 14, 15, 19, 20 and 21 in both working Excel (with formulas intact) and PDF (with searchable text) format.

Exhibit 1 - Filing History

Provide a list of all previously approved Department (CDI) file numbers for rate, rule, new program or form filings that have been submitted for this line, subline, and program within the last three years. If there have been no rate filings in the last three years, provide the file number of the last approved rate filing. In addition, provide the CDI file number for the initial new program application associated with the introduction of this program. If this initial CDI file number cannot be provided, explain why in Exhibit 1.

Provide a list of all previously approved Department (CDI) file numbers for any models that have been submitted for this line, subline, and program. Include new model submissions and revisions/refreshes to existing model submissions. See "Section VI. Completing the Application, Application Page 12 - Model Disclosure" for definitions of each of these model types.

Exhibit 2 - Rate Level History

List all of the approved rate level changes required to bring premiums to the current rate level on Standard Exhibits Template Page 2 - Exhibit 5. For example, for policies with an annual policy term, provide the last eight years of approved rate level history per coverage affected by this filing. Provide the CDI file numbers and effective date associated with each rate change. The following is an example of the rate changes for private passenger auto liability:

CDI File #	Effective Date	BI	PD	MP	UM	Combined
24-XXXX	MM-DD-2024	+10.0	-5.0	+1.0	+4.0	+8.0
22-XXXX	MM-DD-2022	+5.0	0.0	0.0	0.0	+4.0
19-XXXX	MM-DD-2019	- 5.0	+2.0	0.0	0.0	-4.0
17-XXXX	MM-DD-201l7	- 5.0	-2.0	+5.0	0.0	-4.8

Exhibit 3 - Policy Term Distribution

List the policy term options that are available and provide the percentage of business written in each option.

Exhibit 4 - Premium Adjustment Factor

From the rate level changes in Exhibit 2 - *Rate Level History*, show how the premium adjustment factors were derived to bring premiums on Standard Exhibits Template Page 2 - Exhibit 5 to the current rate level. If premium adjustment factors are calculated in a different manner than the parallelogram method explain any differences in factors greater than 1%. These premium adjustment factors must reconcile with the premium adjustment factors on Page 6, line 3 of the Rate Template.

Exhibit 5 - Premium Trend Factor

Refer to instructions on the completion of the Standard Exhibits Template for premium trend, in Section VI. C. above.

Exhibit 6 - Miscellaneous Fees and Other Charges

Provide the total amount of fees and other charges identified on Page 8 of the Application for each year in the recorded period. These fees include but are not limited to: policy fees, installment fees (fixed dollar), fixed expense fees, endorsement fees, inspection fees, cancellation fees, reinstatement fees, late fees, SR-22 fees, and other similar fixed dollar charges.

The amount of fees and other charges reported should derive from the total of all charges for these individual policy transactions. These reported fees should not be reduced by any corresponding expenses.

The reported total fees and other charges should be included on Page 6 of the Rate Template, line 5 - miscellaneous fees and other charges.

If there are changes to fees between the recorded period and the proposed rating period, fees entered on Page 6, line 5 of the Rate Template, must be at the current fee level. Exhibit 6 must show the actual historic fees and the adjustment to the current level.

Exhibit 7 - Loss and Defense and Cost Containment Expense (DCCE) Development Factors

Refer to instructions on the completion of the Standard Exhibits Template for loss and DCCE development, in Section VI. C. above.

Exhibit 8 - Loss and DCCE Trend

Refer to instructions on the completion of the Standard Exhibits Template for loss and DCCE trend, in Section VI. C. above.

Exhibit 9 - Catastrophe Adjustment

Pursuant to CCR §2644.5, support the catastrophe adjustment factors that are shown on Page 6, line 13 of the Rate Template. This exhibit must include each of the following:

- The insurer's full history of actual California catastrophe and non-catastrophe loss experience, net of actual and expected subrogation recoveries[6], available for the coverage;
- The insurer's full history of actual subrogation recoveries[6] and expected subrogation recoveries[6], shown separately;
- A demonstration of how the loading was derived;
- The definition of catastrophic loss;
- The total outstanding catastrophe reserves, including any bulk or IBNR reserves; and
- The name and dates of any major event or events contributing to the year's catastrophic losses (e.g., Cedar Fire) and the peril or perils associated with those losses.

For homeowners, no less than twenty years may be used. For private passenger auto physical damage, no less than ten years may be used. There shall be no catastrophe adjustment for private passenger auto liability.

Additionally, CCR §2644.5 permits the use of one or more catastrophe models for fire following earthquake, wildfire, and terrorism exposures in any line of insurance. Model information and data may be reviewed outside of the complete rate application process in a pre-application required information determination (PRID) procedure created under CCR §2648.5, where the Model Advisor will issue an initial determination as to what model information must be submitted as part of a complete rate application relying upon a model.

- If a rate application is submitted with a PRID, insurers must submit all information and data regarding a model specified in the PRID.

- If a rate application includes catastrophe model(s) without a PRID, insurers must submit a completed Wildfire Catastrophe Model Checklist in its entirety including the signed Expert Certifications (Form G-1 through G-7), the appendix of preliminary test cases and the "Disclosures for End-Users' Use of Wildfire Catastrophe Models" section.

[6] Subrogation recoveries also includes the proceeds from any sale or divestiture of subrogation rights.

- If a rate application includes model(s) pending PRID procedure review, the rate application will be considered incomplete until the PRID for the model(s) is available and submitted with the rate application.

Exhibit 10 – Credibility Adjustment

Experience Credibility

A credibility adjustment is necessary if the data in the three-year recorded period is less than fully credible. In the event the data is fully credible with *fewer* than three years of experience, only as many years as needed to be fully credible shall be used as the recorded period. If the data in the three-year recorded period has less than 25% credibility, up to three additional years shall be added to the recorded period until the data is at least 25% credible. Refer to CCR §2642.6. If after six years, the data remains less than 25% credible, alternative complementary loss and DCCE may be used, provided that the alternative is the most actuarially sound method. Refer to CCR §2644.23(i).

Pursuant to CCR §2644.23, if the data is not 100% credible, indicate how the loss and DCCE credibility factor on Page 6, line 14 of the Rate Template was determined. Provide the credibility formula or table that was used to derive the factor.

If alternative loss and DCCE are used as permitted by CCR §2644.23(i), then the credibility weighted projected ultimate loss and DCCE should be entered on Page 6, lines 7 and 8 of the Rate Template. Enter a factor of 1.00 for all loss and DCCE development, trend and catastrophe adjustment on lines 9 through 13, and enter 100% for credibility in line 14.

Detailed data and calculations supporting the development of the credibility-weighted projected ultimate loss and DCCE should be provided within the corresponding exhibits.

The full credibility standard is 3,000 claims for each homeowners form and for each coverage for private passenger auto. The calculation for partial credibility is the square root of the ratio of the actual number of incurred claims[7] in the recorded period divided by the full credibility standard. For other lines of insurance, the standard for full and partial credibility shall be calculated using the most actuarially sound method.

For lines of insurance other than homeowners and private passenger auto, the standard for full credibility shall be determined using the most actuarially sound method. Insurers must

[7] Incurred claims are defined as reported claims less claims closed without payment.

provide the credibility standard used, its derivation, if applicable, and justification why it is the most actuarially sound.

Insurers must provide and explain the source of the data used to calculate the credibility of the data, including the type of data used to determine the credibility of the data (reported claim count, incurred claim count, exposures, etc.) and how this data reconciles to the data in the Rate Template and Standard Exhibits.

Loss Trend Credibility

The standard for full credibility for loss trend shall be 6,000 total claims over the data period selected for each form for homeowners and each coverage for private passenger auto. For example, if the rolling 4-quarter data period selected for loss (and premium) trend is 12points, the loss trend credibility will be based on the total claim count for the 15 quarters used to calculate the 12-point rolling 4-quarter trend.

For lines of insurance other than homeowners and private passenger auto, the standard for full credibility for loss trend shall be determined using the most actuarially sound method. Insurers must provide the credibility standard used, including its derivation and justification why it is the most actuarially sound.

Insurers must provide and explain the source of the data used to calculate the credibility of the data, including the type of data used to determine the credibility of the data (reported claim count, incurred claim count, exposures, etc.) and how this data reconciles to the data in the Rate Template and Standard Exhibits.

For all lines of insurance other than private passenger auto, the complement of credibility for loss trend shall be determined using the most actuarially sound method; for private passenger auto, refer to CCR §2644.7(d).

Exhibit 11 – Ancillary Income

Provide the breakdown of the ancillary income by transaction type for each year in the recorded period. Ancillary income is defined as income that was derived from operations directly related to insurance (NSF fees, premium finance revenues, installment finance charges (expressed in terms of % APR) and membership dues) but not insurance premium. **Expenses** associated with collecting ancillary income **must not be deducted** from the ancillary income. The total ancillary income must be shown on Page 6, line 15 of the Rate Template.

Exhibit 12 – Reinsurance Premium and Recoverables

For medical malpractice with facultative reinsurance attachment points above $1 million and for earthquake coverage where the cost of reinsurance is included in the rate development, provide the basis for the reinsurance premium and recoverables data entered on Page 6 of

the Rate Template for each year of the recorded period. Provide the average direct commission rate on premiums subject to these reinsurance agreements. *[Note: Rows for reinsurance information are hidden at the bottom of the Page 6 of the Rate Template unless "Earthquake w/consideration for cost of reinsurance" or one of the "Medical Malpractice" options indicating "incl. reinsurance costs" is selected as the Detailed Line Description from the pull-down menus on Page 1 of the Rate Template.]*

Copies of the reinsurance agreements must be provided. The reinsurance premium must be net of ceded and contingent commissions.

Ratemaking for all lines other than earthquake and medical malpractice must be on a direct basis, with no consideration for the cost or benefits of reinsurance.

Exhibit 13 – Variance Request

This exhibit must identify, support and explain the bases for variance according to CCR §2644.27, Variance Request. When a variance is requested, Page 11 of the Application must be completed and all information pertaining to the variance must be shown and fully supported within this exhibit. Specifically, all variance filings shall:

- Identify each and every variance request;
- Identify the extent or amount of the variance requested and the applicable component of the ratemaking formula;
- Set forth the expected results 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
- 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.

Exhibit 14 – Rate Distribution

Provide the overall proposed rate impact of the Application, and demonstrate how that impact is distributed between the base rate (including by peril), fixed premium (whether derived from fixed expenses or flat dollar optional coverages), variable premium, rate classification relativity changes etc. Display this information separately for the total insurer group and for each of its affiliated companies, as well as for each program, subline, coverage or policy form.

Support for any rate relativity changes should be provided in Exhibit 15. The rate impact due to changes in rate classification relativities, if any, shown in Exhibit 14 should reconcile with Exhibit 15.

Exhibit 15 – Rate Classification Relativities

Provide actuarial support for the changes in all rate classification relativities shown in Exhibit 14. The support must include the current, indicated and proposed relativities. Display this information separately for the total insurer group and for each of its affiliated companies, as well as for each program, subline, coverage or policy form.

If the insurer submits a univariate analysis in support of its rate classification relativity changes, the insurer must include a description of how any potential correlations between rating variables have been addressed. In addition, the support must include exposure, premium, loss, and claim count data underlying the indicated relativities, as well as the credibility associated with each category, based on the credibility standard utilized. Justification for the credibility standard utilized must be provided in the Filing Memorandum.

If a model is being used to support the changes to the rate classification relativities, insurers must submit a completed model checklist (refer to section "II. G. Model Checklist"). If the insurer's *current* rating plan is based on the output of a predictive model, and changes to all or some of the rate classification relativities are being proposed without the support of a complete model refresh, the insurer must provide an explanation of how the insurer determined that its proposed selections do not compromise the integrity of the current rating plan.

[Note: Exhibit 15 applies to all lines other than private passenger auto. For private passenger auto, a separate classification plan filing must be submitted.]

For private passenger auto, refer to CIC §1861.02 and Title 10, Chapter 5, Subchapter 4.7 of the CCR, §2632.1 through §2632.16.

Exhibit 16 – New Program

Explain the source used to develop the rates for the new program (such as an affiliated company or unaffiliated company). For new programs that are based upon the loss costs of an Advisory Organization, indicate the edition date and the CDI file number of the loss costs that are adopted by the insurer. The most recently approved loss costs should be used; if not, explain the reason. Refer to additional instructions on Loss Cost Multiplier filings in Section VII.

Indicate whether the new program or a similar program has been written in any state by the insurer or an affiliated company; if the same or similar program has been written in California, provide the CDI file number. Explain the reason for the new program development and the relationship and/or differences between the proposed rates, coverage, and eligibility requirements to any similar existing program(s).

If an insurer intends to replace an existing program, or if any policyholders are to be renewed into a "replacement" program from an existing program, the Filing Type for this filing must be identified as a rate or transferred program filing and not as a new program filing.

Exhibit 17 - Super Group - Corporate Structure Verification Exhibit

This exhibit applies only to the private passenger auto line of insurance. "Super Group" is a Department term intended to apply to those insurers that have common ownership but whose California operations are separate in accordance with CIC §1861.16(c). Each insurer issuing a policy described in CIC §660(a) and asserting Super Group status must provide this exhibit to verify compliance with CIC §1861.16(c).

Each insurer group writing private passenger auto must comply with CIC §1861.16(b) unless the insurer group can demonstrate that CIC §1861.16(c) is applicable. If the insurer believes the Application qualifies for an exception under CIC §1861.16(c):

- Identify each insurer or group of insurers within the corporate structure that writes private passenger auto insurance in California with different rates and/or rating plans under CIC §1861.16(c) (commonly referred to as the "Super Group" exemption). Disregard rate differences due to group insurance plans pursuant to CIC §1861.12 (See "Section IV. Private Passenger Auto," above).
- Provide an organizational chart that illustrates the structure of every insurance company related to the applicant by common ownership and offering private passenger auto insurance in California. This chart must include:
    - The name and position of each member of the executive staff of the entire group organization, and
    - The name and position of each president and other department directors and officers of **each** insurance company within the Super Group.
- Clearly explain how the sales, marketing, and policy service operations are completely separate among each insurer group/company operating autonomously under CIC §1861.16(c) (A through H), demonstrating how the insurers satisfy each of the following conditions:
    - The business operations of the insurers are independently managed and directed.
    - The insurers do not jointly develop loss or expense statistics or other data used in the ratemaking, or in the preparation of rating systems or rate filings.
    - The insurers do not jointly maintain or share loss or expense statistics, or other data used in ratemaking or in the preparation of rating systems or rate filings. This condition shall not apply if the data is generally available to the industry through a nonaffiliated third party and is obtained from that third party.

- The insurers do not utilize each others' marketing, sales or underwriting data.
- The insurers act independently of each other in determining, filing, and applying base rates, factors, class plans, and underwriting rules, and in the making of insurance policy forms.
- The insurers' sales operations are separate.
- The insurers' marketing operations are separate.
- ○ The insurers' policy service operations are separate.

Additionally, provide the locations of the sales, marketing and policy service operations.

Exhibit 18 – Rules and Eligibility Guidelines

Provide the information requested in Page 10 of the Application according to the type of rule change requested: introducing a new rule, revising an existing rule, adopting an Advisory Organization rule, or withdrawing an approved rule. For each rule type, this exhibit must include the rate impact to the current book of business. Detail showing the support and justification for the associated premium charge, rate and/or premium development method must also be provided.

Note that a complete copy of the rate manual and eligibility guidelines must be submitted with ***all rate, rule, transferred and new program filings***.

See the *Questionnaire for Homeowners or Residential Property* as posted on the Department's public website and on SERFF for additional information required in Exhibit 18 for homeowners and residential property lines.

Exhibit 19 – Supplemental Information

This exhibit may be used to provide supplemental information that is not specific to any of the above listed exhibits.

Exhibit 20 - Customer Dislocation

Insurers must submit tables in Exhibit 20 displaying customer dislocation in increments of 5%[8] for all filings proposing a change of any type that results in a rate adjustment to any individual

[8] Insurers shall not provide increment groups that span more than 5%. Rather, there should be as many 5% groupings as needed to capture all customer dislocation detail up to the maximum rate change impact. For example, if the maximum customer rate change is 63%, there should be 5% increment groups up to 65%. Grouping customer dislocation above or below a certain percentage is not allowable (i.e., greater than x% or lower than -x%).

customer. For private passenger auto, homeowners lines and other residential property lines, include a profile of the risk characteristics of customers receiving rate increases in excess of 25%.

In addition to the standard customer dislocation tables, insurers submitting rate applications for homeowners, residential property, commercial property, commercial fire, and farm owners lines of business must submit additional tables showing the number of policies and the average % and $ rate impact by ZIP code (see sample table below).

ZIP Code	Number of Policies	Average $ Rate Impact	Average % Rate Impact	Max $ Impact
90001				
90002				
Total				

For the homeowners line, this information shall be provided separately by policy form. See the *Questionnaire for Homeowners or Residential Property* as posted on the Department's public website and on SERFF for additional information required in Exhibit 20 for homeowners and residential property lines.

Provide the evaluation date, including current premiums, proposed premiums, and total policy count as instructed.

The Department may require a more granular customer dislocation exhibit after review of the submitted information.

Exhibit 21 - Insurer's Ratemaking Calculations for Specialty Filings

Provide the development of the insurer's calculations of the indicated rate change and the proposed overall rate change for specialty rate filings. If the components in this exhibit do not reconcile with Page 6 of the Rate Template, provide a full explanation. For a complete definition of specialty insurance, refer to CCR §2642.7(d).

VII. Loss Cost Multiplier Filing Instructions

For every filed line/coverage, form or program using a Loss Cost Multiplier, Page 8 of the Rate Template, the **Loss Cost Multiplier Calculation** ("LCM Calculation") must be completed and filed in conjunction with the Application. Examples of such filings include new or existing program rate filings that involve the adoption of Advisory Organization loss costs, and existing program rate filings where the current LCM is being revised.

The LCM Calculation page requires that the insurer provide the following information specific to the program under rate review:

A. New Program Filings

- The CDI file number associated with the approved Advisory Organization filing supporting the loss costs to be adopted. The most recently approved loss costs should be used; if they are not, explain the reason in the Filing Memorandum.
- The Adjusting & Other Expense (AOE) or LAE load as filed by the Advisory Organization.
- The basis of the AOE or LAE load filed by the Advisory Organization.

The AOE or LAE load filed by the Advisory Organization is converted to an AOE load as a percent of loss and DCCE. This load is applied to the company's projected credibility-weighted loss and DCCE per exposure to calculate the projected credibility-weighted loss and LAE per exposure. The LCM Calculation derives the maximum permitted LCM for the filed line/coverage based on this resulting projected credibility-weighted loss and LAE per exposure and the maximum premium calculated in the corresponding Rate Calculation page (Page 7 of the Rate Template).

B. Existing Program Filings

- The CDI file number associated with the Advisory Organization filing supporting the company's current loss costs.
- The current company LCM. This figure is the company's final LCM adjusted for any loss cost modification, if applicable.
- The CDI file number(s) associated with **all** changes to Advisory Organization loss costs since the filing underlying the company's current loss costs, separated by commas.
- The cumulative percent change in loss costs identified in the CDI file number(s) listed above. If multiple Advisory Organization loss cost filings have been approved between the filing underlying the company's current loss costs and the filing underlying the loss costs to be adopted, the percent change entered must be the cumulative impact of all such filings. For instance, if the percent changes approved in the last two Advisory Organization filings were 5.00% and 3.00%, the cumulative impact of those two filings is 8.15%.
- The cumulative percentage change in loss costs associated with the CDI file number(s) listed above, *adjusted for the company's own distribution*. For instance, if the 5.00% approved Advisory Organization change from above is based on two classes of equal premium volume receiving 2.00% and 8.00% changes, respectively, and the company writes only the first class of business, that particular Advisory Organization change adjusted for the company's distribution is 2.00%. All changes must be similarly adjusted.

- The rate impact to the insurer's book from changes other than updating the loss cost or loss cost multiplier. Provide the rate impact of these changes in Exhibit 14 and the details of these changes in Exhibit 15.
- The proposed company LCM.

Page 8 of the Rate Template calculates the maximum permitted LCM for the filed line/coverage, form or program based on the company's current LCM and the company adjusted cumulative percentage changes in loss costs approved in the line/coverage, form or program subject to the maximum permitted earned premium calculated in the corresponding Rate Calculation page (Page 7). This maximum permitted LCM must also be adjusted to consider any other rate impacts to the insurer's book from changes other than updating the loss cost or loss cost multiplier.

Companies with separate LCMs by program/tier that are not accompanied by separate Rate Calculation pages shall compare the proposed weighted average LCM of all programs/tiers within the filed line/coverage, form or program to the aggregate maximum permitted LCM for that line/coverage, form or program. For instance, a company submitting a Rate Template for commercial multiple peril non-liability/liability combined shall only complete one Rate Calculation page and its corresponding LCM Calculation page. However, the company may maintain separate LCMs for non-liability and liability. In this case, the two current LCMs shall be weighted and input into the single LCM Calculation page. The proposed separate LCMs, when weighted, shall be evaluated relative to the maximum permitted LCM generated from the combined LCM Calculation page. Provide justification for the selected weights used in calculating both the current and proposed weighted average LCM.

END OF INSTRUCTIONS