Transcript of Hearing

Date: July 18, 2019
Case: Health Insurance Rate Presentation (2019-00031)

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COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, VIRGINIA

CASE NO. INS-2019-00031

Ex Parte: In the matter of presentations of premium rates in connection with health insurance coverage issued in the individual and small group markets

VOLUME I

July 18, 2019

PROCEEDINGS BEFORE:

The Hon. Judith Williams Jagdmann, Chairman

The Hon. Mark C. Christie, Commissioner

The Hon. Patricia West, Commissioner

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Reported by: Ruth A. Levy, RPR

APPEARANCES:

SCOTT WHITE
Commissioner of Insurance

DAVID SHEA
Health Actuary

Company Presentations:

TIMOTHY CONNELL
HealthKeepers/Anthem Health Plans of Virginia

ZACHARY HOFFMAN
Cigna Health and Life Insurance Company

MARGARET CHANCE
JAMES JUILLERAT
Optima Health Plan

SHEILA SCHROER
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

RYAN MORGAN
UnitedHealthcare Insurance Company

PETER BERRY
CareFirst BlueChoice, Inc./Group Hospitalization and Medical Services, Inc.

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EXHIBITS

(None marked.)

P R O C E E D I N G S

BAILIFF: Today's docket consists of Case No. INS-2019-00031, the Honorable Judge Judith W. Jagdmann, Chairman, presiding.

JUDGE JAGDMANN: Good morning, everyone. We are here today for the annual rate presentations on insurance plans to be offered in the individual and small group markets as of January 1st of next year. As you know, under Virginia law, the Commission must review and approve the premium rates and forms for these health benefit plans, whether they are sold on the federal exchange for Virginia or off exchange.

The Commission must also perform plan management functions required to certify participation in the federal exchange pursuant to Virginia Code Section 38.2-326. There are legal deadlines that govern our process. First, the U.S. Department of Health and Human Services requires the Commission's Bureau of Insurance to complete its review and recommendations of plans on their rates for certification on the federal exchange no later than August the 21st this

year.

Second, Virginia law requires insurance carriers to notify their customers of increases in annual premiums or deductibles at least 75 days before the proposed renewal of their health insurance. The deadline for notifying customers this year is October the 18th.

To meet these deadlines, insurance companies recently filed their rates and forms for insurance plans proposed to be offered for use as of January the 1st of next year. Given the importance of the health insurance to Virginia's small businesses and individuals, the Commission is reviewing these health insurance premiums and increases in deductibles prior to any ultimate approval for use in Virginia.

Today's presentations are part of that review and are designed to serve as an overview of the range of rate impact or change for plans on the individual and small group markets.

Our April 15th, 2019 order directing presentations instructed the Bureau to

coordinate presentations by insurance companies for the Commission. The Bureau has done this. Today, we'll be hearing from insurance carriers in the individual and small group markets, representing over 90 percent of the projected insureds in each market. The Bureau will also participate today by providing background information and presenting a summary of recent Bureau activities in its review of the latest rate and form filings for health insurance plans.

We will hear first from Scott White, the Commissioner of Insurance, and head of the Bureau. After his introductory comments, David Shea, the Bureau's health actuary, will discuss the Bureau's review of recent filings. Afterwards, the designated insurance companies will provide presentations about their proposed rate changes.

The companies provided presentation exhibits as part of their rate filings that will be part of the record for this matter. For each company presenting today, be prepared to speak to your rate filings for

plans both on and off the federal exchange and for plans in the individual and small group markets.

I note that today's proceeding is open to the public and is being webcast. Members of the public who wish to provide comments on one or more specific filings may do so in writing. You can go to the Bureau of Insurance's website. And we also have prepared some instructions on how to submit these filings, and you will find those in hard copy at the back of this room.

For all of today's speakers, I ask that, when you come to the podium, speak into the microphone and speak clearly. Give your name and address for the court reporter so we can record who is making these presentations. You are encouraged to use the audiovisual equipment to display any charts or other materials you are discussing.

While Judge Christie, Judge West, and I may have questions for the speakers, this is not an evidentiary hearing. This is not an evidentiary hearing. There will be no swearing in of witnesses or

cross-examination.

Are there any preliminary matters we need to address? Okay. Hearing none, I note I have an order of presentation that we will follow. With that, we will begin with the Commissioner of Insurance, Scott White.

MR. WHITE: Thank you, Judges, and good morning. So this marks the seventh time in which we've asked health carriers who participate in the individual and small group markets to appear here before the Commission and discuss their proposed rates. You know, before the carriers give their presentations, you're going to be hearing a few remarks from myself, from David Shea, who's our chief actuary, giving a general overview of the Bureau's rate review process, the proposed rates, and also some information on carrier participation.

To that point, I asked David a few days ago if he could describe the rate review process this year, you know, as compared to prior years. And the answer he gave was things have been pretty quiet. And I think that's fair, based on what I've observed. I

think we are several years removed from all of the market disruption and instability and uncertainty that led to, you know, major carriers exiting the market and significant rate increases in many areas of the state.

You know, I think, as you're going to hear today, while there certainly are many challenges going forward, particularly in the individual market, I do think it's fair to say that there has been continued improvement this year in several important ways.

So, first of all, I do have to give the caveat that the rates have not been finalized, but if you look at the total weighted average premium this year, it is more than 18 percent lower than the rates were last year. David's going to go into a little more detail about that, but we think that's good news.

Secondly, when you look at market stability, so we have a new carrier entering the market this year; that marks the second year in a row. We also have another carrier who has expanded into several major new localities. So, again, we view that as a

positive.

So turning to the rate review process very quickly, so the Bureau has been reviewing the rates that were filed by the carriers back on May 25th. We have a staff of five who are responsible primarily for conducting an initial review. What they do is they do a review of the accuracy, the completeness, whether they comply with state and federal rules. They turn it over then to the actuaries that work closely with them to conduct a more detailed actuarial review, again, done under the direction of David.

From a legal standpoint, in order to have your rates reviewed or approved by the Bureau in Virginia, you have to demonstrate a few things: That being you have to show that the rates are reasonable in relationship to the benefits. You have to show that they are actuarially justified. And of course, they have to meet the 75 percent loss ratio standard.

I do want to point out this year we made some changes to our rate filing process this year that we think improved the process;

we think things have gone very smoothly, at least thus far, knock on wood. One positive from the standpoint of today's hearing that I did want to mention that has been very different than in years past is that carriers have filed their final proposed rates and also any changes to their service areas. So, again, this is a little different from years past. What we are looking at today should be and hopefully will be very similar to the final rates that are approved. So we view that as a benefit.

So with that, Judges, what I would like to do at this time is provide you with a general overview of Virginia's individual and small group markets. It's going to be very similar to the presentation that I gave last year. I am going to use updated numbers. And we are going to provide a few new slides this year. I'm going to try and run those slides very quickly before I turn it over to David.

I do want to give a shoutout to Toni Janoski who did a great job and worked very hard on helping us prepare these slides this

morning.

So with that, hopefully this will work, and Jonathan's there if I can't advance the slides. Okay. So we always start with the big picture. I like to look at the big picture. And this shows our various health insurance markets in Virginia for 2018. I would point your attention to the right-hand side. This represents our employer-sponsored coverage.

If you look at the upper right in the blue, those are our self-funded plans. Of course, we do not regulate those; they're regulated by the Department of Labor. And as you can see, they make up over a third of our entire market at 35 percent. The rest of that on that portion of the pie chart, the large employer and small group makes up well over a half; I think it's around 53 percent. So that gives you kind of an idea of the importance of the employer market when it comes to healthcare in Virginia.

On the left-hand side, I would point out that the Medicaid, Medicare, and other public government programs, that makes up

another third of the market. We've also included in the green the uninsured. That is at 10 percent. And then if you go all the way up to the top with the brown, that's the individual market at 4 percent. And I think it always surprises people when you point out how small that actual number is, when we actually think about how much attention the individual market gets when we're talking about, in the media, through Congress and our state legislatures, and also the resources we spend making sure that market is properly regulated.

So turning to this next slide, what we tried to do here is we've got two pie charts. The one on the left, we combined the self-funded plans with the commercial market, just to give you, again, a sense of how much bigger the self-funded market is when you compare, again, the large markets, small group, and individual market.

Self-funded plans in the yellow, it's over 3 million. And the next biggest market in the state is the gray, the large group market; it's about a little over a

million. So about a third of what we have with our self-funded plans. You can see, with the individual and small group, those are roughly the same size, again, about 4 percent overall of the market, at around 350,000 or so for both groups.

On the right-hand side, that pie chart, what we're trying to do there is just show you this is what we call the commercial market, right; these are the markets subject to the ACA and this is the markets that the Bureau of Insurance regulates.

What we tried to do here is show some trends in the markets, a snapshot in time, if you will. And that time period being 2008 to 2018, which was the last year we had good data.

2008, if you'll recall, that's before the implementation of the ACA. The other date I would point out is 2014, a very important year, because that's the year that the market reforms, as they're called, were implemented, including the Marketplace.

So focusing on the left-hand column for the employer, you can see that it

actually decreased slightly during that time period. It went from 59 percent to 53 percent. As a percentage of the market, it was made up by, as you can see, the Medicaid, Medicare, and the other public governmental programs, such as the VA. So those all increased.

Looking at the non-group, that's the second column, and that is really the individual market. And you can see back in 2008, it's at about 5 percent. And it's been fairly steady throughout that time period. In 2014, again, when the Marketplace comes into the picture, it jumps all the way to 7 percent, goes up to 8 percent the next year, but then it drops back down beginning in 2016. And it sits today at about 4 percent, so not much movement when you look back to where it was in 2008.

And I would turn your attention to the far right column, the uninsured percentage. Again, if you recall, one of the main purposes of the ACA was to lower the amount of the uninsured population. So if you look at Virginia, you can see in 2008,

it's about 12 percent. And between 2008 and 2013, it hovers between 12 and 13 percent. So when, again, the marketplace goes into effect, it goes down a couple percentage points. And since that time, it's been around 9 or 10 percent. So, again, two percentage points difference since 2008; certainly, I would have thought they probably would have thought there would have been more progress.

But I will say that with Medicaid expansion going into effect this year, you're going to see, I think, a big difference when we look at this chart next year. It should go down somewhat dramatically.

So what we're trying to show here is this is just the number of carriers on the individual market. This is both on and off exchange, from the time period of 2014 to what we project in 2020. The yellow represents on and off exchange, while the blue is off exchange only.

So you can see, in 2014, we start out with 11 carriers. A steady increase the next two years; we're at 16 carriers in 2016.

And that's pretty robust. But after that time period, we have declines to where, two years later, it's half of that, right? It's all the way down to eight.

And 2018 is a year you're going to hear talked about; I think David's going to bring it up. It's based on everything that was going on in 2017. All the uncertainty, most of it coming out of Washington, the government -- the federal government stopped paying CSRs to the plans. There was a lot of talk about repeal and replace in the halls of Congress. And they stopped paying the individual mandate penalty. So that created a lot of uncertainty. And a lot of the major carriers actually pulled out of the state in 2018.

You can also see, though, the next two years, it has somewhat stabilized. We're back; we got a carrier last year and we have a new carrier this year, so we're up to ten. So that does demonstrate, I think, some measure of resiliency.

What this slide shows, this is just a visual representation of how the plans are

spread out throughout the state in the individual market. Clearly the colors that pop out at you are the blue and yellow. The blue represents one carrier writing in that area while the yellow is two. And I think those combined make up about 85 percent. Obviously, you're looking at the rural parts of the state, where you have this lack of competition.

But you can see the smattering of red, green, and purple. Those all represent areas where there were three, four, or five or more carriers writing in those particular areas.

What I would just point out here is, if you looked at this map last year, you'll see a couple differences. Number one, in 70 percent of the localities in Virginia last year, you had only one carrier. So in that sense, it is an improvement.

And another thing is there were no areas in the state where you had five or more carriers writing coverage. So you can see, in Hanover County and that little area in Northern Virginia, representing 3 percent of

the market total, you do have that. So, again, some measure of improvement, although we would like to see, obviously, more competition.

So this gives an example of the market share in the individual market, based on 2020 projected covered lives. I think the takeaway here is you do have a lot of concentration. If you look at the top four writers, that gets you to well over 90 percent of the entire market. HealthKeepers is now the biggest writer this year, as they've moved into 20 new localities. They went above Optima and Cigna. So, again, they are the top writer.

The other thing I would point out, if you had looked at this chart just a few years ago, it would have looked a lot different. Cigna did not enter the market until 2017. And as I alluded to earlier, you had a lot of major writers that exited the market in 2018 that would have been prominently displayed on that chart.

So let's turn to the small group markets. Again, the blue is off exchange

only, while the yellow is on and off exchange. Looking at 2014, you can see there are 19 writers, a slight spike the next year to 23. And then it levels off and is pretty consistent; I think it's between 16 and 18 writers all the way up to what we project this year.

So I think it's useful to compare this slide to what we saw in the individual market. There are three things that jump out at me. First of all, you have a lot more carriers writing business. You have a lot more stability. And again, the small group market was not subject to the same level of uncertainty that characterized the individual market. So I think that helps explain that.

And also, notice how many more writers you have writing off exchange as compared to the individual market. And I think that has to do with you just don't have the incentives, if you're a small business, to go on to the shop exchange; it doesn't have the same level of tax credits or subsidies available.

So what this slide shows is, again, this is an individual representation of carrier concentrations in the small group market. The two colors that pop out are the green and yellow. The yellow represents 10 or 11 writers in those particular localities, while the green represents 12 or 13. So that makes up well over 95 percent of the market. The thing I would say about this is anywhere in Virginia, if you're a small business, you're going to have between 10 and 15 carriers to potentially purchase coverage from. So, again, much more competition throughout the state in the small group market.

JUDGE JAGDMANN: And just for the record, small group is defined by how many members? There's been a lot of back and forth on that right now.

MR. WHITE: Fifty, yeah.

So, Judges, this is the market share for the small group for 2020 projected covered lives. You do have more writers on the one hand, but again, I do think it has a fair amount of concentration. I was trying

to do the math before the hearing. And if you look at the top, I think, five writers, that makes up -- maybe four writers, that makes up 85 percent. When you get down to top six, it's well over 90.

So the other thing I would point out, that Anthem, with their Anthem plans of Virginia, and also HealthKeepers, they make up 42 percent of the market alone. So again, there's more writers, but still, you do have that problem with concentration.

What we're trying to show here is a comparison between the small group and the individual group in terms of enrollment, both on and off exchange for the period of 2014 to what we project in 2020. I would focus, again, the blue being individual, while the yellow represents small group.

So let's focus on the individual very quickly. You can see, in 2014, how much lower the enrollment is as compared to the small group. It's only 265,000 plus enrollees. But next year, it jumps all the way up to over 400,000. It's actually a little bit more than the small group. And it

peaks the next year, in 2016, with 418,000 enrollees.

But after that period of time is when the decline -- pretty steady decline in enrollment begins to occur to where, for plan year 2019 and what we project to be the case next year, just over 300,000. So a very dramatic difference from our peak in 2016. We lost over 115,000 enrollees in a two-year period between 2016 and 2018.

If there is one silver lining in looking at this chart, you can see that, where we are projected to be next year -- or even this year -- over 300,000, that is more than where we started out at the first year of the marketplace back in 2014.

JUDGE CHRISTIE: Let me ask you, Scott.

MR. WHITE: Sure.

JUDGE CHRISTIE: So what this shows then is you've had a -- I mean, no other way to describe it -- a huge drop in the number of people who are buying individual policies. In just two years, you've dropped from 418,000 to 300,000, which, by my math, is

over a one-third drop.

So I'm going to assume -- or you tell us -- is that mostly people who are not getting subsidies and simply cannot afford to buy individual policies?

MR. WHITE: Yeah. Judge, I think that does explain a lot of it. There are different factors. And we actually do have a slide to your very point, a few slides later that I think will kind of answer that question. But yeah, for the most part, I think that's accurate.

JUDGE CHRISTIE: Well, that's not a healthy market. I mean, what that shows is the individual market is just suffering catastrophic damage. Because these people who don't get subsidies who have to pay for it themselves simply cannot afford individual policies.

MR. WHITE: Yeah. One caveat I would make is, remember -- and we're going to talk a little bit about this -- with Medicaid expansion, that's taking about 40-some-thousand people out of the market that otherwise would have been in the

individual market. So you could say, if Medicaid expansion had not occurred, the numbers would roughly be maybe to where they were in 2018.

But I won't dispute the point. Certainly, we would have expected the individual market to be much more populated than it otherwise was.

JUDGE CHRISTIE: Yeah. But the people who are really getting hurt -- it seems to me, the people who are really getting hurt by the dramatic increase in healthcare costs -- and ACA's driven a lot of it because of the mandated benefits -- are the guy who makes $50,000, he's a landscaper he's a plumber, he's a carpenter; he doesn't get subsidies, he's not eligible for Medicaid, and these are the people that are getting killed.

MR. WHITE: Right.

JUDGE CHRISTIE: Because they just simply cannot afford to buy a health insurance policy.

MR. WHITE: It's the concept we talked about last year called the subsidy

cliff, right? There's no reason for you not to be in the individual market if you're eligible for subsidies, but once you hit above that 400 percent federal poverty level and you lose eligibility for the subsidies, the fact that we've seen such dramatic rate increases has really priced those folks out of the market.

So two things are happening: They're either uninsured or they found some other means to purchase insurance, whether it's a short-term limited duration plan, or some kind of small employer plan, if they're a sole proprietor. Again, we'll talk about how that's giving those folks a few more options. But yeah, in that sense, Judge, it's not a good situation.

JUDGE CHRISTIE: Yeah, because it cuts off about 48,000, if I'm not mistaken. If you're making 50- or 52,000, again, you're talking about the self-employed, self-employed people, you know, plumber, landscaper, they can't afford these rates. They don't have subsidies. They're not getting checks or otherwise subsidized.

They're not eligible for Medicaid. And these are the people who are getting slammed.

MR. WHITE: Right. And I think that's right. So we have the Market Stability Working Group you're aware of that kind of looked at this issue. I think the takeaway when it came out is just how challenging it is. And the action to reform the market, to make it more affordable to the folks you're talking about, that's going to have to be done, I think, at the federal level.

We've talked about having a reinsurance program and doing other things, but certainly, at the end of the day, there's going to be the need, more money, more subsidies, more reinsurance; it's going to require more money to make it more affordable to these folks who can't afford it currently. More competition would help as well.

JUDGE CHRISTIE: Well, more competition or giving them options, like association health plans, or something they can buy, which they used to be able to buy.

MR. WHITE: Oh, and Judge, I think

that is part of it. And I think it's going to increase. And we have a slide that's going to show these folks are going to have more options to purchase coverage; it's not as robust. I mean, that is the policy debate about which is better. But if you are in that category and you need insurance and you can't afford it on the individual market, it's hard to argue that something is better than nothing.

JUDGE CHRISTIE: Well, it looks like where we are with the ACA is it didn't really affect the large group market that much. I mean, the large group market was pretty much unscathed. They were -- they had the economies of scale to handle it.

And, you know, people who are eligible for Medicaid, they're on Medicaid. So it really looks like the real damage has been done in this individual market for these people who are not subsidized, they're out there working every day, they're making too much money to be -- to be qualified for a subsidy, and they're trying to pay it for themselves, and it looks like that's where

the real damage has been done.

MR. WHITE: Well, and I would point out the small group market has been pretty stable. And when you compare the small group to the individual market, you can see, again, they were not subject to the same level of uncertainty and policies going on in Washington that I think it's beyond dispute that that has harmed the individual market. Again, not paying the CSR payments and other things, it hasn't helped.

JUDGE CHRISTIE: And these are the self-employed people who are out there on their own trying to make a living, and they're the ones who have been really slammed by this.

MR. WHITE: Now, in Virginia, the good thing is we did have a law passed a few years ago that if you are a sole proprietor and you are in the individual market, you can now get coverage in a small group market. And a lot of folks have done that. And so that's one reason why the numbers have gone down a little bit. It hasn't been a lot, but it has some impact.

JUDGE CHRISTIE: Okay.

MR. WHITE: Yeah, those are good points. Did I finish this slide? Yes.

So this kind of gets to your point, Judge. What we've done here is combine the total weighted average premium with the enrollment numbers in the individual market we just looked at. And you can see, if not causation, certainly a correlation between rising premiums and declining enrollment. Particularly, on the right-hand side of that chart, you can see, between 2017 and 2018, premiums increased over $300 a month, and you can see that was in the midst of a sharp decline in enrollment that continued last year.

I mean, last year, I believe it was about a nine percent average increase. But on top of a 70 percent increase the year before, that just doesn't help. So we need these premiums to continue to decrease substantially in order to make it somewhat affordable, again, to those folks who aren't eligible for subsidies.

JUDGE JAGDMANN: So this is monthly

premium?

MR. WHITE: Yeah.

JUDGE CHRISTIE: The problem with the individual market, though, is you suffer a 33 percent decline in the number of people enrolling; I mean, you start to get to that point, we used to hear the term death spiral, where there's just not enough people in the market to keep the market healthy.

MR. WHITE: That's right. And the people who are staying in the market who aren't subsidized, typically, are the ones who are ill and they're the ones who are going to pay any amount of premium to stay in there and obtain coverage.

JUDGE CHRISTIE: Right. I mean, the healthy 30-year-old, you know, people doing landscaping, plumbing, carpentry, Sheetrock hanging, they're the ones who are getting out because they can't afford it, but they're also the healthy pool that is essential to keep the cost down for who's left in the pool.

MR. WHITE: That's right. And they've been given more options, as we're

going to look at, with some changes to the federal rules pertaining to short-term limited duration plans. Again, that could have an impact on the market as well.

JUDGE CHRISTIE: Now, let me ask another question on another topic, because you said the good news this year is there's 18 percent decline in premium increase -- not increase but decline, which is good. I think that's probably the first time we've ever had an actual decline in the cost of premiums. So that's very good news.

But it seems to me there's only three ways the premiums go down: Either utilization goes down, the cost from providers goes down, or the rates last year were too high. Now, which one of those three or all of the above?

MR. WHITE: Well, I might defer a little bit to David, but I do know the rates were too high in many cases. We're going to talk a little bit about 2017 that alluded to, when there was all that uncertainty. It did cause a lot of carriers to significantly increase their rates. And in some cases,

they overcorrected too much. They were charging premiums more than was necessary to cover their claims, their administrative costs and the reasonable profits.

So I think that's where, number one, you saw them correcting that with lower premiums. And you're also going to see certain carriers have to pay rebates back to consumers if they didn't meet the medical loss ratio standard of 80 percent.

So this gets to your point earlier, Judge. What we wanted to show here was the estimated distribution of enrollment by federal poverty level. As you know, whether you're eligible for a subsidy or not depends on your FPL. Anyone above 400 percent is not eligible for a subsidy.

We looked at three years of this to see what the impact was, 2016 through 2018. 2016 is the gray, 2017 is the orange, and 2018 is the blue. So I'd focus your attention at the very top at the 400 plus. That's the folks, obviously, ineligible for a subsidy. You can see in 2016 they're about 31 percent of the individual market. And

just two years later, they're down to 17 percent. So that kind of gets to your point; they're either uninsured or they've found coverage somewhere else.

And that's been -- the converse of that, as you can see, at the lower levels, the percentages have gone up. So that is the stark example of what you were saying.

I will say, I think this chart might look a little different next year because of Medicaid expansion. So Medicaid expansion is going to apply to anyone in the federal poverty level between 0 and 138 percent. So you can see that represented on that chart. Those folks, as of this year, should have already migrated into the Medicaid program. So we would expect the numbers at the bottom to go down a little bit.

And we have gotten a lot of questions, Judges, on Medicaid expansion, given the overlap I just talked about: What is the impact on the individual market given the folks that will be moving into Medicaid or should be moving into it? And one thing we've tried to do is work with DMAS to make

sure that happens, because the folks who should be on Medicaid but don't go over there and stay in the individual market do lose their subsidy. So we've been trying to coordinate that. And I think it's gone very smoothly.

But we did ask our consultants to model what they think the impact would be in terms of enrollment. And what they said was we think, this year, about 44,300 will move from the individual market over into Medicaid. And then the next following two years, that should get as high as 70,000. So we'll be monitoring that.

It should also have an impact on rates at a certain point. Obviously, it's too early for the experience to have developed to make any reasonable assumptions about what that might be. But what we've seen from the carriers' filings thus far is it ranges from zero percent to -2.3, so not much change at this point, not much of a factor.

So this is my final slide, Judges. And again, this gets back to the discussion

we just had a few minutes ago is, Hey, what is the impact or the potential impact of these new coverage options we read about in the news on the individual market enrollees? So what am I talking about here? Medicaid expansion. Again, the changes to the federal rules that make these short-term, limited duration plans more appealing and a fairly recent Virginia law that allows sole proprietors to obtain coverage now in the small group, which has already occurred. And we've also included transitional and grandfathered plans.

So if you look at the column on the far left, this is our consultants kind of removing all of these options, and this is what we would call our baseline column. I would focus on the orange and the blue. The orange represents the subsidized population in the marketplace and the blue would be the unsubsidized, and I think that would be both on and off exchange.

So beginning in 2019, when you factor in all of these alternatives, what you can see is a steady decline in our individual

market, starting in 2019, projected all the way out to 2023. When you get to 2023, I think you're left with about 217,000 individuals in the individual market, and of that, a little over 21,000 that are not subsidized.

So, again, think back to 2016, where we had 418,000 and, projected in 2023, all the way down to 217,000, a dramatic decline.

JUDGE JAGDMANN: And this is largely picked up through Medicaid expansion you're saying?

MR. WHITE: Yeah, Medicaid expansion. They cap out, I think it's 70,400, based on what our consultants are telling us.

JUDGE CHRISTIE: So the sole proprietor, individual, self-employed part of this bar chart goes down dramatically even more than it has already.

MR. WHITE: Yeah, I noticed that, too. It's going to continue to -- and I will say, there were some changes to the law this year that expanded a little bit. I think it caught some areas that it should have picked

up to allow some mom-and-pops to take advantage of this as well.

So we do think, you know -- and we've already seen thousands of sole proprietors move into the small group that would otherwise be facing much higher premiums in the individual market.

JUDGE CHRISTIE: Well, what's the status of the association health plan option for a sole proprietor? Was that the one that was stopped by litigation --

MR. WHITE: That's correct.

JUDGE CHRISTIE: -- by certain interest groups who wanted to stop it?

MR. WHITE: Yeah. I mean, today, you can obtain coverage through an association health plan, but it certainly doesn't have the expanded -- it didn't expand in the way the Trump administration was attempting with the changes to the federal rules. That's been stayed, is my understanding.

JUDGE CHRISTIE: Well, Virginia law allows it, correct? Our law allows it?

MR. WHITE: Our law allows it, but

we allowed the changes. We incorporated the changes to the federal rules, but once they were stayed by a federal court, we went back to the status quo. But we do -- yeah, you can get coverage through a sole proprietorship, it's just much -- or through an AHP; it's just much more limited than it otherwise would be if the federal rules had gone into affect.

JUDGE CHRISTIE: Because a lot of Virginians used to get individual coverage through associations. I mean, if you're self-employed, one of the main options you used to buy through, like, the Farm Bureau, if you were an individual business person.

MR. WHITE: Right.

JUDGE CHRISTIE: And I was a solo practice attorney, and I got it through an association. That's the only way I could afford it. But now, these people don't have that option, because ACA has foreclosed that, right?

MR. WHITE: Well, a federal court has put a stop to the --

JUDGE CHRISTIE: Well, he cited the

ACA, as I recall --

MR. WHITE: Right.

JUDGE CHRISTIE: -- in denying that option.

MR. WHITE: Right. So we are monitoring that. We had actually modeled that, our consultants had modeled that, but we removed that. Again, with the court case, it is in flux, so we'll just see what happens.

So that's all I have, Judges. Thank you. And at this point, I'm going to turn it over to David.

JUDGE JAGDMANN: Thank you. Mr. Shea?

MR. SHEA: Thank you, Scott. Good morning, Judges. My name is David Shea, and I'm the health actuary for the Bureau of Insurance. And I will be going over -- Scott alluded to some changes in our rate filing and rate review process this year. And I'll be going over a little bit more detail in that.

And then I'm going to be sharing some data and financial results that we

pulled from our filings from this year. And hopefully we'll show, over time, more of a visual of how things have progressed up to today.

So this is not our first rodeo with the ACA rate filing process. Over the years, we do get together, prior to every ACA rate filing season, often more than once, and talk about the process from last year and what we can do to make it better for everybody in the following year.

So one of the things that we changed, historically, Virginia has always been one of the first states out of the gate with their rate submissions to the ACA. And that tended to get a lot of attention, naturally. And we thought, well, for a couple of reasons, why don't we move it a little later into the, not year, but month, really, and give carriers a little bit more time to get a little bit more additional information before they have to file.

And so we moved our date to May 24th this year. That was the deadline for initial rate and form submissions. We are looking at

a deadline of August 21st of submitting our QHP recommendations to CMS. The non-QHPs happen a little bit later in the year.

Also, something else we decided to change this year is we turned off public access to SERFF on May 31st. So SERFF was open for a few days. And what we've also seen, historically, it's really that first day that carriers submit their initial filings; that's where everybody runs into SERFF, gets all their information out, and you see some reports in newspapers, possibly on the radio about what carriers have filed in Virginia this year.

Truthfully, after those first couple of days, there's really not any activity going on at all, because they've got all the initial information from their first set of filings. And the next thing that happens is, sometime in October, CMS announces the rate increases that they've approved, and that gets additional attention. So really, from that first day of rate filing submission all the way to October, it stays pretty quiet as far as rate increase information goes,

because everybody knows things are changing.

So we shut off public access to SERFF. And one more important change we made is we set a deadline of July 10th for carriers to submit voluntary service area expansion and voluntary rate filing revisions. So basically, July 10th was pencils down; give us your best estimates for your rates for 2020 by July 10th. The only thing that will be allowed after July 10th -- also, keep in mind, we are still in the middle of the rate review process. So no filings have been approved.

But the only thing that's allowed after July 10th is changes that are made based on questions that we have for the carriers. There probably will be a few -- and I'm going to say fairly minor -- changes from what you see today from the carriers' rate presentations. Some of them, in fact, will be the rates that are ultimately approved. Because after July 10th, carriers cannot voluntarily make a change. They have to make a change based on our direction.

And so those three big changes have really helped to increase some efficiency and some relative calmness in the rate review process.

I mentioned last year, one of the other things that we added to really improve the efficiency in the analytical power is we introduced a rate filing template that literally contains probably 99 percent of the information that carriers have put into their filings. It contains a lot of historical experience, a lot of projections, and a lot of details under that, one of which I will share with you in a few minutes.

We did make some changes to the filing template this year that required carriers to go back and make changes to last year's template. We do need two sets of templates, prior year and current year, so we can analyze the changes. We don't anticipate big changes like that this year, so when carriers file again for 2021, they should only have to complete one template because they will have already done 2020, which we have now.

JUDGE JAGDMANN: Is this a Virginia-only template?

MR. SHEA: This is a Virginia-only template. And one of the powers it has is particularly half of Scott's presentation was developed from the summary tools we used from the templates to generate maps and to generate graphs and to generate comparisons and to generate data.

JUDGE JAGDMANN: I would assume it gets rid of a lot of back-and-forth with carriers, for where is this information; I assume it's --

MR. SHEA: Absolutely.

JUDGE JAGDMANN: -- an efficiency booster.

MR. SHEA: That's very true. It's like one-stop shopping for everything.

Every year, I have a slide entitled pricing challenges. And I'll just tell you that this slide is relatively empty compared to prior years. Scott mentioned that this has been a pretty quiet year. You know, there hasn't been much legislative noise or activity going on compared to other years.

It's been pretty quiet.

JUDGE JAGDMANN: Well, when you say quiet, it doesn't mean the Bureau's not doing anything.

MR. SHEA: Oh, no. I'm not talking about what we're doing.

JUDGE JAGDMANN: I just want the record to be clear.

MR. SHEA: It's been quiet from the standpoint --

JUDGE JAGDMANN: I'm sure the pencils have been sharp.

MR. SHEA: Pencils are very sharp. But quiet from the carriers' standpoint, really, that there are no material changes or uncertainty looming out there for 2020 right now. I just want to clarify that. It's been relatively quiet from that standpoint. You know, we don't have nonpayment of CSRs. We don't have the elimination of the individual mandate.

JUDGE JAGDMANN: Right.

MR. SHEA: AHPs, short-term plans, all of those things were actually -- and Medicaid -- all of those things were actually

baked into last year's rates, the rates that small groups and individuals are paying today. So again, relatively speaking, this has been pretty quiet.

So, you know, the biggest challenge in the individual market, primarily -- and it is true to some degree in the small group market -- is carriers to try to figure out, from one year to the next, how their health status of their population changes relative to the statewide average. That gets into the risk adjustment, payments and receipts.

Medical and drug trend can also be a challenge, but, you know, carriers have gotten a lot more sophisticated these days. And while still a challenge, not as much, certainly, as figuring out the relative health status of your population.

Speaking of medical and drug trends --

JUDGE JAGDMANN: You're saying not a challenge. It's not a challenge because it's a known?

MR. SHEA: Yeah, they've got some pretty good data. And that's exactly what's

actually up on the screen.

From our rate filing templates and summary tools, I put together a chart of a few carriers. And again, this was all public -- this is all public information contained in the rate filings. And there's a few notable things -- and I apologize; it's a little bit hard to read on the screen -- but all the way on the right-hand column, it's bluish and labeled total -- top is the individual pricing trends ranging somewhere from almost 5 percent to almost 9 percent.

And then in the small group market, the bottom box, all the way on the right-hand side, those pricing trends are remarkably consistent between 7 and 7 and a half. These trends are consistent with recent industry reporting that pricing trends for 2020 will be somewhere in the range of 5 to 8 percent. I would say that the carriers that I have shown here pretty much fall into that category.

And the other couple of things that I'd like to point out to you with respect to pricing trends is we do ask the carriers to

split their trends into four major service categories: In-patient, out-patient, physician, and prescription drugs. And below that, split those into cost and utilization.

JUDGE JAGDMANN: And utilization just being --

MR. SHEA: That's the use of services.

JUDGE JAGDMANN: How frequent a person uses it, right?

MR. SHEA: Yes. And the couple of things that I'd like to point out to you that's, again, pretty consistent among all the carriers, is all of their drug trends are generally higher than the other trends, in-patient, out-patient, and physician -- which is not surprising; that's very consistent with what's been going on in the industry for two or three years now and will continue.

Also, cost is the major -- between cost and utilization, it's the cost that's the major driver. Utilization is relatively low; that really is not what's driving pricing trends these days. And it hasn't

been for a while. It's been cost that's been the main driver of pricing trends. And experience trends.

Now, this visual here is hopefully going to provide a good way to look at why the rate increases are relatively low in individual this year compared to other years. The blue bar, what this shows is that is the aggregated loss ratio experience for carriers in the individual market in Virginia. So in --

JUDGE JAGDMANN: That's how much they paid out?

MR. SHEA: These are their loss ratios.

JUDGE JAGDMANN: Yes. How much they --

MR. SHEA: How much they paid out of their premium in claims.

JUDGE JAGDMANN: Okay.

MR. SHEA: So the first year, they settled in at around 87 percent. Next year, it went up a little bit. And in 2016, it was almost 96 percent. So they had very little money, in fact, hardly any, and on an

aggregate basis, to pay administrative expenses, taxes, fees, commissions, all of that kind of stuff.

What's notable about 2016 is that was the basis for pricing in 2018. You have to remember -- I know these dates get kind of crazy -- but carriers priced 2018 off of 2016 in 2017. Did you follow that?

JUDGE JAGDMANN: Right. Because they have to file before the end of 2017, right.

MR. SHEA: Exactly. So this year, they're pricing 2020 off of 2018 in 2019.

JUDGE JAGDMANN: Right.

MR. SHEA: So going back to 2016 -- and generally speaking, in fact, this is true of all the individual carriers currently in our market today, their loss ratio patterns looked just like this. They steadily went up year after year, and every carrier in Virginia had a decreasing loss ratio in 2018 over 2017. Every carrier.

So the entire market experienced -- the reason being, though, they were all pricing 2018 off of 2016. So they've seen --

they were looking at the last three years, '14, '15, '16. This is getting worse and worse and worse; I've got to price my business off of 2016. Huge rate increases resulted.

And again, in 2017, there was -- that was the year of the infamous vote on repeal and replace. That was taking up a lot of oxygen in the room. And then you had the CSR nonpayments. And then there was also talk about let's have some more options for ACA; I mean, it was just an enormous amount of upheaval. Couple that with high loss ratios, it was just a storm, a big storm that was brewing.

JUDGE CHRISTIE: Let me ask you this, because the loss ratio is what they call in the stock business a trailing -- or in the economic business -- it's just a trailing indicator. A loss ratio is simply how much money went out relative to money that came in, right?

MR. SHEA: Uh-huh.

JUDGE CHRISTIE: So whether the money went out is a function of how much

providers charged and utilization.

So if the MLRs are going down, meaning -- the core of this is how -- is how much money is being paid out to providers and how much is being utilization. So what went down in those two categories, which is the actual money going out the door? Because again, the MLR is just, you know, after the storm, how wet the streets are. What is the money going out?

JUDGE JAGDMANN: What's the cause?

JUDGE CHRISTIE: And if the price is coming down for health insurance, is it because of lower -- the providers are getting less or the utilization has gone down?

JUDGE JAGDMANN: Maybe it was -- I'm just going to hazard a guess here -- well, does it have something to do with these high deductibles? You know --

JUDGE CHRISTIE: Well, that would certainly reflect in less money out the door.

MR. SHEA: Not to a great degree. Not really. Not from one year to the next.

JUDGE JAGDMANN: Not a great degree? That's what I get for guessing.

MR. SHEA: Not that huge drop. The question you're asking, I believe, goes back to the slide before. Now, these pricing trends, those are expectations. They are based on historical facts. Those are expectations.

What you're asking is how did -- which one of those drove that 70 percent? Was it lower cost than expected? Lower utilization than expected? Lower --

JUDGE CHRISTIE: Exactly. Because if health insurance -- if the cost of health insurance goes down, it has to be because the money that carriers are paying doctors and hospitals and drug companies is going down. I mean, that's ultimately what --

MR. SHEA: Or not going up as fast.

JUDGE CHRISTIE: -- brings it down. Or yes, or the increase is moderated. Or again, utilization goes down. And that could be related.

JUDGE JAGDMANN: That's what I was talking about; you're not going to go, if you have a $7,000 deductible. I know --

JUDGE CHRISTIE: It definitely could

be related to it.

JUDGE JAGDMANN: And people are denied --

MR. SHEA: I can't answer that question now, because what that gets into is, again, going back to these pricing trends, what that gets into, so what did this look like for 2018? What did the experience look like? Now, we do have that information in our rate filing templates, but I just don't have that information handy with me today.

But also I don't have the information because I don't know what carriers anticipated. I'd have to do comparisons to 2018 pricing trends to 20 -- let me take that as a follow-up, because I've got some information.

JUDGE CHRISTIE: Well, and maybe the carriers can address it, because it's --

MR. SHEA: That's true, too.

JUDGE CHRISTIE: -- just commonsense. If health insurance costs are coming down, it's because the cost of providers is coming down. I mean, it has to be. It's not like there's a big rock candy

mountain that does this.

MR. SHEA: But just keep in mind, too --

JUDGE JAGDMANN: Or utilization.

JUDGE CHRISTIE: Or utilization is coming down. I mean, money out the door has to be moderating. Because that's what drives up premiums.

MR. SHEA: It is. It is. But you can't forget the denominator in this equation. And the denominator is the premium. We're not looking at claims cost; we're looking at a ratio. So we will see --

JUDGE JAGDMANN: Oh, I see what you're saying --

MR. SHEA: -- likely claims cost could increase. The issue though, the premium went up so high, it went up a lot faster than the claims did.

JUDGE JAGDMANN: Oh, yeah, that's a good point. Good point.

MR. SHEA: So loss ratio can be a little bit deceiving if you get twisted about it. But I will follow that up.

JUDGE CHRISTIE: But that also gets

to the question of the rebate and how much people are going to get rebated.

MR. SHEA: Yes, it, does. It does directly lead to that.

Also notable, the orange bar is small group, pretty stable. Very stable. Reason being the ACA did not make a dramatic change to the small group market. Not a dramatic one. The small group benefits, the benefits that were covered, were generally -- well, that's what the basis is for Virginia VHBs. And so small groups were already having coverage like that anyway.

The addition of the metal levels really didn't change offerings. Generally, the offerings in small group are a bit richer than they are in individual, because you have the employer paying a part of the premium, so you can afford a little bit richer benefit.

But primarily speaking, the ACA didn't have such a huge impact on small groups.

JUDGE CHRISTIE: Or large groups.

MR. SHEA: Or large groups. Even less on large groups.

JUDGE CHRISTIE: Or even less on self-insured.

MR. SHEA: Right.

JUDGE CHRISTIE: So it really hit -- the hit came with the individual market.

MR. SHEA: The hit came with the individual market because you can't underwrite anymore. That's another thing, going back to pre days. And people say, Well, I've got a policy for $83, but it's like, yeah, but your neighbor couldn't pass underwriting, so they couldn't get anything. Well, now they can.

This is a chart of the -- and you had seen this in one of Scott's slides earlier -- the weighted average monthly premium over the years. You can see that huge spike in 2018 of 69 percent. And, obviously, the drop this year is some carriers have filed rate decreases. And the rate increases themselves are not as high as historically they've been. So that explains a lot of the 2020 drop in average premiums.

The average annual increase in the Virginia market, the Virginia market for

individual, is 12 percent. So if you take all those from 2014 to 2020 and average them out each year, it's a 12 percent increase.

JUDGE JAGDMANN: Per year?

MR. SHEA: Twelve percent a year.

JUDGE JAGDMANN: Twelve per year. Now, that's compounded, I guess.

MR. SHEA: Oh, well, sure.

JUDGE JAGDMANN: Right. So it's pretty high.

JUDGE CHRISTIE: Well, that's a lot.

MR. SHEA: It is a lot.

JUDGE JAGDMANN: I'm glad the trend is moderating, but we can't -- you know, let's --

MR. SHEA: You don't want to go back to that.

JUDGE JAGDMANN: Let's not delude ourselves. They're high.

MR. SHEA: And as long as everything stays quiet and the rules of the road don't change, we can hopefully see moderated premium increases each year. And it also helps that, if the market is stable, carriers will want to come in.

Because we actually had a couple of carriers tell us that they just can't stomach this market anymore, way back when. Devotes an enormous amount of resources for a relatively small population. And it's got a laser beam on it as far as legislative activity and let's get rid of it. So if there is calmness, that will be reflected in the premium changes.

JUDGE CHRISTIE: Yeah, but let's get real. 2014, if you were making $50,000 as a landscaper, plumber, carpenter, and you see 12 percent annual increase in your health insurance, that is not good. That is not calm. That is not happy talk, okay. You have been priced out of the market. So let's be real about this.

MR. SHEA: Yeah, very true. There's not a lot around that goes up on an average of 12 percent a year, bottom line.

JUDGE CHRISTIE: Well, not sustainably, because people's household incomes aren't going up 12 percent a year.

MR. SHEA: Exactly.

JUDGE JAGDMANN: The salaries

aren't.

JUDGE CHRISTIE: So they can't pay it.

MR. SHEA: A little different story in the small group market. Their average annual change is 5 percent.

JUDGE CHRISTIE: Well, again, the groups were never the ones that suffered the most damage from ACA.

MR. SHEA: No.

JUDGE CHRISTIE: The large group and small group have been fairly stable because they've absorbed it, because they were able to absorb it. Again, it's the individual market and the self-employed people who have taken the hit.

MR. SHEA: That's quite true. Again, small group, pretty stable, a 5 percent annual change. And my last slide is our presenting companies for the day. We've already said that we chose to have the carriers here that represent the vast majority of the market. And we have that in these companies today. In both the individual and small group market, these

carriers represent over 90 percent of those markets.

And that concludes my presentation. Do you-all have any more questions?

JUDGE JAGDMANN: Not right now. We may call you back; you never know.

MR. SHEA: All right. Thank you.

JUDGE JAGDMANN: Thank you, Mr. Shea.

JUDGE CHRISTIE: Thank you. You did a great job.

MR. SHEA: Thank you.

JUDGE JAGDMANN: We'll now hear from Cigna Health & Life Insurance Company.

Mr. Shea, while everybody's getting set up, I'll just ask you a question. Are you aware of any other state that does these insurance presentations like we're doing?

MR. SHEA: Maybe Maryland. Let's ask the carriers who operate in different states. California, Maine, and Maryland. I mean, I would be really surprised if Virginia was the only one.

JUDGE JAGDMANN: Okay.

MR. SHEA: I know Maine does it

every year.

MR. WHITE: Judge, I think we had HealthKeepers going first, just so we had these slides in a certain order.

JUDGE JAGDMANN: Oh, okay. We will go with HealthKeepers. That's totally fine.

MR. CONNELL: Good morning. Tim Connell, director and actuary with Anthem.

JUDGE JAGDMANN: Welcome.

MR. CONNELL: I'm here to talk about our individual and small group business, and representing different legal entities, Anthem Health Plans of Virginia, and small group as well as HealthKeepers and small group and individual. And our small group business is entirely off exchange and individual is both on and off. And I'll try to maneuver here.

JUDGE JAGDMANN: Can you help him with the audiovisual, please? Just make it a little larger for us. Oh, it's not audiovisual. Okay. We'll deal.

MR. CONNELL: I'm not sure how to control it though. I'm glad the Commissioner had trouble, too. I don't feel as bad.

JUDGE JAGDMANN: Jonathan can help

you.

MR. CONNELL: I'll start with this exhibit here. So happy to report we're reporting, as has been discussed, we're giving a decrease of about 5.6 percent. And so I think this is good news for consumers.

And the top section kind of lays out some of the benefit plans. And this might be a good time to scroll down. I was going to get into kind of the rate changes below that. Am I supposed to have something to control that? Okay. You got it.

So I think there are probably different ways the carriers can approach this schedule. And the way I approached it was I think items at the top are sort of business-as-usual kind of events. You know, we have these kind of components every year. There's going to be trend. There's going to be items for, unfortunately, the health insured tax moratorium comes and goes, which might be a plus or a minus, depending on the year; other admin and other expenses.

So the items at the top kind of paint the business-as-usual picture. And

there's still those influences pushing rates upward. So those would be trend and morbidity. But I guess what probably calls your attention is what's on the other column at the bottom. So I'll speak to those. And there are a few items that are influencing that number.

I'd say the first one is favorable claim experience. And I think this goes back to the 2018 data, as David was mentioning. We've seen better loss ratios than we expected. I think to address Judge Christie's questions of whether that was in the cost utilization, I would say it probably wouldn't speak to the trend document but might speak to something more like the morbidity adjustment that we all reflected going into 2018.

JUDGE JAGDMANN: So meaning people were more well, less sick, whatever? A healthier population?

MR. CONNELL: Yeah, better health risk mix than we expected. Morbidity could go into cost or it could go to unit cost or to utilization. I would probably say it's

more utilization that was lower than expected, because we didn't have as many sick members. It's still an ongoing concern, though, as we spoke about the market shrinking. We think the people that are more willing to leave and ready to leave are the ones that don't need as much healthcare. The ones that remain on are probably ones that still have more use of services.

So we're seeing the favorable claim experience in 2018. And we've gotten a little bit of a look at 2019, so we think that's continuing. I think Judge Christie also said it's kind of a looking-back loss ratio as what we did before. So it would -- one influence would be what rate impact we -- rate action we took in 2019. It was a modest rate action in 2019, but actually, we're still seeing good enough experience that we think we can take the decrease now, too.

JUDGE CHRISTIE: Well, do you see a -- and I'm not asking, obviously, to get into individual contracts, but have you been able to push back on cost increases from providers to the point of trying to get control of

your -- now, obviously, that doesn't go to utilization, because utilization is patient driven. But just the cost of services, have you been able to, through your contracting ability, to keep better control of cost of service?

MR. CONNELL: Oh, sure. We're always working to do that. I think like the schedule that was on the trend showed earlier, the cost is still the major driver though. The folks working on our negotiations and provider deals are pushing hard. That's actually a part of the other difference, as well, though, as some of our cost-containing initiatives.

We have made some -- we think we're enhancing our discounts, we're making some changes to provider fee schedules, which we think is going to help out. Another big influence on the other is our taking our pharmacy benefit manager in-house. That's something that you may have heard about in the news. But we're thinking there's a bigger one-time impact from moving from our old PBM to the in-house PBM, which is going

to help the rates there, too. And that's going to be across all segments.

So I think our cost containment initiatives, you know, together, are probably maybe 5 percent of that number, but the majority of it's still that favorable experience in the other.

Some small items are also contained in it. Like David was mentioning, it's sort of a tough job to estimate the risk adjustment and morbidity. I think there's a little bit of a correlation between the two. If you do get a much sicker population, and your morbidity is way up, you would also expect that there would be some offset on the risk adjustment side that maybe you get a little bit more compensation that way.

We do believe, though, that there's some market deterioration overall. So even sometimes when your morbidity goes up, you may not get that compensation on risk adjustment.

And I'll talk still more about the concerns in the market. So I think this is definitely a good year for the rates. But

the shrinking population is still a concern. And some of the charts that showed that earlier, particularly in the individual market, you really saw the drop-off of membership. I think the numbers were over 400,000 just a couple of years ago. They're just over 300,000 last year. Now they will continue to drop from the Medicaid expansion; that might be sort of an outside reason, just for that drop. But that's still a concern.

And we think there's just a higher level of morbidity to the population as a whole because of that. So I think that will still be an ongoing influence that is a little bit out of our control.

JUDGE JAGDMANN: When I was looking at your maximum and minimum rate change, I guess that's on a percentage basis, not on a premium dollar basis -- I mean, not on what it actually costs. It's rate of change, as opposed to --

MR. CONNELL: It's the rate of change, correct. And we usually see that most popular plan ends up pretty close to the average that we're giving, so the -5 there

versus the -5.6 overall.

So some of the reasons for that are we also reevaluate our benefit relativity model every year, which kind of tells us where are we pricing certain products. And some of those might have plus or minus indicators every year. I think that's the majority of what's causing some of that differential between the plans. But in general, those are -- they're falling pretty close to the average.

JUDGE JAGDMANN: And you may or may not know this: Does the average -- I wonder what percentage of your insureds actually meet their deductible and actually use the insurance.

MR. CONNELL: I would have to probably go back and look at that. I don't have that handy. I think, as our most popular plan -- and remember, on our Silver Plans, I think our deductible is 6,250. I think it's a little bit cut off on this exhibit. Your member who doesn't have any cost sharing reduction has to meet that deductible. But a large part of our

population, in addition to getting premium subsidies, also get what's called the cost sharing subsidy. That's the item mentioned earlier that the funding was cut for that a couple of years ago.

And so many of our members, really, the majority of our members will have something lower than that 6,250 that they have to meet.

JUDGE JAGDMANN: Yeah, that makes sense, because it would be a very small population. And they're probably looking for a different product.

MR. CONNELL: Right. If a member is not eligible for cost sharing subsidy, they would probably look for something different.

JUDGE JAGDMANN: Okay. Thank you.

MR. CONNELL: But members that are paying the full level deductible, you'd expect on an average population -- yeah, I'd probably have to look those numbers up, but it would be, you know, I assume, less than half of the people would probably meet that deductible.

And we're still -- I also want to speak to ongoing, trying to keep the costs contained. Our provider team is working very hard to keep costs down. I think our PBM will pay some dividends in the future as well. I think there's probably a bigger one-time impact as we move to it in 2020. But those are just ongoing things that Anthem is trying to continue to do to hold the costs down.

Our cost of care team works on new initiatives all the time to make sure it's avoiding any waste or inefficient use of claims dollars.

I'll also speak to just the uncertainty with the population moving so much. We mentioned a few of these items earlier. Medicaid expansion is happening. We know our population is decreasing because of that. We've come to learn that it may not happen right away; that there's a bit of a lag as these members realize that they're eligible for Medicaid and they get moved over.

As we look at our enrollment

accounts, we didn't see them drop off as much early on as we would have thought. We talked to some of the Anthem states that have gone through this before. And I think it might be a more gradual process, but probably by the mid or end of 2020, we think that hopefully that Medicaid expansion is all sort of migrated over.

But it does create some uncertainty then, just as to what kind of risk population you have, who's moving in and who's moving out, and the sole proprietor bill, as well, is probably causing some migration between the individual small group market causing a little bit of uncertainty.

All right. Can you scroll down, please. There's another individual page. Okay. So this is our age and area chart. And for the most part, these are staying pretty much the same. The age factor chart has not been changed; that's usually dictated by CMS. And we're not getting any indications there are changes.

Our area factors are staying pretty stable. We actually have reentered some

localities that we were not in in 2019. In addition to that, we think that's going to result in some more leverage to providers and better control of discounts and hoping to lead to some better results there and allow an area factor change in reduction there.

Move to small group. Any more questions on individual?

JUDGE JAGDMANN: No. Thank you.

MR. CONNELL: So we have pages for each of our legal entity, and I'll just preface by saying that the overall increases are very similar. And we actually start with the combined experience of both legal entities together when we do our pricing.

There's just different networks we use. This is the HealthKeepers that's up front. And they operate on a slightly different network so there was just a slight network differential in the overall increase, but generally, they are very similar.

Again, modest increases. I think this is good news for the market, a little bit lower than they have been. So I think we're seeing, in the other category, once

again, some of the same influences I mentioned for individual. That probably one item is the favorable experience we've been seeing from 2018. We think this is continuing to some extent in 2019 as well.

And then the other cost containment initiatives that we mentioned, particularly our move to our in-house PBM, is helping bring down the rates there as well.

JUDGE JAGDMANN: Now, is the mail order, the mail-in prescription? Or is this --

MR. CONNELL: Our PBM would do all of that. They would also control the retail price that members and Anthem pay at the pharmacy as well as mail order.

JUDGE JAGDMANN: Okay.

MR. CONNELL: And I think here we're showing the age and area, which we're not changing any of those factors for the small group market.

And here's small group Anthem health plans. This operates a slightly different network than the HealthKeepers, but generally, a similar story to what we saw

before. And again, I think I'll mention again that the min and max rate increases are still pretty close together. You'll usually find those are related to some benefit change that was made; that's probably the main reason on the minimum plan there.

As well as, the other is going to contain, again, the favorability of our experience, as well as cost containment initiatives like our PBM change.

And also, like our HealthKeepers legal entity, our factors are not changing for age or area. The area change is actually just a recalibration where we're trying to make our area factors for the state average to 1.0, and that's just as members shifted from one area to another. We just recalibrated that and everyone got a slight increase there.

So small group is, like we said, running a little more stable. And like we said on those increases that were shown earlier, increases have been much more stable than the individual market. Still have some concerns. We've seen morbidity change and

market shrinking, as well, here. So it's not without any concerns.

But the idea of sole proprietors now moving into the small group market is a bit of a concern. Usually, those small, small groups might be selectively choosing, and we have some concerns about that in our morbidity levels. We also know that, in the small group market, more carriers are offering non-ACA related options. And that might be causing some of the market shrinkage that's been happening in small group.

I saw in the chart earlier that 2020 was projected to stabilize and go back up. That might be based on how other carriers and myself are projecting where enrollment is going to be in 2020. It's a bit of an estimate at this point. But I do have concerns that, overall, the 2020 market will continue to shrink maybe the levels it has in the last few years.

That's all I had. Any questions?

JUDGE JAGDMANN: Well, thank you very much. We appreciate your being here today.

Okay. Who's next on our audiovisual? Cigna.

MR. HOFFMAN: Good morning, Judge. My name is Zachary Hoffman. I'm the signing actuary for Cigna's individual product in Virginia. I'm starting at the top of the exhibit here. Our average rate change that we're requesting is 1.3 percent; for adults and children, 1.3 percent; 1.7 percent for children. Just to note, there are no changes or differences in methodology or assumptions; it's just a matter of the plan selection that factors into that weighted average.

Moving down to the drivers of the rate change, our most popular plan is the Cigna Connect 6500 plan in Northern Virginia. There's also our maximum rate change plan on the right. And our minimum rate change plan is the Cigna Connect 1500, which is a Gold Plan.

Overall, from 2019 to 2020, relatively minor plan design changes. Really, the largest or the most meaningful one is the increase in the out-of-pocket max 7,900 to 8,150.

So for the actual drivers of the requested rate change, since the individual mandate penalty was set to zero for 2019, there's no expected impact there. For other morbidity, similar to other carriers, I believe we're seeing a better health status with our risk pool than we had previously anticipated through all the turmoil that happened during the 2018 pricing cycle.

Trend, based on the exhibit that was shared earlier, we're towards the bottom of the pack in terms of controlling the unit cost that we experience for our members at 4.9 percent. On the other main items, risk adjustment, we're expecting relatively the same position as before.

JUDGE JAGDMANN: For you, was trend mainly utilization or a little bit of both?

MR. HOFFMAN: Unit cost is still the primary driver, but a little bit closer together.

The next two items are expenses. So the first is the health insurance industry fee coming back. There was a holiday on that fee for 2019. So we're expecting that to be

about 1.7 percent, which is offset some by the next line item, which is reflecting the decrease in the exchange user fee.

And then the final item, in the main section are changes to the plan benefit design.

Moving on to the next section there, so Other Change 1 is only impacting the Silver Plan. That reflects how we are required to load the plans for CSR being defunded as a matter of the expected mix of members that qualify for those plans. So in the case of looking at 2019 pricing to 2020, we overanticipated the amount of membership that would leave for Medicaid expansion. So as a result, we had more members than we were initially expecting on those higher cost sharing variations.

And the final item, Other Change 2, this is a combination of a few factors. Really, the main driver here, though, is, as David discussed in his presentation, when we were pressing for 2019 rates, we were using 2017 experience. This year, we're using 2018 experience. So for us, we saw a very

dramatic difference in our market share and our risk pool between 2017 and 2018, had a pretty large expansion in membership and also have a different network construction. So a lot of that is a result of that very dramatic shift in the experience that we're using to price the product.

So, really, no changes to the age factor year over year. For our tobacco factor, we're actually proposing a reduction there. Previously, tobacco users were charged a 25 percent surcharge. We are proposing to reduce that to a zero percent surcharge.

The other items on this page are the geographic factors. It is showing a decrease there, but that is due to a recalibration of how those factors are being normalized. So really, those are flat, as far as actual impact to rates.

JUDGE JAGDMANN: Okay. Thank you.

MR. HOFFMAN: Any questions?

JUDGE JAGDMANN: No. Thank you very much.

MR. HOFFMAN: All right. Thank you.

JUDGE JAGDMANN: Optima?

MR. JUILLERAT: Good morning. I'm James Juillerat. I'm the chief actuary for Optima Health. Just a brief introduction of our company. Optima and Sentara are an integrated health system. We are a not-for-profit company. And in 2018, Sentara provided $390 million in uncompensated care. And that is $170 million more than we would have paid in taxes if we had been a for-profit. But just an example of, when we do make profits, it gets reinvested back into the community.

Today, I'm going to turn it over to Margaret Chance. She's going to go over the individual product, and then I'll step back up and go over the small group product.

JUDGE JAGDMANN: Thank you.

MS. CHANCE: Good morning. Okay. So my name is Margaret Chance. I am a principal and consulting actuary with Milliman. I am the certifying actuary for the Optima Health Plan individual filing.

So I think -- it's really small; I don't know if you have a larger version of

that.

JUDGE JAGDMANN: I have a paper copy.

MS. CHANCE: Okay. Good. Because I can't see that, but I have my own copy. So overall, the requested average rate change is a decrease of 11.3 percent for 2020 rates. So that's a positive.

We illustrate three plans. The most popular is the OptimaFit Silver 6600 Direct. It has about 50 percent of the overall membership, approximately 11,000 of which is in one rating area. So that's the rating area that's illustrated for you, and the rate change.

So if we take a look at, for the most part, there's -- I don't know; sounds a little bit awkward. There's a couple of drivers that made costs go up. And there's a few drivers that are driving the cost down as well. So I'd like to talk about a few of those.

With respect to what's shown as other morbidity, that specifically, as we discussed, we based the rate development on

2018 plan experience. And Optima had procured a significant amount of membership during that plan year. And when we looked at emerging 2019 enrollment, we actually saw that that was coming down. And we looked specifically at the members that were retained by the company. And in fact, their costs, in general, were higher compared to the overall costs that were used in pricing the prior year.

So we've sort of explicitly determined that amount. So that caused the cost for 2020 to go up some. While Optima is assuming that they will regain some of that membership back in 2020, it's not enough to fully get us back to where 2018 was. So that's one item.

Another item is trend. One item to note in my illustration is that I also include the impact of cost sharing and the leveraging of that. So if you have a $20 co-pay, that's 20 percent when the cost is $100. The cost goes up next year. You still pay $20. The cost to the company is more, is a higher change. So that's included, and my

trend numbers average around 10 percent.

A significant driver downward is related to the risk adjustment mechanism. This is twofold. One is, with respect to the other morbidity component, you will also then be compensated for that in some fashion. It's not a one-to-one. So we would see a higher expected receipt for risk adjustment.

But also, another major item with respect to the change to 2019 is that in -- when Optima was pricing rates over the past two years and the procurement of a significant amount of membership, it was reasonably -- it was a reasonable assumption to make that, having a larger portion of the population, the majority of certain regions and, in some cases, there would be no -- you wouldn't necessarily know how to project if there's a receipt in that case or a pay-in in that case. Because you assume that you're further influencing that market average.

So during those plan years, that was the assumption made in pricing. Because there is no other way to know how different

regions of the state vary in this regard. There's not public information available on that, nor any internal information on that.

As we looked at -- during the course of the past year, it became -- some projections were done by Optima and consulting firms to say that, in fact, Optima was going to be receiving a fairly sizable transfer receipt -- sizable relative to zero, certainly -- which to this day, I still struggle -- as an actuary, in reasonableness, I struggle a bit, because it doesn't really make sense.

And the only thing it seems to indicate is that you have regions of the state that, overall, are less healthy. And those that are more healthy are not the ones that Optima is in.

So with that being said, of course, that's going to have a significant impact on the cost. And so the 2020 rates are reflective of what they are seeing now in the actual risk transfer payments that have recently been released by the federal government.

A small increase due to return of the health insured tax, about 1 percent. With it, a projected decrease in membership compared to 2019 pricing; administrative expenses have gone up a little bit. So it's about a couple points.

Small change due to benefits, network changes, just some recontracting that Optima has worked on to help further reduce the cost of care.

With respect to CSR payments, again, that was based on emerging 2019 data, probably a combination of membership loss in general and also, with the Medicaid expansion, perhaps losing more of the higher cost members, because they moved into Medicaid, than was assumed in the prior year.

With respect to the area factor revisions, so one of the things that the company did this year, besides revisions, just looking at more up-to-date experience that you have available. We were able to -- the company considered looking at sort of a regional rate development. And James can speak more to the specifics of those -- your

questions.

But basically, you can see -- it's on the next page, I guess, but you can see that, what the company did was, for -- we have one rating factor for area 9, which is sort of their target primary market. And then one factor for the remaining areas in which they do business. And so that was just a company decision to be made. So you can see that for areas 2, 7, and 12, that results in lower rates, and in area 4, that results in higher rates.

So in the -- by plan illustrations, we specifically showed the areas impacted by those as far as the lowest and the highest of that amount.

Minor increase due to some revised capitation rates based on experience, and then a lowering of the profit and risk margin from that assumed in 2019.

JUDGE JAGDMANN: So I was just looking at your rates. Is this largely a Medicaid plan?

MS. CHANCE: Which one? I'm sorry.

JUDGE JAGDMANN: I mean, are these plans largely -- the population that purchases these, are they largely the subsidized population?

MS. CHANCE: Yeah.

JUDGE JAGDMANN: Because it's high.

MS. CHANCE: I don't have the numbers on that, but it is fairly substantial. I have a couple of documents here. Let me see. I don't have that one handy. But it is -- I mean, I think that's the situation that's a marketwide --

JUDGE JAGDMANN: Yeah, I think so.

MS. CHANCE: I've seen it across multiple clients and multiple states. All right.

JUDGE JAGDMANN: Okay. Thank you.

MS. CHANCE: Thank you.

MR. JUILLERAT: This is James. I'm back. I think I have the answer to that last question. We're 89 percent subsidized for the individual product.

JUDGE JAGDMANN: Okay.

MR. JUILLERAT: For the small group products, you can see that we have an 8.8

percent overall increase. Looking at the products, our most popular plan is the Optima Vantage Gold. And the benefits for that have been quite stable. The MOOP increased $500, and that's really about it. That is our most popular plan.

I will just comment on the min and the max plans. They actually have zero membership in that region. They have memberships in other regions, but those -- we did have the min and max of those plans; we were required to choose.

Flipping on to the components, individual mandate is zero because this is small group. Other morbidity is zero. We didn't feel that -- or when we built this, the assumptions that Medicaid expansion and association and things of that nature would not have a significant impact on our small group business.

Our trends are our big component, of course. And as David Shea pointed out earlier, these are very similar to what the carriers are using. We do see a decrease because of risk adjustment. Now, the risk

adjustment transfer for this product are relatively small. They're usually plus or minus $5 PMPM. But in this case, we are projecting to have an increase in risk adjustment receivable, which pushes the premium down.

The health insurance fee moratorium that other carriers have mentioned is going away in 2020, so we have to build it back in the rates.

Benefit changes, mostly minor; they're on the .8. The min plan has a big number there for benefit changes. And if we scroll back up to that plan, it really is just big benefit changes. If you notice, the in-network PCP office visit co-pay, we switched from having co-pays to co-insurance. And that's a pretty big change. And that just reflects that benefit change.

The max plan also has a large changing factor. That's primarily for that network difference. We have a product that is a narrow network product that excludes certain providers. And the assumption is based on how much steerage we could move away

from those providers has changed. And so that's what's driving that.

Our region factor, 1.7 percent, this varies by region. If you notice, it's 1.7 for the most popular plan, but it's a big negative and another big negative for the others. When we get to the next page and I talk about area factors, I'll speak more to this. But it's basically the combining of areas, like Margaret mentioned, on the individual products that's causing -- you know, we've got --

JUDGE JAGDMANN: Some go up and some go down?

MR. JUILLERAT: Yeah, exactly. You average them together, and that's what's driving that.

Demographics is a fairly small one. And claims experience, basically, went up 2.3 percent more than what we would have expected. So if we took last year's claims times our trends versus -- well, I should say, two years ago claims times our trends, and then compared that to actual, it was a 2 percent difference. So that's built into

there.

And change in trend, our trend did go up .8 percent from last year. That varies a bit by benefit, because of deductible leveraging. And then the other .3 and 2.2, etc. That's primarily based on some capitation arrangements we have with external vendors, transplants, and things like that.

All right. We, of course, use the same CMS prescribed age factors. We do not have a tobacco load for small group. If you notice, on our region factors, you can see some big movement there. And this comes back to the comment I made earlier about the averaging. And you can see that the 1.075 factor, which is in regions 1, 3, 8, 11, and 12 -- I think I looked at that wrong. That's where we were combining the regions together. And as you pointed out before, you average things together and they move.

JUDGE JAGDMANN: Right.

MR. JUILLERAT: And I think that's it. Are there any questions?

JUDGE JAGDMANN: No. Thank you very much.

JUDGE JAGDMANN: Kaiser is next.

MS. SCHROER: Good morning. I'm Sheila Schroer. I am Kaiser's chief actuary for the Mid-Atlantic region. I think you can blow up the big table there. We don't have any changes to area factors or rating -- age factors rating or tobacco, so it's all change of zero.

Okay. For our most popular plan -- this is individual, right? Yes. We have about 15,000 members -- or close to 16,000 members in a $5,500 deductible, 35 percent co-insurance plan. The out-of-the-pocket maximum has increased from 7,900 to 8,200. And PCP co-pays for kids under 5 are waived, so there's no deductible there. And then for everyone else -- it looks like it's cut off on the screen, but for everyone else, the first three visits is just $50, no deductible. And then beginning with the fourth visit, you have to meet your deductible.

And for this plan, we're asking an overall 4.4 percent rate decrease. I want to go through the minimum and maximum plans and

then come back to the components of the rate change.

So moving on the minimum. We have about 600 members in a 3,200 deductible 20 percent co-insurance plan that is HSA compatible. The out-of-the-pocket maximum has increased from 6,000 to 6,650. And then the PCP co-pay is 20 percent co-insurance after you've met the deductible. This plan we're asking for a 12.3 percent decrease.

Then going through the max plan really quickly, it's 6,000 deductible, 35 percent co-insurance plan with about 735 members. The out-of-pocket maximum has increased from 7,900 to 8,200. And the PCP co-pay has increased from $35 to $40. And on this particular plan, the deductible does not apply to PCP visits, so it's always a co-pay; the deductible does not come into play. And we're asking for a -2.1 percent rate change on this plan.

So going down to the components of the rate change, we did tease out an individual mandate of 4 percent. And I think this really should go away and be lumped in

with other morbidity, but it's really to reflect that we think people are going to continue to leave the market. So we've got 4 percent for all plans there.

For other morbidity, we've got a -14.1 percent change. And this is reflecting that we've lost over half of the membership of our pool. Those members have gone to Medicaid expansion or to other carriers. And so the makeup of the pool is just very different now than what it has been.

The trend is at 4.8 percent. And for Kaiser, that really reflects budgeted expenses, fixed expenses. It's not utilization driven. So that's the difference. And then for risk adjustment, we've got a 3.8 percent increase and a 1.1 percent increase for the return of the health insurance provider fee. And then that's offset by a 1.1 percent reduction for other non-benefit expenses.

The benefit changes, which I went through a little bit at the beginning, range from a -.5 percent to a -1 percent change. Those were made to keep the AVs in the

allowable AV range.

Then for all other ranges from a small increase, half a percent increase up to a minus -- or down to a -10.2 percent decrease, the big decrease there is on a Silver Plan, where the cost share reduction load has been decreased from what it was in the past. And that's because we had fewer subsidy members now than we used to have.

Okay. That's it for individual. Any questions?

All right. Small group. We have an overall 4 percent increase request for small group. Our most popular plan is a zero deductible $15 co-pay plan. No changes to the out-of-pocket maximum of 2,500. And no changes to the $15 PCP co-pay. We've got 2,500 members in this plan. I should also mention that we operate in areas 7, 10, and 12, and we don't vary rates. So it's the same. So even though it says area 10 on here, it's all of them. Then for our -- oh, and we're asking for a 5.4 percent increase on this plan.

For the minimum plan, we've got

3,000 deductible, zero percent co-insurance HSA plan. The deductible did increase from $2,500. And so did the out-of-pocket maximum, which went from 6,000 to 6,650. And those increases are offset by a reduction in co-insurance from 20 percent down to zero. And we are asking for a .6 percent increase on this plan.

Then the maximum rate change plan was 700 members. It's a $1,400 deductible, zero percent co-insurance plan that is HSA compatible. The out-of-pocket maximum is increasing from 4- to 5,000. And then PCP co-pays, it's at zero percent after you meet your deductible.

JUDGE JAGDMANN: Did you drop co-insurance on a lot of your plans?

MS. SCHROER: Pardon me?

JUDGE JAGDMANN: Did you drop co-insurance on a lot of your plans?

MS. SCHROER: No. Just on a couple to try to make it more attractive to consumers, because customers think co-insurance is confusing.

JUDGE JAGDMANN: It is confusing.

MS. SCHROER: They like co-pays.
JUDGE JAGDMANN: Yeah.
MS. SCHROER: Okay. And we're asking for 5.7 increase on this plan. So going down to the components, we've got a 4.2 percent increase for morbidity, same 4.8 percent trend; a 4 percent increase on risk adjustment. We have been growing in our small group pool, and the pool is changing quite a bit. So that's our best estimate of risk adjustment at this point.
Return of the health insurer fee is 1 percent, and then a reduction of 4.2 percent for other non-benefit expenses. And then benefit changes range from zero to -3.9 percent decrease. Again, that's because of keeping in the AV range or just to get the rate at the bottom end of the range to make it more competitive. And then other changes range from -4 to -5 percent roughly, and that's driven by the margin load on the rate. And that's all I have.
JUDGE JAGDMANN: Okay. Well, thank you very much.
MS. SCHROER: Thank you.

JUDGE JAGDMANN: UnitedHealthcare.

MR. MORGAN: Good morning. Thank you judges and the Bureau of Insurance for the opportunity to present today. My name is Ryan Morgan. I'm with UnitedHealthcare. My work address is 10701 Research Drive, Wauwatosa, Wisconsin 53226.

So I'm here today -- and because of the new format, I'll just be talking about UnitedHealthcare Insurance Company, which is the largest of our four licensed, and this is for small group only. United is licensed and has our PPO plans. And it's about 71,000 members. So it's a good one to talk about, because it makes up about 80 percent of our total block. And all these plans are off exchange only.

So as you can see here, our overall increase is 13.3 percent. I'll spend most of the time talking about the most popular plan column, because a lot of the other ones are pretty similar to that. So you can see the biggest single increase is the trend rate of 7.9 percent. And that's actually just our approved 2019 trend, because this document is

looking at comparing 1-1-2019 to 1-1-2020 rates. So actually, 2020 trend is pretty similar to that as 8.1 percent. So just slightly higher but pretty close.

The other big -- I guess, fairly big increase component here is the HIT moratorium the other carriers have talked about. So that was a 2.5 percent impact increase in rates. Probably the most, I guess, complicated thing on here, the way I put this together is the benefit change of -6.9 percent. So there's actually two pieces to that that's reflecting both the benefit decrease.

So you can see at the top, for this most popular plan, which is our Gold 10 POS plan, that we did have an increase in the individual out-of-pocket, from 6500 to 7500. So part of that -6.9 percent is kind of the decrease associated with that. We also just -- United has a model that we use nationwide with our price relativities. And so there was kind of a bias in that model that actually made most of our benefit relativity smaller. So that's reflected in

there, too.

And so you can actually look at that benefit changes line in tandem with the one, two below it, the resloping offset line. So that plus 4.2 percent kind of offsets that. That's just like the bias part. So, basically, you could more or less look at that and say that the difference of those -- so 2.7 percent, if you combine those together, is the impact of just the benefit change alone.

The other items, so the July 2019 increase of 2 percent, so that was an already filed and approved increase for July of 2019, but that is reflected in here as well, because we're, again, comparing 1-1-2020 versus 1-1-2019.

And then we have area offset, so this whole analysis is looking at area 10, which is our most -- most of our membership, or at least the largest chunk. And so we did not make any area changes in that region, but we did, in some others, take decreases that were -- have less members. So we wanted to keep the rates neutral and positive, so we

accomplished that by increasing statewide .3 percent. So it's an increase here but if you looked at a different region, it could be a decrease.

So those are the, I guess, driving factors for the most popular plan. And then you'll see the other columns are pretty similar. Really, just the benefit changes line is the biggest drivers. So for example, the Silver 14 our minimum rate plan, you can see that one had a pretty big increase in the individual deductible from $3,000 to $4,000. So you'd expect a big benefit decrease associated with that, and that's indeed what you find here.

And as then for our maximum rate, this Platinum 14 plan that had the biggest increase, yeah, so that one didn't have a benefit change, but generally, in kind of what I was talking about before, this newer version of our pricing model seemed to be the Platinum, kind of the richer plans that had a little bit bigger shift from year to year. So that's why. Yeah, that one came out as our maximum increase at 18.1 percent.

So I think that's all I had to

cover. Do you have any questions?

JUDGE JAGDMANN: I do not. Thank you very much.

CareFirst?

MR. BERRY: Good morning. My name is Peter Berry. I'm chief actuary for CareFirst. Our address is 10455 Mill Run Circle, Owings Mills, Maryland, 21117.

Today I'll be presenting our small group rates. CareFirst sells an HMO and a PPO under two separate entities in Virginia BlueChoice and GHMSI.

And the first slide is for our HMO BlueChoice. As you can see up there, the average rate increase is 9.4 percent. That's primarily driven by three things: You can see trend there, which is in the range that David Shea had described for most carriers. We have the HIT fee, which is around 2, 3 percent. And then the other dynamic is that this product has about just almost 40,000 members. It was relatively flat in 2017. And then in January '18, we saw about, since January till now, we've seen about 14 percent growth. So it's a material change in the

population.

And what we saw there was that this is a relatively healthy block, and it pays into the risk adjustment system. And it looks like we're paying more than we expected to in 2020, so that's adding a little bit to the rate, maybe 2 to 3 percent. So that's what makes up the 9.4.

The one number I wanted to call out on this screen is that you can see our maximum rate increase for that maximum plan is about 23 percent. That's an outlier. Out of the 40,000 members, there's about 150 members who have the plan in question. That plan is being remapped from '19 to '20 into a different plan. And just by mechanically, we have to show that rate change, but it's very unlikely those 150 members --

JUDGE JAGDMANN: Right. Those are different benefits?

MR. BERRY: Yeah. Different benefits. And those 150 members would have -- of the 53 plans we offer, they'll be able to find a plan that have a 23 percent rate increase. So that's just more an artifact of

the template.

So if we move down. So this is our PPO GHMSI -- oh, I'm sorry; this is the age factor. So we are only in rating area 10, because of the BlueCross licensing requirements. So there's no area issues and no changes to area age factors.

GHMSI, much better story, kind of opposite dynamic; we're just above flat, a .7 percent increase. The increase for last year for both BlueChoice and GHMSI was about 2 percent. So this is consistent with last year, just about flat.

Also, enrollment, we have about 15,000 members. Enrollment was flat in 2017, increased 15 percent since January 2018. So we're very pleased about that, with an opposite dynamic, where we're going to be receiving a little bit more risk adjustment for these relatively sicker members, and that's keeping that rate increase down to about flat. And you can see that the mins and maxes are much closer to the average here. We don't have the outlier issue.

So those are the highlights. I'll

be happy to answer any questions.

JUDGE JAGDMANN: Thank you very much.

MR. BERRY: Thank you.

JUDGE JAGDMANN: Okay. Is there anything further from the Bureau?

MR. WHITE: Nothing, Your Honor.

JUDGE JAGDMANN: All right. This concludes today's procedures.

JUDGE CHRISTIE: Well, let me just ask, before you leave, I want to ask Scott: Can you just address a little bit -- I think David was going to get into this -- but talk about the process for determining the MLR and the rebates. And you were going to say some comments about that.

MR. WHITE: Yeah, Judge. I do think I touched on it a little bit. So, you know, in 2017, we've talked a lot about that and the uncertainty that developed. And I think, as I mentioned, it caused some carriers to price their premiums very significantly to address that uncertainty.

So in certain cases, we determined they probably paid more than necessary based

on their claims, administrative costs, and regional profit. So as you know, there is -- carriers are required to pay back a rebate to consumers if they failed to meet the minimum loss standard threshold. So as you know, that's 80 percent of premiums has to be paid on claims.

So we do know in Virginia that CMS is looking at several carriers, both in the individual market, and too, in the small group market. And they will likely owe rebates to Virginia consumers. Again, that is a federal program. We are -- we have no role in that. We are monitoring it. And we are having discussions with CMS, just to make sure that we're on top of that.

JUDGE CHRISTIE: All right.

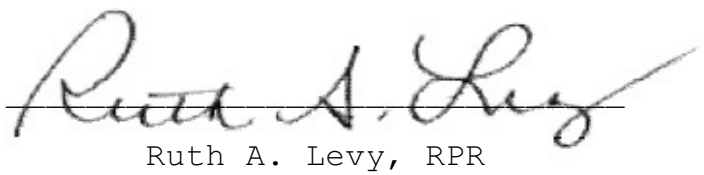
JUDGE JAGDMANN: Scott, thank you for that update. And with that, we stand adjourned. And we thank everyone for their presentations today. Thank you for being with us.

(Hearing concluded at 11:32 a.m.)

CERTIFICATE OF REPORTER

I, Ruth A. Levy, RPR, do hereby certify that the proceedings were heard before me in the State Corporation Commission hearing herein; further that the foregoing is a true and accurate record of the testimony and other incidents of the hearing herein; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

Given under my hand, this 29th day of July, 2019.



Ruth A. Levy, RPR

Notary Public, Commonwealth of Virginia
My Commission Expires August 31, 2022
Notary Registration No. 224511

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