STATE CORPORATION COMMISSION, BUREAU OF INSURANCE
Effective January 1, 2020

CHAPTER 130
RULES GOVERNING THE FILING OF RATES FOR INDIVIDUAL AND GROUP ACCIDENT AND SICKNESS INSURANCE

14VAC5-130-10. Purpose.

The purposes of this chapter are to (i) implement procedures for the filing or filing and approval of rates for individual and 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 anticipated to be reasonable in relation to the premiums charged.

14VAC5-130-20. [Reserved].

14VAC5-130-30. Scope.

A. This chapter applies to:

1. All individual and group accident and sickness insurance policies, subscriber contracts of health maintenance organizations or health services plans, dental plans, and optometric plans delivered or issued for delivery in this Commonwealth.

2. All health insurance coverage issued in the individual and small group markets.

3. Individual and group Medicare supplement insurance policies and group subscriber contracts of health maintenance organizations or health services plans providing Medicare supplement coverage delivered or issued for delivery in this Commonwealth.

4. Individual and group long-term care policies issued before October 1, 2003.

B. Except as otherwise provided, nothing contained in this chapter shall be construed to relieve an insurer of complying with the statutory requirements set forth in Title 38.2 of the Code of Virginia.

14VAC5-130-40. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"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.

"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 multiple employer welfare arrangement, 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 an insurer.

"Health maintenance organization" means any person who undertakes to provide or arrange for one or more health care plans as defined in § 38.2-4300 of the Code of Virginia.

"Health system" means an organization that consists of either (i) at least one hospital plus at least one group of physicians or (ii) more than one group of physicians.

"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. Student health insurance coverage shall be considered a type of individual health insurance coverage.

"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.

"Insurer" means a person licensed to issue or that issues any insurance policy in this Commonwealth.

"Medicare supplement policy" means an individual or group accident and sickness insurance policy or certificate, or a health maintenance organization subscription contract or evidence of coverage, 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. For group policies, the term does not include 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 a combination of employees and labor organizations, for employees, former employees, or combination of employees and labor organizations or for members or former members, or combination thereof, of the labor organizations.

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

"Policy" means an insurance policy, form, contract, certificate of insurance, evidence of coverage, subscriber contract or other similar document. A policy shall include any rider or endorsement affecting benefits attached to the base policy.

"Premium" means all moneys paid by an employer, eligible employee, or member as a condition of coverage from an insurer, 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.

"Rate" or "premium rate" means any rate of premium, policy fee, membership fee, or any other charge made by an insurer for or in connection with a contract or policy of insurance. "Rate" shall not include a membership fee paid to become a member of an organization or association, one of the benefits of which is the purchase of insurance coverage.

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

"Small employer" has the same meaning as in § 38.2-3431 of the Code of Virginia.

"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.

"Student health insurance coverage" means a type of individual health insurance coverage offered in the individual market that is provided pursuant to a written agreement between an institution of higher education, as defined by the Higher Education Act of 1965 (Public Law No. 89-329), and a health carrier and provided to students enrolled in that institution of higher education and their dependents, and that does not make health insurance coverage available other than in connection with enrollment as a student or as a dependent of a student in the institution of higher education, and does not condition eligibility for health insurance coverage on any health status-related factor related to a student or a dependent of the student.

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 and rating factors were determined and shall describe and provide the calculation of the anticipated loss ratio. Except for individual and small employer group health insurance coverage, 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. Insurers 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, for example, 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 individual or small employer group health insurance coverage 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 default Uniform Age Rating Curve as specified in guidance by the federal Secretary of Health and Human Services in accordance with 45 CFR 147.102 (a)(1)(iii); 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).

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 younger than 21 years of age, 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.

5. Premium rates for student health insurance coverage may be based on school-specific community rating and are exempt from subdivisions 1 through 4 of this subsection.

F. If the proposed area rate factors set forth in a rate filing for individual or small employer group health insurance coverage by an insurer for a rating area exceed by more than 15% the weighted average of the proposed area rate factors among all rating areas in which the insurer offers health benefit plans in that market, then:

1. The insurer's rate filing shall include in a publicly available and unredacted form:

a. A comparison of the area rate factor for individual and small employer group health benefit plans that utilize the same provider network and provider reimbursement levels of the health benefit plans that are subject to the filing;

b. A detailed disclosure of the area rate factor methodology, which shall include any third-party resources or representations from a person other than the signing actuary, on which the signing actuary relied, provided that disclosure of third-party resources shall address that the source data only reflects differences in unit cost and provider practice patterns; and

c. To the extent that the insurer is deriving any area rate factor from experience data, by rating area for the experience period used:

(1) The (i) total enrollment; (ii) total premiums; (iii) allowed claims; (iv) incurred claims excluding anticipated or, if available, actual risk adjustment payments or receipts; (v) incurred claims including anticipated or, if available, actual risk adjustment payments or receipts; and (vi) loss ratio for each of their rating areas in that market; and

(2) Aggregated incurred claims for any health system exceeding 30% of total incurred claims for that rating area in that market.

2. The commission shall hold a public hearing on the proposed premium rates prior to the approval of the rate filing.

3. The commission shall not approve the proposed rate filing if (i) a variance in area rate factors, indexed to the same rating region for both the individual and small group markets, of 15% or more exists between health benefit plans an insurer intends to offer in the individual market and health benefit plans intended to be offered in the small group market, when those plans utilize the same provider network and provider reimbursement levels and (ii) the methodologies used to calculate the area rate factors are different between the two markets.

G. Beginning for plan year 2020, an insurer with an approved rate filing that contains at least one area rate factor that exceeds by more than 25% the weighted average of the area rate factors among all rating areas in a market in which the insurer offers individual or small employer group health insurance coverage shall file with the commission for each calendar quarter during that plan year a report that provides, for each rating area within the market in which the insurer operates, the plan's (i) enrollment; (ii) total premiums; (iii) allowed claims; (iv) incurred claims excluding anticipated or, if available, actual risk adjustment payments or receipts; (v) incurred claims including anticipated or, if available, actual risk adjustment payments or receipts; (vi) loss ratio; and (vii) aggregate incurred claims, for each health system exceeding 25% of total incurred claims for that rating area. The insurer shall make each such quarterly report publicly available, without redaction, not later than 45 days after the end of the calendar quarter.

H. The commission may investigate and determine whether a rate is excessive, unfairly discriminatory, or unreasonable in relation to the benefits provided. In the event of disapproval or withdrawal of approval by the commission of a rate submission, an insurer may proceed using the process described 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.

B. The actuarial memorandum shall contain the following information:

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

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

3. The expected 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. 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.

8. For individual or small employer group health insurance coverage, a certification by a qualified actuary to include (i) the methodology used to calculate the AV metal value for each plan; (ii) the appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits are based; (iii) the development of the index rate in accordance with federal regulations and the development of plan specific premium rates using allowable modifiers to the index rate; and (iv) the geographic rating factors, which should reflect differences only in the costs of delivery (which can include unit cost and provider practice pattern differences) and not differences in population morbidity by geographic area.

9. For student health insurance coverage, a certification by a qualified actuary to include the methodology used to calculate an AV level of coverage that meets a minimum 60%.

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 in this subsection:

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	n/a	n/a	55%	50%	n/a
Disability Income Protection, Accident Only, Specified Disease and Other, whether paid on an expense incurred or indemnity basis	60%	55%	50%	45%	60%
Short-term Limited Duration	n/a	n/a	n/a	n/a	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.

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. For individual or group Medicare supplement policies, the loss ratios are identified in 14VAC5-170-120 A.

6. Notwithstanding subdivisions 1 through 4 of this subsection, all individual health insurance coverage shall be originally priced to meet a minimum 75% loss ratio and, except for student health insurance coverage such coverage shall be guaranteed renewable or noncancellable.

7. Notwithstanding subdivisions 1 through 4 of this subsection, all small employer group health insurance coverage 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 expected average annual premium per policy and per member shall be computed by the insurer 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.

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 premiums, 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 expected 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. Historical and projected experience, including:

a. Virginia and, if applicable, national or manual 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 manual, or blended);

c. If the basis is blended, the credibility factor assigned to the Virginia 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 insurer 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 insurers revising rates only annually, the rate revision should be identical to the current submission. For insurers that have had more frequent rate revisions, the annual revision should reflect the compounding impact of all such revisions for the previous 12 months.

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

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 if applicable, 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 individual or small employer group health insurance coverage, a certification by a qualified actuary to include (i) the methodology used to calculate the AV metal value for each plan; (ii) the appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits are based; (iii) the development of the index rate in accordance with federal regulations and the development of plan specific premium rates using allowable modifiers to the index rate; and (iv) the geographic rating factors, which should reflect differences only in the costs of delivery (which can include unit cost and provider practice pattern differences) and not differences in population morbidity by geographic area.

16. For student health insurance coverage, a certification by a qualified actuary to include the methodology used to calculate an AV level of coverage that meets a minimum 60%.

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

A. For individual accident and sickness insurance that is "excepted benefits" as defined in § 38.2-3431 of the Code of Virginia and Medicare supplement insurance, 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 individual and small employer group health insurance coverage or short-term limited duration insurance, 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.

14VAC5-130-80. [Repealed].

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

A. This section shall only apply to individual or small employer group health insurance coverage, except for grandfathered plans and student health insurance coverage.

B. An insurer shall consider the claims experience of all individual health insurance coverage members, other than those in grandfathered plans and student health insurance coverage, to be members of a single risk pool.

C. An insurer shall consider the claims experience of all small employer group health insurance coverage members, other than those in grandfathered plans, to be members of a single risk pool.

D. Each plan year or policy year, as applicable, an insurer shall establish an index rate based on the total combined claims costs for providing essential health benefits within the single risk pool. 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 and the health benefit exchange user fees. The premium rate for all of the insurer's plans shall use the applicable index rate, as adjusted in accordance with subsection E of this section.

E. An insurer 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 in accordance with 45 CFR 156.80 (d)(2):

1. Actuarial value and cost-sharing design of the plan.

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

3. Benefits provided under the plan that are in addition to the essential health benefits.

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

5. Only catastrophic plans may be adjusted for 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, rate, 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 insurer 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 or the application 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.