Rate Review Requirements Checklist
For all Rate Filings for Forms Issued in the Individual and Small Group Markets, Hospital Confinement Indemnity, Disability Income Protection, Accident Only, Specified Disease and Other, whether paid on an expense incurred or indemnity basis, and Medicare Supplement

NOTE: This document is intended to assist carriers in preparing rate filings for individual and selected group accident and sickness insurance coverage for approval by the Bureau of Insurance. It provides guidance based on current Virginia laws and regulations. It should be noted, however, that this checklist should not be used exclusive of other important resources, including, but not limited to, any and all other applicable state insurance laws and associated rules and regulations. It is the responsibility of the carriers to verify that their products comply with all relevant statutory and regulatory requirements. Note that some regulatory references in the comments column are approximate. Please review the applicable Administrative Code for the full text of the regulation.

REVIEW REQUIREMENTS	REFERENCE	COMMENTS	LOCATION IN THE FILING TO INCLUDE EXHIBIT NAME OR NUMBER	FILER'S NOTES
General Filing Requirements				
Agent Commissions	§ 38.2-316.1	Describe agent commissions including any limitations or exceptions. (ACA Individual and Small Group Markets Only)		
Certification of Compliance	14VAC5-100-40 3	Certificate of Compliance signed by General Counsel or officer of the company, or attorney, or actuary representing company is required. This is not required if this is a rate only filing.		
Information about the filing	14VAC5-100-70	When submitting an Individual Accident and Sickness form, a company must file the applicable rates, rules and classification of risks with the Commission.		
Company Name and NAIC No.	Administrative Letter 1983-7	The transmittal letter must include the name and NAIC number of the company for which the filing is made.		
Additional SERFF Filing Requirements	***14VAC5-100-40 and SERFF Filing Instructions***	***Additional SERFF filing requirements must be met as specified below for life and health forms and rate filings.***		
General Information Filing Description		All submissions must provide a brief summary of the filing, including a statement describing whether the rate or rate manual is new or a revision of an existing rate or rate manual.		
		Identification of SERFF or state tracking number for the previously approved rate or rate manual.		
HELP TIP:		If a form or rate filing is submitted as new in Virginia, but was previously disapproved or withdrawn in Virginia, please provide details such as the tracking information, form number, and the date that the form or rate filing was disapproved or withdrawn, if available.		
REVIEW REQUIREMENTS	**REFERENCE**	**COMMENTS**	**LOCATION IN THE FILING TO INCLUDE**	**FILER'S NOTES**

REVIEW REQUIREMENTS	REFERENCE	COMMENTS	LOCATION IN THE FILING TO INCLUDE EXHIBIT NAME OR NUMBER	FILER'S NOTES
			EXHIBIT NAME OR NUMBER	
Rate Changes		(i) Include a statement regarding an increase, decrease, revision of former rates. (ii) Specify the percentage amount(s) of the change(s). (iii) Specify the number of affected policyholders. (iv) Specify the reason for the proposed change(s).		
	14VAC5-130-50 B	Include an actuarial memorandum describing the basis on which rates were determined including a description of the calculation of the anticipated loss ratio.		
Individual and Small Group Markets – Uniform Age Rating Curve	14VAC5-130- 50 E 1 Virginia Rate Template	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) The rating area; (c) Age, consistent with the Federal Default Standard Age Curve; (d) Tobacco use, except the rate must not vary more than 1.5 to 1. If included in a small group form, employees must be given the option to avoid the tobacco surcharge by participating in certain wellness programs.		
	14VAC5-130-50 E 2	A premium rate must not vary by any other factor not described in 14VAC5-130-50 E 1.		
	14VAC5-130-50 E 3	For family coverage, permitted rating variations must be applied based on the portion of premium 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 must be taken into account in determining the total family premium.		
	14VAC5-130-50 E 4	The premium charged must not be adjusted more frequently than annually except that the premium rate may be changed to reflect changes to: (i) Family composition of the member or; (ii) Coverage requested by the member.		
	14VAC5-130-50 E 5	Premium Rates for student health insurance coverage may be based on school-specific community rating and are exempt from subdivision 1 through 4 above.		
Accident and Sickness Insurance Rate Filing Requirements – Filing a	14VAC5-130-60 A	New rate submission must include: (i) Form number of applicable policy or certificate, application, and endorsements; (ii) Rate Sheet(s);		

REVIEW REQUIREMENTS	REFERENCE	COMMENTS	LOCATION IN THE FILING TO INCLUDE EXHIBIT NAME OR NUMBER	FILER'S NOTES
Rate for a New Policy Form		(iii) An actuarial memorandum; (iv) All information required in SERFF. Unified Rate Review Template shall also be filed for coverage issued in the individual or small group markets, *except for student health insurance coverage.*		
	14VAC5-130-60 B	**An Actuarial Memorandum that includes:**		
	14VAC5-130-60 B 1	A description of the type of policy or coverage, including benefits, renewability, general marketing method, and issue age limits.		
	14VAC5-130-60 B 2	A description of how rates were determined, including the general description and source of each assumption used.		
	14VAC5-130-60 B 3	The estimated average annual premium per policy and per member.		
	14VAC5-130-60 B 4	The anticipated loss ratio and a description of how it was calculated.		
	14VAC5-130-60 B 5	The minimum anticipated loss ratio presumed reasonable in accordance with 14VAC5-130-65.		
	14VAC5-130-60 B 6	If the anticipated loss ratio is less than the minimum anticipated loss ratio, include supporting documentation for the use of such premiums.		
	14VAC5-130-60 B 7	*For coverage issued in the Individual or Small Group Health Insurance Market:* A certification by a qualified actuary of the actuarial value of each plan of benefits included and the AV calculation summary.		
	14VAC5-130-60 B 8	A certification by a qualified actuary that, to the best of his or her knowledge and judgment, the rate filing is in compliance with the applicable laws and regulations of Virginia and the premiums are reasonable in relation to the benefits provided.		
Reasonableness of benefits in relation to initial premiums	14VAC5-130-65 A	Benefits are deemed reasonable in relation to premiums if the anticipated loss ratio of policy form, including riders and endorsements, is at least as great as specified in the table provided, taking into account the qualifications and adjustments in subdivisions 1 through 9 below. The below anticipated loss ratio standards do not apply to a class of business where such standards are in conflict with specific statutes or regulations.		

REVIEW REQUIREMENTS	REFERENCE	COMMENTS	LOCATION IN THE FILING TO INCLUDE EXHIBIT NAME OR NUMBER	FILER'S NOTES
	14VAC5-130-65 A 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 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%		

	14VAC5-130-65 A 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.		
	14VAC5-130-65 A 3	If the expected average annual premium is less than $100, subtract 10 percentage points from the numbers in the table.		
	14VAC5-130-65 A 4	If the expected average annual premium is $1,000 or more, add five percentage points to the numbers in the table.		
	14VAC5-130-65 A 5	Group Medicare supplement policies are expected to return to policyholders in the form of aggregate benefits under the policy at least 75% of the aggregate amount of premiums collected.		

REVIEW REQUIREMENTS	REFERENCE	COMMENTS	LOCATION IN THE FILING TO INCLUDE EXHIBIT NAME OR NUMBER	FILER'S NOTES
	14VAC5-130-65 A 6	Medicare supplement policies issued prior to July 30, 1992, as a result of solicitation of individuals through the mail or by mass media advertising, which shall include both print and broadcast advertising, are expected to return to policyholders in the form of aggregate benefits under the policy at least 60% of the aggregate amount of premiums collected.		
	14VAC5-130-65 A 7	Medicare supplement policies issued prior to July 30, 1992, sold on an individual rather than a group basis are expected to return to policyholders in the form of aggregate benefits under the policy at least 60% of the aggregate amount of premiums collected.		
	14VAC5-130-65 A 8	All health insurance coverage issued in the individual health insurance market shall be originally priced to meet a minimum 75% loss ratio and, except for student health insurance coverage, must be guaranteed renewable or noncancellable.		
	14VAC5-130-65 A 9	All health insurance coverage issued in the small group health insurance market must be originally priced to meet a minimum 75% loss ratio and must be guaranteed renewable or noncancellable.		
	14VAC5-130-65 B	The average annual premium per policy 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).*		

REVIEW REQUIREMENTS	REFERENCE	COMMENTS	LOCATION IN THE FILING TO INCLUDE EXHIBIT NAME OR NUMBER	FILER'S NOTES
For Rate Revision, all Accident and Sickness Forms; Subscriber Contracts of Hospital, Medical or Surgical Plans; Dental Plans; Optometric Plans; Health Insurance Coverage in the Individual and Small Group Markets; Group Medicare supplement forms and subscriber contracts of hospital, medical or surgical plans – Filing a Rate Revision	14VAC5-130-70 A	Rate revision submission must include: (i) New Rate Sheet; (ii) An actuarial memorandum; and (iii) All information required in SERFF. Unified Rate Review Template shall be filed for coverage issued in the individual or small group markets, *except for student health insurance coverage.*		
	14VAC5-130-70 B	**Actuarial Memorandum that includes:**		
	14VAC5-130-70 B 1	A description of the type of policy, including benefits, renewability, issue age limits, and if applicable, whether the policy includes grandfathered, non-grandfathered plans, or both.		
	14VAC5-130-70 B 2	The scope and reason for the premium or rate revision.		
	14VAC5-130-70 B 3	A comparison of the revised premiums with the current premium scale, including all percentage rate changes and any rating factor changes.		
	14VAC5-130-70 B 4	A statement of whether the revision applies only to new business, only to in-force business, or to both.		
	14VAC5-130-70 B 5	The estimated average annual premium per policy and per member, before and after the proposed rate revision. If different changes by rating classification are requested, the filing also must include: (i) Range of changes; and (ii) average overall change, including a detailed explanation of how the change was determined.		
	14VAC5-130-70 B 6	*The following is applicable to all coverage with the exception of coverage issued in the small group market:* Submit Form 130-A showing historical and projected experience, including: (i) Projections for future experience, and Virginia and national historical experience of earned premiums, paid claims, incurred claims and loss from inception through most		

REVIEW REQUIREMENTS	REFERENCE	COMMENTS	LOCATION IN THE FILING TO INCLUDE EXHIBIT NAME OR NUMBER	FILER'S NOTES
		recent quarter. Virginia and national experience should be shown separately. Missing experience should be estimated with all estimation assumptions and methodologies provided in detail; (ii) A statement of the basis for determining the rate revision (Virginia, national, or blended); and (iii) If blended, provide the credibility factor assigned to the national experience.		
	14VAC5-130-70 B 7	Details and dates of all past rate revisions, including annual rate revisions members will experience resulting from this filing. If a company only revises rates annually, the rate revision must be identical to the current submission. If a company has had more frequent rate revisions, the annual revision must reflect the compounding impact of all revisions for the past 12 months.		
	14VAC5-130-70 B 8	A description of how revised rates were determined, including the general description and source of each assumption of Form 130-A. For claims, provide historical and projected claims by major service category for both cost and utilization on Form 130-B.		
	14VAC5-130-70 B 9	If the rate revision applies to new business, provide the anticipated loss ratio and a description of how it was calculated.		
	14VAC5-130-70 B 10	If the rate revision applies to in-force business provide: (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.		
	14VAC5-130-70 B 11	The loss ratio that was originally anticipated for the policy.		
	14VAC5-130-70 B 12	If 9, 10a, or 10b is less than 11, supporting documentation for the use of such premiums or rates.		
	14VAC5-130-70 B 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.		
	14VAC5-130-70 B 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.		

	14VAC5-130-70 B 15	For coverage issued in the individual or small group health insurance markets, a certification by a qualified actuary of the actuarial value of each plan of benefits included and the AV calculation summary.		
Health Insurance Issuer – Filing a Rate Revision	14VAC5-130-75 A	For individual accident and sickness insurance, individual, and 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 the present values of the future and lifetime loss ratios are at least as great as the standards in 14VAC5-130-70 B 11. Interest, at a rate consistent with that assumed in the original effective date of the form to the effective date of the revision and the present value of future premiums.		
Health Insurance Issuer – Filing a Rate Revision	14VAC5-130-75 B	For coverage issued in the small group health insurance market, the anticipated loss ratio over the entire period for which the revised rates are computed to provide coverage must be at least as great as the standards in 14VAC5-130-70 B 11.		
Health Insurance Issuer – Filing a Rate Revision	14VAC5-130-75 C	Revised premiums for policies issued on or after the effective date of the revision must meet the standards in 14VAC5-130-65, except the average annual premium shall be determined on actual rather than anticipated distribution of business.		
Medicare Supplement Requirements		*Applicable requirements for Medicare Supplement insurance rate filings in addition to the above:*		
Standardized Medicare Supplement Forms	14VAC5-170-120 A 1	A Medicare supplement policy or certificate shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire premium period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy or certificate form: (a) At least 75% of the aggregate amount of premiums earned in the case of group policies; or (b) At least 65% of the aggregate amount of premiums earned in the case of individual policies.		
	14VAC5-170-120 A 2	All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.		

Pre-Standardized Medicare Supplement Forms	14VAC5-170-120 A 3	For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet: (a) The originally filed anticipated loss ratio when combined with the actual experience since inception; (b) The appropriate loss ratio requirement from subdivisions 1 a and 1 b of this subsection when combined with actual experience beginning with July 1, 1991, to date; and (c) The appropriate loss ratio requirement from subdivisions 1 a and 1 b of this subsection over the entire future period for which the rates are computed to provide coverage.		
Annual Rate and Experience Filing	14VAC5-170-120 C	An issuer of Medicare supplement policies and certificates issued before or after July 30, 1992, in this Commonwealth shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the State Corporation Commission in accordance with the filing requirements and procedures prescribed by the State Corporation Commission. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.		
Actuarial Certification for Medicare Supplement Rate Revision Filings	14VAC5-170-120 C	For annual rate and experience filings, an actuarial certificate by a qualified actuary that the best of the actuary's knowledge and judgment, the following items are true with respect to the filing as follows: 1. The assumptions present the actuary's best judgment as to the reasonable value for each assumption and are consistent with the issuer's business plan at the time of the filing; 2. The anticipated lifetime loss ratio, future loss ratios, and except for policies issued prior to July 30, 1992, third-year loss ratios all exceed the applicable ratio; 3. Except for policies issued prior to July 30, 1992, the filed rates maintain the proper relationship between policies which had different rating methodologies; 4. The filing was prepared based on the current standards of practices as promulgated by the Actuarial Standards Board, including the data quality standard of practice, as described at: www.actuary.org; 5. The filing is in compliance with the applicable laws and regulations in this Commonwealth; and		

		6. The premiums are reasonable in relation to the benefits provided.		
Actuarial Certification for Medicare Supplement Rate Revision Filings	14VAC5-170-130 B	For proposed rate changes, an actuarial certificate by a qualified actuary that to the best of the actuary's knowledge and judgment, the following items are true with respect to the filing as follows: 1. The assumptions present the actuary's best judgment as to the reasonable value for each assumption and are consistent with the issuer's business plan at the time of the filing; 2. The anticipated lifetime loss ratio, future loss ratios, and except for policies issued prior to July 30, 1992, third-year loss ratio all exceed the applicable ratio; 3. The filing was prepared based on the current standards or practices as promulgated by the Actuary Standards Board including the data qualify standard of practice as described at: www.actuary.org; 4. The filing is in compliance with applicable laws and regulations in this Commonwealth; and 5. The premiums are reasonable in relation to the benefits provided.		
Change in the Rating Structure or Methodology of a Medicare Supplement Form	14VAC5-170-130 D 3	A change in the rating structure or methodology shall be considered a discontinuance under subdivision 1 of this subsection unless the issuer complies with the following requirements: (a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the State Corporation Commission, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates. (b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change.		
For Coverage in the Individual and Small Group Health Insurance Markets Risk Pools and Index Rates	14VAC5-130-81 A & B	The claims experience of all enrollees in all health benefit plans are members of a single risk pool. *(Not applicable to grandfathered coverage).*		
	14VAC5-130-81 C	Each plan year or policy year, as applicable, a health insurance issuer shall: 1. Establish an index rate based on the total combined claim costs for providing essential health benefits within the single risk pool of the individual or small group market;		

		2. 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, and 3. 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.		
	14VAC5-130-81 D	A health insurance issuer may vary premium rates for a particular plan from its index rate for a relevant state market based on the following actuarially justified plan–specified factors: 1. The actuarial value and cost-sharing design on 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.		
Area Rate Factors	§ 38.2-3447 D	Describe and provide detailed actuarial support for any Area Rate Factors. If the proposed area rate factors exceed by more than 15 percent the weighted average of the proposed area rate factors among all rating areas in which the health carrier offers health benefit plans in that market, then: 1. The filing shall include in a publicly available and unredacted form: a. A comparison of the area rate factor for individual and small 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 disclosure 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 health carrier 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 percent of total incurred claims for that rating area in that market.		
Unique Plan Design AV Certification	45 CFR 156.135	Health issuers in the individual and/or small group market must describe whether the AV Metal Values included in Worksheet 2 of the URRT were entirely based on the AV Calculator, or whether an acceptable alternative methodology was used to generate the AV Metal Value of one or more plans. If an alternate methodology was employed to develop the AV Metal Value(s), the actuary must provide a copy of the actuarial certification required by 45 CFR 156.135. The certification must be signed by a member of the American Academy of Actuaries and must indicate that the values were developed in accordance with generally accepted actuarial principles and methodologies. The actuary must indicate the reason an alternate methodology was used, explain why the benefits for those plans for which an acceptable alternative methodology was used are not compatible with the AV Calculator, and state the chosen alternate methodology that was used for each applicable plan. The actuary must describe the process that was used to develop the AV Metal Value.		
Exchange Certified Stand-Alone Dental Plans	45 CFR § 156.150(b) § 38.2-326	The level of coverage must be certified by a member of the American Academy of Actuaries using generally accepted actuarial principles.		

Access to Administrative Letters, Administrative Orders, Regulations and Laws is available at:

http://www.scc.virginia.gov/boi/laws.aspx

The Forms and Rates Section of the Life and Health Division rate review requirements. Please contact this section at (804) 371-9532 if you have questions or need additional information about this line of insurance.

I hereby certify that I have reviewed the attached rate review requirement filing and determined that it is in compliance with the rate review requirement checklist.

Signed: _____

Name (please print): _____

Company Name: _____

Date: _____ Phone No: ( ) _____ FAX No: ( )_____

E-Mail Address: _____