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

PROPOSED TEXT OF REGULATION

CATASTROPHE MODELING AND RATEMAKING

August 16, 2024 **REG-2023-00010**

Title 10. Investment
Chapter 5. Insurance Commissioner
Subchapter 4.8 Review of Rates
Article 4. Determination of Reasonable Rates

Amend Section 2644.4. Projected Losses.

(a) Unless projected losses are based on catastrophe models as permitted pursuant to subdivision (d) of this Section 2644.4, ~~P~~projected losses means the insurer's historic noncatastrophe losses per exposure, adjusted by catastrophe adjustment, as prescribed in ~~s~~Section 2644.5, by loss development, as prescribed in ~~s~~Section 2644.6, and by loss trend, as prescribed in Section 2644.7.

(b) Projected losses shall be calculated by applying the loss development and loss trend factor separately to data from each accident ~~-~~year, report year or policy year, as applicable, in the recorded period.

(1) For occurrence policies, projected losses shall be calculated on an accident-year basis. ~~However,~~

(2) ~~f~~For claims-made policies, projected losses shall be calculated on a report-year basis.

(3~~c~~) For mechanical breakdown and similar insurance as defined in subdivision (b) of Section 2642.7~~policies providing multi-year coverage, such as mechanical breakdown~~, projected losses may be calculated on a policy-year basis.

(c~~d~~) For professional liability and errors and omissions coverage, the insurer shall, in lieu of the computation of projected losses specified in ~~s~~Sections 2644.5 through 2644.7, tender an alternative computation of projected losses, which the Commissioner shall approve if the Commissioner finds the projection to have been made in the most actuarially sound ~~actuarial~~ manner. ~~Nothing in this section precludes the Commissioner from requiring the additional filing of~~The insurer shall also provide projected losses computed in the manner specified in ~~s~~Sections 2644.5 through 2644.7 and in any other manner as may be required by the Commissioner.

(d) For the earthquake, flood, or any other line of insurance for which projected losses are permitted to be modeled pursuant to subdivision (c) of Section 2644.4.5, projected losses may be based on catastrophe models.

~~(e) For the earthquake line of business and for the fire following earthquake exposure in other lines, projected losses and defense and cost containment expenses may be based on complex catastrophe models using geological and structural engineering science and insurance claim expertise. The use of such models shall conform to the standards of practice as set forth by the Actuarial Standards Board and the applicant shall have the burden of proving, by a preponderance of the evidence, that the model is based upon the best available scientific information for assessing earthquake frequency, severity, damage and loss, and that the projected losses derived from the model meet all applicable statutory standards.~~

Adopt Section 2644.4.5. Use of Catastrophe Models.

(a) Permitted uses.

(1) For the earthquake and flood lines, projected annual aggregate losses may be based on catastrophe models.

(2) The catastrophe adjustment for the fire following earthquake exposure, and for terrorism exposure, in lines other than earthquake and flood may be based on projected annual aggregate losses derived from catastrophe models.

(b) Wildfire exposure.

The catastrophe adjustment for wildfire exposure in lines of insurance other than earthquake and flood may be based on catastrophe models, provided that the insurer complies with Section 2644.4.8.

(c) Additional lines or exposures.

(1) In addition to the permissible uses of catastrophe models specified in subdivisions (a) and (b) of this Section 2644.4.5, at the Commissioner's discretion, models may be used in cases where limited historic insurance data is available:

(A) To project annual aggregate losses in lines of insurance other than those specified in subdivision (a)(1) of this section, or

(B) To determine the catastrophe adjustment for exposures to perils other than those specified in subdivision (a)(2) or (b) of this section.

(2) The Commissioner may allow modeling for such additional lines or exposures only if, taking into account the circumstances under which, and the conditions pursuant to which, modeling for the additional line or coverage in question is to be permitted, it is in the Commissioner's judgment reasonably foreseeable that permitting modeling would serve two or more of the following purposes of Proposition 103:

(A) Protecting consumers from arbitrary insurance rates and practices.

(B) Encouraging a competitive insurance marketplace.

(C) Ensuring that insurance is fair, available and affordable to all Californians.

(3) In the event the requirement of subdivision (c)(2) of this section is satisfied, the Commissioner's decision as to whether to allow modeling for additional lines or exposures shall be based upon the following factors:

(A) The degree to which the peril is an emerging or a newly recognized peril for ratemaking purposes.

(B) The degree to which a model is likely to be reliable for ratemaking purposes.

(C) The extent to which any historical insurance data is unavailable.

(D) The degree to which available historical insurance data is not predictive of future costs.

(d) Under no circumstances, however, will modeling be permitted for the reason that an individual company lacks data that is otherwise available.

(e) Catastrophe models shall be run on the insurer's in-force business as of the end of the most recent year in the recorded period.

(f) The use of catastrophe models shall conform to the standards of practice as set forth by the Actuarial Standards Board, and the applicant shall have the burden of demonstrating that

(1) the model is based upon what in the Commissioner's assessment is the best available scientific information for assessing frequency, severity, damage and loss,

(2) the applicant's use of its selected model(s) produces the most actuarially sound estimate of projected catastrophe losses,

(3) the projected losses derived from the model meet all applicable statutory, regulatory and other legal standards, and

(4) the model incorporates what in the Commissioner's assessment is the best available scientific information on risk mitigation at the property, community, and landscape scales including, but not limited to forest management, prescribed fire, and risk mitigation initiated by local and regional utility companies.

(g) This section is hereby expressly included within the range of regulations sections specified in subdivision (a) of Section 2648.4, notwithstanding that this section's adoption is subsequent in time to the adoption of, or the effectiveness of any amendments to, Section 2648.4.

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

Adopt Section 2644.4.8. Distressed Areas; Insurer Commitments.

An insurer that opts to make, fulfill and document the fulfillment of its insurer commitments in the manner specified in this Section 2644.4.8 may use catastrophe modeling as permitted by Section 2644.4.5 for purposes of modeling the catastrophe adjustment for wildfire exposure for commercial property insurance and qualifying residential property insurance.

As used in this section, the term "qualifying residential property insurance" shall mean a policy of residential property insurance as defined in Insurance Code section 10087, except that renter's insurance policies do not fall within the meaning of qualifying residential property insurance. Additionally, an HO-6 policy, or its equivalent, is not included within the meaning of qualifying residential property insurance.

(a) Distressed areas, and properties insured by FAIR Plan policies, that are to be used in insurer commitments.

(1) Distressed areas.

For purposes of this section distressed areas shall include the following:

(A) Undermarketed ZIP Codes.

The Commissioner shall publish an initial bulletin containing a list of the Undermarketed ZIP Codes determined pursuant to this subdivision (a)(1)(A). The Commissioner shall by subsequent bulletins update the list of Undermarketed ZIP Codes from time to time as conditions warrant, but in any event no less frequently than once per year. For purposes of this section, an Undermarketed ZIP Code shall mean a ZIP Code, as determined by the Commissioner, which at least partially overlaps a high

or very high fire hazard severity zone as shown on current maps published by the Department of Forestry and Fire Protection (Cal Fire) and in which ZIP Code either:

1. At least fifteen percent (15%) of the sum of the following are insured by the FAIR Plan:

a. The number of residential properties in the ZIP Code that are insured by the FAIR Plan, and

b. The number of residential properties in the ZIP Code that are insured in the voluntary market by admitted insurers under a policy of qualifying residential property insurance; or

2. The average premium per $1,000.00 of Coverage A in the ZIP Code is at least four dollars ($4.00) while the median income of the ZIP Code is no higher than the fiftieth (50th) percentile for California.

(B) Distressed counties.

The Commissioner shall publish an initial bulletin containing a list of the distressed counties determined pursuant to this subdivision (a)(1)(B). The Commissioner shall by subsequent bulletins update the list of distressed counties from time to time as conditions warrant, but in any event no less frequently than once per year. For purposes of this section, a county shall be a distressed county if the percentage of structures situated in that county that are at high or very high wildfire risk is no lower than the 50th percentile of counties in the state, as determined by the Commissioner.

(2) Properties insured by the FAIR Plan exposed to wildfire risk.
Policies insuring properties that the insurer has classified as moderate to very high wildfire risk and that immediately prior to the insurer's insuring them, on a date subsequent to the approval of its rate application described in subdivision (c) of this section, had been covered under the FAIR Plan.

(b) Statewide market calculations.

(1) Calculation of statewide market share.

For purposes of this section the Department will calculate an estimate of the number of earned exposures of qualifying residential property insurance statewide based on the most recent experience year reported to the Department, such initial

evaluation period ending on December 31, 2023, which figure shall be used as the denominator in the calculation of statewide market share for each insurer. The Commissioner shall publish a bulletin with the estimate of statewide earned exposures, no less frequently than once per year.

The numerator to be used in the calculation of each insurer's statewide market share shall be the number of earned exposures of qualifying residential property insurance policies in the most recent 12-month period used in its recorded period as submitted in the insurer's rate application pursuant to subdivision (c) of this section.

In order to calculate its statewide market share, the insurer shall divide its numerator by the denominator, each as described in this subdivision (b)(1), and the insurer's statewide market share shall be the resulting quotient, rounded to the thousandths place.

(2) Statewide distressed areas earned exposures.

For purposes of this section the Department will calculate an estimate of the total number of earned exposures of qualifying residential property insurance in both the voluntary market and the FAIR Plan inside the distressed areas of the state based on the most recent experience year/dataset reporting such relevant information to the Department, such initial evaluation period ending on December 31, 2023, which figure shall be used in the calculation of each insurer's residential commitment inside the distressed areas pursuant to subdivision (d) below. The Commissioner shall publish a bulletin that includes the estimate of statewide distressed areas earned exposures, no less frequently than once per year.

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

(d) Insurer commitments with respect to qualifying residential property insurance. The insurer shall commit in writing to achieving no later than two years (730 days) after the approval of its rate filing (the insurer's "performance date" hereinafter), or maintaining, the insurer's earned exposure commitment in the distressed areas of the state as follows:

(1) Eighty-five percent standard.

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

(B) In the event the insurer already meets or exceed the eighty-five percent standard set forth above in subdivision (d)(1)(A) of this section at the time

of its rate application, the insurer shall commit to maintaining at least the same number of earned exposures in the distressed areas as it reported in the rate application filing pursuant to subdivision (c), for at least three years (1,095 days) after the approval of the rate application.

(2) Five percent increment.

The insurer may instead commit to writing additional policies as specified in subdivision (d)(3) in the voluntary market inside the distressed areas of the state such that, on the performance date, the insurer has increased its number of earned exposures inside the distressed areas by at least the number of policies equal to five percent (5%) of its earned exposures in the distressed areas of the state within the most recent 12 month period used in its recorded period as submitted in the insurer's rate application pursuant to subdivision (c) of the section.

(3) In the event that one or more of the bulletins described in subdivision (a) of this section that is or are referred to in an insurer's approved rate application pursuant to subdivision (c) of this section (the insurer's "starting bulletin or bulletins" hereinafter) have been updated since the time the application was filed, then the insurer may satisfy its insurer commitment by:

(A) Writing policies in distressed areas as defined in the insurer's starting bulletin or bulletins and/or in any subsequently updated bulletin as the commissioner may publish from time to time; or

(B) If subdivision (d)(1)(B) of this section is applicable to the rate application, maintaining earned exposures in distressed areas as defined in the insurer's starting bulletin or bulletins and/or in any subsequently updated bulletin as the commissioner may publish from time to time.

(4) The additional policies written in order to satisfy the requirement of this subdivision (d) shall include only the following:

(A) Policies of qualifying residential property insurance insuring properties in distressed areas of the state; and/or

(B) Policies of qualifying residential property insurance insuring properties that the insurer has classified as moderate to very high wildfire risk and that immediately prior to the insurer's insuring them, on a date subsequent to the approval of its rate application described in subdivision (c) of this section, had been covered under the FAIR Plan.

An insurer may count a policy described in this subdivision (d)(3)(B) as insuring a property within the distressed areas of the state for purposes of fulfilling its insurer commitment, any contrary provision of this section notwithstanding.

(e) Low-premium-volume insurers.

(1) An insurer whose direct California annual premium from qualifying residential property insurance policies is less than $10 million may comply with this section without making an insurer commitment pursuant to subdivision (d) of this section, until such time as subdivision (e)(2) is applicable to the insurer.

(2) No later than March 31 of the calendar year immediately following the calendar year during which an insurer described in subdivision (e)(1) of this section determines that it has met or exceeded $10 million of direct California annual premium from qualifying residential property insurance policies, the insurer shall submit a rate application as described in subdivision (c) of this section, which application contains an insurer commitment that conforms to subdivision (d) of this section.

(3) An insurer described in subdivision (e)(1) of this section shall calculate its direct California annual premium from qualifying residential property insurance policies annually.

(f) Insurer commitments with respect to commercial property insurance.

(1) For purposes of this subdivision (f), eligible ZIP Codes shall include all ZIP Codes in the state that at least partially overlap a high or very high fire hazard severity zone, as shown on the most current map published by Cal Fire. The Commissioner shall publish an initial bulletin containing a list of the eligible ZIP Codes determined pursuant to this subdivision (f)(1). The Commissioner shall by subsequent bulletins update the list of eligible ZIP Codes from time to time as conditions warrant.

(2) Insured exposure requirement. At the time of an insurer's first rate application filing subsequent to the effective date of this section, the insurer must commit in writing to increase its writing of policies in the eligible ZIP codes equivalent to five percent (5%) of its total insurable value in eligible ZIP codes as of the end of the most recent 12-month period used in its recorded period, no later than two years (730 days) after the approval of the rate filing in which the insurer includes its insurer commitment.

(3) In the event that the bulletin described in subdivision (f)(1) of this section that is referred to in an insurer's approved rate application pursuant to subdivision (f)(2) of this section (the insurer's "initial bulletin" hereinafter) has been updated since the time the application was filed, then the insurer may satisfy its insurer commitment by writing policies in eligible ZIP Codes as defined in the insurer's initial bulletin and/or in any subsequently updated bulletin as the commissioner may publish from time to time pursuant to subdivision (f)(1).

(4) In the event the insurer is unable to timely meet the requirement in (f)(2), the insurer shall file a new application pursuant to subdivision (h)(1)(C), if applicable, or subdivision (h)(2), of this section.

(g) Documenting the insurer's fulfilment of its insurer commitment.

The insurer shall create and maintain a wildfire risk portfolio. An insured property shall be added to the insurer's wildfire risk portfolio at the time the location and, if applicable, prior FAIR Plan coverage status of the insured property are fully documented pursuant to the provisions of this subdivision (g).

(1) For qualified residential insurer commitment.

(A) In addition to the material called for in subdivision (g)(3) below that is applicable to any property in its wildfire risk portfolio, the insurer shall maintain and keep current a document entitled "Wildfire Risk Portfolio Register," which shall list, for each property added to the portfolio, the following information: the date the property was added to the portfolio; the address of the property, including the ZIP Code; if the property is being added to the portfolio solely on the basis that it lies within a distressed county but not any Undermarketed ZIP Code, the county in which the property is situated; the inception date of the policy; the termination date of the policy, if the policy has terminated; and if the property is being added to the portfolio on the basis of subdivision (g)(1)(B), below, an identification of the insurer's documentation of the property's prior FAIR Plan coverage.

(B) To document that the FAIR Plan was insuring the property in question immediately prior to the inception, on or after the effective date of this section, of a policy insuring that property that is issued by the insurer seeking to add the property to its portfolio after such effective date, the insurer shall have on file:

1. A carrier discovery report or

2. Other documentation demonstrating that the property had been insured under the FAIR plan immediately preceding the date the insurer issues its policy. Such documentation may include (1) copies of declaration pages from the FAIR Plan, (2) a subscribing loss underwriting exchange report and/or (3) an electronic copy of the entire application completed by the insured and submitted to the insurer, on which application the insured has identified the prior insurer as the FAIR Plan.

(2) For commercial insurer commitment. In addition to the material called for in subdivisions (g)(3) below that is applicable to any property in its wildfire risk portfolio, the insurer shall maintain and keep current a document entitled "Wildfire Risk Portfolio Register," which shall list, for each property added to the portfolio, the following information: the date the property was added to the portfolio; the address of the property, including the ZIP Code; the total number of exposures insured under each policy; the inception date of the policy; the property's total insurable value, and the termination date of the policy, if the policy has terminated.

(3) For both qualified residential insurer commitment and commercial insurer commitment.

(A) The Wildfire Risk Portfolio Register shall be maintained as a digital file that is sortable by all fields.

(B) The insurer shall maintain a digital file for each insured property added to its wildfire risk portfolio, in which file shall be stored an electronic copy of each record necessary for purposes of supporting the property's status of lying within a distressed area of the state for purposes of satisfying the insurer's insurer commitment.

(C) The insurer shall maintain its Wildfire Risk Portfolio Register, as well as the digital file described in subdivision (g)(3)(B) of this section for each property added to its wildfire risk portfolio, until such time as at least five years (1,825 days) have passed since:

1. The date that is two years (730 days) following the approval of the insurer's rate application pursuant to subdivision (c) of this section, in the event that subdivision (d)(1)(A), (d)(2) or (f)(2) of this section is applicable;

2. The date that is three years (1,095 days) following the approval of the insurer's rate application pursuant to subdivision (d) of this section, in the event that subdivision (d)(1)(B) of this section is applicable;

3. The date by which the insurer has committed to fulfill or complete the fulfilment of its alternative commitment, in the event that subdivision (j) of this section is applicable; or

4. The date of the approval of the insurer's rate application renouncing the insurer's insurer commitment, in the event that subdivision (h)(2) of this section is applicable.

(h) Modification of, or failure to fulfill, insurer commitment.

(1) Modification when insurer loses significant market share.

(A) Residential insurers whose insurer commitment stated in the original rate application filing included an undertaking to write additional policies in distressed areas.

In the event that, subsequent to approval of its rate application described in subdivision (c) of this section (hereinafter, the "original application"), an insurer files a new rate application in which the insurer recalculates its insurer commitment as specified in subdivision (d) of this section on the basis that the insurer's statewide market share as calculated pursuant to subdivision (b)(1) of this section is at least five percent (5%) lower than was used for purposes of calculating the insurer commitment contained in the insurer's original rate application, then the new rate application may contain a modified insurer commitment pursuant to subdivision (d) of this section that reflects the recalculated insurer commitment, which insurer commitment shall become effective if and when the new rate application is approved.

(B) Residential insurers whose performance met or exceeded the applicable standard or requirement at the time of initial rate application filing.

An insurer may modify its insurer commitment that was made pursuant to subdivision (d)(1)(B) of this section as follows: The insurer may reduce its earned exposures in distressed areas of the state by up to five percent (5%) below the level reported in the original application, to the extent that is indicated by the amount of the diminution of the insurer's statewide market share, but in no event below the eighty-five percent standard set forth in subdivision (d)(1)(B) of this section

(C) Modification of commercial insurer commitments.

An insurer may modify its insurer commitment as follows: In the event the insurer is unable to timely meet the requirement in (f)(2), the insurer shall file a new application in which it modifies its insurer commitment accordingly. The insurer may reduce its insurer commitment in eligible ZIP Codes of the state by no more than the decline in its total insurable value reported in the original rate application filing.

(2) Failure to fulfill an insurer commitment.

If at any time an insurer fails to fulfill its insurer commitment, or within a period of two years after the approval of its original application, or at any point

thereafter, fails to make reasonable progress toward timely fulfilling its insurer commitment, then the insurer shall immediately submit a new rate application renouncing its insurer commitment as described in subdivision (d) or (f) of this section. In this case the new rate application shall not make use of catastrophe modeling as permitted by Section 2644.4.5.

(i) Insurer Attestation.

An insurer that obtained approval to use catastrophe modeling in its original application shall file one of the following attestations in every subsequent rate application until such time as that insurer has attested that it has fulfilled its commitment:

(1) An attestation that the insurer has fulfilled, or is taking reasonable steps to fulfill, its insurer commitment.

(2) An attestation that the insurer's rate application modifying its insurer commitment pursuant to subdivision (h)(1) of this section has been approved and the insurer has fulfilled, or is taking reasonable steps to fulfill, its modified insurer commitment.

(j) Alternative Insurer Commitments.

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

(1) An insurer may propose an alternative commitment pursuant to this subdivision (j) on one or more of the following bases:

(A) its size,

(B) its scope of coverages, or

(C) the frequency or severity of recent events impacting the insurer.

(2) Such rate application filing shall include a statement:

(A) setting forth the reason why this subdivision (j) is applicable, and

(B) describing the proposed alternative commitment in sufficient detail to allow the Commissioner to evaluate whether the alternative increases availability of qualifying residential property insurance and/or commercial property insurance.

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

(l) If any provision or clause of this section or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of this section which can be given effect without the invalid provision or application. To this end, the provisions of this section are hereby declared to be severable.NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

Amend Section 2644.5. Catastrophe Adjustment.

In those insurance lines and coverages where catastrophes occur, the actual catastrophic losses of any one ~~accident~~ year in the recorded period are replaced by an adjustment based on the average annual loss generated from one or more catastrophe models as described in Section 2644.4.5, or an adjustment based on a multi-year, long-term average of catastrophe losses net of actual and anticipated salvage and subrogation recoveries, as described in subdivision (b) of this section, or except as prohibited in subdivision (e) of this section a combination of the methods specified in subdivisions (a) and (b).~~:~~

(a) For fire following earthquake, wildfire, and terrorism exposures in any line of insurance, an insurer may include an adjustment based on the average annual loss generated from one or more catastrophe models. The use of such models shall comply with the requirements set forth in subdivision (e) of Section 2644.4.5. Further, the average annual loss may be adjusted to include a provision for defense and cost containment expenses (DCCE), either by applying a historical ratio of noncatastrophe DCCE to noncatastrophe loss or by applying a historical ratio of catastrophe DCCE to catastrophe loss.

(b) In any event, an insurer may project its catastrophe adjustment~~loading~~ based on a multi-year, long-term average of catastrophe ~~claims~~losses and DCCE, net of actual and anticipated salvage and subrogation recoveries. Catastrophe adjustment for perils other than those that are permitted to be modeled under subdivision (a) of this section or pursuant to subdivision (c) of Section 2644.4.5 must be based on such multiyear long-term average.

(1) For residential and commercial property lines, the adjustment shall be based on the average of the ratio of ultimate catastrophe losses and DCCE to amount of insurance years (AIY). For purposes of this section, the term AIY shall reflect the total combined limits (dwelling, additional structures, personal contents and loss of use) pertaining to the property coverages underlying each policy. For private passenger and commercial automobile physical damage, the adjustment shall be

based on the average of the ratio of ultimate catastrophe losses and DCCE to ultimate noncatastrophe losses and DCCE.

(2) The number of years over which the average shall be calculated shall be at least 20 years for ~~homeowners multiple peril fire,~~residential and commercial property lines and at least 10 years for private passenger, and commercial, auto physical damage. Where the insurer does not have enough years of data, or has a limited amount of data for years for which it does have data, the insurer's data shall be supplemented by appropriate data for those years. The number of years over which the average shall be calculated for any other line with catastrophe exposure that is permitted under this subdivision (b) to have a catastrophe adjustment shall be based on the most actuarially sound assumptions. There shall be no catastrophe adjustment for private passenger, or commercial, auto liability.

(c) Regardless of which method is used for catastrophe adjustment, insurers shall submit all of the following, based on the data aggregation method used for the recorded period, whether the recorded period is expressed in terms of accident years, policy years or report years, through the most recent year of the recorded period:

(1) The insurer's history, by year, of California catastrophe losses, displayed separately for paid losses, case-incurred losses and Incurred But Not Reported (IBNR) reserves.

(2) The insurer's history, by year, of California noncatastrophe losses, displayed separately for paid losses, case-incurred losses and IBNR reserves.

(3) The insurer's history, by year, of California catastrophe Defense and Cost Containment Expenses (DCCE), displayed separately for paid DCCE, case-incurred DCCE and IBNR reserves.

(4) The insurer's history, by year, of California noncatastrophe DCCE, displayed separately for paid DCCE, case-incurred DCCE and IBNR reserves.

(5) The insurer's history, by year, of California received salvage and subrogation recoveries. Subrogation recoveries shall include the proceeds of any actual sale or divestiture of subrogation rights.

(6) The insurer's history, by year, of California anticipated salvage and subrogation recoverables. Subrogation recoverables shall include the reasonably foreseeable proceeds of any anticipated sale or divestiture of subrogation rights.

(7) The insurer's history, by year, of California AIY for residential and commercial property lines.

(8) For residential and commercial property lines, the insurer's projected AIY for the policy effective period. The trend factor that is used to project AIY shall be based

on the exponential curve of best fit. Insurers shall file the most recent 27 quarters of company-specific AIY and earned exposure data. The insurer shall file its rate change application using the single data period for AIY and, as specified in section 2644.7, premium and loss trend, which data period the insurer determines to be the most actuarially sound. The Commissioner may require the use of an alternative data period if the Commissioner determines that use of such alternative data period is the most actuarially sound approach.

(9) For private passenger and commercial auto physical damage, the insurer's projected ultimate noncatastrophe losses for the most recent year in the recorded period, as determined by the application of Sections 2644.6 and 2644.7.

(10) The insurer's current definition of catastrophe and the period of time it has used such definition.

(11) The insurer's definition of wildfire and the period of time it has used such definition.

(12) The name of any major event or events contributing to the year's catastrophic losses, for instance, the "Cedar Fire," and the peril or perils associated with those losses.

(d) The catastrophe adjustment shall reflect any changes between the insurer's historical and prospective exposure to catastrophe due to a change in ~~the~~:

(1) The insurer's coverage or other policy terms; or

(2) The insurer's mix of business. ~~There shall be no catastrophe adjustment for private passenger auto liability.~~

(e) For any individual peril, projected aggregate catastrophe losses cannot be based upon a combination of modeled and historical losses associated with that peril.

(f) Catastrophe adjustment, whether based on modeled or nonmodeled losses as prescribed by 2644.5(a) or (b) above, shall apply as a single annual projection once all other adjustments to loss have been made. The catastrophe adjustment shall be expressed as a dollar amount of catastrophe losses per earned exposure, where earned exposure is taken from the most recent year of the recorded period.

(g) For residential and commercial property lines, no trend shall be applied to the catastrophe adjustment except for the trend factor that is used to project AIY as described in subdivision (c)(8) of this section.

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

Amend Section 2644.8. Projected Defense and Cost Containment Expenses.

(a) The meaning of the term "~~P~~projected defense and cost containment expenses (DCCE)" ~~means~~includes both the company's noncatastrophe historic costs ~~per exposure~~ associated with the defense and cost containment of noncatastrophe claims, ~~adjusted for catastrophes,~~ developed and trended in the manner described in ~~s~~Sections ~~2644.5,~~ 2644.6 and 2644.7, and the company's costs associated with the defense and cost containment of catastrophe claims, as prescribed in Section 2644.5.

(1) DCCE associated with noncatastrophe losses shall be developed:

(A) separately from losses;

(B) with losses; or

(C) as a ratio to losses.

(2) DCCE associated with noncatastrophe losses shall be trended:

(A) separately from losses; or

(B) with losses.

(3) Any provision for DCCE associated with catastrophe losses shall be determined in accordance with subdivisions (a) and (b) of Section 2644.5.

(b) ~~Defense and cost containment expenses may be added to losses for loss development and trend or may be developed using ratios of defense and cost containment expenses to losses.~~ The insurer shall provide its data separately for loss and DCCE, and demonstrate that its selections of development and trend for DCCE ~~is~~are the most actuarially sound selections.

(c) The projected DCCE shall be reflected per exposure for purposes of subdivision (a)(1)(A) of Section 2644.2 and subdivision (a)(1)(A) of Section 2644.3.

(d~~c~~) For professional liability and errors and omissions coverage, the insurer shall tender an alternative computation of projected ~~defense and cost containment expenses~~DCCE, which the Commissioner shall approve if the Commissioner finds the projection to have been made in the most actuarially sound ~~actuarial~~ manner. The insurer shall also provide projected DCCE in a manner specified in subdivisions (a) through (c) of this Section 2644.8 and in any other manner as may be required by the Commissioner. ~~Nothing in this section precludes the Commissioner from requiring the additional filing of projected defense and cost containment expenses computed in the manner specified in sections (a) and (b).~~

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

Amend Section 2644.27. Variance Request.

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

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

(i) identify each and every variance request;

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

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

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

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

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

(i) a consumer or a consumer's representative requests a hearing within forty-five days of public notice and the Commissioner grants the hearing, or determines not to grant the hearing and issues written findings in support of that decision, or

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

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

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

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

(A) The insurer meeting the qualifications set forth below may obtain an increase in the applicable efficiency standard by the amount of its "Allocated Costs" for its Special Investigations Unit ("SIU") expense for the most recent year. The term SIU as used in this section has the same meaning as that term has in Section 2698.30, subdivision (p). The term "Allocated Costs" means those costs set forth in subsection (iii) and attributable to investigations of claims made on the line of insurance subject to Insurance Code section 1861.05, subdivision (b) for which the variance is sought.

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

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

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

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

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

are made and that the contracted agency investigates in California on behalf of the insurer seeking the variance.

(vi) No expense that is included within the Defense and Cost Containment Expense portion of an insurer's complete rate application can be included in whole or in part as the basis for a variance based on SIU expenses. The terms "Defense and Cost Containment Expense" or "DCCE" when used with regard to any variance have the same meaning as those terms have in Section 2644.23, subdivision (c).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) A plan to restore the financial condition;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(10~~9~~) That the maximum permitted earned premium would be confiscatory as applied. This is the constitutionally mandated variance articulated in *20th Century v. Garamendi* (1994) 8 Cal.4th 216 which is an end result test applied to the enterprise as a whole. Use of this variance requires a hearing pursuant to Section 2646.4.

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

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

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

Title 10. Investment
Chapter 5. Insurance Commissioner
Subchapter 4.8. Review of Rates
Article 8. Timelines for Scheduling and Commencing Hearings

Adopt: Section 2648.5. Pre-Application Required Information Determination ("PRID") Procedure

(a) Definitions.

As used in this section, each of the following terms has the meaning set forth below:

(1) "Pre-application required information determination" or "PRID" means a nonadjudicative determination the California Department of Insurance issues before an insurer submits a complete rate application and that specifies all information and data regarding a model that are required to be provided to the Commissioner as part of a complete rate application that relies upon the model for purposes of requesting a proposed rate change pursuant to Insurance Code section 1861.05.

(2) "Pre-application required information determination procedure" or "PRID procedure" means a nonadjudicative procedure before the California Department of Insurance that takes place before an insurer submits a complete rate application and the purpose of which is to determine all information and data regarding a model that are required to be provided to the Commissioner as part of a complete rate application that relies upon the model for purposes of requesting a proposed rate change pursuant to Insurance Code section 1861.05.

(3) The term "model" means any simplified representation of relationships among real world variables, entities, responses, actions, or events using appropriate statistical, financial, economic, mathematical, non-quantitative, or scientific concepts and equations, or any combination thereof, and that consists of three components: one or more information input components, which deliver data and assumptions to the model; one or more processing components, which transform input into output; and one or more results components, which translate the output into useful business information. Types of models include, without limitation, "catastrophe risk models," "complex catastrophe models," "probabilistic catastrophe models," "third-party models," "wildfire models," "wildfire risk models," "risk models," and models referencing other perils; the meaning of the term "model" also includes without limitation a "Wildfire Risk Model" as described in Section 2644.9, subdivision (b)(6)(A).

(4) "Required model information" means all required information and data regarding a model, that the Commissioner requires to be submitted as part of a complete rate application that relies upon the model, because such information and data will aid

the Commissioner in determining whether the model is reliable to perform the functions for which an insurer proposes to use the model, for purposes of the Commissioner's evaluation of a complete rate application.

(5) "Complete rate application" means an application submitted by an insurer desiring to change any property and casualty rate pursuant to Insurance Code section 1861.05 and shall include without limitation all required model information and all information and data specified in Section 2648.4, regardless of whether any such information and data is included in its initial complete rate application submission or is subsequently submitted as part of the rate proceeding, including without limitation in response to requests for further information and data by the Department.

(6) "Public information" means all information provided to the Commissioner as part of a complete rate application submitted pursuant to article 10 of division 1, part 2, chapter 9 of the Insurance Code.

(7) "Confidential PRID information" means information, data, testimony, evidence, hearings, briefs, pleadings, correspondence, discovery, working papers, and other material created or exchanged for purposes of a PRID procedure, and that are not included in any complete rate application subsequently submitted or otherwise provided to the Commissioner.

(8) "Model Advisor" means the person within the Department of Insurance who oversees a PRID procedure.

(a) For purposes of determining appropriate rates for a property and casualty line of business, the Commissioner requires insurers seeking to rely upon modeled information, including without limitation modeled financial projections such as aggregate catastrophe loss projections and other types of projected losses, to submit all required model information as part of a complete rate application. Required model information shall include, in addition to any information specified in the complete rate application requirements set forth in Section 2648.4, information that demonstrates the model uses established concepts, data, equations, and principles, as well as best available scientific information and data, insurance claims expertise, and other assumptions appropriate for the risk or peril being modeled.

(b) The purpose of a pre-application required information determination procedure or PRID procedure shall be for the Department of Insurance to issue a PRID that specifies all required model information to be included in a complete rate application that relies upon the model. The purpose of the PRID procedure shall not be to determine how a specific model shall apply in any particular complete rate application, nor shall the parties examine any nonaggregated insurer-specific information as part of the PRID procedure.

(c) Required model information specified in a PRID shall not be provided to the Commissioner and shall not be public information until or unless an insurer subsequently submits a complete rate application to the Commissioner that relies upon the model.

(d) Confidential PRID information shall not be public information and shall be considered to be information received in official confidence by the Department of Insurance. Accordingly, confidential PRID information shall not be subject to disclosure in response to requests pursuant to the California Public Records Act (commencing with Government Code section 7920.000).

(e) The Commissioner shall delegate authority to oversee a PRID procedure and issue a pre-application required information determination to the Model Advisor. The Model Advisor is authorized to hire outside consultant(s) with relevant knowledge and subject matter expertise to assist in determining required model information.

(f) The Department of Insurance may initiate a PRID procedure by submitting a Notice of PRID procedure to the Model Advisor.

(g) Any person other than the Department may petition to initiate a PRID procedure, or petition to participate in a PRID procedure, by following the procedure set forth in Section 2661.4 and may be eligible for compensation pursuant to Insurance Code section 1861.10 and Sections 2661.1 through 2662.8 and this Section. A petition to initiate a PRID procedure may be combined with a petition to participate in a PRID procedure.

(1) The Model Advisor shall grant the petition to initiate a PRID procedure only if the Model Advisor determines that the petitioner has demonstrated it is more likely than not that the Commissioner would benefit from a PRID and either of the following conditions exist: (i) there is no currently valid PRID under this Section; or (ii) the model has not been previously been subject to public review in any other forum in California, including without limitation as part of a complete rate application, within the prior four years.

(2) The Model Advisor shall rule on a petition to initiate the PRID procedure, a petition to participate in a PRID procedure, or a combined petition, within 10 business days after receipt of the petition by the Model Advisor.

(3) The owner or vendor of a model may decline to participate as a party in a PRID procedure as to that model, but shall provide witness testimony, documents, and other information in response to subpoena.

(4) The Commissioner shall decide any requests for compensation by participants to a PRID procedure in accordance with Section 2662.6 and this Section. For purposes of a request for compensation based upon participation in a PRID procedure, the following additional standards shall apply:

(A) The Model Advisor shall determine a participant has made a "substantial contribution" to a PRID procedure only where the participant demonstrates that as a result of its participation, the Model Advisor has included in the PRID additional information or data regarding the model that would not otherwise have been identified without the requestor's participation in the PRID procedure, Section 2661.1(k) notwithstanding.

(B) A party may not request compensation for fees and expenses based upon work that unnecessarily duplicates the work of another party. Work that materially supplements, complements, or contributes to the substantial contribution of another party shall not be considered unnecessarily duplicative.

(C) To the extent the substantial contribution claimed by a participant duplicates the substantial contribution of another party to the PRID procedure, the Commissioner may find that neither party has made a substantial contribution.

(5) The insurer shall pay any award of compensation arising out of a PRID procedure initiated to examine a model created by that insurer or its affiliates.

(h) The Model Advisor shall publicly notice a PRID procedure within three (3) business days after receiving a petition to initiate a PRID procedure or a Notice of PRID Procedure from the Department. Petitions to participate shall be considered timely if submitted within five (5) business days after the Model Advisor issues public notice of the PRID procedure. The PRID procedure shall be initiated five (5) business days after the Model Advisor has issued a ruling granting any petition to participate in the PRID procedure.

(i) Within 15 business days after a PRID procedure has been initiated, all parties to a PRID procedure under this section shall:

(1) File a statement with the Model Advisor describing how the parties will avoid duplication. The statement shall disclose without limitation working agreements among the parties, lead counsel arrangements on certain issues, sharing of expert witnesses among the parties, and intent to file joint documents; and

(2) Enter into a stipulated nondisclosure agreement that shall only govern the treatment of all confidential PRID information. The agreement shall specify, at a minimum, that (i) the representatives of the parties that participate in the PRID procedure shall not share any confidential PRID information with any other person, including without limitation persons employed by the same party but not involved in the PRID procedure; and (ii) the parties that participate in the PRID procedure shall return or destroy all confidential PRID information within an agreed-upon length of time after a PRID has been issued. After all parties have entered into the agreement, the parties shall submit a stipulation and proposed protective order based upon the parties' nondisclosure agreement to the Model Advisor for review. Alternatively, if

the parties are unable to agree upon a stipulated nondisclosure agreement, any party may, no later than the fifteenth business day after the initiation of the PRID procedure as determined pursuant to Subdivision (h), submit a proposed protective order to the Model Advisor. No later than 10 business days after a proposed protective order has been received by the Model Advisor, the Model Advisor shall determine whether there is a significant public interest in the non-disclosure of confidential PRID information, and, upon a finding there is, enter an order thereon. Following the conclusion of the PRID procedure, the Model Advisor shall retain jurisdiction to enforce the terms of the protective order.

(3) Unless a party is the Department of Insurance or demonstrates that it represents the interests of consumers, the Model Advisor may, upon a finding that the disclosure of certain confidential PRID information to such non-Department or nonconsumer-party would cause irreparable harm to the owner or vendor of the model, enter an order specifying the confidential PRID information that party shall not receive.

(j) To the extent not otherwise specified herein, the Model Advisor may, without limitation: control the course of the PRID procedure; grant or deny a petition to initiate or participate in the PRID procedure; administer oaths; issue subpoenas; rule on motions to compel discovery; receive evidence and testimony; upon notice, hold appropriate conferences before and during the procedure; rule upon procedural objections or motions; receive offers of proof; hear argument; and fix the time and place for the filing of any briefs.

(k) During a PRID procedure, all parties may propound discovery on the owner or vendor of the model to provide information and data regarding the model, including the production of documents and testimony. The parties shall not otherwise engage in discovery.

(l) During a PRID procedure, any party may proffer expert testimony and cross-examine other parties' experts regarding the reliability of the model and what constitutes required model information.

(m) The terms of the confidentiality order notwithstanding, the inclusion of any required model information in a subsequent complete rate application proceeding shall make such information public information.

(n) In a complete rate application that is submitted by an insurer subsequent to a PRID procedure, any person may rely upon the PRID to determine what is required model information. A PRID is not specific to any one complete rate application but may be relied upon in multiple complete rate applications by unaffiliated insurers. A PRID shall be valid in any complete rate application proceeding relying upon that model through the four-year anniversary date of its issuance, provided that the model has not been substantively updated, amended, altered, or changed subsequent to the issuance of the PRID. The validity of a PRID shall be determined as of the date of the submission of the complete rate application relying upon the PRID.

(o) In the event a model is substantively updated, amended, altered, or changed subsequent to the issuance of a PRID but prior to the submission of a complete rate application using or relying upon the model as substantively updated, amended, altered, or changed, then (i) the original PRID is no longer valid for purposes of determining required model information, and (ii) any party may initiate or participate in, pursuant to this Section, a subsequent PRID procedure limited to the issue of whether and how the prior PRID should be substantively updated, amended, altered, or changed.

(p) The PRID procedure shall stand submitted when the Model Advisor closes the record. The Model Advisor shall close the record no later than 90 business days after issuing the confidentiality order specified in this Section unless all parties agree or the Model Advisor determines there is good cause to keep the record open. The Model Advisor shall issue a final pre-application required information determination that specifies all required model information within 15 business days after the PRID procedure is submitted.

(q) As an alternative to issuing a PRID, the Model Advisor may issue a declination to specify a set of required model information after a PRID procedure, if the Model Advisor determines that there is no set of required model information that could reasonably be relied upon to support the use and inclusion of any of the modeled financial projections, modeled catastrophe adjustments, modeled projected losses, or any other type of modeled loss outputs and projections for purposes of reviewing an insurer's complete rate application. In the event the Model Advisor declines to specify a set of required model information, any insurer may still seek to rely upon the model in a subsequent complete rate application but shall publicly produce any information and data the Commissioner requires regarding that model as part of the complete rate application.

(r) At any time prior to the Model Advisor issuing a PRID, the parties to a PRID procedure may stipulate to a set of required model information. The parties shall submit any such stipulation and a proposed set of required model information to the Model Advisor for review. No later than 15 business days after submission of the stipulation and proposed set of required model information, the Model Advisor shall determine whether the proposed required model information satisfies the standards set forth herein and issue an order either adopting or declining to adopt the proposed set of required model information as the PRID for that model.

(s) A PRID shall be subject to judicial review in accordance with Insurance Code sections 1858.6 and 1861.09. For purposes of judicial review, a declination by the Model Advisor shall not be considered a final decision.

(t) Any Department costs associated with a PRID procedure shall be construed to be administrative and operational costs arising from the provisions of article 10 of division 1, part 2, chapter 9 of the Insurance Code.

(u) Nothing in this section shall be construed as prohibiting the creation of a publicly available model for use in projecting annual aggregate catastrophe losses.

NOTE: Authority cited: Sections 1850.4, 1858.6, 1861.01, 1861.05, 1861.07, 1861.09, 1861.10, and 12924, Insurance Code; Sections 7922.630, 7927.705, 11415.50 and 11415.60, Government Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 7, 1077.3, 1850.4, 1858.6, 1861.01, 1861.05, 1861.07, 1861.08, 1861.09, 1861.10, 12919, and 12921, Insurance Code; Sections 7922.630, 7929.000, 11415.50, 11415.60, 11507.6, 11507.7, and 11513, Government Code; Sections 350, 351, 352, and 1040, Evidence Code; *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805; and *State Farm Mutual Automobile Ins. Co. v. Garamendi*, 32 Cal.4th 1029 (2004).