Newfoundland & Labrador

BOARD OF COMMISSIONERS OF PUBLIC UTILITIES

AUTOMOBILE INSURANCE

FILING GUIDELINES

MANDATORY FILINGS
FEBRUARY 1, 2021

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1.0 GENERAL INFORMATION

The Board has established a mandatory rate filing schedule in accordance with Section 9 of Newfoundland and Labrador Regulation 56/19 ("NLR 56/19") which requires an insurer to file for approval of its rates and risk classification system at least once every three years for each category of automobile insurance written in the province. All mandatory filings must be made under either the Mandatory Filing Guidelines or the Mandatory Simplified Filing Guidelines.

These Mandatory Filing Guidelines are to be used by insurers, including Facility Association, for all types of vehicles that do not qualify under the Mandatory Simplified Filing Guidelines. Filings made under the Mandatory Filing Guidelines **require actuarial support** for the proposed rating program in accordance with the requirements set out in this document.

A rate filing is required under the Mandatory Filing Guidelines, along with actuarial analysis, **at least once every three years** where the vehicle class or written premium volume of the vehicle class does not qualify for the Mandatory Simplified filing option.

Proposed rates filed under the Mandatory Filing Guidelines require prior approval of the Board. The Board will prohibit the rates where it determines, as per Section 10 of NLR 56/19, that the proposed rates:

a) are not just and reasonable in the circumstances;
b) would impair the solvency of the insurer;
c) are excessive in relation to the financial circumstances of the insurer; or
d) violate the *Automobile Insurance Act*, the *Insurance Companies Act* or the respective regulations under these Acts.

The Board maintains a Benchmark Schedule which includes guideline assumptions that may be used by insurers in the rate filing process. Insurers must confirm they are referencing the most recently accepted Benchmark Schedule when proposing to adopt any of the Board's guideline assumptions. Insurers are not required to use the Board's guideline assumptions but justification for the use of alternate assumptions must be provided.

Failure to adhere to any of the guidelines or legislated requirements may result in a delay in the review process or the filing being returned to the insurer.

The Mandatory Filing Guidelines and associated exhibits, as well as the Benchmark Schedule, can be downloaded from the Board's website at www.pub.nl.ca/insurance.htm.

1.1 Board Mandate

The Board has regulatory responsibilities related to automobile insurance with respect to:

a) rates;
b) risk classification systems; and
c) underwriting guidelines.

Sections 49 and 51 of the *Automobile Insurance Act* require insurers to file the rates and rate changes it proposes to charge for automobile insurance with the Board. Section 50 of the *Automobile Insurance Act* prohibits insurers from charging rates that have not been approved by the Board.

Section 96.2(4) of the *Insurance Companies Act* requires an insurer to file the risk classification system it intends to use in determining rates for each coverage and category of automobile insurance with the Board. Where the Board determines that an insurer's risk classification system, or an element of the risk classification system, is prohibited under Section 96.2(3) of the *Insurance Companies Act*, the insurer will be ordered to bring its risk classification system or its filing into compliance.

Section 96.1(4) of the *Insurance Companies Act* requires an insurer to file the underwriting rules it intends to use to decline to issue, terminate or refuse to renew a contract, or refuse to provide or continue a coverage or endorsement with the Board. Where the Board determines that any underwriting rule is prohibited under Section 96.2(2) or Section 96.2(5) of the *Insurance Companies Act*, the insurer will be notified that it is prohibited from using the rule.

1.2 Categories of Automobile Insurance

The following categories of automobile insurance are used for the purposes of the Mandatory Filing Guidelines as per Section 2 of NLR 56/19:

> Private Passenger Automobiles - means an automobile used for the purposes listed under the heading "Type of Use-Private Passenger" in the Automobile Statistical Plan prepared under Section 82 of the *Insurance Companies Act*.
>
> Commercial Vehicles - means a vehicle designed or used primarily to transport materials, goods, tools or equipment in connection with an occupation or business. Proposals for Interurban Vehicles may be included as part of a Commercial Vehicles filing.
>
> Miscellaneous Vehicles - means any of the following vehicles when used for personal use only: (i) motorcycles, (ii) all-terrain vehicles, (iii) mopeds, (iv) snowmobiles, (v) trailer homes, (vi) antique cars, and (vii) classic cars.

Public Vehicles - means an automobile used primarily to provide transportation services to the public and includes ambulances, daily rental vehicles, funeral hearses, private buses, public buses, school buses and taxis.

Other Vehicles - means any vehicle type that does not meet the definition of Private Passenger Automobiles, Commercial Vehicles, Miscellaneous Vehicles or Public Vehicles as defined above.

A separate filing must be submitted for each category of automobile insurance.

Proposals for multiple vehicle classes within the same category may be bundled and filed as a single filing. For example, a single Miscellaneous Vehicles filing could include proposals for motorcycles, all-terrain vehicles and snowmobiles. **Insurers are strongly encouraged to bundle filings where possible.**

As per Section 9(6) of NLR 56/19, insurers are not required to file the rates proposed to be charged for automobile insurance relating to a fleet[1].

1.3 Mandatory Filing Schedule

The Board has established a mandatory rate filing schedule in accordance with Section 9(1) of NLR 56/19. An insurer is required to file for approval of its rates and risk classification system within **three years of the date of last filed rates** for each category of automobile insurance it writes and **every three years thereafter**. Filings are required under the mandatory schedule even if the proposal is for no change in rates.

The date of the last filed rates refers to:

a) the date of the most recent Board Order for a Category 2 or Category 3 IAO rate filing approved under the former regulations, or
b) the date of the most recent Board Order for a Mandatory or Mandatory Simplified rate filing approved under the current regulations.

Rates accepted by the Board on a file and use basis under the former Category 1 or CLEAR Simplified filing categories do not qualify for the purposes of the mandatory filing schedule, nor do rates approved by the Board under the current Expedited Approval or Supplemental filing categories. Therefore, to satisfy the Board's mandatory filing schedule, insurers must file either a Mandatory or Mandatory Simplified filing for each category of automobile insurance at least once every three years.

[1] "Fleet" refers to a group of at least 5 automobiles that meet the criteria as set out in Section 2(c) of NLR 56/19.

Insurers should regularly review its indicated and current rate levels for all categories of automobile insurance and file changes whenever necessary rather than waiting for the mandatory filing deadline.

1.3.1 Extension

Section 9(4) of NLR 56/19 provides for extending the mandatory filing schedule in certain circumstances. Insurers that are unable to file rates within the mandatory timeframe may apply to the Board for an extension. The Board may grant an extension if it is satisfied that the delay is due to exceptional circumstances and that extending the time period is not contrary to public interest.

1.4 Prohibited Elements

1.4.1 Underwriting Rules

Section 96.1 of the *Insurance Companies Act* and associated regulations prohibit insurers from using underwriting rules based on the following:

a) age, sex or marital status;
b) not at fault losses;
c) insured has inquired as to coverage or has advised of an accident for which no payment of indemnity was made;
d) nonpayment of premium, other than first payment, where a dishonored payment was replaced within 30 days of its original date;
e) insured has been declined or refused insurance by another insurer;
f) lapses in insurance coverage of less than 24 months, with specific exceptions;
g) insured does not have another insurance policy of any kind with the insurer;
h) insured is or was insured through Facility Association;
i) vehicle age, except that the insurer may require a satisfactory inspection certificate be provided where the vehicle is eight years or older;
j) the length of time the applicant or a person insured under a contract has held a valid driver's license for the type of vehicle being insured;
k) the lack of a driver training program unless otherwise required by law; and
l) credit information.

In addition, an insurer is prohibited from using any underwriting rule which:

a) is subjective;
b) is arbitrary;

c) bears little or no relationship to the risk to be borne by the insurer in respect of an insured; or
d) is contrary to public policy.

The Board may from time to time notify insurers in a general circular of specific underwriting rules it deems to be in violation of these legislative provisions.

1.4.2 Risk Classification System

Section 96.2 of the *Insurance Companies Act* and associated regulations prohibit insurers from using the following as elements in any risk classification system:

a) age, sex, and marital status with the exception of discounts to insureds aged 55 years and older;
b) not at fault losses;
c) insured has inquired as to coverage or has advised of an accident for which no payment of indemnity was made;
d) nonpayment of premium, other than the first payment, if amount is paid within 30 days it was due;
e) insured has been declined or refused insurance by another insurer;
f) lapse in insurance coverage of less than 24 months, with specific exceptions;
g) any element associated with an excluded driver or the claim of a driver subsequently excluded; and
h) credit information.

In addition, insurers are prohibited from using a risk classification system that:

a) is not just and reasonable in the circumstances;
b) is not reasonably predictive of the risk;
c) does not distinguish fairly between risks; or
d) is otherwise prohibited in the regulations.

The Board may from time to time notify insurers in a general circular of specific elements of a risk classification system it deems to be in violation of these legislative provisions.

1.5 Confidentiality

Rate filings will be treated as confidential in view of existing privacy legislation and will only be released in accordance with the *Access to Information and Protection of Privacy Act* ("ATIPPA"). In particular, a person seeking the release of information not subject to routine disclosure must make a request under ATIPPA within the context of the provisions of the legislation.

1.6 Review Timeline

As per Section 10 of NLR 56/19 the Board shall approve, prohibit or vary rates under the Mandatory filing process within 90 days from the date the Board received the filing. The Board may extend the time period by a maximum of 90 days if required.

The review timeline will commence on the day the filing is received by the Board provided it is found to be complete. A filing will not be considered complete until all required documentation and information sufficient to permit a full review has been filed in accordance with the Mandatory Filing Guidelines. Incomplete filings may result in a delay in the review process or the filing being returned to the insurer.

Filings submitted after 3 p.m. Newfoundland Time will be considered received on the next business day of the Board.

1.7 Effective Dates

The proposed effective dates for both new business and renewals must be no earlier than 90 days following receipt of the filing by the Board.

In the event an insurer requires a change to its proposed effective dates following the issuance of a Board Order, the Board must be notified of this change in advance.

1.8 Costs

All costs associated with the rate review process will be recovered as part of the Board's annual assessments to Industry. The Board will no longer invoice insurers for company specific rate filings on a case-by-case basis.

In the event that a public hearing is held for a rate filing, all applicable hearing related costs may be ordered by the Board to be assessed against the insurer in accordance with Section 90 of the *Public Utilities Act*.

1.9 Filing Submission

Filings made under the Mandatory Filing Guidelines must be submitted **electronically** to ito@pub.nl.ca. A hard copy is not required.

Board staff will determine if the filing requires actuarial review and will forward the filing documentation to its consulting actuaries accordingly. Insurers are not required to copy the Board's consulting actuaries when filings are initially submitted.

1.10 Manual Pages

Updated underwriting and rating manual pages must be submitted electronically to ito@pub.nl.ca within 30 days of filing approval.

2.0 FILING FORMAT

All Mandatory rate filings must be submitted in the following format:

Section	Description
1	Cover Letter
2	Table of Contents
3	Certifications (Officer and Actuary)
4	Actuarial Support
5	Underwriting and Rating Rule Changes
6	Rate Exhibits
7	Dependent Categories (if applicable)
Appendix A	Rate Filing Summary
Appendix B	Rating Examples
Appendix C	Rate Model Indications

Section 1 – Cover Letter

The cover letter should provide details on the filing being submitted including, but not limited to, a summary of the proposed changes by coverage, the rationale for the proposed changes, the overall rate level impact with and without capping, and the proposed effective dates.

Section 2 – Table of Contents

The table of contents must show the main headings noted above plus the key headings within each of the sections. It must be detailed enough to allow the reader to quickly isolate key information.

Section 3 – Certifications

The "Certificates of Officer and Actuary - Mandatory" template is available for download on the Board's website.

3.a. Certificate of the Officer

A scan of an original signed certificate of an authorized officer of the insurer must be included in each filing. Authorized officers are the President, CEO, COO, CFO, any Vice-President, the Treasurer, or the Corporate Secretary or Chief Agent for Canada, of the insurer.

The Certificate of the Officer must identify a person authorized by the insurer to act as the contact person for the insurer. All filing correspondence will occur between this person, Board staff and the Board's consulting actuaries.

3.b. Certificate of the Actuary

Filings that result in a rate level change, or filings for a category of automobile insurance previously not written by an insurer, must include a scan of an original certificate of a Fellow of the Canadian Institute of Actuaries.

Section 4 – Actuarial Support

Insurers must provide detailed support for any rate level change. Actuarial support must contain the data and a narrative description for all ratemaking steps for each of the specific rate changes being proposed.

At a minimum, details must be provided for Third Party Liability (Bodily Injury and Property Damage-Tort), Direct Compensation Property Damage ("DCPD"), Accident Benefits, Uninsured Automobile, Collision, Comprehensive, All Perils, Specified Perils and Underinsured Motorist, **even if a rate level change is not proposed for each of these coverages**.

Each subsection outlined below must contain the necessary documentation for all of the individual coverages. In general, documentation must be in sufficient detail to enable the reviewer to trace the resulting rates from the raw data experience and other support data.

The Board does not require insurers to use a specific ratemaking methodology; however, adequate actuarial documentation and support is required for the rate levels proposed. If judgment is applied, then an explanation (i.e., supporting, objective rationale) as to why a particular factor was judgmentally selected must be provided.

The Board expects that insurers will utilize the same methodologies and consistently derived assumptions in each filing. Where methodologies or the process for developing assumptions are changed from the prior filings, the insurer must provide the reasons for the changes, as well as the impact of the changes on the indicated rate levels.

Where the proposed rate/differential changes differ from the indications, insurers will need to provide a descriptive narrative explaining the rationale behind the proposed deviations. The Board will only consider evidence, apart from actuarial methodology, that is presented to them by the insurer within the filing documentation. This evidence might include, but is not limited to, competition, market share, business plans, etc. The rationale provided should be as detailed as possible in order to illustrate to the Board that the rate/differential selections are reasonable deviations from rate/differential indications.

All support provided in this section must reconcile with the information provided in Appendix A – Rate Filing Summary.

In addition to the specific information requirements set out herein, insurers must also provide the excel spreadsheets and/or other information used in determining their rate level change indications in Appendix C – Rate Model Indications. All data must be provided in an excel format that can be fully manipulated with formulas intact.

The support for an overall rate change must be comprised of the following subsections, **in the order set out below**. Each section or subsection must be labelled according to the numbering scheme provided and contain all data, data definitions and sources, and any narrative necessary to explain or clarify the various ratemaking steps.

4.a. Overall Description of the Ratemaking Methodology and Summary

4.b. Losses

1. Loss Development
2. Loss Trend
3. Treatment of Large Losses
4. Catastrophe (or Excess Claim) Procedure
5. Other Adjustments

4.c. Allocated Loss Adjustment Expenses (“ALAE”)

4.d. Unallocated Loss Adjustment Expenses (“ULAE”)

4.e. Premium

1. On-level Adjustments
2. Premium Trend
3. Other Adjustments

4.f. Other Expenses

1. Exposure Variable Expenses (“Fixed”)

    a. Health Levy
2. Premium Variable Expenses (“Variable”)
    a. Contingent Commissions

4.g. Profit Provisions

4.h. Credibility

1. Credibility Standards
2. Complement of Credibility

4.i. Other Adjustments

4.j. Summary Rate Level Indications

4.k. Territorial Indications

1. Indicated Differentials
2. Off-balance
3. Definitions

4.l. Implementation of New Vehicle Rate Group Table, including CLEAR

1. Overall Description for Implementing a New Vehicle Rate Group Methodology
2. Off-balance

4.m. Changes to Current Rating Variables and/or Rating Algorithm

1. Indicated Differentials
2. Off-balance

4.n. Introduction of New Rating Variables and/or Rating Algorithm

1. Indicated Differentials
2. Off-balance

4.o. Discounts/Surcharges

1. Indicated Discounts or Surcharges
2. Off-balance

4.p. Endorsements

1. Revision to Current Endorsements
2. Introduction of New Endorsements
3. Off-balance

4.q. Rating Based on Group Membership

1. Indicated Discounts or Rates for Groups

4.r. Usage Based Insurance (UBI) Discount Programs

1. Description of the UBI Discount Program
2. Reasonableness of Proposed UBI Discounts
3. Application of UBI Discounts in Premium Determination
4. UBI Discount Program Costs and the Impact on Company Expenses

4.a. Overall Description of the Ratemaking Methodology and Summary

This section must indicate the type of approach used and generally summarize the process. Insurers may use either a pure premium or a loss ratio ratemaking approach. A general description of the data must also be included. Detailed information on the data must be included in the subsections using that data. For example, collision loss data must state whether it is all deductibles combined or for a specific deductible level.

Rate level indications are to be based on the insurer's most recent quarter-ending three to five complete accident years[2] of experience. This is subject to data availability – it is recognized that some companies compile data by accident half-year; in this case, the most recent half-year ending three to five complete accident years of experience should be presented. This is referred to as the "experience period" and it should be no older than six months from the date of the filing.

Where data compiled by the General Insurance Statistical Agency ("GISA") is used, for either the individual insurer or industry-wide, it should be based on the latest release by GISA – typically May for prior year-end, and November for mid-year.

The weight assigned to each accident year is a matter of judgment. Any changes from the weights used in the insurer's last approved rate filing in Newfoundland and Labrador must be identified, explained, and the impact of the change in weights on the rate level indication must be provided. For an initial filing, the rationale for the particular weights that are applied must be provided.

[2] Although these guidelines generally reference accident years, it should be understood that policy years or other segmentation of data may be used.

4.b. Losses

If losses are considered together with ALAE it must be noted in this section and all references to "loss" in this subsection should be considered as referring to "losses and allocated loss adjustment expenses". In this event, subsection 4.c. can be omitted.

The type of loss and claim count data included in the experience period must be described in this subsection (i.e., accident year or policy year). Where another basis is used, justification must be provided. The number of individual years included in the experience period, the weights assigned to those individual years, and the respective valuation dates should also be noted.

The insurer's own data in Newfoundland and Labrador must be used to the extent that it is credible. The source of the data should be clearly noted (e.g., insurer internal data, insurer data as provided by GISA).

When industry-wide data is used for the experience period, Facility Association Residual Market losses must be excluded.

The experience period loss amounts and/or claim counts must be adjusted for the impact of insurance reforms; this is discussed in subsection 4.b.5. The impact of insurance reforms (e.g., Bodily Injury deductible increase) and the development of loss trends are viewed as being tied together. Insurers must identify and quantify the impact of such reforms as part of its trend analysis. The measurement of the impact of the reform is expected to be updated as applicable data emerges for such analysis. Consistency between the reform adjustment applied to the historical experience period loss data and the reform adjustment within the loss trend analysis is expected.

Data at the major sub-coverage level is generally required for the experience period loss amount and claim count data.

Loss amount and claim count experience period data should be subdivided at the major sub-coverage level as follows, with consideration given to homogeneity and credibility of the data. The following are the major sub-coverages from GISA; finer break-down of claims experience may be determined to be more appropriate:

- Bodily Injury
- Property Damage*

*includes Property Damage-Tort and DCPD until DCPD information is available from the insurer or GISA. Then the components should be separated as follows:

- Accident Benefits
- Underinsured Motorist

- Uninsured Automobile
- Collision
- Comprehensive
- All Perils
- Specified Perils

4.b.1 Loss Development

The loss amount and claim count data must be developed to an ultimate level through the use of appropriate development procedures. Standard actuarial methodologies must be used to derive ultimate accident year loss amounts and claim counts.

The specific loss development approach used in the filing must be outlined and the details of the calculations must be disclosed in this subsection. All judgments associated with the process of loss development must be disclosed in detail and supported (e.g., the rationale for the selected loss development factors).

Reference to the selections made in the rate filing being “those of the Appointed Actuary” is not sufficient support; detailed supporting worksheets must be provided. If the selections of the Appointed Actuary are based on combined data with different vehicle categories or jurisdictions, insurers must provide the experience of the specific vehicle categories and/or jurisdictions in the discussion to validate the selections.

Loss development should be based on the insurer's own Newfoundland and Labrador data to the extent possible. At a minimum, and as a requirement, the history of unadjusted company loss development accident year data valued at 12-month intervals should be provided (so-called "triangles" of loss valuations at various stages of development).

Should the insurer find it necessary to rely on a different source of internal Newfoundland and Labrador data (such as affiliated insurer data), the filing must identify the source of the data and provide an explanation of its applicability.

In those cases where the insurer relies upon industry loss development factors (e.g., GISA loss development factors) to estimate its ultimate losses, the insurer must explain why use of industry loss development factors experience is more appropriate than ultimate loss estimates based on its own loss development data.

Where data from other jurisdictions is used, the insurer must demonstrate to the extent possible that the inclusion of such data does not materially distort the loss development factor selections. Where loss development pattern differences do exist between jurisdictions, the insurer must

explain in detail why the use of the different jurisdictional data is appropriate in the circumstances.

Loss development factors should be based on the most recently available accident year data aligned to match the valuation of the experience period data where possible – so both are at the same level of maturity. Segmentation by accident half-year instead of accident year is also appropriate. More recent data may be used as long as appropriate support is provided. If loss development for a partial accident year is used, then comparable experience at the same level of maturity must be provided to support the selected loss development factors.

If credibility procedures are used in the selection of loss development factors, the support for the full credibility standard should be disclosed, application of the credibility standard should be presented, and the complement of credibility should be disclosed and supported.

The general approach to loss development can be expected to remain reasonably constant over the years for the insurer. Any change in either the approach or the underlying data from the prior rate filing should be disclosed and supported, and the impact of the change in methodology on the rate level indication must be provided.

All data used in the process of loss development must be exhibited and labelled (e.g., are the losses paid or case incurred, what are the dates of valuation).

4.b.2. Loss Trend

The Board publishes loss trend selection reports from its consulting actuaries for Private Passenger Automobiles and Commercial Vehicles based on industry-wide Newfoundland and Labrador data released by GISA on a semi-annual basis. The proposed loss trend selections are circulated to Industry for review and comment prior to being implemented as the Board's benchmark loss trends. ***Insurers are not required to use the Board's benchmark loss trends, but full rationale for the use of different trend rates must be provided and supported*.**

Where the insurer chooses to use its own loss trend selections based on industry Newfoundland and Labrador data, it will be expected to provide the information outlined below and comment on why its selections are more appropriate in the circumstances than the application of the Board's benchmark trends. A comparison table of the trends and alternative indications using the Board's benchmark trends should be provided in this subsection.

Where the insurer chooses to use its own loss trend selections based on its own Newfoundland and Labrador data, it will be expected to provide the information outlined below and comment on why its selections are more appropriate in the circumstances than the application of the Board's benchmark trends. A comparison table of the trends and alternative indications using the Board's benchmark trends should be provided in this subsection. In addition, full support must

be provided to show the insurer's own data is fully credible for the purpose of determining loss trends; including how the full credibility standard for loss trend purposes was determined for each coverage.

The specific loss trend approach used must be outlined and the details of the calculations must be fully supported and disclosed in this subsection. All judgments associated with the process of loss trend selections must be disclosed in detail and supported.

The loss trend analysis should be based on the most recent available Newfoundland and Labrador experience. Where GISA data is used, the latest release by GISA – typically May for prior year-end, and November for mid-year – should be used.

The loss trend analysis should give consideration to the effect of individual data exclusions, statistically supported scalar parameters for reforms or other changes, and seasonality. The analysis should include the statistics that underlie the basis for rationale of the selected trend model.

The effect of reform measures on loss trend is to be considered and the rationale for any adjustments must be provided.

Although loss cost trends are generally considered sufficient, frequency and severity trends are often reviewed and analyzed separately in the selection of trend factors. Loss trend selections that do not follow the indicated loss trends must be rationalized and explained.

A narrative explaining the rationale for any difference between the past and future trend rates must be included.

If credibility weighting procedures are used in selecting the loss trend rate, the support for the full credibility standard must be disclosed, the application of the credibility standard must be presented, and the complement of credibility must be disclosed and supported.

The length of the trend period will depend on the term of coverage offered by the insurer, the proposed effective date, and the valuation date of the loss data. Each of these items must be disclosed with supporting calculations to show how the loss cost projection factors for each year in the experience period are determined. The trend projection factors must be divided into past trend and future trend components, with each component fully disclosed and supported in detail, as described above.

The general approach to estimating loss trend is expected to remain reasonably constant over time for the insurer. Any changes in approach or underlying data from the prior rate filing must be disclosed and supported, including the impact of such changes.

All data used in the process of estimating loss trends must be exhibited, at least in summary form, and labelled (e.g., are losses paid or incurred, developed or undeveloped).

4.b.3. Treatment of Large Losses

If a procedure is used to estimate the impact of large losses, that procedure must be included in this subsection.

The filing must clearly describe how large losses are defined and indicate how such large losses in the experience period have been handled. If losses have been capped, the number of such losses and the effects of the caps must be demonstrated. The large loss adjustment must be based on a sufficiently long historical period (e.g., 10 to 20 years) to capture a long-term average. If a large loss capping adjustment is applied, rate indications should be provided with and without an adjustment for large loss capping. The insurer should ensure that large losses do not cause significant instability in the rates from one period to the next.

4.b.4. Catastrophe (or Excess Claim) Procedure

Comprehensive, Specified Perils, and All Perils coverages are subject to losses arising from natural catastrophes. If a procedure is used to estimate the impact of such losses, that procedure must be included in this subsection.

The specific catastrophe procedure used must be outlined and the details of the calculations must be disclosed and supported. All judgments associated with the process of calculating the catastrophe provision must be disclosed in detail and supported.

The catastrophe procedure must make use of the insurer's own data to the extent possible, augmented where necessary by other relevant data. All data used in calculating a provision for catastrophe losses must be exhibited and labelled.

The general approach to estimating catastrophe losses can be expected to remain reasonably constant over the years for the insurer. Any changes in either the approach or the underlying data from the prior rate filing must be disclosed and supported.

4.b.5. Other Adjustments

Any other adjustments to the loss data must be disclosed, documented, and supported in this subsection. Examples would include adjustments to historical loss experience to reflect product changes, reforms and/or changes to Harmonized Sales Tax.

Data must be exhibited and labelled, procedures must be outlined, and changes from the prior rate filing must be noted and justified.

4.c. Allocated Loss Adjustment Expenses

If ALAE are considered separate from losses, provide the same detailed information as for the losses in subsection 4.b.

4.d. Unallocated Loss Adjustment Expenses

The specific ULAE approach used must be outlined and details of the calculations must be disclosed and supported. All judgments associated with the estimation of ULAE must be disclosed in detail and supported.

The estimate of ULAE must make use of the insurer's own data for each category of insurance and coverage to the extent possible. Should the insurer find it necessary to include outside data or a different source of internal data, the filing must identify the source of the data and provide an explanation of its applicability in the circumstances. All data used in the process of estimating ULAE must be exhibited and labelled (e.g., are the ULAE paid or incurred, calendar year or accident year).

It is expected the ULAE supporting data should be consistent with the most recent ULAE data submitted to GISA. Where the ULAE data varies significantly from the information submitted to GISA, further detail must be provided to support the selected ULAE.

Where the ULAE varies significantly from year to year, further explanation must be provided. Where the ULAE varies significantly from the industry average, further detail must be provided.

4.e. Premium

The premium data must be described in this subsection. The experience period should match the basis used for the loss experience period and the source of the premium data must also be disclosed. Direct premiums (i.e., prior to any reinsurance transactions) must be the basis for ratemaking. Direct premiums must not include premiums for the Facility Association Residual Market business.

Finance fees or charges collected through premium instalment plans should not be included with premiums.

4.e.1. On-level Adjustments

If the insurer uses a loss ratio approach to ratemaking, earned premium must be adjusted to the level of the present rates through the use of an appropriate on-level procedure. Both the unadjusted and the adjusted premiums must be displayed.

If on-level adjustments are made by means of a factor approach (e.g., parallelogram) the calculations must be disclosed. If on-level adjustments are made by means of calculating premiums at present rates through computer re-rating of policies (i.e. extension of exposures), a description of the process must be provided with a comparison of the results obtained using the parallelogram method. Any significant difference must be explained.

The on-level procedure should adjust premiums to the full current manual rate before the application of any capping. The reduction of historical earned premiums due to capped rate level increases for some policyholders must be reserved. Full support showing the impact of capping reversal must be provided.

The insurer's history of rate changes for each coverage for the prior five years must be included in this section.

4.e.2 Premium Trend

Premium trend must be considered for coverages with inflation-sensitive exposure bases that may result in a corresponding change in premium income to the insurer. The changing mix of exposures with respect to the makes and models of vehicles for Physical Damage coverages is an example of a change in mix of exposures which could produce premium trend[3]. Other examples are the changing mix of deductibles for Physical Damage coverages and shifts to increased limits for Bodily Injury.

The specific premium trend approach used in the filing must be outlined and details of the calculations must be disclosed and supported. All judgments associated with the process of premium trend must be disclosed in detail and supported.

The general approach to estimating premium trend is expected to remain reasonably constant over time for the insurer. Any changes in approach or underlying data from the prior rate filing must be disclosed and supported, including the impact of such changes.

Premium trend must make use of the insurer's own data to the extent possible.

To the extent that the premium trend measures changes in the mix of business over time for the insurer's own portfolio, a commensurate adjustment to the loss experience for the changing mix of business must also be included in the analysis.

Should the insurer find it necessary to include outside data or a different source of internal data, the filing must identify the source of the data and provide an explanation of its applicability in

[3] Note, each year a new CLEAR table is produced, and the premium trend is accounted for in the development of the rate groups within each new table. Hence, only the insurers changing mix of vehicles from year to year should be accounted for in the premium trend.

the circumstances. All data used in the process of estimating premium trend must be exhibited and labelled.

4.e.3. Other Adjustments

Any other adjustments to the premium data must be disclosed, documented, and supported in this subsection.

Data must be exhibited and labelled, procedures must be outlined, and changes from the prior rate filing must be noted. The impact of any changes in approach must be disclosed.

4.f. Other Expenses

Other expenses (i.e., non-claims related expenses) must be divided between exposure variable (fixed) and premium variable (variable) expenses in a manner that is consistent with the way the insurer conducts its business, the manner in which expenses are incurred, and the type of unit insured. The details of this segregation of expenses must be disclosed and documented.

Selected expense levels must be fully supported with at least the three most recent years of company experience. Selected expense levels that are not in line with company experience must be fully explained. Any one-time expenses that create significant variances in one or more years must be explained. Any significant differences in expense data from that submitted to GISA must be explained.

The insurer must explain how expenses are allocated to Newfoundland and Labrador automobiles and state when the allocation was last performed. The Board will also consider the type of distribution channel that an insurer uses to assess an appropriate expense provision.

The Board will not accept the loading of all or a majority of expenses into a single coverage or select coverages. Expenses must be distributed equitably among all coverages offered by the insurer and the manner by which the distribution is affected must be explained.

The selected expense level should be stated exclusive of any reduction for finance fee revenues.

Finance fee revenues should be separately and clearly identified. Finance fee revenues can either be treated as additional revenues or as a separately identified negative expense (in either case as a percentage of premiums) and must be considered in calculating the rate level change indication.

The Board will not accept the inclusion of reinsurance expenses in any form as part of a filing unless it can be demonstrated through documentary evidence and full justification that inclusion of the expense is reasonable.

There must be no expense provision established in respect of the Facility Association Residual Market. No additional expense is to be provided for by servicing carriers in respect of servicing Facility Association business because such costs are reflected in the rates charged by the Facility Association.

The Board is unlikely to approve any filing that would pass through to consumers an expense provision that is significantly higher than the industry average unless full justification to support the selected expense level is provided.

4.f.1. Exposure Variable Expenses (Fixed)

Some expenses can be expected to vary in relationship to the number of units insured (exposures) rather than in relationship to the premium volume.

The specific approach to estimating exposure variable expenses used in the filing must be outlined and details of the calculations must be disclosed. All judgments associated with the process of estimating exposure variable expenses must be disclosed in detail and supported.

Exposure variable expenses must make use of the insurer's own data. Should the insurer find it necessary to include outside data or a different source of internal data, the filing must identify the source of the data and provide an explanation of its applicability in the circumstances. All data used in the process of estimating exposure variable expenses must be exhibited and labelled.

4.f.1.a Health Levy

The Government of Newfoundland and Labrador assesses an annually adjusted amount to industry to cover the cost of health services provided to victims of automobile accidents. The annual levy is set as a dollar amount per insured vehicle and is reset annually, usually in January.

The amount included for the Health Levy must be determined by multiplying the latest levy amount by the number of vehicles insured for each year in the experience period. This amount is then allocated to Bodily Injury coverage as an additional fixed expense.

Please refer to the Board's Benchmark Schedule for current Health Levy information.

4.f.2 Premium Variable Expenses (Variable)

Some expenses can be expected to vary in relationship to the premium volume rather than in relationship to the number of units insured.

The specific approach to estimating premium variable expenses used in the filing must be outlined and details of the calculations must be disclosed. All judgments associated with the process of estimating premium variable expenses must be disclosed in detail and supported.

Premium variable expenses must make use of the insurer's own data. Should the insurer find it necessary to include outside data or a different source of internal data to estimate these expenses, the filing must identify the source of the data and provide an explanation of its applicability in the circumstances. All data used in the process of estimating premium variable expenses must be exhibited and labelled.

4.f.2.a Contingent Commissions

The Board does not prohibit the inclusion of contingent commissions. However, the amount must be reasonable and supported.

Where premium variable expenses include an element for contingent commissions (or profit commissions, contingent profit commissions, etc.), the insurer must outline the basis upon which contingent commission payments are determined and paid.

The provision should reflect the level of commissions expected to be paid if any experience related bases for such payments reflect the projected level used in the application. Any long-term goals or targets for such payments should be stated.

The Board is unlikely to approve any filing that contains a contingent commission provision that is higher than the industry average. Where such a provision is proposed, the insurer must provide rationale and support for why the proposed level of the provision should be allowed.

4.g Profit Provisions

All insurers must derive their rate indications based on a target profit provision stated as a percentage of premium, with the same provision for all coverages.

The target profit provision must be clearly stated in the ratemaking formula for the development of the actuarially indicated rate. If the target profit provision deviates from the Board's profit benchmark, the specific approach for the determination of the target profit provision must be outlined and the details of the calculations must be provided. All judgments associated with the process of calculating the target profit provision must be documented and supported.

Insurers that use a target return on equity approach in their rate model must illustrate how the target return on equity is related to the target profit provision in the model steps.

All costs, including expected claims costs and expense costs, must be discounted to reflect the investment income on policyholder supplied funds.

The insurer must provide the basis of the selected investment return assumption for discounting, and compare it with the actual investment returns earned in the recent past as reported in the annual P&C-1 financial statements.

While the expected investment return selected should consider new money rates, the Board anticipates that the selected expected investment return will be close to the actual investment return the insurer earned within the recent past and reflect the mix of all investment assets expected to be held by the insurer. Significant differences must be explained and justified.

Assumed claims payment patterns must be supported by the insurer's Newfoundland and Labrador paid loss development information.

If the proposed rates are different from those which are actuarially indicated based on the target profit provision assumption, the insurer must provide the proposed profit provision underlying the proposed rates. If the proposed profit provision is below the Board's benchmark, the insurer should explain why it is willing to accept the lower profit provision.

The general approach in selecting the discount rates (i.e., selected expected investment return) or claims payment patterns can be expected to remain reasonably constant over the years for the insurer. Any change in either the approach or the underlying data from the prior rate filing should be disclosed and supported.

The Board is unlikely to approve a rate filing that passes along a target profit provision that is greater than the Board's benchmark on an all-coverages combined basis.

Please refer to the Board's Benchmark Schedule for the current profit provision benchmarks.

4.h. Credibility

The Newfoundland and Labrador experience of the insurer may not be of sufficient volume to produce stable overall province-wide rate level indications that are actuarially credible. In such cases, credibility procedures can be useful as a means of augmenting the insurer's Newfoundland and Labrador data.

The approach to credibility can be expected to remain reasonably constant over the years for the insurer. Any changes from the prior rate filing in the credibility standards, procedures and the complement of credibility must be disclosed and supported.

4.h.1. Credibility Standards

The standard for 100% credibility and the formula for calculating partial credibility must be disclosed with an explanation regarding their derivation and application in the filing.

Credibility standards based on claim counts that have been developed to ultimate levels are acceptable. Exposure based credibility or expected claims credibility are also acceptable approaches especially for territorial indications.

A commonly used standard of 1,082 claims for short tail, low severity/low volatility coverages, such as property damage and physical damage, is considered reasonable. The use of a higher standard in long-tail, high severity/high volatility coverages in the form of a multiplier of the base standard, is considered reasonable.

Until enough experience years with Bodily Injury, Property Damage-Tort, and DCPD have emerged, splitting of Third Party Liability into Bodily Injury and Property Damage (i.e., Property Damage-Tort and DCPD combined), and assigning separate credibility standards is the preferred approach.

It is expected the standard for full credibility for loss trends would be higher than the standard selected for the insurer's loss experience period (usually 3 to 5 years) used to determine the rate indications.

The general approach to selecting credibility standards is expected to remain reasonably constant over the years for an insurer. Any changes in either the approach or the underlying data from the prior rate filing must be disclosed and supported.

4.h.2. Complement of Credibility

The data source used as the ballast to which the complement of credibility applies must be disclosed and supported.

In calculating the complement of credibility, which incorporates or requires trending, it is acceptable for the trend period to be from the effective date of the current rates to the effective date of the proposed rates, which may be more or less than one year. The Board will generally accept a one year trend period to be reasonable unless justification is provided for extending the period beyond one year.

If the credibility complement includes a provision for any prior filing rate inadequacy, then it must be based on the gap between the Board's accepted indicated rate change and the approved rate change. Specifically, if prior filing indications/loss ratios are utilized in the credibility complement and the Board Order required changes to the insurer's indications to obtain the Board indications, the insurer must adjust its prior indication for those Board Order changes before utilizing it in the current credibility complement. Any adjustment for rate inadequacy, therefore, would be measured by comparing the previously approved rates to the Board indications.

If an alternative body of experience data (e.g., industry data excluding the Facility Association Residual Market data) is used as a credibility complement, exhibits must be included to show the adjustments made to this data for all risk distribution differences. Differences in loss costs or loss ratios due to differences in risk characteristics (other than distributional differences by rating variables) between the data groups should be considered and adjusted where appropriate.

However, in the case of non-PPA lines and very specialized companies, an adjustment of industry data to match an insurer's mix may distort values more than not adjusting the alternative data at all. In these instances, the insurer must provide an explanation and rationale for not making adjustments.

The general approach to calculating complement of credibility is expected to remain reasonably constant over the years for an insurer. Any changes in either the approach or the underlying data from the prior rate filing must be disclosed and supported.

4.i. Other Adjustments

Any other adjustments made to the data, which affect expected premium or losses must be quantified and their effect on rates must be disclosed and supported in this section.

Any additional support the insurer wishes to include to support its proposed changes should be included in this section.

4.j. Summary Rate Level Indications

Summary sheets must be provided showing how the data combines with the adjustments and provisions outlined in subsections (4.b.) - (4.i.). The insurer may use forms that are relevant to its particular situation.

Proposed rate changes should be in the same direction and same relative magnitude as the indicated rate change direction at the coverage level. Explanation should be provided for any significant differences at the coverage level between the indicated and proposed rate changes. For example, if the indicated rate change for Bodily Injury is positive and the indicated rate change for Accident Benefits is negative, the Board expects a proposed increase in the rates for Bodily Injury and a proposed decrease in the rates for Accident Benefits. In the case where a discrepancy is present, explanations should be provided. The proposed rate change should not exceed the indicated rate change at an individual coverage level.

Significant differences at the coverage level, and overall, between the indicated and proposed rate changes must be explained in detail.

4.k. Territorial Indications

4.k.1 Indicated Differentials

If the insurer is requesting changes to territory differentials, the insurer must outline its ratemaking process for territorial differentials in detail including the specifics of any market influences. **Territorial differential indications must be provided at least once every three years, even if no changes are proposed[4].**

Territorial indications must be calculated by making use of the insurer's own data. Should the insurer find it necessary to include outside data or a different source of internal data, the filing must identify the source of the data and provide an explanation of its applicability in the circumstances. All data used in the process of developing territorial indications must be exhibited and labelled.

When a predictive model or some other analytical pricing method such as the Generalized Linear Model (GLM) or Generalized Additive Model (GAM) is used to analyze the territory differentials, a complete description of the model, data source, data variables, and assumptions must be provided. When different data segments are used in the analysis, details of the data and any adjustments made to the data prior to application should be clearly provided. The result derived from traditional methods such as loss ratio method should also be provided to reconcile general direction.

A comparison of current, indicated, and proposed (if changes are being made) territorial differentials must be provided for each coverage by territory. Proposed changes should generally be in the direction indicated. Any capping applied to the differentials should be disclosed. Where deviations beyond capping from indications are proposed, the rationale for the deviation must be provided in detail. Included in this must be the written premium distribution and the exposure distribution by coverage, by territory.

If credibility procedures are used, they must be disclosed and supported in the same detail as outlined in subsection 4.h.

Costs must be fairly allocated between territories.

[4] Note, if the insurer files multiple Mandatory rate filings within a three year period, it is not necessary to provide territorial differential indications in each of these filings if no changes are proposed. The insurer would only need to state the date of its last filed differential indications in such circumstances to confirm that it is in compliance with the three year requirement.

The general approach to calculating territorial differentials can be expected to remain reasonably constant over the years for the insurer. Any changes in either the approach or the underlying data from the prior rate filing should be disclosed and supported.

4.k.2 Off-balance

The aggregate premium may be increased or decreased through the introduction of new territorial rates or rate differentials or by changes to existing ones. The filing must account for these changes through the use of off-balance procedures or by accounting for the premium change in its rate level.

All data used in the process of calculating the off-balance must be exhibited and labelled. The calculation of the off-balance amount must be shown. All judgments associated with the process of calculating the off-balance must be disclosed and supported.

Off-balance calculations must make use of the insurer's own distribution of business. Should the insurer find it necessary to include outside data or a different source of internal data, the filing must identify the source of the data and provide an explanation of its applicability in the circumstances.

4.k.3 Definitions

The Superintendent of Insurance has jurisdiction over territory definitions in the province. If the insurer wishes to deviate from the approved territory definitions it must seek approval from the Superintendent of Insurance prior to making an application to the Board.

If any proposed changes are made to territorial boundaries, a map showing the current and proposed territorial boundaries must be provided.

4.l. Implementation of a New Vehicle Rate Group Table, including CLEAR

The procedures used for replacing the insurer’s current vehicle rate group methodology and implementing a new methodology must be fully described in this section.

4.l.1. Overall Description for Implementing a New Vehicle Rate Group Methodology

If the insurer is requesting changes to the vehicle rate group table, the ratemaking process must be outlined in detail in this section.

This section should indicate the insurer’s approach for implementing the new vehicle rate group methodology. The vehicle rate group table that is being used, any modifications to a standard VICC table, and capping procedures, if any, should be described in this section.

Any changes to the differentials assigned to a vehicle rate group should be described and supported in this section.

Where an insurer proposes to adopt a rate group table as published by IBC without alterations, it is not necessary to submit a copy of the table with the filing. In such cases, the insurer need only provide the table identification (i.e., year and type).

Where an insurer proposes to alter a published rate group table in any way, a copy of the proposed table must be provided with the filing, along with supporting justification for the proposed alterations. It is strongly recommended that insurers proposing alterations to rate group tables contact Board staff prior to submission of the filing to discuss.

4.l.2. Off-balance

The aggregate premium may be increased or decreased through the introduction of a new vehicle rate group table and/or changes to vehicle rate group differentials. The filing must account for these through the use of off-balance procedures or by accounting for the premium change in its rate level.

All data used in the process of calculating the off-balance must be exhibited and labelled. The calculation of the off-balance amount must be shown. All judgments associated with the process of calculating the off-balance must be disclosed and supported.

Off-balance calculations must make use of the insurer's own distribution of business. Should the insurer find it necessary to include outside data or a different source of internal data, the filing must identify the source of the data and provide an explanation of its applicability in the circumstances.

4.m. Changes to Current Rating Variables and/or Rating Algorithm

4.m.1. Indicated Differentials

If the insurer is requesting changes to current classification differentials, limit of liability differentials, deductible differentials, or other rate differentials, the ratemaking process must be outlined in detail in this section. **Indications for all current rating variables must be provided at least once every three years, even if no changes are proposed[5].**

[5] Note, if the insurer files multiple Mandatory rate filings within a three year period, it is not necessary to provide rating variable indications in each of these filings if no changes are proposed. The insurer would only need to state the date of its last filed rating variable indications in such circumstances to confirm that it is in compliance with the three year requirement.

Classification, limit of liability, deductible, and other rate differential indications must make use of the insurer's own data. Should the insurer find it necessary to include outside data or a different source of company data, the filing must identify the source of the data and provide an explanation of its applicability in the circumstances. All data used in the process of developing classification, limit of liability, deductible, or other rate differential indications must be exhibited and labelled.

A comparison of current, indicated, and proposed differentials must be provided for each coverage for which classification, limit of liability, deductible, or other rate differentials are changing. Included in this must be the written premium distribution and the exposure distribution by classification, limit of liability, deductible or other rate differential.

When a predictive model or some other analytical pricing method such as the GLM or GAM is used to analyze the classification rating differentials, a complete description of the model, data source, data variables, and assumptions must be provided. When different data segments are used in the analysis, details of the data and any adjustments made to the data prior to application should be clearly provided. The result derived from traditional methods such as loss ratio method should also be provided to reconcile general direction.

If credibility procedures are used, they must be disclosed in the same detail as outlined in subsection 4.h.

Proposed changes should generally be in the direction indicated. Where the proposed differentials differ from the indicated differentials, the reasons for the deviation must be provided. Any capping applied to the differentials should be disclosed.

The general approach to calculating rate differentials can be expected to remain reasonably constant over the years for the insurer. Any change in either the approach or the underlying data from the prior rate filing must be disclosed and supported.

4.m.2. Off-balance

The aggregate premium may be increased or decreased through the changes to classification, limit of liability, deductible, or other rate differentials. The filing must account for these changes through the use of off-balance procedures or by accounting for the premium change in its rate level.

All data used in the process of calculating the off-balance must be exhibited and labelled. The calculation of each off-balance must be shown. All judgments associated with the process of calculating the off-balance must be disclosed and supported.

Off-balance calculations must be based on the insurer's own distribution of business by classification, limit of liability, deductible, or other rate differential. Should the insurer find it necessary to include outside data or a different source of internal data, the filing must identify the source of the data and provide an explanation of its applicability in the circumstances.

4.n. Introduction of New Rating Variables and/or Rating Algorithm

Insurers may introduce other new rating variable(s) into their rating programs. Data should be provided in support of a new rating variable. The Board will consider non-Newfoundland and Labrador data, provided they are credible and relevant to the current Newfoundland and Labrador product. Where the insurer is introducing a rating variable to its algorithm, the approach and a general narrative of the process must be outlined in detail.

4.n.1. Indicated Differentials

Rate differential indications should make use of the insurer's own data where possible. Should an insurer find it necessary to rely on outside data or a different source of company data, the filing must identify the source of the data and provide an explanation of its applicability in the analysis. All data used in the process of developing rate differential indications for a proposed rating variable must be exhibited and labelled.

A comparison of the indicated and proposed differentials must be provided by coverage to which the proposed rating variable would apply. Included in this should be the written premium distribution and the exposure distribution.

When a predictive model or some other analytical pricing methods such as the GLM or GAM is used to analyze the proposed classification variables and rating differentials, a complete description of the model, data source, data variables and assumptions must be provided. The result derived from traditional methods such as loss ratio method should also be provided to reconcile general direction.

The method of selecting the classification variables included, excluded or held fixed in this alternate analysis must be outlined. Model results should be included to sufficiently show the correlation of the results between variables. If judgment is applied in the inclusion or exclusion of the variables in the proposal, the basis of the judgment should be provided.

If credibility procedures are used, they must be disclosed in the same detail as outlined in subsection 4.h.

Proposed changes should generally be in the direction indicated. Where the proposed differentials differ from the indicated differentials, the reasons for the deviation must be provided. Any capping applied to the differentials should be disclosed.

4.n.2. Off-balance

The aggregate premium may be increased or decreased through the introduction of a new rating variable. The filing must account for these changes using off-balance procedures or by accounting for the premium change in its rate level.

All data used in the process of calculating the off-balance must be exhibited and labelled. The calculation of each off-balance must be shown. Any distributions used to calculate off-balance factors for new rating variables must be fully supported. All judgments associated with the process of calculating the off-balance should be disclosed and supported.

Off-balance calculations should be based on the insurer's own distribution of business by classification, limit of liability, deductible, or other rate differential. Should an insurer find it necessary to rely on outside data or a different source of internal data, the filing must identify the source of the data and provide an explanation of its applicability in the circumstance.

4.o. Discounts/Surcharges

Insurers must fully explain the methodology they use to derive discounts or surcharges.

4.o.1. Indicated Discounts or Surcharges

The ratemaking process must be outlined in detail where the insurer proposes to introduce or make changes to the amount or criteria of a discount (except a group discount which is to be disclosed in section 4.q.) or surcharge.

The insurers must provide rationale and support for discount and surcharge changes. Company specific loss data should be used to the extent possible. If the insurer finds it necessary to rely on outside data or a different source of company data, the insurer must identify the source of the data and provide an explanation of its applicability. All data used in the process of developing the indicated discounts or surcharges should be exhibited and labelled.

When a predictive model or some other analytical pricing methods such as GLM or GAM are used to analyze the proposed discounts or surcharges, a complete description of the model, data source, data variables and assumptions must be provided. The result derived from traditional methods such as the loss ratio method should also be provided to reconcile general direction.

A comparison of current, indicated and proposed discounts or surcharges must be provided for each coverage when a change is proposed. Included in this should be the written premium distribution and the exposure distribution by discounts or surcharges.

If credibility procedures are used, they must be disclosed in the same detail as outlined in section 4.h.

A current and proposed distribution of the insurer's book of business that is affected by the discount or surcharge change must be provided to determine the average premium changes. All assumptions and detailed calculations must be provided to support the rate level change.

The general approach to calculating discounts or surcharges can be expected to remain reasonably constant over the years for the insurer. Any change in either the approach or the underlying data from the prior rate filing should be disclosed and supported.

4.o.2. Off-balance

The aggregate premium may be increased or decreased through the introduction of new discounts or surcharges, or by changes to existing ones. The filing must account for these changes using off-balance procedures or by accounting for the premium change in its rate level.

All data used in the process of calculating the off-balance must be exhibited and labelled. The calculation of each off-balance must be shown. Any distributions used to calculate off-balance factors for new discounts must be fully supported. All judgments associated with the process of calculating the off-balance should be disclosed and supported.

Off-balance calculations should be based on the insurer's own distribution of business for discounts or surcharges. Should the insurer find it necessary to rely on outside data or a different source of internal data, the filing must identify the source of the data and provide an explanation of its applicability in the circumstances.

The general approach to calculating the off-balance can be expected to remain reasonably constant over the years for the insurer. Any change in either the approach or the underlying data from the prior rate filing should be disclosed and supported.

4.p. Endorsements

All proposed changes to endorsements must be disclosed in this section. This includes the introduction of a new endorsement, introduction of a new rate, change to an existing rate or coverage, or elimination of an endorsement. All current and proposed endorsements must also be filed as part the insurer's rating manual.

The required information for proposing endorsement changes include:

a) endorsement wording (including approval from the Superintendent where applicable);
b) current (if applicable) and proposed premium;
c) qualification criteria; and
d) supporting justification.

4.p.1. Revision to Current Endorsements

For revisions to current endorsements, the insurer must provide its own loss experience to support the proposed changes. If such experience is not available, the insurer must provide the information that it used in its decision-making to support the changes, and must explain why it is relevant.

4.p.2. Introduction of New Endorsements

For the introduction of new endorsements, the insurer must provide supporting materials for any premiums that will be charged and explain why it is relevant. If non-standard wording is being used, the Board will require approval of that wording by the Superintendent of Insurance before addressing any rate issues. If the insurer uses a Standard Endorsement Form, no approval from the Superintendent of Insurance is needed.

4.p.3. Off-balance

The aggregate premium may be increased or decreased through the introduction of new endorsements, or by changes to existing ones. The filing must account for these changes using off-balance procedures or by accounting for the premium change in its rate level.

All data used in the process of calculating the off-balance must be exhibited and labelled. The calculation of each off-balance must be shown. All judgments associated with the process of calculating the off-balance should be disclosed and supported.

Off-balance calculations should be based on the insurer's own distribution of business for endorsements. Should the insurer find it necessary to rely on outside data or a different source of internal data, the filing must identify the source of the data and provide an explanation of its applicability in the circumstances.

The general approach to calculating the off-balance can be expected to remain reasonably constant over the years for the insurer. Any change in either the approach or the underlying data from the prior rate filing should be disclosed and supported.

4.q. Rating Based on Group Membership

The ratemaking process must be outlined in detail where the insurer proposes (a) a discount or schedule of rates based on membership in a group; or (b) discounts or a schedule of rates that vary among groups.

A discount or a schedule of rates based on group membership should be based on:

- lower loss costs experience,

- risk management programs,
- identifiable characteristics of a group that would result in lower loss exposure,
- lower expenses based on lower administrative costs, or
- lower acquisition cost.

The insurer must maintain separate premium and loss statistics to support a discount or schedule of rates based on group membership. The basis of the discount or rates must be defined in sufficient detail so that naming individual organizations is not necessary. The insurer is not expected to develop a unique discount or schedule of rates for a specific group unless such a group is of sufficient size that its own experience supports such a discount or schedule of rates. Support for discounts and rates must be based on credible data and therefore only in the instance of large groups would a unique discount or schedule of rates be appropriate. In the case where more than one discount is proposed (e.g., variation of discounts based on types of groups), a list of groups and discounts applicable is to be submitted with the filing.

The insurer's own loss data must be used to the extent possible. If the insurer finds it necessary to include outside data or a different source of company data, the insurer must identify the source of the data and provide an explanation of its applicability. All data used in the process of developing the indicated discounts or rates based on group membership must be exhibited and labelled.

A comparison of current, indicated and proposed discounts or rates must be provided for each coverage when a change is proposed. Included in this must be the written premium distribution and the exposure distribution by discounts or schedule of rates.

If credibility procedures are used, they must be disclosed in the same detail as outlined in subsection 4.h.

4.r. Usage Based Insurance (UBI) Discount Programs

Section 15 of NLR 56/19 sets out the regulations for insurers opting to introduce usage based technology for automobile insurance in the province. Insurers are required to act in compliance with these regulations in all circumstances where usage based technology is utilized.

Insurers are required to file appropriate actuarial support to have discounts approved by the Board. The Board recognizes that initially there will be little or no Newfoundland and Labrador-specific data to provide in a filing. However, the Board is supportive of innovation and is willing to review data from, and the discounts offered in, other jurisdictions. Insurers may support their initial UBI discount program filing with any reasonable existing data available.

Insurers will be expected, in future mandatory filings, to include Newfoundland and Labrador-specific data to support continued inclusion of a UBI discount program once it becomes available.

UBI-related rates and risk classification system elements must be just, reasonable and meet the statutory standards applicable to all rates and risk classification systems.

There are generally two forms of UBI discount programs:

The first form uses a telematics device installed in a vehicle for a period of time to determine the UBI discount to assign to the policyholder. Such discounts will stay on the policyholder's record unchanged.

The second form continuously updates the policyholder's UBI discount by monitoring driving behaviour based on an approved calculation method. This approach is generally based on a telematics device or mobile phone app. With this form, the insurer must clearly state how the midterm discount adjustments are to be handled. It is not acceptable to remove all or part of a UBI discount midterm.

If the insurer determines that any of the criteria initially used to determine prospective UBI discounts needs to be changed, the insurer will be required to re-file its UBI discount program with necessary adjustments with the Board. For example, if the majority of participating consumers do not qualify for a discount in premiums in subsequent renewal periods, the insurer may need to consider whether the rating factors need to be recalibrated (e.g., rating factors such as speed, acceleration or braking).

In the first and subsequent mandatory filings after the UBI discount program has been in place for one full year, the insurer must account for any differences between the actual and the actuarially-projected average UBI discount and, as a result, the average rate level changes that flow from the discount.

4.r.1 Description of the UBI Discount Program

The insurer must provide a description of the UBI discount program, which includes or covers:

a) the enrollment process;
b) the length of time the driver behaviour will be monitored;
c) the criteria for a policyholder to receive a discount;
d) the frequency of changes to a policyholder's UBI discount;
e) information to be provided to the insureds before and after they choose to opt into the UBI discount program;
f) the process for handling mid-term changes, such as vehicle replacement;
g) the cancellation process; and

h) a declaration that lost revenue due to the proposed UBI discount program will not be off-balanced to base rates for non-UBI policyholders.

4.r.2. Reasonableness of Proposed UBI Discounts

The insurer must demonstrate that proposed UBI factors and discounts are just, reasonable and meet the statutory standards applicable to all rates and risk classification systems.

To that end, this section must clearly identify and present:

a) what rating factors/driving behaviours (e.g., acceleration or deceleration rates, speed, distance travelled) are being considered in determining the UBI discounts;
b) how the rating factors/driving behaviours are measured (e.g., frequency, occurrence, relevant thresholds);
c) how data under the UBI discount program is to be collected, normalized, categorized and used for rating purposes (e.g., total occurrences averaged);
d) what available data/relevant claim experience (e.g., claim severity, claim frequency, loss costs) was used to support the significance of each rating factor being used in the UBI discount program;
e) what available data was used to support the proposed discounts, including how UBI related expenses are considered in developing the proposed discounts; and
f) how the UBI discounts will be applied (e.g., how the rating factors map into the proposed discounts, the amount of the proposed discounts, the coverages to which the proposed discounts will be applied, frequency of re-calibration of a policyholder's discount, etc.).

4.r.3. Application of UBI Discounts in Premium Determination

The insurer must clearly explain how the UBI rating factors lead to the policyholder's UBI discount and how the discount is applied in determining the policyholder's premium.

In each filing, a side-by-side comparison of the insurer's current and proposed UBI rating algorithm must be presented, with proposed changes highlighted.

4.r.4. UBI Discount Program Costs and the Impact on Company Expenses

The insurer's expenses are an important component in rate determination. The insurer must clearly demonstrate the up-front or start-up costs associated with developing and introducing a UBI discount program, as well as all ongoing maintenance and other expenses associated with offering the program, including but not limited to:

a) all costs associated with the UBI device;
b) all costs associated with telematics devices and/or mobile phone apps;

c) data transfer and analysis;
d) marketing; and
e) any third-party provider contracts.

The insurers should treat UBI start-up costs as part of research and development and not specifically allocate them. It is expected that over time, the ongoing operational costs associated with UBI will be borne only by those enrolled in the UBI discount program.

Section 5 – Underwriting and Rating Rule Changes

5.a. Underwriting Rule Changes

Underwriting rules are those rules used to govern the decision to accept or decline a risk or a coverage, deductible level, or liability limit.

All additions, deletions and/or changes to underwriting rules must be filed in this section. Underwriting rules are subject to review, but are not "approved" by the Board. Insurers will be notified if any proposed underwriting rule is found to be non-compliant, otherwise they are accepted as filed.

Section 96.1 of the *Insurance Companies Act* and associated regulations prohibit insurers from using certain underwriting rules in the province. Please refer to Section 1.4 of this document for additional details.

5.b. Rating Rule Changes

Rating rules are those rules or definitions by which a risk is assigned to a specific rating cell or by which a discount or surcharge is applied. Examples include rules by which territory, vehicle use or class are assigned. Rating rules are part of an insurer's risk classification system and must be filed according to these requirements. Any rate level impact resulting from changes must be quantified and its impact should be reflected in the proposed rate level changes.

All rating rule changes are to be filed in this section. The required information must include: (i) a description of the proposed changes, (ii) the rationale for the proposed changes, (iii) the rate level effects of the proposed changes, if any, (iv) an estimate of the number of policies affected, and (v) the calculations that validate the rate level effect of the proposed changes based on the expected distribution of business.

Section 96.2 of the *Insurance Companies Act* and associated regulations prohibits insurers from using certain elements in its risk classification system in the province. Please refer to Section 1.4 of this document for additional details.

Section 6 – Rate Exhibits

Exhibits illustrating current and proposed rating algorithms, base rates, discounts/surcharges, and differentials, clearly identified as either current or proposed, must be disclosed in this section, including any explanatory material in support of the proposed changes.

To facilitate the review process, all of 6.a. - 6.d. **must be included** even if there are no proposed changes to the element.

6.a. Algorithm

Exhibits illustrating current and proposed algorithms for all coverages, including discounts and surcharges, must be disclosed in this section.

6.b. Base Rates

Exhibits illustrating current and proposed base rates must be disclosed in this section.

6.c. Differentials

Exhibits illustrating current and proposed differentials must be disclosed in this section.

6.d. Discounts and Surcharges

Exhibits illustrating all current and proposed discounts (including group discounts, if applicable) and surcharges for each applicable coverage must be disclosed in this section.

6.e. Calculation of Final Rates

The filing must clearly describe and show how current manual territorial base rates are transformed into proposed manual territorial base rates through the application of the proposed rate change in combination with any off-balance.

6.f. Calculation of Rate Level Change

The filing must clearly describe and show how the rate level impact of changes to base rates, differentials and discounts or surcharges, in combination with any off-balance, are used to calculate the overall rate level change on a per coverage basis, and on a combined basis for all coverages. This calculation must reconcile with the Proposed Overall Rate Level Change in Appendix A – Rate Filing Summary before any renewal capping.

6.g. Dislocation and Capping

Rate capping may be considered in minimizing rate dislocation for renewal policyholders. Any capping procedure and associated rules for eligibility must be fully described in this section. The disclosure should include the rationale for imposing the cap, how the cap is applied, the length of time the cap will apply, how long it will take for the impact of the cap to be exhausted, and how the cap will be removed.

Insurers are encouraged to review other options regarding their proposal and avoid rate capping procedures, where appropriate.

Any proposed capping procedures should generally be applied on a vehicle premium basis and no negative rate capping is permitted.

Capping procedures should generally apply for a maximum of two annual renewal cycles, however insurers can request a longer capping period provided that justification for the longer period is provided.

Insurers must take into account the impact that proposed rate changes will have on consumers. Information on rate dislocation is required in Appendix A - Rate Filing Summary.

Insurers must provide the “uncapped” overall rate level change along with the “capped” overall proposed rate level change in a filing where capping is proposed.

Insurers are required to track all policies where capping has been applied, along with the reason for the capping.

Section 7 - Dependent Categories (if applicable)

For those categories of automobile insurance or vehicle classes that are dependent on the rate filing submitted, please provide the following:

a) a list of all dependent categories impacted by the proposed changes;
b) the rate level effects of the proposed changes;
c) the calculations that validate the rate level effect of the proposed changes; and
d) a copy of the rating rule that stipulates the linkage to the dependent category of automobile insurance.

Insurers must state whether the relationship between the dependent category and the category being filed has changed or not. If the relationship has changed, the insurer should explain the rationale for and the impact of the proposed change.

Appendix A – Rate Filing Summary

The "Rate Filing Summary-Mandatory" Excel template is available for download on the Board's website. This file should be sent as a separate document in the rate filing package and identified as Appendix A in the file name.

The Rate Filing Summary document contains certain key information on the nature of the proposed rate level and/or rating program changes. All data used in the Actuarial Support section (Section 4) should reconcile to the information presented in the Rate Filing Summary.

For Miscellaneous Vehicles, Public Vehicles and Other Vehicles, where more than one vehicle class may be included in the filing submission, **a separate Rate Filing Summary must be completed for each vehicle class included in the filing**. For example, for Miscellaneous Vehicles, a separate Rate Filing Summary would be required for motorcycles, all-terrain vehicles, snowmobiles, etc.

Publication

Section 13 of NLR 56/19 requires the Board to publish specific information pertaining to rate applications within 30 days of approving, prohibiting or varying rates. This information has been included in the "Publication" tab in the Rate Filing Summary Excel document. The information in the Publication tab will be exported to pdf format and published to the Board's website with the corresponding Board Order.

A separate publication form must be completed for each vehicle class included in the filing.

Appendix B – Rating Examples

The rating examples Excel templates are available for download on the Board's website. The applicable files should be sent as separate documents in the rate filing package and identified as Appendix B in the file name.

This section sets out rating examples covering the categories of automobile insurance using the Canadian Automobile Insurance Rate Regulators' harmonized profiles. There are separate templates for Private Passenger, Commercial, Miscellaneous and Taxi.

These profiles are to be used for all filings that require rating examples. Insurers must file with the Board those rating examples that would be affected by the filing. These profiles will be published to the Board's website, with the accompanying Board Order, in accordance with Section 13 of NLR 56/19.

The rating examples must be completed according to the risk description specified. Insurers must provide both current and proposed rating criteria for each of the rating examples as required. Rating territories must be those as defined in the insurer's Automobile Insurance Manual.

Any additional information pertaining to the rating example must be disclosed with a detailed description for each affected rating example.

Specific instructions and key assumptions that must be adopted when completing these rating examples are:

- All rates are to be stated on an annual basis. If annual policies are not issued, the rates must be converted to an annual basis.
- All risks must be rated strictly according to the information provided. DO NOT provide preferred rates unless the criteria as stated fit the eligibility rules for a preferred class. If so, provide only the preferred rates, and state so.
- Clearly identify all applicable surcharges/discounts that apply to each of the coverages.
- If the insurer does not write a particular limit or deductible level for a described profile, provide the premiums using the closest limit/deductible and note the applicable limit/deductible on the profile.
- If the insurer provides group discounts, provide the individual non-group rate plus the rates with the highest discount applied.
- For multiple operator risks, provide premiums by coverage by operator using separate sheets. Also, the total policy premium combining all operators must be submitted.
- If, based on the insurer’s underwriting rules, a risk profile described in a specified rating example is not written, that fact is to be indicated, and rates need not be provided for that example. However, the insurer must explain why the rating example is not appropriate under the circumstances.
- If a rating example does not describe a unique rate, the insurer is to provide the highest and lowest rate that could be charged on the described risk, and disclose the assumption underlying the difference.
- Include the premiums for all perils only if collision and comprehensive are not offered.
- Unless stated explicitly in the profile, do not assume the operator has progressed through the graduated licensing system.

Appendix C – Rate Model Indications

Insurers must provide the excel spreadsheets and/or other information used in determining their rate level change indications in Appendix C – Rate Model Indications. All data must be provided in an excel format that can be fully manipulated with formulas intact. Any files included in Appendix C should be sent as separate documents in the rate filing package and identified as Appendix C in the file name.