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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

9:36 a.m. to 11:32 a.m.

Job No.: 252127

Pages: 1-109

Reported by: Ruth A. Levy, RPR

1 APPEARANCES:

2 SCOTT WHITE
Commissioner of Insurance

3 DAVID SHEA
4 Health Actuary

5
6 Company Presentations:

7 TIMOTHY CONNELL
8 HealthKeepers/Anthem Health Plans of Virginia

9 ZACHARY HOFFMAN
10 Cigna Health and Life Insurance Company

11 MARGARET CHANCE
12 JAMES JUILLERAT
Optima Health Plan

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

16 RYAN MORGAN
17 UnitedHealthcare Insurance Company

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

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EXHIBITS

(None marked.)

1 P R O C E E D I N G S

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

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

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

1 year.

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

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

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

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

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

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

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

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

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

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

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

1 cross-examination.

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

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

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

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

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

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

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

1 positive.

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

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

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

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

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

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

1 morning.

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

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

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

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

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

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

1 million. So about a third of what we have
2 with our self-funded plans. You can see,
3 with the individual and small group, those
4 are roughly the same size, again, about 4
5 percent overall of the market, at around
6 350,000 or so for both groups.

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

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

18 2008, if you'll recall, that's
19 before the implementation of the ACA. The
20 other date I would point out is 2014, a very
21 important year, because that's the year that
22 the market reforms, as they're called, were
23 implemented, including the Marketplace.

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

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

8 Looking at the non-group, that's the
9 second column, and that is really the
10 individual market. And you can see back in
11 2008, it's at about 5 percent. And it's been
12 fairly steady throughout that time period.
13 In 2014, again, when the Marketplace comes
14 into the picture, it jumps all the way to 7
15 percent, goes up to 8 percent the next year,
16 but then it drops back down beginning in
17 2016. And it sits today at about 4 percent,
18 so not much movement when you look back to
19 where it was in 2008.

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

1 it's about 12 percent. And between 2008 and
2 2013, it hovers between 12 and 13 percent.
3 So when, again, the marketplace goes into
4 effect, it goes down a couple percentage
5 points. And since that time, it's been
6 around 9 or 10 percent. So, again, two
7 percentage points difference since 2008;
8 certainly, I would have thought they probably
9 would have thought there would have been more
10 progress.

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

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

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

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

5 And 2018 is a year you're going to
6 hear talked about; I think David's going to
7 bring it up. It's based on everything that
8 was going on in 2017. All the uncertainty,
9 most of it coming out of Washington, the
10 government -- the federal government stopped
11 paying CSRs to the plans. There was a lot of
12 talk about repeal and replace in the halls of
13 Congress. And they stopped paying the
14 individual mandate penalty. So that created
15 a lot of uncertainty. And a lot of the major
16 carriers actually pulled out of the state in
17 2018.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 MR. WHITE: Fifty, yeah.

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

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

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

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

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

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

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

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

17 JUDGE CHRISTIE: Let me ask you,
18 Scott.

19 MR. WHITE: Sure.

20 JUDGE CHRISTIE: So what this shows
21 then is you've had a -- I mean, no other way
22 to describe it -- a huge drop in the number
23 of people who are buying individual policies.
24 In just two years, you've dropped from
25 418,000 to 300,000, which, by my math, is

1 over a one-third drop.

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

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

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

20 MR. WHITE: Yeah. One caveat I
21 would make is, remember -- and we're going to
22 talk a little bit about this -- with Medicaid
23 expansion, that's taking about
24 40-some-thousand people out of the market
25 that otherwise would have been in the

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

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

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

20 MR. WHITE: Right.

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

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

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

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

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

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

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

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

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

25 MR. WHITE: Oh, and Judge, I think

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

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

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

1 the real damage has been done.

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

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

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

1 JUDGE CHRISTIE: Okay.

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

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

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

25 JUDGE JAGDMANN: So this is monthly

1 premium?

2 MR. WHITE: Yeah.

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

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

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

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

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

5 JUDGE CHRISTIE: Now, let me ask
6 another question on another topic, because
7 you said the good news this year is there's
8 18 percent decline in premium increase -- not
9 increase but decline, which is good. I think
10 that's probably the first time we've ever had
11 an actual decline in the cost of premiums.
12 So that's very good news.

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

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

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

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

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

18 We looked at three years of this to
19 see what the impact was, 2016 through 2018.
20 2016 is the gray, 2017 is the orange, and
21 2018 is the blue. So I'd focus your
22 attention at the very top at the 400 plus.
23 That's the folks, obviously, ineligible for a
24 subsidy. You can see in 2016 they're about
25 31 percent of the individual market. And

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 MR. WHITE: Yeah, Medicaid
14 expansion. They cap out, I think it's
15 70,400, based on what our consultants are
16 telling us.

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

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

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

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

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

12 MR. WHITE: That's correct.

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

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

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

25 MR. WHITE: Our law allows it, but

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

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

16 MR. WHITE: Right.

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

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

25 JUDGE CHRISTIE: Well, he cited the

1 ACA, as I recall --

2 MR. WHITE: Right.

3 JUDGE CHRISTIE: -- in denying that
4 option.

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

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

14 JUDGE JAGDMANN: Thank you.
15 Mr. Shea?

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

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

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

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

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

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

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

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

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

1 because everybody knows things are
2 changing.

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

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

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

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

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

1 JUDGE JAGDMANN: Is this a
2 Virginia-only template?

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

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

14 MR. SHEA: Absolutely.

15 JUDGE JAGDMANN: -- an efficiency
16 booster.

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

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

1 It's been pretty quiet.

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

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

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

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

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

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

22 JUDGE JAGDMANN: Right.

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

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

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

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

19 Speaking of medical and drug
20 trends --

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

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

1 actually up on the screen.

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

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

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

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

5 JUDGE JAGDMANN: And utilization
6 just being --

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

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

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

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

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

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

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

14 MR. SHEA: These are their loss
15 ratios.

16 JUDGE JAGDMANN: Yes. How much
17 they --

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

20 JUDGE JAGDMANN: Okay.

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

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

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

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

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

14 JUDGE JAGDMANN: Right.

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

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

1 they were looking at the last three years,
2 '14, '15, '16. This is getting worse and
3 worse and worse; I've got to price my
4 business off of 2016. Huge rate increases
5 resulted.

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

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

23 MR. SHEA: Uh-huh.

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

1 providers charged and utilization.

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

11 JUDGE JAGDMANN: What's the cause?

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

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

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

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

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

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

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

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

17 MR. SHEA: Or not going up as fast.

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

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

25 JUDGE CHRISTIE: It definitely could

1 be related to it.

2 JUDGE JAGDMANN: And people are
3 denied --

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

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

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

20 MR. SHEA: That's true, too.

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

1 mountain that does this.

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

4 JUDGE JAGDMANN: Or utilization.

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

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

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

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

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

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

25 JUDGE CHRISTIE: But that also gets

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

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

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

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

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

23 JUDGE CHRISTIE: Or large groups.

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

1 JUDGE CHRISTIE: Or even less on
2 self-insured.

3 MR. SHEA: Right.

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

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

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

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

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

4 JUDGE JAGDMANN: Per year?

5 MR. SHEA: Twelve percent a year.

6 JUDGE JAGDMANN: Twelve per year.

7 Now, that's compounded, I guess.

8 MR. SHEA: Oh, well, sure.

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

11 JUDGE CHRISTIE: Well, that's a lot.

12 MR. SHEA: It is a lot.

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

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

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

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

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

10 JUDGE CHRISTIE: Yeah, but let's get
11 real. 2014, if you were making \$50,000 as a
12 landscaper, plumber, carpenter, and you see
13 12 percent annual increase in your health
14 insurance, that is not good. That is not
15 calm. That is not happy talk, okay. You
16 have been priced out of the market. So let's
17 be real about this.

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

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

24 MR. SHEA: Exactly.

25 JUDGE JAGDMANN: The salaries

1 aren't.

2 JUDGE CHRISTIE: So they can't pay
3 it.

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

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

10 MR. SHEA: No.

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

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

1 carriers represent over 90 percent of those
2 markets.

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

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

7 MR. SHEA: All right. Thank you.

8 JUDGE JAGDMANN: Thank you,
9 Mr. Shea.

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

12 MR. SHEA: Thank you.

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

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

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

24 JUDGE JAGDMANN: Okay.

25 MR. SHEA: I know Maine does it

1 every year.

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

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

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

9 JUDGE JAGDMANN: Welcome.

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

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

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

25 JUDGE JAGDMANN: Jonathan can help

1 you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the shrinking population is still a concern.
2 And some of the charts that showed that
3 earlier, particularly in the individual
4 market, you really saw the drop-off of
5 membership. I think the numbers were over
6 400,000 just a couple of years ago. They're
7 just over 300,000 last year. Now they will
8 continue to drop from the Medicaid expansion;
9 that might be sort of an outside reason, just
10 for that drop. But that's still a concern.

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

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

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

1 versus the -5.6 overall.

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

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

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

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

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

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

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

18 JUDGE JAGDMANN: Okay. Thank you.

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

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

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

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

25 As we look at our enrollment

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

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

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

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

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

7 Move to small group. Any more
8 questions on individual?

9 JUDGE JAGDMANN: No. Thank you.

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

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

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

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

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

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

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

17 JUDGE JAGDMANN: Okay.

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

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

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

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

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

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

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

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

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

22 That's all I had. Any questions?

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

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

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

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

21 Overall, from 2019 to 2020,
22 relatively minor plan design changes.
23 Really, the largest or the most meaningful
24 one is the increase in the out-of-pocket max
25 7,900 to 8,150.

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

10 Trend, based on the exhibit that was
11 shared earlier, we're towards the bottom of
12 the pack in terms of controlling the unit
13 cost that we experience for our members at
14 4.9 percent. On the other main items, risk
15 adjustment, we're expecting relatively the
16 same position as before.

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

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

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

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

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

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

19 And the final item, Other Change 2,
20 this is a combination of a few factors.
21 Really, the main driver here, though, is, as
22 David discussed in his presentation, when we
23 were pressing for 2019 rates, we were using
24 2017 experience. This year, we're using 2018
25 experience. So for us, we saw a very

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

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

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

21 JUDGE JAGDMANN: Okay. Thank you.

22 MR. HOFFMAN: Any questions?

23 JUDGE JAGDMANN: No. Thank you very
24 much.

25 MR. HOFFMAN: All right. Thank you.

1 JUDGE JAGDMANN: Optima?

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

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

18 JUDGE JAGDMANN: Thank you.

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

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

1 that.

2 JUDGE JAGDMANN: I have a paper
3 copy.

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

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

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

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

1 2018 plan experience. And Optima had
2 procured a significant amount of membership
3 during that plan year. And when we looked at
4 emerging 2019 enrollment, we actually saw
5 that that was coming down. And we looked
6 specifically at the members that were
7 retained by the company. And in fact, their
8 costs, in general, were higher compared to
9 the overall costs that were used in pricing
10 the prior year.

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

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

1 trend numbers average around 10 percent.

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

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

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

1 regions of the state vary in this regard.

2 There's not public information available on
3 that, nor any internal information on that.

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

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

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

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

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

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

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

1 questions.

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

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

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

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

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

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

5 MS. CHANCE: Yeah.

6 JUDGE JAGDMANN: Because it's high.

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

13 JUDGE JAGDMANN: Yeah, I think so.

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

17 JUDGE JAGDMANN: Okay. Thank you.

18 MS. CHANCE: Thank you.

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

23 JUDGE JAGDMANN: Okay.

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

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

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

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

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

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

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

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

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

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

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

13 JUDGE JAGDMANN: Some go up and some
14 go down?

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

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

1 there.

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

9 All right. We, of course, use the
10 same CMS prescribed age factors. We do not
11 have a tobacco load for small group. If you
12 notice, on our region factors, you can see
13 some big movement there. And this comes back
14 to the comment I made earlier about the
15 averaging. And you can see that the 1.075
16 factor, which is in regions 1, 3, 8, 11, and
17 12 -- I think I looked at that wrong. That's
18 where we were combining the regions together.
19 And as you pointed out before, you average
20 things together and they move.

21 JUDGE JAGDMANN: Right.

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

24 JUDGE JAGDMANN: No. Thank you very
25 much.

1 JUDGE JAGDMANN: Kaiser is next.

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

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

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

1 then come back to the components of the rate
2 change.

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

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

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

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

5 For other morbidity, we've got a
6 -14.1 percent change. And this is reflecting
7 that we've lost over half of the membership
8 of our pool. Those members have gone to
9 Medicaid expansion or to other carriers. And
10 so the makeup of the pool is just very
11 different now than what it has been.

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

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

1 allowable AV range.

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

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

12 All right. Small group. We have an
13 overall 4 percent increase request for small
14 group. Our most popular plan is a zero
15 deductible \$15 co-pay plan. No changes to
16 the out-of-pocket maximum of 2,500. And no
17 changes to the \$15 PCP co-pay. We've got
18 2,500 members in this plan. I should also
19 mention that we operate in areas 7, 10, and
20 12, and we don't vary rates. So it's the
21 same. So even though it says area 10 on
22 here, it's all of them. Then for our -- oh,
23 and we're asking for a 5.4 percent increase
24 on this plan.

25 For the minimum plan, we've got

1 3,000 deductible, zero percent co-insurance
2 HSA plan. The deductible did increase from
3 \$2,500. And so did the out-of-pocket
4 maximum, which went from 6,000 to 6,650. And
5 those increases are offset by a reduction in
6 co-insurance from 20 percent down to zero.
7 And we are asking for a .6 percent increase
8 on this plan.

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

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

18 MS. SCHROER: Pardon me?

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

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

25 JUDGE JAGDMANN: It is confusing.

1 MS. SCHROER: They like co-pays.

2 JUDGE JAGDMANN: Yeah.

3 MS. SCHROER: Okay. And we're
4 asking for 5.7 increase on this plan. So
5 going down to the components, we've got a 4.2
6 percent increase for morbidity, same 4.8
7 percent trend; a 4 percent increase on risk
8 adjustment. We have been growing in our
9 small group pool, and the pool is changing
10 quite a bit. So that's our best estimate of
11 risk adjustment at this point.

12 Return of the health insurer fee is
13 1 percent, and then a reduction of 4.2
14 percent for other non-benefit expenses. And
15 then benefit changes range from zero to -3.9
16 percent decrease. Again, that's because of
17 keeping in the AV range or just to get the
18 rate at the bottom end of the range to make
19 it more competitive. And then other changes
20 range from -4 to -5 percent roughly, and
21 that's driven by the margin load on the rate.
22 And that's all I have.

23 JUDGE JAGDMANN: Okay. Well, thank
24 you very much.

25 MS. SCHROER: Thank you.

1 JUDGE JAGDMANN: UnitedHealthcare.

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

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

18 So as you can see here, our overall
19 increase is 13.3 percent. I'll spend most of
20 the time talking about the most popular plan
21 column, because a lot of the other ones are
22 pretty similar to that. So you can see the
23 biggest single increase is the trend rate of
24 7.9 percent. And that's actually just our
25 approved 2019 trend, because this document is

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

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

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

1 there, too.

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

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

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

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

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

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

25 So I think that's all I had to

1 cover. Do you have any questions?

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

4 CareFirst?

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

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

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

1 population.

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

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

19 JUDGE JAGDMANN: Right. Those are
20 different benefits?

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

1 the template.

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

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

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

25 So those are the highlights. I'll

1 be happy to answer any questions.

2 JUDGE JAGDMANN: Thank you very
3 much.

4 MR. BERRY: Thank you.

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

7 MR. WHITE: Nothing, Your Honor.

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

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

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

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

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

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

17 JUDGE CHRISTIE: All right.

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

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

24

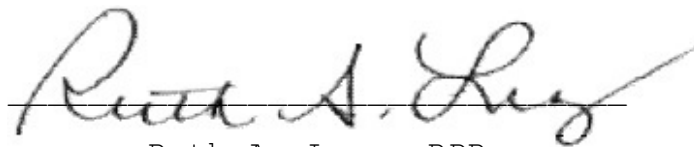
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I, Ruth A. Levy, RPR, do hereby certify that the proceedings were heard before me in the State Corporation Commission hearing herein; further that the foregoing is a true and accurate record of the testimony and other incidents of the hearing herein; 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

Transcript of Hearing
Conducted on July 18, 2019

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