1 COMMONWEALTH OF VIRGINIA
2 STATE CORPORATION COMMISSION
3 **
4 In re:
5 PRESENTATION OF PREMIUM RATES
6 IN CONNECTION WITH HEALTH
7 INSURANCE COVERAGE CASE NO. INS-2017-00050
8 ISSUED IN THE INDIVIDUAL
9 AND SMALL GROUP MARKETS.
10 **
11 TRANSCRIPT OF PROCEEDINGS BEFORE
12 THE HONORABLE MARK C. CHRISTIE
13 THE HONORABLE JAMES C. DIMITRI
14 THE HONORABLE JUDITH WILLIAMS JAGDMANN
15 July 25, 2017
16 9:30 a.m. - 11:58 a.m.
17 Richmond, Virginia
18
19
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3 Honorable Mark C. Christie, Presiding
4 Honorable James C. Dimitri, Member
5 Honorable Judith Williams Jagdmann, Member
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1 I N D E X

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3 PRESENTERS: Page

4 Aetna Group 26

5 Anthem Group 36

6 CareFirst, Inc, Group 48

7 Cigna Health Group 60

8 Kaiser Foundation Group 64

9 Piedmont Community Health Group 72

10 Sentara Health Management Group 75

11 United Health Group 87

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1 THE CLERK: Today's docket consists of
2 Case Number INS-2017-00050, in the matter of
3 presentations of premium rates in connection with
4 health insurance coverage issued in the individual and
5 small group markets. The Honorable Judge Mark C.
6 Christie presiding.
7 THE HEARING EXAMINER: Okay. Well, good
8 morning, everybody. We are here today for the rate
9 presentations -- we do this annually -- rate
10 presentations on insurance plans to be offered in the
11 individual and small group insurance markets as of
12 January 1st of next year.
13 As you know, under Virginia law the
14 Commission is required to review and approve the
15 premium rates and forms for all such health benefit
16 plans whether or not they are sold on the exchange or
17 off. The Commission also must perform planned
18 management functions required to certify plans for
19 participation in the federal health benefit exchange
20 pursuant to Virginia Code Section 38.2-326.
21 There are also some key legal deadlines
22 that are in effect here and that govern what we are
23 doing. First the U.S. Department of Health and Human
24 Services requires that the Commission's Bureau of
25 Insurance complete its review and recommendation of

1 plans and their rates for certification on the federal
2 exchange no later than August 16 of 2017 for this
3 year. August 16.
4 Second, Virginia law requires insurance
5 carriers to notify their customers of increases in
6 annual premiums or deductibles at least 75 days before
7 the proposed renewal of their health insurance, and
8 that deadline for notifying customers, which of course
9 insurance companies have to meet, this year is
10 October 18th.
11 To meet these deadlines to comply with
12 these laws insurance companies recently filed their
13 rates and forms for insurance plans proposed to be
14 offered for use as of January 1, 2018.
15 Given the importance of the cost of
16 health insurance to Virginia's small businesses and
17 individuals, many of whom are self-employed and paying
18 these costs directly out of pocket, the Commission is
19 closely reviewing these health insurance premium rates
20 and increases in deductibles prior to any ultimate
21 approval for use in Virginia.
22 As part of the evaluation of these
23 filings, on May 4 of 2017 the Commission issued an
24 order directing presentations. Today's presentations
25 are designed to serve as an overview of the range of

1 rate impact or change for plans in the individual and
2 small group markets.
3 The Commission's Bureau of Insurance was
4 directed to detail for each company the scenarios that
5 should be covered through the presentations. The
6 Bureau has done this and will participate today by
7 providing background information and presenting a
8 summary of recent Bureau activities in relation to its
9 view of the latest rate and form filings for health
10 insurance plans.
11 Now, today we'll hear first from Jackie
12 Cunningham, who's the Commissioner of insurance and
13 head of Bureau of Insurance. And Jackie will provide
14 introductory remarks and identify the companies
15 presenting today.
16 Next we will hear from the Bureau's
17 health actuary, David Shea, who will then provide an
18 overview of what the Bureau has been doing to review
19 the recent filings. Afterwards the insurance
20 companies will provide individual presentations about
21 their proposed rate changes. For each company that is
22 presenting here today please be prepared to speak to
23 your proposed rate filings for plans both on and off
24 the federal exchange and for plans in the individual
25 and small group markets.

1 Let me note that today's proceeding is
2 open to the public. And I want to also note that it
3 is being webcast. So for those of you who are going
4 to be speaking, when you speak please speak into a
5 nearby microphone and speak clearly.
6 Members of the public who wish to provide
7 comments on one or more specific rate or form filings
8 may do so in writing. You can go to the Bureau of
9 Insurance website, and we've also prepared today some
10 instructions on how to submit those comments, and
11 those instructions are available in hard copy at the
12 back of the courtroom.
13 We would like the Bureau and Company
14 representatives to use the podium when you make your
15 presentations so please come forward. Again, I
16 encourage people to make sure the microphone is on
17 because this is being webcast and so what you say will
18 be -- to make sure what you say is clear to the people
19 who may be listening via the Internet.
20 You're encouraged to use the audio visual
21 equipment to display any charts or other materials you
22 may be discussing. While we may have questions for
23 the speakers, this is not an evidentiary hearing where
24 there will be swearing in and cross-examination.
25 Are there any other preliminary matters

1 we need to discuss? Hearing none, then I do have a
2 order of presentation which we'll follow, and in that
3 order of presentation the companies will go in
4 alphabetical order.
5 And when you come to speak, please give
6 your name and address for the court reporter so that
7 she can record who is making these presentations by
8 name.
9 With that we will begin with the
10 Commissioner of Insurance head of the Bureau, Jackie
11 Cunningham.
12 MS. CUNNINGHAM: Good morning,
13 Commissioners. Good morning, everyone. Thank you all
14 for coming. I'm going to be very brief because
15 we've -- this is either the fifth -- fifth year that
16 we've done these presentations and the format is
17 virtually the same as in the past. So I just wanted
18 to thank everybody, thank my staff, thank the
19 companies for meeting some rather challenging
20 deadlines this year. And I will kind of give you an
21 overview of the companies that will be presenting
22 today.
23 We will hear from the Aetna Group, which
24 includes Aetna Health, Incorporated, Aetna Life
25 Insurance Company, Innovation Health Insurance

1 Company, and Innovation Health Plan. We will hear
2 from the Anthem Group, which is Anthem Health Plans of
3 Virginia and Healthkeepers, Inc. We will hear from
4 the CareFirst Group, which includes CareFirst
5 BlueChoice, Inc., and Group Hospitalization and
6 Medical Services, Incorporated.
7 We will hear from Cigna Health Group,
8 which includes Cigna Health and Life Insurance
9 Company. We will hear from the Kaiser Foundation
10 Group, which includes the Kaiser Foundation Health
11 Plan of the Mid-Atlantic States. We will hear from
12 Piedmont Community Health Group, which includes
13 Piedmont Community Healthcare HMO, Incorporated.
14 And finally -- no, actually not finally.
15 We will hear from Sentara Health Management Group,
16 which includes Optima Health Insurance Company and
17 Optima Health Plan. And finally we will hear from
18 United Health Group, which includes Optimum Choice,
19 UnitedHealthcare Insurance Company, UnitedHealthcare
20 of the Mid-Atlantic, Incorporated, and
21 UnitedHealthcare Plan of the River Valley,
22 Incorporated.
23 So with that I know we have a full agenda
24 so I won't take any more of your time. And with the
25 Court's permission I guess I'll turn it over to David

1 Shea, who is our health actuary who will provide some
2 details of the format of the presentations and the
3 information that was presented and requested in
4 connection with these presentations.
5 THE HEARING EXAMINER: Well, before you
6 leave we need to do one thing. In case anyone out
7 there didn't know, Jackie is retiring. This is
8 Jackie's -- she's not leaving tomorrow but this will
9 be her last health insurance rate presentation. And,
10 as she mentioned, she's been doing this for the whole
11 five years of the ACA. And before that Jackie, as
12 many of you know, was the deputy for life and health.
13 So she's been involved in health insurance regulation
14 for many, many years, and we just want to thank you
15 again, Jackie, for all the wonderful work you've done
16 over the many years in the health insurance area.
17 So we'll see you again, but these
18 people -- not in a public forum like this but we want
19 to thank you at this opportunity.
20 MS. CUNNINGHAM: Thank you, Judge.
21 MR. SHEA: Good morning, Judges and
22 everyone. David Shea, health actuary for the Bureau
23 of Insurance. As we had agreed earlier this year, I'm
24 going to severely limit my comments from the past as
25 we want to give the companies an opportunity to talk

1 about their rates for 2018, which is the reason for
2 our presentations today.
3 So I've just got a very few brief slides
4 to go over. Just as a recap, the filing deadline for
5 2018 ACA rates in Virginia was May the 3rd, and
6 everybody reached that date or earlier. As you had
7 mentioned, Judge Christie, the rate approval deadline
8 for QHPs is August the 16th. Now, what that means is
9 that's the deadline for the Bureau of Insurance to
10 submit all of the data and information to CMS and our
11 QHP recommendation. So basically that day is the last
12 day anything can possibly change. In fact, I would
13 say nothing can change on that date, unless something
14 catastrophic happens. And then there's a much later
15 rate approval deadline for non QHPs and that's August
16 the 6th. October 6th. I'm sorry.
17 COMMISSIONER JAGDMANN: When you say non
18 qualified health plans, does that mean off exchange?
19 MR. SHEA: Off exchange, yes, it does.
20 And as we do each year we're just going to go through
21 a brief list of what are going to be the main rate
22 drivers that have caused increases or changes in ACA
23 rates for 2008. And, again, you'll hear these from
24 the companies in a little bit more detail.
25 There's generally always medical trend;

1 the use of services and cost of services. Companies
2 have had two or three years of experience in ACA so
3 now what they're looking at is did the experience that
4 came in, how closely did that match their projections
5 for that period of time; the morbidity of their
6 population, in other words, the relative health of
7 their population, compared to all other carriers'
8 populations in a state and a market.
9 There was a change for 2018 in what's
10 called the federal default age curve. All rates have
11 the same age factors applied to them. There were no
12 changes in the adult factors by age, but what they did
13 in the past there was one factor for a child, zero to
14 19 or zero to 20. I think it's 19. And what the
15 federal government did was they expanded the child
16 factors. Instead of one factor for all children they
17 expanded it into seven. Now, the net result of those
18 changes means that child rates alone will increase
19 anywhere from 20-and-a-half to over 50 percent just
20 from these factor changes. And the companies will
21 explain how they worked those into the 2018 rates.
22 Also --
23 COMMISSIONER JAGDMANN: If you could
24 explain that to me a little bit.
25 MR. SHEA: Sure.

1 COMMISSIONER JAGDMANN: Is it by age, is
2 it by health of the child?
3 MR. SHEA: It is absolutely not by health
4 of the child because recognizing health in rates is
5 not allowed. So what they've done is in the past
6 there was one rate for all children ages zero to 19.
7 And I'm doing this from memory so forgive me if I'm
8 wrong, but I believe the factor for a child was on the
9 order of .65. So you would take a rate for a
10 21-year-old, multiply it by .65, and get a rate for a
11 child. Now, that covers the expected cost of the
12 child anywhere age 0 to age 19. And it was generally
13 recognized that that probably wasn't appropriate, that
14 the factors -- the cost for children in those age
15 ranges is a bit higher than 35 percent lower than a
16 21-year-old.
17 So what they did was they expanded the
18 ranges. And I forget the exact ranges but they went
19 from one child factor to seven. So, for example, I
20 think the first range may be children ages 0 to 2, and
21 then 3 to 5, and so forth and so on, up to age 19.
22 And what they did was from that .65 number every
23 factor for the new child ages went up. They raised
24 them all, which is -- the result is anywhere from a 20
25 to a 50 percent increase in those factors alone.

1 COMMISSIONER JAGDMANN: The children's
2 rates now are above a 21-year-old.
3 MR. SHEA: They're not above. They did
4 not want that to happen. So if I recall correctly,
5 the highest child factor is now .97. So instead of
6 being 35 percent below a 21-year old, it's three
7 percent below a 21-year-old. So it's never higher,
8 but they raised them all. And, again, the companies
9 will explain how they work those into their rates.
10 Also -- and this is a relatively small
11 number in the scheme of the health insurance. There
12 was a health insurance tax that was taken away last
13 year. Insurance companies didn't have to factor that
14 into their premiums for 2017, but the moratorium on
15 that tax was lifted. So they had to put it back in
16 2018. That can result anywhere from a one to
17 three percent increase in premiums. Likewise last
18 year it was a one to three percent decrease.
19 And this is kind of technical and wonky
20 but the actuarial value calculator that every carrier
21 has to use to figure out whether the plan is a
22 platinum or a gold or a silver, the ranges were
23 expanded to facilitate changes in the calculator from
24 one year to the next that resulted in plans falling
25 out of a medal level just because of some technical

1 changes. So they're giving insurance companies a
2 little bit more leeway in those values. We're
3 probably not going to get into that today. That's,
4 again, kind of just a side note.
5 THE HEARING EXAMINER: Let me ask you,
6 David, before you leave that I'd just like
7 clarification because every year we hear all about
8 morbidity and trend as far as rate drivers. And
9 you've discussed it and insurance companies discussed
10 it. Now, morbidity, as I understand it, and correct
11 me if I'm wrong, is a composition of the insured pool
12 in terms of health and age, correct?
13 MR. SHEA: That is correct.
14 THE HEARING EXAMINER: So it's like the
15 data regarding the status of the pool.
16 MR. SHEA: And it's generally in this
17 instance because every carrier can rate by age.
18 THE HEARING EXAMINER: Right.
19 MR. SHEA: If your population gets older
20 or younger, the rates automatically account for that.
21 But as your population gets healthier or less healthy,
22 you've got to figure out how that's going to work into
23 your rates and that's -- risk adjustment is the
24 mechanism that they use to try to adjust for that.
25 THE HEARING EXAMINER: Right. And then

1 trend, then, is the actual usage of healthcare
2 services, correct?
3 MR. SHEA: Yes. It's the cost and usage
4 of the healthcare services. As it changes, with
5 everything else being equal, from one year to the
6 next, it's the change in the cost and utilization of
7 health care services.
8 THE HEARING EXAMINER: But in your
9 scenarios that you've given them -- and you've done
10 this every year -- you have two lines, one for
11 morbidity and one for trend, each one showing the
12 impact. But it seems like they are related, are they
13 not? I mean if the morbidity is older, sicker, then
14 the trend by logic is going to be -- usage is going to
15 be a lot higher. So while you -- you know, format
16 wise you have those as two separate items but it does
17 look like they're inextricably linked.
18 MR. SHEA: And that's a really good point
19 and that's a big challenge for health insurance
20 companies and particularly actuaries, the actuaries in
21 the room. It's vital that they be able to look at
22 their data and try to discern which is just underlying
23 normal trend and which is changes in morbidity because
24 the changes in morbidity --
25 THE HEARING EXAMINER: Drive the trend.

1 MR. SHEA: Yes. But they're going to --
2 some money is going to exchange hands based on changes
3 in morbidity, so it's crucial that insurance companies
4 separate those two. Because the morbidity comes under
5 risk adjustment.
6 COMMISSIONER JAGDMANN: That's what I was
7 going to ask. So that's under your risk adjustment.
8 MR. SHEA: Bingo.
9 COMMISSIONER JAGDMANN: And risk
10 adjustment --
11 MR. SHEA: So they got to be able to
12 separate those two.
13 COMMISSIONER JAGDMANN: And if you're new
14 to this, risk adjustment was designed to make sure
15 that if one carrier just happened to get a sicker pool
16 they weren't disadvantaged.
17 MR. SHEA: Exactly. Because their rates
18 cannot reflect the health status of their population.
19 It cannot. So they rely on risk adjustment. If they
20 get a less healthy population they will be a net
21 receiver of risk adjustment payments, and if they get
22 a healthier population there will be a net payer. So,
23 again, you're absolutely right. If you just look at
24 the data and don't account for it, morbidity changes
25 is going to be in your trend but it's vital that they

1 separate the two.
2 THE HEARING EXAMINER: Well, I wonder --
3 I'm sorry, go ahead.
4 COMMISSIONER DIMITRI: I just want to ask
5 you if there is a new treatment that's developed or a
6 new medication that is expensive but people need that
7 treatment, where is that reflected in the premium
8 calculation?
9 MR. SHEA: That's generally going to be
10 in medical trend. Now, keep in mind, particularly for
11 the carriers who have to file ACA rates, they're
12 basing their rates on data that will ultimately be two
13 years old by the time these rates are in effect. So
14 they're sitting back around 2016 and they've got to
15 think about what new treatments and what new
16 technologies and what new prescription drugs are going
17 to be available in the future and how will that
18 compare to the costs they have today.
19 So they've got to keep a realtime look at
20 what's going on in the healthcare world and try to
21 figure out how that's going to impact the cost that
22 they see today. But those changes should be reflected
23 in medical trend.
24 THE HEARING EXAMINER: Let me also ask
25 about reinsurance. Because each of the last several

1 years you've talked about the three Rs and of the big
2 Rs was reinsurance. And last year you told us it was
3 going to expire. Now, as I understood reinsurance,
4 that was exactly to address morbidity and trend; that
5 reinsurance was if a carrier had a higher than
6 expected trend, medical expenditure, which, again, is
7 tied to the worst morbidity than they expected, that
8 reinsurance was to address that, that it was payments
9 to the companies based on the worst trend or worst
10 morbidity. Right?
11 MR. SHEA: You can't really -- believe it
12 or not, reinsurance addresses something separate from
13 morbidity and trend. And, trust me, I feel the
14 actuary's pain, because this world has made it
15 incredibly challenging to try to parse all of these
16 impacts out.
17 Reinsurance, the purpose of reinsurance
18 was to cover the cost of high cost claimants. Now,
19 those won't necessarily be people who are less
20 healthy. It could be a premature infant, it could be
21 a motorcycle accident. Very, very costly claims. And
22 so in order to encourage companies to participate in
23 these markets, part of the ACA included a reinsurance
24 mechanism that said for the first three years we will
25 try to insulate you from these high cost claimants.

1 Believe it or not, that's separate from normal trend
2 because it's not normal. It makes your trends look
3 really weird when they're in there. And it's separate
4 from morbidity because you can have, for example, a
5 person with diabetes who we know what their morbidity
6 profile looks like but they won't necessarily be high
7 cost claimants from one year to the next. I mean
8 we're talking high cost. $250,000, in that general
9 range.
10 So for the first three years of the
11 program there was a reinsurance mechanism and they
12 started out reimbursing a large portion of the claims
13 and then the next year they reduced it and then the
14 next year they reduced it again. It was in there
15 three years. And last year, the rates for 2017, there
16 was no reinsurance mechanism reflected. It was
17 totally gone, and this is the second year of that.
18 And, again, there's no reinsurance in here.
19 We've kind of talked about population
20 morbidity as far as pricing challenges go. This year
21 in particular there seems to be a considerable amount
22 of regulatory uncertainty. I know we've all seen the
23 news and heard all of the stuff going on, but one item
24 that's of particular interest and concern to insurance
25 carriers are cost-sharing reductions, for people who

1 qualify for cost-sharing reductions. Part of the ACA
2 says that insurance companies will be reimbursed for
3 those cost-sharing reductions. I'll give you a simple
4 example.
5 According to the law, a company sells
6 for, let's say, a silver plan with a $1,000
7 deductible. Another part of the law says you've got
8 to lower those cost-sharing amounts for people who
9 qualify by income. So there could be a person that
10 qualifies by income that can purchase a $1,000
11 deductible plan but what they get is $100 deductible
12 plan. They pay the rate for $1,000, they get a $100
13 deductible. So when they go and access the health
14 care system, their card says, I have a $100
15 deductible. Now the rate they've paid is for a $1,000
16 deductible.
17 So the insurance company says, yes,
18 you're right, you have a $100 deductible. That's all
19 you're responsible for. So because the claims don't
20 match the premium that got paid, part of the ACA says
21 the government will reimburse the carrier for the
22 difference in the deductible. So the carrier gets
23 another $900 for that individual.
24 That $900 is a cost-sharing reduction
25 payment, and every carrier gets that. Currently --

1 COMMISSIONER JAGDMANN: So you have
2 premium reductions and cost reductions.
3 MR. SHEA: You have premium subsidies and
4 you have cost-sharing reductions, yes. And currently
5 the federal government is committing to making those
6 payments on a month-by-month basis. I don't know
7 which month they've currently committed to. It may be
8 next month. I'm not sure. But -- and you can
9 understand hopefully by that example how critical
10 these payments are to an insurance company. They rely
11 on that because that's how they process the claims but
12 that's not the premium they're taking in.
13 So it's mandatory that they get these
14 payments. And that's currently -- it's a little bit
15 uncertain as to whether they'll come in or not.
16 COMMISSIONER DIMITRI: So are all of the
17 rates in the plans for us, do they assume that CSRs
18 are going to continue?
19 MR. SHEA: That's a great question, and
20 the answer is yes. Currently in all of our filings
21 carriers have assumed basically the status quo. And
22 going back to that deadline of August 16th I
23 mentioned, again, unless something catastrophic
24 happens, August 16th is when everything gets submitted
25 to CMS, and barring any unforeseen changes coming back

1 to us, our job technically is done and everything is
2 chiseled in stone. So no changes to plans, no changes
3 to premiums, nothing.
4 Now, of course, that's -- our job is
5 done. We still have to wait for the insurance
6 companies to agree to sell QHPs for 2018. But our job
7 will be done. So all the rates that will be sitting
8 out there for Virginia assume that cost-sharing
9 reduction payments will continue.
10 COMMISSIONER DIMITRI: So someone who is
11 issued this silver plan that you talked about and
12 is -- it has a $1,000 deductible, the policy that they
13 get is going to say, your deductible is $100?
14 MR. SHEA: $100. And that's all they'll
15 be responsible for. But they're paying the premium
16 for a $1,000 deductible, which is why the insurance
17 company gets reimbursed to match the claims to the
18 premium. So that's kind of like a sort of Sword of
19 Damocles, so to speak, hanging out there over the ACA
20 for now.
21 On a much smaller scale but still
22 important, special enrollment periods, there have been
23 some work on the part of the federal government to try
24 to tighten those up and to prevent anti-selection.
25 The enforcement of the individual mandate is a little

1 hazy right now. There seems to be word that it's not
2 going to be enforced as strongly as it has been in the
3 past, and that's another concern because, as you're
4 aware, the individual mandate exists to try to get
5 everybody into the single risk pool as much as
6 possible. And if there is no mandate, then it will
7 tend to fall apart.
8 My next few slides are just -- and we
9 don't need to go over these in any type of detail.
10 Everybody's got them in front of them. For 2018 we
11 didn't have any carriers enter the market. We did
12 have a few exits, and you can see them there. Some
13 folks still have non ACA compliant plans out there.
14 And some folks have chosen to leave a market with
15 their PPO entity but stay with their HMO entity.
16 Here's a list of the individual market exits we've
17 received for 2018. And there's a list of small group
18 market exits.
19 In particular of note, when you see
20 something like Healthkeepers on exchange only, the
21 shop, the small group exchange, probably didn't
22 fulfill its planned goals. And there never really was
23 a lot of enrollment in there to begin with. And so in
24 particular when you see something like Healthkeepers
25 or Innovation Health Plan leaving the small group on

1 exchange market, we don't have any data really on on
2 versus off exchange but my suspicion for those is
3 there probably was not much enrollment at all. And
4 those carriers can still sell off exchange, which is
5 where the vast majority of small groups purchase their
6 policies.
7 COMMISSIONER JAGDMANN: But you've got
8 Healthkeepers on only. Are you saying it's on the
9 exchange?
10 MR. SHEA: I'm sorry. The way that reads
11 these are small group exits, and Healthkeepers exited
12 the on exchange small group market.
13 COMMISSIONER JAGDMANN: So I thought if
14 you're on the exchange you have to be off also,
15 correct?
16 MR. SHEA: Very true. Very true. So but
17 these folks are -- a lot of these folks are still off
18 exchange, which is where the vast majority of business
19 is.
20 So unless there are any further questions
21 for me, I will go ahead and start having our
22 presenters come up. As it has been in the past, you
23 can see up on the screen I've got the documents on the
24 right-hand side of the screen going down in
25 alphabetical order. Just a little bit of

1 housekeeping. In order to make your documents show up
2 on the screen fully just follow these little
3 instructions right here. Okay? I have them written
4 down for everybody.
5 COMMISSIONER JAGDMANN: You better be
6 handy just in case.
7 MR. SHEA: I am. I am. Here you go.
8 Number one -- I'll do it for Aetna. So, Amy, you're
9 lucky. Click on your Pdf. Okay?
10 THE HEARING EXAMINER: They'd probably
11 prefer you do it for all of them.
12 MR. SHEA: I'll be jumping up and down.
13 Click view. Full screen mode. And just navigate
14 through your presentation. When you're done hit
15 escape and close the file. Okay? I got it all
16 written right here.
17 So, Amy, I hope you were paying
18 attention. It's your turn. So I'd like to have Aetna
19 come up for our first presentation.
20 MR. BUCCI: Good morning. My name is
21 Mike Bucci. I'm with Aetna. The address you asked
22 for, 509 Progress Drive, Linithicum, Maryland. I'm
23 the executive director for Aetna's operation in the
24 capitol market which we define as Virginia, D.C. and
25 Maryland. Amy Ovuka is our head actuary. She will be

1 up here doing most of the heavy lifting. She was
2 paying attention, David. Thank you for that.
3 We're going to talk about our two
4 entities that David referenced, Aetna and Innovation
5 Health, which is our joint venture with the Nova
6 health system in Virginia. I'll talk very briefly a
7 little bit about Aetna's market presence, and then I
8 will tee up a little bit of Amy's talk around the
9 actuarial discussion, but the meat of our discussion
10 will be led by Amy.
11 So Aetna is the second largest commercial
12 payer in the state. About 700,000 Virginians have an
13 Aetna ID in their purse or wallet. I'm very happy
14 about that. We think that that success has been
15 largely driven by partnerships with providers
16 throughout the state. An example of that would be the
17 Innovation Health joint venture. We're proud to be
18 entering into new markets in Virginia. We recently
19 were awarded a Medicaid contract, so that's another
20 30,000 Virginians that now are covered by Aetna by the
21 Medicaid program. David did a great job of describing
22 some of the complexity. In the market you saw --
23 THE HEARING EXAMINER: Let me just
24 clarify, Mr. Bucci. Aetna is -- as I understand it,
25 you're here today simply for a small group off

1 exchange product, correct?
2 MR. BUCCI: That is correct. I was going
3 to briefly reference the fact we are exiting
4 individual. David spoke to a lot of the regulatory
5 complexity that exists, and to the extent that I could
6 add to that, he's dead on; that we looked at that
7 environment. Some of the structural challenges that
8 we see exist there. We've, as we've publicly
9 disclosed, experienced some pretty significant
10 financial losses in the individual markets across the
11 country, and so we are exiting the individual market
12 in Virginia both with Aetna and Innovation Health for
13 2018. But we will be continuing to offer ACA
14 compliant small group plans to our customers and
15 prospects throughout Virginia.
16 COMMISSIONER JAGDMANN: So historically
17 you were experiencing losses in on exchange product?
18 MR. BUCCI: In the individual market,
19 that's correct. We, again, publicly disclosed we lost
20 about $700 million across the country 2014 through
21 2016 in the individual market. We reduced our
22 individual footprint from 15 states to four, including
23 Virginia, for 2017 but are still projecting a loss of
24 about $200 million in 2017. So it's been a
25 challenging business environment for us.

1 In small group, as I said, we are going
2 to continue in the marketplace. And I'll turn it to
3 Amy to walk us through the process that we followed to
4 submit the rates for Virginia.
5 MS. OVUKA: Okay, David. Hopefully I got
6 that right.
7 Good morning. I'm Amy Ovuka and my
8 address is 6720 Rockledge Drive, Bethesda, Maryland,
9 20817.
10 As Mike alluded to today, we are going to
11 cover our small group filings and we have four legal
12 entities to cover this morning.
13 This first page outlines the rate
14 increase for our most popular plan, and you can see
15 here the rate increase is 2.2 percent but that's
16 broken into five different components. The first one
17 is population morbidity. And in general we're not
18 expecting to attract a very different population in
19 2018 than we did in 2017.
20 The next line item is medical trend, and
21 that is 11.4 percent year over year.
22 The next item is the reinstatement of the
23 health insurer fee, and that adds 3.2 percent as our
24 consumers have to pay that fee in 2018 but they did
25 not have to pay it in 2017.

1 COMMISSIONER JAGDMANN: Is that for the
2 exchange, to run the exchanges?
3 MS. OVUKA: Oh, the actual cost?
4 COMMISSIONER JAGDMANN: Yeah. Do you
5 know where the money goes?
6 MS. OVUKA: I do not know all of the
7 details where the money goes. I'm sorry, I can't go
8 into all of these details.
9 COMMISSIONER JAGDMANN: It just goes away
10 from you.
11 MS. OVUKA: The next item is the revised
12 age curve, and as David spoke about the age factors
13 increase for children but they stayed the same for
14 adults. However, it is a revenue net zero impact, and
15 here we're talking about rates for a 40-year-old. So
16 rates for children will increase, but that -- since
17 it's revenue net zero rates for adults then decrease.
18 So for a 40-year-old the impact is a decrease of 2.9
19 percent.
20 That will vary carrier by carrier given
21 their underlying demographic distribution.
22 COMMISSIONER JAGDMANN: Okay. So just to
23 sort of back up just a little, so I'm looking this is
24 for rating area seven which is --
25 MS. OVUKA: Richmond.

1 COMMISSIONER JAGDMANN: Richmond. Non
2 tobacco smoker, it's a silver plan which -- healthier
3 benefits. This is the plan where you would get
4 subsidies if you were on exchange, I guess.
5 MS. OVUKA: That be would in the
6 individual markets. This is small group.
7 COMMISSIONER JAGDMANN: Right, this is
8 small group and it's off exchange, but it's a
9 heathier -- I mean it's a --
10 MS. OVUKA: Middle of the road.
11 COMMISSIONER JAGDMANN: Middle of the
12 road. I don't see the age, but you said it was for a
13 40 --
14 MS. OVUKA: This is for a 40-year-old.
15 It's really small at the bottom here.
16 COMMISSIONER JAGDMANN: Okay. Forty --
17 oh, there it is. Okay. Thank you. Just trying to,
18 where am I?
19 MS. OVUKA: That's fine.
20 And then the last bucket for the rate
21 change is the other changes. This is kind of a
22 catch-all bucket, but a few things I would highlight
23 are claims experience coming in different than
24 expected, benefits changes year over year, and also a
25 change in the risk transfer payment due to the risk

1 adjustment program. That was different than expected.
2 The next page outlines the scenarios for
3 the minimum rate increase and the maximum rate
4 increase. For this legal entity the minimum rate
5 increase is negative 20.1 percent and the maximum rate
6 increase is 34.2 percent. You can see all the buckets
7 the percentage are the same for all lines except for
8 other changes, and that's just due to different
9 benefit changes year over year in the different
10 scenarios.
11 And then lastly we have the change in the
12 area factors year over year. We had a very small
13 change in our area factors. For this legal entity the
14 most significant one is that you can see last year the
15 1.0 rating area was essentially Virginia Beach rating
16 area nine. This year it's rating area seven. So
17 we're pretty much just shifting what is our 1.0 rate
18 but has no overall net impact to the premiums.
19 We also outline our tobacco use factors
20 and we use a 1.0 for both tobacco users and non
21 tobacco users.
22 COMMISSIONER JAGDMANN: So if you go back
23 one page, I'm just sort of orienting myself, so I
24 guess the one on the left, that is your average annual
25 rate change and that's a -- it will be a silver plan

1 it looks like going forward.
2 MS. OVUKA: That's correct.
3 COMMISSIONER JAGDMANN: With a $6,000
4 maximum out-of-pocket and a $5,000 -- no, a $5,000
5 deductible and a 7,000.
6 MS. OVUKA: Correct.
7 COMMISSIONER JAGDMANN: 80 percent
8 co-insurance.
9 MS. OVUKA: Yes.
10 COMMISSIONER JAGDMANN: And then the one
11 with the least -- and this would be helpful if
12 everybody just kind of sort of hit the highlights of
13 that for us, too, because it's lot of information on
14 one page. The one, I guess, with the -- on the right
15 is the one with the maximum. That's going to be a
16 silver plan for '18 with 6,550 maximum out-of-pocket,
17 and with a $5,000 deductible.
18 MS. OVUKA: Those are the 2017 plans and
19 then the description for the 2018 plans.
20 COMMISSIONER JAGDMANN: Excuse me.
21 Right. So the $7,000 out-of-pocket maximum and a
22 $5,000 deductible. Okay.
23 MS. OVUKA: Okay? The next legal entity
24 we will review is our Aetna PPO plans. The rate --
25 this scenario is going to be really similar to the

1 last legal entity that we reviewed. The average
2 increase for our most popular plan is 2.8 percent.
3 Again, the same buckets, and actually even our other
4 changes is very similar in this legal entity as well.
5 As we move on to the scenarios of the
6 minimum rate change and the maximum rate change, the
7 minimum range change here is negative 33.26 and the
8 maximum rate change is 35.1 percent. The one thing
9 I'd point out on the left scenario here for the
10 minimum rate change, this was an indemnity plan that
11 is no longer going to be -- in 2017 that is no longer
12 offered in 2018, which is why this other bucket is so
13 large here.
14 As we move to area factors, these are the
15 same as the last filing. So no changes there.
16 Next I'm going to move on to our
17 Innovation Health filings. And so these reflect our
18 partnership with the Nova Health Systems in Northern
19 Virginia. These plans are also only offered in
20 Northern Virginia. The rate increase for our most
21 popular plan is a gold plan and it's 15.1 percent.
22 Here we have the same drivers of the rate increase;
23 population morbidity, trend is 10.3 percent, health
24 insurer's fee is 3.2, the revised age curve is 3.4.
25 Again, slightly different number because it's a

1 different underlying demographic population in that
2 region. And then other changes is worth 2.4 percent.
3 COMMISSIONER JAGDMANN: And I guess -- we
4 haven't talked about this but I guess is this a
5 monthly rate we're talking about?
6 MS. OVUKA: It is a monthly per member,
7 per month, yes.
8 As we move on to the minimum and maximum
9 rate scenarios, the minimum rate change is 1.1
10 percent. That's moving from a silver to a bronze plan
11 in 2018. And the maximum rate change is 33.2 percent.
12 Again, the other bucket varies because of different
13 benefit changes year over year.
14 For area factor changes we just kind
15 of -- they all -- all the areas this is offered in are
16 rating areas ten, 11 and 12 in Northern Virginia.
17 They all have the same area factor. We just rebased
18 our base rate. So no premium impact there.
19 The last filing we have to review is the
20 Innovation Health HMO plans. The rate increase for
21 our most popular plan is 15 percent. Again, the
22 magnitude of the drivers are very similar to the prior
23 filing.
24 As we move to the minimum and maximum
25 rate scenarios, the minimum rate change is negative

1 10.1 percent and the maximum rate change is 51.1
2 percent. That is moving from a bronze to a silver
3 plan.
4 And lastly the rating area factors, again
5 moving all of our area factors to a 1.0 in Northern
6 Virginia.
7 Are there any further questions?
8 THE HEARING EXAMINER: No. Thank you
9 very much.
10 MS. OVUKA: Thank you.
11 COMMISSIONER JAGDMANN: Thank you.
12 THE HEARING EXAMINER: The next carrier
13 is Anthem. We welcome back Mr. Connell. You've been
14 here several times.
15 MR. CONNELL: Yes. Good morning. Good
16 to see you again.
17 All right. Good morning. My name's Tim
18 Connell. I'm a director and actuary with Anthem.
19 Address is 2221 Edward Holland Drive in Richmond,
20 Virginia. I'm here to discuss Anthem rates for
21 individual and small group for 2018, including two
22 legal entities, Healthkeepers and Anthem Health Plans
23 of Virginia.
24 And I'll start with individual and give
25 you a little context as well. This has been such a

1 challenging segment for us. And David alluded a
2 little bit to this in his opening remarks. Just
3 trying to grasp what you're going to have in any given
4 year has been quite a challenge. We see quite a bit
5 of turnover from year to year, we get a different type
6 of population every year, and we've really found that
7 a challenge to understand who is, you know, who is
8 staying, who is remaining with us, who is joining in a
9 different year. It's just been a challenge with the
10 stability and the turnover in the population that we
11 have from year to year.
12 I think we also mentioned carrier exits,
13 too, makes it more of a challenge. And as we filed
14 the rates this year we didn't understand but now we
15 know that some carriers have exited and they're not
16 going to be in the market in 2018.
17 So some other challenges have been that
18 we've seen the market seemed to have peaked; that it's
19 reached a -- it's seen some growth in '14 and '15 as a
20 lot of non grandfathered business moved into the ACA
21 market. '16 was a little bit stable, and we're seeing
22 maybe that it's topped out and it might be starting to
23 shrink now. And I think that market shrinkage is sort
24 of disconcerting to us, that that's going to be, you
25 know, sort of more morbidity changes along the lines

1 of what we saw last year.
2 And I'll start here on slide one. I'll
3 say that we picked our rating areas that had the
4 highest enrollment and highest membership. In the
5 individual market we used area nine, which is the
6 Norfolk, Virginia Beach rating area. And as you can
7 see, the high increase down there at the bottom is
8 sort of the one that sticks out, but I'll try to go
9 through some of the elements, and you saw a little bit
10 on the last presentation about what these elements are
11 and we've talked a little bit about it. I'll just
12 draw your attention to a few of the items.
13 Morbidity, that's certainly been a
14 concern for ours, and we noticed a pretty sharp
15 increase in morbidity in the 2016 experience. I think
16 this one caught us off guard. And if you looked at
17 our past presentations we probably had a lower number
18 in there on the morbidity line. But we're assuming
19 that nine percent number, so just under nine percent.
20 That's about the level of morbidity change that we
21 have observed in the past. And I think as we talked
22 about earlier, that's something we try to measure and
23 bring out separately from just average trend.
24 So the underlying trend might be what's
25 going on in the environment, but the morbidity is

1 something we try to look at using independent risk
2 scores and other internal data to understand are we
3 getting sicker people. We definitely saw that in
4 2016.
5 So going through the lines again, the
6 trend, that also is a little bit higher. We've seen
7 some high experience in all of our -- really in a lot
8 of our blocks. Group business as well. So that's a
9 little bit higher than it's been. And, as we
10 mentioned, the health insurer fee reinstatement coming
11 back in, that's going to be a slight hit to the
12 individual market. We'll see that again in small
13 group.
14 I would characterize the other -- maybe
15 I'll step back before I get to the other change. The
16 revised age curve I think we discussed, too. We're
17 looking at a 40-year-old rate so those adults are
18 going to be a little bit less than average as far as
19 total block. With the new revised age curve we're
20 giving higher increases to the child ages. There's
21 not really a way around that, but I think the new
22 curve was designed, as David said, to reflect maybe a
23 little bit better the expenses that those of younger
24 ages have and also to be a little more gradual in
25 phasing up to the adult rate.

1 So there's a one-time bump that's going
2 to happen at these ages, but then the previous rate
3 curve had a very steep hit when the member hit 21. So
4 instead of that steep hit, now it's going to be a more
5 gradual one. I think from age like 15 to 21 will be
6 going up. So I think it's probably a disruption in
7 next year's rate, but in future years it should be
8 less disruption as people age into the adult rate.
9 As mentioned, this is lowering the adult
10 rate a little bit. It's actually raising the child
11 rates quite a bit, as we'll see on the next page.
12 And then the other changes, I would
13 characterize this amount as being inadequate rates for
14 '17. We're really seeing that the losses are -- you
15 know, we've seen them in 2016 and we think they're
16 continuing in '17. And, you know, we need to kind of
17 make some correction for that.
18 Any questions so far?
19 Here's our page with the average. Again,
20 you see the adult rates a little bit lower than the
21 overall average and those child rates are going to be
22 a little higher. So those are highlighted there at
23 the top.
24 Here we have a minimum and maximum plan,
25 and I'll speak to the -- the minimum plan is fairly

1 close to what our most popular was on the prior page.
2 So I'll speak a little bit to the gold plan that's
3 getting a little higher increase.
4 It's fewer members. You can see it's not
5 too many members in that plan as of today. But we are
6 seeing even more adverse experience in the gold plans
7 than we see in the other medals. And what we do in
8 trying to evaluate that is, as we've mentioned, we're
9 not rating on the health status but we're looking at
10 it post risk adjustment. We have some internal rating
11 tools that allow us to look at that, and so even
12 though this block of gold members might receive, say,
13 over $100 per member per month in risk adjustment
14 receivables -- and that's just an illustrative number.
15 I don't have the exact number, but it's a pretty large
16 number. But even after receiving that, the experience
17 is in this block is poor enough that it needs even
18 more of an increase than the other medals, and that's
19 what we're seeing in this gold plan.
20 There are some slight modifications to
21 the benefit plans. I don't think I went over that in
22 the last slide, but if you have any questions on that
23 I can pause for that, too.
24 We tend to keep the actuarial value at a
25 similar level to what it was in the prior year.

1 Any questions?
2 COMMISSIONER DIMITRI: Let me just ask
3 you in the individual plan when you talk about
4 children, is this the situation where a family
5 purchases an individual policy for the child alone?
6 MR. CONNELL: These wouldn't be
7 child-only policies. These would be usually a family
8 contract with the adult and child.
9 COMMISSIONER DIMITRI: So how many would
10 there be -- for example, when you say you have 2400
11 members in the gold plan here, how many would be
12 children?
13 MR. CONNELL: I don't have that number
14 with me. I think we did see a little more -- the
15 weighting of percentage of children was a little bit
16 higher in the gold plans, and as a result the gold
17 plan we're giving on average was a little bit higher
18 than what we would have gotten from just the average
19 gold. But I don't have the exact numbers. I would
20 say maybe 10 to 20 percent might be child.
21 COMMISSIONER DIMITRI: That would be 21
22 and under?
23 MR. CONNELL: Right.
24 COMMISSIONER DIMITRI: Thank you.
25 MR. CONNELL: That's kind of small there.

1 Is that okay? I'm on the full screen mode so I have
2 to back up.
3 So we made some slight changes to the
4 area factors, and I think like it was presented in the
5 Aetna presentation these are net neutral to the
6 premium. But, again, we looked at the experience
7 after risk adjustment of certain areas. We did find a
8 few areas that were performing worse and we wanted to
9 make sure that we were priced adequately in those
10 areas. We really just made an offsetting adjustment.
11 Once we moved up a few areas that needed an increase
12 we -- to make it net neutral we reduced the other
13 areas in the state and that's where the negatives come
14 in.
15 But generally we try to keep those
16 changes fairly modest. I know in a couple of the
17 areas it got an increase. There's still actually like
18 Charlottesville, Richmond, area two and area seven,
19 are still -- have one of the lower factors in the
20 state.
21 All right. I'll move on to small group.
22 THE HEARING EXAMINER: This is an off
23 exchange product, correct?
24 MR. CONNELL: Correct. It was mentioned
25 earlier that we exited our on exchange business in

1 Healthkeepers. Anthem Health Plans of Virginia has
2 always been just off exchange. I'll get to the
3 Healthkeepers in a moment. But we had very little
4 membership on that on exchange small group product.
5 For the exchange it was really individual that seemed
6 to attract the members.
7 All right. So our most popular plan is a
8 platinum plan in the Anthem Health Plans, which is a
9 PPO product. And the average increase for the
10 40-year-old is going to be 7.6 percent. So I think
11 you'll see some -- a lot more modest numbers here
12 compared to the individual. Similar trend, similar
13 number for the health insurer fee, and the age curve.
14 Age curve is a little bit more. I think there's a
15 little more children on policies in the small group
16 market. And the other changes, generally I'd
17 characterize those as benefit or experience changes.
18 And in this plan we try to highlight at the top the
19 main benefit levels of the plan, the co-pays and the
20 out-of-pockets and the deductibles. We did make a few
21 cost-sharing adjustments a little bit below those main
22 lines; things like ER co-pays, other maybe specialist
23 co-pays might have changed. We did make a few
24 cost-sharing increases on those plans, which those
25 benefit changes, I think, are leading to some of that

1 negative four percent.
2 All right. I'll move on to slide five.
3 And, again, we see that the same age curve applying to
4 the small group block is going to mean that, yes, the
5 child rates will go up quite a bit more than the adult
6 rates. The slowest minimum product actually is the
7 same product that saw before, the platinum one that is
8 also our most popular. And in the bronze plan we're
9 seeing a little bit more of an increase there on
10 the -- mainly due to benefit changes I think there,
11 too.
12 And area, the last worksheet on this,
13 this legal entity, no area changes were made on the
14 PPO.
15 All right. Our small group Healthkeepers
16 will look similar to what our Anthem Health Plans of
17 Virginia did. Similar assumptions were used there.
18 Just a slightly different number in the experience and
19 some of the network changes that are happening in
20 Healthkeepers. The increase is slightly higher there.
21 This is our most popular plan. It's a
22 gold. There is still a slight other of negative
23 there, and I'll flip to the platinum, which is getting
24 the minimum. I think that's the same benefit design
25 as what was on our PPO legal entity. And the maximum

1 is the bronze plan. I would point out one other
2 thing, too. Along with these rates that are one Q of
3 '18, we do file quarterly step changes for two Q and
4 three Q and four Q. And we have the ability to refile
5 at a later time, but initially we file those with the
6 intent on hopefully those rates will be the final
7 ones. And our rates as you go further out into the
8 year do get a little bit lower than what's stated on
9 these average annuals. For example, the Healthkeepers
10 in the two Q is going to drop from the fourteen nine
11 at the top page to about twelve seven.
12 I'd say one of the reasons for a little
13 higher increases this year is the reinstatement of the
14 fee, as we mentioned. We also had a little bit of
15 adverse experience back to 2016 in the small group
16 block. All right.
17 I have a few prepared remarks to close.
18 Are there any more questions on the rates?
19 THE HEARING EXAMINER: There's been
20 several references to the health insurance fee that's
21 being reinstated this year. I think it was waived
22 last year. My information is that's 3.7 percent.
23 Does that sound right?
24 MR. CONNELL: I think insurers might have
25 a slightly different estimate, and there's an nominal

1 fee and there's also the fact that some of the fee
2 can't be deducted for taxes. And so some of the for
3 profit companies will have maybe a little bit extra
4 added onto that. But I'd say, yeah, the three,
5 three-and-a-half range is pretty reasonable.
6 THE HEARING EXAMINER: That's in addition
7 to the premium?
8 MR. CONNELL: Yes.
9 THE HEARING EXAMINER: Okay.
10 MR. CONNELL: Just closing remarks here
11 I'd like to make. Anthem Blue Cross Blue Shield is
12 committed to offering coverage to Virginia consumers
13 and to submitting rate filings that reflect levels of
14 risk that Anthem deems reasonable. As mentioned
15 earlier, the current environment already presents
16 issues with market stability and challenging rate
17 increases. Furthermore, a significant number of
18 matters that could dramatically impact the
19 sustainability of the marketplace remain unresolved,
20 including whether cost-sharing reductions, as we
21 mentioned earlier, will continue to be funded, whether
22 taxes on the fully insured coverage will be restored,
23 and whether Congress will enact legislation repealing
24 and/or replacing the Affordable Care Act. This
25 unprecedented level of uncertainty makes it

1 challenging for us to predict the sufficient comfort,
2 the sustainability of the marketplace next year.
3 We are closely monitoring developments in
4 Washington in the hopes that some action or actions
5 will be taken by Congress or the administration to
6 reduce the level of uncertainty regarding the future
7 of the marketplace such that a reevaluation of our
8 filing is not necessary. If, however, we aren't able
9 to gain certainty on some of these items quickly,
10 Anthem will evaluate potential adjustments to our
11 filing, which could include changes to our
12 participation in the Virginia individual ACA market by
13 rating area.
14 We will take a thoughtful and deliberate
15 approach to the consideration of any changes to our
16 participation in the Virginia market. Anthem remains
17 committed to continue discussions with policymakers
18 and regulators on ways to stabilize the individual
19 insurance market for the benefit of Virginia's
20 healthcare consumers.
21 THE HEARING EXAMINER: Okay, Mr. Connell.
22 Thank you very much.
23 CareFirst is next.
24 MR. BERRY: Good morning. My name is
25 Peter Berry. I am the chief actuary for CareFirst.

1 Our address is 10455 Mill Run Circle, Owings Mills,
2 Maryland.
3 Today I'm going to be addressing, like
4 others, the individual and small group market. I'll
5 be also addressing our two entities, the Group
6 Hospital and Medical Services, Inc., which I'll refer
7 to as GHMSI, which is our PPO products, and also
8 BlueChoice, which is our other entity, which is our
9 HMO and POS products.
10 So the order here is we have individual
11 first and then I'll talk about small group. I'll be
12 happy to answer questions on all of them, but I think
13 what we'll see is small, the increases are flat to
14 negative. So like other carriers the small group
15 market is much more stable and so I will tend to spend
16 most of my time talking about individual.
17 On the screen here you'll see the GHMSI.
18 This is our PPO plan. This year we have two plans.
19 Both plans are on and off the exchange. We have a
20 silver 3500 plan and a gold 1000 plan. I'm sorry.
21 Let me make sure that's right.
22 Yes, that's right. Good.
23 And so when we see our most popular in
24 our min and max there's only two plans to choose from.
25 I want to start -- this is the one that's the most

1 concerning, is the individual PPO. You may or may not
2 remember last year I stood here and shared with the
3 three of you that we were exiting the bronze metallic
4 level in Virginia and we expect that to have an impact
5 on the morbidity of the population that we would
6 insure as we were only offering gold and silver.
7 Generally speaking, healthier people buy the leaner
8 plans. And this is what we observed.
9 What you see here on this plan, which is
10 the most popular plan, is a 55 percent increase on
11 this silver plan. And there's basically two drivers
12 do that. When we looked at the base period experience
13 moving from 2015 to 2016, that increased by
14 22 percent. So that's actual claims coming through in
15 the base period.
16 Last year we also made assumptions on how
17 much sicker we thought the population would be in '17.
18 Now that we actually have '17 members in the bucket we
19 can say, okay, well, who terminated and what was their
20 relative morbidity, who did we keep, now let's make
21 assumptions about the new folks. And what we see here
22 is that for the PPO we actually underestimated the
23 morbidity change in '17 by about 18 percent. Another
24 way of saying that is the people we kept versus the
25 people we lost were about 18 percent sicker than we

1 thought they would be, and that's a big driver here
2 because that flows through the '18 rates. The numbers
3 were we lost about 30 percent of the membership and
4 they were about 30 percent sicker than the people who
5 were there the prior year. So those in the chart
6 there that you'll see, those are the main drivers of
7 the 55 percent.
8 This one here -- again, because we only
9 have two plans, a lot of this is repetitive and so I
10 probably won't spend too much time on it. You can't
11 really see it on this, but on the left side we have
12 the gold plan I mentioned. That sees a 44 percent
13 increase. It's a little less because of some of the
14 benefit modifications we made on the silver. And also
15 the way that we calibrate our pricing model increased
16 the silver a little bit more than the gold. But it's
17 the same story on gold. It's the same base period
18 experience, it's the same morbidity change. That has
19 to be done at the market level. And so what we really
20 see driving here is the '15 experience to '16 and the
21 population that we're continuing to insure.
22 I'll just comment with regards to rating
23 area. We're only in one rating area, rating area ten,
24 so we don't really have an issue of rating factors.
25 So that's that one.

1 Off exchange, like I said, the benefits
2 are the same on and off exchange. The only difference
3 is you can't have a portion coverage on exchange on an
4 FFM and we offer off exchange. So there's a slight
5 little bit of difference in pricing there. But
6 generally speaking they're the same.
7 With regards to the changes on the
8 increases, we did this year reflect, because these are
9 separate products on and off because of the abortion,
10 on on exchange plans for silver we did impact what we
11 thought the what's called induced demand would be on
12 the CSR products. And what this means is the lower
13 the co-pay is for somebody, the more likely they are
14 to go to the doctor. And so that's called induced
15 demand. You can price it in. Because the CSR plans
16 subsidize co-pays for our members, we do reflect that
17 in the pricing. So that does cause some differences
18 between the silver plans off and on. But everything
19 else is generally the same.
20 Again, there is that, and we get there.
21 So that's the GMHSI individual PPO. Again, like I
22 said, this is the one where we're seeing the big
23 increases, the 55 percent for an age 40 male in
24 silver, 44 for gold. Let me pause there before I get
25 on to BlueChoice and see if you have any questions.

1 Okay. That's the bad news. The good
2 news was that we also got out of bronze in BlueChoice
3 and we had to make assumptions for morbidity for that
4 block as well. Our initial -- the base period
5 experience, believe it or not, changed about exactly
6 as the PPO; went up by about 22 percent. However, the
7 population that we kept was slightly healthier than we
8 assumed, and so that leverages down the increase some.
9 So you can see here that even though the base period
10 went up the same, by the time you get down to the rate
11 it only increased 18 percent.
12 Now, I have to caveat that by saying when
13 we looked at the morbidity change from '16 to '17, we
14 looked at who we lost, we looked at who we kept, and
15 we normalized for age and all that stuff. But then we
16 have to make assumptions on the new members. And what
17 we initially assume is, since we don't know anything
18 about them, we assume they have the same morbidity as
19 the existing. We're continuing to look at that, and
20 unfortunately we don't have definitive data yet, but
21 it looks like the new members we got were actually
22 significantly sicker than the existing. So I do have
23 to caveat my good news statement with that, and we're
24 continuing to look at that. But right now what we've
25 put in for BlueChoice is actually a lot lower than the

1 PPO. So we're pleased about that. Again, rating area
2 ten.
3 So that's the individual market for us
4 right now. Right now we have assumed -- I'll make a
5 couple of other comments about BlueChoice. We have
6 assumed that CSRs will continue to be funded. We are
7 continuing, like everyone else, to monitor what's
8 happening at the federal level. And we're also taking
9 a look around the country to see how people are
10 handling that.
11 The one other comment I'll make is in
12 regards to the enforcement of the mandate. We have
13 made a provision in our BlueChoice rates -- not in our
14 PPO rates but in our BlueChoice HMO rates -- for a
15 deterioration morbidity for non enforcement of the
16 mandate. Now, the total morbidity assumption
17 deterioration in '18, we assumed that the population
18 would get 20 percent sicker. Some of that is just
19 what we've seen in the past. As we lose members, we
20 lose the healthier members and we keep the sicker
21 members and it goes up. That number in '16 was
22 actually 20 percent deterioration. It looks to be
23 16 percent in '17. So if you think about that, out of
24 total change in '18, that total 20, probably about 15
25 of it is what we would have expected anyway and then

1 there's an additional five associated with the non
2 enforcement of the mandate. There's several studies
3 out there that we've reviewed that we believe that
4 that's a reasonable number.
5 So that's my presentation on individual,
6 and let me pause again there and see if you have any
7 questions. Move on to small group. I think we can do
8 this fairly quickly.
9 Like most carriers we are mostly off
10 exchange in the small group market. I think we have
11 three plans on the shop, as it's called. In
12 BlueChoice we have 50 plans off. So most of this is
13 off exchange business. What we saw from '15 to '16,
14 unlike individual we saw a 22 percent increase, we saw
15 low single digit increases in our experience on the
16 order of two percent for a small group, which is very
17 encouraging. We took the opportunity there to lower
18 our trends from 8.4 down to seven. So that
19 accounts -- that's over two years so that accounts for
20 about a three percent drop in rates. As you can see
21 here -- keep going. Sorry. Wrong group.
22 Most popular plan for GHMSI shows a five
23 percent drop for an age 40. And that's primarily
24 driven by the drop in the trend and then the revised
25 age curve dynamic that people have been talking about,

1 how when they raised the kids' rates, the adult rates
2 dropped relative to that. So you see about a 3.3
3 percent drop there and that accounts for the five. So
4 we're very encouraged to see very either moderate or
5 negative increases on small group.
6 COMMISSIONER DIMITRI: Let me ask you
7 on -- and this goes for the other plans you
8 illustrated, you have a 5.1 percent decrease here in
9 the rate from 1/17 to 1/18. It's not for exactly the
10 same product, though, is it? I mean the deductibles
11 increased -- you know, using this as an example, the
12 small group, the deductibles have increased in 2018,
13 so it's a little -- you know, to say that the rate has
14 gone down 5.1 percent, the rate itself has gone down
15 but in terms -- you're not getting the same thing I
16 guess is what I'm saying.
17 MR. BERRY: You're absolutely right.
18 That's a great point. I'll address that. For us our
19 modifications to our small group plans in 2018 was in
20 response to the federal AV calculator being released.
21 And, as you might know, the actual value, you have to
22 put your benefits into their calculator and you have
23 to be within a span, a range, a plus or minus two,
24 around, for a particular medal. What happens when
25 they rebased the -- their AV calculator and sent it

1 out, we put our plans in for '17, we were outside the
2 range, and so we had to make slight modifications to
3 move ourselves back into the range. And that really
4 is the justification and accounts for the benefit
5 changes that you see.
6 You're absolutely right. There were
7 changes to move the AV up to get back into the -- I'm
8 sorry, to move the AV down to get back into the range,
9 and one of those was raising the deductible here, as
10 you see, from 2,000 to 2500 in our most popular
11 platinum plan.
12 COMMISSIONER JAGDMANN: So you're saying
13 the actual rates you charged have to fit within --
14 MR. BERRY: Not the rates. Basically you
15 put your benefits in and it gives you a number. Like
16 .8 is gold .7 is silver. And you have to be within
17 plus or minus two. So we put our benefits in, it
18 spits out a number, and then we go, oh, we got to
19 adjust our benefits to get back within the range. In
20 a small group that accounts for the benefit changes
21 that you see in '18. I think our preference would
22 have been not to change the benefits at all.
23 THE HEARING EXAMINER: In general it
24 seems like, if you look at all the plans submitted
25 this year, across carriers, the individual premium

1 increases are far larger than the small group. And is
2 the biggest single factor, is it the morbidity is just
3 better, the trend is better in the small group market
4 versus individual?
5 MR. BERRY: Yeah. There's a lot of
6 reasons, I think. Generally speaking, the small group
7 market you've got people who are at work, you've got
8 the risk spread over groups rather than individuals.
9 Introducing guaranteed issue into the individual pool
10 that we use to be underwritten and then having a
11 relatively weak mandate, what we saw was that people
12 whose house are on fire are buying insurance. And
13 that drives up the morbidity very quickly. And we've
14 seen that every year since 2014.
15 THE HEARING EXAMINER: You mean adverse
16 selection?
17 MR. BERRY: Yeah, that's adverse
18 selection. And so that's much more pronounced in the
19 individual market than it would be in a small group
20 market.
21 Very quickly, here again you see on the
22 bottom line you see a minus five two and a four six
23 for min and maxes. We're in one rating area. Minus
24 four two, off exchange. That was on exchange. We did
25 a scan. We only have three plans. But all the

1 numbers here are very comparable. Here you see off
2 exchange we have, you know, upwards of 15 plans, and
3 the maximum was a minus 1.6 for an age 40. We go to
4 BlueChoice, this one, it's about flat.
5 COMMISSIONER JAGDMANN: I just had a
6 question, just an observation. I would assume that
7 with -- that your morbidity would be lower with your
8 higher deductible plans just because people would
9 think twice before they go. Is that what you've been
10 finding?
11 MR. BERRY: That's absolutely true. And
12 once you normalize for age and different things it's
13 very pronounced that the folks with the gold and
14 platinum plans, when we used to have platinum in
15 individual, were much sicker. And that's supposed to
16 be captured in the risk adjustment mechanisms but, as
17 people have talked about, it's imperfect.
18 Just to finish up here, so small group on
19 exchange BlueChoice we have about 50 plans on
20 exchange, three off. Our most popular plan is this
21 silver here. It's at a .4. Again, we're very, very
22 close to flat here on these. A minus .6 versus a .4.
23 And, again, we're in one rating area. Off exchange,
24 minus one. These are all numbers that are here. You
25 have more plans here off exchange so there's a little

1 bit more variation. But, again, minus four to plus
2 three. Very moderate increases.
3 And that's it. Any additional questions?
4 THE HEARING EXAMINER: I think not.
5 Thank you very much.
6 Okay. Cigna.
7 MR. ZORNOSA: Good morning. My name is
8 Nick Zornosa. I'm the lead pricing actuary for
9 Cigna's individual health business, and I'm here today
10 actually in place of Zachary Hoffman. Zach is the
11 signing actuary, the filing actuary for the Virginia
12 filing. Zach put together the filing and he actually
13 put together this presentation that we're going to go
14 through today also. Zach had a conflict and he
15 couldn't be here today. Zach is on my staff, so I'm
16 going to be representing his work and walking everyone
17 through this.
18 So 2018 is Cigna's second year serving
19 the individual exchange market in Virginia. 2017
20 obviously is our first year. So a lot of what we are
21 going to be talking about is -- will -- from an
22 actuarial perspective we had to develop rates for 2018
23 without access to direct data in the Virginia
24 marketplace. So we assembled other internal Cigna
25 data that we had and adjusted as we needed to.

1 So to walk through the exhibits, what you
2 see here is the rate increase on our most popular
3 plan. The most popular plan in 2017 is a 68 percent
4 actuarial value plan with a $4500 deductible, 85
5 percent co-insurance and a maximum out-the-pocket of
6 $7,150.
7 And 2018, the plan is staying mostly the
8 same. The actuarial value is very comparable. The
9 out-of-pocket to going up to 7,350 and co-insurance is
10 changing to 80 percent.
11 So the rate increases, splitting to the
12 different component drivers for an age 40-year-old, we
13 have population morbidity, which is the most wrecking
14 item here, 23.4 percent driven by population
15 morbidity. That is driven primarily by the issue that
16 I mentioned earlier, not having access to direct
17 Virginia data to price.
18 So when we priced 2017 we used other
19 individual health data that we had from other states.
20 That's, naturally, an inexact process. We did the
21 best we could, but looking back and reviewing our
22 rates for 2018 we found that our morbidity ended up
23 being a bit lower, and actually 2016 was the first
24 year that we had our own internal data on the product
25 type that we're offing in Virginia. So the product

1 that we're offering in Virginia is a more managed,
2 narrower network product than what we had experienced
3 in 2014 and 2015.
4 So what's different now than when we were
5 here last year and we were filing for 2017 is we
6 finally had access to that type of product in other
7 states. So that's really what's driving the large
8 morbidity increase here.
9 The other components, trend, representing
10 unit and utilization cost increases, 7.8 percent year
11 over year. The health insurance fee moratorium we
12 estimated at a 4.4 percent change. And then the
13 revised age curve as having a favorable impact at 1.7
14 percent. And on this plan the other changes come out
15 to a 4.7 percent cost increase, and the driver there
16 is largely customer utilization patterns, specifically
17 what we would call the induced demand factor.
18 Any questions so far?
19 COMMISSIONER JAGDMANN: It's always worst
20 to go first. We get all our questions out.
21 MR. ZORNOSA: Heavy on the early alphabet
22 letters here.
23 COMMISSIONER JAGDMANN: We might go
24 reversed next year. I guess it's going to be best to
25 be in the middle.

1 MR. ZORNOSA: We're fine with that, too.
2 So what you see --
3 THE HEARING EXAMINER: David does a very
4 good job talking about the actuarial issues, and
5 obviously actuarial issues is what this is all about.
6 So David always covers those very clearly.
7 MR. ZORNOSA: Doing a lot of the heavy
8 lifting.
9 So what we see here are the minimum and
10 maximum annual rate changes. The minimum change here
11 is in rating area ten. It is a 27.8 percent rate
12 increase. The plan here in question had a favorable
13 impact from the actuarial value being lower, as you
14 see there, from a 70.8 percent actuarial value in 2017
15 being mapped to a plan with a 68.6 actuarial value.
16 So the -- we're able to pass that savings on into the
17 premium and keep the premium increases lower for
18 people in that plan.
19 And looking at the components on the
20 bottom, most of them are the same. The one that is
21 different is the other changes really, which is where
22 that plan design change is coming out, is also an
23 induced demand utilization impact that's coming out
24 there. As people are in a cheaper plan they tend to
25 be better healthcare consumers.

1 And then the plan with the maximum annual
2 rate change, this is a gold plan, 2017, 2018; similar
3 to some of the other comments that we've had in the
4 room. We've had sustained unfavorable performance in
5 our gold plans for the most part as the inefficiencies
6 in the risk adjustment mechanism aren't quite able to
7 make those plans work for us. So we're seeing a 85.6
8 percent rate increase on the gold plan driven by the
9 other changes there, the 36.1 percent.
10 Okay. Our rating area factors decreased
11 slightly in rating area ten, which is the Northern
12 Virginia market that we're in. And then our tobacco
13 load is the same from 2017 to 2018.
14 THE HEARING EXAMINER: Okay. Thank you.
15 MR. ZORNOSA: All right. Thank you.
16 THE HEARING EXAMINER: Kaiser.
17 MS. SCHROER: All right. Good morning.
18 My name is Sheila Schroer. I am an executive director
19 and chief actuary for Kaiser's mid-atlantic region.
20 Our address is 2101 East Jefferson Street, Rockville,
21 Maryland. Thank you for the opportunity to speak
22 today.
23 All right. This first page shows our
24 most popular plan with over 20 percent of our
25 enrollment. It is a 6,000 deductible plan, which is

1 unchanged from '17 to 8 -- 2017 to 2018, but we did
2 increase some of the other cost-sharing components
3 between the years, mostly to stay within the AV range.
4 Looking at the components of the rate
5 increase, for our individual block we have not seen
6 big changes in morbidity the last couple of years,
7 even though we have grown enrollment consistently,
8 which is actually surprising to me. So we're assuming
9 zero percent morbidity again.
10 For trend we have a 3.8 percent trend,
11 which, as we've seen, is a lot lower than some of the
12 other carrier trends. The reason for that is Kaiser's
13 trend is mostly made up of budgeted fixed costs. In
14 other words, it's the salaries we're paying our
15 physicians.
16 Health insurance fee is going up about
17 one percent. That amount is actually lower than most
18 of the other carriers, primarily because we get a
19 discount because we are not-for-profit 501(3)(c)
20 corporation, and we also don't pay federal income
21 taxes. So there's no non deductibility to worry
22 about.
23 The revised age curve is a two percent
24 reduction, and then the biggest component of the rate
25 change falls in other, which is made up of a couple of

1 things; the benefit changes, the -- we've also updated
2 our benefit relativity model, which is something that
3 we should do every year but Kaiser had not updated it
4 in several years. So by updating the model we are
5 picking up the changes in the cost-sharing, the value
6 of the cost-sharing components, which drift and change
7 a little bit every year. But if you don't update your
8 model every year, then it can look like a big change
9 if you're doing several years of catch-up. So that
10 flows through all of our benefits.
11 COMMISSIONER JAGDMANN: What is a benefit
12 relativity? I don't really understand that.
13 MS. SCHROER: Yeah.
14 COMMISSIONER JAGDMANN: Is that trend by
15 another name?
16 MS. SCHROER: It's kind of like the AV,
17 but a benefit relativity means it's the relationship
18 between two different products. So if you have a 100
19 deductible product, you have a higher relativity than
20 if you have a 1,000 deductible product. So the
21 relative value of the cost-sharing is that difference.
22 COMMISSIONER JAGDMANN: I think I'll need
23 another lesson later, but that's a good start.
24 MS. SCHROER: You can ask David later.
25 THE HEARING EXAMINER: But your model,

1 and we've had this discussion before, but you have --
2 tend to have lower changes to the morbidity and
3 certainly trend and that's because you -- Kaiser
4 really is in the business, is it not, of not only
5 being the insurer but also being the healthcare
6 provider. You're not entering into contracts with
7 networks of physicians or hospitals, you are providing
8 the health services yourself.
9 MS. SCHROER: That is mostly true. We do
10 have contracts with non Kaiser providers, but that's
11 for a very small portion of our business. And that's
12 for like if there's a specialty that Kaiser doesn't
13 provide we will send members outside of the network to
14 get the specialty care.
15 THE HEARING EXAMINER: So you have much
16 more control over your health care costs.
17 MS. SCHROER: Yes.
18 THE HEARING EXAMINER: Right.
19 MS. SCHROER: All right. This page shows
20 our 24 percent average increase at the top compared to
21 the average adult and child rate. The difference
22 between those two is solely due to the change in CMS
23 age curve. The plan on the left with five percent of
24 our enrollment is the minimum increase plan. And the
25 plan on the right with about six percent of our

1 enrollment is the maximum increase plan. The minimum
2 increase plan has a zero deductible and low
3 cost-sharing components. It's a gold plan. The
4 maximum increase plan is a high deductible plan. The
5 rate increase components are the same as on the prior
6 page except in the other bucket, which is where we get
7 into the benefit change and benefit model update that
8 we did.
9 There is a leveraging impact for high
10 deductible plans in the benefit model, so when we
11 updated the impact on high deductibles is more
12 pronounced than on low deductibles.
13 All right. Any questions on these pages
14 before I move on?
15 Okay. This page is just wrong so ignore
16 it. My apologies. We do not vary rates by rating
17 area. We are in areas seven, ten and 12, and those
18 amounts should be factors of one. And then we have
19 not changed our tobacco use factor.
20 All right. So that is individual.
21 Moving on to small group, we have over a quarter of
22 our enrollment is in this plan. It's a very low
23 cost-share plan. It's an overall increase of .6
24 percent. The morbidity trend, health insurance fee,
25 rate revised age curve are very similar to the

1 individual impacts. And then other changes, again,
2 the benefit model update actually improves this plan.
3 So you can even see that we've increased or lowered
4 the co-pays on PCP for this plan, but we're also,
5 because of the benefit model, still getting a rate
6 decrease for the net change.
7 COMMISSIONER DIMITRI: So what is the
8 real driver here, to end up at virtually no change in
9 the rate? Is it the stability and size of the member
10 group or --
11 MS. SCHROER: It is stability. I
12 wouldn't say it's the size of this pool because our
13 small group pool is not very big. Surprisingly it is
14 stable though.
15 COMMISSIONER DIMITRI: Do you normally
16 get -- if you do have a plan with, you know, say
17 20,000 members versus 2- or 3,000, over time is the
18 movement in cost typically more moderate for that
19 larger group where you don't have, you know, people
20 coming in and sort of cherry-picking the plans they
21 want?
22 MS. SCHROER: Exactly, yes. Yes. One
23 person's impact on that larger pool is not going to be
24 as pronounced as on the smaller pool. So you're
25 exactly right. And, again, because of our cost

1 structure and the way we pay our doctors, it just
2 doesn't -- it doesn't impact us when we get sick
3 people as much as a sicker person going to another
4 carrier.
5 COMMISSIONER DIMITRI: Why is that? Why
6 would it go, you know, for the same coverage?
7 MS. SCHROER: So think of it this way: A
8 healthy person might go see the doctor once a year for
9 their annual checkup. Someone who is sicker might go,
10 let's say, once a month. We still pay our providers
11 the same amount of money whether the person -- whether
12 the member goes once a year or once a month. The
13 provider gets the same amount of dollars.
14 COMMISSIONER JAGDMANN: It's a capitated
15 rate.
16 THE HEARING EXAMINER: You control
17 your --
18 MS. SCHROER: It's like a capitated rate.
19 THE HEARING EXAMINER: You control your
20 healthcare costs.
21 MS. SCHROER: Exactly, yes. Yeah.
22 THE HEARING EXAMINER: Because you employ
23 the providers.
24 MS. SCHROER: Yes. It's a very different
25 kind of relationship. I'm still learning, too, and

1 I've been there two years.
2 Okay. Minimum and max. We have a 4.4
3 percent overall average rate change; the adults at 1.7
4 and child is at it looks like 29 percent. The min and
5 the max plans -- let me explain that minimum plan just
6 for a moment. It is a point of service plan. The
7 cost-sharing components, there's three rows and those
8 are different tiers. The top row is for cost-sharing
9 when a member goes to see a Kaiser doctor. The second
10 tier is your cost-sharing if you go to a non Kaiser
11 doctor that's in Kaiser's expanded network. And then
12 the third tier is your cost-sharing if you go outside
13 of that network.
14 So this is a plan where you don't have to
15 go see a Kaiser doctor to get your care. You can go
16 outside Kaiser but you will pay a little bit more.
17 And this is the plan that's getting the minimum
18 increase. The vast majority of our expenses are in
19 that first tier of the plan design.
20 Then the maximum is a straight-up high
21 deductible HMO. We've increased the cost-share
22 components a little bit there. You can see the number
23 of members in each of these plans. It's under 400 in
24 these plans, so there's not a lot of enrollment in
25 here.

1 All right. Then, again, this is just not
2 updated. Factors are all one for rating area seven,
3 ten and 12, and then we don't rate for tobacco.
4 And that is all I have. Is there any
5 questions?
6 THE HEARING EXAMINER: We've already
7 asked them. Thank you very much.
8 MS. SCHROER: Thank you very much.
9 THE HEARING EXAMINER: Piedmont.
10 MR. DAVIS: Good morning. I'm Zach
11 Davis. I'm a consulting actuary with Millman here
12 representing Piedmont Community Healthcare HMO.
13 So for Piedmont's individual plans here
14 the most popular plan had an 18.3 percent rate
15 increase, and the main drivers are the trend, the
16 change in the federal age curve, and then some other
17 factors which are related to plan design changes
18 similar to the other presenters.
19 The minimum plan design here or the
20 minimum change was 7.1 percent and the maximum was
21 20.4 percent. Again, the minimum was driven by plan
22 design changes and the maximum was our catastrophic
23 plan which had a pretty dramatic change in the
24 enrollment, the age of the members enrolled, so that
25 was causing the large other change there.

1 For Piedmont we file in five rating areas
2 and they all have the same rating factor and there's
3 no change from last year.
4 We file a tiered tobacco factor and,
5 again --
6 THE HEARING EXAMINER: Can I ask you a
7 question? I was curious about your -- when I saw your
8 rating area chart, my impression of Piedmont has
9 always been you serve Lynchburg area, basically
10 focused in Lynchburg --
11 MR. DAVIS: Right.
12 THE HEARING EXAMINER: -- but you listed
13 other rating areas, including Richmond. Is there a
14 reason why --
15 MR. DAVIS: We have a small presence in
16 select counties in other rating areas, but our
17 majority, I believe over 90 percent, is in that
18 Lynchburg area.
19 THE HEARING EXAMINER: Is in Lynchburg.
20 Right. Okay.
21 MR. DAVIS: Yeah.
22 So we file a tiered tobacco factor.
23 There's been no change from to 2017 to 2018. So
24 that's the individual.
25 For small group, our most popular plan

1 actually only had 104 members. We don't have a very
2 large presence in the small group ACA market. It had
3 a ten percent rate increase. Again, the main drivers
4 are trend and our age curve. We have a particularly
5 large amount of children in the small group population
6 so you're seeing a pretty big decrease on the adults
7 because the children are increasing so much, since
8 this rate represents an age four to a year.
9 Going to our minimum plan here, minus 5.4
10 percent and our maximum plan of 15.9 percent. We made
11 a -- Piedmont terminated their PPO products and
12 cross-walked their members into an HMO POS product, so
13 a lot of the changes here is due to the cross-walk.
14 You can see the change in deductible went from 2500 to
15 4500. That's just how the cross-walk was designed.
16 And then our maximum plan here is 15.9 percent. And
17 then, you know, again, the drivers are just the plan
18 design changes.
19 For small group, the same; 1.0 rating
20 area. There's no changes from '17 to '18. And we
21 file a tobacco factor and we did not change that
22 either.
23 THE HEARING EXAMINER: All right. I
24 think what we will do here is take a 15-minute break
25 and then give everybody a little break here, the court

1 reporter and everybody else, and come back and
2 complete I think we have Sentara and United. So I've
3 got 11:09. Let's come back at 11:25 and resume.
4 (Recess.)
5 THE HEARING EXAMINER: Okay. Sentara.
6 MR. RATZLAFF: I trust everyone is
7 refreshed from the brief break. Thank you very much
8 for that. My name is Dean Ratzlaff, representing
9 Sentara Health Plan from Virginia Beach. Our address
10 is 4417 Corporation Lane, the zip code is 23462.
11 So we, like Kaiser, are a provider-owned
12 health plan, although we go outside of our own
13 provider system and we do contract with other doctors
14 throughout the state and we use the name Optima.
15 Optima is technically a subsidiary of Sentara.
16 We have two legal entities. The very
17 first one in individual doesn't happen to have any
18 members in it right now. We -- I'll briefly skim
19 through some of the items, but I'm going to do this
20 one rather quick because it has no members at the
21 moment. Trend, 7.1 percent. Pretty standard. We're
22 not assuming any changes in the morbidity or health
23 that drives the claims of the members. And overall
24 this is a 9.1 percent rate increase.
25 Again, same plan for high and low. And

1 then these are the area factors that we have; the
2 tobacco factor has stayed constant at 1.2. So
3 somebody who does admit to smoking tobacco will
4 receive a 20 percent higher premium.
5 THE HEARING EXAMINER: Optima, you've
6 always been very concentrated in the Hampton Roads
7 area, correct?
8 MR. RATZLAFF: Correct.
9 THE HEARING EXAMINER: So you reference
10 your model is similar to Kaiser in that you
11 obviously -- I mean Sentara obviously has the largest
12 hospital chain in Hampton Roads. And so that's your
13 provider network. And that's why you can control the
14 costs more because you actually own the provider
15 network.
16 MR. RATZLAFF: Yeah. I like to think of
17 the Hampton Roads area as our base because we can work
18 with our provider network to control costs. We do
19 have a presence across the state, but we're not as
20 effective in controlling costs outside of Hampton
21 Roads because we're working with other providers.
22 THE HEARING EXAMINER: Yeah. If you go
23 into other areas you have to contract with those
24 hospitals of different chains, like Carillon or Bon
25 Secours, whoever it might be.

1 MR. RATZLAFF: Correct. So this is where
2 we have some more membership, and I'll just kind of
3 walk through it. First off, you'll notice that our
4 most populated plan is a silver plan. That's not
5 uncommon, given that that's where I believe over
6 70 percent of the members are, both for us and what
7 I've seen in nationwide statistics. You can see that
8 we are raising the deductible a little bit going into
9 2018 from $4,000 to 4600. This would be capitalizing
10 on the what we call the de minimus range, which is
11 allowing us to lower the actuarial value by a couple
12 of additional percentage points.
13 Our morbidity expectation is 9.6 percent.
14 We're nailing a trend of 8.1 percent. As mentioned
15 before, the reintroduction of the health insurance fee
16 varies from insurers depending upon the size of their
17 business as well as their status as for profit or
18 nonprofit. We are actually organized as a nonprofit,
19 and we are estimating this will affect the rates by
20 1.0 percent.
21 The age curve, as has been mentioned
22 before, is generally one to three percent depending
23 upon the carrier. If you're not under age 21, your
24 rates will go down by 1.7 percent in our plan.
25 And then the biggest driver of the other

1 changes is that benefit change that I mentioned
2 before. Increasing the deductible from 4000 to 4600
3 does have a downward impact on the rates. So
4 finalizing an increase of about 12.7 percent for this
5 particular plan.
6 We overall are filing an average annual
7 rate change of 19.3. The minimum rate change happens
8 in another silver plan. Now, if you follow very
9 closely you'll notice that this is identical to the
10 plan on the prior page with one exception. We call
11 this our select plan, and members that elect for this
12 plan have to go to the Sentara provider network. So
13 this is where we can really control costs.
14 Once again, the items above the other
15 changes are going to be the same. Morbidity 9.6
16 percent, trend 8.1 percent, and so on. Here again, a
17 big driver of the other changes is our benefit
18 adjustment. That is bringing the premium down. We've
19 also made some tweaks to our risk adjustment. We have
20 felt that with the changes in the risk adjustment
21 model occurring in 2018, that will also have a small
22 downward impact on our premiums.
23 By contrast, our plan that's increasing
24 the most is once again a gold plan. I think we have
25 seen that for a lot of carriers. The benefits are

1 changing here. That does have an impact. And what's
2 also really driving this is, identical to what other
3 carriers have mentioned that, we've had some very poor
4 experience in our gold block of business and so we've
5 made some adjustments to account for the fact that
6 we've just been losing a lot more money in gold than
7 we have in some of the other medal levels.
8 We recalibrated our area factors to put
9 our home base, Virginia Beach, at a 1.0 and there's
10 been no change to our tobacco factors.
11 That concludes individual. Before I move
12 on to small group, are there any questions?
13 With small group, the picture is
14 different than the individual. First off, a quick
15 glance at the benefits shows us that we're not making
16 any significant changes. The major benefits are shown
17 here and they are staying static from 2017 to 2018.
18 We are assuming that the morbidity, again the portion
19 of claims driven by health status, will not change
20 going into 2018. Our trend, which as David described
21 earlier, is a slightly different concept than
22 morbidity. We are choosing a trend of 8.8 percent.
23 In this case the reintroduction of the health
24 insurance fee increases premiums by .7 percent. And
25 the revised age curve for a 40-year-old brings it down

1 to .9 percent.

2 Some of the other changes are a slight

3 reduction in profit. We made a business decision to

4 reduce our profit margin by .7 percent. The risk

5 adjustment also has had a slight downward impact on

6 our premium. This is, once again, due to some changes

7 that the government has made in the risk adjustment

8 model going into 2018. And then we have -- when we

9 set our 2017 rates there was an expectation that our

10 2016 claims costs would come in at a certain level,

11 and what we did find is that they came in 4.9 percent

12 higher than that. So those components just mentioned

13 make up the 2.4 percent and the other changes

14 resulting in a final increase of just under 9 percent

15 for this plan.

16 Overall we are filing a 9.4 percent rate

17 increase. When we look at the plan with the lowest

18 increase, unlike individual where gold was kind of

19 leading the way in terms of rate increases, in this

20 case gold is our minimum rate increase, and you can

21 see that, once again, the benefits are not changing in

22 terms of the deductible and co-insurance. However,

23 the maximum out-of-pocket, or MOOP, we have raised

24 that up, and in this case it does reflect that

25 opportunity in the actuarial value calculator to lower

1 the benefits by a little bit but still retain the same
2 medal status.
3 COMMISSIONER DIMITRI: The maximum
4 out-of-pocket, is that effectively a cap on
5 co-insurance, co-pay, everything?
6 MR. RATZLAFF: Yes. When it says $8,000,
7 that means the member will never pay more than $8,000
8 throughout the course of the year no matter how high
9 their medical expenses are.
10 COMMISSIONER DIMITRI: Okay. So the
11 deductible has its own cap. So is it the co-insurance
12 that is the real factor that might lead someone to
13 have to lay out up to $8,000?
14 MR. RATZLAFF: Yes, it is. So they will
15 pay 100 percent of the deductible. If they have a
16 very severe medical ailment, maybe $100,000 plus, they
17 pay the fires $1500, and then now if you take the
18 remaining, say, 98,500, multiply it by 20 percent,
19 that's just shy of 20,000, but instead of paying that
20 full 20,000 we would say, you've already paid 1500,
21 you're going to pay up to 8800 and we'll stop it
22 there. So then Optima, we will pay the rest of the
23 medical expenses that the doctor needs.
24 COMMISSIONER DIMITRI: Thanks.
25 MR. RATZLAFF: Once again, the big driver

1 between the max and the minimum is kind of embedded
2 within inside the other. Here it's a downward force
3 of 2.9 percent. And we did decrease profit a little
4 bit just like in the prior plan. We did this across
5 the board for this block of minus .7 percent. We do
6 have a slight downward impact of 1.8 percent due to
7 risk adjustment changes, but then offsetting those is
8 the fact that when we set our 2017 premiums we
9 expected our 2016 claim costs to be at a certain
10 level. And it has come in, indeed, 4.9 percent
11 higher. So embedded within the other changes are some
12 positives and some negatives that balance each other
13 out.
14 Our bronze has a plan that, unlike some
15 others, has not having significant changes to its
16 benefits. When we look at the other changes, which
17 has really what causes this to be the highest increase
18 in premium, what we see are that the same items I
19 mentioned before about a decrease in our profit margin
20 of .7 percent, change in risk adjustment that has
21 favorable to premium, but here we have had some very
22 poor experience in bronze. And so we have adjusted it
23 to try to have it at a similar loss ratio, or a
24 similar ratio of claims to premium, as what we see in
25 the other medal levels. So that has what has driving

1 this plan to be the highest increase.
2 No changes to our area factors, and we do
3 not have a tobacco factor for this block.
4 Our other and slightly more populated
5 legal entity has Optima Health Plan. Once again, if
6 you look at the cost sharing for the most common plan
7 we elected only to change the MOOP here. Population
8 morbidity, and in fact all the way down to that
9 revised age curve, will be identical to what we saw
10 previously with one exception. That has the trend.
11 This has our HMO business, whereas the other legal
12 entity was our PPO business. We are estimating a 9.0
13 percent trend as opposed to the 8.8 percent trend that
14 we saw in the prior block of business.
15 Embedded within the downward force of .9
16 percent and the other changes has a change to the area
17 factors. The increase in the MOOP does have a
18 downward force on the premium as well. And then in
19 this instance our experience came in about
20 three-and-a-half percent higher than what it was built
21 upon in the 2017 rates. So some downward and some
22 upward pressure, net being a downward force of
23 negative .9 percent.
24 Overall we're looking to ask for a 9.5
25 percent rate increase. The lowest rate increase has

1 in a gold plan, once again. You can see the benefits
2 there, again with only the MOOP, but as well as the
3 outpatient co-pay changing slightly there.
4 Embedded within the negative 3.2 percent
5 other changes are some of the same factors previously
6 mentioned. A change in our area factors has a
7 lowering effect, as does the benefit change in risk
8 adjustment impact. However, we did have -- experience
9 claims that came in 3.5 higher -- percent higher than
10 what we expected during the setting of the 2017 rates.
11 It just so happens by coincidence that our final rate
12 increase for this plan has 3.5 percent as well.
13 Moving towards the end, our plan with the
14 maximum rate change has a silver plan. You can see a
15 little bit more changes in the benefits here. The
16 deductible and co-insurance have been undergoing some
17 changes. This happens to be a plan where we've had
18 very, very few members and we are actually mapping
19 them into a very different kind of plan. And it's
20 that different kind of plan that really drives the
21 42 percent other changes.
22 The biggest driver here has the benefit
23 changes. They constitute about 38 percent out of that
24 42 percent, and, as you can see, changing the
25 deductible co-insurance and the MOOP, they all work

1 together to make this a much richer plan than the
2 members would have experienced back in 2017.
3 COMMISSIONER JAGDMANN: So has this for
4 somebody that wants to sort of basically self-insure
5 up to about $4,000 and then they realize that after
6 they get to 7,000 you're going to pay for everything?
7 Has that sort of --
8 MR. RATZLAFF: Yeah, that's absolutely
9 correct. So they would be on the hook, so to speak,
10 for the first $4,000 in costs, and then in this
11 particular case they would not have to pay anything in
12 terms of co-insurance and their medical expenses.
13 Now, what you don't see here has that we do have a
14 number of cost-sharing items for prescription drugs.
15 And some prescription drugs are very inexpensive,
16 generics, some are very expensive. Sovaldi, Harvoni
17 for hepatitis C, and others, if they happen to take
18 one of those more expensive ones they will easily blow
19 past that $7,350 MOOP.
20 And just as a side note, the maximum
21 out-of-pocket, there has a limit on it that we as
22 insurers are allowed to pay as protection to the
23 consumers. That's set by the federal government and
24 it has adjusted for medical inflation each and every
25 year.

1 COMMISSIONER JAGDMANN: And so this --
2 your maximum out-of-pocket includes drugs.
3 MR. RATZLAFF: That has correct. Anytime
4 we show the maximum out-of-pocket it includes
5 everything that our plan covers, medical as well as
6 drugs.
7 COMMISSIONER JAGDMANN: Thank you.
8 MR. RATZLAFF: In 2017 we actually had
9 different area factors depending upon what quarter it
10 was. We were trying to get our areas more equivalent
11 in terms of the loss ratio. We're also making some
12 more adjustments going to 2018, as you can see there.
13 But when it come to tobacco, which unfortunately has
14 not labeled but the small box on the right, we once
15 again have no premium increase if a person smokes, as
16 some other insurers have found out, because it's
17 essentially based upon self-report. We've not found a
18 lot of impact if we raise the premium for somebody who
19 admits that they are a smoker.
20 THE HEARING EXAMINER: I guess that's
21 because they just won't tell you next year.
22 MR. RATZLAFF: That's pretty much the
23 case. And if there has a carrier that has no impact
24 as being a smoker, they may just go ahead and go over
25 there and not tell them.

1 Well, that concludes my presentation.
2 Thank you very much.
3 COMMISSIONER JAGDMANN: Thank you.
4 THE HEARING EXAMINER: Thank you.
5 United.
6 MR. FLEIG: Good morning. John Fleig
7 with United. I'm here with Dan Akier, who will
8 actually go over the numbers. We're here to talk
9 about our off exchange small group market. We have
10 four different companies; UnitedHealthcare,
11 UnitedHealthcare of the Mid-Atlantic, Optimum Choice,
12 Inc., and a very small plan UnitedHealthcare of River
13 Valley.
14 And before I get started, or Dan gets
15 started, I'd like to thank Commissioner Cunningham for
16 the 22 years I've known her. I hate to say it's that
17 long but it has. And wish you the best of luck and
18 thanks for all the help you've given me over the
19 years.
20 THE HEARING EXAMINER: So you got the
21 easy part.
22 MR. FLEIG: I do.
23 MR. AKIER: I got the hard part. I'm the
24 last person before lunch. I've seen enough of these
25 so I should have it figured out.

1 Good morning. My name has Dan Akier.
2 I'm with UnitedHealthcare. I'm the signing actuary
3 for three of these four legal entities. I do not sign
4 for River Valley, which has the smaller entity that
5 John mentioned. That's taken care of by another team.
6 So without further ado, we'll get started.
7 So our most popular plan on Optimum
8 Choice has a total rate increase of 4.24 percent,
9 mainly driven by trend and the health insurance fee,
10 which has at 2.9 percent. The other changes, we
11 didn't spike out the revised age curve for the three
12 entities I'm responsible for. That would be a minus
13 3.4 percent. And for River Valley that will be 2.9
14 percent. Negative 2.9. So I just wanted to make that
15 note.
16 You know, primarily the other changes are
17 driven by base rate actions. We have taken our rate
18 development, plan design changes, our model changes,
19 our pricing model changes, which has -- our pricing
20 model has recalibrated each year. So that will drive
21 that other change's bucket.
22 Our minimum change in Optimum, which we
23 call OCI, has about 1.6 percent. And similar to the
24 other plan I talked about, you know, the same trend,
25 same health insurance fee, and, you know, a little

1 more than the other changes with plan design and
2 model. Pricing model driven changes.
3 As for our maximum annual rate change,
4 it's about 17.8 percent. The same trend, same health
5 insurer fee. But this one had a larger -- this one
6 had an increase in the other changes due to design and
7 model changes.
8 And we have no area changes in the three
9 licenses I'm responsible for. So this will be the
10 same for OCI, UnitedHealthcare of the Mid-Atlantic,
11 and for UHIC. And we have no tobacco factors. It's
12 1.0. So that's why there are NAs right here.
13 Any questions on OCI?
14 THE HEARING EXAMINER: Just to clarify,
15 we're talking about a small group off exchange
16 product?
17 MR. AKIER: Yes. I'm sorry. This is all
18 small group, yes. We are no longer on the individual
19 exchange. These are all small group off exchange,
20 yes.
21 Moving into UnitedHealthcare River
22 Valley, the most -- and I meant to say, too, our rates
23 for our rate for River Valley has rating area five,
24 Bristol. For the other three entities they're all
25 Richmond, rating area seven.

1 So for River Valley, again about 400 to
2 500 members, very small, small block. The most
3 popular plan has a rate decrease of minus 7.6 percent.
4 You see their trend has 7.8 percent and their health
5 insurance fee has 3.2.
6 Other changes, they made base rate
7 actions during the middle of the year as well, so they
8 have seven one rate cuts in addition to rate cuts for
9 1/1/18. So that's what's driving a lot of the -- a
10 lot of this decrease here for this most popular plan.
11 Their minimum rate change has minus 12
12 percent. Again, same trend in health insurer fee as
13 in the last plan, and other changes driven by those
14 base rate actions they've taken third quarter this
15 year and also for 1/1/18, in addition to, you know,
16 some plan design changes and pricing model changes.
17 And the maximum annual rate change is 9.9
18 percent. Again, same trend. It's like a broken
19 record. Same health insurance fee. And, again, just
20 to reiterate, their revised age curve has a minus 2.9
21 percent. So that's included in the other changes, as
22 I noted before.
23 And they do have some changes for the
24 area factors. They've only -- they kept -- they made
25 no changes of Bristol and they lowered the other areas

1 by five percent. Not much membership in the other
2 areas but they saw some favorability so they decided
3 to make a five percent rate cut in those other areas.
4 And they also have no tobacco factors.
5 Any questions for UHIC or the River
6 Valley?
7 I'll move to UnitedHealthcare of the
8 Mid-Atlantic. Most popular plan. Had a rate increase
9 of -- has a rate increase of 16.6 percent. Again, see
10 the same trend in health insurer fee that we saw in
11 OCI. And the other changes are driven by plan design
12 change and, again, the pricing model has driving those
13 increases.
14 And then our least expensive, or our
15 smallest annual change, minimum annual change, is a
16 silver plan that's getting a 4.7 percent increase.
17 Again, trend 6.7, health insurer fee 2.9, and the
18 other changes we're seeing; again, plan design,
19 pricing model. And, again, the revised age curve for
20 us is minus 3.4 percent for UHCMA. That's, again,
21 baked into the other changes.
22 Our maximum change is a gold plan. And
23 that has getting an 18 percent change. 18 percent
24 increase. We're typically seeing -- this is an HSA
25 plan. We're typically -- we are seeing in our pricing

1 model our experience isn't as strong in HSA markets,
2 so we are seeing across all the states I'm responsible
3 for nationwide in our company we're seeing some larger
4 increases to HSA plans. So this isn't atypical what
5 we're seeing in our company.
6 And that's a lot what's driving here is
7 the pricing model change and the other changes.
8 And, again, no change area factors and no
9 tobacco.
10 And last but not least would be
11 UnitedHealthcare Insurance Company. And our most
12 popular plan had a 3.9 percent increase. The same
13 trend, same health insurer fee as the other two
14 licenses I'm responsible for, and, again, this one,
15 you know, plan design change and pricing model driving
16 the other changes.
17 And also across the board we took a
18 three-and-a-half percent rate increase based on our
19 rate development for 1/1/18. So that's also -- I
20 didn't mention it but that's also part of the other
21 changes.
22 Our least popular -- our least -- our
23 lowest -- our minimum annual rate change -- I
24 shouldn't say our least popular but it's not that
25 popular with only five people in it -- had an 8.1

1 percent decrease versus one Q 17 and largely driven by
2 the benefit change. You can see the deductible goes
3 from 2,000 to 3500, so that's going to make the plan
4 leaner. So that's the biggest driver there for that
5 rate decrease.
6 And the plan in UHIC with the largest
7 increase would be 20.9 percent. It's a gold plan.
8 Mainly driven by the pricing model. By a pricing
9 model, updated pricing model. And, again, like in our
10 other entities, other than River Valley, no increase,
11 no changes to the areas factors, and no tobacco.
12 THE HEARING EXAMINER: So you don't do
13 tobacco either.
14 MR. AKIER: No. I could have put 1.0 in
15 there. Any other questions?
16 THE HEARING EXAMINER: I don't think so.
17 Thank you, Mr. Akier.
18 MR. AKIER: Thank you.
19 THE HEARING EXAMINER: Well, that
20 concludes the presentations. Let me thank all the
21 carriers for your hard work in presenting these -- the
22 data today. Very detailed. We are aware of the
23 challenges you face. We're also aware of the
24 challenges consumers face in paying for health
25 insurance. And the Bureau will do what it always

1 does, which it will review rate applications very
2 closely, very carefully, look very carefully at the
3 actuarial data. As we all know, these rates are
4 driven by actuarial data, the factors that we heard
5 about today, so the Bureau will do the absolute best
6 it can to try to scrub these and be fair to all
7 concerned.
8 So with that, we thank you very much,
9 and, again, Jackie, thank you for all your many years
10 of service and we'll see somebody else sitting there
11 next year. But we thank you.
12 And thank everybody again. Thank you.
13 (The hearing concluded at 11:58 a.m.)
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1 COURT REPORTER'S CERTIFICATE

2

3 I, Carol M. Tayloe, RMR, CMRS, CCR,

4 certify that I recorded verbatim by stenotype the

5 proceedings in the captioned cause before the

6 HONORABLE MARK C. CHRISTIE, Hearing Examiner,

7 Richmond, Virginia, on July 25, 2017.

8 I further certify that to the best of my

9 knowledge and belief, the foregoing transcript

10 constitutes a true and correct transcript of the said

11 proceedings.

12 Given under my hand this_____________day

13 of______________ 2017, at Norfolk, Virginia.

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15 ________________________________

16 Carol M. Tayloe

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