FSRA is actively reviewing all FSCO regulatory direction, including but not limited to forms, guidelines and FAQs.

Until FSRA issues new regulatory direction, all existing regulatory direction remains in force.

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Other than Private Passenger Automobile Filing Guidelines - Major

A. General Information

Rate and Risk Classification System Legislation and Regulations

Sections 410 to 417 of the Insurance Act (the Act), R.S.O. 1990, Chap. I.8, as amended, set out certain requirements pertaining to rates and risk classification systems for automobile insurance. The Automobile Insurance Rate Stabilization Act, 2003, as amended (AIRSA) applies to insurers and contracts of automobile insurance with respect to the Personal Vehicles — Private Passenger Automobile category of automobile insurance. As stated in Regulation 664, sections 410 to 417 of the Act apply to contracts and endorsements to contracts of automobile insurance on Ontario Automobile Policy (OAP1) or Ontario Driver's Policy (OPF2), but do not apply to contracts insuring "fleets". (Please refer to Regulation 664 for the definition of fleet.)

For the purposes of these Filing Guidelines and the associated Technical Notes, the terms "FSCO" and "Superintendent" are used interchangeably to mean "the Superintendent of Financial Services".

Regulation 7/00 Unfair or Deceptive Acts or Practices outlines prohibited factors for rating of automobile insurance. Regulation 664 further outlines those criteria that are prohibited for the rating of automobile insurance in Ontario. Pursuant to section 16 of Regulation 664, insurers are prohibited from using the following elements in a risk classification system for classifying risks for any coverage or category of automobile insurance:

1. Past claims arising out of accidents occurring on or after September 1, 2010 for which an insured person was 25 per cent or less at fault.
2. The existence or non-existence of a medical, surgical, dental or hospitalization plan or any other arrangement or plan providing coverage to a person who would be an insured person under the contract for services and treatment that the insurer would otherwise be required to pay for under the Statutory Accident Benefits Schedule.
3. The existence or non-existence of an income continuation plan, a sick leave plan or any other arrangement or plan providing coverage to a person who would be an insured person under the contract for benefits that the insurer would otherwise be required to pay for under the Statutory Accident Benefits Schedule.

4. A lapse in automobile insurance coverage unless,
    a. the insured person contravened section 2 of the Compulsory Automobile Insurance Act during the lapse in coverage; or
    b. the lapse of coverage resulted directly or indirectly from,
        i. the termination of a policy of automobile insurance as a result of the insured person's failure to pay the premiums due under the policy,
        ii. the suspension of the insured person's driver's licence as a result of a conviction for an offence related to the use or operation of an automobile, or
        iii. an accident or a conviction for an offence related to the use or operation of an automobile, if the insured person did not inform the insurer of the accident or conviction and the accident or conviction would likely have led to the insured person being charged a higher premium.

Regulation 664 goes on to indicate that, except as permitted under subsection 16(5), no element of a risk classification system shall use any of the following factors:

1. The level of income of a person who would be an insured person under the contract.
2. The employment history of a person who would be an insured person under the contract.
3. The occupation, profession or employment circumstances of a person who would be an insured person under the contract, unless the contract is in respect of a commercial vehicle or a public vehicle or a vehicle used in the course of carrying on a business, trade or profession.
4. The fact whether a person who would be an insured person under the contract has a credit card.
5. The credit history of a person who would be an insured person under the contract.
6. The credit rating of a person who would be an insured person under the contract.
7. The fact whether a person who would be an insured person under the contract is bankrupt or has a history of bankruptcy.
8. The residence history of a person who would be an insured person under the contract.
9. The fact whether a person who would be an insured person under the contract owns a home.
10. The gross or net worth of a person who would be an insured person under the contract.
11. The indebtedness of a person who would be an insured person under the contract.
12. The fact whether a person who would be an insured person under the contract has made premium payments that were late or dishonoured in respect of a contract of automobile insurance that was not terminated by reason of the late or dishonoured payments.
13. A minor accident that occurred on or after June 1, 2016.

Regulations 7/00 and 664 should be reviewed when preparing automobile insurance rate filings in order to ensure compliance with the Regulations.

Processes for Approval and Authorization

Proposed changes to rates and risk classifications for Private Passenger Automobile (PPA) insurance are subject to:

- the **simplified** filing guidelines (refer to the **PPA Filing Guidelines - Simplified**) where the filing changes satisfy the criteria established by the Superintendent (refer to Exhibit 1 of the Technical Notes),
- the CLEAR simplified filing guidelines for filing changes to vehicle rate groups; refer to the **PPA Filing Guidelines - CLEAR Simplified** or
- the **major** filing requirements (refer to the PPA Filing Guidelines - Major).

Proposed changes to rates and risk classifications for Non-PPA Automobile insurance are subject to:

- the **major** filing requirements (refer to the **Other than PPA Filing Guidelines - Major**), where the filing is the initial application for the category, or the insurer satisfies the criteria established by the Superintendent (refer to Exhibit 3 of the Technical Notes) or where FSCO considers it appropriate in the circumstances; or
- the **minor** filing requirements (refer to the **Other than PPA Filing Guidelines - Minor** in all other cases.

Filing Requirements

The legislation provides that an application for approval of rates and a risk classification system shall be in a form approved by the Superintendent and shall be filed together with such information, material and evidence as the Superintendent specifies. The Technical Notes also form part of the Filing Guidelines, and are to be considered in conjunction with these instructions for their application where appropriate. In general, the **Other than Private Passenger Filing Guidelines - Minor** are to be used for filings for rates and risk classification systems that do not qualify for filing under any other filing guideline. Where FSCO considers it necessary, an insurer may be requested to file full actuarial indications and documentation in accordance with these Guidelines. An insurer that is filing rates for the first time for a category other than Private Passenger Automobile must use these Guidelines.

The purpose of these Other than Private Passenger Filing Guidelines - Major is to communicate to insurers the requirements of FSCO for prior approval automobile insurance filings and to provide a systematic approach through which insurers may provide that information and thus facilitate the process of preparing as well as reviewing these filings.

There are separate guidelines for changes to private passenger automobile insurance rates and risk classification systems (refer to the **Private Passenger Automobile Filing Guidelines - Major**). In the case where the rating structure of a category of automobile insurance required to be filed under legislation is dependent upon the insurer's private passenger automobile rates, the information for the dependant category can be submitted with the private passenger automobile insurance filing (refer to Section 8 under the **Private Passenger Automobile Filing Guidelines**.

There are also separate filing guidelines for filing changes to endorsement rates (other than OPCF 44R) and for filing changes to fees. Refer to the **Endorsement Filing Guidelines**.

Affiliated Insurers

An insurer is considered to be affiliated with another insurer if one insurer is the subsidiary of the other or both are subsidiaries of the same body corporate or each of the insurers is controlled by the same person [s. 414 (3)].

The Superintendent may require that affiliated insurers who write automobile insurance to file applications for approval of risk classification systems and rates concurrently [s. 414 (1)]. When deciding upon an insurer's application, the Superintendent may consider the risk classification systems and rates of its affiliates [s. 414 (2)]. The intent of these provisions is that the Superintendent would be able to look at the consolidated picture of the affiliated insurers in determining whether the risk classification system and rates meet the statutory tests.

All criteria used to determine whether an individual receives coverage from an affiliated insurer and/or affect the rates charged to an individual must be filed for approval with the Superintendent. Any process or criteria used for segmentation of business between the affiliated companies must be in compliance with the legislation and its regulations. FSCO will examine the net impact on the consumer who applies for insurance to the affiliated group in applying the statutory standards.

Section 2(1) of Ontario Regulation 7/00 defines the following as an unfair or deceptive act or practice:

> 8. When, in connection with a request for a quotation for automobile insurance or an application for automobile insurance made to an affiliated insurer, or an offer by an affiliated insurer to renew an existing contract of automobile insurance, such a person fails to provide the lowest rate available from the insurer or any of the insurers with which it is affiliated in accordance with,
>
> i. their declination grounds, and
>
> ii. their rates and risk classification systems as approved under the Act or the Automobile Insurance Rate Stabilization Act, 2003.

Required Rates and Risk Classification System Elements

In order for an application to be approved, insurers must have filed rates and risk classification systems for the following:

- Optional accident benefits as set out in the Statutory Accident Benefits Schedule (SABS). Insurers must offer and file their rates and risk classification systems for all categories of automobile insurance for "Optional Accident Benefits" as follows:
  - combined medical rehabilitation and attendant care benefit of $130,000;
  - combined medical rehabilitation and attendant care benefit of $1 Million for non-catastrophic injuries;

- catastrophic benefit of additional $1 Million;
- caregiver benefit of up to $250 per week for first dependant plus up to $50 per week per additional dependant for non-catastrophic injuries, and housekeeping and home maintenance benefit of up to $100 per week for non-catastrophic injuries;
- dependant care benefit of up to $75 per week for first dependant plus up to $25 per week per additional dependant, to maximum of $150 per week;
- increased income replacement benefits;
- increased death and funeral benefits;
- indexation benefit.

- Added Coverage to Offset Tort Deductible Endorsement (OPCF 48)
- A $500 deductible for Comprehensive coverage and a $500 deductible for Direct Compensation - Property Damage (DC-PD) coverage and Collision or Upset coverage. These deductible levels must be established for all categories of automobile insurance though an insured may choose to purchase higher or lower deductibles.

Filing Format

Subject to the guidelines set forth in Section C, the filing should contain the following informational sections in this order:

1. Table of Contents
2. Summary of Information (Appendix A) – refer to ARCTICS
3.a. Certificate of the Officer/Designate (Appendix B1)
3.b. Certificate of the Actuary (Appendix B2)
4. Actuarial Support
5. Discount/Surcharge Changes
6. Rating Rule Changes
7. Final Rates/Rate Level Change
8. Dependent Categories (if applicable)
9. Automobile Insurance Manual Pages
10. Rating Examples (Appendix C) – refer to ARCTICS
11. Fees Changes (Appendix D) – refer to ARCTICS
12. Optional Accident Benefits and Tort Deductible Changes (Appendix E) – refer to ARCTICS

Authorization Process

Filings must be submitted by using our electronic web-based filing system called Automated Rates and Classification Technical Information Communication System (ARCTICS). If you require a password, the "ARCTICS Main Contact" for your company can arrange for access.

Upon FSCO's receipt of a filing, each insurer will receive an electronic acknowledgement of receipt. The

filing will then be reviewed for completeness based on these Filing Guidelines and the insurer will be informed of any information required to complete the filing. Until such time as a filing is complete, the statutory time periods governing approval of filings do not begin to run.

Once a filing is complete, FSCO will review the technical components of the filing. FSCO may request further information from the insurer.

Once an insurer has received notification of authorization from FSCO of its filing, it must file one copy of its complete automobile insurance manual, containing the revised risk classification system, including rating rule changes, if applicable, with FSCO in electronic format (or CD) within 30 days according to the **Filing Guidelines for Automobile Insurance Manuals**.

The insurer may be subject to regulatory action by FSCO if it fails to provide the required information within this time frame.

Note

FSCO may receive access requests under the Freedom of Information and Protection of Privacy Act (FIPPA) for any record in its custody or control. Section 17 of the FIPPA recognizes that certain types of information supplied in confidence by third parties should be exempt from disclosure in the event of an access request if disclosure could result in the harms listed in Section 17. These types of information may include algorithms, base rates, differentials and any information included under Sections 4 through 7 of the filing requirements.

If you think that Section 17 of FIPPA might be applicable to a request for access to your rate filing, please list or stamp all of the pages of the filing that are confidential and give the reasons for the confidentiality. While this exercise does not guarantee that records will not be disclosed, it will be useful in assisting FSCO in responding to an access request.

B. Definitions

Affiliated Insurers

Two or more insurers are considered to be affiliated if any of the following criteria are met:

i. one of the insurers is a subsidiary of another insurer;

ii. both are subsidiaries of the same body corporate;

iii. each of the insurers is controlled by the same person.

Allocated Loss Adjustment Expenses (ALAE)

All external expenses that can be directly charged to a particular claim file, whether a loss payment is made or not, including:

i. adjuster's accounts (including all disbursements) - excluding staff adjusters;

ii. appraisal costs (including appraisal centre costs) - excluding staff appraisal costs or costs included under (i);

iii. legal expenses including all first party legal costs charged to a particular claim file - excluding staff legal fees or costs or fees included under (i);

iv. all other external claims expenses.

Average Rate

For a Coverage: The average Rate for the Coverage expressed in premium dollars per insured vehicle for a 12-month policy term.

For multiple Coverages:

i. For each Coverage in question, multiply the Average Rate for the Coverage by the fraction A/B, in which:

   A = the total number of vehicles insured by the Insurer that had that Coverage in the most recently completed calendar year; and

   B = the total number of vehicles insured by the Insurer in the most recently completed calendar year;

ii. Add the amounts determined under (i).

Category of Automobile Insurance

For purposes of these Filing Guidelines, categories of automobile insurance include the following:

personal vehicles - private passenger automobiles
personal vehicles - motorcycles
personal vehicles - motor homes
personal vehicles - trailer and camper units
personal vehicles - off-road vehicles
personal vehicles - motorized snow vehicles
personal vehicles - historic vehicles
commercial vehicles
public vehicles - taxis and limousines
public vehicles - other than taxis and limousines
OPF 2 – Ontario Driver’s Policy

The above category titles should be used when possible. If subdivisions of the above categories have been made, the insurer should indicate within which of the above categories the subdivisions fall.

Coverage

For the purposes of these Filing Guidelines, Coverages are the following:

Liability - Bodily Injury
Liability - Property Damage
Standard Accident Benefits
Uninsured Automobile
Direct Compensation - Property Damage
Specified Perils
Comprehensive
Collision or Upset
All Perils
Family Protection (OPCF 44R)

Endorsement

An endorsement (policy change form), approved by the Superintendent under section 227 of the Act, to a contract of automobile insurance. Standard Ontario endorsements are issued under a series of OPCF numbers. Non-standard endorsements, which must also be approved by the Superintendent, are uniquely identified by each insurer. For purposes of these Filing Guidelines, OPCF 44R is treated as a **Coverage**, not as an endorsement.

Expedited Approval

Process of regulation in which insurers may have their risk classification systems or rates approved within thirty days after filing them with FSCO in accordance with legislation. An insurer must comply with criteria set out in regulation to be able to file under the expedited process. The expedited approval system applies to coverages, including OPCF 44R, for personal vehicles - private passenger automobiles written on OAP 1, except those contracts written by the Facility Association. Contracts written on Ontario Policy Form 4, 6, 7, or 8, or contracts of automobile insurance that insure fleets or any endorsements on those contracts, are exempt from the file and use, expedited approval and prior approval systems of regulation.

Fleet

Means a group of not fewer than five automobiles that meets the following requirements:

1. At least five of the automobiles in the group are commercial vehicles, public vehicles or vehicles used for business purposes.
2. The automobiles in the group are,
    i. under common ownership or management, and any automobiles in the group that are subject to a lease agreement for a period in excess of 30 days are leased to the same insured person, or
    ii. available for hire through a common online-enabled application or system for the pre-arrangement of transportation, and insured under a contract of automobile insurance in which the automobile owner or lessee, as the case may be, has coverage as an insured named in the contract.

Investment Income

All income attributable to the investment of policyholder supplied funds and shareholder supplied funds and surplus, including realized capital gains (and losses), net of investment expenses.

Investment Return on Cash Flow

The rate of return associated with the portion of investment income earned from the investment of insurance cash flows or the investment of policyholder-supplied funds.

Rate

All amounts payable as premium under contracts of automobile insurance, or endorsements to such contracts, for an identified risk exposure. Rates may be expressed in terms of dollars and/or in terms of multiplicative or additive factors to be applied to a base premium amount. Rates are to include all provisions reflecting surcharges/discounts for applicable risk exposures. Rates are to be inclusive of commissions and other expense provisions used by the insurer, and are to be considered prior to the granting of policyholder dividends. Rates are subject to the provisions of legislation. For purposes of these Filing Guidelines, rates filed are to exclude amounts payable on endorsements other than OPCF44R.

Rate Differentials

Multiplicative or additive factors/rates that are applied to the base rate for a particular territory to arrive at the rates for that territory, by class, limit of liability, deductible, etc.

Rating Algorithm

The manner in which base rates, rate differentials, and other surcharges/discounts are combined to arrive at the premium charged to an individual risk.

Rating Rule

A rule 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, driver classification and vehicle rating group are assigned. Rating rules differ from underwriting rules that involve the decision to accept or decline a risk.

Risk Classification System

The elements used for the purpose of classifying risks in the determination of rates for a coverage or category of automobile insurance, including the variables, criteria, rules and procedures for that purpose.

Territorial Base Rate

The rate that serves as the starting point for each territory for developing all other rates by class, limit of liability, deductible, etc. It is the rate in the territory for that particular combination of class, limit of liability, deductible, etc. for which the multiplicative factors are all 1.00 and the additive factors are all zero.

Unallocated Loss Adjustment Expenses (ULAE)

All claims settlement and processing costs, excluding ALAE, but including staff adjusters, appraisers,

advisors, lawyers, clerical support, and a portion of general expenses reasonably attributable to the claims function.

Underwriting Profit

Direct premiums earned less undiscounted claims and adjustment expenses, plus investment income earned on cash flow, less commissions and other acquisition expenses, less taxes (excluding income and real estate taxes), less general expenses (applicable to insurance operations) divided by direct premiums earned.

Proposed Underwriting Profit Provision

The provision for underwriting profit in the **proposed** rate, expressed as percentage of the rate.

Target Underwriting Profit Provision

The provision for underwriting profit in the **actuarially indicated** rate expressed as a percentage of the rate.

Underwriting Rules

Those rules that govern the decision by an insurer to accept or decline a risk, coverage or endorsement. Such rules are subject to the provisions of sections 237 and 238 of the Act. Filing of such rules must be made using the **Filing Guidelines for Underwriting Rules** or, for endorsements, the **Endorsement Filing Guidelines** issued by FSCO.

C. Guidelines for Other Than Private Passenger Automobile Major Filing

Section 1: Table of Contents

This section contains a listing of the contents of Sections 2 through 12 of the filing and should be in sufficient detail to serve as a reference, by page number, for the location of specific elements of the filing. FSCO will only accept filing submissions only through the electronic web-based filing system called **ARCTICS**.

Section 2: Summary of Information

The summary section contains certain key information on the nature of the filed rate level or risk classification system changes. All data used in the Actuarial Support section (Section 4) should reconcile to the information presented in **Appendix A**.

Specific instructions to complete the Appendix are outlined below:

- In responding to Question 1, check **all** the items that are applicable to the filing. While 1.a) and 1.b) are mutually exclusive, other changes (listed in 1.c) through 1.m)) may be applicable.
- In responding to Question 2, proposed effective dates are to be listed for both new and renewal business. This information is important in reviewing trend assumptions and also in approving

the filing. If there are any changes to the proposed effective dates you should notify us immediately. In determining renewal dates, the notice periods set out in section 236 of the Act should be taken into consideration.

- In responding to Question 4, the indicated rate level change for each coverage, and on an all coverages combined basis, must be disclosed under the following circumstances:
    - where changes to base rates are being proposed, except if such changes to base rates result solely from off-balancing differential or discount changes; or
    - where changes to differentials are being proposed if such changes result in an overall rate level change.

- In responding to Question 4, the impact of **all** proposed changes to rates or rules, including base rate changes, differential changes, discount or surcharge changes, and rating rule changes, must be disclosed under the proposed rate level change column. The impact by coverage must be calculated on an uncapped basis, and disclosed.
- In responding to Questions 4a and 4b, insurers should exclude endorsement premiums. If they are unable to do so, insurers should indicate that endorsement premiums are included in the indicated rate level change and proposed average rate level change calculations. It is important that insurers be consistent with respect to the inclusion or exclusion of endorsement premiums between filings. See question 4b of Appendix A for further instructions.
- In responding to Question 4b, the exposure weights for each coverage should be disclosed in percentage terms based on the number of insured vehicles under Bodily Injury and should reflect the current distribution level.
- In responding to Question 5a, prior approved rate level changes should be shown. The All Coverages Combined Rate Level Change should be based on the on-level premium weights that were applicable at the time of the rate change.
- In responding to Question 5b, the Average Cumulative Rate Change is to be calculated by:
    - taking the All Coverages Combined Rate Level Change from the response to question 4;
    - taking each All Coverages Combined Rate Level Change that occurred after January 1 of the year up to the proposed renewal effective date from the responses to question 5a,

      and then using the following formula:

      $$\left[\prod_{\text{all } i, d} (1 + i)(1 - d) \right] - 1$$

      where:

i = the proposed rate level increase or approved rate level increase(s) that occurred within the 12 months before the proposed rate change is expected to be effective for renewal business; and

d = the proposed rate level decrease or approved rate level decrease(s) that occurred within the 12 months before the proposed rate change is expected to be effective for renewal business.

- In responding to Question 9, please refer to the definition of Underwriting Profit Provision in these guidelines.
- In responding to Question 12c, the same formula as Question 5b is to be used except take the All Coverages Combined Rate Level Change from the response to 12b.

Section 3: Certificates of the Actuary and of the Officer/Designate

3.a. Certificate of the Officer/Designate

Each filing must be accompanied by a signed authorized Certificate of the Officer/Designate. A copy of the Officer/Designate form is attached as **Appendix B1**. Authorized officers are the President, Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, or Chief Agent for Canada. Alternately, the President, Chief Executive Officer, Chief Operating Officer, or Chief Financial Officer may authorize a designate to sign the Certificate of the Officer/Designate. The Designate should be of Vice-President rank or above.

To designate an alternate, an original signed letter of authorization must be submitted for our files. **A copy of this authorization must be included with each filing where a designate signs the certificate.**

3.b. Certificate of the Actuary

Filings that result in a rate level change, or where differential changes are proposed, or filings for a category of automobile insurance previously not written by an insurer, must be accompanied by a Certificate of a Fellow of the Canadian Institute of Actuaries. A copy of the required form is attached as **Appendix B2**. A Certificate of the Actuary is not required when the company is filing only for fee changes (see Appendix D). It is also not required for filing Optional Accident Benefit/Tort Deductible rate filings (see Appendix E).

Section 4: Actuarial Support

The insurer must provide detailed support for any rate level change. Actuarial support should contain the data and narrative description of all ratemaking steps for each of the specific rate changes being proposed. At a minimum, detail should be provided for Liability - Bodily Injury, Liability - Property Damage, Standard Accident Benefits (by sub-coverage), Uninsured Automobile, Direct Compensation Property Damage, Collision, Comprehensive, All Perils, Specified Perils and OPCF 44R, **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 (e.g., the section on loss trend

must contain loss trend documentation for Liability, Accident Benefits, Collision, etc.). In general, documentation must be in sufficient detail to enable the reviewer to trace the resulting rates from the raw data experience and other supporting data. FSCO does not require insurers to use a specific ratemaking methodology. However, insurers are required to provide adequate actuarial documenta-tion and support for the rate levels subject to prior approval.

All support provided in this section must reconcile to the Summary of Information (Appendix A).

Sections (4.a.) - (4.j.) must be completed in all cases, whether or not the filing proposes any overall rate level change. In addition, sections (4.k.) - (4.n.), as applicable, must be completed if the insurer proposes to change territorial, classification, limit of liability, deductible, or other rate differentials, whether with or without any overall rate level change.

The support for an overall rate level change should be comprised of the following subsections, **in the order set out below**. Each section or subsection should 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.

Overall Rate Level Indication:

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. Automobile Insurance Reform Adjustment Factors
6. Other Adjustments

4.c. Allocated Loss Adjustment Expenses (ALAE)

1. ALAE Development
2. ALAE Trend
3. Catastrophe Procedure
4. Other Adjustments

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
2. Premium Variable Expenses

4.g. Underwriting Profit Provision

4.h. Credibility

4.i. Other Adjustments

4.j. Summary Rate Level Indications

Rate Differential Indications:

4.k. Territorial Indications

1. Indicated Differentials
2. Off-balance

4.l. Implementation of Rate Group System Differentials

1. Overall Description for Implementing CLEAR
2. Off-balance

4.m. Classification/Limit of Liability/Deductible or Other Rate Differential Indications

1. Indicated Differentials
2. Off-balance

4.n. Rating Based on Group Membership

1. Indicated Discounts or Rates
2. Off-balance

4.o. Usage-Based Insurance Pricing Programs (UBIP)

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

An insurer may use either a pure premium or a loss ratio ratemaking approach. This section must indicate the type of approach used and generally outline the process in a summary narrative. A general description of the data must also be included. Specific and detailed information on the data must be included in the

appropriate subsections using that data. For example, liability loss data should state whether it is for all limits combined or if it is for a specific (basic) limit.

The filing must include the most recent complete year of data that is available. Should the filing rely on industry experience, FSCO would expect the filing to be based on the most recent industry data.

4.b. Losses (see also Technical Notes)

If losses are considered together with ALAE, this should 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 data must be described in this subsection (i.e., accident year or policy year). Where another basis is used, justification must be provided. The experience period and the respective valuation dates should also be noted. The source of the data should be clearly noted (e.g., company internal data, company data as reported to GISA). Direct losses (i.e., prior to any reinsurance transactions) should be the basis for ratemaking and should **not** be reduced by the insurer's cession to the Risk Sharing Pool. Direct losses should **not** include losses incurred on the Facility Association Residual Market risk business. Similarly, where industry-wide statistics are used, Facility Association Residual Market Risks results should be excluded. Losses covered by policy endorsements should be excluded For Standard Accident Benefits, losses should be at the sub-coverage level as defined by the Automobile Statistical Plan. Refer to the Technical Notes for a break-down of sub-coverages used in the Loss Development Exhibits of GISA Automobile Statistical Plan.

If the type of loss data differs from the basis described in this section, details on the differences must be provided.

4.b.1. Loss Development (see also Technical Notes)

The data must be developed to an ultimate level through the use of an appropriate loss development procedure.

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

Loss development should be based on the insurer's own data to the extent possible. At a minimum, the history of unadjusted company loss development data valued at 12-month intervals should be provided (so-called "triangles" of loss valuations at various stages of development). In very few cases should it be necessary to rely on outside data. Should the insurer find it necessary to rely on outside data or a different source of internal data (such as affiliated company data), the filing must identify the source of the data and provide an explanation of its applicability. 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).

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

The general approach to loss development is expected to remain reasonably constant over the years for an insurer. Any change in either the approach or the underlying data from the prior rate filing should be disclosed and supported.

4.b.2. Loss Trend (see also **Technical Notes**)

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

Loss trend should be based on a review of the most recent available industry data experience, giving consideration to the effect of data exclusions on industry data. 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 instant circumstance. All data used in the process of estimating annual loss trend must be exhibited, at least in summary form, and labelled (e.g., are losses paid or incurred, developed or undeveloped).

If credibility procedures are used in estimating loss trend, the selection of the credibility criterion 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 dis-closed. If trend is divided into past trend and future trend components, each component must be fully disclosed and supported in the detail described above.

The general approach to estimating loss trend 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.b.3. Treatment of Large Losses (see also **Technical Notes**)

The filing must clearly indicate how 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 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 (see also **Technical Notes**)

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 should be outlined and the details of the calculations should 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 should 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 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.b.5. Automobile Insurance Reform Adjustment Factors (see also **Technical Notes**)

Historical loss experience should be adjusted to reflect the expected effect of automobile insurance reforms on loss costs in loss trend and rate level analysis.

Post-reform data experience should be reviewed and provided in filings as it becomes available.

The filing must clearly indicate how the historical loss experience has been adjusted for the expected cost changes associated with automobile insurance reforms. Where the reform changes are expected to have a retrospective effect on loss costs, details on the procedure of adjusting prior accident years' loss costs should be provided.

4.b.6. Other Adjustments

Any other adjustments to the loss data should 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.

4.c. Allocated Loss Adjustment Expenses (ALAE)

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

4.d. Unallocated Loss Adjustment Expenses (ULAE)

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 should 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 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 instant circumstance. 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).

The general approach to estimating ULAE is expected to remain reasonably constant over the years for the insurer. Any change from the prior rate filing in either the approach or the underlying data must be disclosed and supported. Where the ULAE varies significantly from the industry average, further detail must be provided. Also, where the ULAE varies significantly from the information submitted to GISA, further detail must be provided.

4.e. Premium

The premium data must be described in this subsection. The experience period and the source of the premium data must also be disclosed. Direct premiums (i.e., prior to any reinsurance transactions) should be the basis for ratemaking and must not be reduced by the insurer's cessions to the Risk Sharing Pool. Direct premiums must not include premiums for the Facility Association Residual Market risk business. Endorsement premiums should be excluded (except OPCF44R).

If the premium data differs from the basis described in this section, details on the differences must be provided.

4.e.1. On-level Adjustments (see also **Technical Notes**)

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

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 (see also **Technical Notes**)

Premium trend must be considered for coverages with inflation-sensitive exposure bases or for coverages where a changing mix of exposures 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 cars for physical damage coverages is an example of a change in mix of exposures which could produce premium trend. (Under **CLEAR** [Canadian Loss Experience Automobile Rating], premium trend is already accounted for in the development of the rate groups.)

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

Premium trend should make use of the insurer's own data to the extent possible. 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 instant circumstance. All data used in the process of estimating premium trend must be exhibited and labelled.

The general approach to estimating premium trend can be expected to remain reason¬ably 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, explained, and supported.

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.

4.f. Other Expenses (see also Technical Notes, Exhibit 2)

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 should be disclosed and documented.

Where an insurer is proposing to vary rates based on the type of distribution system, separate expense statistics must be maintained and filed in support of the rates.

For the latest year, the allocation of expenses to the category of insurance filed should also be reported.

There must be no expense provision established in respect of the Facility Association Residual Market, unless there is a known subsidy in its operation. Risk Sharing Pool must be treated as direct business and therefore must be reflected in the direct loss and premium data.

No additional expense should be provided for by servicing carriers in respect of servicing Facility Association business, as such costs are reflected in the rates charged by the Facility Association. Any significant differences in expense differences in data submitted to GISA must be explained.

FSCO is not likely to approve any filing that will pass through to consumers an expense provision, excluding ULAE and ALAE, that is significantly higher than the industry average expense provision set out in Exhibit 2 of the **Technical Notes**, without details indicating the cause for the higher expenses.

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 should be disclosed. All judgments associated with the process of estimating exposure variable expenses must be disclosed in detail and supported.

Exposure variable expenses should make use of the insurer's own data. 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 instant circumstance. All data used in the process of estimating exposure variable expenses must be exhibited and labelled.

Exposure variable expenses are subject to trend. The elements of trend discussed in subsection (4.b.2.) apply to this subsection as well.

The general approach to estimating exposure variable expenses can be expected to remain reason-ably 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.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 should make use of the insurer's own data. Should the insurer find it necessary to rely on 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 instant circumstance. All data used in the process of estimating premium variable expenses must be exhibited and labelled.

The general approach to estimating premium variable expenses 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.g. Underwriting Profit Provision (see also Technical Notes)

All insurers must submit their rate indications based on a target underwriting profit provision.

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

Insurers that use a cost of capital approach in their rate model must illustrate how the cost of capital is related to the target underwriting 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, before the inclusion of the underwriting profit provision.

Insurers must provide the basis of the selected investment return assumption in discounting, and compare with the actual investment returns earned in the recent past. Assumed claims payment patterns must be supported by paid loss development information.

If the proposed rates are different from those which are actuarially indicated based on the target underwriting provision, the insurer must provide the proposed underwriting provision underlying the proposed rates.

The general approach in selecting the discount rates 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.

4.h. Credibility (see also Technical Notes)

The Ontario 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 Ontario data.

The standard for 100% credibility and the formula for calculating partial credibility must be disclosed and supported.

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

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 standard or procedure 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 the rates must be disclosed and supported 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. If more than one year of loss and/or premium data is used in the ratemaking process, the weight that each of the years receives must be disclosed. If these weights are different from the insurer's prior filing, the change must be disclosed, explained, and supported.

4.k. Territorial Indications

4.k.1. Indicated Differentials and Proposed Differentials (see also **Technical Notes**)

Territorial indications should be calculated by making use of the insurer's own data. 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 instant circumstance. All data used in the process of developing territorial indications must be exhibited and labelled.

A comparison of the current, indicated and proposed territorial differentials must be provided for each coverage for which rates are changing by territory, as well as the rebased current, proposed and indicated differentials. Included in this should be the written premium distribution and the exposure distribution by coverage, by territory.

The rebased indicated and proposed changes must be provided and they must all be in the direction of the indication as well as within +/-10%.

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

The general approach to calculating territorial 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 should be disclosed and supported. Costs must be fairly allocated between territories. The rates for newly formed adjoining territories should not vary by more than +/-10%.

In order to ensure rate equity and minimize rate dislocation, insurers must cap territorial differential changes at +/-10% from the current differential in the direction of the coverage indication. The +/-10% is to be measured from the current differential after re-basing the average proposed differentials to the same average current differentials for each coverage. FSCO is not likely to approve territorial differential changes outside of the +/-10% parameter.

The requirements for changes must be in the direction of the indication and within +/-10% on and all coverages, as well as an overall basis.

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. [In the event that the change in territorial differentials is not off-balanced and instead a rate level change is generated, subsections (4.a.) - (4.j.) must also be completed.]

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 should be disclosed and supported.

Off-balance calculations should make use of the insurer's own distribution of business. 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 instant circumstance.

The general approach to calculating the off-balance is 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.k.3. Definitions (see also **Technical Notes**)

Any changes to territorial definitions must be accompanied by colour maps showing current and proposed territorial boundaries as appropriate. There may not be more than 55 territories in the Province, of which a maximum of ten may be in the City of Toronto, and all territories must be geographically contiguous. Bodies of water are generally not appropriate to use for the establishment of a contiguous area. A common territorial definition must be used for all coverages, and a written description of all territories should accompany filings where definition/boundary changes are made.

Insurers should be aware not to rely exclusively on Canada Post’s FSA or postal code assignments when creating territories as the manner in which Canada Post assigns postal codes and FSA’s may introduce

issues of non-contiguity. In any case, where territory definitions are being changed, an attestation of contiguity may be required.

4.l. Implementation of Rate Group Differentials

The procedures used for replacing the insurer's current rate group methodology and implementing a new methodology must be fully described in this section. The technical information required should be comprised of the following subsections, **in the order set out below**.

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

This section should indicate the company's approach for implementing the new rate group methodology. The rate group table that is being used and capping procedures, if any, should be described in this section. A list of vehicles, by make, model and model year, that have been capped, should also be provided.

4.l.2. Off-balance

The aggregate premium may be increased or decreased through the introduction of a new rate group methodology. The filing must account for these through the use of off-balance procedures or by accounting for the premium change in its rate level. In the event that the change is not off-balanced, and instead a rate level change is generated, subsections (4.a.) - (4.j.) must also be completed.

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 should be disclosed and supported.

Off-balance calculations should make use of the insurer's own distribution of business. 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 instant circumstance.

4.m. Classification/Limit of Liability/Deductible or Other Rate Differential Indications

4.m.1. Indicated Differentials (see also **Technical Notes**)

If the insurer is requesting changes in classification differentials, limit of liability differentials, deductible differentials, or other rate differentials, the ratemaking process must be outlined in detail.

Classification, limit of liability, deductible, and other rate differential indications should make use of the insurer's own data. Should the 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 instant circumstance. 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 the 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 should 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 Generalized Linear Model (GLM) or Generalized Additive Model (GAM) is used to analyze the proposed classification variables and rating differentials, a complete description of the model, 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 method of selecting the classification variables based on 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 proposed risk classification systeml, 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).

Where there are composite variables with interdependencies, any proposed change to the composite variable must be reviewed in the context of loss experience across all of the individual elements collectively (i.e. univariate analysis will not be deemed sufficient).

Please refer to the **Technical Notes** for further details and requirements for predictive models.

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 introduction of new classification, limit of liability, deductible, or other 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. In the event that the change in classification, limit of liability, deductible, or other rate differentials is not off-balanced and instead a rate level change is generated, subsections (4.a.) - (4.j.) must also be completed.

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 distributions of business by classification, limit of liability, deductible, or other rate differential. 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 instant circumstance.

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 must be disclosed and supported.

4.n. Rating Based on Group Membership

This section **must** be completed by any insurer that is introducing or proposing changes to its rates and risk classification system based on group membership. Insurers are responsible for ensuring that any business receiving a discount based on group membership meets all of the regulatory requirements and that group business is monitored on an ongoing basis to ensure compliance.

There are restrictions on when group membership can be used in a risk classification system. Under Section 16(5) of Regulation 664, as amended:

> Membership in an organized group shall not be used as an element of a risk classification system unless the group consists of no fewer than 100 members other than associate members of the group, a group marketing plan has been entered into that meets the requirements of section 17 and the group is,
>
> a. a trade union, a professional or occupational association or an alumni association;
>
> b. a non-profit entity that has been in existence for at least 24 months;
>
> c. a group of employees of the same employer; or
>
> d. a group of members of a credit union that satisfies the requirements of subsection (7).

Only members of such groups referred to above, and their spouses and children under certain conditions, are eligible for a preferential rate under a risk classification system based on group membership. This preferential group rate or group discount is based on lower loss costs due to favourable experience.

Insurers must ensure that all group business complies with the regulatory requirements. Particular attention should be given to the following requirements:

- Groups must contain a minimum of 100 members within Ontario and there should be reasonable efforts expended to ensure that penetration in the group ultimately meets or exceeds the 100 member threshold. It is notable that in the recent two group market surveys, many of the groups reported less than 10 exposures written. Since 2003, prospective groups must have no fewer than 100 members and insurers should have plans to increase penetration in groups with a minimal number of exposures written.
- All groups must have a group marketing plan which meets the requirements set out in Regulation 664. Persons are not eligible for a group rate or discount if there is not a valid group marketing plan in place. Any group written without a group marketing plan is in non-compliance with the regulation.

Also, under Regulation 664 insurers are prohibited from using the existence of medical, surgical, dental, hospitalization, income continuation benefit or sick leave plans in their risk classification systems.

Even if no changes are being proposed, all existing group discounts (including group methodologies) must still be provided in the filing if applicable.

4.n.1. Indicated Discounts or Rates for Groups

The ratemaking process must be outlined in detail where an insurer proposes:

- a discount or schedule of rates based on membership in a group; or
- discounts or a schedule of rates that vary among groups.

A discount or a schedule of rates based on group membership could be based on lower loss costs based on favourable experience, or risk management programs, or identifiable characteristics of a group that would result in lower loss exposure or lower expenses based on lower administrative expense or lower acquisition cost.

Insurers should 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 should be defined in sufficient detail so that naming individual organizations is not necessary. Insurers are 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 actuarially credible 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 required to be submitted with the filing, as well as on a periodic basis. Insurers should complete a regular compliance review of group business to ensure that the business continues to qualify as a group and that the group discount continues to be supported.

The insurer's own 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 rates based on group membership should 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 should 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.).

The general approach to calculating discounts or rates based on group membership can be expected to remain reasonably constant over the years. Any change in either the approach or the underlying data from the prior rate filing should be disclosed and supported.

4.n.2. Off-balance

The aggregate premium may be increased or decreased through the introduction of new discounts or rates, 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. In the event that the change in discount or rate is not off-balanced and instead a rate level change is generated, subsections (4.a.) - (4.j.) must also be completed.

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 group discounts or schedule of rates. 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. Any change in either the approach or the underlying data from the prior rate filing should be disclosed and supported.

4.o. Usage-Based Insurance Pricing (UBIP) Programs for Private Passenger Automobile Insurance

Insurers are required to file appropriate actuarial support to have discounts approved by FSCO.

As UBIP programs are new to Ontario, there may be no insurer-specific and/or Ontario-specific data to support the program proposed by an insurer. FSCO is prepared to accept data and experience from other jurisdictions within which the same or similar UBIP program is operating. However, as insurers gain experience with their UBIPs, we expect that they will increasingly rely on their own Ontario data in subsequent filings.

Implementation of a UBIP program may result in a change to the premium and loss cost levels. The impact of UBIP discounts on rate levels (whether off-balancing the rate changes or not) and the associated expected loss cost savings should be provided in the filing. Similarly, data and assumptions used in the estimation of any premiums and loss cost impacts associated with changes to the UBIP program should also be provided.

See the **Technical Notes** for further information on conditional approval of initial UBIP programs and subsequent reporting requirements.

Section 5: Discount/Surcharge Changes

Where an insurer is proposing to adopt a new discount only, in order to recognize safe driving habits, and the discount is currently in use by another auto insurer in Ontario, an insurer may provide supporting information, i.e., the names of the specific insurer, the rating rule for the discount, and the details and level of the discount proposed, in this section. Discounts/surcharges are considered “differentials” but must be transparent and displayed on the Certificate of Insurance issued to the named insured.

An insurer wishing to introduce a discount or surcharge that is new or unique to the jurisdiction must also provide supporting information. This would include a description of the discount surcharge, the rating rules associated and the details and level proposed. Discounts/surcharges are considered “differentials” and adequate support should be provided.

After initially adopting a new/unique discount/surcharge where an approval has been obtained absent full actuarial support, the insurer is expected to provide indicated differentials for the discount/surcharge in each subsequent major filing, until such time as the discount is adequately supported.

If the insurer is requesting changes in the amount or value of a discount (except a group discount which is to be disclosed in section 4.n) or surcharge, or is introducing a new discount (except a group discount

which is to be disclosed in section 4.n, or a safe driving discount) or surcharge, the approach used in costing and a general narrative of the process must be outlined in detail.

The derivation of the discount or surcharge should make use of the insurer's own data, where possible. The justification for the discount may be from lower expenses due to lower acquisition costs or lower administrative costs or lower loss costs. The filing must clearly indicate the basis for the discount or surcharge. The insurer must have appropriate information to support the discount or surcharge. Should the 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 instant circumstance. All data used in the process of developing the discount or surcharge must be exhibited and labelled.

A comparison of current, indicated and proposed discounts or surcharges must be provided for each coverage for which discounts or surcharges are changing. Included in this should be the written premium distribution and the exposure distribution for the discounts or surcharges. The estimated impact of discounts or surcharges should be supported by actual exposure distribution. Where actual exposures are not available, assumptions used in the estimation of expected exposure distribution must be provided in an exhibit.

If no changes to discounts/surcharges are proposed in the filing, insurers must still list all existing discounts and surcharges (including expense-based discounts and group discounts, if applicable).

A current and a 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 change (shift). All assumptions and detailed calculations must be provided to support the rate level change.

Insurers seeking to remove a discount must provide the rationale for and the impact of the removal. FSCO is unlikely to approve the removal of a discount that has been in the market less than three years, as this is considered a minimum amount of time for an acceptable level of experience to be captured.

FSCO is unlikely to approve a rate filing where the insurer’s proposed rate level change includes an overstatement with respect to the estimated impact of the introduction of a new discount.

Section 6: Rating Rule Changes

Rating rules are those rules 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 driving record are assigned. Rating rules are part of an insurer’s risk classification system and must be filed according to these guidelines. Rate level impact as a result of the rating rule changes should be quantified and its impact should be reflected in the proposed rate level changes.

Underwriting rules, which are those rules used to govern the decision to accept or decline a risk or a coverage, deductible level, or liability limit, must be filed using the **Filing Guidelines for Underwriting Rules**.

Draft automobile insurance manual pages that describe changes to rules or definitions must be included with the filing. Subsequent automobile insurance manual filings should include rating rule changes that have been approved through the rate filing process and underwriting/declination rule changes that have been approved through the underwriting/declination rule filing process.

The required information should include: (i) a description of the proposed changes, (ii) the rationale for the proposed changes, (iii) the rate level effects of the proposed changes, and (iv) calculations that validate the rate level effect of the proposed changes based on the expected distribution of business.

6.a. Rating Rule Changes for Classification Variables

Any change to a rating rule for a particular classification must be disclosed in this section. A current and a proposed distribution of the classification that is affected by the rating rule change must be provided to determine the average premium change (shift) and impact on the overall rate level. All assumptions and detailed calculations must be provided to support the rate level change.

6.b. Rating Rule Changes for Discounts and Surcharges

Any change to a rating rule for a particular discount or surcharge must be disclosed in this section. Also the rating rule applicable to a newly proposed discount or surcharge must be disclosed in this section. A current and a proposed distribution of the business that is affected by the rating rule change must be provided to determine the average premium change (shift) and impact on the overall rate level. Also all assumptions and the rationale to support the use of the rating rule must be disclosed.

Section 7: Final Rates/Rate Level Change

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 7.a. - 7.d. must be included even though the change may be to only one of the elements**.

7.a. Algorithm

Exhibits illustrating current and proposed algorithms for all coverages, including discounts and surcharges, 6-month policy (if applicable) and Optional Accident Benefits (OAB) calculations, must be disclosed in this section.

7.b. Base Rates

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

7.c. Differentials

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

7.d. Discounts and Surcharges

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

7.e. Calculation of Final Rates

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

7.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 which may be applied, are used to calculate the overall rate level change on a per coverage basis. This calculation should reconcile with the Proposed Overall Rate Level Change from Appendix A, Question 4a or Question 12, if applicable.

7.g. Dislocation and Capping Premium Increases (Rate Capping) (see also Technical Notes)

Insurers should take into consideration the impact that proposed rate changes will have on consumers. Information on rate dislocation is required in Appendix A. Any proposed capping procedure, as well as calculation of capping impact, must be fully described in this section.

The coverages that the capping procedure will apply to must be calculated. The capping impact must be calculated based on the main coverages, including OPCF 44R, but excluding endorsements and Optional Accident Benefit coverages.

While capping is usually done at the differential level, capping at the total premium level is permitted only under the limited circumstances outlined below. Capping premium increases (positive capping) will be considered for approval by FSCO in minimizing rate dislocation under the following circumstances:

a. Insurance Company Mergers and Acquisitions: Due to the potential complexity of such situations, insurers will be required to develop a plan to phase out positive capping (if it is proposed) within a two-year time period.

b. Extensive Risk Classification System Changes: When insurers are introducing new variables or unbundling existing ones that create, for example, a situation in which more than 20% of their customers see an increase of more than 20%, positive capping may be considered for a period of two-years or less (i.e. from the effective date of the approved rate filing for renewal business).

c. Insurers may continue to submit rate filings during this period; however, no new positive capping will be considered for approval by FSCO unless the positive capping from the previously approved filing has been exhausted.

Requirements:

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

b. Insurers are required to track all policies where positive capping has been applied and the reason. Insurers are also required to track all policies on which the positive cap has not been applied where the premium increase exceeds the cap. This information must be tracked by the insurer on a semi-annual basis and made available to FSCO upon request.

Capping will not be permitted under the following circumstances:

a. Base rate changes only;

b. Broker portfolio transfers or acquisitions;

c. Premium decreases (negative capping).

Section 8: Other Than Private Passenger Automobile - Dependent Categories

For those categories of automobile insurance that are dependent on the Other than PPA rate filing submitted, please provide the following:

i. the rate level effects of the proposed changes;

ii. the calculations that validate the rate level effect of the proposed changes;

iii. a copy of the rating rule that stipulates the linkage to the category of automobile insurance; and

iv. Section 10 - rating examples must be completed for the dependent category of automobile insurance. Refer to ARCTICS - see Appendix C Other Than PPA Risk Profiles.xlsx.

Section 9: Automobile Insurance Manual Pages Containing Revised Risk Classification System

A draft set of automobile insurance manual pages containing proposed rating rules, discounts, surcharges or definition changes **must be provided** with the filing. A draft set of automobile insurance manual pages that contain the rates by territory and class, driving record, etc. is optional at the time of submitting the filing.

Any changes or additions to the rating rules, definitions or text in the proposed manual should be denoted by a sidebar (|).

A final and complete set of automobile insurance manual pages in electronic format (or CD) containing the approved risk classification system **must** be submitted within 30 days after the rate filing has been approved. The insurer is also required to include a copy of the most current vehicle rate group tables in the complete manual. **Refer to the Filing Guidelines for Automobile Insurance Manuals for instructions.** The insurer may be subject to regulatory action by FSCO if it fails to provide the required information within this time frame.

Section 10: Rating Examples

Appendix C sets out rating examples covering the categories of automobile insurance subject to legislation. Each insurer must file with FSCO those rating examples that would be affected by the filing. It should be noted that these rating examples may not be the same examples required in future filings. Also FSCO may require additional and/or different rating examples as a consequence of the review process. Please refer to the Excel versions of the rating examples entitled Appendix C – Rating Profiles for Other than PPA Filings in the Help Screen of **ARCTICS**. Note that only electronic Excel files attached to the filing in ARCTICS will be accepted by FSCO, otherwise the filing will be deemed incomplete.

The rating examples must be completed according to the risk description specified. Each insurer must

provide both current and proposed rating criteria for each of the rating examples as required. The rating territories should be those as defined in the insurer's auto 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 should 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 should be converted to an annual basis.
- All risks should 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.
- Unless stated explicitly in the profile, do not assume the operator has progressed through the graduated licensing system.
- The rating territories should be those as defined in the insurer’s auto insurance manual.
- Assume the accident involved collision coverage only and that the claim was greater than $1,000.
- 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. In addition, the total policy premium combining all operators should 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.

- Any additional information pertaining to the rating examples must be disclosed under the Classification Treatment section of the template with detailed description for each affected rating example.

- In order for FSCO to consider a non-standard insurer's competitive position in the non-standard market, the insurer is encouraged to provide in its filing its average premium comparison, based on the various risk portfolios, to the average premium of the Facility Association and the insurer's non-standard competitors. Additional information with respect to any observed anti-selection, or the insurer's ability to control growth, or any other observed volatility in the non-standard market must be provided for consideration by FSCO in the filing.

A template file in Excel is available in the Help Screen of **ARCTICS**.

Insurers should note the following rules with respect to completing the template file before providing them to FSCO:

1. Template must remain protected and cannot be changed in any way.
2. Template must be attached to the ARCTICS Other Than PPA rate filing as an individual file, not zipped or in a folder.
3. There can be only one version of the file – the final version. Original/revised versions must be deleted from ARCTICS.
4. Files must be in Excel format, not as a pdf.
5. The file must be called Appendix C_Other Than PPA Risk Profiles.
6. The company name should be chosen from the drop down box, and the effective dates for new business and renewals should be entered on the first page.
7. Fill in premiums in ALL spaces provided. Note that individual coverage premiums rounded to a whole number should be entered (e.g., you must separate UA premium from standard AB premium and provide both figures in the applicable columns). If no premium is charged, type in "0". Provide the Current and Proposed Risk Profile Criteria, as well as comments, to the limit of 255 characters, in the tables on the bottom of each profile page.
8. If your company is only writing groups as per the definition in Regulation 664, please complete both templates using non-group rate.
9. Template must be submitted with each Other Than PPA filing, including dependent categories if applicable, even if no premium changes are proposed.
10. The filing must be returned and re-submitted in ARCTICS when changes to template file (e.g., effective date revision and/or correction of premium) are required.

Section 11: Fees Changes

If the company is proposing to make changes or add new fees, Appendix D must be submitted. A Certificate of the Actuary is not required where the only change proposed is for fees. The rationale for changesand the Certificate of the Officer are required.

Section 12: Optional Accident Benefits and Tort Deductible Changes

If the company is proposing to make these changes, Appendix E must be submitted. The Optional Accident Benefits details must be included in Section 7 even if no changes are being proposed in the filing. A Certificate of the Actuary is not required where the only change is for Optional Accident Benefits and Tort Deductible. The rationale for changes, a Certificate of the Officer and draft automobile insurance manual pages are required.