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Transcript of Hearing

Date: August 10, 2022

Case: INS-2022-00040

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<p>1 STATE CORPORATION COMMISSION 2 BUREAU OF INSURANCE 3 2023 ACA Rate Presentations 4 CASE NO.: INS-2022-00040 5 6 Ex Parte: In the matter of 7 presentations of premium rates 8 in connection with individual and 9 small group health insurance 10 coverage 11 12 13 14 15 Conducted Virtually 16 Wednesday, August 10, 2022 17 9:30 a.m. ET 18 19 20 21 22 23 Job No.: 451329 24 Pages: 1 - 93 25 Reported By: Victoria Lynn Wilson, RMR, CRR</p>	<p>1 A P P E A R A N C E S 2 ALEXANDER SKIRPAN, 3 CHIEF HEARING EXAMINER 4 STATE CORPORATION COMMISSION 5 6 JULIE BLAUVELT 7 Life & Health Division Deputy 8 Commissioner 9 SCC Bureau of Insurance 10 11 DAVID SHEA 12 Health Actuary 13 SCC Bureau of Insurance 14 15 P R E S E N T E R S 16 TIM CONNELL 17 ANTHEM HEALTH PLANS OF VIRGINIA, INC. 18 HEALTHKEEPERS, INC. 19 20 JAMES CHU 21 KAISER FOUNDATION HEALTH PLAN OF THE 22 MID-ATLANTIC STATES, INC. 23 24 25</p>
<p>1 STATE CORPORATION COMMISSION, BUREAU OF 2 INSURANCE, 2023 ACA Rate Presentations, conducted 3 virtually. 4 5 6 7 8 9 10 Pursuant to scheduling, before Victoria Lynn 11 Wilson, Registered Merit Reporter, Certified 12 Realtime Reporter, E-Notary Public in and for the 13 State of Maryland. 14 15 16 17 18 19 20 21 22 23 24 25</p>	<p>1 P R E S E N T E R S C O N T I N U E D 2 LYDIA TOLMAN, WAKELY CONSULTING 3 JACQUELYN YOUNG, WAKELY CONSULTING 4 RYAN ZIEMANN 5 PIEDMONT COMMUNITY HEALTHCARE HMO, INC. 6 PIEDMONT COMMUNITY HEALTHCARE, INC. 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25</p>

<p>1 C O N T E N T S</p> <p>2 WELCOME AND INTRODUCTION PAGE</p> <p>3 BROAD OVERVIEW OF VIRGINIA'S 6</p> <p>4 INDIVIDUAL AND SMALL GROUP</p> <p>5 HEALTH INSURANCE MARKETS</p> <p>6 AND KEY ISSUES 10</p> <p>7 DISCUSSION OF KEY OBSERVATIONS -</p> <p>8 VIRGINIA'S INDIVIDUAL AND SMALL</p> <p>9 GROUP HEALTH INSURANCE RATES 32</p> <p>10 PRESENTATION OF CARRIERS' RATES</p> <p>11 Anthem Health Plans of Virginia, Inc.</p> <p>12 and HealthKeepers, Inc. 46</p> <p>13 Kaiser Foundation Health Plan of the</p> <p>14 Mid-Atlantic States, Inc. 66</p> <p>15 Piedmont Community Healthcare</p> <p>16 HMO, Inc. and Piedmont Community</p> <p>17 Healthcare, Inc. 75</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22 P R O C E E D I N G S</p> <p>23 CHIEF HEARING EXAMINER SKIRPAN: Good</p> <p>24 morning. I'm Alexander Skirpan, the Chief Hearing</p> <p>25 Examiner for the Commission, and I'm here with</p>	5	<p>1 before the proposed renewal of their individual</p> <p>2 health insurance coverage. That deadline for</p> <p>3 notifying customers this year is October 18, 2022.</p> <p>4 To meet these deadlines, insurance</p> <p>5 companies recently filed their rates and forms for</p> <p>6 health insurance plans proposed to be offered for</p> <p>7 use in Virginia as of January 1, 2023.</p> <p>8 Given the importance of the cost of health</p> <p>9 insurance to Virginians and small enterprises</p> <p>10 conducting business in the Commonwealth, this</p> <p>11 Commission has for at least the last decade</p> <p>12 reviewed the health insurance premium rates and</p> <p>13 associated deductibles before approving them for</p> <p>14 use in the Commonwealth.</p> <p>15 The Commission is sensitive to the effects</p> <p>16 of health insurance premiums and deductibles on</p> <p>17 our residents and small businesses in normal</p> <p>18 times, and the impact of factors surrounding</p> <p>19 COVID-19 could intensify the effect.</p> <p>20 Today's presentations are part of the</p> <p>21 Commission's review of the health plans offered</p> <p>22 for purchase in Virginia in the individual and</p> <p>23 small group markets.</p> <p>24 The Commission issued an order directing</p> <p>25 presentations and instructed the Bureau of</p>	7
<p>1 members of the Bureau of Insurance to convene the</p> <p>2 2022 Presentation of Premium Rates in connection</p> <p>3 with the health insurance coverage issued in the</p> <p>4 individual and small group markets in the</p> <p>5 Commonwealth effective January 1, 2023.</p> <p>6 Under Virginia law, the Commission must</p> <p>7 review and approve premium rates and forms for a</p> <p>8 health benefit plan, whether it's offered on the</p> <p>9 Virginia Health Benefit Exchange, on the Federal</p> <p>10 Platform, or whether they are sold off the</p> <p>11 exchange.</p> <p>12 The Commission must also perform plan</p> <p>13 management functions required to certify health</p> <p>14 plans for participation in the exchange, and</p> <p>15 because Virginia still uses the Federal Exchange</p> <p>16 platform, there are federal deadlines that govern</p> <p>17 our process.</p> <p>18 First, the U.S. Department of Health and</p> <p>19 Human Services requires that the Bureau of</p> <p>20 Insurance complete its review and recommendations</p> <p>21 of health plans for certification on the Federal</p> <p>22 Platform no later than August 17, 2022.</p> <p>23 Second, Virginia law requires insurance</p> <p>24 carriers to notify their customers of increases in</p> <p>25 annual premiums or deductibles at least 75 days</p>	6	<p>1 Insurance to coordinate presentations by insurance</p> <p>2 companies for the Commission, and the Bureau has</p> <p>3 done this.</p> <p>4 We are going to hear from insurance</p> <p>5 carriers in the individual and small group markets</p> <p>6 in Virginia who represent a significant percentage</p> <p>7 of the projected insured in each market.</p> <p>8 The Bureau will also participate today by</p> <p>9 providing background and presenting a summary of</p> <p>10 the recent Bureau activities in its review of the</p> <p>11 latest rate and form filings for health insurance</p> <p>12 plans.</p> <p>13 We will hear first from Julie Blauvelt,</p> <p>14 the deputy commissioner of insurance for life and</p> <p>15 health. Then we'll hear from David Shea, the</p> <p>16 Bureau's health actuary, who will discuss the</p> <p>17 Bureau's review of recent carriers' plans for</p> <p>18 participation in Virginia's ACA marketplace.</p> <p>19 Afterwards, the designated insurance</p> <p>20 companies will provide presentations about their</p> <p>21 rate plans and their plans and rate charges.</p> <p>22 The insurance carriers submitted</p> <p>23 presentations and exhibits as a part of their rate</p> <p>24 filings with the Commission. Copies of those</p> <p>25 filings will become part of the record.</p>	8

<p style="text-align: right;">9</p> <p>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 Virginia Exchange and for 4 plans in the individual and small group markets, 5 as instructed by the 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 today may do so by 11 visiting the Commission's website and following 12 the instructions on how to submit your comments. 13 To today's presenters, I ask that you 14 speak clearly into your microphone and provide 15 your name and address, as well as who you 16 represent, so that the court reporter can 17 transcribe accurately all that is said during this 18 proceeding. 19 When not speaking, I also ask that you 20 mute your microphone to lessen the occurrence of 21 interference in the presentations. 22 Finally, should any presenter experience 23 technical difficulties during their presentations, 24 I ask that you contact the ITD coordinator, Bruce 25 Nichols at (804) 371-9337 or Bruce.Nichols@SCC.</p>	<p style="text-align: right;">11</p> <p>1 health plan applications for carriers' 2 participation on the Virginia Health Benefits 3 Exchange and trying to meet the time frames that 4 the federal agencies require. 5 So, I want to thank all of them for their 6 hard work on this presentation and to get us to 7 this point in our reviews. 8 Today we're going to be discussing 9 proposed ACA rates for 2023 submitted by health 10 insurance carriers in the Virginia individual and 11 small group health insurance markets. 12 Next slide, please. 13 Okay. You've just heard from Alexander 14 Skirpan, the chief hearing examiner, and then I'm 15 going to walk us through an overview of the 16 individual and small group ACA markets through the 17 years and what we expect for 2023 and talk a 18 little bit about the issues most affecting the 19 markets. 20 Then David Shea is going to help us look a 21 little bit more in depth into what's driving the 22 rates that we're seeing for 2023. He's the 23 Bureau's health actuary. 24 And then, finally, we've invited a 25 sampling of carriers who plan to participate in</p>
<p style="text-align: right;">10</p> <p>1 Virginia, spelled out, dot gov. 2 While I may have questions for speakers, 3 this is neither an adversarial nor evidentiary 4 proceeding, and there's no swearing in of 5 witnesses or cross-examinations. 6 Now, are there any preliminary matters 7 that anyone wants to bring before the Commission 8 at this time? 9 Hearing none, I will follow the order of 10 presentation provided to me and call on Julie 11 Blauvelt, Deputy Commissioner of Insurance for 12 Life and Health, to begin presentations. 13 Julie, you may begin. 14 MS. BLAUVELT: Thank you. 15 Can everyone hear me? 16 CHIEF HEARING EXAMINER SKIRPAN: Yes. 17 MS. BLAUVELT: Okay. We're going to show 18 slides. So, good morning and welcome, everyone, 19 to the Annual Virginia ACA Rate Presentation. 20 As Alexander said, I'm Julie Blauvelt, 21 Deputy Commissioner of the Life and Health 22 Division within the Bureau of Insurance, where we 23 have a really wonderful, dedicated, tireless staff 24 of individuals who work really hard to review and 25 approve ACA final forms, rates, and qualified</p>	<p style="text-align: right;">12</p> <p>1 Virginia's individual and small group markets in 2 2023 so that we can hear from them about their 3 rate development and issues surrounding that. 4 And then we'll go back to Alexander 5 Skirpan who will close us out -- close out the 6 presentations. 7 Next slide, please. 8 So, most individuals who buy comprehensive 9 health insurance coverage buy it through the 10 Health Insurance Marketplace, which, in Virginia, 11 is also known as the Health Benefit Exchange, the 12 Virginia Health Benefit Exchange. 13 Virginia, we started preparing in 2020 to 14 operate a state-based exchange for 2021. The 15 Virginia Health Benefit Exchange is a division of 16 the State Corporation Commission, just like the 17 Bureau of Insurance is a separate division of the 18 SCC. 19 The Bureau of Insurance has been 20 performing plan management for the Federal 21 Exchange in Virginia since it began in 2014, and 22 we continue to perform plan management for the 23 Virginia Exchange. 24 Now, as part of the Bureau of Insurance's 25 plan management duties each year, we review</p>

<p>13</p> <p>1 proposed rates submitted by carriers and their 2 policy forms and marketplace information to make 3 sure that it complies with state requirements. 4 And since Virginia, as a state-based exchange, 5 still uses the FederalHealthcare.gov platform, we 6 have to make sure that the plans meet all Federal 7 Platform requirements, as well, in our reviews. 8 Right now, the Virginia Exchange, as I 9 said, still uses the Federal Platform, which is 10 Healthcare.gov and because of this, there's been 11 no change to how consumers buy their coverage in 12 Virginia. The Virginia Exchange, though, does 13 plan to move to its own platform for plan year 14 2024, but until then, consumers will not notice a 15 change with purchasing coverage or in consumer 16 assistance. 17 Next slide, please. 18 I want to spend a little bit of time this 19 year talking about two important initiatives. One 20 is a state initiative and one is a federal 21 initiative that help curb the cost of health 22 insurance coverage for consumers. Both of these 23 initiatives only impact those with individual 24 health insurance coverage. 25 So, the state initiative impact -- or</p>	<p>15</p> <p>1 available from the state. 2 So, with the payment parameters we 3 establish for 2023, it was projected that carriers 4 would be able to lower their premium by 5 15.6 percent versus what the premium would have 6 been without reinsurance. 7 It's important to know that this is not a 8 guarantee that everyone's premium rate will 9 decrease by 15.6 percent. This is an average 10 decrease from what the rate would have been 11 without reinsurance. 12 And David Shea is going to explain a 13 little more about the effect of this program on 14 premiums later in his presentation, but it appears 15 from the rate filings that the program actually 16 acted to reduce rates from what they would have 17 been by 19.2 percent, on average. 18 Again, that doesn't mean that everyone in 19 the individual market will see a premium decrease 20 of 19.2 percent. Subsidized individuals, those 21 who receive federal tax credits to help with their 22 premium payments, won't see much change in premium 23 because, as premiums go down, so does the premium 24 of the second lowest cost silver plan, which is 25 what the benchmark is for the subsidies.</p>
<p>14</p> <p>1 initiative impacting individual health insurance 2 coverage is the Commonwealth Health Reinsurance 3 Program. 4 In 2021, the General Assembly directed the 5 SCC to apply to operate a reinsurance program 6 beginning in 2023 for up to five years, and it 7 would use a combination of state and federal 8 funding. 9 Virginia's application to establish the 10 program was approved by federal agencies on May 18 11 of this year, allowing carriers to reduce their 12 rates for 2023 in the individual market. 13 The way a reinsurance program works, it 14 reduces rates because a portion of the carrier's 15 expense of claims is paid for, in this case, by 16 federal and state funds so that insurers don't 17 have to price those costs into their standard 18 premiums. 19 For 2023, Virginia's reinsurance program 20 is going to pay a 70 percent coinsurance for 21 covered individuals' annual claims that fall 22 between 40,000 and 155,000. These are called the 23 "payment parameters" of the program, and the SCC 24 will establish the payment parameters for the 25 program each year based on the expected funds</p>	<p>16</p> <p>1 And, in fact, that's how we're able to get 2 federal funding for the program, because the 3 federal government is paying less per individual 4 in tax credits or APTC. 5 Unsubsidized individuals are the ones who 6 benefit from the reinsurance program, and we are 7 expecting more unsubsidized individuals to come 8 into the individual market because of the reduced 9 premiums. 10 If you want to read more about the 11 program, you can go to our website shown here on 12 the slide. 13 Next slide, please. 14 So, one of the federal initiatives most 15 helping to curb the cost of individual health 16 insurance is the American Rescue Plan or ARPA. 17 Increased subsidies under ARPA became 18 fully available in 2021 and they remained in 2022. 19 Subsidies are set to expire at the end of 2022, 20 but federal legislation is being seriously 21 considered to continue subsidies through 2025 at 22 this time. 23 ARPA limits the portion of household 24 income that a consumer has to pay for their health 25 insurance premiums in the individual market. So,</p>

<p>17</p> <p>1 with ARPA, subsidies don't stop at the 400 percent 2 federal poverty level that they used to. A 3 consumer doesn't need to spend any more than 8-1/2 4 percent of household income on health insurance 5 premium, and the rest can be subsidized. 6 Also, consumers who are at 150 percent or 7 less of the federal poverty level can get plans 8 for zero-dollar premium. And this is different 9 from how it used to be, when everyone used to need 10 to pay a portion no matter their federal poverty 11 level. 12 So, we know that a concern for consumers 13 of other than the high premium cost is high plan 14 cost share, such as deductibles and coinsurance 15 and co-pays. And for 2023, the maximum 16 out-of-pocket limit is \$9,100 for an individual 17 and 18,200 for a family. 18 You can see that these would be very 19 difficult for a consumer to meet year over year, 20 and the ACA created cost share reduction plans 21 that further limit cost shares for people in the 22 individual market who are between 100 and 23 250 percent of the federal poverty level. 24 And ARPA increases the amount of financial 25 assistance for people at lower income levels, as</p>	<p>19</p> <p>1 participates on the Virginia Exchange, submitted 2 their intentions to exit the individual market in 3 Virginia after this year, 2022. Their service 4 area is mainly in the Richmond and Northern 5 Virginia Areas, and Bright Health enrollees will 6 be notified that they'll be automatically enrolled 7 into the most popular similar plan of another 8 exchange carrier for 2023. 9 Coming into the market is an Aetna 10 affiliated carrier, Aetna Health, Inc., an HMO. 11 They're re-entering the exchange for 2023 12 following their exit in 2017. 13 Under Virginia law, a carrier that exits a 14 market completely has to stay out of that market 15 for at least five years. Aetna Health service 16 area is going to mirror the service area of Aetna 17 Life Insurance Company which currently provides 18 coverage on the exchange. 19 Also, over the years, you'll see that 20 we've only ever had one off-exchange carrier in 21 the individual market, and you may notice we have 22 an additional off-exchange carrier for 2023. 23 Anthem Health Plans, Anthem's PPO, filed 24 to provide coverage solely off the exchange for 25 2023, and we're going to hear from Anthem later in</p>
<p>18</p> <p>1 we talked about, who are already eligible for 2 these reduced cost share plans under the ACA. 3 Under ARPA, the second lowest cost silver 4 plan will be fully subsidized for people earning 5 up to 150 percent of federal poverty level. As a 6 result, low income people can now qualify for 7 premium for these silver plans with smaller 8 deductibles for covered health benefits. 9 Next slide, please. 10 So, at this time, our reviews of these 11 filings are essentially complete but not yet 12 finalized. So, the information in these slides 13 could change but, based on the applications we 14 received, looks like we'll continue to have 12 15 carriers participating in Virginia Exchange in 16 2023. 17 This number remains for a second year at 18 the highest number of carriers that we've had on 19 the exchange in Virginia since the exchange began 20 in 2014. 21 Even though the total number of carriers 22 participating on the exchange is the same, there 23 are a couple changes in the carriers that plan to 24 participate for 2023. 25 Bright Health, which currently</p>	<p>20</p> <p>1 the presentation, and we'll talk to them about 2 their reasoning for entering the off-exchange 3 individual market during their presentation. 4 Next slide, please. 5 These enrollment projections are from the 6 individual carriers for 2023 without them having 7 the benefit of knowing what new carriers are 8 entering the market or who will be increasing 9 their service area because, in Virginia, we don't 10 make our ACA form and rate filings public until 11 today, the day of the rate presentations. 12 We instituted a process a few years back 13 for ACA form and rate submissions where those 14 submissions are not publicly available until 15 today. It's mostly so that when a carrier submits 16 their rates, they're submitting their best and 17 final offer without the knowledge of who may or 18 may not be their competition and what the 19 competitors' rates are in that region. And, so, 20 we think the prospect of competition should keep 21 the rates true. 22 Carriers, as well as the public, haven't 23 been able to see any competitors' rates until 24 today or know who's participating alongside of 25 them in the market.</p>

<p style="text-align: right;">21</p> <p>1 So, these presentations also -- I'm sorry. 2 Those projections also assume that ARPA subsidies 3 will terminate at the end of 2022, and we asked 4 carriers to file with that assumption back in May. 5 So, with the ARPA subsidies are extended, we 6 probably will see increased enrollment. 7 HealthKeepers is showing the highest 8 market share. And behind them, the next four 9 carriers project themselves to be a lot closer to 10 each other in 2023 as far as their projected 11 enrollment than they are now in 2022. 12 I think the largest changes in this slide 13 from those 2022 projections are that Optimum 14 Choice, which is a United HealthCare company that 15 serves the Northern Virginia and Richmond Areas, 16 projects to be one of the top five largest in the 17 individual market by enrollment for 2023. 18 The other change I notice is that 19 Innovation Health Plan, which is an Aetna company 20 serving the Northern Virginia Area, was one of the 21 top five, and by their 2022 projections, and they 22 now expect their membership to increase from what 23 it is currently, but the projections are 24 significantly scaled back from what they projected 25 in 2022.</p>	<p style="text-align: right;">23</p> <p>1 The Northern Virginia and Richmond Areas, 2 as you can see, are especially well-represented 3 and we show five-plus carriers there but, 4 actually, it's in the neighborhood of about eight 5 to nine carriers serving those areas. 6 Carriers right now can't voluntarily 7 change their service area at this point, so the 8 projection of service area to be covered would 9 only change if a carrier exits the exchange fully 10 or if they're not approved to participate on the 11 exchange or in a particular area. 12 Next slide, please. 13 Another success story is the premium 14 amounts on this slide, and these amounts represent 15 the average total premium for the plans that 16 enrollees actually selected or are projected to 17 select. 18 As we'll see in a later slide, in most 19 cases, the premium amounts shown here are not the 20 actual cost to the enrollee in the individual 21 market because of the federal subsidies that are 22 available. 23 We'll look at some information about the 24 premium that most individuals actually pay in a 25 later slide.</p>
<p style="text-align: right;">22</p> <p>1 Again, though, this is without knowing 2 what other carriers are participating and where, 3 but it does somewhat match the actual market share 4 for 2022 that we're seeing. 5 Next slide, please. 6 We're very happy about this slide. This 7 slide is a great demonstration of the proposed 8 increased participation by carriers on the 9 Virginia Exchange and in the individual market. 10 2023 is going to be the first year since 11 the marketplace began in Virginia that at least 12 two carriers plan to provide exchange coverage in 13 every city and every county of Virginia. 14 And these will be two unaffiliated carriers in 15 every city and every county. 16 Currently, in this year, 2022, there is 17 about 20 percent of the state that still only has 18 one choice of carrier on the exchange. 19 I think as -- I think something behind 20 this is that both Optima Health Plan and Piedmont 21 Community Healthcare HMO submitted significant 22 expansions for their service area for 2023, and 23 Optima Health Plan actually plans to cover almost 24 the entire state except for a handful of counties 25 and cities.</p>	<p style="text-align: right;">24</p> <p>1 So, the projected 2023 premium number is, 2 thanks to the Virginia's reinsurance program that 3 takes effect in 2023, the average rate per member 4 per month is projected to be at its lowest since 5 2017. 6 Carriers are also estimating the highest 7 enrollment in the last five years for 2023, and 8 these estimated enrollment numbers were assuming 9 lower premiums for the reinsurance program, of 10 course, but the projected enrollment also assumed 11 that ARPA subsidies would end for 2023, which now 12 it appears probably will be unlikely. 13 As we look on the dip in enrollment in 14 2019, we are reminded that effective January 1 of 15 2019, Virginia did expand Medicaid to adults up to 16 138 percent federal poverty level. So, over 2019 17 and 2020, we think about 70,000 individuals newly 18 eligible for Medicaid left the commercial 19 individual market. 20 You'll also note, of course, that premiums 21 were at their highest in 2019. And enrollment hit 22 a low point in 2020, but in 2021 and '22, ARPA 23 subsidies took effect and enrollment, you can see, 24 starts to increase. 25 At some point, this market will see a</p>

<p style="text-align: right;">25</p> <p>1 large influx of people coming from Medicaid back 2 to the commercial market. This is because during 3 the COVID-19 public health emergency, states were 4 required to maintain enrollment of almost all 5 Medicaid enrollees and not terminate their 6 enrollment. 7 So, when this public health emergency 8 expires, state Medicaid offices will have to have 9 about a year to return to normal operations. 10 Given that states will have about a year 11 to unwind those no longer eligible for Medicaid 12 and because the public health emergency continues 13 to be extended, we really didn't see carriers 14 making any adjustments to rates as a result of the 15 expected change. 16 And the current public health emergency is 17 set to end October 13 of this year, but HHS has 18 said it will provide 60 days' notice if it doesn't 19 intend to extend the public health emergency. So, 20 that means that if we don't hear anything pretty 21 much by the end of this week, that should signal 22 that the public health emergency will again be 23 extended. 24 And we would definitely be remiss to talk 25 about enrollment growth and not acknowledge the</p>	<p style="text-align: right;">27</p> <p>1 we'll take a look at what might be behind the 2 larger increase during the carrier presentations 3 portion. We've asked a couple carriers in the 4 small group market to try to address these trends. 5 Also, the Bureau of Insurance plans to use 6 actuarial consultants for a couple of projects, 7 using funds through a federal grant to increase 8 market stabilization and flexibility in the small 9 group market. 10 The Bureau plans to do a scan of the small 11 group market to get a better picture of the makeup 12 of who's in the market to be able to assess any 13 potential initiatives that the General Assembly 14 may want to consider. 15 Also, we plan to create some educational 16 materials that highlight the existence of some 17 recent federal tax advantage tools to help small 18 businesses afford to provide health benefits. 19 Next slide, please. 20 All right. So, switching back to the 21 individual market, I wanted to spend some time 22 looking at what the cost of insurance is for most 23 individuals on the Exchange in Virginia. 24 On an earlier slide, we saw that the 25 average premium as of March 1st of this year was</p>
<p style="text-align: right;">26</p> <p>1 great work of Virginia's navigators, who are 2 Enroll Virginia and Boat People SOS, and they work 3 very hard to inform consumers of the existence of 4 subsidies for health insurance and to help enroll 5 individuals on the exchange. 6 Their work and their increased presence in 7 Virginia has been made possible through increased 8 grants that the Virginia, as a state-based 9 exchange, has been able to offer since 2020. 10 Next slide, please. 11 So, enrollment in the small group market 12 is projected by carriers to almost exactly match 13 the size of the individual market. The premium 14 rate in this market, however, tells a very 15 different story. 16 The average premium for the plan selected 17 is higher this year and as projected for 2023. 18 Even though the percentage change in premium from 19 2022 to projected '23 is along the same lines as 20 it's been trending for the last few years, it will 21 be the largest percentage increase in average 22 premium per member per month in at least the last 23 five years in the small group market. 24 Even so, enrollment is expected to remain 25 steady at what it's been the past few years, and</p>	<p style="text-align: right;">28</p> <p>1 \$566. And that's in the ballpark of the average 2 premium shown on this slide, using data from the 3 open enrollment period for 2022, but as you can 4 see by this chart, most people don't pay that full 5 premium. 6 In fact, about a third of individuals on 7 the Exchange pay a monthly premium that is \$10 or 8 less. And around 82 to 92 percent of individuals 9 receive subsidies in the form of advanced premium 10 tax credits or APTC. That reduces their monthly 11 premium, on average, by 453 to \$521, so that the 12 actual average premium paid by people who receive 13 tax credits was 67 to \$91 per month. 14 Next slide, please. 15 In this slide, we're taking a look at the 16 types of enrollment that make up the individual 17 market for those who hold comprehensive health 18 insurance coverage and how the two initiatives 19 that we discussed before, the state reinsurance 20 program and federal ARPA, are expected to change 21 the makeup of the individual market. 22 You might notice that the presence or 23 absence of the initiatives creates big changes in 24 the subsidized versus unsubsidized portions of 25 these bars.</p>

<p style="text-align: right;">29</p> <p>1 These numbers are based on modeling that 2 Oliver Wyman did for the Bureau in the fall of 3 2021. And in the bar on the left, they estimated 4 that during 2022, total enrollment in the 5 individual market will be right at 300,000, which 6 seems right on point based on enrollment figures 7 carriers filed with us. 8 You'll see that the majority of the 9 enrollment is orange, representing subsidized 10 enrollment through the Exchange. 11 The next three bars all model how 12 enrollment in the individual market could be 13 expected to change in 2023 depending on what 14 occurs with ARPA and state reinsurance. 15 So, as we know, we will have a state 16 reinsurance program that did reduce premiums for 17 2023 by almost 20 percent from what they would 18 have been without reinsurance for the unsubsidized 19 individuals. 20 So, you can see the dramatic growth in the 21 blue unsubsidized portion of the bar in the second 22 and third bars, and these estimates represent how 23 the subsidized orange portion shrinks without ARPA 24 and the unsubsidized blue portion will grow 25 without ARPA, but the subsidized portion moving to</p>	<p style="text-align: right;">31</p> <p>1 story of all areas of Virginia having a choice in 2 carriers on the exchange. We see decreasing 3 premium rates for the unsubsidized population 4 through the reinsurance program and ARPA subsidies 5 increasing subsidized enrollment. 6 With the continued extension of the public 7 health emergency, we didn't see carriers adjusting 8 their rates for an expected Medicaid unwinding for 9 2023. 10 In the carrier presentation, we hope to 11 hear from some small group carriers who might be 12 able to discuss what changes they're seeing in the 13 small group market. Also, the Bureau of Insurance 14 plans to use actuarial consultants to do a couple 15 of projects using funds through a federal grant to 16 increase market stabilization and flexibility in 17 the small group market. 18 So, are there any questions on this 19 portion of the presentation from Alexander before 20 I turn it over to David Shea, the Bureau's health 21 actuary, to look at a deeper dive of the ACA 22 rates? 23 CHIEF HEARING EXAMINER SKIRPAN: I did 24 have a question. You talked a few times about the 25 legislation extending things. Can you go through</p>
<p style="text-align: right;">30</p> <p>1 the unsubsidized if ARPA is not extended. 2 We expect that most individuals who have 3 subsidized insurance in 2022 would have remained 4 in the market for at least another year even 5 without reinsurance. However, with reinsurance, 6 the total number of insureds will grow to even 7 more in 2023 than in 2022 with about 16,000 8 unsubsidized individuals expected to come into the 9 market as the price point that resulted from our 10 reinsurance program that the payment parameters 11 that were set. 12 Also, you can see how the orange 13 subsidized market is unaffected by our reinsurance 14 program in the middle two bars but drastically 15 affected when ARPA subsidies are available, which 16 are the outside two bars. 17 And the last bar, the bar on the all the 18 way right, is a scenario where we have both ARPA 19 and reinsurance, and that brings up the most total 20 enrollment in the individual market and is also 21 the most likely scenario for 2023. 22 Next slide, please. 23 We spent a lot of time discussing the 24 individual market and how it seems to be on a good 25 track with increasing competition, the success</p>	<p style="text-align: right;">32</p> <p>1 just how that's worked into the planning or into 2 how you're dealing with that, if that's 3 appropriate? 4 MS. BLAUVELT: David is going to get into 5 that in his slides. 6 CHIEF HEARING EXAMINER SKIRPAN: Okay. 7 Well, then I'll just wait for him. 8 MS. BLAUVELT: Okay. 9 CHIEF HEARING EXAMINER SKIRPAN: Okay. 10 Thank you. 11 MS. BLAUVELT: Sure. Anything else? 12 CHIEF HEARING EXAMINER SKIRPAN: That's 13 it. 14 MS. BLAUVELT: Okay. Come back to me if 15 David doesn't answer your question. 16 CHIEF HEARING EXAMINER SKIRPAN: Okay. 17 MS. BLAUVELT: All right. Thank you. I'm 18 going to turn it over to David Shea now. 19 CHIEF HEARING EXAMINER SKIRPAN: Thank 20 you. 21 MR. SHEA: All right. Thank you, Julie. 22 And good morning, everybody. 23 We can go onto the next slide, please. 24 Every year the federal government releases 25 what's called the "Notice of Benefit and Payment</p>

<p style="text-align: right;">33</p> <p>1 Parameters," and these usually include quite a few 2 changes, not necessarily directly affecting rate 3 filings. 4 This year, in particular, there were a 5 couple. They -- all carriers are now required to 6 have standardized plan offerings. For every 7 network type, metal level, and service area where 8 they offer nonstandardized plans, they've got to 9 come up with two sets of standardized plans for 10 every metal level, bronze equivalent, and silver 11 CSR variation. 12 So, what this means is a local HMO that's 13 in one service area offering a silver and a bronze 14 plan has to offer two more silver and two more 15 bronze plans and six more silver CSR variations to 16 fulfill this requirement. And, obviously, there 17 are several sets of standardized plans across the 18 country based on specific state laws with respect 19 to designs of those plans. 20 The jury is still out as to whether these 21 standardized plans will become popular enough and 22 have enough substantial enrollment, but we shall 23 see. 24 These two plans, in fact, will be 25 highlighted on Healthcare.gov, so consumers' eyes</p>	<p style="text-align: right;">35</p> <p>1 what this means is you can't have a silver plan 2 that has a 68 percent actuarial value. It has to 3 have 70 to 72. 4 This increases the generosity of silver 5 plans and, therefore, will increase the amount of 6 premium tax credits available to consumers who 7 enroll in those plans. 8 Next slide. 9 So, the headline in Virginia this year for 10 the ACA market is our successful 1332 waiver 11 application which allowed us to introduce a 12 reinsurance program. Julie mentioned quite a few 13 of those details earlier. 14 What we asked carriers to do to support 15 these adjustments is to send us what's called a 16 "claim probability distribution." What that is is 17 a listing of claims by dollar amount, so how many 18 people had claims between 0 and \$100, how many had 19 claims between 100 and 200, so forth and so on. 20 And carriers can construct these tables 21 either from their own claims data or from other 22 data from consulting firms or so forth and so on. 23 We asked them to submit the claim probability 24 distribution table that supported their 25 reinsurance adjustment.</p>
<p style="text-align: right;">34</p> <p>1 will be directed towards these in some way. 2 The other sort of behind-the-curtain 3 change is changes in the de minimis ranges of the 4 actuarial value. So, the actuarial value is the 5 platinum, gold, silver, and bronze percentages 6 that represent the generosity, the relative 7 generosity, of plans. 8 When the ACA came into existence, for 9 example, the silver plan has an actuarial value of 10 70 percent, and when the companies run these plans 11 to figure out exactly what those values are, that 12 70 percent could be 2 percent higher or 2 percent 13 lower and still be certified as a silver plan. 14 Over time, those ranges expanded for 15 several reasons, and, in fact, a silver plan could 16 go from a 70 percent plan all the way down to 66. 17 So, the ranges were not exactly symmetrical. 18 Bottom line is they, more or less, 19 returned to the plus or minus two around each one. 20 However, for silver QHPs, it's plus two and zero. 21 What this does, in effect, is the 22 actuarial value calculator where the plan values 23 are determined, this, more or less, forces silver 24 QHP plans to be a little bit richer than they 25 would otherwise. So, that plus two minus zero,</p>	<p style="text-align: right;">36</p> <p>1 And the results of this, carriers adjust 2 their rates for reinsurance anywhere from about a 3 10 percent decrease to a 33 percent decrease. 4 This was based on individual carrier experience. 5 And as Julie mentioned, the reinsurance 6 program resulted in rates that are 19 percent 7 lower than they otherwise would have been. 8 So, what they would have been in the 9 individual market in Virginia this year -- the 10 average rate increase was about 2 percent prior to 11 reinsurance. After reinsurance, it's about a 12 minus 17 percent. So, that's a 19 percent drop in 13 rates because of the existence of the reinsurance 14 program. 15 And Julie mentioned earlier what the 16 average rate in the market will be, the lowest 17 it's been in probably forever, and those are the 18 average rates that -- it would have been about 19 \$600 without the reinsurance program. It's a 20 little under \$500 with the program. 21 Next slide, please. 22 We took a look in both markets to try to 23 see what were the main premium drivers. Now, the 24 winner by far in the individual market was the 25 reinsurance program.</p>

<p>37</p> <p>1 And other than that, in the individual 2 market, carriers indicated that their worsening 3 experience, claims coming in a little bit higher 4 than they thought they would, added a bit to that 5 rate, and an average trend of about 5.6 was 6 another driver in the individual market. 7 When we get down to the small group 8 market, an average rate increase of 3.1 percent, a 9 sort of similar to historical averages, the main 10 driver there was a trend increase of about 7 11 percent. 12 The small group market also experienced 13 some morbidity changes. What that means is the 14 health status of the populations that the carriers 15 are insuring are changing and, so, that drove 16 about a 4 percent. And their experience was at 17 least a little better than the individual sign. 18 That drove about 2 percent. 19 There were lots of little -- obviously, 20 when you look at these numbers, you're, like, 21 "Well, how do you get to 3.1?" There were a lot 22 of little negatives that really would take up the 23 whole page that caused the average rate for the 24 small group to be about 3.1 percent. 25 Next slide, please.</p>	<p>39</p> <p>1 markets. And as you see over the last three 2 years, the actuals and expecteds are pretty much 3 stabilizing around in the low eighties. 4 In Virginia, the minimum loss ratio 5 requirement in the individual and small group 6 market is 75 percent. And the federal loss ratio, 7 medical loss ratio, is 80 percent. 8 The difference is, in Virginia, the loss 9 ratio minimum is for carrier's projected 10 experience. On the federal level, the loss ratio 11 applies to actual experience. So, carriers have 12 to look back and see were they above or below the 13 federal 80 percent. And if they were below the 14 80 percent, they're required to refund premiums to 15 their consumers. 16 But you can see here that it doesn't 17 appear that, at least on average, carriers aren't 18 expecting to refund premiums, at least on the 19 federal level. 20 Next slide, please. 21 This is somewhat of a success story. Even 22 without the reinsurance adjustment for 2023, the 23 rate change would have been 2 percent. So, that's 24 pretty low on a historical basis, and it's been 25 negative for the last few years. So, that is</p>
<p>38</p> <p>1 This is a slide that we have been 2 including in our presentations each year to see 3 how pricing trends for carriers compare. And we 4 take a look at a little bit more detail than just 5 an overall trend number. 6 What you see here are changes in the cost 7 of services and changes in the utilization of 8 services by inpatient, outpatient, physician, and 9 prescription drugs. These are the trends that the 10 presenting carriers today used in their pricing, 11 and they are very consistent and within a 12 historical range of trends over the last few 13 years. 14 It's been quite a while since we've seen 15 pricing trends approach double digits. 16 And, again, you see in the individual 17 market, Kaiser's trends are lower. They've got a 18 different business model, but that's consistent 19 with their historical trends. And in 20 HealthKeepers and Piedmont, those are certainly 21 within the range of historical trends. 22 Next slide, please. 23 Julie had mentioned how the experience has 24 changed over time. This shows the loss ratio 25 experience of the individual and small group</p>	<p>40</p> <p>1 certainly beneficial to consumers and is 2 indicative of the increased competition in the 3 Virginia individual market. 4 Next slide, please. 5 So, some key takeaways from this 6 information is 2023 rate changes are consistent 7 with the historical ones for both individual and 8 small group. For individual, even prior to 9 reinsurance, the rate change is consistent with 10 historical ones. Pricing changes are also within 11 historical ranges. 12 And Julie mentioned this, and I'll just 13 drive it home again. Year-over-year average rate 14 decreases, increasing membership and increasing 15 competition, it points to an individual market 16 that is thriving, really, in Virginia, and we hope 17 that continues into the future. 18 I've got a couple more slides to cover. 19 Next slide, please, before we turn it over to our 20 presenting companies, and there they are. 21 The companies that are going to be 22 presenting today are Tim Connell with Anthem and 23 HealthKeepers, James Chu with Kaiser, and Katie -- 24 I've forgotten your name. Am I getting that 25 right? -- and Lydia, possibly, with Piedmont.</p>

<p style="text-align: right;">41</p> <p>1 And they'll just be tossing off the presentations 2 to each other when we get to them. 3 I've got one more slide, and then I'll 4 turn it over to Tim. Next slide, please. 5 These are some questions that we provided 6 to the presenting carriers prior to the 7 presentations today. I'm not going to read 8 through all of these, but the first stop point 9 we'd like all of them to address is how did 10 COVID-19 impact their experience and projections. 11 And you can see we've got some questions for 12 individual carriers. We've also got some specific 13 carrier questions. 14 One thing I want to wrap up with respect 15 to ARPA before we turn it over to the carriers, 16 when -- we had directed -- at the beginning of the 17 ACA pricing season, we had directed our carriers 18 to assume that ARPA would expire at the end of 19 2022, which was where the political winds were 20 blowing at the time. There didn't seem to be any 21 appetite to extend the subsidies. 22 Well, roll forward three months and things 23 have somewhat dramatically changed. And along 24 these lines, we felt like we really should give 25 carriers an opportunity to adjust their rates, if</p>	<p style="text-align: right;">43</p> <p>1 discussing the elements that impacted your rate 2 change, we noticed in a few cases that reinsurance 3 was somewhat of a drive -- I'm sorry -- risk 4 adjustment reinsurance was certainly a driver. 5 Risk adjustment was somewhat of a driver in some 6 of the rate changes, and we would like for you to 7 go into a little bit more detail about what's 8 driving your risk adjustment change, either 9 positive or negative, and what that means for your 10 book of business. 11 So, with that, are there any questions? 12 Alexander, in particular, did I answer 13 yours? 14 CHIEF HEARING EXAMINER SKIRPAN: Yes, I 15 think so. You covered it, as to what you're 16 doing. It does raise questions about those 17 carriers who didn't want to change their rates 18 given that there's going to be more subsidy but -- 19 MR. SHEA: Well, let me go into a little 20 bit of detail about what type of impact ARPA has 21 on a carrier's book of business. 22 Generally speaking, those subsidies, as 23 we've seen, serve to increase enrollment. Now, if 24 a carrier assumes that, "Oh, now that ARPA is 25 coming in, I'm going to get 2,000 more members,</p>
<p style="text-align: right;">42</p> <p>1 they so desire, now that it is fairly certain ARPA 2 subsidies will be extended at least for the next 3 three years. 4 We had one carrier accept our offer to 5 request a resubmission. They will be filing no 6 later than the end of the day today. They have 7 previewed their changes to us. No guarantee of 8 approval, but we did allow carriers -- and, again, 9 we had one carrier take us up on that offer. So, 10 we said, you know, if ARPA seems like it's going 11 to be a certainty, this will be your opportunity 12 to adjust your rate filing. 13 Now, I have a couple of other questions 14 for carriers that we'd like for them to address in 15 their presentation beyond the ones that are shown 16 on the screen. 17 If you could just give us a general sense 18 of, over time, how your cost-sharing elements have 19 changed, how much, you know, deductibles have gone 20 up, generally; co-pays usually don't change too 21 much; and have you -- are you moving toward less 22 rich coinsurance and out-of-pocket maximums. Just 23 give us a general sense of how your plan offerings 24 have been evolving over time. 25 And, in particular, when you get to</p>	<p style="text-align: right;">44</p> <p>1 but it's really not going to change the profile of 2 my book of business," there's really no reason for 3 a carrier to refile because the rates won't 4 change. They'll simply have more members. 5 The things that a rate will -- that will 6 cause a rate to change, particularly if you're 7 bringing in a different group of people than you 8 have had before, it may change the health status 9 of your population compared to the state. 10 So, what we ask carriers to do is, if 11 you're going to request a resubmission, we'd like 12 for you to tell us how much it's going to impact 13 enrollment and how much it's going to impact the 14 morbidity of either your population or the 15 population as a whole and how that change will 16 affect rates. 17 Again, increasing membership without a 18 change in rates at all is probably not a real good 19 reason for a carrier to refile just to change an 20 enrollment number. We were more interested in 21 things that would impact rates. 22 Most carriers also indicated early on 23 that, while they were pretty sure ARPA had 24 increased their membership, they really had no way 25 of telling who came to them because of ARPA. And,</p>

<p style="text-align: right;">45</p> <p>1 so, they really had no way of knowing the health 2 status of that population compared to who they 3 had. 4 So, the vast majority of carriers simply 5 said, "I really didn't have a good handle on what 6 those people looked like before so, I know that 7 you're offering me to refile, I'm really not going 8 to be able to make a good assessment on that." 9 And, so -- but we did have one carrier say that 10 they could, so they're going to resubmit again by 11 the end of the day today. 12 Does that help? 13 CHIEF HEARING EXAMINER SKIRPAN: That was 14 very helpful. Thank you. 15 MR. SHEA: Okay. Well, thank you. 16 Are there any other questions? 17 And if not, I am going to turn this over 18 to Anthem and HealthKeepers and Tim Connell to do 19 our first carrier presentation. 20 Tim. 21 MR. CONNELL: Hi. Good morning. Can you 22 hear me? 23 MR. SHEA: Yes. 24 CHIEF HEARING EXAMINER SKIRPAN: Yes. 25 Good morning.</p>	<p style="text-align: right;">47</p> <p>1 expected. And I think we're expecting that -- you 2 know, I would say we expect that to continue with 3 the inflationary pressures that are out there. I 4 think everyone is pretty well aware of how 5 inflation is running. 6 We see that pretty strongly correlated to 7 the medical and pharmacy field. Probably can 8 understand that, you know, the pandemic has put a 9 strain on providers. Right now we're hearing 10 quite a bit of pressure on that side, as far as 11 provider reimbursement. 12 So, we think this inflation pressure might 13 be part of what we're seeing in our experience 14 and, also, it doesn't look like it's going to 15 abate any time soon. And, so, that's kind of an 16 ongoing effect that we're trying to reflect in the 17 overall pricing. 18 I also understand that, even on the 19 Medicaid side, I think there's some changes maybe 20 happening on the reimbursement there. I heard 21 that statement yesterday, but I'm not quite as 22 familiar with that. So, just the general 23 environment right now, I think, is we're seeing 24 this inflationary pressure. 25 And I did want to also -- I'll kind of</p>
<p style="text-align: right;">46</p> <p>1 MR. CONNELL: Good morning. My name is 2 Tim Connell. I'm a director and actuary with 3 Elevance Health. And if that name sounds 4 unfamiliar, that's the new name of our holding 5 company, and I'll refer in the presentations to us 6 as "Anthem," what we're known here as in the local 7 markets. Our address is 2015 Staples Mill Road, 8 Richmond, Virginia. 9 And I'll start with just kind of some 10 general remarks before getting into some of the 11 specific slides. We'll probably come back to 12 these a little bit, too. And I think one of these 13 is kind of the questions that were in the lead-up 14 asking about some of our rate changes and how 15 they've moved up a little bit. 16 I did want to kind of emphasize that we 17 are seeing more cost pressures in recent times, 18 and we expect that some of this in 2021, with, you 19 know, the COVID pandemic initially had a great 20 suppression on claim experience, and we knew that 21 was temporary. We knew things were going to kind 22 of return after that. 23 And probably later in 2020, they started 24 to return. I think -- I think we saw quite a 25 rebound in 2021, even a higher extent than what we</p>	<p style="text-align: right;">48</p> <p>1 play back what Mr. Shea mentioned earlier, too, 2 that it's going to be a part of our -- part of my 3 comments on some of these, especially on the slide 4 that shows specific plans. 5 It's somewhat of an obscure concept, this 6 idea of the actuarial value, the AV, de minimis 7 changes that were mentioned. And we see it -- I 8 think I'll just use an example of our individual 9 silver plans. There was an actuarial value that 10 used to be from 66 to 72, which allowed for 11 some -- a little wider variation in benefits. And 12 instead of going down to 66, the minimum now is 13 70 percent. 14 So, what that did was, as David mentioned, 15 that's going to enrich some of the benefits on our 16 plans, really by CMS guidance. That's what they 17 wanted us to do. But that will actually increase 18 the premium for those plans. Those plans that 19 were maybe below the de minimis, the new de 20 minimus range, now have to move up to meet that 21 new minimum range for benefits. 22 I believe CMS did this to make plans more 23 comparables because silver plans could look pretty 24 different from the bottom and the top of that 25 range, as far as benefits go. And, so, that's</p>

<p style="text-align: right;">49</p> <p>1 something that's kind of influencing, you know, 2 some of these plans' specific rates. 3 I'll probably draw on that comment again, 4 where we had to -- where we had been lower on the 5 range, we had to move those plans up to meet the 6 new range, which they gave us the guidance on that 7 pretty late, which that will probably be a comment 8 I make again when we talk about ARPA. 9 So, that's one of my general comments. 10 And, of course, when we go through the slides, I 11 think reinsurance, as we mentioned, is going to be 12 a pretty beg -- you know, probably the number 13 jumps off the page a little bit more than the 14 other impacts. So, we'll probably talk about that 15 and get into that a little bit, too. 16 All right. So, now, this is our first 17 slide. It's a new offering. We're making an 18 individual EPO plan available, off-exchange only. 19 And, so, this was a bit of a new -- you know, we 20 made this new offering thinking of -- we have some 21 business that's still -- under the old ACA rules, 22 it's called a "grandfather plan." And these are 23 people that have been on the plans for, I think, 24 about 12 years now, at least, some longer. 25 And these grandfather plans are a block of</p>	<p style="text-align: right;">51</p> <p>1 So, that was kind of our rationale for 2 entering here. There is some risk, I think, you 3 know, the fact that it's a little different 4 network, it's a little broader network, than 5 typically carriers offer in this market. You 6 know, we're trying this off-exchange only, but we 7 want to kind of see how that working -- you know, 8 how that offering works with those customers and 9 any potential take-up that we might get. 10 All right. So, I'm kind of looking at my 11 notes here. So, I'll probably talk more about 12 some of the other specific questions as we get 13 into some of the other slides. So, could we page 14 down, please. 15 And these show our area factors and which 16 these are, of course, new offerings, so you can't 17 see current and prior, but these are new area 18 factors, which align closer to our -- actually our 19 PPO network, which is very similar to this one in 20 our small group market. 21 You can page down again. 22 And, so, here we have our Anthem small 23 group plans, and this is our PPO offering, and I 24 think there might be a HealthKeepers slide below. 25 Probably most of my comments are going to apply to</p>
<p style="text-align: right;">50</p> <p>1 business that people are not out to join this kind 2 of plan now, but if they have those plans and they 3 want to keep them, you know, the ACA has allowed 4 that if carriers can still offer them, they can 5 keep these grandfathered plans. 6 What we see over time, though, is people 7 leave these plans over time. The block has been 8 shrinking. And we think that this EPO offering is 9 a way that might attract some of those members 10 to -- you know, this network being very similar to 11 the network offered on these grandfather plans, it 12 might offer a path for these members to leave and 13 also get an ACA product that might look and feel a 14 little similar to the ones they have today. So, 15 we're kind of thinking about that grandfather 16 population. 17 Sometimes as plans -- you know, as the 18 number of members in a product get very small, you 19 know, we have to make a decision to say that maybe 20 we can't sustain this product anymore because the 21 membership is so slow. So, we've had a few plans 22 like that over the years that we've closed. And 23 having this product available might be an offering 24 that could help attract those members to stay on 25 an Anthem plan.</p>	<p style="text-align: right;">52</p> <p>1 both, so I'll just kind of try to mention most of 2 them here, and we might skim past that slide when 3 that comes up. 4 So, I think what we're seeing in this 5 market is a more of a return to the kind of 6 premium trends we might have seen a few years ago. 7 I think we had a pretty good run of low increases 8 for a while, but I think one we've stopped and 9 seen while those trends have really accelerated in 10 2021, and with the inflation, you know, it seems 11 pretty lucky that we expect those to continue 12 going forward. 13 And, so, you know, we're not talking real 14 high increases, I think, compared to some we've 15 seen historically, but back from, you know, 16 relatively flat rate changes for a couple of 17 years, to maybe in the, you know, 7 to 9 percent 18 range. And I think what we have here is the 9 19 percent for the first quarter of 2023. 20 And getting into some of the comments -- 21 some of the numbers below, I think one thing I 22 mentioned was the benefit changes. I believe 23 those ones that have both our most popular and our 24 maximum change were influenced by that minimum AV 25 change that had to be made. So, that's why</p>

<p style="text-align: right;">53</p> <p>1 there's slight increase there. 2 I will say the experience and model 3 changes, the other changes, generally, we saw a 4 slightly unfavorable experience in the market. 5 So, I think we probably, you know, are in that 1 6 percent range unfavorable, and it just might have 7 varied a little bit between, you know, that and 8 the other -- we reevaluate the plan through an 9 updated -- what we call a "relativity model" 10 between plans. 11 So, sometimes there's some fluctuation in 12 that modeling and how that comes out, but most of 13 that is probably -- I would relate to experience. 14 I did want to comment, too, that sometimes 15 it's hard to put a specific number on one category 16 like this because I think a lot of 17 these components that you see on the page here 18 interact with one another. 19 And I'll mention an example that we tend 20 to look at this internally is maybe looking at 21 experience along with risk adjustment together 22 because, where our experience was higher and we 23 saw a higher claim experience, we actually did get 24 a -- with the CMS publishing risk adjustment 25 results for 2021, we actually did observe that our</p>	<p style="text-align: right;">55</p> <p>1 were just -- that's when we found out that we were 2 a little bit more of a receiver than we had 3 expected to be. 4 So, that was a change we decided to make 5 with our refiled rates. It wasn't in our initial 6 rates, but it came through on the refile. 7 So, we made that assumption that we think 8 that our risk adjustment position will remain 9 relatively stable over time. 10 I think David also asked about plan 11 designs and our approach to that. I think we take 12 a slightly different approach in the individual 13 and small group markets. I think with our small 14 group employer population, we might leave plans 15 relatively stable over time. 16 I think our group customers like to have 17 the same kind of benefits from year to year, if we 18 can offer that. So, we tend not to make drastic 19 changes, you know, for multiple plans in a given 20 year. 21 One thing we will look at is that 22 out-of-pocket number. If there's an opportunity 23 to look like the out-of-pocket can move up -- you 24 know, every year the CMS gives us guidance on what 25 the maximum out-of-pocket can be, so we will</p>
<p style="text-align: right;">54</p> <p>1 risk adjustment, our position in the market, 2 improved. 3 That means that we are more of a receiver 4 from the risk adjustment program. That does mean 5 that we have usually higher risk people in our 6 population. So, while we saw the claims that went 7 along with that, we did get some -- you know, we 8 got some, looks like, appropriate compensation 9 from that from the risk adjustment program. 10 So, this will be a comment I will return 11 to in individual, as well, but we -- so, when we 12 look at it together, the experience with the 13 favorable risk adjustment, you know, we were kind 14 of tracking close to -- you know, close to 15 expected results in our experience but, again, we 16 kind of think those, you know, with the trends 17 going up where they are, that there's still that 18 risk in the market. 19 I think I might just touch on -- I think I 20 touched on one of David's last questions about the 21 risk adjustment. So, we really base this 22 change -- you know, we had been monitoring our 23 risk adjustment position from prior years. We had 24 been a receiver in the market in small group, and 25 I think when the 2021 results came through, we</p>	<p style="text-align: right;">56</p> <p>1 sometimes look at those plans and say, "Well, you 2 know, maybe to get a little lower price, the 3 customers might be willing to take an out-of- 4 pocket that's a little bit higher." 5 But you can see here that these out-of- 6 pockets are pretty well below the minimum. So, we 7 do see a lot of customers that, you know, maybe 8 take plans in that gold range. Those are a pretty 9 popular range. And, actually, our most popular is 10 a platinum in this case. So, our customers still 11 kind of like the benefits slightly on the richer 12 end. 13 We tend not to change them, unless, you 14 know, like the AV range had to be changed this 15 year, or if, you know, sometimes we'll relook at 16 plans if we think it's appropriate and we don't 17 think there will be must disruption. 18 In the individual market, which I don't 19 want to jump too far ahead, but we might take a 20 slightly different approach there with benefits, 21 where I feel like the market there is so cost- 22 sensitive, price-sensitive, that we want to make 23 sure we're competing as best we can, and probably 24 there's a more regular look at, you know, keeping 25 the plan that's going to be attractive and staying</p>

<p style="text-align: right;">57</p> <p>1 within the AV range but also might, if there are 2 changes that increase the cost share from year to 3 year, we tend to take those, one, thinking that 4 the customers, they prefer the lower price, if 5 they can get it, and, also, when, as Ms. Blauvelt 6 mentioned earlier, many of these members are on a 7 cost-sharing plan. They get a cost-sharing 8 reduction with their benefits. 9 So, when we might, say, raise a cost share 10 on a silver plan, those would be impacting only 11 the members that don't get any cost-sharing 12 reduction. Those that get the cost-sharing 13 reduction would still see a relatively small cost 14 share that they would have to meet. 15 So, I think it's a slightly different 16 approach for each market, but I think just because 17 the individual is so price-sensitive, that's why 18 we -- that's kind of how our thinking is there. 19 Any questions so far? 20 No. 21 I'll get into a little bit to COVID-19, 22 which was a question. So, I think we 23 underestimated COVID-19, how long the duration 24 would last. And our approach was sort of a 25 minimal approach, I guess you could say, which we</p>	<p style="text-align: right;">59</p> <p>1 no matter what, with vaccines, with boosters being 2 available, new treatments there. 3 And then the other side is that we -- even 4 if there's a chance, which we think, you know, may 5 happen, that the COVID experience will drop off in 6 the future period, we think there's probably some 7 suppressed utilization from other services that 8 would cut -- would fill in. 9 That's a bit of an unknown and it's a bit 10 of a risk out of there, that people that are 11 delaying services, you know, how serious do their 12 conditions get, are there treatments that are 13 missed or that could have headed off a more 14 severe episode. 15 So, that's one thing that's a bit of a 16 risk, and we don't build in any -- as David Shea 17 referred to, the morbidity increase, we didn't 18 build morbidity for COVID-19, but we do see some 19 risk there that people could be coming back sicker 20 or people could have long COVID that might hit 21 down the road and more severe episodes or a sicker 22 population could be the result. 23 Anything questions on COVID-19? 24 All right. 25 CHIEF HEARING EXAMINER SKIRPAN: No, I</p>
<p style="text-align: right;">58</p> <p>1 said -- and we tend to think of COVID-19 kind of 2 together with any, perhaps, you know, suppressed 3 or delayed utilization for other services. 4 And, so, if a patient -- if hospitals are 5 filling up with their beds for COVID patients, it 6 means likely they're not available if a patient 7 with maybe something else or to go in for another 8 service in the hospital, that the COVID still 9 might be blocking other potential utilization. 10 So, we kind of look at that together. 11 And, so, we really left the assumption of 12 whatever -- we took the COVID that was in the 13 experience and we said, "Let's just project that 14 number going forward." 15 One thinking was we don't know how long 16 this pandemic will last. You know, there will be 17 new drug treatments. There will be new cases, 18 perhaps new variants. Even when we submitted the 19 first time, it looked like COVID was, you know, 20 falling off, and then, sure enough, a new wave 21 kind of hit again in the summer. 22 And, so, yeah, I think there's the belief 23 that this could still continue and we have new 24 variants into the next year. There will still 25 be -- I think there are added costs to the system</p>	<p style="text-align: right;">60</p> <p>1 don't think so. 2 MR. CONNELL: All right. Next slide, 3 please. 4 And I'm having a hard time reading these 5 on the screen, but they're relatively unchanged on 6 our age and area factors here. 7 So, you can go to the next page, please. 8 So, HealthKeepers Individual. So, I think 9 some of the comments I made earlier will come back 10 here. Like, our most popular plan is the silver 11 plan that had been on the low end of the actuarial 12 value scale from 2022, and that new de minimis 13 range is causing us to enrich their benefits. 14 So, if you look at the deductible, for 15 example, the out-of-pocket actually did go up with 16 the allowable maximum, but we did reduce the 17 deductible and the coinsurance, which have a 18 bigger impact in bringing the premiums up. So, 19 that's a theme that we'll see throughout, that 20 some of these plans that had that de minimus 21 change are seeing a little bit of benefit increase 22 for that. 23 But the number that probably jumps off the 24 page is the reinsurance and the 18.3 reduction for 25 that. So, it is a good timing for this program.</p>

<p style="text-align: right;">61</p> <p>1 We were looking like, similar to small group, 2 looking at kind of a -- maybe a normal trend or, 3 you know, high, single-digit kind of increase 4 prior to that, and the reinsurance is 5 definitely -- definitely helping bring the rate 6 down. 7 So, this -- as we saw earlier, that's, I 8 think, the fourth year in a row of decreases that 9 Anthem has also had but I think the whole market 10 has seen. 11 I'll also mention ARPA quickly. Where we 12 reflected ARPA in the line called "Other 13 Morbidity," so that's about a 1.2 percent 14 increase, and that's one that, as we saw ARPA come 15 on and more people being eligible for subsidy, our 16 assumption was that those would be relatively 17 healthier people. 18 And we use the morbidity assumption to 19 more reflect what we think is going to happen 20 marketwide. There is an interaction between risk 21 adjustment and morbidity, that if you get 22 healthier people but your competitors do not, you 23 might see a decrease in morbidity but you might 24 see an increase in risk adjustment. 25 So, really, our increase in morbidity, we</p>	<p style="text-align: right;">63</p> <p>1 this Medicaid redeterminations will happen. 2 People that had been staying on Medicaid for an 3 extended time will maybe not be eligible anymore. 4 They may look to the individual market to continue 5 their insurance. 6 And usually when there kind of a process 7 happens, we would expect some anti-selection to 8 happen there, too. 9 We did not build anything in for that 10 explicitly, one reason being we're not sure when 11 the public health emergency will be over and 12 that's -- I don't think anyone wants to take a 13 guess at when that will be. 14 But it is a risk out there, that if it 15 happens, you know, within six months or so, there 16 will be a time next year where that Medicaid 17 population will be looking at our -- you know, 18 looking at the individual products, and I think 19 that does present some risk of morbidity change 20 that we had not yet reflected. 21 So, I think having some other risks out 22 there was one consideration we made to not elect a 23 change. I think we also were thinking is this 24 bill, you know, ready to pass or for sure to pass. 25 I think most people agree that it probably is, but</p>
<p style="text-align: right;">62</p> <p>1 did not have any offsetting adjustment in risk 2 adjustment. The risk adjustment of minus 3.4 was 3 really due, similar to small group, of what we saw 4 with the results of the CMS marketwide results for 5 2021. 6 But we did build in the 1.2 for ARPA, with 7 the assumption that -- it was also a very similar 8 assumption we made when ARPA came in, when the 9 ARPA subsidies began. We thought we'd see a mix 10 of healthier people coming in, worth about that 1 11 percent, and with the ARPA subsidies that had to 12 expire, we had put that 1 percent back in, back 13 into the premiums. 14 So, yeah, we also elected -- it was kind 15 of -- this is where we love the federal 16 government's timing on things. They've done this 17 before with the Health Insurance Acts and other 18 things that come very late or too late for us, 19 but, yes, we did see the message that there was an 20 opportunity to change. 21 I think, given some of the risks out there 22 in the market, and Ms. Blauvelt mentioned one of 23 them that's kind of on our minds, when the public 24 health emergency is declared over, there is -- 25 what we're calling internally is we're calling</p>	<p style="text-align: right;">64</p> <p>1 just having that pass into law was one 2 consideration, too. 3 I'm thinking. All right. I think 4 that's -- those are most of my comments. And I 5 will mention just quickly here the risk adjustment 6 that David Shea had asked about before. 7 This was a result that we did change a 8 little more significantly than we thought from a 9 risk adjustment perspective. We were expecting to 10 be a payor in this market, which we had been in 11 previous years, and when we got the results at the 12 end of June, we're actually very close to the 13 market average, just slightly above market 14 average, on the morbidity measured by risk 15 adjustment. 16 So, that means, instead of paying at the 17 risk adjustment, we were, you know, not -- you 18 know, maybe a slight -- just a very slight 19 receiver. So, we did change that assumption with 20 the idea that we'd expect that market position to 21 remain relatively stable going forward. 22 That was another negative that we brought 23 into the race here. 24 Next slide, please. 25 I think that might be it. These are our</p>

<p style="text-align: right;">65</p> <p>1 area factors and age factors. 2 Next slide. 3 And I think I covered most of our comments 4 for small group. We combine these two books of 5 business when we do our analysis for -- we combine 6 the two legal entities together. And, so, 7 typically, we tend to have the rate increases be 8 very close to one another. And I think most of 9 the comments I said earlier on small group would 10 apply to this, as well. 11 All right. I think that's it. 12 Next -- you can just slide through the 13 next couple slides. I think that probably will 14 wrap up mine. 15 All right. Any other questions? 16 CHIEF HEARING EXAMINER SKIRPAN: No, I 17 don't have any. I think you've covered everything 18 well. Thank you. 19 MR. CONNELL: All right. Thank you. 20 CHIEF HEARING EXAMINER SKIRPAN: And, I 21 guess, go ahead. 22 MR. CHU: Okay. Hey, everyone. My name 23 is James Chu. I'm a director within Actuarial 24 Services at Kaiser, and I'm the certifying actuary 25 for 2023 ACA Virginia rates, and our company</p>	<p style="text-align: right;">67</p> <p>1 guidance, we assume that ARPA subsidies wouldn't 2 be extended. 3 Between ARPA subsidies not being extended, 4 which would lower enrollment expectations for 5 2023, and reinsurance implementation, which would 6 increase enrollment expectations for 2023, we 7 thought that they would largely trade off. So, we 8 expect the market size to be roughly constant 9 going from 2022 to 2023. 10 However, as best as we can -- sorry. 11 Subsidies were extended through 2025, ARPA 12 subsidies were, and we estimate -- again, it's 13 really hard to identify who exactly is joining 14 because of ARPA subsidies versus just joining. We 15 estimated that ARPA subsidies would increase 16 enrollment by around 10 to 15 percent. I think 17 that's slightly lower than what Oliver Wyman was 18 expecting. 19 Even if the market is growing, it's hard 20 to understand the risk of the specific numbers 21 that are staying on because of ARPA subsidies. We 22 probably would expect them to be slightly lower 23 risk, given that they are on the margin of 24 purchasing coverage, but with the ARPA subsidy 25 extension, we think the market risk might have a</p>
<p style="text-align: right;">66</p> <p>1 address is 2001 -- 2101 East Jefferson Street, 2 Rockville, Maryland, 20852. 3 I'll address some of the questions that we 4 had on the top. So, the first one was around 5 COVID. So, in 2021, COVID was around 5 to 6 6 percent of our costs. So, this reflects both the 7 COVID treatment costs, as well as the cost for 8 COVID testing and COVID vaccination. 9 I think, like Tim was saying before, it's 10 really hard to say how we think COVID will change 11 going from 2021 to 2023. I think we can all 12 expect that COVID is largely here to stay. A lot 13 of that 5 percent of the cost will be around, but 14 we can probably expect some sort of modest 15 decrease in that, but we wouldn't expect that to 16 have a huge impact on trend. 17 On the flip side, COVID, while in 2021 18 there was a return on a lot of the deferred care 19 that was put off in 2020. There was probably 20 still some sort of care suppression in 2021, and 21 we expect, as that comes back, that will also put 22 some upward pressure on rates going into 2023. 23 There was also a question about ARPA 24 subsidies and reinsurance for the individual 25 market. So, like Julie mentioned, based off of</p>	<p style="text-align: right;">68</p> <p>1 modest decrease of 0 to 3 percent, and should that 2 happen, that would probably offset Kaiser's 3 negative margin within the individual market. 4 Any questions about those three topics? 5 CHIEF HEARING EXAMINER SKIRPAN: I don't 6 have any. Thank you. 7 MR. CHU: Great. Let's talk about the 8 individual market. 9 So, Kaiser's rate increase is minus 12.3. 10 So, the biggest driver in that, again, is 11 reinsurance. 12 To estimate the impact of reinsurance, we 13 utilized the claims probability distribution that 14 David described before. The impact of the 15 reinsurance receipts themselves are probably only 16 going to be 11 percent for Kaiser. 17 That's a combination of a lot of things. 18 It's a little bit of Kaiser's risk provides, a 19 little bit of the fact that the data system used 20 to calculate those reinsurance payments does not 21 fully capture Kaiser's cost structure the way that 22 we deliver care and, also, driven by the way that 23 Kaiser manages costs. But, yeah, you can see that 24 reinsurance line item as at minus 11 percent 25 there.</p>

<p style="text-align: right;">69</p> <p>1 The other morbidity line, the minus 6.2, 2 that reflects the lower morbidity going from 2020 3 to 20 -- that number reflects -- sorry. That 4 reflects our morbidity assumptions going from 2021 5 to 2023. A lot of that was driven by Kaiser's 6 rate decrease in 2022.</p> <p>7 So, last year, we submitted a minus 8 13 percent rate increase, and that increased our 9 enrollment by 30 percent. And a lot of those 10 members that we brought on were very low risk. 11 So, that did bring down our morbidity assumptions 12 that we're using for 2023.</p> <p>13 Trend, we're assuming 2 percent. Risk 14 adjustment, in general, the impact of it is 15 relatively flat. Risk assessment is a pretty 16 complicated beast, but this is colored by a lot of 17 things. I mean Kaiser's risk is going down, but 18 so is the market. So, that was sort of a 19 trade-off.</p> <p>20 The statewide average premium has always 21 gone down quite a bit, as we've seen in this slide 22 before, and that's also going to provide some 23 favorability in risk adjustment.</p> <p>24 Regarding the other non-benefit expenses, 25 that will -- that mostly reflects admin, and that</p>	<p style="text-align: right;">71</p> <p>1 every couple years, we do utilize a third-party 2 model, and we update it to the newest version of 3 that model. And based off of the version of that 4 model, it did say that -- it did estimate that our 5 deductible plans should be priced lower and our 6 nondeductible plans should be priced higher, and 7 that reflects how our gold plan has a 4 percent 8 increase relative to the catastrophic plan, which 9 had an 8 percent decrease.</p> <p>10 And the last factor is a catchall. Just 11 given the fact that -- given the way that all 12 these factors interact, it's not really fully able 13 to -- it's not really possible to fully isolate 14 the impact of any of these one specific drivers. 15 And that covers the balance to get us to the rate 16 increases for each of these specific plans.</p> <p>17 Any questions there?</p> <p>18 CHIEF HEARING EXAMINER SKIRPAN: No. Keep 19 attacking.</p> <p>20 MR. CHU: Next slide.</p> <p>21 So, we aren't changing any of our tobacco 22 or area factors. So, our tobacco factor is 1.2, 23 and we don't vary or our rates based off of 24 geography.</p> <p>25 Next slide.</p>
<p style="text-align: right;">70</p> <p>1 reflects a slight increase in admin costs. That 2 was largely due to 2021 admin costs being a lot 3 lower than expected, and we expect a rebound on 4 those going into 2023.</p> <p>5 For the benefit changes, we're showing a 6 minus .2 for the first plan, and that reflects the 7 increase of the out-of-pocket max going from 69.50 8 to 72.50. For the next point on the catastrophic 9 plan, it's a minus 1.7, and that's both the 10 deductible and out-of-pocket max going from 8700 11 to 9100. And then, finally, for the last plan, 12 the gold virtual four plan, the plan did get 13 slightly richer. The generic drug co-pay went 14 from \$10 after deductible to \$5 after deductible.</p> <p>15 The next driver is the base experience 16 change, and this reflects the changes in 17 morbidity, the change in experience from 2020 to 18 2021. Again, I don't think that anyone really 19 expected that big rebound in cost that we saw in 20 2021, and that's what that 2 percent reflects.</p> <p>21 The market change reflects our change in 22 margin target. For 2023, we are assuming -- we 23 are projecting a loss ratio of around 95 percent 24 with a margin of 97 percent.</p> <p>25 And the last item is model changes. So,</p>	<p style="text-align: right;">72</p> <p>1 So, now I want to talk about small group 2 rates. So, sort of for our small group is -- I 3 mean it's pretty different, just like the prior 4 speakers have noted. While the individual market 5 has been growing and is going to become 6 additionally robust because of the reinsurance 7 plan, but the small group market is slightly 8 struggling.</p> <p>9 And for Kaiser, especially, going from 10 2020 to 2021, the story was pretty rough. So, the 11 small group claims jumped pretty significantly, 12 again, due to the claims rebound after COVID.</p> <p>13 But on top of that, while other carriers 14 benefitted from more favorable risk adjustment 15 changes, Kaiser's risk adjustment became less 16 favorable. So, it's sort of a double whammy. You 17 wouldn't necessarily expect claims to increase and 18 to pay more in risk adjustment, as well, and that 19 was surprising to us, as well. That is partially 20 driven by the increase in the market risk, which 21 has increased faster than expected.</p> <p>22 Yeah, so, given all those factors, we are 23 filing a rate increase of 9 percent.</p> <p>24 Going to the specific drivers, so, the 25 other morbidity -- that reflects the morbidity</p>

<p style="text-align: right;">73</p> <p>1 expectations going from 2021 to 2023. Again, I 2 think that we're slightly more pessimistic about 3 how the risk will change, and we think that the 4 overall risk will go up in this market. 5 Regarding risk assessment, that captures a 6 lot of the unfavorability in risk adjustment that 7 we saw, especially going from 2020 to 2021 and the 8 potential unfavorable changes in the market risk 9 going forward. 10 For non-benefit expenses, this had 11 downward pressure on our rates. This was a 12 combination of a couple factors. First of all, 13 because the small group rates are increasing, 14 because our admin costs are relatively fixed, 15 because the rates themselves are increasing, 16 admin, as a percentage of total rates, will go 17 down. 18 We also moved some costs from healthcare 19 quality expenses to medical expenses just to 20 better align with the medical loss ratio 21 definitions as set forth by the MBPP. And then 22 we've also lowered our commissions. 23 For benefit changes, a lot of the minus 24 .2 percent rate impact, that largely reflects the 25 increase in the out-of-pocket max going from 6,000</p>	<p style="text-align: right;">75</p> <p>1 MS. TOLMAN: I'm Lydia Tolman from Wakely 2 Consulting Company presenting on behalf of 3 Piedmont Community Healthcare HMO and Piedmont 4 Community Healthcare, located at 2316 Atherholt 5 Road, Lynchburg, Virginia. 6 My colleague Jackie Young, also from 7 Wakely Consulting, and Ryan Ziemann from Piedmont 8 will also be presenting. 9 I will cover the individual rate 10 presentation and first three questions for the 11 individual HMO plans. My colleague Jackie will 12 cover the small group rate presentation and 13 question for both the small group HMO and PPO 14 plans. And, finally, Ryan will address the 15 question around service areas expansion for the 16 HMO products and decision to reenter the small 17 group market for the PPO products. 18 So, for individual, Piedmont will be 19 offering five renewing plans plus CSR variations 20 in 2023. The most popular plan is expected to be 21 their bronze 7500 plan, which currently has about 22 a third of their membership. 23 The maximum rate change is a 14.9 percent 24 decrease for our gold plan. And the minimum rate 25 change is a 20 percent decrease for our silver</p>
<p style="text-align: right;">74</p> <p>1 to 6,600. 2 The margin change reflects an improvement 3 in our margin target just to allow us to reach a 4 more sustainable margin, although we are still 5 projecting a minus 13 percent margin in 2023 with 6 a loss ratio of 99 percent. 7 The underlying morbidity change reflects 8 that increase in cost going from 2020 to 2021, 9 and, then, again, that other changes the balance 10 factor. 11 Next slide. 12 And, again, like the individual market, we 13 don't vary our rates by geography, and we don't 14 charge a tobacco factor for small group. Right 15 now it does say that the current tobacco factor is 16 1.2, but that's an error. We've resubmitted this 17 form online. 18 Any questions for me? Otherwise, I'll 19 pass it off to the next presenter. 20 CHIEF HEARING EXAMINER SKIRPAN: I don't 21 have any questions. We can move to the next 22 presenter. 23 MR. CHU: Thanks. 24 MS. TOLMAN: Hello. Can you hear me? 25 CHIEF HEARING EXAMINER SKIRPAN: Yes.</p>	<p style="text-align: right;">76</p> <p>1 5800 plan. 2 For all plans, we assumed a slight 3 morbidity improvement due to ARP from 2021 4 experience in our 2019 manual, which was used to 5 develop the rates. 6 For trend, we assumed a change in our 7 trend of about one point. So, trend improved 8 slightly from our 2022 filing, which is what is 9 represented here. 10 And then for risk adjustment and 11 experience, which is in the yellow section below, 12 we saw from 2020 to 2021 experience that our 13 claims increased quite a bit but our risk 14 adjustment receivable was much, much higher in 15 2021. 16 For our 2023 filing, we needed that, 17 slightly, but we still expect to be in a 18 receivable position. So, these two offset. 19 The biggest impact to the filing is, like 20 the other carriers, the reinsurance program, which 21 is decreasing our rate 17 percent. 22 Our other non-benefit expenses reflects a 23 slight increase in our administrative cost that we 24 think is appropriate for the expected improved 25 competitive positioning and additional members.</p>

<p style="text-align: right;">77</p> <p>1 And then, lastly, in the bottom section, 2 we have the change in our paid to allowed ratio of 3 6.1 percent, which reflects a mix change. So, 4 this is showing that we're going to have a lot 5 more bronze members in our total population. 6 And then the change to benefits for each 7 specific plan is included in the other change. 8 COVID, specifically, was included in 2022 9 in our other morbidity line. And then for 2023, 10 we have moved that to the other line. 11 For COVID, specifically, we assumed that 12 there was pent up demand in 2021 experience. 13 Piedmont has a growing population and is not fully 14 credible when we went to do a COVID study, so we 15 relied on the SOA, Society of Actuaries, COVID 16 model results for both the individual and small 17 group lines of business, assuming the impact of 18 pent up demand in 2021 will not be present in the 19 2023 projections. 20 One of the questions we received from the 21 BOI was what Piedmont experience could also 22 justify, and we found that even though it was not 23 fully credible, it was consistent with the 20 -- 24 or the COVID model results from the Society of 25 Actuaries.</p>	<p style="text-align: right;">79</p> <p>1 not reflected in our 2021 experience, and that not 2 all new members joining from April 2021 when ARPA 3 passed to December 2022 would leave if ARP 4 enhanced subsidies were discontinued. 5 Any questions? 6 CHIEF HEARING EXAMINER SKIRPAN: Can you 7 go over with having ARPA extended, how do you see 8 that impacting things. 9 MS. TOLMAN: Sure. So, we looked at what 10 would happen if ARPA was extended, but as we 11 noted, we are assuming a slight decrease in our 12 morbidity assumption from 2021 to 2023 because we 13 assumed a lot of the members who joined due to 14 ARPA would stick around even with the loss of the 15 subsidies. Part of that was driven by just lower 16 premium rates, as well, with the introduction of 17 the reinsurance program. 18 So, when we went back to our model and 19 switched over to ARPA continuing, we saw a very, 20 very, very immaterial change in our morbidity 21 assumption, and since we didn't explicitly add or 22 decrease any enrollment for ARPA, we didn't think 23 anything had changed to our filing was necessary. 24 CHIEF HEARING EXAMINER SKIRPAN: Okay. 25 Thank you.</p>
<p style="text-align: right;">78</p> <p>1 And then the next question was what was 2 the projected effect of reinsurance on enrollment 3 and morbidity. Piedmont did not assume an impact 4 to their specific enrollment morbidity for 5 reinsurance. 6 We did model the expected reinsurance 7 receivable on the Wakely ACA data that we have. 8 We have a large proprietary database and modeled 9 what we thought the paid receivable would be, 10 included that in the rate buildup. 11 And although premiums will be lower, we 12 don't think this will translate to lower premiums 13 for subsidy-eligible members. So, we didn't think 14 there should be a specific adjustment to 15 Piedmont's enrollment. 16 And then, lastly, does the impact of the 17 elimination of ARPA -- what is the impact of 18 elimination of ARPA on enrollment and morbidity. 19 Again, we assumed no large impact to Piedmont for 20 enrollment changes, but we assumed a slight 21 decrease in morbidity from our 2021 experience 22 period and a larger but still small decrease in 23 morbidity from our 2019 and manual experience. 24 We anticipated improved morbidities for 25 members that joined in 2022 due to ARPA, which is</p>	<p style="text-align: right;">80</p> <p>1 MS. TOLMAN: All right. Next slide. 2 So, this shows our tobacco load. We did 3 want to point out that we have removed the tobacco 4 load going into 2023. I believe there's some 5 legislation on the table to get rid of the tobacco 6 load or significantly minimize the tobacco load. 7 And after some internal discussions and review of 8 tobacco members, we decided that, just for ease of 9 operations, we would remove the tobacco load 10 entirely. 11 The geographic areas we are significantly 12 expanding this year and, so, to develop our 13 geographic area factors, we looked at the 2022 14 contracts versus the 2023 contracts. We also 15 considered the geographic cost factor that is used 16 in the risk adjustment program. And we 17 reevaluated our area specific factor and 18 re-normalized, which results in the rates shown 19 over to the right. 20 Any questions? 21 CHIEF HEARING EXAMINER SKIRPAN: No. 22 MS. TOLMAN: Okay. Next slide. And with 23 that, I will pass it to my colleague Jackie. 24 MS. YOUNG: So, my name is Jackie Young. 25 I'm also from Wakely Consulting Group presenting</p>

<p style="text-align: right;">81</p> <p>1 on Piedmont Community Health Plan's behalf here. 2 So, moving on to the presentation of small 3 group rates, we'll start with the HMO. 4 As an overview, under the HMO entity, 5 Piedmont has 18 HMO plans, as well as 18 POS 6 plans, 14 of which are renewing and 4 are new for 7 both plan types. So, all plans are offered off 8 exchange. The HMO is still only offered in rating 9 area 6, Lynchburg, while the POS has expanded, 10 similar to an individual, across the rating areas 11 now -- a quick overview. 12 Now, referring to this first slide, the 13 overall rate change for this segment was a 14 0.2 percent decrease, so very little change 15 overall. The most popular plan is the Piedmont 16 Choice POS silver, and it has a 23.50 deductible, 17 approximately 250 members as of Q1 '22. 18 We had a relatively small range for the 19 rate change across all plans here. The minimum 20 rate change was a 3 percent decrease for that 21 Piedmont Choice POS silver HSA. The maximum rate 22 change -- and apologies for not catching this 23 sooner -- was actually a 2.2 percent increase, 24 which was the POS plan ending in 15 here, so HIOS 25 40015, state benefit design is listed, so the</p>	<p style="text-align: right;">83</p> <p>1 from last year, again just looking at the risk of 2 our current population, just assuming a slight mix 3 change so that we have more gold membership to 4 increase that expected risk receivables, what's 5 happening there. 6 Offsetting these negative changes, 7 non-benefit expenses increased slightly, same as 8 individual. Piedmont is now investing slightly 9 more for upcoming expansion efforts, so a slight 10 change there. 11 Change in underlying experience minus 12 trend was actually pretty small. We did see a 13 small increase to cost of about 1.7 percent from 14 2022 to 2023, so pretty minimal in the scheme of 15 things. And similar to points made, this is 16 pretty in line with the adjustment to risk 17 adjustment amounts. So, if you see there that 18 negative 1.9 percent that we assume for that risk 19 adjustment change goes hand in hand with the 20 expected claims we're going to assume in 2023, 21 which is the 1.7 percent we have for the change in 22 underlying experience. 23 We have a small change in the paid to 24 allowed, which, again, here represents a small 25 change in mix anticipated for 2023 with slightly</p>
<p style="text-align: right;">82</p> <p>1 54.50 deductible and the 89.50 moot. 2 So, focusing on the rate change 3 components, I'll go through these and then maybe I 4 can stop and answer any questions you have. 5 So, to start, we are showing a 3.5 percent 6 decrease for morbidity. This is driven by changes 7 in the COVID impact and the way in which we 8 allocated it, so it's similar to individual. 9 Where last year we were expecting increases based 10 on 2020 morbidity shifts, we're now expecting 11 decreases from COVID impact due to the impact of 12 pent up demand that we saw in 2021, which is now, 13 in part, included in the other category. And I'll 14 touch on this further after presenting the 15 remaining slides. 16 We had a slight decrease in our trend 17 assumption, which is shown here, again similar to 18 individual, .7 percent represents the change in 19 our trend assumption. 20 For risk adjustment, based on the current 21 risk of our members that we saw at the end of 22 2021, and then our assumed mix changes going into 23 2023, we are actually expecting slight increases 24 to our risk receivables. So, in 2023, we 25 anticipated closer to \$40 PMPM rather than the \$30</p>	<p style="text-align: right;">84</p> <p>1 more gold membership. 2 And with that, I think that really covers 3 our explicit changes. The other change includes 4 our actual trend, some COVID impact, PBM savings, 5 and clean edit savings. So, that's what lumped 6 into that other category. 7 But I just went over a lot, so I'm going 8 to stop and take a second to ask for any 9 questions. 10 CHIEF HEARING EXAMINER SKIRPAN: Just as a 11 general, how is inflation reflected in this? 12 MS. YOUNG: Yeah, so, I think, in general, 13 we did think about that when going through trend 14 and COVID. So, we made sure when looking at our 15 trend assumption, we were going off of publicly 16 available sources for what was considered 17 reasonable healthcare trend going from 2021 to 18 2023. 19 You know, I think, on average, you know, 20 we could have gone lower. So, I think we sort of 21 did consider it to try to be more conservative 22 there. You know, I think, in total, the trend 23 probably doesn't look as high, too, because we're 24 considering the COVID impact and the deflating of 25 the pent up demand in 2021 going from 2023. That</p>

<p style="text-align: right;">85</p> <p>1 impact is coming down some. 2 So, when you combine the two, I think, in 3 total, it doesn't seem like much impact, but I do 4 think we have been more conservative in our 5 overall trend amounts to try to take into account 6 the expected inflation going to 2023. 7 And just to add to that, we looked at 8 several studies on trend, and we found that 2021 9 looked like it had the biggest impact from 10 inflation, still some drivers for sure in 2022 and 11 2023, but most of that is already covered in our 12 2021 experience, the additional inflation. 13 CHIEF HEARING EXAMINER SKIRPAN: Okay. 14 Thank you. 15 MS. YOUNG: All right. If we can go to 16 the next slide, not too much to report here. We 17 have no changes to the tobacco factors from the 18 prior year. We're still not applying any tobacco 19 load. 20 And similar to individual, Piedmont is 21 expanding into these new areas, so we had to 22 renormalize and redistribute the rating areas 23 after thinking through the contracting, the GCS 24 where current experience lies, to get from the 25 original rating areas in 2022 to the factors in</p>	<p style="text-align: right;">87</p> <p>1 Same rating area factors as were shown for the HMO 2 product. And same as the HMO product, we are not 3 adding a tobacco load. So, same old/same old. 4 Any other questions there? 5 CHIEF HEARING EXAMINER SKIRPAN: No, no 6 questions. Thank you. 7 MS. YOUNG: All right. And I'll, just 8 before I pass it over to Ryan, I do want to more 9 explicitly address the questions posed by the 10 group. 11 So, to address the COVID-19 impact on 12 experience and projections, I know we already 13 touched on it briefly, but due to the pent up 14 demand from COVID, Piedmont did see noticeably 15 higher medical PMPM costs in early 2021 for the 16 small group business, as well as what we saw for 17 the individual, which have since leveled off 18 slightly. 19 And, again, Piedmont has a growing 20 population. Small group is not fully credible for 21 a full-on COVID study, which is why we relied on 22 the SOA COVID model results for both lines of 23 business. So, assuming the impact of pent up 24 demand in 2021 will not be present in the 2023 25 projections, we're assuming a slight decrease.</p>
<p style="text-align: right;">86</p> <p>1 2023. 2 Any questions there? 3 CHIEF HEARING EXAMINER SKIRPAN: No. 4 Thank you. 5 MS. YOUNG: All right. So, we can go 6 ahead and move on to the PPO. All right. And 7 I'll give a quick overview of the new PPO product. 8 So, under the new PPO entity, Piedmont is 9 offering, again, 18 plans across the same 8 rating 10 areas as the HMO. On this slide, we're only 11 showing the one plan since this is a new line of 12 business, and we're showing our most -- 13 anticipated most popular, which is the Piedmont 14 PPO gold with the \$2,000 deductible. 15 So, not much more to report here without 16 reaching, but for reference, the buildup of our 17 PPO pricing was very much consistent with that of 18 our HMO products. We just adjusted AVs for 19 additional anticipated utilization for out-of- 20 network cost. 21 In a second, I'll pass it over to Ryan to 22 get more of the business decision as to why we 23 started this new product again, but for now, I'll 24 move on to the next slide. 25 And with that, again, not much reported.</p>	<p style="text-align: right;">88</p> <p>1 To address your other questions, I think, 2 for the most part, we went through risk 3 adjustment, again, assuming a slightly higher PMPM 4 based on our current numbers but a slightly 5 different mix, assuming more gold membership, 6 which is for that higher receivable amount. 7 And then for cost sharing, no major cost 8 sharing changes since we don't have the 9 standardized benefits like individual. There were 10 some slight increases in deductible and moots but 11 nothing all that notable in terms of cost sharing 12 changes. 13 Any other questions before I pass to Ryan? 14 CHIEF HEARING EXAMINER SKIRPAN: I don't 15 have any. Thank you. 16 MS. YOUNG: Great. 17 All yours. 18 MR. ZIEMANN: All right. Thank you. 19 Good morning. I'm Ryan Ziemann, chief 20 financial officer of Piedmont Community Health 21 Plan, which I'll refer to generally as "PCHP." 22 PCHP is the owner of both Piedmont 23 Community Healthcare, Inc., and Piedmont Community 24 Healthcare HMO, Inc. PCHP acts as the 25 administrator for both of subsidiary and insurance</p>



<p style="text-align: right;">89</p> <p>1 organization. I'll talk a little bit about the 2 expansion rationale. 3 So, in 2021, PCHP, with the support of our 4 owner, which is Centra Health, underwent a project 5 to overhaul the technology stack upon which PCHP 6 sits. This project included the replacement of 7 our claim administrator, connecting to a new claim 8 processing platform, replacing our phone, CRM 9 eligibility, invoicing portals, and several other 10 systems. 11 That project left us with a foundation of 12 scaleable for future growth with a need to achieve 13 scale in order both to offset the investment 14 costs, as well as provide greater stability to the 15 company, having membership levels at around 10,000 16 for a health insurance company just doesn't 17 provide the predictability that we need as an 18 organization for the long term. 19 Health insurance, as you know, is a 20 business that's subject to significant volatility 21 and claims expense and has considerable overhead 22 cost. So, the best opportunity to thin those 23 overhead costs, reduce volatility, and improve the 24 predictability and profitability is by achieving 25 scale through growth.</p>	<p style="text-align: right;">91</p> <p>1 We are always disappointed when we can't 2 move new business to Piedmont, but as a community- 3 focused organization, we still feel like we've 4 successfully fulfilled our mission by helping keep 5 rates lower for Virginians. 6 In terms of the small group expansion, in 7 2023, Piedmont Community Healthcare, Inc., will be 8 reentering the small group market and doing so 9 with a PPO product. 10 In assessing the markets that PCHP serves, 11 we determined there's a strong general familiarity 12 with the PPO benefit design, as well as the desire 13 for broader national network access. The 14 structure already exists, essentially, within PCHP 15 to administer similar designed benefits through 16 our HMO POS products. 17 So, PPO offering was a natural extension 18 for those groups that are really looking for a 19 traditional PPO and also desire the security and 20 availability of national network access. 21 Any questions for myself or the rest of 22 our actuarial team? 23 CHIEF HEARING EXAMINER SKIRPAN: No, I 24 don't. Thank you. 25 MR. ZIEMANN: Thank you. I think that</p>
<p style="text-align: right;">90</p> <p>1 So, furthermore, we believe that PCHP 2 provides a unique high-touch local-based 3 community-focused approach at providing insurance 4 for our members and providers. It's also our 5 belief that there's a desire for such an approach 6 outside of the Lynchburg Areas that we've 7 traditionally served. 8 So, finally, there's many areas of 9 Virginia that have product segments with little to 10 no competition, at least historically, obviously. 11 From the earlier presentation, that's beginning to 12 change in 2023, and we're glad to be a part of 13 that. 14 Our mission statement is Piedmont exists 15 to help others by improving health in the 16 communities in which we serve. So, we know that 17 health can't be improved without the financial 18 access to healthcare. 19 The markets that were active and cross our 20 various product lines, we've seen a demonstrable 21 impact in a reduction to the cost of insurance to 22 local employers, local individuals, whether by 23 moving business to our paper or by encouraging 24 more competitive rates from our peers, some of 25 whom are on this call.</p>	<p style="text-align: right;">92</p> <p>1 concludes the Piedmont presentation. 2 CHIEF HEARING EXAMINER SKIRPAN: Okay. 3 Well, that also, I guess, concludes the 4 presentation today for everyone. 5 I want to thank the Bureau and for all the 6 participants that have been in today. 7 And I also want to provide that, you know, 8 for those listening to this, members of the 9 public, if you wish to provide written comments on 10 what you've heard today, you may do so by visiting 11 the Commission's website and following the 12 instructions on how to submit your comments. 13 With that, if there's nothing further to 14 come before us, I'll give anybody a chance, if 15 there's anyone that needs to say anything at this 16 point, this is your chance. 17 Hearing none, I thank everyone for their 18 participation, and we're adjourned. Thank you. 19 (Off the record at 11:23 a.m. ET.) 20 21 22 23 24 25</p>

Transcript of Hearing
August 10, 2022

1 CERTIFICATE OF SHORTHAND REPORTER-NOTARY PUBLIC

2 I, Victoria Lynn Wilson, the officer
3 before whom the foregoing proceedings were taken,
4 do hereby certify that the foregoing transcript is
5 a true and correct record of the proceedings; that
6 said proceedings were taken by me stenographically
7 and thereafter reduced to typewriting under my
8 direction; and that I am neither counsel for,
9 related to, nor employed by any of the parties to
10 this case and have no interest, financial or
11 otherwise, in its outcome.

12 IN WITNESS WHEREOF, I have hereunto set my
13 hand and affixed my notarial seal this 16th day of
14 August, 2022.
15 My commission expires February 3, 2024.

16
17  
18 VICTORIA LYNN WILSON
19 NOTARY PUBLIC IN AND FOR
20 THE STATE OF MARYLAND

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