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# Transcript of Hearing

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1

COMMONWEATH OF VIRGINIA
STATE CORPORATION COMMISSION

2021 PRESENTATION OF PREMIUM RATES

Virtual Meeting
Wednesday, August 11, 2021
10:00 a.m.

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Pages: 1 - 124
Reported by: Lori Roy, RPR, CCR

2

A P P E A R A N C E S:

JEHMAL HUDSON, COMMISSIONER
JUDY JAGDMANN, COMMISSIONER
ANGELA NAVARRO, COMMISSIONER

JULIE BLAUVELT, DEPUTY COMMISSIONER
DAVID SHEA, ACTUARY

WEN XU, KAISER REPRESENTATIVE
STEVEN GIORI, CIGNA REPRESENTATIVE
TIM J. CONNELL, ANTHEM REPRESENTATIVE
STEVEN C. SCHNEIDER, AETNA REPRESENTATIVE
GRAHAM SUTHERLIN, OPTIMA REPRESENTATIVE

TAYLOR MATHES, ORGANIZER

3

1 COMMISSIONER HUDSON: Good morning. I'm
2 Jehmal Hudson and I'm joined by my colleagues,
3 which is Navarro and Jagdmann, to convene the 2021
4 Presentations of Premiums Rates in connection with
5 the health insurance coverage issued in the
6 individual and small market groups in the
7 Commonwealth effective as of January 1, 2022.
8 As you know, under Virginia law, the
9 Commission must review and approve premium rates
10 and forms for the health benefits plan whether
11 they're offered on the Federal Exchange for
12 Virginia or whether they're sold off the Exchange.
13 The Commission must also perform plan
14 management functions required to certify health
15 plans for participation in the Federal Exchange,
16 and they are legal deadlines that govern our
17 process.
18 First, the U.S. Department of Health and
19 Human Services requires that the Commission's
20 Bureau of Insurance complete its review and
21 recommendations of health plans on their rates for
22 certification on the Federal Exchange no later than
23 August 18, 2021.
24 Second, Virginia law requires insurance
25 carriers to notify their customers of increases in

4

1 annual premiums or deductibles at least 75 days
2 before the proposed renewal of their health
3 insurance. That deadline for notifying customers
4 this year is October 18, 2021. To meet these
5 deadlines, insurance companies recently filed their
6 rates and forms for health insurance plans proposed
7 to be offered for use in Virginia as of January 1,
8 2022.
9 Given the importance of the cost of health
10 insurance to Virginians and small enterprises
11 conducting business in the Commonwealth, this
12 Commission has for at least the last decade
13 reviewed the health insurance premium rates and
14 associated deductibles before approving them for
15 use in the Commonwealth.
16 We are sensitive to the effect of health
17 insurance premiums and deductibles on our residents
18 and small businesses in normal times, and it could
19 be more so during COVID-19.
20 Today's presentations are part of our
21 review of the health plans offered for the purchase
22 in Virginia in the individual and small group
23 markets. We issued an order directing
24 presentations that instructed our Bureau of
25 Insurance to coordinate presentations by insurance

5

1 companies for the Commission, and the Bureau has
2 done this.
3 We are going to hear from insurance
4 carriers in the individual and small group markets
5 in Virginia who represent a significant percentage
6 of the projected insured in each market.
7 The Bureau will also participate today by
8 providing background in presenting a summary of the
9 recent Bureau activities and its review of the
10 latest rate and form filings for health insurance
11 plans.
12 We will hear first from Julie Blauvelt,
13 the Deputy Commissioner of Insurance for Life and
14 Health. Then we'll hear from David Shea, the
15 Bureau's health actuary who will discuss the
16 Bureau's review of the recent carriers' plans for
17 participation in the Virginia ACA marketplace.
18 Afterwards, the designated insurance companies will
19 provide presentations about their plans and rate
20 changes.
21 The insurance carriers submitted
22 presentation exhibits as a part of their rate
23 filings with the Commission. Copies of those
24 filings have been passed to the bailiff and will
25 become part of the record.

6

1 For each carrier presenting today, we ask
2 that you be prepared to speak to your rate filings
3 for plans on and off the Federal Exchange and for
4 plans in the individual and small group markets as
5 instructed by our Bureau of Insurance.
6 Today's proceeding is being held virtually
7 on Microsoft Teams. It is also being webcast to
8 the public. Members of the public who wish to
9 provide written comments on the filings discussed
10 as a part of the presentations may do so by
11 visiting the Commission's website and following the
12 instructions on how to submit your comments.
13 To today's presenters, we ask that you
14 speak clearly into your microphone and provide your
15 name and address, as well as who you represent, so
16 that the court reporter can transcribe accurately
17 the Commission's communications of this proceeding.
18 When not speaking, we also ask that you mute your
19 microphone to lessen the occurrence of interference
20 in the presentations.
21 Finally, should any presenter experience
22 technical difficulties during their presentation,
23 we ask that you contact the ITD coordinator, Bruce
24 Nichols, at (804) 371-9337 or at
25 bruce.nichols@scc.virginia.gov.

7

1 While Commissioners Jagdmann, Navarro and
2 I may have questions for the speakers, this is
3 neither an adversarial nor evidentiary proceeding,
4 and there is no swearing in of witnesses or
5 cross-examination.
6 Now, are there any preliminary matters
7 that the staff or presenters want to bring before
8 the Commission?
9 Hearing none, I will follow the order of
10 presentation provided to the Commission and call on
11 Julie Blauvelt, Deputy Commissioner of Insurance
12 for Life and Health, to be begin presentations.
13 Julie, you may again.
14 DEPUTY COMMISSIONER BLAUVELT: Thank you,
15 Judge Hudson.
16 I want to welcome everyone, as Judge
17 Hudson as done, to the 2022 Health Insurance Rate
18 presentations.
19 And we can go to the next slide.
20 So as Judge Hudson explained, the Bureau
21 of Insurance, which is part of the State
22 Corporation Commission, does review in its plan
23 management activities, review plans on the Exchange
24 and off the Exchange. We have -- the Bureau of
25 Insurance has performed plan management activities

8

1 for the Exchange ever since its inception back in
2 2014.
3 In 2021, the current year, this is our
4 first year of being a state-based Exchange,
5 although we are still using the healthcare.gov
6 platform, the Federal platform, so the change to a
7 state-based Exchange probably was not very evident
8 to consumers since we still use that platform, and
9 there aren't many changes.
10 But each year we do need to look at the
11 rates and the forms that are newly filed by the
12 carriers who proposed to participate in the market,
13 and this slide is showing the projected number of
14 carriers that have filed an application to be on
15 the Exchange in 2022.
16 So you'll see this, three more carriers
17 that have proposed to participate on the Exchange
18 in 2022 that are currently participating. There
19 are a couple of new carriers who have never
20 participated, and one carrier, Aetna Life Insurance
21 Company, who was participating -- has participated
22 on the Virginia Exchange before back in 2016 but
23 exited the market after 2016 and had to sit out
24 five years by law and are able to come back into
25 the market for 2022.

9

1 So the information that's going to be
2 presented in these slides is not final information.
3 You will hear the words "projected" and "potential"
4 a lot because we have not finally issued approval
5 on any policy forms or rates or plan designs. So
6 this is all still under review.
7 And I believe if there are not any
8 questions, we can move to the next slide.
9 Commissioner, before we move to the next
10 slide, I will say that it is very encouraging to
11 see that the level of participation has increased
12 over the past few years.
13 COMMISSIONER HUDSON: Can you tell quickly
14 about what are some of the identifying factors as
15 to that case?
16 DEPUTY COMMISSIONER BLAUVELT: I guess
17 potentially with a couple of the carriers that have
18 come into the market, I think it's part of maybe a
19 national decision by those carriers to come back in
20 to individual markets, you know, nationally. I
21 think there is less uncertainty than there has been
22 in years past.
23 And in particular, in Virginia, I think
24 possibly Virginia is particularly attractive to
25 some carriers because of the steps that it's taking

10

1 to stabilize the individual market, like setting it
2 up its own state-based exchange where there are
3 some flexibility to do things a little differently.
4 And just this past session, there was a reinsurance
5 program that was passed that we are working on now
6 to reduce the risk to the carriers in the
7 individual market, and also part of that same Bill
8 was discussion about possible subsidies to
9 encourage enrollment in the individual markets. So
10 I think for those reasons Virginia is particularly
11 attractive to carriers.
12 COMMISSIONER HUDSON: Thank you.
13 DEPUTY COMMISSIONER BLAUVELT: Okay. Next
14 slide.
15 Okay. This is information about the
16 filings as of July 28th that we've received, and
17 we, in the -- Virginia, in part of our plan
18 management process, we set a date whereby rates
19 cannot be voluntarily changed by the carriers and
20 service area cannot be voluntarily changed by the
21 service carriers.
22 So this map is based on information that
23 now cannot be voluntarily changed by the carriers.
24 The only changes that can happen are if for some
25 reason a carrier is not approved for a particular

11

1 service area or the carrier withdraws at some point
2 in time coming up. But for now, things look a lot
3 better in Virginia than they even did last year.
4 Last year we had about 40 percent of
5 Virginia localities that were the blue color, which
6 represents just one carrier in that market or in
7 that area. Now, we have less than a quarter of
8 Virginia that is represented by only one carrier on
9 the Exchange.
10 So to break this slide down a little bit,
11 and you'll look at the potentially new participants
12 in some areas, we see the Roanoke and Blacksburg
13 area has the potential for two new carriers coming
14 in for 2022.
15 And we see also in central Virginia,
16 there's been an increase in several carriers
17 possibly coming into that market as well. Some are
18 brand new carriers possibly to the Exchange and
19 some that represents an expansion of their service
20 area.
21 As far as southwest Virginia, I believe
22 this is the first time that we've had, you know,
23 coverage in that particular area by more than just
24 one carrier. So it's great to see all of the
25 expansion and happening in Virginia.

12

1 If there aren't any questions on that, I
2 will move to the next slide.
3 Okay. And once again, this is based on
4 projected information from the carriers for their
5 2022 projected. So this is looking at -- and maybe
6 at this point I will explain a little bit about how
7 we have come to the process that we are at now.
8 So in Virginia, today is the first day
9 that rates and form filings of carriers who want to
10 participate in the individual and small group
11 markets are publicly available. They are now
12 publicly available on our website, but up until
13 today, carriers and the public have not been able
14 to see these filings. So when a carrier submits
15 its information to us, they don't know, you know,
16 what new carriers are going to be coming into the
17 market or what carriers may be potentially
18 expanding into a market that they're in.
19 So we think that this process has -- the
20 way that we have arrived at this process, we think
21 that it allows for the carrier to present its best
22 and final offer. I guess, you know, with the
23 prospect of competition in the area, not knowing,
24 it kind of forces them to provide the best and
25 final offer. So as I said with the map slide,

13

1 there is no chance to change rates at this point.
2 So that was just a little aside for...
3 But going back to this slide where it was
4 showing the carrier participation in the projected
5 lives, other than the addition of several carriers
6 in the market we -- the biggest change probably
7 is -- HealthKeepers is projecting to have 47
8 percent of the market, and again this based on, you
9 know, information. They did not know who all was
10 going to be participating along with them in the
11 market. So that's up from 40 percent from last
12 year the HealthKeepers participation projections.
13 Also we had a couple of carriers pretty
14 drastically, I guess, reduce their projected
15 covered lives. Piedmont was one that increased its
16 projections to double their enrollment, and they're
17 one of the ones that expanded into southwestern
18 Virginia. So with the potential of expanding their
19 service area, they thought that enrollment would
20 also grow with that.
21 And let's see. I think -- I think that's
22 all that I was going to say on that slide unless
23 there are any questions about that.
24 COMMISSIONER JAGDMANN: Ms. Blauvelt,
25 I have one just for clarification.

14

1 DEPUTY COMMISSIONER BLAUVELT: Yes.
2 COMMISSIONER JAGDMANN: And I think you
3 said this, but I just want to make sure.
4 This is -- these are the companies' own
5 projections. They're not the Bureau's projections,
6 are they?
7 DEPUTY COMMISSIONER BLAUVELT: That's
8 correct. That's correct.
9 COMMISSIONER JAGDMANN: And we have
10 unnamed applicant. Is that -- at some point we'll
11 know who that is or --
12 DEPUTY COMMISSIONER BLAUVELT: Yes.
13 COMMISSIONER JAGDMANN: Were they not
14 named before the slide was prepared?
15 DEPUTY COMMISSIONER BLAUVELT: They are
16 a -- we have a carrier that is not yet licensed in
17 Virginia that has filed to participate on the
18 Exchange. So under our law, we can't reveal
19 anything about that carrier's application until
20 it's approved.
21 COMMISSIONER JAGDMANN: Understood. Thank
22 you very much.
23 DEPUTY COMMISSIONER BLAUVELT: Uh-huh.
24 We can go to the next slide if there
25 aren't any other questions.

15

1 Okay. This slide is a slide that came
2 from a study that Oliver Wyman did for us in
3 preparation for the application we have to submit
4 for our reinsurance program for 2023, but we
5 thought it was a good slide to look at the
6 enrollment numbers.
7 Enrollment -- looking at the enrollment
8 numbers in the individual market can be very
9 tricky. Enrollment changes quite a bit from the
10 beginning of a year to the end of a calendar year.
11 We see a lot of enrollment in the beginning when,
12 you know, open enrollment has just ended. But
13 then, you know, as people need to pay for the
14 policies, we see some enrollment drop off because
15 on the Exchange people are automatically enrolled
16 into plans. So people may be enrolled that, you
17 know, never really planned to actually have a plan
18 pay for it. So you have a lot of enrollment in the
19 beginning, and by the time you get to the end of
20 the year, enrollment really trails off.
21 But the way that these enrollment numbers
22 have been gathered, it is an average enrollment
23 throughout the entire year, except for the 2021.
24 It's year to date. So we think that's the best way
25 to show enrollment in the individual market is just

16

1 an average over the year.
2 Breaking down each one of these bars, you
3 can see that the lighter blue is the subsidized
4 population, the darker blue is the unsubsidized
5 population, and then we have the gray bar at the
6 top that is the grandfathered-in transitional
7 plans, and you can see how those change over the
8 year.
9 I think we know we've established in years
10 past in these presentations about the -- how -- how
11 the subsidized population has changed from 2018 to
12 2019 and how that's largely based on the Medicaid
13 expansion that occurred in 2019, and you can see
14 that the unsubsidized market has decreased quite a
15 bit over the years, and we think that's largely a
16 factor of, you know, high rates for the
17 unsubsidized population, especially in 2018 and
18 2019.
19 If we were to look back one year before
20 2018 at the unsubsidized market, which we'll see in
21 another slide, the total ACA market for 2017. But
22 in 2017, the unsubsidized market was double that
23 amount, about 134,000. So there was really a big
24 drop off in the unsubsidized market from 2017 to
25 '18 because of the high rates.

17

1 Looking to the 2021 figures that we've got
2 there, we see the unsubsidized people coming back
3 into the market a little, and I should explain as
4 well that the 2021 numbers that are taken here,
5 that is through the end of March. So it does take
6 into affect the special enrollment period that
7 began in February 15 -- February 15 of this year
8 for COVID. But it does not take into effect any of
9 the American Rescue Plan subsidies at this point.
10 So we're not seeing, you know, a big
11 increase in the subsidized market, but if we were
12 to look further at projections that we've just
13 received from Oliver Wyman, I think it would show,
14 you know, that for the rest of this year and for
15 2022, we are going to see a big shift in the
16 unsubsidized population.
17 So for 2022, that's probably going to
18 decrease by about half of what it is right now, and
19 also we project to get about 30,000 more subsidized
20 enrollees that are not in the ACA market currently.
21 So I think that is what I had prepared to
22 talk about on this slide. If anyone has any
23 questions, please let me know. If not -- yes.
24 Judge Navarro, did you have a question?
25 I'm sorry. I can't hear you. Okay.

18

1 Okay. We can move to the next slide.
2 Okay. This slide shows enrollment and
3 average premium per member per month. And you'll
4 see there are a couple of ways that we're looking
5 at premium. There's a little difference between my
6 premium slide and David Shea's premium slide when
7 he's going to talk -- when he has his presentation
8 later.
9 My premium slide here is based on the
10 actual amount, you know, taking the revenue that
11 carriers brought in, divided by the member months
12 that they had over the year. So this shows the
13 premium of, you know, what a person -- the plan
14 that a person actually purchased where -- in
15 comparison to, you know, the average approved
16 rates.
17 So looking at this slide, you can see in
18 2017 when rates were around $400. We had a large
19 amount ACA market, and as I talked about with the
20 previous slide, the subsidized population was about
21 134,000 of that 390,000 in 2017.
22 You can see, you know, the drop off
23 through the years down through 2020 in enrollment
24 as premiums are increasing, and then as we talked
25 about in the previous slide with Medicaid expansion

19

1 in 2019, that accounted for a lot as well.
2 If you look at the 2021 premium number,
3 you can see that it is slightly higher than the
4 2020 number, and this is -- shows a little bit of
5 the difference that I was talking about and what
6 David is going to discuss because the approved
7 rates actually showed a decrease in premium for
8 2021 on average, but this slide is showing that per
9 member per month the premium was actually a little
10 more in 2021 or so far in 2021 in ways than it was
11 in 2020.
12 You know, just speculating, I think this
13 could be that that means the plans that were
14 purchased were higher premium than, you know, what
15 showed as an average premium. That could be the
16 age of the population, since older consumers will
17 pay more in premium because they can -- carriers
18 can rate that way, or it could be the value of the
19 plan that's purchased has higher value or the areas
20 of the state that people are purchasing these plans
21 are higher cost areas of the state.
22 And then the estimate for 2022, we can see
23 that as estimated, the rate will decrease -- is
24 estimated to decrease quite a bit.
25 Yes.

20

1 COMMISSIONER JAGDMANN: I'm just going to
2 ask a question. Now, you're talking here about
3 premium, the amounts -- I guess, the cost, not the
4 amount collected, or is this the amount collected?
5 DEPUTY COMMISSIONER BLAUVELT: This is the
6 actual premium, and actually -- but this is -- if
7 you take a carrier's total revenue for a year and
8 divide it by the member months, that's how we
9 arrive at this number.
10 COMMISSIONER JAGDMANN: So if a person,
11 you know, let's say went on the Exchange and
12 selected a policy and paid for three months, how
13 would that affect this number, and then dropped
14 off? Would that affect this number at all, or are
15 you just looking at the people who purchased a
16 policy and -- just trying to make sure I understand
17 what the data is.
18 DEPUTY COMMISSIONER BLAUVELT: Right. So
19 the revenue that person would have paid for three
20 months, you take that revenue and you divide it by
21 those three months. So it would be their average
22 premium for those three months.
23 COMMISSIONER JAGDMANN: Got you. Thank
24 you.
25 DEPUTY COMMISSIONER BLAUVELT: Another

21

1 thing I did want to -- thank you, Judge Jagdmann,
2 because there was another thing I wanted to talk
3 about on this slide, and that is that the average
4 amount, this is before any ARPA subsidies came into
5 effect, the average amount that a subsidized person
6 pays for their premium is about 16 percent of these
7 amounts. That's 1/6, 16 percent of these amounts
8 is what the average subsidized person pays in
9 premium.
10 Okay. We can go to the next slide, if
11 there aren't any questions.
12 So this is looking at the small group
13 market enrollment and premium, and most of this
14 presentation is focused on the individual market,
15 but we do have this slide in just to kind of show
16 the small group market and how that's going. It's
17 not, as you can see, as volatile in premium change
18 or membership change as the individual market.
19 So, you know, premium is steadily rising
20 and enrollment decreasing some, but for 2022 it's
21 projected to increase some.
22 We did -- in Virginia, we did have a law
23 that came into effect in 2018, I believe, for -- to
24 be able to allow sole proprietors who under federal
25 law should be only covered by individual coverage

22

1 but allow them to participate in a small group
2 market. Though, you know, possibly that's a reason
3 for some of these exits in the small group market,
4 but possibly, you know, especially during this
5 time, some employers are not offering small group
6 coverage or have found other types of coverage
7 rather than ACA comprehensive policies.
8 If there aren't any questions, we can go
9 to the next slide.
10 We discussed some about the American
11 Rescue Plan. So here are some figures and points
12 of interest about the American Rescue. One thing I
13 do want to highlight and make a plug for, I guess,
14 is the special enrollment period because that's
15 going to be ending very soon, in four days. So
16 that has been open for people to enroll in ACA
17 coverage. Like I said, that's going to be ending,
18 and the next chance to enroll in an ACA plan
19 without a qualifying event will be in November 1st
20 when -- for the 2022 plan year.
21 Also the big thing that we know that was
22 instituted with the American Rescue Plan were the
23 subsidies. The increased subsidies are available
24 to people for years 2021 and 2022.
25 So for current enrollees on the Exchange,

23

1 if they wanted to take care or take advantage of
2 those subsidies, they were able to April 1. Also
3 new enrollees could come on and take advantage of
4 those subsidies April 1. For people who were on
5 the Exchange, you know, since January, those
6 subsidies will be retroactive back to the
7 beginning. I understand when they file their
8 taxes, they will be able to collect those extra
9 subsidies.
10 Also, households with people who, for any
11 week during 2021, received unemployment, they can
12 receive coverage equal to 133 percent of federal
13 poverty level, and that means that free coverage is
14 available for anyone who collected unemployment for
15 any week in 2021, and that coverage that they
16 obtain is the highest level of coverage, 94 percent
17 AV value. So that's even higher than a platinum
18 plan as far as cost sharing -- you know, the lowest
19 cost share plans that are out there.
20 Also, COBRA premiums are fully subsidized
21 through September of 2021, and anybody who had
22 excess marketplace subsidies that they may have
23 owed back for 2020, they're not required to repay
24 those subsidies.
25 Any questions on that slide before we move

24

1 to the next slide? Okay.
2 Here are some actual affects of those
3 subsidies and the plans that were instituted. So
4 nationally we've seen 34 percent of new and
5 returning customers being able to select a plan for
6 $10 a month or less.
7 And actually in Virginia, the last bullet
8 point there, we've seen 33 percent of those new and
9 returning customers being able to select a plan for
10 $10 or less. So very close to the national average
11 in Virginia. The average monthly premium after
12 APTC funded consumers those tax credits, advanced
13 tax credits is 25 percent less.
14 Returning consumers can reenroll to lower
15 their premium on the Exchange by 40 percent on
16 average, and we have seen, you know, people using
17 their tax credits to actually go on and choose more
18 robust plans because the median deductible has
19 fallen by about 90 percent.
20 And in Virginia, we've seen a increase of
21 over 40,000 members, consumers selecting new plans
22 since the start of the special enrollment period on
23 February 15th.
24 And if we look at special enrollment, that
25 period during that same time frame last year,

25

1 which, of course, there wasn't the broad COVID
2 special emergency period, but it could come on for
3 other types of special emergencies, that number
4 compares 16,662 from last year.
5 COMMISSIONER JAGDMANN: Ms. Blauvelt, if I
6 may, I noticed in the presentations that a lot of
7 the -- you know, the deductibles tend to be very
8 high in these examples that we've chosen, and I
9 noticed you mentioned the median deductible fell by
10 almost 20 percent. Now, these are just examples
11 that we're seeing. It doesn't mean that every plan
12 these companies have has a 6,000 deductible, does
13 it? I mean, just for the record, there are plans
14 with lower deductibles?
15 DEPUTY COMMISSIONER BLAUVELT: Yes, that's
16 right.
17 That means that, you know, people are
18 choosing to -- when they want to use their
19 subsidies, they could either purchase that second
20 lowest cost silver plan for their subsidy, or they
21 can use their subsidy to purchase some more robust
22 plan.
23 You know, maybe they were paying $50 a
24 month before ARPA. With ARPA, may they could get a
25 free plan, but maybe if they still want to continue

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1 paying that $50 a month, that would get them a plan
2 with much less cost sharing. So we've seen that
3 happening that they -- the median deductible is
4 going down so people are choosing more robust
5 plans.
6 COMMISSIONER JAGDMANN: Thank you.
7 COMMISSIONER HUDSON: Ms. Blauvelt, if we
8 can stay on the Virginia bullet points. It seems
9 to me that, you know, it's very encouraging that
10 the increase in enrollment of the Exchange during
11 the special enrollment period looks very good, and
12 I know, you know, the Bureau of Insurance is
13 working very closely with the HPE director,
14 Victoria Savoy, in putting up our own Exchange.
15 And I guess my question is, if you can
16 answer it, what are some of the advantages when you
17 compare a state-based Exchange to the federal
18 Exchange, and what are some of the challenges.
19 DEPUTY COMMISSIONER BLAUVELT: Yeah, sure.
20 Definitely some of the advantages are
21 being able to -- you know, not just the State
22 Corporation Commission, but opening it up and
23 having discussion with other stakeholders, everyone
24 who is affected by the Exchange, consumers, the
25 carriers, the providers, all of the community that

27

1 has something to do with the Exchange, definitely
2 the navigators, the consumer service
3 representatives, all are able to fully participate
4 and have a discussion about things that we see that
5 we may want to change.
6 In the interim part, when we're on the
7 federal Exchange, we have less ability to make
8 changes. Like, for example, if we wanted to
9 increase the open enrollment period, you know, or
10 change the open enrollment period, we don't really
11 have that option on the federal platform, which we
12 will when we move to a fully state-based Exchange.
13 But as far as consumer outreach, you know,
14 we have more ability to work with the navigators
15 and to require certain information from the
16 navigators and get more information about the
17 people who are participating on the Exchange, the
18 consumers who are on the Exchange.
19 So I think, you know, all those factors
20 can really be helpful as we move forward and as we
21 try to look at potentially subsidies. Whether the
22 state's going to offer subsidies to people on the
23 Exchange is certainly helpful to have all of that
24 information available to us so we can make informed
25 decisions about what we want to do going forward.

28

1 I think, you know, one of the challenges
2 is -- and I know all states have run into this, I
3 guess, with their state-based Exchanges -- is, you
4 know, wanting to offer one door that everybody can
5 come through, you know, whether it's someone who
6 may be eligible for Medicaid versus someone who can
7 receive subsidies versus someone who can't, but
8 anyone can come to that one door.
9 You know, states have found it a little
10 difficult and much more, you know, of a job, I
11 guess, to try to coordinate the activities between
12 the Exchange and Medicaid. Whereas right now, you
13 know, I think -- I think with the federal Exchange,
14 there is more opportunity, but -- but once we get
15 passed that hurdle, I think there will be, you
16 know, better advantages.
17 COMMISSIONER HUDSON: Great. Thank you.
18 DEPUTY COMMISSIONER BLAUVELT: Okay. We
19 can move to the next slide.
20 This is a chart from the Kaiser Family
21 Foundation that kind of breaks down the subsidies
22 that we've been talking about, the increased
23 subsidies with ARPA.
24 So you can see that there is opportunity
25 for, you know, zero cost to people in the 100 to

29

1 150 federal poverty level, and also what we've been
2 hearing about is a big opportunity for over people
3 over 400 percent of federal poverty level who
4 previously were not eligible for any subsidies.
5 Now their cost will be limited or is limited to
6 eight and a half percent of their premium.
7 Nationally, the figures are that about 29
8 -- that there are 29 million uninsured, and the
9 figures that we've seen, about half of that number
10 will now be able to get coverage for absolutely
11 free, and about five million more nationally will
12 be able to get coverage with the subsidy when they
13 weren't able to have a subsidy prior.
14 So about a third of that 29 million
15 uninsured number still will not be able to get
16 coverage either because they're in a state who
17 hasn't expanded Medicaid, you know, where no
18 subsidies are provided under 100 percent, or for
19 some other reason they aren't eligible to get
20 individual coverage on the Exchange.
21 If there aren't any questions, we can move
22 to the next slide.
23 This just breaks down and takes a little
24 closer look at the ARPA subsidies and kind of how
25 they can advantage some people.

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1 So if we look at someone who is just over
2 the 400 percent federal poverty level, and that
3 works out to about $52,000 a year, and we're
4 looking at a person age 24 versus a person age 64,
5 because as we discussed a little bit in the
6 beginning, the carriers are able to rate a consumer
7 who is age 64 years old three times higher than
8 someone who is 21 years old.
9 So if a premium, annual premium, for this
10 24-year-old person is 4,233, and the ARPA subsidy
11 at eight and a half percent of their income is
12 about 4,420, so they do not even, you know, each
13 the subsidy level, so they would have to pay their
14 entire primary, that same person or a different
15 person that makes the same amount, $52,000 a year
16 just above the 400 percent mark, they're age 64, so
17 their premium is three times that of the 24 year
18 old.
19 They can stand to gain substantial
20 subsidies under ARPA. But using that same
21 threshold of the eight and a half percent, you can
22 see the amount of subsidies they are able to
23 obtain.
24 And if we take an example of -- look at a
25 person in the Richmond area, we look at the second

31

1 lowest cost silver plan, which is what those
2 subsidies are based on, and that 64 year old's
3 premium for a month is $939. The -- previously
4 where they got no subsidy with the ARPA subsidies,
5 with using the cost of that silver plan and the
6 eight and a half percent that they would pay, they
7 would be eligible for a 570-dollar a month subsidy
8 on that $939 premium.
9 So that's just a little example to kind of
10 break down how these subsidies are helpful.
11 If there aren't any questions, we can go
12 to the next slide.
13 Okay. There have been some other proposed
14 federal changes as well, and a couple of them that
15 I wanted to talk about today were in the third
16 round, the most recent round, of the updates to the
17 notice in 2022, Notice of Benefit and Payment
18 Parameters.
19 One of those proposed changes that we
20 still haven't seen the final change, but was to
21 extend the open enrollment period, the annual open
22 enrollment period, which usually ends December
23 15th, extend that for this year to January 15 so an
24 extra month. Mainly, the reason for that or the
25 purpose for that is to allow people who are

32

1 automatically enrolled in a plan, if they find --
2 you know, if they get into January, they see their
3 premium and their subsidy for that plan and they
4 realize they -- you know, they didn't want to be
5 enrolled into that plan and they want to make a
6 change, so that allows them a little time period to
7 make that change.
8 We know that the America Association of
9 Health Insurance Plans did make a comment that, you
10 know, these changes to the special enrollment
11 period have the potential to destabilize Exchanges
12 with bringing in sicker populations. And I think
13 their proposal was to possibly, you know, institute
14 a targeted special enrollment period for people who
15 do have that problem that, you know, realized after
16 they got enrolled their plan wasn't what they
17 expected it to be.
18 And I think, you know, there are also some
19 concerns with having a monthly special enrollment
20 period as well. I think the reason for having a
21 special -- monthly special enrollment period for
22 150 percent of federal poverty level or less is
23 because that population may not have as much access
24 to know about the annual special enrollment period
25 and, you know, may miss that opportunity to enroll,

33

1 and we definitely, you know, want to have as many
2 consumers enrolled as can be. So I think that was
3 the thinking there for proposing that monthly
4 special enrollment period.
5 If there are not any questions, then we
6 can move to the next slide.
7 All right. In the beginning, we also
8 talked about some initiatives Virginia is
9 beginning, and one of them is the reinsurance
10 program that was passed in this last General
11 Assembly session, and it directs the State
12 Corporation Commission to develop a 1332
13 Reinsurance Waiver Application for the plan year
14 2023.
15 And the way that -- the way that, you
16 know, we would be able to receive federal funding
17 for this program is that there is less risk to the
18 carriers if you have a reinsurance program. So the
19 carriers would be expected to reduce their premiums
20 because of the less risk. Because carriers are
21 reducing their premiums, that means the federal
22 government needs to pay less in subsidies.
23 So what states have done is ask for the
24 federal government to pass through that amount that
25 they would have paid in state subsidies to the

34

1 states to be able to reimburse carriers for high
2 cost claims. So that's kind of that circle of how
3 reinsurance program works.
4 We are -- you know, have been working with
5 Oliver Wyman in studying the individual market,
6 getting information about the individual market to
7 model out what the state costs would be to figure
8 out how much of a premium reduction we might be
9 able to see in 2023 and to submit our application.
10 A draft of the application we plan to have
11 by October 1 and have a public comment period on
12 that application before the final application is
13 submitted January 1.
14 Also, I can mention under that same House
15 Bill 2332 that directed us to do the reinsurance
16 program, it also -- there's a working group that's
17 involved in looking at potential for providing
18 state subsidies, and we will issue a report in the
19 fall of this year on that as well.
20 Okay. If there aren't any questions, we
21 can move to my last slide, and then we'll move on
22 to David's slide.
23 So overall, I think it's encouraging
24 seeing the extra participation in the market,
25 carriers expanding their areas so we have more

35

1 choices to Virginia consumers in the individual
2 market. Rates appear to be going in the right
3 direction and declining on average, and our
4 unsubsidized market was growing, you know, before
5 the ARPA subsidies. Of course, that will change
6 because of the ARPA subsidies. So we'll have less
7 unsubsidized people.
8 The small group seems to be, you know,
9 moving along. Small group market seems to be going
10 along very nicely as well. So we think that
11 Virginia -- you know, the initiatives that Virginia
12 has taken, along with the national initiatives,
13 have been helpful in increasing the number of
14 consumers who are participating on the Exchange and
15 in the individual market.
16 I think, unless there are any other
17 questions, we can move into David Shea's portion of
18 the presentation.
19 ACTUARY SHEA: I'd like to thank Julie and
20 good morning, Judges.
21 I've got a few slides that I'll provide
22 some commentary on and certainly stop me along the
23 way if you've got any questions.
24 Julie kind of mentioned some of the key
25 dates we had this year. Initial rates were due to

36

1 the Bureau May 21st, and our deadline to submit QHP
2 recommendations is next Wednesday. We also
3 complete our non-QHP reviews on the same date,
4 although we technically have a little bit more
5 time.
6 The review process is the same for both.
7 So we usually get them all done at the same time.
8 And as mentioned earlier SERF was turned off April
9 1st and just turned back on today so that the
10 public can see all of the contents of the rate
11 filings.
12 And July 15th was a deadline for carriers
13 to submit voluntary service area and voluntary rate
14 changes. After that date, any change they make
15 must be at the request of the Bureau.
16 Next slide.
17 COMMISSIONER JAGDMANN: David --
18 ACTUARY SHEA: Yes.
19 COMMISSIONER JAGDMANN: -- before you
20 leave, if I may ask a clarifying point, on THAT
21 second bullet, the public assess was suspended not
22 to not deny public access but to promote definitive
23 pricing, was it not?
24 ACTUARY SHEA: Oh, yes. Absolutely.
25 COMMISSIONER JAGDMANN: You know, I just

37

1 wanted to clarified that.
2 ACTUARY SHEA: Yes. It's not that, Oh, we
3 never want the public to see this, is we just want
4 everybody to put their best rates forward, and
5 that's one of the best ways to do that is just
6 basically turn the lights off, and then the lights
7 got turned back on today.
8 COMMISSIONER JAGDMANN: Thank you.
9 ACTUARY SHEA: Next slide.
10 This slide is the same slide that we had
11 last year. COVID-19 is far and away the biggest
12 pricing challenge that carriers had this year, as
13 it was last year. It basically eclipsed every
14 other kind of assumption they had to make.
15 So let's go to the next slide to provide a
16 little bit more -- a little of bit high level on
17 what happened. Last year COVID-19 was the biggest
18 challenge in pricing, but they did -- most
19 carriers -- I mean, every carrier didn't have a lot
20 of information.
21 Basically, when they filed their rates
22 near the end of May, the pandemic had really just
23 started to pick up steam and places were closing.
24 So at the time they filed their rates, they
25 acknowledged -- the majority of the carriers

38

1 acknowledged that they had no information to go on
2 to determine what impact COVID-19 would have on
3 their business, and so the majority of carriers in
4 last year's filings made no change in their rates
5 due to COVID-19.
6 This year, however, one carrier, one
7 carrier was the sole one that didn't include any
8 impact for COVID-19, and each carrier is going to
9 mention during their presentations the impact that
10 COVID-19 has had on their rates for 2022.
11 In the individual market, the COVID-19
12 impact ranged from about seven-tenths of a percent
13 to 22 and a half percent. Now that's a pretty wide
14 range, and when these slides were put together,
15 some of our filings were still under review. Those
16 numbers will change a little bit.
17 But a key takeaway here is the average
18 rate change in the individual market was minus 1.7
19 percent. If you remove the impact of COVID-19, it
20 went down another 5 percent. So basically COVID-19
21 impacted average rates about 5 percent in the
22 individual market.
23 In small group, it was somewhat similar,
24 not as much of an impact, and again carriers will
25 speak it to this individually when they make their

39

1 presentations.
2 Are there any questions on this before we
3 move on?
4 COMMISSIONER HUDSON: Mr. Shea, I do have
5 a couple of questions.
6 ACTUARY SHEA: Uh-huh.
7 COMMISSIONER HUDSON: The first one is I
8 know that we don't regulate providers --
9 ACTUARY SHEA: Right.
10 COMMISSIONER HUDSON: -- but I just wanted
11 to know what kind of impacts did COVID have on
12 providers, especially when it comes to the effect
13 of providing reimbursement rates?
14 ACTUARY SHEA: Got you.
15 You know, it's probably -- it will
16 probably be better if some of our presenters speak
17 to that. I can only go on certain anecdotal
18 information, and, you know, certain things that we
19 heard were like some providers were working on or
20 trying to get a little bit more money because they
21 were -- had to shut down for so long, and there was
22 a financial impact. And also there was some move
23 to telehealth during COVID-19, and I'm hoping that
24 maybe one of the carriers could bring that up
25 today.

40

1 But it's a little bit uncertain as to what
2 direct impact it has had. They probably are still
3 in negotiations, and unfortunately a lot of the
4 providers are starting to see another wave of
5 increased admissions due to the pandemic. So I
6 guess the jury is still out, but the carriers who
7 are presenting are much more well suited to speak
8 to that.
9 COMMISSIONER HUDSON: Great. And we
10 definitely touched on my second question. I hope
11 that the carriers can actually talk about not only
12 the impacts of COVID on their reimbursement rates,
13 but also with telehealth as well that during the
14 pandemic I would like to hear exactly what have
15 been some of the advantages and impacts as well.
16 So I hope they actually speak to it as well.
17 Thank you.
18 ACTUARY SHEA: Okay. Great. Thanks.
19 Next slide. We put this together every
20 year. This is kind of like basic health insurance
21 pricing. Carriers have to try -- one of the basic
22 things they need to try to figure out is how much
23 their costs, their claims costs are changing from
24 the period they're looking at to the period they're
25 looking toward.

41

1 And one of the basic elements of health
2 insurance pricing is called trend, and that is the
3 change in the cost of services and the change in
4 the usage or utilization of services over time.
5 These changes should not reflect any type of plan
6 design changes. There's no deductible impacts in
7 here at all. There's no impact on whether a
8 carrier's population is getting less healthy or
9 more healthy. There's no demographic changes.
10 This is supposed to be what's known as the secular
11 trend, the underlying change in cost and
12 utilization for those services that a healthcare
13 carrier sees coming in from their providers and the
14 usage for their customers.
15 Generally -- this year is a teeny -- a
16 little bit of an exception. It's interesting.
17 Generally, all of these carriers are doing
18 independent analyses of their business, and the
19 changes they're seeing, but generally what we see
20 is when you roll them all up together, they end up
21 with a fairly tight range.
22 Over the last few years, if you look at
23 the column on the right-hand side under total, you
24 will see numbers just for our four presenters to --
25 five presenters today, but four of them have

42

1 experience in the Virginia market, and you will see
2 that with one notable exception, that the trends
3 are in the range of four to seven or eight percent.
4 That's generally the way it has been for the last
5 few years. And generally speaking, the cost
6 changes are usually greater than the utilization or
7 usage changes.
8 Looking at things this year, again this
9 goes back to the impact of COVID-19, it has really
10 caused a little bit of consternation in what
11 carriers are trying to analyze as far as their
12 trends go, because particularly last year in 2020,
13 for several months, starting around March or April
14 and then probably going into the summer, carriers
15 experienced a lot fewer claims than they had in the
16 past, and, of course, we all know why. But that
17 gets to make it very challenging to figure out.
18 So how am I going to project my claims
19 next year if I'm missing some this year. So
20 they've had to make quite a few adjustments for
21 that. That comes into that COVID impact I talked
22 about earlier.
23 These trends are supposed to be pure and
24 simple trends. Let's take all of the noise out and
25 figure out what is our underlying costs and usage

43

1 of services trend looking into 2022. And again, by
2 and large, these are all independent analyses by
3 different companies, but they all fall within a
4 rather tight range.
5 And if there are -- yes.
6 COMMISSIONER NAVARRO: I'm glad you can
7 hear me.
8 I just have a clarifying question about
9 what you're saying. So is it that perhaps
10 individuals are putting off certain types of
11 medical treatment during this pandemic that
12 carriers might have to forecast going forward? Is
13 that sort of what you're alluding to on the
14 utilization side?
15 ACTUARY SHEA: Yeah. In this case, as far
16 as what we'll called suppressed utilization, folks
17 couldn't have services done because frankly the
18 places were closed, and most places did away with
19 nonemergency surgeries. Elective surgeries pretty
20 much didn't go on for a few months during last
21 year.
22 So carriers tried to -- had to figure out,
23 okay, so what claims am I missing under a normal
24 environment, and how can I figure out what was
25 missing, so I don't -- I don't want to increase a

44

1 number that I know is too low going into the future
2 because I'm going to see some additional services.
3 Some of those services that are foregone
4 are probably not going to come back. For example,
5 I know someone who goes to a dermatologist every
6 three months. Well, they had to miss two of their
7 three-month appointments, but they're not going to
8 go back and do two more three-month appointments.
9 They're just going to move on.
10 There are other things that got delayed
11 that are going to happen. And so again COVID-19,
12 very big pricing challenge for carriers.
13 These numbers that we're looking at here
14 are what some folks in the industry would call
15 normal run rate. It's like taking all the noise
16 out. What is just your general increase in the
17 cost of medical services and the usage of medical
18 services by those four places of treatment:
19 Inpatient on the hospital side, outpatient on the
20 hospital side, physicians and prescription drugs?
21 Those are the four big categories.
22 And so what they want to try to do is
23 outside all of that noise, what's my general
24 increase in claims cost from one year to the next?
25 And that's what these numbers represent.

45

1 Does that help?
2 COMMISSIONER NAVARRO: Yes, thank you.
3 ACTUARY SHEA: Sure.
4 COMMISSIONER JAGDMANN: David, if I may,
5 would inflation be factored into trend?
6 ACTUARY SHEA: Not the inflation that you
7 generally think about and hear about on the news.
8 This is the increase in the use of medical
9 services, the cost of medical services and the
10 usage of medical services. Totally -- I mean, yes,
11 the medical care component of CPI, we know what
12 that is. But in one sense, the way that generally
13 works is on the medical CPI is you take a certain
14 market basket of services, and you say all of those
15 services, what's going to be the change in the cost
16 of those services or what has been the change in
17 those cost of services that we've seen.
18 Well, for health insurance carriers, they
19 don't look at a market basket because they know
20 that there's going to be a shift in services from
21 maybe a less costly type of treatment to a more
22 costly type of treatment or vice-a-versa. The
23 regular inflation rate, and particularly the
24 medical CPI, doesn't measure things like that. It
25 fixes things and says, what increase in those

46

1 things did we see?
2 Another major difference is the CPI
3 numbers, the inflation numbers you see, they are
4 always historical. These numbers here are
5 projected. They are looking at what they've seen
6 in the past, and they're anticipating what they
7 will see in the future. So that's another big
8 difference here.
9 COMMISSIONER JAGDMANN: Well, is inflation
10 picked up anywhere? It's got to be picked up
11 somewhere.
12 ACTUARY SHEA: Well, inflation, if you
13 want to think about just pure inflation, you would
14 look at the cost. But again inflation in the
15 medical care universe -- and I think we can
16 probably all agree, inflation in medical care has
17 been -- has largely out pasted over all inflation
18 for many, many years.
19 COMMISSIONER JAGDMANN: Correct.
20 ACTUARY SHEA: And generally, one other
21 element that isn't necessarily reflected in
22 inflation is usage of services.
23 For example, in the -- one of the ways to
24 calculate regular CPI or the inflation rate, if
25 there is a sale on Pepsi products over the next

47

1 three months but the inflation rate is based on
2 Coke products, it will not reflect the shift from
3 going from Coke to Pepsi. It won't reflect that.
4 It will just say, well, what's the change in Coke
5 then? It will reflect the fact that people's
6 behavior is changing. So there's a little bit of
7 behavior change in here.
8 What mix of services do we think they're
9 to be using compared to what they used today, and
10 how are they going to use those services?
11 Does that help?
12 COMMISSIONER JAGDMANN: And I guess they
13 already know what their contracts are with certain
14 providers anyway. So that --
15 ACTUARY SHEA: Yes, they absolutely know
16 what the contracts are, but what they have to
17 monitor is, I know I'm going to pay dollar amounts
18 for all of these services.
19 COMMISSIONER JAGDMANN: Right.
20 ACTUARY SHEA: But I know that when people
21 come in to use these services, that's -- the mix of
22 those is going to change over time. So I need to
23 start reflecting that, and I also need to start
24 reflecting the fact that of those services, there
25 is going to be certain ones that get used more

48

1 than, and we're going to see higher utilization and
2 higher changes in that. So that's what they have
3 to look for.
4 COMMISSIONER JAGDMANN: So this is really
5 the trend. This is the projections of things that
6 are really more difficult that you have to predict.
7 You don't have to --
8 ACTUARY SHEA: Yeah. And you know
9 what's -- it's funny you mentioned difficulty in
10 predicting trend. I would argue that most health
11 insurance carriers these days, particularly the
12 ones that are operating in the ACA market, they've
13 been doing trends for so long that several -- a lot
14 of carriers have fairly sophisticated systems that
15 analyze what their trends are, but when you throw
16 in COVID-19, when you throw in risk adjustment and
17 how carriers have to figure out how their
18 population is changing relative to the average in
19 the state -- now I'm not saying analyzing price and
20 trends is a walk in the park, but compared to all
21 the other things, some of the other things they
22 have to analyze for the ACA...
23 Oh, another challenging one. The affect
24 of ARPA on folks' business, because they've never
25 seen that before. And so they're like, wow, we've

49

1 never lived in a world where subsidies have greatly
2 increased and where open enrollment periods are a
3 lot more frequent than they used to be.
4 That's a challenge to try to figure out
5 how is that impacting your business, but when you
6 talk about just these normal trends, the carriers
7 are like, yeah, once I get all the noise out, I
8 think I've got a pretty good idea of what my trends
9 are.
10 Does that help?
11 COMMISSIONER JAGDMANN: It does. Thank
12 you.
13 ACTUARY SHEA: Sure.
14 Okay. If we want to move to the next
15 slide.
16 What you are looking at here is lost ratio
17 experience in the ACA market in Virginia.
18 Individual is the blue column, small group is the
19 orange, and lost ratios is simply the ratio of
20 claims to premium.
21 One thing you can kind of tease out, if
22 you look at the orange bars, similar to what Julie
23 showed on the average rates, pretty steady over
24 time, not a lot of variation, not very volatile at
25 all. In fact, in some ways it's rather remarkable

50

1 that those numbers are so close year after year.
2 One of the main reasons why that's the way
3 small group is, is the ACA really did not change
4 the small group market much at all. In Virginia,
5 primarily, and in many other states, the changes
6 made in small group were relatively small compared
7 to how the market operated.
8 The change in individual -- the individual
9 market, however, was substantial. And so what you
10 had there was again carriers were coming into a
11 market that most of them were not familiar with.
12 Particularly you had to enroll everybody that
13 showed up at your door, and you couldn't charge
14 them a different premium based on their health
15 status. That's probably one of the biggest changes
16 in the individual market.
17 So it got to be very challenging for
18 carriers in that market to try to estimate what
19 their world will look like in this new environment.
20 And what the result of that is, the first few years
21 of the ACA, which we're going to say that
22 started -- for the individual and small group
23 market, that started in 2014. That's the first
24 year that carriers had to offer health insurance
25 coverage.

51

1 So if you think about rolling the clock
2 back, in 2014, carriers had to submit their rates
3 in May of 2013. So they didn't even know what
4 their year 2013 looked like. They had to look back
5 to 2012, which wasn't terribly helpful because that
6 wasn't the market they're going to be in.
7 So they were kind of flying blind for the
8 first two or three years in the individual market
9 because it takes a couple of years for you to
10 really figure out what -- when you look in the
11 rearview mirror what actually happened.
12 The reason why that 2017 loss ratio for
13 individual was so high is by the time they got to
14 2017, they had -- they filed their rates in 2016.
15 So they only had two full years of claims
16 experience to go by, and a good number of the
17 carriers were looking at experience that wasn't
18 terribly favorable.
19 So they had to -- by the time they could
20 catch up with it, their loss ratio in 2017 on
21 average had reached about 94 percent. So then
22 there was a massive over correction because a lot
23 of -- some carriers left the market because of the
24 financial results, and so the ones that were left
25 were scrambling to try to figure out, okay, where

52

1 should my rates be? They're getting -- the
2 experience is getting worst and worst.
3 So now as we look back on that, what you'd
4 call a rate correction, you know, you can argue a
5 little bit that, well, there was some over
6 correction there. Again, a lot more volatile than
7 small business, some group, because the individual
8 market was changing so much many carriers had a
9 hard time getting a beat on what was going on.
10 So in the last few years, you've had very,
11 very favorable loss ratio experience. And as you
12 can see, moving into 2021 and 2022, which again
13 those are right now estimates, we won't know what
14 2021 looks like until April or May of next year.
15 So what you're seeing as the loss ratios
16 are drifting up, and what we're now seeing is in
17 the rates, the rates are drifting down, because
18 carriers are looking backward -- and now this is
19 all in general, it doesn't apply to one carrier in
20 particular, but in general they're all looking back
21 at 2019 and 2020 and looking at very favorable
22 experience and thinking, well, I've got some
23 favorable experience. I've got some room to
24 actually lower my rates, which raises the loss
25 ratio a bit.

53

1 I know that sounds a little bit confusing,
2 but that's kind of how it works in general.
3 The takeaway here is individual is much
4 more volatile than small group. It's not
5 surprising to anybody. Those are the reasons why
6 it's more volatile than small group.
7 So are there any questions on this? Okay.
8 We'll move on to the next slide.
9 This slide -- I'm glad Julie mentioned her
10 slide on average premium per member per month.
11 This slide represents the average rate change in
12 the individual market in Virginia over the last few
13 years. And these rate changes, we basically pulled
14 them from filings each year.
15 Let me give you an example of how -- of
16 why these numbers won't necessarily tie to the
17 dollar amounts Julie showed you earlier, because if
18 you go back and divide two dollar amounts, you're
19 are not going to get these percentages on this
20 screen.
21 And, excuse me, I should have mentioned at
22 the beginning, at the top, I've got a little cold.
23 It's not COVID-19, it's just a garden variety cold.
24 But, of course, I would have it today.
25 Anyway, let me give you an example of what

54

1 this chart represents compared to what Julie's
2 chart showed.
3 Let's say that every carrier in the
4 individual market in Virginia this year raised
5 their rates 10 percent. That's what they filed.
6 So we're going to report the average rate change in
7 Virginia was 10 percent. When Julie reports that
8 number, it's going to be a mixture of companies and
9 enrollments and plans and all that kind of stuff.
10 It doesn't reflect how people select plans, how
11 they move among insurance carriers, all that kind
12 of noise, those would be in Julie's numbers.
13 So when you look at, for example, 2018,
14 the average rate change in Virginia that year was
15 56.2 percent. That's the average that all the
16 carriers in the market at the time, that was the
17 average rate change that they filed, and it's
18 literally just summing up the percentages and
19 dividing by the number of carriers. That's all
20 that number is. It's just to give folks an idea of
21 the average rate change in the market.
22 When you look at Julie's number, what that
23 number reflects is -- reflects all the choices that
24 people made in 2018, because, I mean, think about
25 it for a minute. If your average rate change, the

55

1 rate that you're sitting looking at goes up 50
2 percent, probably one of the first things you're
3 going to think about doing is changing your plan
4 design or changing carriers. That will all be
5 reflected in Julie's number.
6 And so it will reflect that shift, but
7 that's not what's reflected here. These are
8 basically the average rate changes that were filed
9 each year in Virginia. Each has good information,
10 but they're different.
11 And as you can see 2020, 2021 and 2022,
12 carriers started looking back at their experience
13 and were thinking, you know, we've really come a
14 long way and now we've got some room to lower our
15 rates. So that's, in fact, what they've been doing
16 for the last three years.
17 Any questions?
18 Okay. Next slide. And so takeaways.
19 we've seen an increase in ACA carrier
20 participation, primarily in the individual market.
21 The small group market again hasn't changed that
22 much. We have had a few new entrants, but by and
23 large it's the same cast of characters each year.
24 We've had an increase in the individual market
25 participation due in part to a more stable

56

1 legislative and regulatory environment.
2 Keep in mind, way back when, when you
3 would hear -- see in -- hear in the news that, you
4 know, the ACA, they're ready for repeal and a
5 replace, and the more they start talking about
6 things like that, and the more it starts getting,
7 you know, spread out among everybody, insurance
8 carriers will start to get a little nervous.
9 They don't mind if you've got a set of
10 rules that everyone plays by and by and large you
11 keep those rules the same from year to year. What
12 carriers don't like, I mean, frankly nobody does,
13 is huge uncertainty, particularly if you're in
14 business to rely on certain rules going forward.
15 So once there starts to be a lot of
16 activity around doing something with the ACA,
17 carriers will start to get nervous and start to do
18 a lot more examining as to whether or not they want
19 to be in this market, whether they can afford to be
20 in this market. There's always, always legislative
21 and regulatory risk in any health insurance
22 business, that's true, but once it gets to a point,
23 certain carriers really can't tolerate it.
24 However, we haven't seen a lot of that in the last
25 few years. So carriers are now coming back in.

57

1 Also, there's been some favorable
2 financial results in Virginia, not only in Virginia
3 but nationwide, and certainly if certain other
4 carriers see that, you know, these carriers can do
5 pretty well, they can generate a profit, that might
6 be something I want to get into.
7 COVID-19, I cannot -- I cannot reinforce
8 how that has been just the biggest challenge over
9 the last couple of years. We talked about pricing
10 trends quite a bit, but I don't mean to demean it,
11 it's not necessarily easy, but relatively speaking
12 carriers can do pricing trends in their sleep.
13 They've got systems and data and analysis set up
14 that they can do a great job in that. But once
15 things like COVID-19 starts throwing a stick in the
16 spokes, it just makes it very challenging.
17 And one last thing, as Julie mentioned,
18 ARPA has driven some increase in enrollment due to
19 the expanded open enrollment period. But right now
20 we really don't have an idea, and maybe some
21 carries can speak to what they've seen up to now,
22 but the expanded subsidies didn't start until April
23 1st. So carriers had to submit their rates May
24 21st. So they hardly had a month of the expanded
25 subsidies under their belt to know how it impacted.

58

1 And if there's no more questions, I'll go
2 to my last slide.
3 And this is a list of our presenting
4 companies today. What we have done in the most
5 recent past is we have chosen a few companies to
6 give presentations to try to, you know, limit the
7 time certainly of the presentations and for there
8 to be a much more focused discussion.
9 All these companies knew in advance that
10 they would be coming. The companies that
11 operate -- well, we have chosen certain companies
12 to talk about both of their markets, individual and
13 small group. That would be Optima and
14 HealthKeepers. Kaiser we asked to present their
15 individual business. They also operate in the
16 small group market. Cigna only operates in the
17 individual market, and Aetna will be speaking about
18 their entry into the individual market, although
19 they do operate in the small group market as well.
20 So with that, I will turn it over to our
21 first presenter, and if you pull the next slide up,
22 I'll know who it is because I don't remember.
23 Oh, I'm sorry, last slide.
24 These are some questions we gave the
25 companies in advance. We would like each one to

59

1 briefly address challenges and opportunities to
2 entering rural areas in Virginia, which can be
3 quite different than urban areas, primarily when
4 you've only got one hospital and a small group of
5 doctors in a certain location.
6 If you've seen anything, what kind of
7 impact has ARPA had on your business so far?
8 And thinking about lack of competition,
9 does that influence the level of your rates?
10 And talk about the impact of certain
11 federal or state initiative possibilities on the
12 individual market following up primarily on some of
13 the things that Julie talked about with respect to
14 the reinsurance program.
15 And then last, but not least, we've asked
16 Aetna to speak to their decision to reenter the
17 market and why specifically the individual market
18 in Virginia.
19 So if there are no other questions, I will
20 turn it over to Graham Sutherlin, and he will be
21 marking it Optima.
22 Graham?
23 MR. SUTHERLIN: Hello. My name is Graham
24 Sutherlin. I'm the director of actuarial services
25 at Optima Health. Our address is 4417 Corporation

60

1 Lane, Virginia Beach, Virginia 23462.
2 If it's all right with you, I'll start
3 with the questions, and I will go through the
4 questions pausing in between for you to ask your
5 comments.
6 The first one being: What are challenges
7 and opportunities to entering the rural market in
8 Virginia.
9 Well, Area 12 is largely the rural
10 sections of Virginia. It's a patchwork of rural
11 counties across the state. It would be helpful if
12 Area 12 were split into smaller contiguous areas so
13 that the rates could be more precisely calculated.
14 Also another challenge is that it's a
15 small -- small data size and lack of credibility,
16 which is an issue for new entrants in the rural
17 market.
18 Any comments on that before I go on to the
19 next one?
20 COMMISSIONER JAGDMANN: Well, do you have
21 any -- we can understand what the ask might be with
22 respect to splitting it up. But with respect to
23 the small data size, is there -- is there any
24 suggestions or in that regard anything that we
25 could do?

61
1 MR. SUTHERLIN: We are working with that
2 to -- you say are other populations, such as the
3 large group data for pricing, when data is limited
4 to increase, and we're also using the information
5 from external data sources to try to strengthen our
6 information to pricing the rural areas.
7 COMMISSIONER JAGDMANN: Thank you.
8 MR. SUTHERLIN: All right. The second
9 question being: What kind of impact has ARPA had
10 on your business.
11 The American Rescue Plan is a
12 multi-faceted piece of legislation. In this
13 comment, we focus on the subsidy component. Where
14 we don't have any hard data to support this yet, we
15 believe increase in the subsidies has been
16 beneficial to the members as it has made the
17 Exchange policies more affordable after the
18 subsidies across the broad spectrum of the federal
19 poverty level.
20 COMMISSIONER JAGDMANN: I will just ask a
21 question in general, if you can.
22 MR. SUTHERLIN: Sure.
23 COMMISSIONER JAGDMANN: You know, with the
24 subsidies or, you know -- and I believe I heard
25 previously that people -- some individuals would be

62
1 moving from, let's say, the high deductible silver
2 plans to, let's say, lower deductible silver plans.
3 I'm just curious in general about your utilization
4 data.
5 I mean, do you find that people -- I mean,
6 I would assume that individuals are more inclined
7 to use a lower deductible plan. I'm just curious
8 about utilization in general, correlation to
9 deductibles.
10 MR. SUTHERLIN: Sure.
11 I mean, I don't have an answer to that
12 now. It's something we certainly at some point can
13 look up and respond to it in the future.
14 COMMISSIONER JAGDMANN: Yes. Thank you.
15 COMMISSIONER NAVARRO: I do have a
16 question about just ARPA subsidies and sort of the
17 impact on the market, especially as it relates to
18 individuals who are using those subsidies versus
19 those who are utilizing Medicaid.
20 Are you seeing any shifts between
21 individuals that are utilizing Medicaid into the
22 individual plans or vice versa right now just given
23 sort of the increase in subsidy levels for certain
24 classes of customers?
25 THE WITNESS: Well, with respect to the

63
1 Medicaid membership, there isn't anything in ARPA
2 that results in an explicit shift. However, given
3 the movement of memberships into Medicaid with
4 COVID, the idea is that some of these members are
5 likely to come into the individual market as ARPA
6 makes it more accessible to them, you know, through
7 funding of small business creating jobs.
8 Ready to move on to the next one? Does
9 the lack of competition influence the level of your
10 rates? The competition has minimal influence on
11 the level of Optima's rates. We develop our
12 premium rights based on a review of historical
13 experience, expected changes for the upcoming claim
14 year, administrative expenses, taxes and fees, and
15 profit and risk margin.
16 And according to state and federal medical
17 option requirements, the company is limited in the
18 amount of premium that can be used to cover plans,
19 expenses, tax and fees, and risk margin. And there
20 isn't an explicit component for using competition
21 in the pricing mechanism.
22 All right. Yeah. In the impact of
23 certain federal and state initial possibilities on
24 the commercial individual market, we do look
25 forward to the reinsurance program. The Commercial

64
1 individual market would be positively effected by
2 the state's initiative instituting a reinsurance
3 program.
4 Reinsurance programs in other states have
5 shown to provide market and rate stability.
6 COMMISSIONER JAGDMANN: Oh, just for those
7 who may be listening or reading the transcript
8 later, we have three plans. You've outlined three
9 plans. Companies file many, many plans. These are
10 just the one representative samples. So I just
11 wanted to clarify that for the record. You've
12 filed many, many plans, I'm assuming.
13 MR. SUTHERLIN: Are you waiting for me to
14 move on to plans or any other questions?
15 COMMISSIONER JAGDMANN: Yeah. Well, I was
16 asking, I guess, for you to confirm that.
17 You filed more than three plans?
18 MR. SUTHERLIN: Oh, yes. Certainly more
19 than three plants, yeah.
20 COMMISSIONER JAGDMANN: Yeah. Like do you
21 know how many you filed?
22 MR. SUTHERLIN: I bet you someone will
23 send me a text with that here in a minute, if we
24 need it.
25 COMMISSIONER JAGDMANN: Now.

65

1 MR. SUTHERLIN: You know, it's in the rage
2 of 15 on the individual market and --
3 COMMISSIONER JAGDMANN: That's all.
4 That's all I was looking for. You know, for
5 somebody that's, you know, not familiar with this
6 area, you know, there are more than the three. We
7 would be here all day if we went through every one
8 of them. These are just categories that we asked
9 for review.
10 Okay.
11 COMMISSIONER HUDSON: Yeah, whenever
12 you're ready, Mr. Sutherlin.
13 MR. SUTHERLIN: So Optima's most popular
14 plan is a silver plan with a 6,600-dollar
15 deductible. Members on this plan will experience a
16 5.4 percent decrease. The plan with the lowest
17 premium rate change is a silver plan with a
18 3,000-dollar deductible which will experience a 5.9
19 percent decrease. And the plan with the maximum
20 rate change is the catastrophic plan with a half of
21 a percent decrease.
22 The major prongs that make up the rate
23 change, including anticipated change to the
24 morbidity of the population and the projection time
25 period, reducing the cost of 8.9 percent compared

66

1 to that use for pricing in 2021 premium levels.
2 Trends estimated at 6.8 percent, we
3 estimate that our risk adjustment receivable will
4 increase in a manner so to decrease the needed
5 premium 6.7 percent.
6 The COVID-19 adjustment listed here is a
7 retrospective adjustment to correct for the reduced
8 utilization in 2020. We're not applying any load
9 to the projection period for COVID-19. As David
10 said, we have nothing in there for suppressed
11 utilization.
12 Regarding network change is a reduction in
13 the provider reimbursement levels due to improved
14 provider reimbursements.
15 An area factor revision represents the
16 needed change in premium due to providers moving
17 from tier 2 in our direct network product to tier
18 1.
19 COMMISSIONER JAGDMANN: And could you
20 describe what it means to move from pier 2 to tier
21 1?
22 MR. SUTHERLIN: Certainly. We have a
23 tiered network meaning that the members payer a
24 higher cost share when they go to certain
25 providers, and we have had providers that we are

67

1 now moving into tier 1 granting more access and a
2 lower cost for the member cost sharing to our
3 members.
4 COMMISSIONER JAGDMANN: Thank you.
5 MR. SUTHERLIN: Any other questions on the
6 individual?
7 COMMISSIONER HUDSON: Mr. Sutherlin, I see
8 that based on the rate filing template that you
9 provided, there are different areas and different
10 area plans. And so I guess my question is for the
11 record. It would be helpful if you can just
12 explain why you might decide to offer one plan
13 versus another, one plan in a particular part of
14 the state as opposed to maybe statewide?
15 MR. SUTHERLIN: So in our individual
16 product, all the products that we are offering --
17 could we flip to the next slide, please? All of
18 the products that we're offering are being provided
19 in the regions that you see here that have an area
20 factor in Table 16. So the products that we offer
21 are offered in that region. We are providing the
22 individual product in the area where we have the
23 strongest provider relationships, and that's why
24 we're choosing to offer individual product in those
25 regions.

68

1 COMMISSIONER HUDSON: Okay. Thank you.
2 COMMISSIONER NAVARRO: I do have a
3 question for you relative to that sort of cost
4 impact for individuals participating in the
5 individual market.
6 So you mentioned your favorable view, of
7 course, of the reinsurance program, but there are
8 other programs, obviously the state-based Exchange.
9 I would just be interested in how that would help
10 to translate to lower costs for individuals and
11 families which, of course, is really very important
12 to us.
13 MR. SUTHERLIN: I'm sorry that I won't be
14 able to answer that today.
15 COMMISSIONER NAVARRO: Okay.
16 COMMISSIONER HUDSON: You may continue, if
17 you have any points you wanted to add.
18 MR. SUTHERLIN: I am done with the
19 individual product, if we're ready to discuss with
20 the small group.
21 COMMISSIONER HUDSON: Yes. You can
22 proceed.
23 MR. SUTHERLIN: So we can advance the
24 slide one, please.
25 In the small group market, Optima's most

69

1 popular plan is a gold plan with a 2,000-dollar
2 deductible. Members on this plan will experience a
3 0.9 percent decrease. The plan with the lowest
4 premium rate change is a platinum plan with a zero
5 dollar deductible which will experience a 9.7
6 percent decrease. And the plan with the maximum
7 rate change is the silver plan with a 7.3 percent
8 increase.
9 The major components that make up the rate
10 change are trend estimated at 7.4 percent, and we
11 estimate that our risk adjustment receivable
12 increase in a manner that will decrease the need of
13 premium to 7 percent.
14 Again, the COVID-19 load here is for
15 retrospective adjustment of the 2020 data, not for
16 suppressed utilization.
17 COMMISSIONER HUDSON: I will ask my
18 colleagues if they have any questions.
19 COMMISSIONER JAGDMANN: I do not. Thank
20 you.
21 COMMISSIONER HUDSON: I don't as well.
22 MR. SUTHERLIN: Thank you for the
23 opportunity to share.
24 COMMISSIONER HUDSON: Thank you very much,
25 Mr. Sutherlin, and thank you for participating in

70

1 our presentation. We really appreciate it.
2 So I guess our next presenter is
3 HealthKeepers, and it's going to be Tim Connell,
4 and Mr. Connell you will be doing the individual as
5 well as small groups?
6 MR. CONNELL: Yes. That's right.
7 COMMISSIONER HUDSON: Great. So whenever
8 you're ready, you may begin.
9 MR. CONNELL: All right. Thank you,
10 everyone. Good morning. My name is Tim Connell,
11 director and actuary with Anthem located at 2015
12 Staples Mill Road. That's Richmond, Virginia
13 23230.
14 And I'll be glad to walk through this
15 sheet. I'll ask what the preference is, if we want
16 to kind of go through the rate development first,
17 or do you want to address some of the questions
18 that you had up upfront first?
19 COMMISSIONER HUDSON: I don't have a
20 particular preference. I think it's totally fine
21 to start with your rate presentation and then get
22 to the questions later. That's totally fine.
23 MR. CONNELL: Get to the questions? Okay.
24 So what you have here is our -- you can
25 see sort of our overall rate on the top right.

71

1 It's about a 2.6 percent or 2.8 percent decrease,
2 and then listed below that, three plans which were
3 requested for this exhibit. The most popular, the
4 minimum and then the maximum.
5 So as we've seen in the last couple of
6 years with Anthem, we're seeing good experience,
7 and that's helping to kind of keep premiums down
8 and adding another year of decrease.
9 So the -- I'll kind of speak to the most
10 popular plans and just make a couple of comments.
11 I know sometimes it's of interest about what's the
12 plan design and, you know, the people that enroll
13 in these plans.
14 So our silver -- fortunately, we have some
15 of the benefit parameters listed right below it
16 since I think our main other plan got cut off a
17 little bit. But the silver is a 6,250 deductible,
18 35 percent coinsurance plan. It is our most
19 popular plan.
20 And I will mention too that when you talk
21 about our silver plans, I don't think we've really
22 mentioned too much of this yet, but the
23 cost-sharing reductions come into play when you
24 talk about these silver plans. These are the plans
25 where lower income numbers are able to, by virtue

72

1 of their income, get reductions to their cost
2 sharing.
3 So when you look at that, it might seem a
4 little scary to see that 6,250 deductible, but, in
5 fact, we're seeing like 90-plus percent of our
6 members that purchase this plan, we call it a
7 parent plan, but what they're purchasing really is
8 a variant of this plan that has a much lower cost
9 share.
10 And I was looking that up earlier. As an
11 example, the highest cost-sharing members will only
12 have a 50-dollar deductible, and really the
13 majority of these cost-sharing members will have an
14 out of pocket, you know, whether than 8,700 listed
15 there, the out-of-pocket maximum they'll have is
16 less than $3,000.
17 So that's just something to consider when
18 the plans on their surface look like they might be
19 pushing a lot of cost share to members, but that
20 CSR subsidy comes into play, and that's where we
21 really see sort of a different decisionmaking part
22 on the customers' part where they're really picking
23 a richer benefit plan because of their income.
24 Any questions on the cost-sharing
25 reduction side of things? I don't think that has

73

1 come up before. It probably has come up in past
2 years. No? Okay.
3 So this most popular plan is pretty close
4 to our average. This is -- what you see is kind of
5 a development of what's pushing increase.
6 I will note a correction that I noticed
7 just yesterday on this. I think the direction
8 should be reversed on the risk adjustment number
9 that -- it's listed as a 1.3 percent increase, but
10 it actually should be a 1.3 percent decrease, and
11 then the reversing entry on that would be the other
12 change. Most of what's in the other is really the
13 favorable experience we've observed, and what will
14 happen is that that other change that's a negative
15 will become less negative.
16 But the reason for that really is the risk
17 adjustment we were -- we made kind of a late change
18 in the rate-filing process. When we saw the 2020
19 risk adjustment results, we went back and adjusted
20 what we thought we would have to pay for risk
21 adjustment, and we are a little bit less of a payor
22 into the program than we had thought initially and
23 what we had thought in 2021's pricing.
24 Risk adjustment is tied into morbidity as
25 well, and what you see on the morbidity line is a

74

1 slight improvement, and this might get into one of
2 the questions that was asked about the ARPA impact.
3 Maybe I'll just address that now, you know, what do
4 we think the impact of ARPA is going to be.
5 I think it's a little mixed. I think
6 there's -- we are seeing probably more favorable
7 impacts from ARPA than unfavorable, and the reason
8 we think that is, as you think back to the slides
9 that were mentioned earlier and the subsidies that
10 are increasing, we think some of the people
11 reentering the market are going to be some of these
12 higher income members that decided to drop out and
13 might now see an opportunity to get back in when
14 they have some premium subsidies.
15 Some independent studies have shown that
16 the higher income levels are probably a little
17 better -- in a better health risk profile, and we
18 think if these members are coming back into the
19 market, that's going to suddenly improve the whole
20 pool of market.
21 So this morbidity, in fact, we wouldn't
22 say is just happening to Anthem, but it would
23 happen to all carriers. So that's kind of how
24 we're viewing the major impact of ARPA. As
25 Mr. Shea mentioned, it's, you know, an unknown.

75

1 you know, there's probably risk going either way.
2 One thing that's happening this year too
3 is just the open -- the extended open enrollment,
4 or I'm not sure if it's a special enrollment
5 period, but the extended time where people can
6 enroll. That's probably still okay in this I think
7 given the situation and the economy and where we
8 are.
9 Generally, we're not really in favor of
10 letting special enrollment periods happen all year
11 around. That usually allows sicker members to come
12 in, into the market. So I think that was talked
13 about earlier too about proposed for 2022 whether
14 it be some special enrollment periods where anyone
15 can come in during a month without a qualifying
16 event, and I do think that's a little bit
17 problematic from the insurance carrier's
18 perspective with, you know, potentially sicker
19 people coming back in when they need the
20 healthcare.
21 But generally, I think that the good
22 outweighs the bad with ARPA, particularly in this
23 year where the extended period is long time, and we
24 know that probably the economy is maybe making
25 people reconsider whether to get coverage. Maybe

76

1 COVID too is another factor that, you know, might
2 inspire people to make sure they have some
3 coverage.
4 So I think overall it's a slight favorable
5 impact is what we're seeing about -- about ARPA.
6 COMMISSIONER JAGDMANN: You were saying
7 people who had exited the market are coming back,
8 and morbidity would be going down, and are you
9 thinking these are younger members? I'm just
10 curious. Is this a younger population, or have you
11 done that kind of granularity, or your thoughts?
12 THE WITNESS: Not necessarily. No, I
13 haven't done had that granularity, but I wouldn't
14 say it's necessary that it's younger people either.
15 I think we saw the exhibit earlier too from
16 Ms. Blauvelt that, you know, actually some of the
17 older people might benefit even more given that
18 their premiums are higher and that sort of puts a
19 burden on their -- as a percent of their income,
20 and they might -- actually might could qualify for
21 more. So it would be relatively healthier people
22 probably in those age buckets than what is out
23 there today.
24 COMMISSIONER NAVARRO: And, Mr. Connell,
25 aren't there also some policies, such as

1 reinsurance that could help mitigate the risk
2 associated with sicker individuals coming back into
3 the market?
4 THE WITNESS: I think well, yeah,
5 reinsurance we can get into that as one of the -- I
6 think one of the questions that was asked about
7 feature programs. I think so. I do think
8 there's -- you know, reinsurance might start to
9 kick in when only a claimant reaches, say, $50,000
10 in claims.
11 So we can -- you know, insurance carriers
12 can suffer from other patients who don't have that
13 kind of catastrophic expense but still sort of
14 drive claimants' claim costs higher and may drive
15 premiums higher. But, yeah, generally I think the
16 reinsurance is going to be a good thing for the
17 market.
18 I think it's still a little bit
19 problematic when we talk about maybe less healthier
20 people coming into the market.
21 I'll say generally too that I think when
22 the market is growing, that tends to be -- and this
23 is a generalization -- is probably a good thing
24 when the market is growing, and I think ARPA is
25 helping the market grow a little bit again.



1 Generally, that means, you know, probably
2 a little bit healthier people are coming back in,
3 and the reverse is probably true when we saw the
4 market shrinking, you know, three, four years ago.
5 That was a concern that it was really the healthier
6 people that were exiting, and we were being left
7 with, you know, probably less healthy risks in the
8 pool overall.
9 And if it's in the pool overall, that
10 means, you know, risk adjustment might compensate
11 you if you get an unfair share of unhealthy people,
12 but if the unhealthy people are just all over the
13 market, you know, it sort of equally distributes to
14 everybody.
15 COMMISSIONER HUDSON: Mr. Connell, as a
16 follow-up, and I think my colleague Judge Navarro,
17 actually posed this question to Mr. Sutherlin, with
18 balance billing, to the extent that you can
19 actually answer that, what kind of impacts will you
20 think they'll actually have on health plans? And
21 if it's not too early to conclude that, what do you
22 think -- what do you project to see how that may
23 actually affect the health plans moving forward,
24 especially when it comes to like cost claims.
25 MR. CONNELL: Yeah, I think it's -- it i



1 early to say and, you know, I've had conversations
2 with our folks internally. I'm not as close to the
3 negotiating process. My feeling is it's -- if it's
4 anything, it's probably going to push costs up from
5 our side of things, push costs and premiums up a
6 little bit.
7 I don't think we know the magnitude of
8 that yet, and I don't know if we know it's going to
9 be severe. But, you know, I think what's probably
10 unfortunate about the Bill, it would have been nice
11 if this Bill had maybe inspired, you know,
12 providers to become in network. So far it doesn't
13 seem like we're seeing that, that it's maybe
14 driving more providers to say, hey, I might be
15 better to go out of network.
16 So it's kind of a challenge with our teams
17 that are trying to negotiate the best deals for our
18 customers and get the best, you know, provider
19 deals to keep as many doctors as possible in
20 network.
21 And there's also just cost of the
22 arbitration process. I think that's a little bit
23 new and unknown, and I don't know of exactly how
24 many cases we've seen so far, but I believe the
25 providers and the insurers share in that cost too.



1 So that's just a new cost to the system that wasn't
2 there before.
3 COMMISSIONER HUDSON: Thank you.
4 MR. CONNELL: All right. I guess the last
5 thing I'll mention on the rates, I'll kind of -- I
6 appreciate Mr. Shea's comments on COVID and the
7 uncertainty that that has brought us. I think we
8 can all agree that that's been the case, and we --
9 I guess we might have been one of the carriers that
10 actually had built in some COVID costs in last
11 year's rates.
12 It's been a challenging item. Really
13 we're doing two separate things with COVID. One is
14 2020, as Mr. Shea alluded to, is -- had some
15 unusual experience where hospitals, providers had
16 to shut down for about three months. So when we
17 look back at 2020, we don't want to take just the
18 street experience. We want to say, well, had it
19 been, you know, a normal year, we would want to say
20 how would 2020 have really looked.
21 And so we've made adjustments on that
22 front, and then we've also tried to project, okay,
23 if 2020 goes forward for the normal year, what
24 additional costs will COVID bring going forward
25 and, you know, the pandemic has still stuck around

81

1 maybe longer than we all had wished it would.
2 So, you know, we're trying to gather, you
3 know, how much to build in for costs. We're
4 building some COVID impacts probably in the
5 neighborhood of one and a half to two percent.
6 However, when we did the 2021's pricing, I think we
7 built in closer to 3 percent.
8 So what you see on the COVID impact is a
9 negative. It doesn't mean we aren't expecting
10 COVID to impact our costs, it means we're building
11 a little bit less than we did in 2021.
12 And that cost could be a variety of
13 things. I would say two months ago we were saying,
14 it's going to be mostly vaccine costs, and maybe
15 that's still -- hopefully, that's what it is, but I
16 think, you know, the pandemic is surprising us
17 with, you know, the different surges and --
18 out surges again and again.
19 COMMISSIONER NAVARRO: Mr. Connell, I do
20 have a follow up on that point. So HealthKeepers
21 is a plan that's provided in a lot of geographies
22 across the Commonwealth.
23 Are you seeing differences in costs
24 relative to COVID-19 depending on the jurisdiction
25 in which the service is occurring or is this -- or

82

1 are you just sort of looking at it on a statewide
2 basis?
3 THE WITNESS: Yes. So far we're just
4 looking on a statewide basis. I think you have a
5 good point that it probably does vary
6 geographically, but I think just the number of
7 cases and the amount of claims that we get, it's
8 been hard to get it at that level of detail yet. I
9 think we just want to get the overall picture
10 probably as close as we can.
11 I'll go -- maybe I'll go to one of the
12 questions about -- speaking of geographies about
13 entering rural areas. I don't know if that's best
14 answered by us. Anthem does participate in all of
15 the rural areas today, and I guess, you know,
16 probably a challenge is -- I think what -- I'm not
17 sure if that was Mr. Shea that mentioned it, but
18 when you're talking about sometimes rural areas and
19 sometimes even, you know, more urban areas, it
20 might be dominated by a single hospital system
21 which might also be in contract with the providers.
22 So, you know, entering a system and
23 getting good negotiated rates can be a challenge,
24 and it can be a challenge for those of us that are
25 in those areas too when -- you know, when they

83

1 demand increases.
2 So what else? Let me go back to other
3 questions. Any other questions on the exhibit, or
4 I can speak to some of the questions from upfront
5 now.
6 COMMISSIONER HUDSON: You can proceed.
7 MR. CONNELL: Okay. So the question is
8 the lack of competition influencing our rates. So
9 I think the short answer is no, that, you know, we
10 really look at our experience by the geographies,
11 and we tend to look at it trying to factor in risk
12 adjustment as well. Really, the Bureau has -- the
13 way we would be able to price in an area is that we
14 would have to change the area factor, and I would
15 say it's pretty scrutinized by the Bureau as far
16 as, you know, what we're presenting and what we're
17 using by area.
18 So I'm not sure that we really could
19 price -- you know, change the rates in an area
20 where we weren't competitive. And like was
21 mentioned earlier, we also don't even know if the
22 area is going to be competitive upfront. We've --
23 you know, just from the presentation earlier, we've
24 learned, oh, guess what? Anthem is not the only
25 carrier in Area A now. Somebody else is in there.

84

1 So until -- and I think the process works
2 pretty well that way, that, you know, carriers have
3 to put their best rates out there, and they may not
4 know if -- you know, how many competitors they're
5 going to have in that area.
6 All right. So did I address the
7 questions?
8 I think the federal and state initiatives,
9 the other one that we kind of touched on was the
10 reinsurance, is probably the big one coming. So we
11 do see that, you know, as a favorable development
12 that, you know, the market has seen some decreases
13 as we saw earlier, and I think without the
14 reinsurance program, you know, I feel like that
15 tendency is going to have to stop at some point.
16 We're going to probably start to see, you
17 know, the rate increases come back. You know, at
18 least we can't stay negative for that long, I don't
19 think; however, the reinsurance program might be a
20 favorable thing to that. So it might be -- you
21 know, it might carry on some of the -- what you saw
22 as, you know, negative and favorable rate changes
23 over the years.
24 Perhaps that can continue a little bit to
25 2023 with the reinsurance program, and we'll have

85

1 to see what parameters are and, you know, how
2 generous that programs is. I think a lot of the
3 details still have to be worked out.
4 All right. Any other questions, or we can
5 move on to small group, or have I touched all the
6 other questions?
7 COMMISSIONER HUDSON: I think we've
8 answered all the questions we had -- answered all
9 the questions on an individual. You can definitely
10 move on to the small group.
11 MS. NAVARRO: I actually just have one
12 further question for you, and this is something
13 that Judge Hudson asked previously, and it's about
14 the impact of telemedicine.
15 And just recognizing that you guys serve
16 rural populations and suburban and urban
17 populations, I'd just be interested in your
18 experience around telemedicine and telehealth given
19 the various populations that you serve, just
20 following up on what Judge Hudson asked earlier.
21 MR. CONNELL: Yeah, I'll give some maybe
22 just general impressions. I'm probably not the
23 best one at Anthem to know, you know, what new ways
24 we're reaching out through telehealth, but I know
25 we've been trying to accommodate members who -- you

86

1 know, during the pandemic, when visits in person
2 weren't possible, we did waive telehealth co-pays,
3 you know, during that temporary time.
4 We really see it kind of moving in that
5 direction, that they may continue, and I think
6 that's probably generally a good thing where
7 members will get care.
8 I think one of the -- maybe underline
9 that, that concern about members, and what the --
10 you know, what's going to happen post-COVID is, you
11 know, one, potential increase to claim costs will
12 be members getting those services that they had
13 delayed, and related to that is if members missed
14 getting something diagnosed. So I think that
15 that's a concern whether there could just be some
16 deteriorating health conditions that we're not as
17 aware of yet.
18 So my impression is telehealth helps that.
19 I think, you know, Anthem is working to help
20 accommodate that and keep it going. Like I said,
21 I'm not as well versed as probably many in our
22 company about what specifically we're doing on that
23 front.
24 COMMISSIONER NAVARRO: Thank you.
25 MR. CONNELL: Uh-huh.

87

1 COMMISSIONER HUDSON: You can proceed now,
2 Mr. Connell.
3 MR. CONNELL: Okay. Can we slide down. I
4 don't know if we want to look at the area factors
5 briefly. There's really not much change in age or
6 geographic factors for the individual market.
7 And maybe slide down to the next, small
8 group, and we can go through that quickly.
9 All right. So we filed two legal entities
10 in small group, and what you see here is the
11 HealthKeepers brand, and I'll just mention
12 something that might be a little confusing on the
13 top part of the page. What we presented here is
14 the first quarter rate increase. So it's the
15 average change for groups renewing in the first
16 quarter for small group. We do have our groups
17 renewing at different policy years. So we have
18 groups renewing in the second, third and fourth
19 quarter.
20 What we file in the annual filing is a
21 representation of all four quarters, you know,
22 first, second, third and fourth, and that might be
23 our final rate, or there's a chance insurers can go
24 back and revise those rates later, but at least
25 initially we filed four quarters worth of rates,

88

1 and when you look at our development for the second
2 through fourth quarters of the year, they would be
3 step -- you know, somewhat step increases, you
4 know, pushing the rate increase up a little bit.
5 And so when you look at the number in
6 blue, the minus 0.5, that's the change for the
7 first quarter, and the 1.8 is actually average over
8 all four quarters of what kind of increases groups
9 would see as of this filing.
10 So it's also kind of, you know, a
11 favorable story, and like we've alluded to, the
12 experience has been pretty good in this market. So
13 we do see that, you know, kind of looking at the
14 most popular, these plans like you might notice
15 are, you know, somewhat richer in benefit when you
16 talk about the most popular plan compared to the
17 individual market, but the increases are of a
18 similar nature and probably, you know, should see
19 favorable -- you know, favorable impact to our
20 members.
21 I don't think I had too specific comments
22 that I haven't covered already on the small group.
23 So any questions on that?
24 COMMISSIONER HUDSON: One quick question I
25 do have is, are you noticing any change in the

89

1 number of small employers offering ACA coverage?
2 MR. CONNELL: We're seeing it being
3 relatively stable. I think one concern we were
4 wondering last year was with -- if the economy
5 might be pushing membership, you know, temporarily
6 down, and I think we did see, you know, membership
7 was able to hold fairly well through that pandemic,
8 you know, with customers being able to maintain
9 their coverage.
10 But I think our -- based on our actual
11 experience and our projections, we're considering
12 it relatively flat, I think relatively stable.
13 COMMISSIONER HUDSON: Thank you.
14 MR. CONNELL: All right. Any other
15 questions, or I can pass it back?
16 COMMISSIONER JAGDMANN: Thank you.
17 COMMISSIONER HUDSON: Thank you very much.
18 Thank for participating in our presentation.
19 MR. CONNELL: Thank you.
20 COMMISSIONER HUDSON: So I guess next we
21 Kaiser. We have Ms. Wen Xu.
22 Did I pronounce your last name correctly?
23 MS. XU: That's right.
24 COMMISSIONER HUDSON: Great. Great. So
25 whenever you're ready, you may begin.

90

1 MS. XU: Good morning, everyone. My name
2 is Wen Xu. I'm the actual director for Kaiser
3 Permanente in the mid Atlantic states and our
4 address is 2101 East Jefferson Street, Rockville,
5 Maryland 20852.
6 And if it's okay with everyone, I'm going
7 to start with the rate exhibit and then move on to
8 the four questions after I [indiscernible].
9 All right. So for plan year 2022, we're
10 filing an overall rate reduction of 13 percent. I
11 am going to start with our most popular plan, which
12 is our bronze 6055 plan, and this plan has a
13 6,000-dollar deductible and in our coinsurance of
14 35 percent and in network out-of-pocket maximum of
15 8,700, which is a slight increase from 8,550 from
16 2021. The in our office visit co-pay here is cut
17 off a little bit in this PowerPoint. So I'll just
18 say that. The in our office visit co-pay is $55
19 for the first three visits, and then 35 percent
20 after deductible, and that co-pay is waived for
21 kids under age 5.
22 Moving on. As of March 1, 2021, this
23 bronze 6005 [sic] has slightly over 8,000 members,
24 which makes up around 27 percent of our total
25 Virginia individual membership.

91

1 For this plan, we're filing a 12.8 percent
2 reduction, and this can be broken down into a few
3 components. So we have a morbidity change that
4 counts for roughly 1.4 percent, 8.6 percent
5 decrease per trend, a rate adjustment accounts for
6 negative 2.1 percent, and then our benefit expense
7 which is mostly just admin expenses contribute to a
8 negative .7 percent impact, and the benefit change
9 of this plan accounts for a small negative .2
10 percent of impact corresponding to the small
11 out-of-pocket maximum increase.
12 And our basic plans contributes to a
13 negative 3.3 percent, and the margin contributes
14 another negative 6 percent of the rate change, and
15 we have no COVID impact for this plan because we
16 assumed that COVID would not have impact on our
17 2022 experience. I'm showing a 1.4 percent other
18 changes here, which include things mostly like the
19 model update.
20 I mean, I'm going to move on to the next
21 plan which is our minimum rate change plan, our
22 catastrophic plan, and this plan has a 8,700
23 deductible, which is a slight increase from 8,550
24 from 2021. Our plan coinsurance is zero percent,
25 unchanged from the prior year, and our

92

1 out-of-pocket maximum is also 8,700, slight
2 increase from 8,550 from 2021. The office visit
3 cost share is no cost share for the first three
4 visits during the plan year, and then no charge
5 after deductible. And as of 3/1/21, this plan has
6 around 250 members in it, less than 1 percent of
7 our total membership.
8 We're filing a 16.8 percent rate reduction
9 of this plan. The impact for morbidity, trend,
10 rate adjustments, margin change and base experience
11 is sustained in terms of the percentage as the most
12 popular plan.
13 The benefit change of the plan accounts
14 for roughly negative .4 percent of rate change, and
15 I'm showing a -- so the other change here also
16 includes mostly the model update.
17 Okay. So moving on to the max rate change
18 plan, this is our silver 2535 plan, and it has a
19 2,500-dollar deductible, 35 percent plan
20 coinsurance, 8,250 out-of-pocket maximum. The
21 office visit cost share is 35-dollar co-pay, which
22 is waived for kids under age five, and these plan
23 parameters stay the same as the 2021 offer rate.
24 And as of 3/1/2021 there's around 350 members
25 enrolled in this plan, a little over 1 percent of

93

1 our total membership.
2 We're filing a 10.8 percent rate reduction
3 for this plan, and again the impact from morbidity,
4 trend, rate adjustment, margin change and base
5 experience change is similar to those mentioned for
6 the previous two plans. The other change is at 3.3
7 percent, and again mostly coming from our model
8 update.
9 And I will stop here to see if there are
10 any questions.
11 COMMISSIONER NAVARRO: Ms. Xu, I do have a
12 question. I think you said for bronze plan that
13 you did not model a COVID impact for that; is that
14 correct?
15 MS. XU: We do not model a COVID impact
16 for all of these plans.
17 COMMISSIONER NAVARRO: For all these
18 plans.
19 Can you talk a little about the factors
20 that led you not to model a COVID impact for your
21 plans?
22 MS. XU: Yeah. So first of all, we
23 assumed that the COVID would not have an impact in
24 our 2022 experience. I mean, like everyone else,
25 all the previous presenters said, I mean, there's

94

1 still a lot of uncertainty with COVID, and at least
2 when at the time we made this refiling, we assumed
3 there would not be any COVID impact.
4 And then, secondly, keep in mind that, you
5 know, for Kaiser we're not like many other
6 traditional carriers in the sense that under our
7 integrated healthcare model, a majority of Kaiser's
8 health care costs is fixed, including those that we
9 paid to our own salaried physicians and our own
10 medical buildings.
11 So this suppressed utilization due to
12 COVID in 2020 -- in 2020 just doesn't impact our
13 healthcare costs much for 2020.
14 I hope that answered the question.
15 COMMISSIONER NAVARRO: Thank you.
16 MS. XU: If there are no other questions,
17 can we move on to the next page, please?
18 COMMISSIONER HUDSON: Yes, you can.
19 MS. XU: Thank you.
20 There's not really much I -- that's worth
21 mentioning here. We did not make any changes to
22 the age, tobacco factors, and our geographic
23 factors stayed the same as prior years, and we did
24 not vary rates by geographic area.
25 All right. If there are no other

95

1 questions, I'm going to move on to these four
2 questions. So first question is, what are the
3 challenges and opportunities to entering rural
4 areas in Virginia.
5 Okay. Again, Kaiser is unique as our
6 integrated model with -- you know, with physical
7 medical office buildings require population
8 density. Now, there is a potential to leverage our
9 robust virtual care capabilities to provide care in
10 rural areas. However, out of area standards and
11 lack of nearby in-person care for follow-up will
12 still drive up costs.
13 All right. The second question, what kind
14 of impact has ARPA had on your business.
15 So here for KP we have experienced
16 increased enrollment. I think our enrollment
17 almost doubled from the same time last year due to
18 the COVID-19 special enrollment period and expanded
19 subsidies included in ARPA. We think that anything
20 that brings in members is a good thing for
21 affordability and stability.
22 All right. Move on to the third question.
23 Does lack of competition influence the level of
24 your rates?
25 There's currently no lack of competition

96

1 in KP's footprint. We agree that competition helps
2 to bring stability to the market and has a possible
3 impact on rates.
4 Okay. If there are no other questions,
5 I'm going to move on to the last question which is
6 discuss the impact of certain federal of state
7 initiative possibilities on the commercial
8 individual market.
9 From the start with some of the federal
10 initiatives, so the first one I have there is the
11 standard plans. The notice of benefit and payment
12 parameter part three calls for a renewed assessment
13 of standardized plans. Kaiser is supportive of
14 standardized plans and believe they're good for
15 consumers. They would be important to tightly
16 coordinate between existing states' standardized
17 plans and proposed plans from CMS.
18 And, secondly, under the federal
19 initiative, as David mentioned earlier, there's,
20 you know, the special enrollment period that the
21 fed is considering right now whether extension of
22 enrollment period or special enrollment period. We
23 think those are good initiatives that will increase
24 access of members to health care.
25 And then on the state side, state

97

1 reinsurance, we think a program that accounts for
2 the interaction with the federal rate adjustment
3 program will help reduce rates and improve
4 stability of individual market. We think that
5 is -- it is important that the future funding of
6 the state reinsurance to be broad based, not just
7 on the full-insured market but also including the
8 self-funded market.
9 And also expanded subsidies, I know that's
10 what Virginia is considering too. Again, KP is
11 supportive of expanded subsidies whether at the
12 state level or federal level, as they help maintain
13 larger market size and improve stability.
14 Any questions or comments?
15 COMMISSIONER HUDSON: No questions here.
16 MS. XU: All right. Thank you everyone.
17 COMMISSIONER HUDSON: Thank you, Ms. Xu,
18 and thank you for participating in our
19 presentation.
20 So next we have Cigna, and our presenter
21 is Steven, last name is Giori?
22 MR. GIORI: You've got it.
23 COMMISSIONER HUDSON: Great.
24 MR. GIORI: Thank you.
25 COMMISSIONER HUDSON: Whenever you're

98

1 ready, you can begin.
2 MR. GIORI: Thank you. So my name is
3 Steven Giori. I'm representing Cigna today. Our
4 address is 900 Cottage Grove Road in Bloomfield,
5 Connecticut, and I think I am going to opt to talk
6 through the slides first, and then I can circle
7 back to the questions that were outlined by all.
8 So Cigna is obviously been on the Exchange
9 in Virginia now, I think it's been four years, at
10 least four years, and we here have, as you can see
11 from the average rate change at the top, filed a 3
12 percent average rate increase.
13 Going through the plan level, rate change
14 factors, you kind of see where that comes in. So
15 kind of starting from our most popular plan, which
16 I would say is probably a good framework because
17 it's, as you can see, the same percent change as
18 our average. That probably gives you a good idea
19 of where the book as a total is heading.
20 So what we are looking at here is a mild
21 increase from trend. We also saw that slide
22 initially that kind of laid out the trend. I mean,
23 we've all got a variety of different trends I think
24 this year, which is intriguing, but I do think that
25 trend continues to be a factor of health care costs

99

1 are increasing as we all know and hear about it on
2 the news. So that's -- you know, we're calculating
3 that to be about 4 percent for this year relatively
4 to what we filed in 2021.
5 There's a pretty big, I would say, a
6 negative number here for risk adjustment which is
7 interesting. So risk adjustment is, as has been
8 mentioned before, the program that helps kind of
9 offset selection in you having a riskier book of
10 business than the market.
11 So in this case, Cigna has a healthier
12 book of business than the statewide average. So
13 that means that things like [indiscernible]
14 healthier or premiums coming down actually are a
15 positive for us. So that is part of the reason why
16 we got such a big negative number there for risk
17 adjustment.
18 And then kind of continuing down here, I
19 would say most of the remaining pieces are
20 relatively small. I would say that there are some
21 minor methodology changes that are in here, as well
22 as, you know, the adverse experience. And we've
23 got a COVID load of 1 percent here as we are seeing
24 some COVID pressure in not only elite 2020 claims
25 but also in '21. And while we all hope that, you

100

1 know, the pandemic subsides for '22, I think at
2 this point it seems likely that it's going to be at
3 least hanging on in some small part for the future.
4 Any questions about what we've got on the
5 slide or anything?
6 COMMISSIONER HUDSON: Not at all.
7 MR. GIORI: Okay. If we can please get to
8 the next slide. Thank you.
9 So not a lot of exciting changes here. As
10 you can see, we've got some expansions into Rating
11 Area 12. So we are attempting to expand our
12 footprint into some of the more rural counties of
13 Virginia. You can see that obviously that's a
14 pretty small rating area, and we didn't really have
15 a good credible bases, so we essentially assumed
16 the rating area ten factor. But beyond that, we
17 are holding ground from a rating area factor
18 perspective.
19 And I suppose if there are no questions,
20 that's a pretty good segue to get into the
21 questions that were posed in advance.
22 COMMISSIONER HUDSON: You can proceed.
23 MR. GIORI: Okay. Thank you. So
24 challenges and opportunities for entering rural
25 areas of Virginia, I mean, this is -- I can kind of

101

1 frame this for maybe all states because I think
2 this is a general dichotomy we see in all markets,
3 that there are urban population centers where we
4 see a lot more carriers, a lot more heavy
5 competition, and then we see, you know, the lesser
6 served rural counties where, you know, there aren't
7 as many carriers, and premiums tend to be higher.
8 So I can definitely see the spirit of those two
9 questions.
10 So I would say the challenge, as has been
11 noted previously with going to rural areas, is
12 probably mostly felt with the hospital
13 negotiations. It's difficult to convince a
14 hospital to negotiate down from, you know, what
15 would be relatively high rates that they have with
16 their existing carrier relationship because they
17 essentially have a captive, you know, audience in
18 those areas. There aren't competing facilities or
19 practitioners for the most part. So they can
20 essentially ask for whatever they want, and if you
21 don't like it, that's okay because they already
22 have their carrier and they already have their
23 members.
24 So we sort of have an uphill battle there
25 to convince that they're -- you know, that you can

102

1 really bring some positive changes for them by, you
2 know, them receiving less money. It's tough to
3 make unless it's in the form of, you know,
4 competitive negotiations.
5 But the opportunities are obvious. I
6 mean, there's lots of membership and not only in
7 Virginia, but lots of markets that would be in
8 rural counties. Probably many more members would
9 join the Exchange if premium rates were brought
10 down to earth. I know that in Virginia at least
11 premium rates have come down in a lot of rural
12 counties over the last few years, but there was
13 certainly a period of time where, you know, premium
14 rates were sky high. So, you know, if you can
15 figure out how to make it work, there's certainly
16 an opportunity there from a business perspective.
17 And I'll just keep going. I'll probably
18 just go to the third one since I already mentioned
19 it about the lack of competition influencing level
20 of rates, because I do think this is probably an
21 area where insurance companies like ourselves get a
22 bad wrap for, you know, charging so much money, but
23 I think it really isn't related to the competitive
24 level. At least from my standpoint, I would look
25 at more the level of uncertainty that we see in new

103

1 change.
2 You know, the regulatory environment has
3 been relatively stability over the last few years,
4 as was already articulated in the primer, and I
5 think that's exactly why you're seeing, you know,
6 stability in the Virginia, you know, rate changes
7 over the last three years. We largely know what to
8 expect.
9 And obviously COVID was a curve ball for
10 everyone, but, you know, at the end of the day, you
11 know, we're not talking about CSR defunding. We're
12 not talking about, you know, major changes to the
13 subsidies. We're not talking about, you know, the
14 Exchange being cut in half in terms of membership.
15 So I feel like, generally speaking, things have
16 stabilized and that's been a good guide, which has
17 reduced the level of risk and uncertainty, and,
18 therefore, has increased competition because it's
19 now safer to come into the Exchange and more
20 carriers are seeing it as an opportunity rather
21 than a risk.
22 So I feel like it -- it's sort of more of
23 a risk and then competitor level, competition level
24 relationship, which is why I think in rural areas
25 you see fewer carriers because, you know, you have

104

1 to win those hospital negotiation battles. And
2 then if you do, there's higher levels of risk
3 related to the membership you do pick up, because
4 if there are only, you know, call it 10,000 members
5 in a particular rating area and you pick up a
6 thousand of them, you know, which thousand are you
7 getting? Are you getting like an average mix? Are
8 you getting, you know, just a thousand people that
9 are, you know, the least healthy who are, you know,
10 attracted to you for some reason that you're not --
11 you know, maybe you accidentally have or you choose
12 to have like a richer formulary? You don't really
13 know what the reason is going to be until, you
14 know, you've already gotten the members.
15 So I feel like it's, generally speaking,
16 we want an average mix of membership. That's what
17 everybody wants, and we want more membership, I
18 would say, in general on the Exchange because that
19 makes it easier to get a more average cohort of
20 membership versus just having, you know, a
21 selection bias.
22 So I just kind of did two. Any questions
23 about either of those two?
24 Okay. So then we've got the regulatory,
25 the ARPA, and then other. So I would kind of break

105

1 from some of the other earlier comments about ARPA.
2 I would say from my perspective, the effective ARPA
3 is -- so far has been probably mixed, and possibly
4 it's still a little too early to really know for
5 sure where this is going.
6 Yes, I 100 percent agree that getting more
7 membership on the Exchange is a good thing, but
8 when you're in an environment, as has been
9 articulated, where you can basically enroll
10 whenever you want, there isn't necessarily an
11 incentive to enroll in preparation for like just
12 having health insurance. You're enrolling because
13 you need it. And if you're in an environment like
14 we are now where I believe the SCP at this point
15 has been going for about a year and two-thirds
16 straight basically, there is really no reason to go
17 out and buy insurance unless you are, you know,
18 going to definitely need it, which I do think it's
19 a great thing as decided that you have that option,
20 that we aren't leaving people out just because they
21 didn't buy insurance.
22 But on the other hand, it does put
23 insurance companies in a awkward position because
24 now, you know, a lot of these SCP members that
25 we're seeing roll in are utilizing at much higher

106

1 rates than our existing book of business. So I
2 would say it's mixed.
3 I'm, you know, waiting to see how the year
4 plays out. Maybe things kind of level out with
5 these new enrollees, but in general I think a
6 stricter special enrollment period is probably a
7 healthy thing so that individuals are encouraged to
8 buy and maintain health insurance, just in general,
9 not just when they need it.
10 COMMISSIONER JAGDMANN: So are you saying
11 that if you continue to have basically open
12 enrollment in perpetuity, it will tend to drive
13 rates up? Is that what you're saying?
14 MR. GIORI: That's exactly what I'm
15 saying.
16 COMMISSIONER JAGDMANN: Because, you know,
17 you won't -- yeah, you won't have a pool of money
18 there. People -- you know, people pay a premium
19 and then they're sick, and they go to the hospital
20 and say, I'm going to get insurance because I'm
21 sick now. And so there's no prior --
22 MR. GIORI: Exactly.
23 COMMISSIONER JAGDMANN: -- contribution,
24 for lack of a word.
25 MR. GIORI: Exactly. So, yeah, it is --

107

1 in the end, it's a good guy in the early part of
2 times, you know, for everyone. It's a good thing
3 for society. But in the long term, it will be a
4 bad thing for, you know, the people who don't
5 necessarily need it right away. It will be a bad
6 thing for people who just want to maintain health
7 insurance coverage in the long term.
8 So I do think that stability there is very
9 important, and, you know, an emphasis more on
10 making sure people are insured versus having, you
11 know, the eligibility kind of in perpetuity.
12 Okay. And I'll just hit this last
13 question about federal or state initiatives. So
14 I've been, you know, proud to be a part of a lot of
15 the changes that are going on here in Virginia as
16 you've been requesting, you know, data for 1332s
17 and talking about other things like surprised
18 billing.
19 In the state level, state perspective, I'm
20 very positive on a lot of the changes that I've
21 seen kind of over the last couple of years. I do
22 think that in general that, you know, having a
23 state-based Exchange is a good thing. I think that
24 it's, you know, maybe more challenging upfront work
25 just to get things off the ground, but then it does

108

1 allow for alert a better relationship between the
2 insurer and the state.
3 I also think that the reinsurance that has
4 been talked about would be a good thing. We have
5 seen reinsurance in a couple of other markets now,
6 and whether, you know, it's small or large, I do
7 think it's positive on the industry and on the
8 Exchange, because at the end of the day, anything
9 that gets more people to enroll is a good thing for
10 the Exchange.
11 I would say balance billing too. I know
12 there are -- you know, there are some concerns that
13 you can have from an industry perspective, from an
14 insurance industry perspective, that is, that, you
15 know, you're essentially giving doctors or
16 facilities sometimes like another option. They
17 don't have to negotiate at all.
18 And, I mean, this is particularly
19 challenging, I think, in rural areas where, you
20 know, you really only have, you know, one choice or
21 you don't have many choices, and you know that
22 you're going to end up with people that need to go
23 to your practice regardless. So that can present
24 challenges, but it also creates a level playing
25 field and allows for, you know, standardized

109

1 practices when it comes to handling out of network
2 surprise bills.
3 And I do think it's a good thing for
4 consumers, because we all hear about the ugly
5 stories, you know, where people are stuck with
6 these large bills. I mean, nobody wants that. So,
7 I mean, anything we can do to avoid that upfront is
8 a good thing. I think it's just a matter of making
9 sure that, you know, hospitals are, you know, kept
10 in good faith with respect to negotiations and with
11 respect to the way that they practice business.
12 And I do -- I do think that is happening in states.
13 And I remember there was a question
14 earlier about this, about the hospital side of
15 things, and I know they are a bit outside of your
16 purview, but they are a big factor here in a lot of
17 the premiums that you're seeing today.
18 Questions?
19 COMMISSIONER HUDSON: No questions here.
20 MR. GIORI: All right. Thank you.
21 COMMISSIONER HUDSON: Thank you, Steven,
22 and thank you for your presentation.
23 MR. GIORI: Of course.
24 COMMISSIONER HUDSON: And last we have
25 Aetna Life, and I believe our presenter is Steve

110

1 Schneider, correct?
2 MR. SCHNEIDER: Can everybody hear me?
3 COMMISSIONER HUDSON: We can but we hear a
4 lot of feedback.
5 MR. SCHNEIDER: Yeah, I'm on the phone.
6 So I'll turn the -- can you hear me now?
7 COMMISSIONER HUDSON: We can, but there's
8 still a lot of feedback there.
9 Yeah. It's misbehaving. Let me see if I
10 can shift it. Okay. How do I --
11 COMMISSIONER HUDSON: Are you calling by
12 phone?
13 (Whereupon, off-the-record discussions
14 ensued.)
15 MR. SCHNEIDER: Hi. Am I back?
16 COMMISSIONER HUDSON: Yes, and we can hear
17 you loud and clear, no --
18 MR. SCHNEIDER: Okay. Apologies. I --
19 there was an audio problem before. It offered me
20 the option to do the phone, and I did it, and it
21 doesn't look like that was a good option.
22 So anyway, sorry about that.
23 COMMISSIONER HUDSON: No worries.
24 Whenever you're ready --
25 MR. SCHNEIDER: So as -- well, first of

111

1 all, thanks -- you know, thanks for the opportunity
2 for us to present. I know we're excited about
3 coming into the market, and I really appreciate the
4 opportunity.
5 So my name is Steve Schneider, and I am
6 the senior director or actuarial who leads the
7 Aetna CVS ACA pricing work, and our address is 151
8 Farmington Avenue, Hartford, Connecticut 06156.
9 So since we're just coming back into the
10 market, there's not really much to show in these
11 exhibits. We don't have any rate actions to show.
12 The only thing really on there is the actual rate
13 at the bottom. As you can see the plan, we don't
14 know what the -- there's no minimum, maximum. We
15 believe that the plan, the silver plan, we're
16 showing is going to be the most popular. It's
17 where it'll have the -- it's the lowest cost
18 silver, and it will have the most -- you know, it
19 will be the one that gets the most exposure and
20 gets the most, but we don't know. So there's not
21 really much there.
22 So what I thought I'd do is I know we have
23 a question about whether -- why we're entering.
24 I'll address that question. I can say a little bit
25 about our product offering and a few comments about

112

1 how we did the pricing, given that we have no
2 experience, and then -- but again, since we're not
3 in the market right now, I can't comment as much on
4 the other questions posed, but I can give a few
5 thoughts on there, if that makes sense.
6 COMMISSIONER HUDSON: Yes, please do.
7 MR. SCHNEIDER: So why we Aetna CVS are
8 getting back into the market -- well, first, I
9 mean, there's been a lot of comments made before
10 about how volatile it was, and we were obviously
11 one of the ones that didn't -- found that just
12 not -- not comfortable enough a few years ago, so
13 we did pull out.
14 But it's always been our commitment, our
15 mission to provide affordable healthcare for all
16 Americans really and, in particular in this case,
17 for Virginians. So we have reconsidered that.
18 There's a bunch of things we thought about in terms
19 of why we are positioned to come back into the
20 market.
21 In particular, we still have, even though
22 it's been, you know, close to five years, I guess,
23 we still have the institutional model at Aetna to
24 do that. I mean, there's a long memory. We've got
25 the capability to do it. So we didn't have to

113

1 build all that up, all that anyway from the ground
2 up.
3 We've talked a lot -- there's been a lot
4 of talk, and I can comment on the actuarial aspects
5 of this in a little while on the COVID pandemic,
6 but kind of on a macro level, it's actually brought
7 into focus a lot of gaps in the health care system.
8 And everyone's, I think, familiar with those
9 disparities that impact the under served
10 communities, just access to people who are
11 unemployed, how they get their insurance, and then
12 just to generally -- a general issue of rising
13 costs. But again COVID has really highlighted the
14 need to address some of those.
15 We've also heard some of the prior
16 presenters talk about the stability. As the ACA
17 has evolved, it's definitely a more stable
18 environment now, partly just by nature of there's
19 been membership and the carriers have those who
20 didn't have more experience, but also just the
21 regulatory environment in Virginia, as well as some
22 other places that's become more certain, and a lot
23 of the issues that we had before have been
24 addressed.
25 In terms of why Virginia and which states

114

1 we're in, we definitely were very deliberate and
2 thoughtful in selecting those, as well as even the
3 areas within the states. As you can see, we're --
4 you'll see we're not in the whole state, not yet
5 anyway.
6 But Virginia, particularly, we felt in
7 those areas -- and we're going to be in Richmond
8 and then in the Roanoke area and then Blacksburg
9 also, and we felt that we could enter there and
10 compete right off the bat. Part of that is due to
11 the provider relationships that we felt we could
12 have, and that's a big part of this, and those
13 were, I think, just kind of statewide. The
14 prospects of having good relations with the
15 providers that we could negotiate with, and in
16 particular those areas we felt.
17 And then I think, you know, last but not
18 least, we can use now, which we didn't have really
19 available before, we can use the CVS assets, CVS
20 stores to our benefit, and I think -- I don't
21 have -- I know we see a lot of national numbers
22 because a lot of the information we have on this is
23 national, but, you know, there's a lot. There's
24 something like 10,000 nationally, and I know
25 there's several hundred in Virginia, and I think

115

1 there's probably a couple of dozen in Richmond.
2 And so that's a big part of our product offerings
3 I'll talk about in a sec, but those are the reasons
4 that we felt that it's a prime time for us to get
5 back into the market.
6 Any questions on there before I kind of
7 shift gears a little and talk about what we're
8 actually coming with?
9 COMMISSIONER HUDSON: No. You can
10 proceed.
11 MR. SCHNEIDER: Okay. So we -- we're --
12 in terms of plan designs, we've got kind of five --
13 there's five plan options we're coming with. I
14 mean, there's variations of these by area, because
15 technically they sometimes need to be filed as a
16 separate plan.
17 But basically we've got five plan designs:
18 One gold, two silver and two bronze. And they're
19 pretty standard in terms of -- you know, typical in
20 terms of their cost-sharing provisions, but we do
21 have some, I think, unique features in them, and
22 it's kind of a hybrid between what a -- the typical
23 insurance aspect that Aetna provides and makes use
24 of our expertise there and also makes use of some
25 of the services that we can avail ourselves of with

116

1 the CVS health, you know, infrastructure.
2 So as examples of that, we can offer low
3 or no cost visits to minute clinics, and, you know,
4 those again, there's a lot -- there's probably a
5 thousand or so in the U.S. There's a number of
6 them, I don't have the number off the top of my
7 head, in Virginia, but it's probably dozens of
8 them, and they're spread across the state,
9 predominantly in the urban areas, but they're
10 pretty widespread.
11 We're opening health hubs at a pretty
12 healthy clip, which is a little different than the
13 minute clinic but a similar thing. It's something
14 that members can make use of at the CVS locations,
15 and there's a care concierge there that's available
16 for that.
17 Obviously CVS is a big player in the
18 prescription market. We offer 90-day refills at
19 people's convenience, and just basically a good
20 simplified member experience that -- where they can
21 pay bills at the -- pay bills at stores and things
22 like that.
23 So those are some of the CVS aspects that
24 are integrated into our broader product offering
25 that's kind of beyond the typical cost shares.

117

1 So a little bit now I talked -- as I said,
2 we don't have any experience, right, so I
3 thought -- to price off of it, or, I guess, that's
4 not technically true. I mean, we can look back at
5 many years ago, but we don't -- it's not really
6 particularly useful because the market has changed
7 so much, as many people have alluded to and even
8 expressed.
9 But -- so I thought I'd just give just a
10 real high level, a couple of comments on just how
11 we do price. And so when I say we don't have
12 experience, it's -- we don't have individual
13 experience, but we do have a lot of data for the
14 other markets, and most critically it's payments
15 that we make to the same providers in the same
16 markets. So we do have data on what it costs, but
17 what we don't have in that data is the risk
18 profile, population profile of the individual
19 markets.
20 So we basically had just to make some
21 assumptions of how it translates. We know from, as
22 some of the others have mentioned, that there's --
23 you know, people are signing up because they need
24 the insurance. So there's going to be a higher
25 incidence, higher risk in there.

118

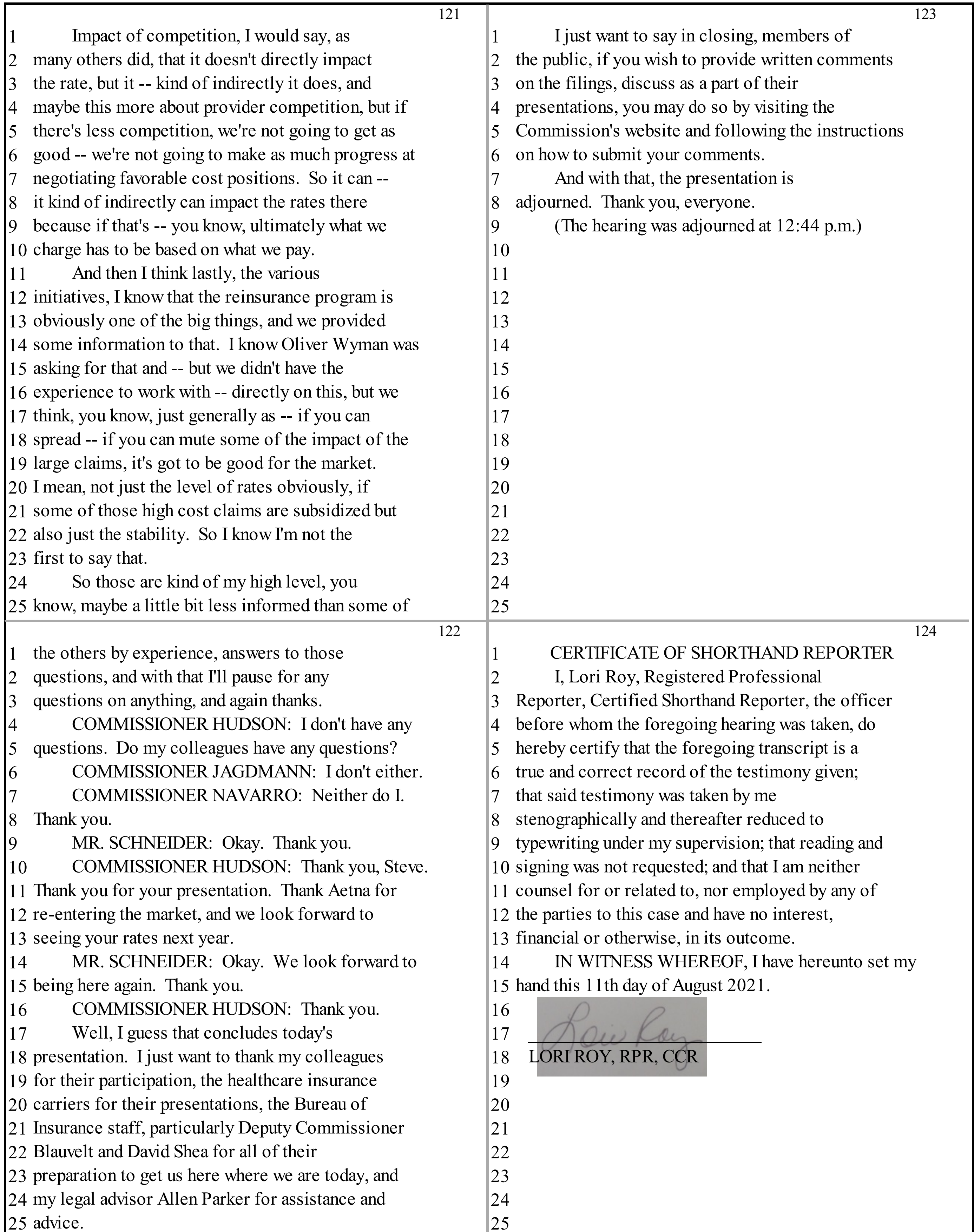
1 We have -- you know, we've got estimates
2 and ways of estimating that. So we essentially
3 just adjust our experience to what we believe the
4 morbidity level of the individual market is there.
5 And as -- I've also mentioned that provider
6 relationships and the ability to negotiate good
7 deals is critical in deciding where we're going to
8 enter, and we did a lot of that as well, and so we
9 also adjusted the experience for those.
10 And so at the end of the day, we -- even
11 though we don't start out with experiences on the
12 individual block, we do our best to approximate it.
13 And, you know, in the end, we came to, I think,
14 pretty -- some pretty competitive rate positions
15 through all this work, and I think we're going to
16 be pretty -- we -- you know, we won't know for sure
17 until we're able to analyze all the other rates,
18 but we believe we'll be in the market and able to
19 play in those areas that we're filing.
20 One maybe more specific point that I
21 should note on there is we do have an assumption
22 for COVID in there. I mean, we recognize -- a lot
23 of what we heard earlier is exactly kind of what
24 we've experienced as well. There's been -- there
25 were -- it's very challenging to know how to

119

1 evaluate your 2020 experience, which is the base
2 period, and I guess that's something that doesn't
3 hurt us maybe as much as it hurts the others
4 because we had to make a number of adjustments
5 anyway.
6 But we do have a prospective adjustment of
7 2 percent in there, and it's -- I would say it's
8 probably mostly testing and vaccines, vaccinations
9 that this is, but our modeling has kind of run the
10 gamut in terms of scenarios that talk about and
11 that address the deferred care, the actual costs of
12 treating COVID, and it's kind of all over the place
13 in terms of what might happen as we've seen -- as
14 we see now. You know, the unexpected often happens
15 within this and -- but I would say probably that
16 the testing and vaccinations is the thing that's
17 driving us to feel like the average -- kind of the
18 average of all of those scenarios is a 2 percent.
19 So I wanted to comment a little bit on
20 that because I know that's an important topic, and
21 others have -- you know, that -- those assumptions
22 are kind of all over the place.
23 As far as the other questions, I can
24 comment on them, but we don't have -- we don't have
25 the business out there in the recent years. It's

120

1 not so much impact on us, but I can talk a little
2 bit about our considerations there.
3 For rural entry, I think it's some of the
4 same comments that were made before. It's hospital
5 negotiations, the ability to get favorable cost
6 arrangements, and we also don't have as many CVS
7 stores in the rural areas. They're often more
8 concentrated in urban areas, and so to the extent
9 we're relying on that, it makes some of the rural
10 areas less attractive.
11 ARPA, I think I would echo what the other
12 commentators have said. There's kind of winds
13 blowing both direction there. There's the general
14 selection, anti-selection dynamic that I know we're
15 all familiar with. But additionally, all the
16 subsidies that are going to increase the membership
17 that we don't -- you know, we don't really know
18 what the population is going to look like, and it
19 might -- there's good reason to think that it could
20 be a more healthier population that could offset
21 some of that. So at the end of the day, we don't
22 really know. I mean, this is a retrospective
23 impact, but projecting forward it's sort of
24 everybody's guess. So we didn't make any
25 adjustments for that in our rates.



121

1 Impact of competition, I would say, as
2 many others did, that it doesn't directly impact
3 the rate, but it -- kind of indirectly it does, and
4 maybe this more about provider competition, but if
5 there's less competition, we're not going to get as
6 good -- we're not going to make as much progress at
7 negotiating favorable cost positions. So it can --
8 it kind of indirectly can impact the rates there
9 because if that's -- you know, ultimately what we
10 charge has to be based on what we pay.
11 And then I think lastly, the various
12 initiatives, I know that the reinsurance program is
13 obviously one of the big things, and we provided
14 some information to that. I know Oliver Wyman was
15 asking for that and -- but we didn't have the
16 experience to work with -- directly on this, but we
17 think, you know, just generally as -- if you can
18 spread -- if you can mute some of the impact of the
19 large claims, it's got to be good for the market.
20 I mean, not just the level of rates obviously, if
21 some of those high cost claims are subsidized but
22 also just the stability. So I know I'm not the
23 first to say that.
24 So those are kind of my high level, you
25 know, maybe a little bit less informed than some of

122

1 the others by experience, answers to those
2 questions, and with that I'll pause for any
3 questions on anything, and again thanks.
4 COMMISSIONER HUDSON: I don't have any
5 questions. Do my colleagues have any questions?
6 COMMISSIONER JAGDMANN: I don't either.
7 COMMISSIONER NAVARRO: Neither do I.
8 Thank you.
9 MR. SCHNEIDER: Okay. Thank you.
10 COMMISSIONER HUDSON: Thank you, Steve.
11 Thank you for your presentation. Thank Aetna for
12 re-entering the market, and we look forward to
13 seeing your rates next year.
14 MR. SCHNEIDER: Okay. We look forward to
15 being here again. Thank you.
16 COMMISSIONER HUDSON: Thank you.
17 Well, I guess that concludes today's
18 presentation. I just want to thank my colleagues
19 for their participation, the healthcare insurance
20 carriers for their presentations, the Bureau of
21 Insurance staff, particularly Deputy Commissioner
22 Blauvelt and David Shea for all of their
23 preparation to get us here where we are today, and
24 my legal advisor Allen Parker for assistance and
25 advice.

123

1 I just want to say in closing, members of
2 the public, if you wish to provide written comments
3 on the filings, discuss as a part of their
4 presentations, you may do so by visiting the
5 Commission's website and following the instructions
6 on how to submit your comments.
7 And with that, the presentation is
8 adjourned. Thank you, everyone.
9 (The hearing was adjourned at 12:44 p.m.)
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124

1 CERTIFICATE OF SHORTHAND REPORTER
2 I, Lori Roy, Registered Professional
3 Reporter, Certified Shorthand Reporter, the officer
4 before whom the foregoing hearing was taken, do
5 hereby certify that the foregoing transcript is a
6 true and correct record of the testimony given;
7 that said testimony was taken by me
8 stenographically and thereafter reduced to
9 typewriting under my supervision; that reading and
10 signing was not requested; and that I am neither
11 counsel for or related to, nor employed by any of
12 the parties to this case and have no interest,
13 financial or otherwise, in its outcome.
14 IN WITNESS WHEREOF, I have hereunto set my
15 hand this 11th day of August 2021.
16
17 ______________________
18 LORI ROY, RPR, CCR
19
20
21
22
23
24
25

**A**

**ability**
27:7, 27:14, 118:6, 120:5
**able**
8:24, 12:13, 21:24, 23:2, 23:8, 24:5, 24:9, 26:21, 27:3, 29:10, 29:12, 29:13, 29:15, 30:6, 30:22, 33:16, 34:1, 34:9, 68:14, 71:25, 83:13, 89:7, 89:8, 118:17, 118:18
**above**
30:16
**absolutely**
29:10, 36:24, 47:15
**aca**
5:17, 16:21, 17:20, 18:19, 22:7, 22:16, 22:18, 48:12, 48:22, 49:17, 50:3, 50:21, 55:19, 56:4, 56:16, 89:1, 111:7, 113:16
**access**
32:23, 36:22, 67:1, 96:24, 113:10
**accessible**
63:6
**accidentally**
104:11
**accommodate**
85:25, 86:20
**according**
63:16
**accounted**
19:1
**accounts**
91:5, 91:9, 92:13, 97:1
**accurately**
6:16
**acknowledged**
37:25, 38:1
**across**
60:11, 61:18, 81:22, 116:8
**actions**
111:11
**activities**
5:9, 7:23, 7:25, 28:11
**activity**
56:16
**actual**
18:10, 20:6, 24:2, 89:10, 90:2, 111:12, 119:11
**actually**
15:17, 18:14, 19:7, 19:9, 20:6, 24:7, 24:17, 40:11, 40:16, 51:11, 52:24, 73:10, 76:16, 76:20, 78:17, 78:19, 78:20, 78:23, 80:10, 85:11, 88:7, 99:14, 113:6, 115:8
**actuarial**
59:24, 111:6, 113:4
**actuary**
2:7, 5:15, 35:19, 36:18, 36:24, 37:2, 37:9, 39:6, 39:9, 39:14, 40:18, 43:15, 45:3, 45:6, 46:12, 46:20, 47:15, 47:20, 48:8, 49:13, 70:11
**add**
68:17
**adding**
71:8
**addition**
13:5
**additional**
44:2, 80:24
**additionally**
120:15
**address**
6:15, 59:1, 59:25, 70:17, 74:3, 84:6, 90:4, 98:4, 111:7, 111:24, 113:14, 119:11
**addressed**
113:24
**adjourned**
123:8, 123:9
**adjust**
118:3
**adjusted**
73:19, 118:9
**adjustment**
48:16, 66:3, 66:6, 66:7, 69:11, 69:15, 73:8, 73:17, 73:19, 73:21, 73:24, 78:10, 83:12, 91:5, 93:4, 97:2, 99:6, 99:7, 99:17, 119:6
**adjustments**
42:20, 80:21, 92:10, 119:4, 120:25
**admin**
91:7
**administrative**
63:14
**admissions**
40:5
**advance**
58:9, 58:25, 68:23, 100:21
**advanced**
24:12
**advantage**
23:1, 23:3, 29:25
**advantages**
26:16, 26:20, 28:16, 40:15
**adversarial**
7:3
**adverse**
99:22
**advice**
122:25
**advisor**
122:24
**aetna**
2:12, 8:20, 58:17, 59:16, 109:25, 111:7, 112:7, 112:23, 115:23, 122:11
**affect**
17:6, 20:13, 20:14, 48:23, 78:23
**affected**
26:24
**affects**
24:2
**afford**
56:19
**affordability**
95:21
**affordable**
61:17, 112:15
**after**
8:23, 24:11, 32:15, 36:14, 50:1, 61:17, 90:8, 90:20, 92:5
**afterwards**
5:18
**again**
7:13, 12:3,

13:8, 38:24, 42:8, 43:1, 44:11, 46:14, 50:10, 52:6, 52:12, 55:21, 69:14, 77:25, 81:18, 93:3, 93:7, 95:5, 97:10, 112:2, 113:13, 116:4, 122:3, 122:15
**age**
19:16, 30:4, 30:7, 30:16, 76:22, 87:5, 90:21, 92:22, 94:22
**ago**
78:4, 81:13, 112:12, 117:5
**agree**
46:16, 80:8, 96:1, 105:6
**alert**
108:1
**all**
9:6, 11:24, 13:9, 13:22, 20:14, 26:25, 27:3, 27:19, 27:23, 28:2, 33:7, 36:7, 36:10, 41:7, 41:17, 41:20, 42:16, 42:24, 43:2, 43:3, 44:15, 44:23, 45:14, 46:16, 46:17, 47:18, 48:20, 49:7, 49:25, 50:4, 52:19, 52:20, 54:9, 54:11, 54:15, 54:19, 54:23, 55:4, 58:9, 60:2, 61:8, 63:22, 65:3, 65:4, 65:7, 67:16, 67:17, 70:9, 74:23, 75:10, 78:12, 80:4, 80:8, 81:1, 82:14, 84:6, 85:4, 85:5, 85:8, 87:9, 87:21, 88:8, 89:14, 90:9, 93:16, 93:17, 93:22, 93:25, 94:25, 95:13, 95:22, 97:16, 98:7, 98:23, 99:1, 99:25, 100:6, 101:1, 101:2, 108:17, 109:4, 109:20, 111:1, 112:15, 113:1, 118:15, 118:17, 119:12, 119:18, 119:22, 120:15, 122:22
**allen**
122:24
**allow**
21:24, 22:1, 31:25, 108:1
**allows**
12:21, 32:6, 75:11, 108:25
**alluded**
80:14, 88:11, 117:7
**alluding**
43:13
**almost**
25:10, 95:17
**along**
13:10, 35:9, 35:10, 35:12, 35:22
**already**
47:13, 88:22, 101:21, 101:22, 102:18, 103:4, 104:14
**also**
3:13, 5:7, 6:7, 6:18, 10:7, 11:15, 13:13, 13:20, 17:19, 22:21, 23:2, 23:10, 23:20, 29:1, 32:18, 33:7, 34:14, 34:16, 36:2, 39:22, 40:13, 47:23, 57:1, 58:15, 60:14, 61:4, 76:25, 79:21, 80:22, 82:21, 83:21, 88:10, 92:1, 92:15, 97:7, 97:9, 98:21, 99:25, 108:3, 108:24, 113:15, 113:20, 114:9, 115:24, 118:5, 118:9, 120:6, 121:22
**although**
8:5, 36:4, 58:18
**always**
46:4, 56:20, 112:14
**america**
32:8
**american**
17:9, 22:10, 22:12, 22:22, 61:11
**americans**
112:16
**among**
54:11, 56:7
**amount**
16:23, 18:10, 18:19, 20:4, 21:4, 21:5, 30:15, 30:22, 33:24, 63:18, 82:7
**amounts**
20:3, 21:7, 47:17, 53:17, 53:18
**analyses**
41:18, 43:2
**analysis**
57:13
**analyze**
42:11, 48:15, 48:22, 118:17
**analyzing**
48:19
**anecdotal**
39:17
**angela**
2:5
**annual**
4:1, 30:9, 31:21, 32:24, 87:20
**another**
16:21, 20:25, 21:2, 38:20, 40:4, 46:2, 46:7, 48:23, 60:14, 67:13, 71:8, 76:1, 91:14, 108:16
**answer**
26:16, 62:11, 68:14, 78:19, 83:9
**answered**
82:14, 85:8, 94:14
**answers**
122:1
**anthem**
2:11, 70:11, 71:6, 74:22, 82:14, 83:24, 85:23, 86:19
**anti-selection**
120:14
**anticipated**
65:23
**anticipating**
46:6

**any**
6:21, 7:6, 9:5, 9:7, 12:1, 13:23, 14:25, 17:8, 17:22, 21:4, 21:11, 22:8, 23:10, 23:15, 23:25, 29:4, 29:21, 31:11, 33:5, 34:20, 35:16, 35:23, 36:14, 38:7, 39:2, 41:5, 53:7, 55:17, 56:21, 60:18, 60:21, 60:23, 61:14, 62:20, 64:14, 66:8, 67:5, 68:17, 69:18, 72:24, 83:3, 85:4, 88:23, 88:25, 89:14, 93:10, 94:3, 94:21, 97:14, 100:4, 104:22, 111:11, 115:6, 117:2, 120:24, 122:2, 122:4, 122:5, 124:11
**anybody**
23:21, 53:5
**anyone**
17:22, 23:14, 28:8, 75:14
**anything**
14:19, 59:6, 60:24, 63:1, 79:4, 95:19, 100:5, 108:8, 109:7, 122:3
**anyway**
47:14, 53:25, 110:22, 113:1, 114:5, 119:5
**anywhere**
46:10
**apologies**
110:18
**appear**
35:2
**applicant**
14:10
**application**
8:14, 14:19, 15:3, 33:13, 34:9, 34:10, 34:12
**apply**
52:19
**applying**
66:8
**appointments**
44:7, 44:8
**appreciate**
70:1, 80:6, 111:3
**approval**
9:4
**approve**
3:9
**approved**
10:25, 14:20, 18:15, 19:6
**approving**
4:14
**approximate**
118:12
**april**
23:2, 23:4, 36:8, 42:13, 52:14, 57:22
**aptc**
24:12
**arbitration**
79:22
**area**
10:20, 11:1, 11:7, 11:13, 11:20, 11:23, 12:23, 13:19, 30:25, 36:13, 60:9, 60:12, 65:6, 66:15, 67:10, 67:19, 67:22, 83:13, 83:14, 83:17, 83:19, 83:22, 83:25, 84:5, 87:4, 94:24, 95:10, 100:11, 100:14, 100:16, 100:17, 102:21, 104:5, 114:8, 115:14
**areas**
11:12, 19:19, 19:21, 34:25, 59:2, 59:3, 60:12, 61:6, 67:9, 82:13, 82:15, 82:18, 82:19, 82:25, 95:4, 95:10, 100:25, 101:11, 101:18, 103:24, 108:19, 114:3, 114:7, 114:16, 116:9, 118:19, 120:7, 120:8, 120:10
**aren't**
8:9, 12:1, 14:25, 21:11, 22:8, 29:19, 29:21, 31:11, 34:20, 76:25, 81:9, 101:6, 101:18, 105:20
**argue**
48:10, 52:4
**around**
18:18, 42:13, 56:16, 75:11, 80:25, 85:18, 90:24, 92:6, 92:24
**arpa**
21:4, 25:24, 28:23, 29:24, 30:10, 30:20, 31:4, 35:5, 35:6, 48:24, 57:18, 59:7, 61:9, 62:16, 63:1, 63:5, 74:2, 74:4, 74:7, 74:24, 75:22, 76:5, 77:24, 95:14, 95:19, 104:25, 105:1, 105:2, 120:11
**arrangements**
120:6
**arrive**
20:9
**arrived**
12:20
**articulated**
103:4, 105:9
**aside**
13:2
**asked**
58:14, 59:15, 65:8, 74:2, 77:6, 85:13, 85:20
**asking**
64:16, 121:15
**aspect**
115:23
**aspects**
113:4, 116:23
**assembly**
33:11
**assess**
36:21
**assessment**
96:12
**assets**
114:19
**assistance**
122:24
**associated**
4:14, 77:2
**association**
32:8
**assume**
62:6
**assumed**
91:16, 93:23, 94:2, 100:15

**assuming**
64:12
**assumption**
37:14, 118:21
**assumptions**
117:21, 119:21
**atlantic**
90:3
**attempting**
100:11
**attracted**
104:10
**attractive**
9:24, 10:11, 120:10
**audience**
101:17
**audio**
110:19
**august**
1:14, 3:23, 124:15
**automatically**
15:15, 32:1
**av**
23:17
**avail**
115:25
**available**
12:11, 12:12, 22:23, 23:14, 27:24, 114:19, 116:15
**avenue**
111:8
**average**
15:22, 16:1, 18:3, 18:15, 19:8, 19:15, 20:21, 21:3, 21:5, 21:8, 24:10, 24:11, 24:16, 35:3, 38:17, 38:21, 48:18, 49:23, 51:21, 53:10, 53:11, 54:6, 54:14, 54:15, 54:17, 54:21, 54:25, 55:8, 73:4, 87:15, 88:7, 98:11, 98:12, 98:18, 99:12, 104:7, 104:16, 104:19, 119:17, 119:18
**avoid**
109:7
**aware**
86:17
**away**
37:11, 43:18, 107:5
**awkward**
105:23

**B**

**back**
8:1, 8:22, 8:24, 9:19, 13:3, 16:19, 17:2, 23:6, 23:23, 36:9, 37:7, 42:9, 44:4, 44:8, 51:2, 51:4, 52:3, 52:20, 53:18, 55:12, 56:2, 56:25, 73:19, 74:8, 74:13, 74:18, 75:19, 76:7, 77:2, 78:2, 80:17, 83:2, 84:17, 87:24, 89:15, 98:7, 110:15, 111:9, 112:8, 112:19, 115:5, 117:4
**background**
5:8
**backward**
52:18
**bad**
75:22, 102:22, 107:4, 107:5
**bailiff**
5:24
**balance**
78:18, 108:11
**ball**
103:9
**bar**
16:5
**bars**
16:2, 49:22
**base**
92:10, 93:4, 119:1
**based**
10:22, 12:3, 13:8, 16:12, 18:9, 31:2, 47:1, 50:14, 63:12, 67:8, 89:10, 97:6, 121:10
**bases**
100:15
**basic**
40:20, 40:21, 41:1, 91:12
**basically**
37:6, 37:13, 37:21, 38:20, 53:13, 55:8, 105:9, 105:16, 106:11, 115:17, 116:19, 117:20
**basis**
82:2, 82:4
**basket**
45:14, 45:19
**bat**
114:10
**battle**
101:24
**battles**
104:1
**beach**
60:1
**beat**
52:9
**because**
9:4, 9:25, 15:14, 16:25, 19:6, 19:17, 21:2, 22:14, 24:18, 29:16, 30:5, 32:23, 33:20, 35:6, 39:20, 42:12, 43:17, 44:2, 45:19, 48:24, 51:5, 51:9, 51:22, 51:23, 52:7, 52:17, 53:17, 54:24, 58:22, 72:23, 91:15, 98:16, 101:1, 101:16, 101:21, 102:20, 103:18, 103:25, 104:3, 104:18, 105:12, 105:20, 105:23, 106:16, 106:20, 108:8, 109:4, 114:22, 115:14, 117:6, 117:23, 119:4, 119:20, 121:9
**become**
5:25, 73:15, 79:12, 113:22
**been**
5:24, 9:21, 11:16, 12:13, 15:22, 22:16, 28:22, 29:1, 31:13, 34:4, 35:13, 40:15, 42:4, 45:16, 46:17, 48:13, 55:15, 57:1, 57:8, 61:15, 79:10, 80:8, 80:9, 80:12, 80:19, 82:8, 85:25, 88:12, 98:8, 98:9, 99:7, 101:10, 103:3, 103:16, 105:3, 105:8,

105:15, 107:14, 107:16, 108:4, 112:9, 112:14, 112:22, 113:3, 113:19, 113:23, 118:24
**before**
4:2, 4:14, 7:7, 8:22, 9:9, 14:14, 16:19, 21:4, 23:25, 25:24, 34:12, 35:4, 36:19, 39:2, 48:25, 60:18, 73:1, 80:2, 99:8, 110:19, 112:9, 113:23, 114:19, 115:6, 120:4, 124:4
**began**
17:7
**begin**
7:12, 70:8, 89:25, 98:1
**beginning**
15:10, 15:11, 15:19, 23:7, 30:6, 33:7, 33:9, 53:22
**behavior**
47:6, 47:7
**being**
6:6, 6:7, 8:4, 24:5, 24:9, 26:21, 60:6, 61:9, 67:18, 78:6, 89:2, 89:8, 103:14, 122:15
**believe**
9:7, 11:21, 21:23, 61:15, 61:24, 79:24, 96:14, 105:14, 109:25, 111:15, 118:3, 118:18
**below**
71:2, 71:15
**belt**
57:25
**beneficial**
61:16
**benefit**
31:17, 71:15, 72:23, 76:17, 88:15, 91:6, 91:8, 92:13, 96:11, 114:20
**benefits**
3:10
**best**
12:21, 12:24, 15:24, 37:4, 37:5, 79:17, 79:18, 82:13, 84:3, 85:23, 118:12
**bet**
64:22
**better**
11:3, 28:16, 39:16, 74:17, 79:15, 108:1
**between**
18:5, 28:11, 60:4, 62:20, 96:16, 108:1, 115:22
**beyond**
100:16, 116:25
**bias**
104:21
**big**
16:23, 17:10, 17:15, 22:21, 29:2, 44:12, 44:21, 46:7, 84:10, 99:5, 99:16, 109:16, 114:12, 115:2, 116:17, 121:13
**biggest**
13:6, 37:11, 37:17, 50:15, 57:8
**bill**
10:7, 34:15, 79:10, 79:11
**billing**
78:18, 107:18, 108:11
**bills**
109:2, 109:6, 116:21
**bit**
11:10, 12:6, 15:9, 16:15, 19:4, 19:24, 30:5, 36:4, 37:16, 38:16, 39:20, 40:1, 41:16, 42:10, 47:6, 52:5, 52:25, 53:1, 57:10, 71:17, 73:21, 75:16, 77:18, 77:25, 78:2, 79:6, 79:22, 81:11, 84:24, 88:4, 90:17, 109:15, 111:24, 117:1, 119:19, 120:2, 121:25
**blacksburg**
11:12, 114:8
**blauvelt**
2:6, 5:12, 7:11, 7:14, 9:16, 10:13, 13:24, 14:1, 14:7, 14:12, 14:15, 14:23, 20:5, 20:18, 20:25, 25:5, 25:15, 26:7, 26:19, 28:18, 76:16, 122:22
**blind**
51:7
**block**
118:12
**bloomfield**
98:4
**blowing**
120:13
**blue**
11:5, 16:3, 16:4, 49:18, 88:6
**book**
98:19, 99:9, 99:12, 106:1
**both**
36:6, 58:12, 120:13
**bottom**
111:13
**brand**
11:18, 87:11
**break**
11:10, 31:10, 104:25
**breaking**
16:2
**breaks**
28:21, 29:23
**briefly**
59:1, 87:5
**bring**
7:7, 39:24, 80:24, 96:2, 102:1
**bringing**
32:12
**brings**
95:20
**broad**
25:1, 61:18, 97:6
**broader**
116:24
**broken**
91:2
**bronze**
90:12, 90:23, 93:12, 115:18
**brought**
18:11, 80:7, 102:9, 113:6
**bruce**
6:23, 6:25
**buckets**
76:22

**build**
81:3, 113:1
**building**
81:4, 81:10
**buildings**
94:10, 95:7
**built**
80:10, 81:7
**bullet**
24:7, 26:8, 36:21
**bunch**
112:18
**burden**
76:19
**bureau**
3:20, 4:24, 5:1, 5:7, 5:9, 6:5, 7:20, 7:24, 26:12, 36:1, 36:15, 83:12, 83:15, 122:20
**bureau's**
5:15, 5:16, 14:5
**business**
4:11, 38:3, 41:18, 48:24, 49:5, 52:7, 56:14, 56:22, 58:15, 59:7, 61:10, 63:7, 95:14, 99:10, 99:12, 102:16, 106:1, 109:11, 119:25
**businesses**
4:18
**buy**
105:17, 105:21, 106:8

**C**

**calculate**
46:24
**calculated**
60:13
**calculating**
99:2
**calendar**
15:10
**call**
7:10, 44:14, 52:4, 72:6, 104:4
**called**
41:2, 43:16
**calling**
110:11
**calls**
96:12
**came**
15:1, 21:4, 21:23, 118:13
**can't**
14:18, 17:25, 28:7, 56:23, 84:18, 112:3
**cannot**
10:19, 10:20, 10:23, 57:7
**capabilities**
95:9
**capability**
112:25
**captive**
101:17
**care**
23:1, 45:11, 46:15, 46:16, 86:7, 94:8, 95:9, 95:11, 96:24, 98:25, 113:7, 116:15, 119:11
**carrier**
6:1, 8:20, 10:25, 11:1, 11:6, 11:8, 11:24, 12:14, 12:21, 13:4, 14:16, 37:19, 38:6, 38:7, 38:8, 41:13, 52:19, 54:3, 55:19, 83:25, 101:16, 101:22
**carrier's**
14:19, 20:7, 41:8, 75:17
**carriers**
3:25, 5:4, 5:16, 5:21, 8:12, 8:14, 8:16, 8:19, 9:17, 9:19, 9:25, 10:6, 10:11, 10:19, 10:21, 10:23, 11:13, 11:16, 11:18, 12:4, 12:9, 12:13, 12:16, 12:17, 13:5, 13:13, 18:11, 19:17, 26:25, 30:6, 33:18, 33:19, 33:20, 34:1, 34:25, 36:12, 37:12, 37:19, 37:25, 38:3, 38:24, 39:24, 40:6, 40:11, 40:21, 41:17, 42:11, 42:14, 43:12, 43:22, 44:12, 45:18, 48:11, 48:14, 48:17, 49:6, 50:10, 50:18, 50:24, 51:2, 51:17, 51:23, 52:8, 52:18, 54:11, 54:16, 54:19, 55:4, 55:12, 56:8, 56:12, 56:17, 56:23, 56:25, 57:4, 57:12, 57:23, 74:23, 77:11, 80:9, 84:2, 94:6, 101:4, 101:7, 103:20, 103:25, 113:19, 122:20
**carries**
57:21
**carry**
84:21
**case**
9:15, 43:15, 80:8, 99:11, 112:16, 124:12
**cases**
79:24, 82:7
**cast**
55:23
**catastrophic**
65:20, 77:13, 91:22
**catch**
51:20
**categories**
44:21, 65:8
**caused**
42:10
**ccr**
1:29, 124:18
**centers**
101:3
**central**
11:15
**certain**
27:15, 39:17, 39:18, 43:10, 45:13, 47:13, 47:25, 56:14, 56:23, 57:3, 58:11, 59:5, 59:10, 62:23, 63:23, 66:24, 96:6, 113:22
**certainly**
27:23, 35:22, 57:3, 58:7, 62:12, 64:18, 66:22, 102:13, 102:15
**certificate**
124:1
**certification**
3:22
**certified**
124:3

**certify**
3:14, 124:5
**challenge**
37:12, 37:18, 44:12, 49:4, 57:8, 60:14, 79:16, 82:16, 82:23, 82:24, 101:10
**challenges**
26:18, 28:1, 59:1, 60:6, 95:3, 100:24, 108:24
**challenging**
42:17, 48:23, 50:17, 57:16, 80:12, 107:24, 108:19, 118:25
**chance**
13:1, 22:18, 87:23
**change**
8:6, 13:1, 13:6, 16:7, 21:17, 21:18, 27:5, 27:10, 31:20, 32:6, 32:7, 35:5, 36:14, 38:4, 38:16, 38:18, 41:3, 41:11, 45:15, 45:16, 47:4, 47:7, 47:22, 50:3, 50:8, 53:11, 54:6, 54:14, 54:17, 54:21, 54:25, 65:17, 65:20, 65:23, 66:12, 66:16, 69:4, 69:7, 69:10, 73:12, 73:14, 73:17, 83:14, 83:19, 87:5, 87:15, 88:6, 88:25, 91:3, 91:8, 91:14, 91:21, 92:10, 92:13, 92:14, 92:15, 92:17, 93:4, 93:5, 93:6, 98:11, 98:13, 98:17, 103:1
**changed**
10:19, 10:20, 10:23, 16:11, 55:21, 117:6
**changes**
5:20, 8:9, 10:24, 15:9, 27:8, 31:14, 31:19, 32:10, 36:14, 41:5, 41:6, 41:9, 41:19, 42:6, 42:7, 48:2, 50:5, 50:15, 53:13, 55:8, 63:13, 84:22, 91:18, 94:21, 99:21, 100:9, 102:1, 103:6, 103:12, 107:15, 107:20
**changing**
40:23, 47:6, 48:18, 52:8, 55:3, 55:4
**characters**
55:23
**charge**
50:13, 92:4, 121:10
**charging**
102:22
**chart**
28:20, 54:1, 54:2
**choice**
108:20
**choices**
35:1, 54:23, 108:21
**choose**
24:17, 104:11
**choosing**
25:18, 26:4, 67:24
**chosen**
25:8, 58:5, 58:11
**cigna**
2:10, 58:16, 97:20, 98:3, 98:8, 99:11
**circle**
34:2, 98:6
**claim**
63:13, 77:14, 86:11
**claimant**
77:9
**claimants**
77:14
**claims**
34:2, 40:23, 42:15, 42:18, 43:23, 44:24, 49:20, 51:15, 77:10, 78:24, 82:7, 99:24, 121:19, 121:21
**clarification**
13:25
**clarified**
37:1
**clarify**
64:11
**clarifying**
36:20, 43:8
**classes**
62:24
**clear**
110:17
**clearly**
6:14
**clinic**
116:13
**clinics**
116:3
**clip**
116:12
**clock**
51:1
**close**
24:10, 50:1, 73:3, 79:2, 82:10, 112:22
**closed**
43:18
**closely**
26:13
**closer**
29:24, 81:7
**closing**
37:23, 123:1
**cms**
96:17
**co-pay**
90:16, 90:18, 90:20, 92:21
**co-pays**
86:2
**cobra**
23:20
**cohort**
104:19
**coinsurance**
71:18, 90:13, 91:24, 92:20
**coke**
47:2, 47:3, 47:4
**cold**
53:22, 53:23
**colleague**
78:16
**colleagues**
3:2, 69:18, 122:5, 122:18
**collect**
23:8
**collected**
20:4, 23:14
**color**
11:5
**column**
41:23, 49:18
**come**
8:24, 9:18, 9:19, 12:7, 23:3, 25:2,

28:5, 28:8, 44:4, 47:21, 55:13, 63:5, 71:23, 73:1, 75:11, 75:15, 84:17, 102:11, 103:19, 112:19
**comes**
39:12, 42:21, 72:20, 78:24, 98:14, 109:1
**comfortable**
112:12
**coming**
11:2, 11:13, 11:17, 12:16, 17:2, 41:13, 50:10, 56:25, 58:10, 74:18, 75:19, 76:7, 77:2, 77:20, 78:2, 84:10, 93:7, 99:14, 111:3, 111:9, 115:8, 115:13
**comment**
32:9, 34:11, 61:13, 112:3, 113:4, 119:19, 119:24
**commentary**
35:22
**commentators**
120:12
**comments**
6:9, 6:12, 60:5, 60:18, 71:10, 80:6, 88:21, 97:14, 105:1, 111:25, 112:9, 117:10, 120:4, 123:2, 123:6
**commercial**
63:24, 63:25, 96:7
**commission**
1:2, 3:9, 3:13, 4:12, 5:1, 5:23, 7:8, 7:10, 7:22, 26:22, 33:12
**commission's**
3:19, 6:11, 6:17, 123:5
**commissioners**
7:1
**commitment**
112:14
**commonwealth**
3:7, 4:11, 4:15, 81:22
**commonweath**
1:1
**communications**
6:17
**communities**
113:10
**community**
26:25
**companies**
4:5, 5:1, 5:18, 14:4, 25:12, 43:3, 54:8, 58:4, 58:5, 58:9, 58:10, 58:11, 58:25, 64:9, 102:21, 105:23
**company**
8:21, 63:17, 86:22
**compare**
26:17
**compared**
47:9, 48:20, 50:6, 54:1, 65:25, 88:16
**compares**
25:4
**comparison**
18:15
**compensate**
78:10
**compete**
114:10
**competing**
101:18
**competition**
12:23, 59:8, 63:9, 63:10, 63:20, 83:8, 95:23, 95:25, 96:1, 101:5, 102:19, 103:18, 103:23, 121:1, 121:4, 121:5
**competitive**
83:20, 83:22, 102:4, 102:23, 118:14
**competitor**
103:23
**competitors**
84:4
**complete**
3:20, 36:3
**component**
45:11, 61:13, 63:20
**components**
69:9, 91:3
**comprehensive**
22:7
**concentrated**
120:8
**concern**
78:5, 86:9, 86:15, 89:3
**concerns**
32:19, 108:12
**concierge**
116:15
**conclude**
78:21
**concludes**
122:17
**conditions**
86:16
**conducting**
4:11
**confirm**
64:16
**confusing**
53:1, 87:12
**connecticut**
98:5, 111:8
**connection**
3:4
**connell**
2:11, 70:3, 70:4, 70:6, 70:9, 70:10, 70:23, 76:24, 78:15, 78:25, 80:4, 81:19, 83:7, 85:21, 86:25, 87:2, 87:3, 89:2, 89:14, 89:19
**consider**
72:17
**considerations**
120:2
**considering**
89:11, 96:21, 97:10
**consternation**
42:10
**consumer**
27:2, 27:13, 30:6
**consumers**
8:8, 19:16, 24:12, 24:14, 24:21, 26:24, 27:18, 33:2, 35:1, 35:14, 96:15, 109:4
**contact**
6:23
**contents**
36:10
**contiguous**
60:12
**continue**
25:25, 68:16, 84:24, 86:5, 106:11
**continues**
98:25
**continuing**
99:18
**contract**
82:21

**contracts**
47:13, 47:16
**contribute**
91:7
**contributes**
91:12, 91:13
**contribution**
106:23
**convene**
3:3
**convenience**
116:19
**conversations**
79:1
**convince**
101:13, 101:25
**coordinate**
4:25, 28:11, 96:16
**coordinator**
6:23
**copies**
5:23
**corporation**
1:2, 7:22, 26:22, 33:12, 59:25
**correct**
14:8, 46:19, 66:7, 93:14, 110:1, 124:6
**correction**
51:22, 52:4, 52:6, 73:6
**correctly**
89:22
**correlation**
62:8
**corresponding**
91:10
**cost**
4:9, 19:21, 20:3, 23:18, 23:19, 25:20, 26:2, 28:25, 29:5, 31:1, 31:5, 34:2, 41:3, 41:11, 42:5, 44:17, 44:24, 45:9, 45:15, 45:17, 46:14, 65:25, 66:24, 67:2, 68:3, 72:1, 72:8, 72:19, 78:24, 79:21, 79:25, 80:1, 81:12, 92:3, 92:21, 111:17, 116:3, 116:25, 120:5, 121:7, 121:21
**cost-sharing**
71:23, 72:11, 72:13, 72:24, 115:20
**costly**
45:21, 45:22
**costs**
34:7, 40:23, 42:25, 68:10, 77:14, 79:4, 79:5, 80:10, 80:24, 81:3, 81:10, 81:14, 81:23, 86:11, 94:8, 94:13, 95:12, 98:25, 113:13, 117:16, 119:11
**cottage**
98:4
**could**
4:18, 19:13, 19:15, 19:18, 23:3, 25:2, 25:19, 25:24, 39:24, 51:19, 60:13, 60:25, 66:19, 67:17, 76:20, 77:1, 81:12, 83:18, 86:15, 114:9, 114:11, 114:15, 120:19, 120:20
**couldn't**
43:17, 50:13
**counsel**
124:11
**counties**
60:11, 100:12, 101:6, 102:8, 102:12
**counts**
91:4
**couple**
8:19, 9:17, 13:13, 18:4, 31:14, 39:5, 51:9, 57:9, 71:5, 71:10, 107:21, 108:5, 115:1, 117:10
**course**
25:1, 35:5, 42:16, 53:24, 68:7, 68:11, 109:23
**court**
6:16
**cover**
63:18
**coverage**
3:5, 11:23, 21:25, 22:6, 22:17, 23:12, 23:13, 23:15, 23:16, 29:10, 29:12, 29:16, 29:20, 50:25, 75:25, 76:3, 89:1, 89:9, 107:7
**covered**
13:15, 21:25, 88:22
**covid**
4:19, 17:8, 25:1, 37:11, 37:17, 38:2, 38:5, 38:8, 38:10, 38:11, 38:19, 38:20, 39:11, 39:23, 40:12, 42:9, 42:21, 44:11, 48:16, 53:23, 57:7, 57:15, 63:4, 66:6, 66:9, 69:14, 76:1, 80:6, 80:10, 80:13, 80:24, 81:4, 81:8, 81:10, 81:24, 91:15, 91:16, 93:13, 93:15, 93:20, 93:23, 94:1, 94:3, 94:12, 95:18, 99:23, 99:24, 103:9, 113:5, 113:13, 118:22, 119:12
**cpi**
45:11, 45:13, 45:24, 46:2, 46:24
**creates**
108:24
**creating**
63:7
**credibility**
60:15
**credible**
100:15
**credits**
24:12, 24:13, 24:17
**critical**
118:7
**critically**
117:14
**cross-examination**
7:5
**csr**
72:20, 103:11
**curious**
62:3, 62:7, 76:10
**current**
8:3, 22:25
**currently**
8:18, 17:20,

95:25
**curve**
103:9
**customers**
3:25, 4:3, 24:5, 24:9, 41:14, 62:24, 72:22, 79:18, 89:8
**cut**
71:16, 90:16, 103:14
**cvs**
111:7, 112:7, 114:19, 116:1, 116:14, 116:17, 116:23, 120:6

D

**darker**
16:4
**data**
20:17, 57:13, 60:15, 60:23, 61:3, 61:5, 61:14, 62:4, 69:15, 107:16, 117:13, 117:16, 117:17
**date**
10:18, 15:24, 36:3, 36:14
**dates**
35:25
**david**
2:7, 5:14, 18:6, 19:6, 35:17, 36:17, 45:4, 66:9, 96:19, 122:22
**david's**
34:22
**day**
12:8, 65:7, 103:10, 108:8, 116:18, 118:10, 120:21, 124:15
**days**
4:1, 22:15, 48:11
**deadline**
4:3, 36:1, 36:12
**deadlines**
3:16, 4:5
**deals**
79:17, 79:19, 118:7
**decade**
4:12
**december**
31:22
**decide**
67:12
**decided**
74:12, 105:19
**deciding**
118:7
**decision**
9:19, 59:16
**decisionmaking**
72:21
**decisions**
27:25
**declining**
35:3
**decrease**
17:18, 19:7, 19:23, 19:24, 65:16, 65:19, 65:21, 66:4, 69:3, 69:6, 69:12, 71:1, 71:8, 73:10, 91:5
**decreased**
16:14
**decreases**
84:12
**decreasing**
21:20
**deductible**
24:18, 25:9, 25:12, 26:3, 41:6, 62:1, 62:2, 62:7, 65:15, 65:18, 69:2, 69:5, 71:17, 72:4, 72:12, 90:13, 90:20, 91:23, 92:5, 92:19
**deductibles**
4:1, 4:14, 4:17, 25:7, 25:14, 62:9
**deferred**
119:11
**definitely**
26:20, 27:1, 33:1, 40:10, 85:9, 101:8, 105:18, 113:17, 114:1
**definitive**
36:22
**defunding**
103:11
**delayed**
44:10, 86:13
**deliberate**
114:1
**demand**
83:1
**demean**
57:10
**demographic**
41:9
**density**
95:8
**deny**
36:22
**department**
3:18
**depending**
81:24
**deputy**
2:6, 5:13, 7:11, 7:14, 9:16, 10:13, 14:1, 14:7, 14:12, 14:15, 14:23, 20:5, 20:18, 20:25, 25:15, 26:19, 28:18, 122:21
**dermatologist**
44:5
**describe**
66:20
**design**
41:6, 55:4, 71:12
**designated**
5:18
**designs**
9:5, 115:12, 115:17
**destabilize**
32:11
**detail**
82:8
**details**
85:3
**deteriorating**
86:16
**determine**
38:2
**develop**
33:12, 63:11
**development**
70:16, 73:5, 84:11, 88:1
**diagnosed**
86:14
**dichotomy**
101:2
**difference**
18:5, 19:5, 46:2, 46:8
**differences**
81:23
**different**
30:14, 43:3, 50:14, 55:10, 59:3, 67:9, 72:21, 81:17, 87:17, 98:23, 116:12
**differently**
10:3
**difficult**
28:10, 48:6,

101:13
**difficulties**
6:22
**difficulty**
48:9
**direct**
40:2, 66:17
**directed**
34:15
**directing**
4:23
**direction**
35:3, 73:7, 86:5, 120:13
**directly**
121:2, 121:16
**director**
26:13, 59:24, 70:11, 90:2, 111:6
**directs**
33:11
**discuss**
5:15, 19:6, 68:19, 96:6, 123:3
**discussed**
6:9, 22:10, 30:5
**discussion**
10:8, 26:23, 27:4, 58:8
**discussions**
110:13
**disparities**
113:9
**distributes**
78:13
**divide**
20:8, 20:20, 53:18
**divided**
18:11
**dividing**
54:19
**doctors**
59:5, 79:19, 108:15
**doing**
41:17, 48:13, 55:3, 55:15, 56:16, 70:4, 80:13, 86:22
**dollar**
31:7, 47:17, 53:17, 53:18, 65:14, 65:18, 69:1, 69:5, 72:12, 90:13, 92:19, 92:21
**dominated**
82:20
**done**
5:2, 7:17, 33:23, 36:7, 43:17, 58:4, 68:18, 76:11, 76:13
**door**
28:4, 28:8, 50:13
**double**
13:16, 16:22
**doubled**
95:17
**down**
11:10, 16:2, 18:23, 26:4, 28:21, 29:23, 31:10, 38:20, 39:21, 52:17, 71:7, 76:8, 80:16, 87:3, 87:7, 89:6, 91:2, 99:14, 99:18, 101:14, 102:10, 102:11
**dozen**
115:1
**dozens**
116:7
**draft**
34:10
**drastically**
13:14
**drifting**
52:16, 52:17
**drive**
77:14, 95:12, 106:12
**driven**
57:18
**driving**
79:14, 119:17
**drop**
15:14, 16:24, 18:22, 74:12
**dropped**
20:13
**drugs**
44:20
**due**
35:25, 38:5, 40:5, 55:25, 57:18, 66:13, 66:16, 94:11, 95:17, 114:10
**during**
4:19, 6:22, 22:4, 23:11, 24:25, 26:10, 38:9, 39:23, 40:13, 43:11, 43:20, 75:15, 86:1, 86:3, 92:4
**dynamic**
120:14

**E**

**each**
5:6, 6:1, 8:10, 16:2, 30:12, 38:8, 53:14, 55:9, 55:23, 58:25
**earlier**
36:8, 42:22, 53:17, 72:10, 74:9, 75:13, 76:15, 83:21, 83:23, 84:13, 85:20, 96:19, 105:1, 109:14, 118:23
**early**
78:21, 79:1, 105:4, 107:1
**earth**
102:10
**easier**
104:19
**east**
90:4
**easy**
57:11
**echo**
120:11
**eclipsed**
37:13
**economy**
75:7, 75:24, 89:4
**effect**
4:16, 17:8, 21:5, 21:23, 39:12
**effected**
64:1
**effective**
3:7, 105:2
**eight**
29:6, 30:11, 30:21, 31:6, 42:3
**either**
25:19, 29:16, 75:1, 76:14, 104:23, 122:6
**elective**
43:19
**element**
46:21
**elements**
41:1
**eligibility**
107:11
**eligible**
28:6, 29:4, 29:19, 31:7
**elite**
99:24
**else**
83:2, 83:25, 93:24

**emergencies**
25:3
**emergency**
25:2
**emphasis**
107:9
**employed**
124:11
**employers**
22:5, 89:1
**encourage**
10:9
**encouraged**
106:7
**encouraging**
9:10, 26:9, 34:23
**end**
15:10, 15:19, 17:5, 37:22, 41:20, 103:10, 107:1, 108:8, 108:22, 118:10, 118:13, 120:21
**ended**
15:12
**ending**
22:15, 22:17
**ends**
31:22
**enough**
112:12
**enroll**
22:16, 22:18, 32:25, 50:12, 71:12, 75:6, 105:9, 105:11, 108:9
**enrolled**
15:15, 15:16, 32:1, 32:5, 32:16, 33:2, 92:25
**enrollees**
17:20, 22:25, 23:3, 106:5
**enrolling**
105:12
**enrollment**
10:9, 13:16, 13:19, 15:6, 15:7, 15:9, 15:11, 15:12, 15:14, 15:18, 15:20, 15:21, 15:22, 15:25, 17:6, 18:2, 18:23, 21:13, 21:20, 22:14, 24:22, 24:24, 26:10, 26:11, 27:9, 27:10, 31:21, 31:22, 32:10, 32:14, 32:19, 32:21, 32:24, 33:4, 49:2, 57:18, 57:19, 75:3, 75:4, 75:10, 75:14, 95:16, 95:18, 96:20, 96:22, 106:6, 106:12
**enrollments**
54:9
**ensued**
110:14
**enter**
114:9, 118:8
**entering**
59:2, 60:7, 82:13, 82:22, 95:3, 100:24, 111:23
**enterprises**
4:10
**entire**
15:23, 30:14
**entities**
87:9
**entrants**
55:22, 60:16
**entry**
58:18, 73:11, 120:3
**environment**
43:24, 50:19, 56:1, 103:2, 105:8, 105:13, 113:18, 113:21
**equal**
23:12
**equally**
78:13
**especially**
16:17, 22:4, 39:12, 62:17, 78:24
**essentially**
100:15, 101:17, 101:20, 108:15, 118:2
**established**
16:9
**estimate**
19:22, 50:18, 66:3, 69:11
**estimated**
19:23, 19:24, 66:2, 69:10
**estimates**
52:13, 118:1
**estimating**
118:2
**evaluate**
119:1
**even**
11:3, 23:17, 30:12, 51:3, 76:17, 82:19, 83:21, 112:21, 114:2, 117:7, 118:10
**event**
22:19, 75:16
**ever**
8:1
**every**
25:11, 37:13, 37:19, 40:19, 44:5, 54:3, 65:7
**everybody**
28:4, 37:4, 50:12, 56:7, 78:14, 104:17, 110:2
**everybody's**
120:24
**everyone**
7:16, 26:23, 56:10, 70:10, 90:1, 90:6, 93:24, 97:16, 103:10, 107:2, 123:8
**everyone's**
113:8
**evident**
8:7
**evidentiary**
7:3
**evolved**
113:17
**exactly**
40:14, 79:23, 103:5, 106:14, 106:22, 106:25, 118:23
**examining**
56:18
**example**
27:8, 30:24, 31:9, 44:4, 46:23, 53:15, 53:25, 54:13, 72:11
**examples**
25:8, 25:10, 116:2
**except**
15:23
**exception**
41:16, 42:2
**excess**
23:22
**exchange**
3:11, 3:12, 3:15, 3:22, 6:3, 7:23, 7:24, 8:1, 8:4, 8:7, 8:15, 8:17, 8:22, 10:2, 11:9, 11:18, 14:18,

15:15, 20:11, 22:25, 23:5, 24:15, 26:10, 26:14, 26:17, 26:18, 26:24, 27:1, 27:7, 27:12, 27:17, 27:18, 27:23, 28:12, 28:13, 29:20, 35:14, 61:17, 68:8, 98:8, 102:9, 103:14, 103:19, 104:18, 105:7, 107:23, 108:8, 108:10
**exchanges**
28:3, 32:11
**excited**
111:2
**exciting**
100:9
**excuse**
53:21
**exhibit**
71:3, 76:15, 83:3, 90:7
**exhibits**
5:22, 111:11
**existing**
96:16, 101:16, 106:1
**exited**
8:23, 76:7
**exiting**
78:6
**exits**
22:3
**expand**
100:11
**expanded**
13:17, 29:17, 57:19, 57:22, 57:24, 95:18, 97:9, 97:11
**expanding**
12:18, 13:18, 34:25
**expansion**
11:19, 11:25, 16:13, 18:25
**expansions**
100:10
**expect**
103:8
**expected**
32:17, 33:19, 63:13
**expecting**
81:9
**expense**
77:13, 91:6
**expenses**
63:14, 63:19, 91:7
**experience**
6:21, 42:1, 49:17, 51:16, 51:17, 52:2, 52:11, 52:22, 52:23, 55:12, 63:13, 65:15, 65:18, 69:2, 69:5, 71:6, 73:13, 80:15, 80:18, 83:10, 85:18, 88:12, 89:11, 91:17, 92:10, 93:5, 93:24, 99:22, 112:2, 113:20, 116:20, 117:2, 117:12, 117:13, 118:3, 118:9, 119:1, 121:16, 122:1
**experienced**
42:15, 95:15, 118:24
**experiences**
118:11
**expertise**
115:24
**explain**
12:6, 17:3, 67:12
**explained**
7:20
**explicit**
63:2, 63:20
**exposure**
111:19
**expressed**
117:8
**extend**
31:21, 31:23
**extended**
75:3, 75:5, 75:23
**extension**
96:21
**extent**
78:18, 120:8
**external**
61:5
**extra**
23:8, 31:24, 34:24

**F**

**facilities**
101:18, 108:16
**fact**
47:5, 47:24, 49:25, 55:15, 72:5, 74:21
**factor**
16:16, 66:15, 67:20, 76:1, 83:11, 83:14, 98:25, 100:16, 100:17, 109:16
**factored**
45:5
**factors**
9:14, 27:19, 87:4, 87:6, 93:19, 94:22, 94:23, 98:14
**fairly**
41:21, 48:14, 89:7
**faith**
109:10
**fall**
34:19, 43:3
**fallen**
24:19
**familiar**
50:11, 65:5, 113:8, 120:15
**families**
68:11
**family**
28:20
**far**
11:21, 19:10, 23:18, 27:13, 37:11, 42:11, 43:15, 59:7, 79:12, 79:24, 82:3, 83:15, 105:3, 119:23
**farmington**
111:8
**favor**
75:9
**favorable**
51:18, 52:11, 52:21, 52:23, 57:1, 68:6, 73:13, 74:6, 76:4, 84:11, 84:20, 84:22, 88:11, 88:19, 120:5, 121:7
**feature**
77:7
**features**
115:21
**february**
17:7, 24:23
**fed**
96:21
**federal**
3:11, 3:15, 3:22, 6:3, 8:6, 21:24, 23:12, 26:17, 27:7, 27:11, 28:13, 29:1, 29:3, 30:2, 31:14,

32:22, 33:16, 33:21, 33:24, 59:11, 61:18, 63:16, 63:23, 84:8, 96:6, 96:9, 96:18, 97:2, 97:12, 107:13
**feedback**
110:4, 110:8
**feel**
84:14, 103:15, 103:22, 104:15, 119:17
**feeling**
79:3
**fees**
63:14, 63:19
**fell**
25:9
**felt**
101:12, 114:6, 114:9, 114:11, 114:16, 115:4
**few**
9:12, 35:21, 41:22, 42:5, 42:20, 43:20, 50:20, 52:10, 53:12, 55:22, 56:25, 58:5, 91:2, 102:12, 103:3, 111:25, 112:4, 112:12
**fewer**
42:15, 103:25
**field**
108:25
**figure**
34:7, 40:22, 42:17, 42:25, 43:22, 43:24, 48:17, 49:4, 51:10, 51:25, 102:15
**figures**
17:1, 22:11, 29:7, 29:9
**file**
23:7, 64:9, 87:20
**filed**
4:5, 8:11, 8:14, 14:17, 37:21, 37:24, 51:14, 54:5, 54:17, 55:8, 64:12, 64:17, 64:21, 87:9, 87:25, 98:11, 99:4, 115:15
**filing**
67:8, 87:20, 88:9, 90:10, 91:1, 92:8, 93:2, 118:19
**filings**
5:10, 5:23, 5:24, 6:2, 6:9, 10:16, 12:9, 12:14, 36:11, 38:4, 38:15, 53:14, 123:3
**final**
9:2, 12:22, 12:25, 31:20, 34:12, 87:23
**finally**
6:21, 9:4
**financial**
39:22, 51:24, 57:2, 124:13
**find**
32:1, 62:5
**fine**
70:20, 70:22
**first**
3:18, 5:12, 8:4, 11:22, 12:8, 39:7, 50:20, 50:23, 51:8, 55:2, 58:21, 60:6, 70:16, 70:18, 87:14, 87:15, 87:22, 88:7, 90:19, 92:3, 93:22, 95:2, 96:10, 98:6, 110:25, 112:8, 121:23
**five**
8:24, 29:11, 41:25, 92:22, 112:22, 115:12, 115:13, 115:17
**fixed**
94:8
**fixes**
45:25
**flat**
89:12
**flexibility**
10:3
**flip**
67:17
**flying**
51:7
**focus**
61:13, 113:7
**focused**
21:14, 58:8
**folks**
43:16, 44:14, 48:24, 54:20, 79:2
**follow**
7:9, 81:20
**follow-up**
78:16, 95:11
**following**
6:11, 59:12, 85:20, 123:5
**footprint**
96:1, 100:12
**forces**
12:24
**forecast**
43:12
**foregoing**
124:4, 124:5
**foregone**
44:3
**form**
5:10, 12:9, 102:3
**forms**
3:10, 4:6, 8:11, 9:5
**formulary**
104:12
**fortunately**
71:14
**forward**
27:20, 27:25, 37:4, 43:12, 56:14, 63:25, 78:23, 80:23, 80:24, 120:23, 122:12, 122:14
**found**
22:6, 28:9, 112:11
**foundation**
28:21
**four**
22:15, 41:24, 41:25, 42:3, 44:18, 44:21, 78:4, 87:21, 87:25, 88:8, 90:8, 95:1, 98:9, 98:10
**fourth**
87:18, 87:22, 88:2
**frame**
24:25, 101:1
**framework**
98:16
**frankly**
43:17, 56:12
**free**
23:13, 25:25, 29:11
**frequent**
49:3
**front**
80:22, 86:23
**full**
51:15
**full-insured**
97:7

**fully**
23:20, 27:3, 27:12
**functions**
3:14
**funded**
24:12
**funding**
33:16, 63:7, 97:5
**funny**
48:9
**further**
17:12, 85:12
**future**
44:1, 46:7, 62:13, 97:5, 100:3

**G**

**gain**
30:19
**gamut**
119:10
**gaps**
113:7
**garden**
53:23
**gather**
81:2
**gathered**
15:22
**gave**
58:24
**gears**
115:7
**general**
33:10, 44:16, 44:23, 52:19, 52:20, 53:2, 61:21, 62:3, 62:8, 85:22, 101:2, 104:18, 106:5, 106:8, 107:22, 113:12, 120:13
**generalization**
77:23
**generally**
41:15, 41:17, 41:19, 42:4, 42:5, 45:7, 45:12, 46:20, 75:9, 75:21, 77:15, 77:21, 78:1, 86:6, 103:15, 104:15, 113:12, 121:17
**generate**
57:5
**generous**
85:2
**geographic**
87:6, 94:22, 94:24
**geographically**
82:6
**geographies**
81:21, 82:12, 83:10
**getting**
34:6, 41:8, 52:1, 52:2, 52:9, 56:6, 82:23, 86:12, 86:14, 104:7, 104:8, 105:6, 112:8
**giori**
2:10, 97:21, 97:22, 97:24, 98:2, 98:3, 100:7, 100:23, 106:14, 106:22, 106:25, 109:20, 109:23
**give**
53:15, 53:25, 54:20, 58:6, 85:21, 112:4, 117:9
**given**
4:9, 62:22, 63:2, 75:7, 76:17, 85:18, 112:1, 124:6
**gives**
98:18
**giving**
108:15
**glad**
43:6, 53:9, 70:14
**go**
7:19, 14:24, 21:10, 22:8, 24:17, 31:11, 37:15, 38:1, 39:17, 42:12, 43:20, 44:8, 51:16, 53:18, 58:1, 60:3, 60:18, 66:24, 70:16, 79:15, 82:11, 83:2, 87:8, 87:23, 102:18, 105:16, 106:19, 108:22
**goes**
42:9, 44:5, 55:1, 80:23
**going**
5:3, 9:1, 12:16, 13:3, 13:10, 13:22, 17:15, 17:17, 18:7, 19:6, 20:1, 21:16, 22:15, 22:17, 26:4, 27:22, 27:25, 35:2, 35:9, 38:8, 42:14, 42:18, 43:12, 44:1, 44:2, 44:4, 44:7, 44:9, 44:11, 45:15, 45:20, 47:3, 47:10, 47:17, 47:22, 47:25, 48:1, 50:21, 51:6, 52:9, 53:19, 54:6, 54:8, 55:3, 56:14, 70:3, 74:4, 74:11, 74:19, 75:1, 76:8, 77:16, 79:4, 79:8, 80:24, 81:14, 83:22, 84:5, 84:15, 84:16, 86:10, 86:20, 90:6, 90:11, 91:20, 95:1, 96:5, 98:5, 98:13, 100:2, 101:11, 102:17, 104:13, 105:5, 105:15, 105:18, 106:20, 107:15, 108:22, 111:16, 114:7, 117:24, 118:7, 118:15, 120:16, 120:18, 121:5, 121:6
**gold**
69:1, 115:18
**good**
3:1, 15:5, 26:11, 35:20, 49:8, 51:16, 55:9, 70:10, 71:6, 75:21, 77:16, 77:23, 82:5, 82:23, 86:6, 88:12, 90:1, 95:20, 96:14, 96:23, 98:16, 98:18, 100:15, 100:20, 103:16, 105:7, 107:1, 107:2, 107:23, 108:4, 108:9, 109:3, 109:8, 109:10, 110:21, 114:14, 116:19, 118:6, 120:19, 121:6, 121:19
**gotten**
104:14

**gov**
6:25, 8:5
**govern**
3:16
**government**
33:22, 33:24
**graham**
2:13, 59:20, 59:22, 59:23
**grandfathered-in**
16:6
**granting**
67:1
**granularity**
76:11, 76:13
**gray**
16:5
**great**
11:24, 28:17, 40:9, 40:18, 57:14, 70:7, 89:24, 97:23, 105:19
**greater**
42:6
**greatly**
49:1
**ground**
100:17, 107:25, 113:1
**group**
4:22, 5:4, 6:4, 12:10, 21:12, 21:16, 22:1, 22:3, 22:5, 34:16, 35:8, 35:9, 38:23, 49:18, 50:3, 50:4, 50:6, 50:22, 52:7, 53:4, 53:6, 55:21, 58:13, 58:16, 58:19, 59:4, 61:3, 68:20, 68:25, 85:5, 85:10, 87:8, 87:10, 87:16, 88:22
**groups**
3:6, 70:5, 87:15, 87:16, 87:18, 88:8
**grove**
98:4
**grow**
13:20, 77:25
**growing**
35:4, 77:22, 77:24
**guess**
9:16, 12:22, 13:14, 20:3, 22:13, 26:15, 28:3, 28:11, 40:6, 47:12, 64:16, 67:10, 70:2, 80:4, 80:9, 82:15, 83:24, 89:20, 112:22, 117:3, 119:2, 120:24, 122:17
**guide**
103:16
**guy**
107:1
**guys**
85:15

**H**

**half**
17:18, 29:6, 29:9, 30:11, 30:21, 31:6, 38:13, 65:20, 81:5, 103:14
**hand**
105:22, 124:15
**handling**
109:1
**hanging**
100:3
**happen**
10:24, 44:11, 73:14, 74:23, 75:10, 86:10, 119:13
**happened**
37:17, 51:11
**happening**
11:25, 26:3, 74:22, 75:2, 109:12
**happens**
119:14
**hard**
52:9, 61:14, 82:8
**hardly**
57:24
**hartford**
111:8
**head**
116:7
**heading**
98:19
**health**
3:5, 3:10, 3:14, 3:18, 3:21, 4:2, 4:6, 4:9, 4:13, 4:16, 4:21, 5:10, 5:14, 5:15, 7:12, 7:17, 32:9, 40:20, 41:1, 45:18, 48:10, 50:14, 50:24, 56:21, 59:25, 74:17, 78:20, 78:23, 86:16, 94:8, 96:24, 98:25, 105:12, 106:8, 107:6, 113:7, 116:1, 116:11
**healthcare**
8:5, 41:12, 75:20, 94:7, 94:13, 112:15, 122:19
**healthier**
76:21, 77:19, 78:2, 78:5, 99:11, 99:14, 120:20
**healthkeepers**
13:7, 13:12, 58:14, 70:3, 81:20, 87:11
**healthy**
41:8, 41:9, 78:7, 104:9, 106:7, 116:12
**hear**
5:3, 5:12, 5:14, 9:3, 17:25, 40:14, 43:7, 45:7, 56:3, 99:1, 109:4, 110:2, 110:3, 110:6, 110:16
**heard**
39:19, 61:24, 113:15, 118:23
**hearing**
7:9, 29:2, 123:9, 124:4
**heavy**
101:4
**held**
6:6
**hello**
59:23
**help**
45:1, 47:11, 49:10, 68:9, 77:1, 86:19, 97:3, 97:12
**helpful**
27:20, 27:23, 31:10, 35:13, 51:5, 60:11, 67:11
**helping**
71:7, 77:25
**helps**
86:18, 96:1, 99:8
**here**
17:4, 18:9, 20:2, 22:11,

24:2, 38:17, 41:7, 44:13, 46:4, 46:8, 47:7, 49:16, 53:3, 55:7, 64:23, 65:7, 66:6, 67:19, 69:14, 70:24, 87:10, 87:13, 90:16, 91:18, 92:15, 93:9, 94:21, 95:15, 97:15, 98:10, 98:20, 99:6, 99:18, 99:21, 99:23, 100:9, 107:15, 109:16, 109:19, 122:15, 122:23
**hereby**
124:5
**hereunto**
124:14
**hey**
79:14
**hi**
110:15
**high**
16:16, 16:25, 25:8, 34:1, 37:16, 51:13, 62:1, 101:15, 102:14, 117:10, 121:21, 121:24
**higher**
19:3, 19:14, 19:19, 19:21, 23:17, 30:7, 48:1, 48:2, 66:24, 74:12, 74:16, 76:18, 77:14, 77:15, 101:7, 104:2, 105:25, 117:24, 117:25
**highest**
23:16, 72:11
**highlight**
22:13
**highlighted**
113:13
**historical**
46:4, 63:12
**hit**
107:12
**hold**
89:7
**holding**
100:17
**hope**
40:10, 40:16, 94:14, 99:25
**hopefully**
81:15
**hoping**
39:23
**hospital**
44:19, 44:20, 59:4, 82:20, 101:12, 101:14, 104:1, 106:19, 109:14, 120:4
**hospitals**
80:15, 109:9
**house**
34:14
**households**
23:10
**however**
38:6, 50:9, 56:24, 63:2, 81:6, 84:19, 95:10
**hpe**
26:13
**hubs**
116:11
**hudson**
2:3, 3:1, 3:2, 7:15, 7:17, 7:20, 9:13, 10:12, 26:7, 28:17, 39:4, 39:7, 39:10, 40:9, 65:11, 67:7, 68:1, 68:16, 68:21, 69:17, 69:21, 69:24, 70:7, 70:19, 78:15, 80:3, 83:6, 85:7, 85:13, 85:20, 87:1, 88:24, 89:13, 89:17, 89:20, 89:24, 94:18, 97:15, 97:17, 97:23, 97:25, 100:6, 100:22, 109:19, 109:21, 109:24, 110:3, 110:7, 110:11, 110:16, 110:23, 112:6, 115:9, 122:4, 122:10, 122:16
**huge**
56:13
**human**
3:19
**hundred**
114:25
**hurdle**
28:15
**hurt**
119:3
**hurts**
119:3
**hybrid**
115:22

**I**

**idea**
49:8, 54:20, 57:20, 63:4, 98:18
**identifying**
9:14
**impact**
38:2, 38:8, 38:9, 38:12, 38:19, 38:24, 39:22, 40:2, 41:7, 42:9, 42:21, 59:7, 59:10, 61:9, 62:17, 63:22, 68:4, 74:2, 74:4, 74:24, 76:5, 81:8, 81:10, 85:14, 88:19, 91:8, 91:10, 91:15, 91:16, 92:9, 93:3, 93:13, 93:15, 93:20, 93:23, 94:3, 94:12, 95:14, 96:3, 96:6, 113:9, 120:1, 120:23, 121:1, 121:2, 121:8, 121:18
**impacted**
38:21, 57:25
**impacting**
49:5
**impacts**
39:11, 40:12, 40:15, 41:6, 74:7, 78:19, 81:4
**importance**
4:9
**important**
68:11, 96:15, 97:5, 107:9, 119:20
**impression**
86:18
**impressions**
85:22
**improve**
74:19, 97:3, 97:13
**improved**
66:13
**improvement**
74:1
**in-person**
95:11
**incentive**
105:11

**inception**
8:1
**incidence**
117:25
**inclined**
62:6
**include**
38:7, 91:18
**included**
95:19
**includes**
92:16
**including**
65:23, 94:8,
97:7
**income**
30:11, 71:25,
72:1, 72:23,
74:12, 74:16,
76:19
**increase**
11:16, 17:11,
21:21, 24:20,
26:10, 27:9,
43:25, 44:16,
44:24, 45:8,
45:25, 55:19,
55:24, 57:18,
61:4, 61:15,
62:23, 66:4,
69:8, 69:12,
73:5, 73:9,
86:11, 87:14,
88:4, 90:15,
91:11, 91:23,
92:2, 96:23,
98:12, 98:21,
120:16
**increased**
9:11, 13:15,
22:23, 28:22,
40:5, 49:2,
95:16, 103:18
**increases**
3:25, 83:1,
84:17, 88:3,
88:8, 88:17
**increasing**
18:24, 35:13,
74:10, 99:1
**independent**
41:18, 43:2,
74:15
**indirectly**
121:3, 121:8
**individual**
3:6, 4:22, 5:4,
6:4, 9:20, 10:1,
10:7, 10:9,
12:10, 15:8,
15:25, 21:14,
21:18, 21:25,
29:20, 34:5,
34:6, 35:1,
35:15, 38:11,
38:18, 38:22,
49:18, 50:8,
50:16, 50:22,
51:8, 51:13,
52:7, 53:3,
53:12, 54:4,
55:20, 55:24,
58:12, 58:15,
58:17, 58:18,
59:12, 59:17,
62:22, 63:5,
63:24, 64:1,
65:2, 67:6,
67:15, 67:22,
67:24, 68:5,
68:19, 70:4,
85:9, 87:6,
88:17, 90:25,
96:8, 97:4,
117:12, 117:18,
118:4, 118:12
**individually**
38:25
**individuals**
43:10, 61:25,
62:6, 62:18,
62:21, 68:4,
68:10, 77:2,
106:7
**industry**
44:14, 108:7,
108:13, 108:14
**inflation**
45:5, 45:6,
45:23, 46:3,
46:9, 46:12,
46:13, 46:14,
46:16, 46:17,
46:22, 46:24,
47:1
**influence**
59:9, 63:9,
63:10, 95:23
**influencing**
83:8, 102:19
**information**
9:1, 9:2,
10:15, 10:22,
12:4, 12:15,
13:9, 27:15,
27:16, 27:24,
34:6, 37:20,
38:1, 39:18,
55:9, 61:4,
61:6, 114:22,
121:14
**informed**
27:24, 121:25
**infrastructure**
116:1
**initial**
35:25, 63:23
**initially**
73:22, 87:25,
98:22
**initiative**
59:11, 64:2,
96:7, 96:19
**initiatives**
33:8, 35:11,
35:12, 84:8,
96:10, 96:23,
107:13, 121:12
**inpatient**
44:19
**inspire**
76:2
**inspired**
79:11
**institute**
32:13
**instituted**
22:22, 24:3
**instituting**
64:2
**institutional**
112:23
**instructed**
4:24, 6:5
**instructions**
6:12, 123:5
**insurance**
3:5, 3:20,
3:24, 4:3, 4:5,
4:6, 4:10, 4:13,
4:17, 4:25, 5:3,
5:10, 5:13,
5:18, 5:21, 6:5,
7:11, 7:17,
7:21, 7:25,
8:20, 26:12,
32:9, 40:20,
41:2, 45:18,
48:11, 50:24,
54:11, 56:7,
56:21, 75:17,
77:11, 102:21,
105:12, 105:17,
105:21, 105:23,
106:8, 106:20,
107:7, 108:14,
113:11, 115:23,
117:24, 122:19,
122:21
**insured**
5:6, 107:10
**insurer**
108:2
**insurers**
79:25, 87:23
**integrated**
94:7, 95:6,
116:24
**interaction**
97:2
**interest**
22:12, 71:11,
124:12
**interested**
68:9, 85:17

**interesting**
41:16, 99:7
**interference**
6:19
**interim**
27:6
**internally**
79:2
**intriguing**
98:24
**involved**
34:17
**issue**
34:18, 60:16, 113:12
**issued**
3:5, 4:23, 9:4
**issues**
113:23
**it'll**
111:17
**itd**
6:23
**item**
80:12

**J**

**jagdmann**
2:4, 3:3, 7:1, 13:24, 14:2, 14:9, 14:13, 14:21, 20:1, 20:10, 20:23, 21:1, 25:5, 26:6, 36:17, 36:19, 36:25, 37:8, 45:4, 46:9, 46:19, 47:12, 47:19, 48:4, 49:11, 60:20, 61:7, 61:20, 61:23, 62:14, 64:6, 64:15, 64:20, 64:25, 65:3, 66:19, 67:4, 69:19, 76:6, 89:16, 106:10, 106:16, 106:23, 122:6
**january**
3:7, 4:7, 23:5, 31:23, 32:2, 34:13
**jefferson**
90:4
**jehmal**
2:3, 3:2
**job**
1:27, 28:10, 57:14
**jobs**
63:7
**join**
102:9
**joined**
3:2
**judge**
7:15, 7:16, 7:20, 17:24, 21:1, 78:16, 85:13, 85:20
**judges**
35:20
**judy**
2:4
**julie**
2:6, 5:12, 7:11, 7:13, 35:19, 35:24, 49:22, 53:9, 53:17, 54:7, 57:17, 59:13
**julie's**
54:1, 54:12, 54:22, 55:5
**july**
10:16, 36:12
**jurisdiction**
81:24
**jury**
40:6

**K**

**kaiser**
2:9, 28:20, 58:14, 89:21, 90:2, 94:5, 95:5, 96:13
**kaiser's**
94:7
**keep**
56:2, 56:11, 71:7, 79:19, 86:20, 94:4, 102:17
**kept**
109:9
**key**
35:24, 38:17
**kick**
77:9
**kids**
90:21, 92:22
**kind**
12:24, 21:15, 28:21, 29:24, 31:9, 34:2, 35:24, 37:14, 39:11, 40:20, 49:21, 51:7, 53:2, 54:9, 54:11, 59:6, 61:9, 70:16, 71:7, 71:9, 73:4, 73:17, 74:23, 76:11, 77:13, 78:19, 79:16, 80:5, 84:9, 86:4, 88:8, 88:10, 88:13, 95:13, 98:14, 98:15, 98:22, 99:8, 99:18, 100:25, 104:22, 104:25, 106:4, 107:11, 107:21, 113:6, 114:13, 115:6, 115:12, 115:22, 116:25, 118:23, 119:9, 119:12, 119:17, 119:22, 120:12, 121:3, 121:8, 121:24
**knew**
58:9
**knowing**
12:23
**known**
41:10
**kp**
95:15, 97:10
**kp's**
96:1

**L**

**lack**
59:8, 60:15, 63:9, 83:8, 95:11, 95:23, 95:25, 102:19, 106:24
**laid**
98:22
**lane**
60:1
**large**
18:18, 43:2, 55:23, 56:10, 61:3, 108:6, 109:6, 121:19
**largely**
16:12, 16:15, 46:17, 60:9, 103:7
**larger**
97:13
**last**
4:12, 11:3, 11:4, 13:11, 24:7, 24:25, 25:4, 33:10, 34:21, 37:11, 37:13, 37:17, 38:4, 41:22, 42:4, 42:12, 43:20, 52:10, 53:12, 55:16, 56:24, 57:9, 57:17, 58:2, 58:23, 59:15,

71:5, 80:4, 80:10, 89:4, 89:22, 95:17, 96:5, 97:21, 102:12, 103:3, 103:7, 107:12, 107:21, 109:24, 114:17
**lastly**
121:11
**late**
73:17
**later**
3:22, 18:8, 64:8, 70:22, 87:24
**latest**
5:10
**law**
3:8, 3:24, 8:24, 14:18, 21:22, 21:25
**leads**
111:6
**learned**
83:24
**least**
4:1, 4:12, 59:15, 84:18, 87:24, 94:1, 98:10, 100:3, 102:10, 102:24, 104:9, 114:18
**leave**
36:20
**leaving**
105:20
**led**
93:20
**left**
51:23, 51:24, 78:6
**legal**
3:16, 87:9, 122:24
**legislation**
61:12
**legislative**
56:1, 56:20
**less**
9:21, 11:7, 24:6, 24:10, 24:13, 26:2, 27:7, 32:22, 33:17, 33:20, 33:22, 35:6, 41:8, 45:21, 72:16, 73:15, 73:21, 77:19, 78:7, 81:11, 92:6, 102:2, 120:10, 121:5, 121:25
**lessen**
6:19
**lesser**
101:5
**let's**
13:21, 20:11, 37:15, 42:24, 54:3, 62:1, 62:2
**letting**
75:10
**level**
9:11, 23:13, 23:16, 29:1, 29:3, 30:2, 30:13, 32:22, 37:16, 59:9, 61:19, 63:9, 63:11, 82:8, 95:23, 97:12, 98:13, 102:19, 102:24, 102:25, 103:17, 103:23, 106:4, 107:19, 108:24, 113:6, 117:10, 118:4, 121:20, 121:24
**levels**
62:23, 66:1, 66:13, 74:16, 104:2
**leverage**
95:8
**licensed**
14:16
**life**
5:13, 7:12, 8:20, 109:25
**lighter**
16:3
**lights**
37:6
**likely**
63:5, 100:2
**limit**
58:6
**limited**
29:5, 61:3, 63:17
**line**
73:25
**list**
58:3
**listed**
66:6, 71:2, 71:15, 72:14, 73:9
**listening**
64:7
**literally**
54:18
**little**
10:3, 11:10, 12:6, 13:2, 17:3, 18:5, 19:4, 19:9, 28:9, 29:23, 30:5, 31:9, 32:6, 36:4, 37:16, 38:16, 39:20, 40:1, 41:16, 42:10, 47:6, 52:5, 53:1, 53:22, 56:8, 71:17, 72:4, 73:21, 74:5, 74:16, 75:16, 77:18, 77:25, 78:2, 79:6, 79:22, 81:11, 84:24, 87:12, 88:4, 90:17, 92:25, 93:19, 105:4, 111:24, 113:5, 115:7, 116:12, 117:1, 119:19, 120:1, 121:25
**lived**
49:1
**lives**
13:5, 13:15
**load**
66:8, 69:14, 99:23
**localities**
11:5
**located**
70:11
**location**
59:5
**locations**
116:14
**long**
39:21, 48:13, 55:14, 75:23, 84:18, 107:3, 107:7, 112:24
**longer**
81:1
**look**
8:10, 11:2, 11:11, 15:5, 16:19, 17:12, 19:2, 24:24, 27:21, 29:24, 30:1, 30:24, 30:25, 41:22, 45:19, 46:14, 48:3, 49:22, 50:19, 51:4, 51:10, 52:3, 54:13, 54:22, 62:13, 63:24, 72:3, 72:18, 80:17, 83:10, 83:11, 87:4, 88:1, 88:5, 102:24, 110:21, 117:4, 120:18, 122:12, 122:14

**looked**
51:4, 80:20
**looking**
12:5, 15:7, 17:1, 18:4, 18:17, 20:15, 21:12, 30:4, 34:17, 40:24, 40:25, 42:8, 43:1, 44:13, 46:5, 49:16, 51:17, 52:18, 52:20, 52:21, 55:1, 55:12, 65:4, 72:10, 82:1, 82:4, 88:13, 98:20
**looks**
26:11, 52:14
**lori**
1:29, 124:2, 124:18
**loss**
51:12, 51:20, 52:11, 52:15, 52:24
**lost**
49:16, 49:19
**lot**
9:4, 11:2, 15:11, 15:18, 19:1, 25:6, 37:19, 40:3, 42:15, 48:13, 49:3, 49:24, 51:22, 52:6, 56:15, 56:18, 56:24, 72:19, 81:21, 85:2, 94:1, 100:9, 101:4, 102:11, 105:24, 107:14, 107:20, 109:16, 110:4, 110:8, 112:9, 113:3, 113:7, 113:22, 114:21, 114:22, 114:23, 116:4, 117:13, 118:8, 118:22
**lots**
102:6, 102:7
**loud**
110:17
**low**
44:1, 116:2
**lower**
24:14, 25:14, 52:24, 55:14, 62:2, 62:7, 67:2, 68:10, 71:25, 72:8
**lowest**
23:18, 25:20, 31:1, 65:16, 69:3, 111:17

**M**

**macro**
113:6
**made**
38:4, 50:6, 54:24, 61:16, 73:17, 80:21, 94:2, 112:9, 120:4
**magnitude**
79:7
**main**
50:2, 71:16
**mainly**
31:24
**maintain**
89:8, 97:12, 106:8, 107:6
**major**
46:2, 65:22, 69:9, 74:24, 103:12
**majority**
37:25, 38:3, 72:13, 94:7
**make**
14:3, 20:16, 22:13, 27:7, 27:24, 32:5, 32:7, 32:9, 36:14, 37:14, 38:25, 42:17, 42:20, 65:22, 69:9, 71:10, 76:2, 94:21, 102:3, 102:15, 116:14, 117:15, 117:20, 119:4, 120:24, 121:6
**makes**
30:15, 57:16, 63:6, 90:24, 104:19, 112:5, 115:23, 115:24, 120:9
**making**
75:24, 107:10, 109:8
**management**
3:14, 7:23, 7:25, 10:18
**manner**
66:4, 69:12
**many**
8:9, 33:1, 46:18, 50:5, 52:8, 64:9, 64:12, 64:21, 79:19, 79:24, 84:4, 86:21, 94:5, 101:7, 102:8, 108:21, 117:5, 117:7, 120:6, 121:2
**map**
10:22, 12:25
**march**
17:5, 42:13, 90:22
**margin**
63:15, 63:19, 91:13, 92:10, 93:4
**mark**
30:16
**marketplace**
5:17, 23:22
**markets**
4:23, 5:4, 6:4, 9:20, 10:9, 12:11, 58:12, 101:2, 102:7, 108:5, 117:14, 117:16, 117:19
**marking**
59:21
**maryland**
90:5
**massive**
51:22
**mathes**
2:15
**matter**
109:8
**matters**
7:6
**max**
92:17
**maximum**
65:19, 69:6, 71:4, 72:15, 90:14, 91:11, 92:1, 92:20, 111:14
**maybe**
9:18, 12:5, 25:23, 25:25, 39:24, 45:21, 57:20, 67:14, 74:3, 75:24, 75:25, 77:19, 79:11, 79:13, 81:1, 81:14, 82:11, 85:21, 86:8, 87:7, 101:1, 104:11, 106:4, 107:24, 118:20, 119:3, 121:4, 121:25
**mean**
25:11, 25:13, 37:19, 45:10, 54:24, 56:12, 57:10, 62:5, 62:11, 81:9,

91:20, 93:24, 93:25, 98:22, 100:25, 102:6, 108:18, 109:6, 109:7, 112:9, 112:24, 115:14, 117:4, 118:22, 120:22, 121:20
**meaning**
66:23
**means**
19:13, 23:13, 25:17, 33:21, 66:20, 78:1, 78:10, 81:10, 99:13
**measure**
45:24
**mechanism**
63:21
**median**
24:18, 25:9, 26:3
**medicaid**
16:12, 18:25, 28:6, 28:12, 29:17, 62:19, 62:21, 63:1, 63:3
**medical**
43:11, 44:17, 45:8, 45:9, 45:10, 45:11, 45:13, 45:24, 46:15, 46:16, 63:16, 94:10, 95:7
**meet**
4:4
**meeting**
1:12
**member**
18:3, 18:11, 19:9, 20:8, 53:10, 67:2, 116:20
**members**
6:8, 24:21, 61:16, 63:4, 65:15, 66:23, 67:3, 69:2, 72:6, 72:11, 72:13, 72:19, 74:12, 74:18, 75:11, 76:9, 85:25, 86:7, 86:9, 86:12, 86:13, 88:20, 90:23, 92:6, 92:24, 95:20, 96:24, 101:23, 102:8, 104:4, 104:14, 105:24, 116:14, 123:1
**membership**
21:18, 63:1, 89:5, 89:6, 90:25, 92:7, 93:1, 102:6, 103:14, 104:3, 104:16, 104:17, 104:20, 105:7, 113:19, 120:16
**memberships**
63:3
**memory**
112:24
**mention**
34:14, 38:9, 71:20, 80:5, 87:11
**mentioned**
25:9, 35:24, 36:8, 48:9, 53:9, 53:21, 57:17, 68:6, 71:22, 74:9, 74:25, 82:17, 83:21, 93:5, 96:19, 99:8, 102:18, 117:22, 118:5
**mentioning**
94:21
**methodology**
99:21
**microphone**
6:14, 6:19
**microsoft**
6:7
**mid**
90:3
**might**
34:8, 43:12, 57:5, 60:21, 67:12, 72:3, 72:18, 74:1, 74:13, 76:1, 76:17, 76:20, 77:8, 78:10, 79:14, 80:9, 82:20, 82:21, 84:19, 84:20, 84:21, 87:12, 87:22, 88:14, 89:5, 119:13, 120:19
**mild**
98:20
**mill**
70:12
**million**
29:8, 29:11, 29:14
**mind**
56:2, 56:9, 94:4
**minimal**
63:10
**minimum**
71:4, 91:21, 111:14
**minor**
99:21
**minus**
38:18, 88:6
**minute**
54:25, 64:23, 116:3, 116:13
**mirror**
51:11
**misbehaving**
110:9
**miss**
32:25, 44:6
**missed**
86:13
**missing**
42:19, 43:23, 43:25
**mission**
112:15
**mitigate**
77:1
**mix**
47:8, 47:21, 104:7, 104:16
**mixed**
74:5, 105:3, 106:2
**mixture**
54:8
**model**
34:7, 91:19, 92:16, 93:7, 93:13, 93:15, 93:20, 94:7, 95:6, 112:23
**modeling**
119:9
**money**
39:20, 102:2, 102:22, 106:17
**monitor**
47:17
**month**
18:3, 19:9, 24:6, 25:24, 26:1, 31:3, 31:7, 31:24, 53:10, 57:24, 75:15
**monthly**
24:11, 32:19, 32:21, 33:3
**months**
18:11, 20:8, 20:12, 20:20, 20:21, 20:22, 42:13, 43:20, 44:6, 47:1, 80:16, 81:13
**morbidity**
65:24, 73:24,

73:25, 74:21, 76:8, 91:3, 92:9, 93:3, 118:4
**more**
4:19, 8:16, 11:23, 17:19, 19:10, 19:17, 24:17, 25:21, 26:4, 27:14, 27:16, 28:10, 28:14, 29:11, 34:25, 36:4, 37:16, 39:20, 40:7, 41:9, 44:8, 45:21, 47:25, 48:6, 49:3, 52:6, 53:4, 53:6, 55:25, 56:5, 56:6, 56:18, 58:1, 58:8, 60:13, 61:17, 62:6, 63:6, 64:17, 64:18, 65:6, 67:1, 74:6, 76:17, 76:21, 79:14, 82:19, 100:12, 101:4, 102:8, 102:25, 103:19, 103:22, 104:17, 104:19, 105:6, 107:9, 107:24, 108:9, 113:17, 113:20, 113:22, 118:20, 120:7, 120:20, 121:4
**morning**
3:1, 35:20, 70:10, 90:1
**most**
21:13, 31:16, 37:18, 43:18, 48:10, 50:11, 58:4, 65:13, 68:25, 71:3, 71:9, 71:18, 73:3, 73:12, 88:14, 88:16, 90:11, 92:11, 98:15, 99:19, 101:19, 111:16, 111:18, 111:19, 111:20, 117:14
**mostly**
81:14, 91:7, 91:18, 92:16, 93:7, 101:12, 119:8
**move**
9:8, 9:9, 12:2, 18:1, 23:25, 27:12, 27:20, 28:19, 29:21, 33:6, 34:21, 35:17, 39:3, 39:22, 44:9, 49:14, 53:8, 54:11, 63:8, 64:14, 66:20, 85:5, 85:10, 90:7, 91:20, 94:17, 95:1, 95:22, 96:5
**movement**
63:3
**moving**
35:9, 52:12, 62:1, 66:16, 67:1, 78:23, 86:4, 90:22, 92:17
**much**
14:22, 26:2, 28:10, 32:23, 34:8, 38:24, 40:7, 40:22, 43:20, 50:4, 52:8, 53:3, 55:22, 58:8, 69:24, 71:22, 72:8, 81:3, 87:5, 89:17, 94:13, 94:20, 102:22, 105:25, 111:10, 111:21, 112:3, 117:7, 119:3, 120:1, 121:6
**multi-faceted**
61:12
**must**
3:9, 3:13, 36:15
**mute**
6:18, 121:18

**N**

**name**
6:15, 59:23, 70:10, 89:22, 90:1, 97:21, 98:2, 111:5
**named**
14:14
**national**
9:19, 24:10, 35:12, 114:21, 114:23
**nationally**
9:20, 24:4, 29:7, 29:11, 114:24
**nationwide**
57:3
**nature**
88:18, 113:18
**navarro**
2:5, 3:3, 7:1, 17:24, 43:6, 45:2, 62:15, 68:2, 68:15, 76:24, 78:16, 81:19, 85:11, 86:24, 93:11, 93:17, 94:15, 122:7
**navigators**
27:2, 27:14, 27:16
**near**
37:22
**nearby**
95:11
**necessarily**
46:21, 53:16, 57:11, 76:12, 105:10, 107:5
**necessary**
76:14
**need**
8:10, 15:13, 40:22, 47:22, 47:23, 64:24, 69:12, 75:19, 105:13, 105:18, 106:9, 107:5, 108:22, 113:14, 115:15, 117:23
**needed**
66:4, 66:16
**needs**
33:22
**negative**
73:14, 73:15, 81:9, 84:18, 84:22, 91:6, 91:8, 91:9, 91:13, 91:14, 92:14, 99:6, 99:16
**negotiate**
79:17, 101:14, 108:17, 114:15, 118:6
**negotiated**
82:23
**negotiating**
79:3, 121:7
**negotiation**
104:1
**negotiations**
40:3, 101:13, 102:4, 109:10, 120:5
**neighborhood**
81:5
**neither**
7:3, 122:7, 124:10
**nervous**
56:8, 56:17

**network**
66:12, 66:17, 66:23, 79:12, 79:15, 79:20, 90:14, 109:1
**never**
8:19, 15:17, 37:3, 48:24, 49:1
**new**
8:19, 11:11, 11:13, 11:18, 12:16, 23:3, 24:4, 24:8, 24:21, 50:19, 55:22, 60:16, 79:23, 80:1, 85:23, 102:25, 106:5
**newly**
8:11
**news**
45:7, 56:3, 99:2
**next**
7:19, 9:8, 9:9, 10:13, 12:2, 14:24, 18:1, 21:10, 22:9, 22:18, 24:1, 28:19, 29:22, 31:12, 33:6, 36:2, 36:16, 37:9, 37:15, 40:19, 42:19, 44:24, 46:25, 49:14, 52:14, 53:8, 55:18, 58:21, 60:19, 63:8, 67:17, 70:2, 87:7, 89:20, 91:20, 94:17, 97:20, 100:8, 122:13
**nice**
79:10
**nicely**
35:10
**nichols**
6:24
**nichols@scc**
6:25
**nobody**
56:12, 109:6
**noise**
42:24, 44:15, 44:23, 49:7, 54:12
**non-qhp**
36:3
**none**
7:9
**nonemergency**
43:19
**normal**
4:18, 43:23, 44:15, 49:6, 80:19, 80:23
**notable**
42:2
**note**
73:6, 118:21
**noted**
101:11
**nothing**
66:10
**notice**
31:17, 88:14, 96:11
**noticed**
25:6, 25:9, 73:6
**noticing**
88:25
**notify**
3:25
**notifying**
4:3
**november**
22:19
**number**
8:13, 19:2, 19:4, 20:9, 20:13, 20:14, 25:3, 29:9, 29:15, 35:13, 44:1, 51:16, 54:8, 54:19, 54:20, 54:22, 54:23, 55:5, 73:8, 82:6, 88:5, 89:1, 99:6, 99:16, 116:5, 116:6, 119:4
**numbers**
15:6, 15:8, 15:21, 17:4, 38:16, 41:24, 44:13, 44:25, 46:3, 46:4, 50:1, 53:16, 54:12, 71:25, 114:21

**O**

**observed**
73:13
**obtain**
23:16, 30:23
**obvious**
102:5
**obviously**
68:8, 98:8, 100:13, 103:9, 112:10, 116:17, 121:13, 121:20
**occurred**
16:13
**occurrence**
6:19
**occurring**
81:25
**october**
4:4, 34:11
**off-the-record**
110:13
**offer**
12:22, 12:25, 27:22, 28:4, 50:24, 67:12, 67:20, 67:24, 92:23, 116:2, 116:18
**offered**
3:11, 4:7, 4:21, 67:21, 110:19
**offering**
22:5, 67:16, 67:18, 89:1, 111:25, 116:24
**offerings**
115:2
**office**
90:16, 90:18, 92:2, 92:21, 95:7
**officer**
124:3
**offset**
99:9, 120:20
**often**
119:14, 120:7
**oh**
36:24, 37:2, 48:23, 58:23, 64:6, 64:18, 83:24
**okay**
10:13, 10:15, 12:3, 15:1, 17:25, 18:1, 18:2, 21:10, 24:1, 28:18, 31:13, 34:20, 40:18, 43:23, 49:14, 51:25, 53:7, 55:18, 65:10, 68:1, 68:15, 70:23, 73:2, 75:6, 80:22, 83:7, 87:3, 90:6, 92:17, 95:5, 96:4, 100:7, 100:23, 101:21, 104:24, 107:12, 110:10, 110:18, 115:11, 122:9, 122:14
**old**
30:7, 30:8,

30:18
**old's**
31:2
**older**
19:16, 76:17
**oliver**
15:2, 17:13, 34:5, 121:14
**once**
12:3, 28:14, 49:7, 56:15, 56:22, 57:14
**one**
8:20, 11:6, 11:8, 11:24, 13:15, 13:17, 13:25, 16:2, 16:19, 22:12, 28:1, 28:4, 28:8, 31:19, 33:9, 37:5, 38:6, 38:7, 39:7, 39:24, 40:21, 41:1, 42:2, 44:24, 45:12, 46:20, 46:23, 48:23, 49:21, 50:2, 50:15, 52:19, 55:2, 57:17, 58:25, 59:4, 60:6, 60:19, 63:8, 64:10, 65:7, 67:12, 67:13, 68:24, 74:1, 75:2, 77:5, 77:6, 80:9, 80:13, 81:5, 82:11, 84:9, 84:10, 85:11, 85:23, 86:8, 86:11, 88:24, 89:3, 96:10, 102:18, 108:20, 111:19, 112:11, 115:18, 118:20, 121:13
**ones**
13:17, 47:25, 48:12, 51:24, 112:11
**only**
10:24, 11:8, 21:25, 39:17, 40:11, 51:15, 57:2, 58:16, 59:4, 72:11, 77:9, 83:24, 99:24, 102:6, 104:4, 108:20, 111:12
**open**
15:12, 22:16, 27:9, 27:10, 31:21, 49:2, 57:19, 75:3, 106:11
**opening**
26:22, 116:11
**operate**
58:11, 58:15, 58:19
**operated**
50:7
**operates**
58:16
**operating**
48:12
**opportunities**
59:1, 60:7, 95:3, 100:24, 102:5
**opportunity**
28:14, 28:24, 29:2, 32:25, 69:23, 74:13, 102:16, 103:20, 111:1, 111:4
**opposed**
67:14
**opt**
98:5
**optima**
2:13, 58:13, 59:21, 59:25
**optima's**
63:11, 65:13, 68:25
**option**
27:11, 63:17, 105:19, 108:16, 110:20, 110:21
**options**
115:13
**orange**
49:19, 49:22
**order**
4:23, 7:9
**organizer**
2:15
**other**
13:5, 14:25, 22:6, 25:3, 26:23, 29:19, 31:13, 35:16, 37:14, 44:10, 46:20, 48:21, 50:5, 57:3, 59:19, 61:2, 64:4, 64:14, 67:5, 68:8, 71:16, 73:11, 73:12, 73:14, 77:12, 83:2, 83:3, 84:9, 85:4, 85:6, 89:14, 91:17, 92:15, 93:6, 94:5, 94:16, 94:25, 96:4, 104:25, 105:1, 105:22, 107:17, 108:5, 112:4, 113:22, 117:14, 118:17, 119:23, 120:11
**others**
117:22, 119:3, 119:21, 121:2, 122:1
**otherwise**
124:13
**ourselves**
102:21, 115:25
**out**
8:23, 23:19, 30:3, 34:7, 34:8, 40:6, 40:22, 42:17, 42:24, 42:25, 43:22, 43:24, 44:16, 46:17, 48:17, 49:4, 49:7, 49:21, 51:10, 51:25, 56:7, 72:14, 74:12, 76:22, 79:15, 81:18, 84:3, 85:3, 85:24, 95:10, 98:22, 102:15, 105:17, 105:20, 106:4, 109:1, 112:13, 118:11, 119:25
**out-of-pocket**
72:15, 90:14, 91:11, 92:1, 92:20
**outcome**
124:13
**outlined**
64:8, 98:7
**outpatient**
44:19
**outreach**
27:13
**outside**
44:23, 109:15
**outweighs**
75:22
**over**
9:12, 16:1, 16:7, 16:15, 18:12, 24:21, 29:2, 29:3, 30:1, 41:4, 41:22, 46:17, 46:25, 47:22, 49:23, 51:22, 52:5, 53:12, 57:8, 58:20, 59:20, 78:12, 84:23, 88:7,

90:23, 92:25, 102:12, 103:3, 103:7, 107:21, 119:12, 119:22
**overall**
34:23, 70:25, 76:4, 78:8, 78:9, 82:9, 90:10
**owed**
23:23
**own**
10:2, 14:4, 26:14, 94:9

**P**

**page**
87:13, 94:17
**pages**
1:28
**paid**
20:12, 20:19, 33:25, 94:9
**pandemic**
37:22, 40:5, 40:14, 43:11, 80:25, 81:16, 86:1, 89:7, 100:1, 113:5
**parameter**
96:12
**parameters**
31:18, 71:15, 85:1, 92:23
**parent**
72:7
**park**
48:20
**parker**
122:24
**part**
4:20, 5:22, 5:25, 6:10, 7:21, 9:18, 10:7, 10:17, 27:6, 55:25, 67:13, 72:21, 72:22, 87:13, 96:12, 99:15, 100:3, 101:19, 107:1, 107:14, 114:10, 114:12, 115:2, 123:3
**participants**
11:11
**participate**
5:7, 8:12, 8:17, 12:10, 14:17, 22:1, 27:3, 82:14
**participated**
8:20, 8:21
**participating**
8:18, 8:21, 13:10, 27:17, 35:14, 68:4, 69:25, 89:18, 97:18
**participation**
3:15, 5:17, 9:11, 13:4, 13:12, 34:24, 55:20, 55:25, 122:19
**particular**
9:23, 10:25, 11:23, 52:20, 67:13, 70:20, 104:5, 112:16, 112:21, 114:16
**particularly**
9:24, 10:10, 42:12, 45:23, 48:11, 50:12, 56:13, 75:22, 108:18, 114:6, 117:6, 122:21
**parties**
124:12
**partly**
113:18
**pass**
33:24, 89:15
**passed**
5:24, 10:5, 28:15, 33:10
**past**
9:12, 9:22, 10:4, 16:10, 42:16, 46:6, 58:5, 73:1
**pasted**
46:17
**patchwork**
60:10
**patients**
77:12
**pause**
122:2
**pausing**
60:4
**pay**
15:13, 15:18, 19:17, 30:13, 31:6, 33:22, 47:17, 73:20, 106:18, 116:21, 121:10
**payer**
66:23
**paying**
25:23, 26:1
**payment**
31:17, 96:11
**payments**
117:14
**payor**
73:21
**pays**
21:6, 21:8
**people**
15:13, 15:15, 15:16, 17:2, 19:20, 20:15, 22:16, 22:24, 23:4, 23:10, 24:16, 25:17, 26:4, 27:17, 27:22, 28:25, 29:2, 29:25, 31:25, 32:14, 35:7, 47:20, 54:10, 54:24, 61:25, 62:5, 71:12, 74:10, 75:5, 75:19, 75:25, 76:2, 76:7, 76:14, 76:17, 76:21, 77:20, 78:2, 78:6, 78:11, 78:12, 104:8, 105:20, 106:18, 107:4, 107:6, 107:10, 108:9, 108:22, 109:5, 113:10, 117:7, 117:23
**people's**
47:5, 116:19
**pepsi**
46:25, 47:3
**percent**
11:4, 13:8, 13:11, 21:6, 21:7, 23:12, 23:16, 24:4, 24:8, 24:13, 24:15, 24:19, 25:10, 29:3, 29:6, 29:18, 30:2, 30:11, 30:16, 30:21, 31:6, 32:22, 38:12, 38:13, 38:19, 38:20, 38:21, 42:3, 51:21, 54:5, 54:7, 54:15, 55:2, 65:16, 65:19, 65:21, 65:25, 66:2, 66:5, 69:3, 69:6, 69:7, 69:10, 69:13, 71:1, 71:18, 72:5, 73:9, 73:10, 76:19, 81:5, 81:7, 90:10, 90:14, 90:19, 90:24, 91:1, 91:4,

91:6, 91:8, 91:10, 91:13, 91:14, 91:17, 91:24, 92:6, 92:8, 92:14, 92:19, 92:25, 93:2, 93:7, 98:12, 98:17, 99:3, 99:23, 105:6, 119:7, 119:18
**percentage**
5:5, 92:11
**percentages**
53:19, 54:18
**perform**
3:13
**performed**
7:25
**perhaps**
43:9, 84:24
**period**
17:6, 22:14, 24:22, 24:25, 25:2, 26:11, 27:9, 27:10, 31:21, 31:22, 32:6, 32:11, 32:14, 32:20, 32:21, 32:24, 33:4, 34:11, 40:24, 57:19, 65:25, 66:9, 75:5, 75:23, 95:18, 96:20, 96:22, 102:13, 106:6, 119:2
**periods**
49:2, 75:10, 75:14
**permanente**
90:3
**perpetuity**
106:12, 107:11
**person**
18:13, 18:14, 20:10, 20:19, 21:5, 21:8, 30:4, 30:10, 30:14, 30:15, 30:25, 86:1
**perspective**
75:18, 100:18, 102:16, 105:2, 107:19, 108:13, 108:14
**phone**
110:5, 110:12, 110:20
**physical**
95:6
**physicians**
44:20, 94:9
**pick**
37:23, 104:3, 104:5
**picked**
46:10
**picking**
72:22
**picture**
82:9
**piece**
61:12
**pieces**
99:19
**piedmont**
13:15
**pier**
66:20
**place**
119:12, 119:22
**places**
37:23, 43:18, 44:18, 113:22
**plan**
3:10, 3:13, 7:22, 7:25, 9:5, 10:17, 15:17, 17:9, 18:13, 19:19, 22:11, 22:18, 22:20, 22:22, 23:18, 24:5, 24:9, 25:11, 25:20, 25:22, 25:25, 26:1, 31:1, 31:5, 32:1, 32:3, 32:5, 32:16, 33:13, 34:10, 41:5, 55:3, 61:11, 62:7, 65:14, 65:15, 65:16, 65:17, 65:19, 65:20, 67:12, 67:13, 69:1, 69:2, 69:3, 69:4, 69:6, 69:7, 71:12, 71:16, 71:18, 71:19, 72:6, 72:7, 72:8, 72:23, 73:3, 81:21, 88:16, 90:9, 90:11, 90:12, 91:1, 91:9, 91:15, 91:21, 91:22, 91:24, 92:4, 92:5, 92:9, 92:12, 92:13, 92:18, 92:19, 92:22, 92:25, 93:3, 93:12, 98:13, 98:15, 111:13, 111:15, 115:12, 115:13, 115:16, 115:17
**planned**
15:17
**plans**
3:15, 3:21, 4:6, 4:21, 5:11, 5:16, 5:19, 6:3, 6:4, 7:23, 15:16, 16:7, 19:13, 19:20, 23:19, 24:3, 24:18, 24:21, 25:13, 26:5, 32:9, 54:9, 54:10, 62:2, 62:22, 63:18, 64:8, 64:9, 64:12, 64:14, 64:17, 67:10, 71:2, 71:10, 71:13, 71:21, 71:24, 72:18, 78:20, 78:23, 88:14, 91:12, 93:6, 93:16, 93:18, 93:21, 96:11, 96:13, 96:14, 96:17
**plants**
64:19
**platform**
8:6, 8:8, 27:11
**platinum**
23:17, 69:4
**play**
71:23, 72:20, 118:19
**player**
116:17
**playing**
108:24
**plays**
56:10, 106:4
**please**
17:23, 67:17, 68:24, 94:17, 100:7, 112:6
**plug**
22:13
**plus**
72:5
**pocket**
72:14
**point**
11:1, 12:6, 13:1, 14:10, 17:9, 24:8, 36:20, 56:22, 62:12, 81:20, 82:5, 84:15, 100:2, 105:14, 118:20
**points**
22:11, 26:8,

68:17
**policies**
15:14, 22:7, 61:17, 76:25
**policy**
9:5, 20:12, 20:16, 87:17
**pool**
74:20, 78:8, 78:9, 106:17
**popular**
65:13, 69:1, 71:3, 71:10, 71:19, 73:3, 88:14, 88:16, 90:11, 92:12, 98:15, 111:16
**population**
16:4, 16:5, 16:11, 16:17, 17:16, 18:20, 19:16, 32:23, 41:8, 48:18, 65:24, 76:10, 95:7, 101:3, 117:18, 120:18, 120:20
**populations**
32:12, 61:2, 85:16, 85:17, 85:19
**portion**
35:17
**posed**
78:17, 100:21, 112:4
**position**
105:23
**positioned**
112:19
**positions**
118:14, 121:7
**positive**
99:15, 102:1, 107:20, 108:7
**positively**
64:1
**possibilities**
59:11, 63:23, 96:7
**possible**
10:8, 79:19, 86:2, 96:2
**possibly**
9:24, 11:17, 11:18, 22:2, 22:4, 32:13, 105:3
**post-covid**
86:10
**potential**
9:3, 11:13, 13:18, 32:11, 34:17, 86:11, 95:8
**potentially**
9:17, 11:11, 12:17, 27:21, 75:18
**poverty**
23:13, 29:1, 29:3, 30:2, 32:22, 61:19
**powerpoint**
90:17
**practice**
108:23, 109:11
**practices**
109:1
**practitioners**
101:19
**precisely**
60:13
**predict**
48:6
**predicting**
48:10
**predominantly**
116:9
**preference**
70:15, 70:20
**preliminary**
7:6
**premium**
1:5, 3:9, 4:13, 18:3, 18:5, 18:6, 18:9, 18:13, 19:2, 19:7, 19:9, 19:14, 19:15, 19:17, 20:3, 20:6, 20:22, 21:6, 21:9, 21:13, 21:17, 21:19, 24:11, 24:15, 29:6, 30:9, 30:17, 31:3, 31:8, 32:3, 34:8, 49:20, 50:14, 53:10, 63:12, 63:18, 65:17, 66:1, 66:5, 66:16, 69:4, 69:13, 74:14, 102:9, 102:11, 102:13, 106:18
**premiums**
3:4, 4:1, 4:17, 18:24, 23:20, 33:19, 33:21, 71:7, 76:18, 77:15, 79:5, 99:14, 101:7, 109:17
**preparation**
15:3, 105:11, 122:23
**prepared**
6:2, 14:14, 17:21
**prescription**
44:20, 116:18
**present**
12:21, 58:14, 108:23, 111:2
**presentation**
1:5, 5:22, 6:22, 7:10, 18:7, 21:14, 35:18, 70:1, 70:21, 83:23, 89:18, 97:19, 109:22, 122:11, 122:18, 123:7
**presentations**
3:4, 4:20, 4:24, 4:25, 5:19, 6:10, 6:20, 7:12, 7:18, 16:10, 25:6, 38:9, 39:1, 58:6, 58:7, 122:20, 123:4
**presented**
9:2, 87:13
**presenter**
6:21, 58:21, 70:2, 97:20, 109:25
**presenters**
6:13, 7:7, 39:16, 41:24, 41:25, 93:25, 113:16
**presenting**
5:8, 6:1, 40:7, 58:3, 83:16
**pressure**
99:24
**pretty**
13:13, 38:13, 43:19, 49:8, 49:23, 57:5, 73:3, 83:15, 84:2, 88:12, 99:5, 100:14, 100:20, 115:19, 116:10, 116:11, 118:14, 118:16
**previous**
18:20, 18:25, 93:6, 93:25
**previously**
29:4, 31:3, 61:25, 85:13, 101:11
**price**
48:19, 83:13, 83:19, 117:3, 117:11
**pricing**
36:23, 37:12,

37:18, 40:21, 41:2, 44:12, 57:9, 57:12, 61:3, 61:6, 63:21, 66:1, 73:23, 81:6, 111:7, 112:1
**primarily**
50:5, 55:20, 59:3, 59:12
**primary**
30:14
**prime**
115:4
**primer**
103:4
**prior**
29:13, 91:25, 94:23, 106:21, 113:15
**probably**
8:7, 13:6, 17:17, 39:15, 39:16, 40:2, 42:14, 44:4, 46:16, 50:15, 55:2, 73:1, 74:6, 74:16, 75:1, 75:6, 75:24, 76:22, 77:23, 78:1, 78:3, 78:7, 79:4, 79:9, 81:4, 82:5, 82:10, 82:16, 84:10, 84:16, 85:22, 86:6, 86:21, 88:18, 98:16, 98:18, 101:12, 102:8, 102:17, 102:20, 105:3, 106:6, 115:1, 116:4, 116:7, 119:8, 119:15
**problem**
32:15, 110:19
**problematic**
75:17, 77:19
**proceed**
68:22, 83:6, 87:1, 100:22, 115:10
**proceeding**
6:6, 6:17, 7:3
**process**
3:17, 10:18, 12:7, 12:19, 12:20, 36:6, 73:18, 79:3, 79:22, 84:1
**product**
66:17, 67:16, 67:22, 67:24, 68:19, 111:25, 115:2, 116:24
**products**
46:25, 47:2, 67:16, 67:18, 67:20
**professional**
124:2
**profile**
74:17, 117:18
**profit**
57:5, 63:15
**program**
10:5, 15:4, 33:10, 33:17, 33:18, 34:3, 34:16, 59:14, 63:25, 64:3, 68:7, 73:22, 84:14, 84:19, 84:25, 97:1, 97:3, 99:8, 121:12
**programs**
64:4, 68:8, 77:7, 85:2
**progress**
121:6
**project**
17:19, 42:18, 78:22, 80:22
**projected**
5:6, 8:13, 9:3, 12:4, 12:5, 13:4, 13:14, 21:21, 46:5
**projecting**
13:7, 120:23
**projection**
65:24, 66:9
**projections**
13:12, 13:16, 14:5, 17:12, 48:5, 89:11
**promote**
36:22
**prongs**
65:22
**pronounce**
89:22
**proposal**
32:13
**proposed**
4:2, 4:6, 8:12, 8:17, 31:13, 31:19, 75:13, 96:17
**proposing**
33:3
**proprietors**
21:24
**prospect**
12:23
**prospective**
119:6
**prospects**
114:14
**proud**
107:14
**provide**
5:19, 6:9, 6:14, 12:24, 35:21, 37:15, 64:5, 95:9, 112:15, 123:2
**provided**
7:10, 29:18, 67:9, 67:18, 81:21, 121:13
**provider**
66:13, 66:14, 67:23, 79:18, 114:11, 118:5, 121:4
**providers**
26:25, 39:8, 39:12, 39:19, 40:4, 41:13, 47:14, 66:16, 66:25, 79:12, 79:14, 79:25, 80:15, 82:21, 114:15, 117:15
**provides**
115:23
**providing**
5:8, 34:17, 39:13, 67:21
**provisions**
115:20
**public**
6:8, 12:13, 34:11, 36:10, 36:21, 36:22, 37:3, 123:2
**publicly**
12:11, 12:12
**pull**
58:21, 112:13
**pulled**
53:13
**purchase**
4:21, 25:19, 25:21, 72:6
**purchased**
18:14, 19:14, 19:19, 20:15
**purchasing**
19:20, 72:7
**pure**
42:23, 46:13
**purpose**
31:25
**purview**
109:16
**push**
79:4, 79:5
**pushing**
72:19, 73:5,

88:4, 89:5
**put**
37:4, 38:14, 40:19, 84:3, 105:22
**puts**
76:18
**putting**
26:14, 43:10

Q

**qhp**
36:1
**qualify**
76:20
**qualifying**
22:19, 75:15
**quarter**
11:7, 87:14, 87:16, 87:19, 88:7
**quarters**
87:21, 87:25, 88:2, 88:8
**question**
17:24, 20:2, 26:15, 40:10, 43:8, 61:9, 61:21, 62:16, 67:10, 68:3, 78:17, 83:7, 85:12, 88:24, 93:12, 94:14, 95:2, 95:13, 95:22, 96:5, 107:13, 109:13, 111:23, 111:24
**questions**
7:2, 9:8, 12:1, 13:23, 14:25, 17:23, 21:11, 22:8, 23:25, 29:21, 31:11, 33:5, 34:20, 35:17, 35:23, 39:2, 39:5, 53:7, 55:17, 58:1, 58:24, 59:19, 60:3, 60:4, 64:14, 67:5, 69:18, 70:17, 70:22, 70:23, 72:24, 74:2, 77:6, 82:12, 83:3, 83:4, 84:7, 85:4, 85:6, 85:8, 85:9, 88:23, 89:15, 90:8, 93:10, 94:16, 95:1, 95:2, 96:4, 97:14, 97:15, 98:7, 100:4, 100:19, 100:21, 101:9, 104:22, 109:18, 109:19, 112:4, 115:6, 119:23, 122:2, 122:3, 122:5
**quick**
88:24
**quickly**
9:13, 87:8
**quite**
15:9, 16:14, 19:24, 42:20, 57:10, 59:3

R

**rage**
65:1
**raised**
54:4
**raises**
52:24
**range**
38:14, 41:21, 42:3, 43:4
**ranged**
38:12
**rate**
5:10, 5:19, 5:22, 6:2, 7:17, 19:18, 19:23, 30:6, 36:10, 36:13, 38:18, 44:15, 45:23, 46:24, 47:1, 52:4, 53:11, 53:13, 54:6, 54:14, 54:17, 54:21, 54:25, 55:1, 55:8, 64:5, 65:17, 65:20, 65:22, 67:8, 69:4, 69:7, 69:9, 70:16, 70:21, 70:25, 84:17, 84:22, 87:14, 87:23, 88:4, 90:7, 90:10, 91:5, 91:14, 91:21, 92:8, 92:10, 92:14, 92:17, 92:23, 93:2, 93:4, 97:2, 98:11, 98:12, 98:13, 103:6, 111:11, 111:12, 118:14, 121:3
**rate-filing**
73:18
**rates**
1:5, 3:4, 3:9, 3:21, 4:6, 4:13, 8:11, 9:5, 10:18, 12:9, 13:1, 16:16, 16:25, 18:16, 18:18, 19:7, 35:2, 35:25, 37:4, 37:21, 37:24, 38:4, 38:10, 38:21, 39:13, 40:12, 49:23, 51:2, 51:14, 52:1, 52:17, 52:24, 54:5, 55:15, 57:23, 59:9, 60:13, 63:10, 63:11, 80:5, 80:11, 82:23, 83:8, 83:19, 84:3, 87:24, 87:25, 94:24, 95:24, 96:3, 97:3, 101:15, 102:9, 102:11, 102:14, 102:20, 106:1, 106:13, 118:17, 120:25, 121:8, 121:20, 122:13
**rather**
22:7, 43:4, 49:25, 103:20
**rating**
100:10, 100:14, 100:16, 100:17, 104:5
**ratio**
49:16, 49:19, 51:12, 51:20, 52:11, 52:25
**ratios**
49:19, 52:15
**re-entering**
122:12
**reached**
51:21
**reaches**
77:9
**reaching**
85:24
**reading**
64:7, 124:9
**ready**
56:4, 63:8, 65:12, 68:19, 70:8, 89:25, 98:1, 110:24
**real**
117:10
**realize**
32:4
**realized**
32:15
**really**
15:17, 15:20,

16:23, 27:10, 27:20, 37:22, 42:9, 48:4, 48:6, 50:3, 51:10, 55:13, 56:23, 57:20, 68:11, 70:1, 71:21, 72:7, 72:12, 72:21, 72:22, 73:12, 73:16, 75:9, 78:5, 80:12, 80:20, 83:10, 83:12, 83:18, 86:4, 87:5, 94:20, 100:14, 102:1, 102:23, 104:12, 105:4, 105:16, 108:20, 111:3, 111:10, 111:12, 111:21, 112:16, 113:13, 114:18, 117:5, 120:17, 120:22
**rearview**
51:11
**reason**
10:25, 22:2, 29:19, 31:24, 32:20, 51:12, 73:16, 74:7, 99:15, 104:10, 104:13, 105:16, 120:19
**reasons**
10:10, 50:2, 53:5, 115:3
**receivable**
66:3, 69:11
**receive**
23:12, 28:7, 33:16
**received**
10:16, 17:13, 23:11
**receiving**
102:2
**recent**
5:9, 5:16, 31:16, 58:5, 119:25
**recently**
4:5
**recognize**
118:22
**recognizing**
85:15
**recommendations**
3:21, 36:2
**reconsider**
75:25
**reconsidered**
112:17
**record**
5:25, 25:13, 64:11, 67:11, 124:6
**reduce**
10:6, 13:14, 33:19, 97:3
**reduced**
66:7, 103:17, 124:8
**reducing**
33:21, 65:25
**reduction**
34:8, 66:12, 72:25, 90:10, 91:2, 92:8, 93:2
**reductions**
71:23, 72:1
**reenroll**
24:14
**reenter**
59:16
**reentering**
74:11
**refiling**
94:2
**refills**
116:18
**reflect**
41:5, 47:2, 47:3, 47:5, 54:10, 55:6
**reflected**
46:21, 55:5, 55:7
**reflecting**
47:23, 47:24
**reflects**
54:23
**regard**
60:24
**regarding**
66:12
**regardless**
108:23
**region**
67:21
**regions**
67:19, 67:25
**registered**
124:2
**regular**
45:23, 46:24
**regulate**
39:8
**regulatory**
56:1, 56:21, 103:2, 104:24, 113:21
**reimburse**
34:1
**reimbursement**
39:13, 40:12, 66:13
**reimbursements**
66:14
**reinforce**
57:7
**reinsurance**
10:4, 15:4, 33:9, 33:13, 33:18, 34:3, 34:15, 59:14, 63:25, 64:2, 64:4, 68:7, 77:1, 77:5, 77:8, 77:16, 84:10, 84:14, 84:19, 84:25, 97:1, 97:6, 108:3, 108:5, 121:12
**related**
86:13, 102:23, 104:3, 124:11
**relates**
62:17
**relations**
114:14
**relationship**
101:16, 103:24, 108:1
**relationships**
67:23, 114:11, 118:6
**relative**
48:18, 68:3, 81:24
**relatively**
50:6, 57:11, 76:21, 89:3, 89:12, 99:3, 99:20, 101:15, 103:3
**rely**
56:14
**relying**
120:9
**remaining**
99:19
**remarkable**
49:25
**remember**
58:22, 109:13
**remove**
38:19
**renewal**
4:2
**renewed**
96:12
**renewing**
87:15, 87:17, 87:18
**repay**
23:23
**repeal**
56:4
**replace**
56:5
**report**
34:18, 54:6

**reported**
1:29
**reporter**
6:16, 124:1,
124:3
**reports**
54:7
**represent**
5:5, 6:15,
44:25
**representation**
87:21
**representative**
2:9, 2:10,
2:11, 2:12,
2:13, 64:10
**representatives**
27:3
**represented**
11:8
**representing**
98:3
**represents**
11:6, 11:19,
53:11, 54:1,
66:15
**request**
36:15
**requested**
71:3, 124:10
**requesting**
107:16
**require**
27:15, 95:7
**required**
3:14, 23:23
**requirements**
63:17
**requires**
3:19, 3:24
**rescue**
17:9, 22:11,
22:12, 22:22,
61:11
**residents**
4:17
**respect**
59:13, 60:22,
62:25, 109:10,
109:11
**respond**
62:13
**rest**
17:14
**result**
50:20
**results**
51:24, 57:2,
63:2, 73:19
**retroactive**
23:6
**retrospective**
66:7, 69:15,
120:22
**returning**
24:5, 24:9,
24:14
**reveal**
14:18
**revenue**
18:10, 20:7,
20:19, 20:20
**reverse**
78:3
**reversed**
73:8
**reversing**
73:11
**review**
3:9, 3:20,
4:21, 5:9, 5:16,
7:22, 7:23, 9:6,
36:6, 38:15,
63:12, 65:9
**reviewed**
4:13
**reviews**
36:3
**revise**
87:24
**revision**
66:15
**richer**
72:23, 88:15,
104:12
**richmond**
30:25, 70:12,
114:7, 115:1
**right**
17:18, 20:18,
25:16, 28:12,
33:7, 35:2,
39:9, 47:19,
52:13, 57:19,
60:2, 61:8,
62:22, 63:22,
70:6, 70:9,
70:25, 71:15,
80:4, 84:6,
85:4, 87:9,
89:14, 89:23,
90:9, 94:25,
95:13, 95:22,
96:21, 97:16,
107:5, 109:20,
112:3, 114:10,
117:2
**right-hand**
41:23
**rights**
63:12
**rising**
21:19, 113:12
**risk**
10:6, 33:17,
33:20, 48:16,
56:21, 63:15,
63:19, 66:3,
69:11, 73:8,
73:16, 73:19,
73:20, 73:24,
74:17, 75:1,
77:1, 78:10,
83:11, 99:6,
99:7, 99:16,
103:17, 103:21,
103:23, 104:2,
117:17, 117:25
**riskier**
99:9
**risks**
78:7
**road**
70:12, 98:4
**roanoke**
11:12, 114:8
**robust**
24:18, 25:21,
26:4, 95:9
**rockville**
90:4
**roll**
41:20, 105:25
**rolling**
51:1
**room**
52:23, 55:14
**roughly**
91:4, 92:14
**round**
31:16
**roy**
1:29, 124:2,
124:18
**rpr**
1:29, 124:18
**rules**
56:10, 56:11,
56:14
**run**
28:2, 44:15,
119:9
**rural**
59:2, 60:7,
60:9, 60:10,
60:16, 61:6,
82:13, 82:15,
82:18, 85:16,
95:3, 95:10,
100:12, 100:24,
101:6, 101:11,
102:8, 102:11,
103:24, 108:19,
120:3, 120:7,
120:9

**S**

**s**
2:1, 73:23,
81:6
**safer**
103:19
**said**
12:25, 14:3,

22:17, 66:10, 86:20, 93:12, 93:25, 117:1, 120:12, 124:7
**salaried**
94:9
**sale**
46:25
**same**
10:7, 24:25, 30:14, 30:15, 30:20, 34:14, 36:3, 36:6, 36:7, 37:10, 55:23, 56:11, 92:23, 94:23, 95:17, 98:17, 117:15, 120:4
**samples**
64:10
**savoy**
26:14
**saw**
73:18, 76:15, 78:3, 84:13, 84:21, 98:21
**say**
9:10, 13:22, 20:11, 45:14, 47:4, 50:21, 54:3, 61:2, 62:1, 62:2, 74:22, 76:14, 77:9, 77:21, 79:1, 79:14, 80:18, 80:19, 81:13, 83:15, 90:18, 98:16, 99:5, 99:19, 99:20, 101:10, 104:18, 105:2, 106:2, 106:20, 108:11, 111:24, 117:11, 119:7, 119:15, 121:1, 121:23, 123:1
**saying**
43:9, 48:19, 76:6, 81:13, 106:10, 106:13, 106:15
**says**
45:25
**scary**
72:4
**scenarios**
119:10, 119:18
**schneider**
2:12, 110:1, 110:2, 110:5, 110:15, 110:18, 110:25, 111:5, 112:7, 115:11, 122:9, 122:14
**scp**
105:14, 105:24
**scrambling**
51:25
**screen**
53:20
**scrutinized**
83:15
**sec**
115:3
**second**
3:24, 25:19, 30:25, 36:21, 40:10, 61:8, 87:18, 87:22, 88:1, 95:13
**secondly**
94:4, 96:18
**sections**
60:10
**secular**
41:10
**see**
8:16, 9:11, 11:12, 11:15, 11:24, 12:14, 13:21, 15:11, 15:14, 16:3, 16:7, 16:13, 16:20, 17:2, 17:15, 18:4, 18:17, 18:22, 19:3, 19:22, 21:17, 27:4, 28:24, 30:22, 32:2, 34:9, 36:10, 37:3, 40:4, 41:19, 41:24, 42:1, 44:2, 46:1, 46:3, 46:7, 48:1, 52:12, 55:11, 56:3, 57:4, 67:7, 67:19, 70:25, 72:4, 72:21, 73:4, 73:25, 74:13, 78:22, 81:8, 84:11, 84:16, 85:1, 86:4, 87:10, 88:9, 88:13, 88:18, 89:6, 93:9, 98:10, 98:14, 98:17, 100:10, 100:13, 101:2, 101:4, 101:5, 101:8, 102:25, 103:25, 106:3, 110:9, 111:13, 114:3, 114:4, 114:21, 119:14
**seeing**
17:10, 25:11, 34:24, 41:19, 52:15, 52:16, 62:20, 71:6, 72:5, 74:6, 76:5, 79:13, 81:23, 89:2, 99:23, 103:5, 103:20, 105:25, 109:17, 122:13
**seem**
72:3, 79:13
**seems**
26:8, 35:8, 35:9, 100:2
**seen**
24:4, 24:8, 24:16, 24:20, 26:2, 29:9, 31:20, 45:17, 46:5, 48:25, 55:19, 56:24, 57:21, 59:6, 71:5, 79:24, 84:12, 107:21, 108:5, 119:13
**sees**
41:13
**segue**
100:20
**select**
24:5, 24:9, 54:10
**selected**
20:12
**selecting**
24:21, 114:2
**selection**
99:9, 104:21, 120:14
**self-funded**
97:8
**send**
64:23
**senior**
111:6
**sense**
45:12, 94:6, 112:5
**sensitive**
4:16
**separate**
80:13, 115:16
**september**
23:21
**serf**
36:8
**serve**
85:15, 85:19
**served**
101:6, 113:9
**service**
10:20, 10:21, 11:1, 11:19, 13:19, 27:2,

36:13, 81:25
**services**
3:19, 41:3, 41:4, 41:12, 43:1, 43:17, 44:2, 44:3, 44:17, 44:18, 45:9, 45:10, 45:14, 45:15, 45:16, 45:17, 45:20, 46:22, 47:8, 47:10, 47:18, 47:21, 47:24, 59:24, 86:12, 115:25
**session**
10:4, 33:11
**set**
10:18, 56:9, 57:13, 124:14
**setting**
10:1
**seven**
42:3
**seven-tenths**
38:12
**several**
11:16, 13:5, 42:13, 48:13, 114:25
**severe**
79:9
**share**
23:19, 66:24, 69:23, 72:9, 72:19, 78:11, 79:25, 92:3, 92:21
**shares**
116:25
**sharing**
23:18, 26:2, 67:2, 72:2
**shea**
2:7, 5:14, 35:19, 36:18, 36:24, 37:2, 37:9, 39:4, 39:6, 39:9, 39:14, 40:18, 43:15, 45:3, 45:6, 46:12, 46:20, 47:15, 47:20, 48:8, 49:13, 74:25, 80:14, 82:17, 122:22
**shea's**
18:6, 35:17, 80:6
**sheet**
70:15
**shift**
17:15, 45:20, 47:2, 55:6, 63:2, 110:10, 115:7
**shifts**
62:20
**short**
83:9
**shorthand**
124:1, 124:3
**should**
6:21, 17:3, 21:25, 41:5, 52:1, 53:21, 73:8, 73:10, 88:18, 118:21
**show**
15:25, 17:13, 21:15, 111:10, 111:11
**showed**
19:7, 19:15, 49:23, 50:13, 53:17, 54:2
**showing**
8:13, 13:4, 19:8, 91:17, 92:15, 111:16
**shown**
64:5, 74:15
**shows**
18:2, 18:12, 19:4
**shrinking**
78:4
**shut**
39:21, 80:16
**sic**
90:23
**sick**
106:19, 106:21
**sicker**
32:12, 75:11, 75:18, 77:2
**side**
41:23, 43:14, 44:19, 44:20, 72:25, 79:5, 96:25, 109:14
**signature-p1kal**
124:16
**significant**
5:5
**signing**
117:23, 124:10
**silver**
25:20, 31:1, 31:5, 62:1, 62:2, 65:14, 65:17, 69:7, 71:14, 71:17, 71:21, 71:24, 92:18, 111:15, 111:18, 115:18
**similar**
38:23, 49:22, 88:18, 93:5, 116:13
**simple**
42:24
**simplified**
116:20
**simply**
49:19
**since**
8:1, 8:8, 19:16, 23:5, 24:22, 71:16, 102:18, 111:9, 112:2
**single**
82:20
**sit**
8:23
**sitting**
55:1
**situation**
75:7
**size**
60:15, 60:23, 97:13
**sky**
102:14
**sleep**
57:12
**slide**
7:19, 8:13, 9:8, 9:10, 10:14, 11:10, 12:2, 12:25, 13:3, 13:22, 14:14, 14:24, 15:1, 15:5, 16:21, 17:22, 18:1, 18:2, 18:6, 18:9, 18:17, 18:20, 18:25, 19:8, 21:3, 21:10, 21:15, 22:9, 23:25, 24:1, 28:19, 29:22, 31:12, 33:6, 34:21, 34:22, 36:16, 37:9, 37:10, 37:15, 40:19, 49:15, 53:8, 53:9, 53:10, 53:11, 55:18, 58:2, 58:21, 58:23, 67:17, 68:24, 87:3, 87:7, 98:21, 100:5, 100:8
**slides**
9:2, 35:21, 38:14, 74:8, 98:6
**slight**
74:1, 76:4,

90:15, 91:23, 92:1
**slightly**
19:3, 90:23
**small**
3:6, 4:10, 4:18, 4:22, 5:4, 6:4, 12:10, 21:12, 21:16, 22:1, 22:3, 22:5, 35:8, 35:9, 38:23, 49:18, 50:3, 50:4, 50:6, 50:22, 52:7, 53:4, 53:6, 55:21, 58:13, 58:16, 58:19, 59:4, 60:15, 60:23, 63:7, 68:20, 68:25, 70:5, 85:5, 85:10, 87:7, 87:10, 87:16, 88:22, 89:1, 91:9, 91:10, 99:20, 100:3, 100:14, 108:6
**smaller**
60:12
**society**
107:3
**sold**
3:12
**sole**
21:24, 38:7
**some**
9:14, 9:25, 10:3, 10:24, 11:1, 11:12, 11:17, 11:19, 14:10, 15:14, 21:20, 21:21, 22:3, 22:5, 22:10, 22:11, 24:2, 25:21, 26:16, 26:18, 26:20, 29:19, 29:25, 31:13, 32:18, 33:8, 35:22, 35:24, 38:15, 39:16, 39:19, 39:22, 40:15, 42:19, 44:2, 44:3, 44:14, 48:21, 49:25, 51:23, 52:5, 52:7, 52:22, 52:23, 55:14, 57:1, 57:18, 57:20, 58:24, 59:12, 61:25, 62:12, 63:4, 70:17, 71:14, 74:10, 74:11, 74:14, 74:15, 75:14, 76:2, 76:16, 76:25, 80:10, 80:14, 81:4, 83:4, 84:12, 84:15, 84:21, 85:21, 86:15, 96:9, 99:20, 99:24, 100:3, 100:10, 100:12, 102:1, 104:10, 105:1, 108:12, 113:14, 113:15, 113:21, 115:21, 115:24, 116:23, 117:20, 117:22, 118:14, 120:3, 120:9, 120:21, 121:14, 121:18, 121:21, 121:25
**somebody**
65:5, 83:25
**someone**
28:5, 28:6, 28:7, 30:1, 30:8, 44:5, 64:22
**something**
27:1, 56:16, 57:6, 62:12, 72:17, 85:12, 86:14, 87:12, 114:24, 116:13, 119:2
**sometimes**
71:11, 82:18, 82:19, 108:16, 115:15
**somewhat**
38:23, 88:3, 88:15
**somewhere**
46:11
**soon**
22:15
**sophisticated**
48:14
**sorry**
17:25, 58:23, 68:13, 110:22
**sort**
43:13, 62:16, 62:23, 68:3, 70:25, 72:21, 76:18, 77:13, 78:13, 82:1, 101:24, 103:22, 120:23
**sounds**
53:1
**sources**
61:5
**southwest**
11:21
**southwestern**
13:17
**speak**
6:2, 6:14, 38:25, 39:16, 40:7, 40:16, 57:21, 59:16, 71:9, 83:4
**speakers**
7:2
**speaking**
6:18, 42:5, 57:11, 58:17, 82:12, 103:15, 104:15
**special**
17:6, 22:14, 24:22, 24:24, 25:2, 25:3, 26:11, 32:10, 32:14, 32:19, 32:21, 32:24, 33:4, 75:4, 75:10, 75:14, 95:18, 96:20, 96:22, 106:6
**specific**
88:21, 118:20
**specifically**
59:17, 86:22
**spectrum**
61:18
**speculating**
19:12
**spirit**
101:8
**split**
60:12
**splitting**
60:22
**spokes**
57:16
**spread**
56:7, 116:8, 121:18
**st**
36:1, 57:24
**stability**
64:5, 95:21, 96:2, 97:4, 97:13, 103:3, 103:6, 107:8, 113:16, 121:22
**stabilize**
10:1
**stabilized**
103:16
**stable**
55:25, 89:3, 89:12, 113:17
**staff**
7:7, 122:21

**stakeholders**
26:23
**stand**
30:19
**standard**
96:11, 115:19
**standardized**
96:13, 96:14, 96:16, 108:25
**standards**
95:10
**standpoint**
102:24
**staples**
70:12
**start**
24:22, 47:23, 56:5, 56:8, 56:17, 57:22, 60:2, 70:21, 77:8, 84:16, 90:7, 90:11, 96:9, 118:11
**started**
37:23, 50:22, 50:23, 55:12
**starting**
40:4, 42:13, 98:15
**starts**
56:6, 56:15, 57:15
**state**
1:2, 7:21, 19:20, 19:21, 26:21, 29:16, 33:11, 33:25, 34:7, 34:18, 48:19, 59:11, 60:11, 63:16, 63:23, 67:14, 84:8, 96:6, 96:25, 97:6, 97:12, 107:13, 107:19, 108:2, 114:4, 116:8
**state's**
27:22, 64:2
**state-based**
8:4, 8:7, 10:2, 26:17, 27:12, 28:3, 68:8, 107:23
**states**
28:2, 28:9, 33:23, 34:1, 50:5, 64:4, 90:3, 96:16, 101:1, 109:12, 113:25, 114:3
**statewide**
67:14, 82:1, 82:4, 99:12, 114:13
**status**
50:15
**stay**
26:8, 84:18, 92:23
**stayed**
94:23
**steadily**
21:19
**steady**
49:23
**steam**
37:23
**stenographically**
124:8
**step**
88:3
**steps**
9:25
**steve**
109:25, 111:5, 122:10
**steven**
2:10, 2:12, 97:21, 98:3, 109:21
**stick**
57:15
**still**
8:5, 8:8, 9:6, 25:25, 29:15, 31:20, 38:15, 40:2, 40:6, 75:6, 77:13, 77:18, 80:25, 81:15, 85:3, 94:1, 95:12, 105:4, 110:8, 112:21, 112:23
**stop**
35:22, 84:15, 93:9
**stores**
114:20, 116:21, 120:7
**stories**
109:5
**story**
88:11
**straight**
105:16
**street**
80:18, 90:4
**strengthen**
61:5
**stricter**
106:6
**strongest**
67:23
**stuck**
80:25, 109:5
**studies**
74:15
**study**
15:2
**studying**
34:5
**stuff**
54:9
**submit**
6:12, 15:3, 34:9, 36:1, 36:13, 51:2, 57:23, 123:6
**submits**
12:14
**submitted**
5:21, 34:13
**subsides**
100:1
**subsidies**
10:8, 17:9, 21:4, 22:23, 23:2, 23:4, 23:6, 23:9, 23:22, 23:24, 24:3, 25:19, 27:21, 27:22, 28:7, 28:21, 28:23, 29:4, 29:18, 29:24, 30:20, 30:22, 31:2, 31:4, 31:10, 33:22, 33:25, 34:18, 35:5, 35:6, 49:1, 57:22, 57:25, 61:15, 61:18, 61:24, 62:16, 62:18, 74:9, 74:14, 95:19, 97:9, 97:11, 103:13, 120:16
**subsidized**
16:3, 16:11, 17:11, 17:19, 18:20, 21:5, 21:8, 23:20, 121:21
**subsidy**
25:20, 25:21, 29:12, 29:13, 30:10, 30:13, 31:4, 31:7, 32:3, 61:13, 62:23, 72:20
**substantial**
30:19, 50:9
**suburban**
85:16
**suddenly**
74:19
**suffer**
77:12
**suggestions**
60:24
**suited**
40:7

**summary**
5:8
**summer**
42:14
**summing**
54:18
**supervision**
124:9
**support**
61:14
**supportive**
96:13, 97:11
**suppose**
100:19
**supposed**
41:10, 42:23
**suppressed**
43:16, 66:10, 69:16, 94:11
**sure**
14:3, 20:16, 26:19, 45:3, 49:13, 61:22, 62:10, 75:4, 76:2, 82:17, 83:18, 105:5, 107:10, 109:9, 118:16
**surface**
72:18
**surgeries**
43:19
**surges**
81:17, 81:18
**surprise**
109:2
**surprised**
107:17
**surprising**
53:5, 81:16
**suspended**
36:21
**sustained**
92:11
**sutherlin**
2:13, 59:20, 59:23, 59:24, 61:1, 61:8, 61:22, 62:10, 64:13, 64:18, 64:22, 65:1, 65:12, 65:13, 66:22, 67:5, 67:7, 67:15, 68:13, 68:18, 68:23, 69:22, 69:25, 78:17
**swearing**
7:4
**system**
80:1, 82:20, 82:22, 113:7
**systems**
48:14, 57:13

**T**

**table**
67:20
**take**
17:5, 17:8, 20:7, 20:20, 23:1, 23:3, 30:24, 42:24, 45:13, 80:17
**takeaway**
38:17, 53:3
**takeaways**
55:18
**taken**
17:4, 35:12, 124:4, 124:7
**takes**
29:23, 51:9
**taking**
9:25, 18:10, 44:15
**talk**
17:22, 18:7, 21:2, 31:15, 40:11, 49:6, 58:12, 59:10, 71:20, 71:24, 77:19, 88:16, 93:19, 98:5, 113:4, 113:16, 115:3, 115:7, 119:10, 120:1
**talked**
18:19, 18:24, 33:8, 42:21, 57:9, 59:13, 75:12, 108:4, 113:3, 117:1
**talking**
19:5, 20:2, 28:22, 56:5, 82:18, 103:11, 103:12, 103:13, 107:17
**targeted**
32:14
**tax**
24:12, 24:13, 24:17, 63:19
**taxes**
23:8, 63:14
**taylor**
2:15
**teams**
6:7, 79:16
**tease**
49:21
**technical**
6:22
**technically**
36:4, 115:15, 117:4
**teeny**
41:15
**telehealth**
39:23, 40:13, 85:18, 85:24, 86:2, 86:18
**telemedicine**
85:14, 85:18
**tell**
9:13
**template**
67:8
**temporarily**
89:5
**temporary**
86:3
**ten**
100:16
**tend**
25:7, 83:11, 101:7, 106:12
**tendency**
84:15
**tends**
77:22
**term**
107:3, 107:7
**terms**
92:11, 103:14, 112:18, 113:25, 115:12, 115:19, 115:20, 119:10, 119:13
**terribly**
51:5, 51:18
**testimony**
124:6, 124:7
**testing**
119:8, 119:16
**text**
64:23
**th**
10:16, 24:23, 31:23, 36:12, 124:15
**thank**
7:14, 10:12, 14:21, 20:23, 21:1, 26:6, 28:17, 35:19, 37:8, 40:17, 45:2, 49:11, 61:7, 62:14, 67:4, 68:1, 69:19, 69:22, 69:24, 69:25, 70:9, 80:3, 86:24, 89:13, 89:16, 89:17, 89:18, 89:19, 94:15, 94:19, 97:16, 97:17, 97:18, 97:24, 98:2, 100:8, 100:23, 109:20, 109:21, 109:22,

122:8, 122:9, 122:10, 122:11, 122:15, 122:16, 122:18, 123:8
**thanks**
40:18, 111:1, 122:3
**thereafter**
124:8
**therefore**
103:18
**thing**
21:1, 21:2, 22:12, 22:21, 49:21, 57:17, 75:2, 77:16, 77:23, 80:5, 84:20, 86:6, 95:20, 105:7, 105:19, 106:7, 107:2, 107:4, 107:6, 107:23, 108:4, 108:9, 109:3, 109:8, 111:12, 116:13, 119:16
**things**
10:3, 11:2, 27:4, 39:18, 40:22, 42:8, 44:10, 45:24, 45:25, 46:1, 48:5, 48:21, 55:2, 56:6, 57:15, 59:13, 72:25, 79:5, 80:13, 81:13, 91:18, 99:13, 103:15, 106:4, 107:17, 107:25, 109:15, 112:18, 116:21, 121:13
**thinking**
33:3, 52:22, 55:13, 59:8, 76:9
**third**
29:14, 31:15, 87:18, 87:22, 95:22, 102:18
**thought**
13:19, 15:5, 73:20, 73:22, 73:23, 111:22, 112:18, 117:3, 117:9
**thoughtful**
114:2
**thoughts**
76:11, 112:5
**thousand**
104:6, 104:8, 116:5
**three**
8:16, 20:12, 20:19, 20:21, 20:22, 30:7, 30:17, 44:6, 47:1, 51:8, 55:16, 64:8, 64:17, 64:19, 65:6, 71:2, 78:4, 80:16, 90:19, 92:3, 96:12, 103:7
**three-month**
44:7, 44:8
**threshold**
30:21
**through**
17:5, 18:23, 23:21, 28:5, 33:24, 60:3, 63:6, 65:7, 70:14, 70:16, 85:24, 87:8, 88:2, 89:7, 98:6, 98:13, 118:15
**throughout**
15:23
**throw**
48:15, 48:16
**throwing**
57:15
**tie**
53:16
**tied**
73:24
**tier**
66:17, 66:20, 67:1
**tiered**
66:23
**tight**
41:21, 43:4
**tightly**
96:15
**tim**
2:11, 70:3, 70:10
**time**
11:2, 11:22, 15:19, 22:5, 24:25, 32:6, 36:5, 36:7, 37:24, 41:4, 47:22, 49:24, 51:13, 51:19, 52:9, 54:16, 58:7, 65:24, 75:5, 75:23, 86:3, 94:2, 95:17, 102:13, 115:4
**times**
4:18, 30:7, 30:17, 107:2
**tobacco**
94:22
**today**
5:7, 6:1, 12:8, 12:13, 31:15, 36:9, 37:7, 39:25, 41:25, 47:9, 53:24, 58:4, 68:14, 76:23, 82:15, 98:3, 109:17, 122:23
**today's**
4:20, 6:6, 6:13, 122:17
**together**
38:14, 40:19, 41:20
**tolerate**
56:23
**top**
16:6, 53:22, 70:25, 87:13, 98:11, 116:6
**topic**
119:20
**total**
16:21, 20:7, 41:23, 90:24, 92:7, 93:1, 98:19
**totally**
45:10, 70:20, 70:22
**touched**
40:10, 84:9, 85:5
**tough**
102:2
**toward**
40:25
**traditional**
94:6
**trails**
15:20
**transcribe**
6:16
**transcript**
64:7, 124:5
**transitional**
16:6
**translate**
68:10
**translates**
117:21
**treating**
119:12
**treatment**
43:11, 44:18, 45:21, 45:22
**trend**
41:2, 41:11, 43:1, 45:5, 48:5, 48:10, 69:10, 91:5,

92:9, 93:4, 98:21, 98:22, 98:25
**trends**
42:2, 42:12, 42:23, 42:24, 48:13, 48:15, 48:20, 49:6, 49:8, 57:10, 57:12, 66:2, 98:23
**tricky**
15:9
**tried**
43:22, 80:22
**true**
56:22, 78:3, 117:4, 124:6
**try**
27:21, 28:11, 40:21, 40:22, 44:22, 49:4, 50:18, 51:25, 58:6, 61:5
**trying**
20:16, 39:20, 42:11, 79:17, 81:2, 83:11, 85:25
**turn**
37:6, 58:20, 59:20, 110:6
**turned**
36:8, 36:9, 37:7
**two**
11:13, 44:6, 44:8, 51:8, 51:15, 53:18, 80:13, 81:5, 81:13, 87:9, 93:6, 101:8, 104:22, 104:23, 115:18
**two-thirds**
105:15
**type**
41:5, 45:21, 45:22
**types**
22:6, 25:3, 43:10
**typewriting**
124:9
**typical**
115:19, 115:22, 116:25

U

**ugly**
109:4
**uh-huh**
14:23, 39:6, 86:25
**ultimately**
121:9
**uncertain**
40:1
**uncertainty**
9:21, 56:13, 80:7, 94:1, 102:25, 103:17
**unchanged**
91:25
**under**
3:8, 9:6, 14:18, 21:24, 29:18, 30:20, 34:14, 38:15, 41:23, 43:23, 57:25, 90:21, 92:22, 94:6, 96:18, 113:9, 124:9
**underline**
86:8
**underlying**
41:11, 42:25
**understand**
20:16, 23:7, 60:21
**understood**
14:21
**unemployed**
113:11
**unemployment**
23:11, 23:14
**unexpected**
119:14
**unfair**
78:11
**unfavorable**
74:7
**unfortunate**
79:10
**unfortunately**
40:3
**unhealthy**
78:11, 78:12
**uninsured**
29:8, 29:15
**unique**
95:5, 115:21
**universe**
46:15
**unknown**
74:25, 79:23
**unless**
13:22, 35:16, 102:3, 105:17
**unnamed**
14:10
**unsubsidized**
16:4, 16:14, 16:17, 16:20, 16:22, 16:24, 17:2, 17:16, 35:4, 35:7
**until**
12:12, 14:19, 52:14, 57:22, 84:1, 104:13, 118:17
**unusual**
80:15
**upcoming**
63:13
**update**
91:19, 92:16, 93:8
**updates**
31:16
**upfront**
70:18, 83:4, 83:22, 107:24, 109:7
**uphill**
101:24
**urban**
59:3, 82:19, 85:16, 101:3, 116:9, 120:8
**usage**
41:4, 41:14, 42:7, 42:25, 44:17, 45:10, 46:22
**use**
4:7, 4:15, 8:8, 25:18, 25:21, 45:8, 47:10, 47:21, 62:7, 66:1, 114:18, 114:19, 115:23, 115:24, 116:14
**useful**
117:6
**using**
8:5, 24:16, 30:20, 31:5, 47:9, 61:4, 62:18, 63:20, 83:17
**usually**
31:22, 36:7, 42:6, 75:11
**utilization**
41:4, 41:12, 42:6, 43:14, 43:16, 48:1, 62:3, 62:8, 66:8, 66:11, 69:16, 94:11
**utilizing**
62:19, 62:21, 105:25

V

**vaccinations**
119:8, 119:16
**vaccine**
81:14
**vaccines**
119:8

**value**
19:18, 19:19, 23:17
**variant**
72:8
**variation**
49:24
**variations**
115:14
**variety**
53:23, 81:12, 98:23
**various**
85:19, 121:11
**vary**
82:5, 94:24
**versa**
62:22
**versed**
86:21
**versus**
28:6, 28:7, 30:4, 62:18, 67:13, 104:20, 107:10
**vice**
62:22
**vice-a-versa**
45:22
**victoria**
26:14
**view**
68:6
**viewing**
74:24
**virginia**
1:1, 3:8, 3:12, 3:24, 4:7, 4:22, 5:5, 5:17, 6:25, 8:22, 9:23, 9:24, 10:10, 10:17, 11:3, 11:5, 11:8, 11:15, 11:21, 11:25, 12:8, 13:18, 14:17, 21:22, 24:7, 24:11, 24:20, 26:8, 33:8, 35:1, 35:11, 42:1, 49:17, 50:4, 53:12, 54:4, 54:7, 54:14, 55:9, 57:2, 59:2, 59:18, 60:1, 60:8, 60:10, 70:12, 90:25, 95:4, 97:10, 98:9, 100:13, 100:25, 102:7, 102:10, 103:6, 107:15, 113:21, 113:25, 114:6, 114:25, 116:7
**virginians**
4:10, 112:17
**virtual**
1:12, 95:9
**virtually**
6:6
**virtue**
71:25
**visit**
90:16, 90:18, 92:2, 92:21
**visiting**
6:11, 123:4
**visits**
86:1, 90:19, 92:4, 116:3
**volatile**
21:17, 49:24, 52:6, 53:4, 53:6, 112:10
**voluntarily**
10:19, 10:20, 10:23
**voluntary**
36:13

**W**

**waiting**
64:13, 106:3
**waive**
86:2
**waived**
90:20, 92:22
**waiver**
33:13
**walk**
48:20, 70:14
**want**
7:7, 7:16, 12:9, 14:3, 21:1, 22:13, 25:18, 25:25, 27:5, 27:25, 32:4, 32:5, 33:1, 37:3, 43:25, 44:22, 46:13, 49:14, 56:18, 57:6, 70:15, 70:17, 80:17, 80:18, 80:19, 82:9, 87:4, 101:20, 104:16, 104:17, 105:10, 107:6, 122:18, 123:1
**wanted**
21:2, 23:1, 27:8, 31:15, 37:1, 39:10, 64:11, 68:17, 119:19
**wanting**
28:4
**wants**
104:17, 109:6
**wave**
40:4
**way**
12:20, 15:21, 15:24, 19:18, 33:15, 35:23, 42:4, 45:12, 50:2, 55:14, 56:2, 75:1, 83:13, 84:2, 109:11
**ways**
18:4, 19:10, 37:5, 46:23, 49:25, 85:23, 118:2
**we'll**
5:14, 14:10, 16:20, 34:21, 35:6, 43:16, 53:8, 84:25, 118:18
**we're**
17:10, 18:4, 25:11, 27:6, 30:3, 44:13, 48:1, 50:21, 52:16, 54:6, 61:4, 66:8, 67:18, 67:24, 68:19, 71:6, 72:5, 74:24, 75:9, 76:5, 79:13, 80:13, 81:2, 81:3, 81:10, 82:3, 83:16, 84:16, 85:24, 86:16, 86:22, 89:2, 89:11, 90:9, 91:1, 92:8, 93:2, 94:5, 99:2, 103:11, 103:13, 105:25, 111:2, 111:9, 111:15, 111:23, 112:2, 114:1, 114:3, 114:4, 114:7, 115:7, 115:11, 115:13, 116:11, 118:7, 118:15, 118:17, 118:19, 120:9, 120:14, 121:5, 121:6
**we've**
10:16, 11:22, 16:9, 17:1, 17:12, 24:4, 24:8, 24:20, 25:8, 26:2, 28:22, 29:1,

29:9, 45:17, 48:25, 55:13, 55:14, 55:19, 55:24, 59:15, 71:5, 71:21, 73:13, 79:24, 80:21, 80:22, 83:22, 83:23, 85:7, 85:25, 88:11, 98:23, 99:22, 100:4, 100:10, 104:24, 112:24, 113:3, 113:15, 115:12, 115:17, 118:1, 118:24, 119:13
**webcast** 6:7
**website** 6:11, 12:12, 123:5
**wednesday** 1:14, 36:2
**week** 23:11, 23:15
**welcome** 7:16
**wen** 2:9, 89:21, 90:2
**went** 20:11, 38:20, 65:7, 73:19
**weren't** 29:13, 83:20, 86:2
**whatever** 101:20
**whenever** 65:11, 70:7, 89:25, 97:25, 105:10, 110:24
**whereas** 28:12
**whereby** 10:18
**whereof** 124:14
**whereupon** 110:13
**whether** 3:10, 3:12, 27:21, 28:5, 41:7, 56:18, 56:19, 72:14, 75:13, 75:25, 86:15, 96:21, 97:11, 108:6, 111:23
**whole** 74:19, 114:4
**wide** 38:13
**widespread** 116:10
**win** 104:1
**winds** 120:12
**wish** 6:8, 123:2
**wished** 81:1
**withdraws** 11:1
**within** 43:3, 114:3, 119:15
**without** 22:19, 75:15, 84:13
**witness** 62:25, 76:12, 77:4, 82:3, 124:14
**witnesses** 7:4
**wondering** 89:4
**word** 106:24
**words** 9:3
**work** 27:14, 102:15, 107:24, 111:7, 118:15, 121:16
**worked** 85:3
**working** 10:5, 26:13, 34:4, 34:16, 39:19, 61:1, 86:19
**works** 30:3, 34:3, 45:13, 53:2, 84:1
**world** 49:1, 50:19
**worries** 110:23
**worst** 52:2
**worth** 87:25, 94:20
**wouldn't** 74:21, 76:13
**wow** 48:25
**wrap** 102:22
**written** 6:9, 123:2
**wyman** 15:2, 17:13, 34:5, 121:14

**X**

**xu** 2:9, 89:21, 89:23, 90:1, 90:2, 93:11, 93:15, 93:22, 94:16, 94:19, 97:16, 97:17

**Y**

**yeah** 26:19, 43:15, 48:8, 49:7, 63:22, 64:15, 64:19, 64:20, 65:11, 77:4, 77:15, 78:25, 85:21, 93:22, 106:17, 106:25, 110:5, 110:9
**year** 4:4, 8:3, 8:4, 8:10, 11:3, 11:4, 13:12, 15:10, 15:20, 15:23, 15:24, 16:1, 16:8, 16:19, 17:7, 17:14, 18:12, 20:7, 22:20, 24:25, 25:4, 30:3, 30:15, 30:17, 31:2, 31:23, 33:13, 34:19, 35:25, 37:11, 37:12, 37:13, 37:17, 38:6, 40:20, 41:15, 42:8, 42:12, 42:19, 43:21, 44:24, 50:1, 50:24, 51:4, 52:14, 53:14, 54:4, 54:14, 55:9, 55:23, 56:11, 63:14, 71:8, 75:2, 75:10, 75:23, 80:19, 80:23, 88:2, 89:4, 90:9, 91:25, 92:4, 95:17, 98:24, 99:3, 105:15, 106:3, 122:13
**year's** 38:4, 80:11
**year-old** 30:10
**years** 8:24, 9:12, 9:22, 16:9, 16:15, 18:23, 22:24, 30:7,

30:8, 41:22, 42:5, 46:18, 50:20, 51:8, 51:9, 51:15, 52:10, 53:13, 55:16, 56:25, 57:9, 71:6, 73:2, 78:4, 84:23, 87:17, 94:23, 98:9, 98:10, 102:12, 103:3, 103:7, 107:21, 112:12, 112:22, 117:5, 119:25
**yesterday**
73:7
**younger**
76:9, 76:10, 76:14

Z

**zero**
28:25, 69:4, 91:24

$

**$10**
24:6, 24:10
**$3,000**
72:16
**$400**
18:18
**$50**
25:23, 26:1
**$50,000**
77:9
**$52,000**
30:3, 30:15
**$55**
90:18
**$939**
31:3, 31:8

.

**.2**
91:9
**.4**
92:14
**.7**
91:8

0

**0.5**
88:6
**0.9**
69:3
**00**
1:16
**06156**
111:8

1

**1.3**
73:9, 73:10
**1.4**
91:4, 91:17
**1.7**
38:18
**1.8**
88:7
**10**
1:16, 54:5, 54:7
**10,000**
104:4, 114:24
**10.8**
93:2
**100**
28:25, 29:18, 105:6
**11**
1:14, 124:15
**12**
60:9, 60:12, 100:11, 123:9
**12.8**
91:1
**124**
1:28
**13**
90:10
**133**
23:12
**1332**
33:12, 107:16
**134,000**
16:23, 18:21
**15**
17:7, 24:23, 31:23, 36:12, 65:2
**150**
29:1, 32:22
**151**
111:7
**16**
21:6, 21:7, 67:20
**16,662**
25:4
**16.8**
92:8
**18**
3:23, 4:4, 16:25
**19**
4:19, 37:11, 37:17, 38:2, 38:5, 38:8, 38:10, 38:11, 38:19, 38:20, 39:23, 42:9, 44:11, 48:16, 53:23, 57:7, 57:15, 66:6, 66:9, 69:14, 81:24, 95:18
**1st**
22:19, 36:9, 57:23

2

**2,000**
69:1
**2,500**
92:19
**2.1**
91:6
**2.6**
71:1
**2.8**
71:1
**20**
25:10
**2012**
51:5
**2013**
51:3, 51:4
**2014**
8:2, 50:23, 51:2
**2015**
70:11
**2016**
8:22, 8:23, 51:14
**2017**
16:21, 16:22, 16:24, 18:18, 18:21, 51:12, 51:14, 51:20
**2018**
16:11, 16:17, 16:20, 21:23, 54:13, 54:24
**2019**
16:12, 16:13, 16:18, 19:1, 52:21
**2020**
18:23, 19:4, 19:11, 23:23, 42:12, 52:21, 55:11, 66:8, 69:15, 73:18, 80:14, 80:17, 80:20, 80:23, 94:12, 94:13, 99:24, 119:1
**2021**
1:5, 1:14, 3:3, 3:23, 4:4, 8:3, 15:23, 17:1, 17:4, 19:2, 19:8, 19:10, 22:24, 23:11, 23:15, 23:21, 52:12, 52:14, 55:11, 66:1, 73:23, 81:6, 81:11, 90:16, 90:22, 91:24, 92:2, 92:23, 99:4, 124:15

**2022**
3:7, 4:8, 7:17, 8:15, 8:18, 8:25, 11:14, 12:5, 17:15, 17:17, 19:22, 21:20, 22:20, 22:24, 31:17, 38:10, 43:1, 52:12, 55:11, 75:13, 90:9, 91:17, 93:24
**2023**
15:4, 33:14, 34:9, 84:25
**20852**
90:5
**21**
30:8, 36:1, 57:24, 99:25
**2101**
90:4
**22**
38:13, 100:1
**23230**
70:13
**2332**
34:15
**23462**
60:1
**24**
30:4, 30:10, 30:17
**25**
24:13
**250**
92:6
**2535**
92:18
**27**
90:24
**28**
10:16
**29**
29:7, 29:8, 29:14

**3**

**3,000**
65:18
**3.3**
91:13, 93:6
**3/1/2021**
92:24
**3/1/21**
92:5
**30,000**
17:19
**33**
24:8
**34**
24:4
**35**
71:18, 90:14, 90:19, 92:19, 92:21
**350**
92:24
**371**
6:24
**384216**
1:27
**390,000**
18:21

**4**

**4,233**
30:10
**4,420**
30:12
**40**
11:4, 13:11, 24:15
**40,000**
24:21
**400**
29:3, 30:2, 30:16
**44**
123:9
**4417**
59:25
**47**
13:7

**5**

**5.4**
65:16
**5.9**
65:18
**50**
55:1, 72:12
**56.2**
54:15
**570**
31:7

**6**

**6,000**
25:12, 90:13
**6,250**
71:17, 72:4
**6,600**
65:14
**6.7**
66:5
**6.8**
66:2
**6005**
90:23
**6055**
90:12
**64**
30:4, 30:7, 30:16, 31:2

**7**

**7.3**
69:7
**7.4**
69:10
**75**
4:1

**8**

**8,000**
90:23
**8,250**
92:20
**8,550**
90:15, 91:23, 92:2
**8,700**
72:14, 90:15, 91:22, 92:1
**8.6**
91:4
**8.9**
65:25
**804**
6:24

**9**

**9.7**
69:5
**90**
24:19, 72:5, 116:18
**900**
98:4
**9337**
6:24
**94**
23:16, 51:21