STATE CORPORATION COMMISSION, BUREAU OF INSURANCE

Rules Governing Filing of Rates for Individual and Group Accident and Sickness Insurance

(effective July 1, 2013)

14VAC5-130-10. Purpose.

The purposes of this chapter (14VAC5-130-10 et seq.) are to: (i) implement procedures for the filing and approval of rates for individual and certain group accident and sickness insurance policy forms and (ii) establish minimum loss ratios to assure that the benefits provided by such policy forms are or are likely to be reasonable in relation to the premiums charged.

14VAC5-130-20. [Reserved]

14VAC5-130-30. Scope.

A. This chapter (14VAC5-130-10 et seq.) applies to all individual accident and sickness insurance policy forms, subscriber contracts of hospital, medical or surgical plans, dental plans, and optometric plans delivered or issued for delivery in this Commonwealth.

B. This chapter also applies to all health insurance coverage issued in the individual and small group markets.

C. This chapter also applies to group Medicare supplement insurance policy forms and group Medicare supplement subscriber contracts of hospital, medical or surgical plans delivered or issued for delivery in this Commonwealth.

D. For purposes of this chapter, a policy form shall include any rider or endorsement form affecting benefits which is attached to the base policy.

E. Except as otherwise provided, nothing contained in this chapter shall be construed to relieve a health insurance issuer of complying with the statutory requirements set forth in Title 38.2 of the Code of Virginia.

14VAC5-130-40. Definitions.

As used in this chapter:

"Actuarial value" or "AV" means the anticipated covered medical spending for Essential Health Benefits (EHB) coverage paid by a health plan for a standard population, computed in accordance with the plan's cost-sharing, divided by the total anticipated allowed charges for EHB coverage provided to a standard population, and expressed as a percentage.

"Anticipated loss ratio" means the ratio of the present value of the future benefits to the present value of the future premiums of a policy form over the entire period for which rates are computed to provide coverage.

"Grandfathered plan" means coverage provided by a health carrier in which an individual was enrolled on March 23, 2010, for as long as such plan maintains that status in accordance with federal law.

"Group health insurance coverage" means in connection with a group health plan, health insurance coverage offered in connection with such plan.

"Group health plan" means an employee welfare benefit plan (as defined in § 3 (1) of the Employee Retirement Income Security Act of 1974 (29 USC § 1002 (1)), to the extent that the plan provides medical care and including items and services paid for as medical care to

employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"Group Medicare supplement policy" means a group policy of accident and sickness insurance, or a group subscriber contract of hospital, medical or surgical plans, covering individuals who are entitled to have payment made under Medicare, which is designed primarily to supplement Medicare by providing benefits for payment of hospital, medical or surgical expenses, or is advertised, marketed or otherwise purported to be a supplement to Medicare. Such term does not include:

1. A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations; or

2. A policy or contract of any professional, trade or occupational association for its members or former retired members, or combination thereof, if such association:

a. Is composed of individuals all of whom are actively engaged in the same profession, trade, or occupation;

b. Has been maintained in good faith for purposes other than obtaining insurance; and

c. Has been in existence for at least two years prior to the date of its initial offering of such policy or plan to its members.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA, or plan provided by another benefit arrangement. "Health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; Medicaid coverage; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

"Health insurance issuer" means an insurance company, or insurance organization (including a health maintenance organization) that is licensed to engage in the business of insurance in this Commonwealth and that is subject to the laws of this Commonwealth that regulate insurance within the meaning of § 514 (b) (2) of the Employee Retirement Income Security Act of 1974 (29 USC § 1144 (b) (2)). Such term does not include a group health plan.

"Health maintenance organization" means:

1. A federally qualified health maintenance organization;

2. An organization recognized under the laws of this Commonwealth as a health maintenance organization; or

3. A similar organization regulated under the laws of this Commonwealth for solvency in the same manner and to the same extent as such a health maintenance organization.

"Individual accident and sickness insurance" means insurance against loss resulting from sickness or from bodily injury or death by accident or accidental means or both when sold on an individual rather than group basis.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, that includes a health benefit plan provided to individuals through a trust arrangement, association, or other discretionary group that is not an employer plan, but does not include coverage defined as "excepted benefits" in § 38.2-3431 of the Code of Virginia or short-term limited duration insurance.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Coverage that would be regulated as individual market coverage if it were not sold through an association is individual market coverage.

"Individual Medicare supplement policy" means an individual policy of accident and health insurance or a subscriber contract of hospital, medical or surgical plans, offered to individuals who are entitled to have payment made under Medicare, which is designed primarily to supplement Medicare by providing benefits for hospital, medical or surgical expenses, or is advertised, marketed or otherwise purported to be a supplement to Medicare.

"Member" means an enrollee, member, subscriber, policyholder, certificate holder, or other individual who is participating in a health benefit plan or covered under health insurance.

"Premium" means all moneys paid by an employer, eligible employee, or member as a condition of coverage from a health insurance issuer, including fees and other contributions associated with a health benefit plan.

"Qualified Actuary" means a member of the American Academy of Actuaries, or other individual qualified as described in the American Academy of Actuaries' U.S. Qualification Standards and the Code of Professional Conduct to render statements of actuarial opinion in the applicable area of practice.

"SERFF" means the National Association of Insurance Commissioner's (NAIC) System for Electronic Rate and Form Filing.

"Small employer" means in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. Effective January 1, 2016, "small employer" means in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

"Small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer. Coverage that would be regulated as small group market coverage if it were not sold through an association is small group market coverage.

14VAC5-130-50. General rules on rate filing; experience records and data.

A. Every policy, rider or endorsement form affecting benefits which is submitted for approval shall be accompanied by a rate filing unless such rider or endorsement form does not require a change in the rate. Any subsequent addition to or change in rates applicable to such policy, rider or endorsement form shall also be filed.

B. Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the anticipated loss ratio. Except for coverage issued in the small group market, interest at a rate consistent with that assumed in the original determination of premiums, shall be used in the calculation of this loss ratio. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the rate filing is in compliance with the applicable laws and regulations of this Commonwealth and that the benefits are reasonable in relation to the premiums.

C. Health insurance issuers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form, including data for rider and endorsement forms which are used with the policy form, on the same basis, including all reserves, as required for the Accident and Health Policy Experience Exhibit. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under forms which provide substantially similar coverage may be combined. The data shall be for each calendar year of experience since the year the form was first issued.

D. In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:

1. Statistical credibility of premiums and benefits, e.g., low exposure, low loss frequency.

2. Experienced and projected trends relative to the kind of coverage, e.g., inflation in medical expenses, economic cycles affecting disability income experience.

3. The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations.

4. The mix of business by risk classification.

E. Rates for coverage issued in the individual or small group markets are required to meet the following:

1. Premium rates with respect to a particular plan or coverage may only vary by:

a. Whether the plan or coverage covers an individual or family;

b. Rating area, as may be established by the commission;

c. Age, consistent with the Uniform Age Rating Curve table below; and

d. Tobacco use, except that the rate shall not vary by more than 1.5 to 1. Employees of a small employer may avoid this surcharge by participating in a wellness program that complies with § 2705(j) of the Public Health Service Act (42 USC § 300gg-4).

Uniform Age Rating Curve

AGE	PREMIUM RATIO	AGE	PREMIUM RATIO	AGE	PREMIUM RATIO
0-20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333

27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64 and older	3.000

2. A premium rate shall not vary by any other factor not described in this subsection.

3. With respect to family coverage, the rating variations permitted in this subsection shall be applied based on the portion of the premium that is attributable to each family member covered under the plan. With respect to family members under age 21, the premiums for no more than the three oldest covered children shall be taken into account in determining the total family premium.

4. The premium charged shall not be adjusted more frequently than annually, except that the premium rate may be changed to reflect changes to (i) the family composition of the member, (ii) the coverage requested by the member, or (iii) the geographic location of the member.

F. In the event of disapproval or withdrawal of approval by the commission of a rate submission, a health insurance issuer may proceed as indicated in § 38.2-1926 of the Code of Virginia.

14VAC5-130-60. Filing of rates for a new policy form.

A. Each rate submission shall include: (i) the applicable policy or certificate form, application and endorsements required by § 38.2-316 of the Code of Virginia, (ii) a rate sheet, (iii) an actuarial memorandum and (iv) all information required in SERFF. For coverage issued in the individual or small group markets, the Unified Rate Review Template shall also be filed.

B. The actuarial memorandum shall contain the following information:

1. A description of the type of policy or coverage, including benefits, renewability, general marketing method, and issue age limits.

2. A description of how rates were determined, including the general description and source of each assumption used.

3. The estimated average annual premium per policy and per anticipated member.

4. The anticipated loss ratio and a description of how it was calculated.

5. The minimum anticipated loss ratio presumed reasonable in this chapter, as specified in 14VAC5-130-65.

6. If the anticipated loss ratio in subdivision 4 of this subsection is less than the minimum loss ratio in subdivision 5 of this subsection, supporting documentation for the use of such premiums shall also be included.

7. For coverage issued in the individual or small group market, a certification by a qualified actuary of the actuarial value of each plan of benefits included and the AV calculation summary.

8. A certification by a qualified actuary that, to the best of the actuary's knowledge and judgment, the rate filing is in compliance with the applicable laws and regulations of this Commonwealth and the premiums are reasonable in relation to the benefits provided.

14VAC5-130-65. Reasonableness of benefits in relation to initial premiums.

A. Benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio of the policy form, including riders and endorsements, is at least as great as specified below:

1. If the expected average annual premium is at least $200 but less than $1,000:

Type of Coverage	Renewal Clause				
	OR	CR	GR	NC	Other
Hospital Confinement Indemnity	60%	55%	55%	50%	60%
Disability Income Protection, Accident Only, Specified Disease and Other, whether paid on an expense incurred or indemnity basis	60%	55%	50%	45%	60%

Definitions of renewal clause:

OR - Optionally renewable: individual policy renewal is at the option of the insurance company.

CR - Conditionally renewable: renewal can be declined by the insurance company only for stated reasons other than deterioration of health or renewal can be declined on a geographic territory basis.

GR - Guaranteed renewable: renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

NC - Noncancellable: renewal cannot be declined nor can rates be revised by the insurance company.

Other - Any other renewal or nonrenewal clauses (e.g., short term nonrenewable policies).

2. If the expected average annual premium is $100 or more but less than $200, subtract five percentage points from the numbers in the table in subdivision 1 of this subsection.

3. If the expected average annual premium is less than $100, subtract 10 percentage points from the numbers in the table in subdivision 1 of this subsection.

4. If the expected average annual premium is $1,000 or more, add five percentage points to the numbers in the table in subdivision 1 of this subsection.

5. Notwithstanding subdivision 1 of this subsection, group Medicare supplement policies, shall be expected to return to policyholders in the form of aggregate benefits under the policy at least 75% of the aggregate amount of premiums collected.

6. Notwithstanding subdivisions 1 and 5 of this subsection, for Medicare supplement policies issued prior to July 30, 1992, as a result of solicitation of individuals through the mails or by mass media advertising, which shall include both print and broadcast advertising, shall be expected to return to policyholders in the form of aggregate benefits under the policy at least 60% of the aggregate amount of premiums collected.

7. Notwithstanding subdivision 1 of this subsection, for Medicare supplement policies issued prior to July 30, 1992, sold on an individual rather than group basis shall be

expected to return to policyholders in the form of aggregate benefits under the policy at least 60% of the aggregate amount of premiums collected.

8. Notwithstanding subdivisions 1 through 4 of this subsection, all health insurance coverage issued in the individual market shall be originally priced to meet a minimum 75% loss ratio and shall be guaranteed renewable or noncancellable.

9. Notwithstanding subdivisions 1 through 4 of this subsection, all health insurance coverage issued in the small group market shall be originally priced to meet a minimum 75% loss ratio and shall be guaranteed renewable or noncancellable.

The above anticipated loss ratio standards do not apply to a type of coverage where such standards are in conflict with specific statutes or regulations.

B. The average annual premium per policy and per member shall be computed by the health insurance issuer based on an anticipated distribution of business by all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

14VAC5-130-70. Filing a rate revision.

A. Each rate revision submission shall include: (i) a new rate sheet; (ii) an actuarial memorandum; and (iii) all information required in SERFF. For coverage issued in the individual or small group markets, the Unified Rate Review Template shall also be filed.

B. The actuarial memorandum shall contain the following information:

1. A description of the type of policy, including benefits, renewability, issue age limits, and if applicable, whether the policy includes grandfathered or nongrandfathered plans or both.

2. The scope and reason for the premium or rate revision.

3. A comparison of the revised premiums with the current premium scale, including all percentage rate changes and any rating factor changes.

4. A statement of whether the revision applies only to new business, only to in-force business, or to both.

5. The estimated average annual premium per policy and per member, before and after the proposed rate revision. Where different changes by rating classification are being requested, the rate filing shall also include (i) the range of changes and (ii) the average overall change with a detailed explanation of how the change was determined.

6. Except for coverage issued in the small group market, historical and projected experience, submitted on Form 130 A, including:

a. Virginia and national historical experience as specified in 14VAC5-130-50 C and projections for future experience;

b. A statement indicating the basis for determining the rate revision (Virginia, national or blended);

c. If the basis is blended, the credibility factor assigned to the national experience;

d. Earned Premiums (EP), Incurred Benefits (IB), Increase in Reserves (IR), and Incurred Loss Ratio = (IB + IR) ÷ (EP); and

e. Any other available data the health insurance issuer may wish to provide. The additional data may include, if available and appropriate, the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates; substitution of actual claim run-offs for claim reserves and liabilities; accumulations of experience funds; substitution of net level policy reserves for preliminary term policy

reserves; adjustments of premiums to an annual mode basis; or other adjustments or schedules suited to the form and to the records of the company. All additional data must be reconciled, as appropriate, to the required data.

7. Details and dates of all past rate revisions, including the annual rate revisions members will experience as a result of this filing. For companies revising rates only annually, the rate revision should be identical to the current submission. For companies that have had more frequent rate revisions, the annual revision should reflect the compounding impact of all such revisions for the previous twelve months.

8. A description of how revised rates were determined, including the general description and source of each assumption on Form 130A. For claims, provide historical and projected claims by major service category for both cost and utilization on Form 130B.

9. If the rate revision applies to new business, provide the anticipated loss ratio and a description of how it was calculated.

10. If the rate revision applies to in-force business:

a. The anticipated loss ratio and a description of how it was calculated; and

b. The estimated cumulative loss ratio, historical and anticipated, and a description of how it was calculated.

11. The loss ratio that was originally anticipated for the policy.

12. If 9, 10a, or 10b is less than 11, supporting documentation for the use of such premiums or rates.

13. The current number of Virginia and national members to which the revision applies for the most recent month for which such data is available, and either premiums in force, premiums earned, or premiums collected for such members in the year immediately prior to the filing of the rate revision.

14. Certification by a qualified actuary that, to the best of the actuary's knowledge and judgment, the rate filing is in compliance with applicable laws and regulations of this Commonwealth and the premiums are reasonable in relation to the benefits provided.

15. For coverage issued in the individual or small group markets, a certification by a qualified actuary of the actuarial value of each plan of benefits included and the AV calculation summary.

14VAC5-130-75. Reasonableness of benefits in relation to revised premiums.

A. For individual accident and sickness insurance, group Medicare supplement insurance, and coverage issued in the individual market, with respect to filings of rate revisions for a previously approved form, benefits shall be deemed reasonable in relation to premiums provided that both subdivisions 1 and 2 of this subsection shall be at least as great as the standards in 14VAC5-130-70 B 11.

1. The anticipated loss ratio over the entire period for which the revised rates are computed to provide coverage; and

2. The ratio of (a) to (b) where (a) is the sum of the accumulated benefits, from the original effective date of the form to the effective date of the revision, and the present value of future benefits, and (b) is the sum of the accumulated premiums from the original effective date of the form to the effective date of the revision and the present value of future premiums.

Present values shall be taken over the entire period for which the revised rates are computed to provide coverage. Accumulated benefits and premiums shall include an explicit estimate of benefits and premiums from the last accounting date to the effective date of the

revision. Interest, at a rate consistent with that assumed in the original determination of premiums shall be used in the calculation of this loss ratio.

B. For coverage issued in the small group market, the anticipated loss ratio over the entire period for which the revised rates are computed to provide coverage shall be at least as great as the standards in 14VAC5-130-70 B 11.

C. If a health insurance issuer wishes to charge a premium for policies issued on or after the effective date of the rate revision that is different from the premium charged for such policies issued prior to the revision date, then with respect to policies issued prior to the effective date of the revision the requirements of subsection A of this section must be satisfied, and with respect to policies issued on and after the effective date of the revision, the standards are the same as in 14VAC5-130-65, except that the average annual premium shall be determined based on an actual rather than an anticipated distribution of business.

14VAC5-130-80. (Repealed.)

14VAC5-130-81. Risk pools and index rate.

A. A health insurance issuer shall consider the claims experience of all enrollees in all health benefit plans, other than grandfathered plans, in the individual market to be members of a single risk pool.

B. A health insurance issuer shall consider the claims experience of all enrollees in all health plans, other than grandfathered plans, in the small group market to be members of a single risk pool.

C. Each plan year or policy year, as applicable, a health insurance issuer shall establish an index rate based on the total combined claims costs for providing essential health benefits within the single risk pool of the individual or small group market. The index rate may be adjusted on a market-wide basis based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs in this Commonwealth. The premium rate for all of the health insurance issuer's plans shall use the applicable index rate, as adjusted in accordance with subsection D of this section.

D. A health insurance issuer may vary premium rates for a particular plan from its index rate for a relevant state market based only on the following actuarially justified plan-specific factors:

1. Cost-sharing design of the plan.

2. The plan's provider network, delivery system characteristics, and utilization management practices.

3. The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits shall be pooled with similar benefits within a single risk pool and the claims experience from those benefits shall be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

4. Administrative costs, excluding health benefit exchange user fees.

5. With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

14VAC5-130-90. Monitoring of experience.

A. The commission may prescribe procedures for the effective monitoring of actual experience under any form subject to this chapter.

B. The commission may request information subsequent to approval of a policy form or rate revision so that it may determine whether premium rates are reasonable in relation to the benefits provided as specified herein in 14VAC5-130-65 and 14VAC5-130-75.

C. If the commission finds that the premium rate filed in accordance with this chapter is or will not meet the originally filed and approved loss ratio, the commission may require appropriate rate adjustments, premium refunds or premium credits as deemed necessary for the coverage to conform with the minimum loss ratio standards set forth in 14VAC5-130-65, and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current rates by the health insurance issuer for the coverage. The commission may take into consideration any previous or expected premium refunds or credits. Detailed supporting documents will be required as necessary to justify the adjustment.

14VAC5-130-100. Severability.

If any provision of this chapter (14VAC5-130-10 et seq.) or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

FORMS

Form 130A, Template for data supporting individual rate revision filings (eff. 7/13)

Form 130B, Trend analysis details (eff. 7/13)

Unified rate review template, at
http://www.serff.com/plan_management_data_templates.htm