Transcript of Hearing

Date: August 10, 2022
Case: INS-2022-00040

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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE
2023 ACA Rate Presentations
CASE NO.: INS-2022-00040

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

Conducted Virtually
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STATE CORPORATION COMMISSION, BUREAU OF INSURANCE, 2023 ACA Rate Presentations, conducted virtually.

Pursuant to scheduling, before Victoria Lynn Wilson, Registered Merit Reporter, Certified Realtime Reporter, E-Notary Public in and for the State of Maryland.

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C O N T E N T S

P R O C E E D I N G S

CHIEF HEARING EXAMINER SKIRPAN: Good morning. I'm Alexander Skirpan, the Chief Hearing Examiner for the Commission, and I'm here with

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members of the Bureau of Insurance to convene the 2022 Presentation of Premium Rates in connection with the health insurance coverage issued in the individual and small group markets in the Commonwealth effective January 1, 2023.

Under Virginia law, the Commission must review and approve premium rates and forms for a health benefit plan, whether it's offered on the Virginia Health Benefit Exchange, on the Federal Platform, or whether they are sold off the exchange.

The Commission must also perform plan management functions required to certify health plans for participation in the exchange, and because Virginia still uses the Federal Exchange platform, there are federal deadlines that govern our process.

First, the U.S. Department of Health and Human Services requires that the Bureau of Insurance complete its review and recommendations of health plans for certification on the Federal Platform no later than August 17, 2022.

Second, Virginia law requires insurance carriers to notify their customers of increases in annual premiums or deductibles at least 75 days

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before the proposed renewal of their individual health insurance coverage. That deadline for notifying customers this year is October 18, 2022.

To meet these deadlines, insurance companies recently filed their rates and forms for health insurance plans proposed to be offered for use in Virginia as of January 1, 2023.

Given the importance of the cost of health insurance to Virginians and small enterprises conducting business in the Commonwealth, this Commission has for at least the last decade reviewed the health insurance premium rates and associated deductibles before approving them for use in the Commonwealth.

The Commission is sensitive to the effects of health insurance premiums and deductibles on our residents and small businesses in normal times, and the impact of factors surrounding COVID-19 could intensify the effect.

Today's presentations are part of the Commission's review of the health plans offered for purchase in Virginia in the individual and small group markets.

The Commission issued an order directing presentations and instructed the Bureau of

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Insurance to coordinate presentations by insurance companies for the Commission, and the Bureau has done this.

We are going to hear from insurance carriers in the individual and small group markets in Virginia who represent a significant percentage of the projected insured in each market.

The Bureau will also participate today by providing background and presenting a summary of the recent Bureau activities in its review of the latest rate and form filings for health insurance plans.

We will hear first from Julie Blauvelt, the deputy commissioner of insurance for life and health. Then we'll hear from David Shea, the Bureau's health actuary, who will discuss the Bureau's review of recent carriers' plans for participation in Virginia's ACA marketplace.

Afterwards, the designated insurance companies will provide presentations about their rate plans and their plans and rate charges.

The insurance carriers submitted presentations and exhibits as a part of their rate filings with the Commission. Copies of those filings will become part of the record.

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For each carrier presenting today, we ask that you be prepared to speak to your rate filings for plans on and off the Virginia Exchange and for plans in the individual and small group markets, as instructed by the Bureau of Insurance.

Today's proceeding is being held virtually on Microsoft Teams. It is also being webcast to the public. Members of the public who wish to provide written comments on the filings discussed as a part of the presentations today may do so by visiting the Commission's website and following the instructions on how to submit your comments.

To today's presenters, I ask that you speak clearly into your microphone and provide your name and address, as well as who you represent, so that the court reporter can transcribe accurately all that is said during this proceeding.

When not speaking, I also ask that you mute your microphone to lessen the occurrence of interference in the presentations.

Finally, should any presenter experience technical difficulties during their presentations, I ask that you contact the ITD coordinator, Bruce Nichols at (804) 371-9337 or Bruce.Nichols@SCC.

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Virginia, spelled out, dot gov.

While I may have questions for speakers, this is neither an adversarial nor evidentiary proceeding, and there's no swearing in of witnesses or cross-examinations.

Now, are there any preliminary matters that anyone wants to bring before the Commission at this time?

Hearing none, I will follow the order of presentation provided to me and call on Julie Blauvelt, Deputy Commissioner of Insurance for Life and Health, to begin presentations.

Julie, you may begin.

MS. BLAUVELT: Thank you.

Can everyone hear me?

CHIEF HEARING EXAMINER SKIRPAN: Yes.

MS. BLAUVELT: Okay. We're going to show slides. So, good morning and welcome, everyone, to the Annual Virginia ACA Rate Presentation.

As Alexander said, I'm Julie Blauvelt, Deputy Commissioner of the Life and Health Division within the Bureau of Insurance, where we have a really wonderful, dedicated, tireless staff of individuals who work really hard to review and approve ACA final forms, rates, and qualified

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health plan applications for carriers' participation on the Virginia Health Benefits Exchange and trying to meet the time frames that the federal agencies require.

So, I want to thank all of them for their hard work on this presentation and to get us to this point in our reviews.

Today we're going to be discussing proposed ACA rates for 2023 submitted by health insurance carriers in the Virginia individual and small group health insurance markets.

Next slide, please.

Okay. You've just heard from Alexander Skirpan, the chief hearing examiner, and then I'm going to walk us through an overview of the individual and small group ACA markets through the years and what we expect for 2023 and talk a little bit about the issues most affecting the markets.

Then David Shea is going to help us look a little bit more in depth into what's driving the rates that we're seeing for 2023. He's the Bureau's health actuary.

And then, finally, we've invited a sampling of carriers who plan to participate in

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Virginia's individual and small group markets in 2023 so that we can hear from them about their rate development and issues surrounding that.

And then we'll go back to Alexander Skirpan who will close us out -- close out the presentations.

Next slide, please.

So, most individuals who buy comprehensive health insurance coverage buy it through the Health Insurance Marketplace, which, in Virginia, is also known as the Health Benefit Exchange, the Virginia Health Benefit Exchange.

Virginia, we started preparing in 2020 to operate a state-based exchange for 2021. The Virginia Health Benefit Exchange is a division of the State Corporation Commission, just like the Bureau of Insurance is a separate division of the SCC.

The Bureau of Insurance has been performing plan management for the Federal Exchange in Virginia since it began in 2014, and we continue to perform plan management for the Virginia Exchange.

Now, as part of the Bureau of Insurance's plan management duties each year, we review

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proposed rates submitted by carriers and their policy forms and marketplace information to make sure that it complies with state requirements. And since Virginia, as a state-based exchange, still uses the FederalHealthcare.gov platform, we have to make sure that the plans meet all Federal Platform requirements, as well, in our reviews.

Right now, the Virginia Exchange, as I said, still uses the Federal Platform, which is Healthcare.gov and because of this, there's been no change to how consumers buy their coverage in Virginia. The Virginia Exchange, though, does plan to move to its own platform for plan year 2024, but until then, consumers will not notice a change with purchasing coverage or in consumer assistance.

Next slide, please.

I want to spend a little bit of time this year talking about two important initiatives. One is a state initiative and one is a federal initiative that help curb the cost of health insurance coverage for consumers. Both of these initiatives only impact those with individual health insurance coverage.

So, the state initiative impact -- or

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initiative impacting individual health insurance coverage is the Commonwealth Health Reinsurance Program.

In 2021, the General Assembly directed the SCC to apply to operate a reinsurance program beginning in 2023 for up to five years, and it would use a combination of state and federal funding.

Virginia's application to establish the program was approved by federal agencies on May 18 of this year, allowing carriers to reduce their rates for 2023 in the individual market.

The way a reinsurance program works, it reduces rates because a portion of the carrier's expense of claims is paid for, in this case, by federal and state funds so that insurers don't have to price those costs into their standard premiums.

For 2023, Virginia's reinsurance program is going to pay a 70 percent coinsurance for covered individuals' annual claims that fall between 40,000 and 155,000. These are called the "payment parameters" of the program, and the SCC will establish the payment parameters for the program each year based on the expected funds

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available from the state.

So, with the payment parameters we establish for 2023, it was projected that carriers would be able to lower their premium by 15.6 percent versus what the premium would have been without reinsurance.

It's important to know that this is not a guarantee that everyone's premium rate will decrease by 15.6 percent. This is an average decrease from what the rate would have been without reinsurance.

And David Shea is going to explain a little more about the effect of this program on premiums later in his presentation, but it appears from the rate filings that the program actually acted to reduce rates from what they would have been by 19.2 percent, on average.

Again, that doesn't mean that everyone in the individual market will see a premium decrease of 19.2 percent. Subsidized individuals, those who receive federal tax credits to help with their premium payments, won't see much change in premium because, as premiums go down, so does the premium of the second lowest cost silver plan, which is what the benchmark is for the subsidies.

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And, in fact, that's how we're able to get federal funding for the program, because the federal government is paying less per individual in tax credits or APTC.

Unsubsidized individuals are the ones who benefit from the reinsurance program, and we are expecting more unsubsidized individuals to come into the individual market because of the reduced premiums.

If you want to read more about the program, you can go to our website shown here on the slide.

Next slide, please.

So, one of the federal initiatives most helping to curb the cost of individual health insurance is the American Rescue Plan or ARPA.

Increased subsidies under ARPA became fully available in 2021 and they remained in 2022. Subsidies are set to expire at the end of 2022, but federal legislation is being seriously considered to continue subsidies through 2025 at this time.

ARPA limits the portion of household income that a consumer has to pay for their health insurance premiums in the individual market. So,

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with ARPA, subsidies don't stop at the 400 percent federal poverty level that they used to. A consumer doesn't need to spend any more than 8-1/2 percent of household income on health insurance premium, and the rest can be subsidized.

Also, consumers who are at 150 percent or less of the federal poverty level can get plans for zero-dollar premium. And this is different from how it used to be, when everyone used to need to pay a portion no matter their federal poverty level.

So, we know that a concern for consumers of other than the high premium cost is high plan cost share, such as deductibles and coinsurance and co-pays. And for 2023, the maximum out-of-pocket limit is $9,100 for an individual and 18,200 for a family.

You can see that these would be very difficult for a consumer to meet year over year, and the ACA created cost share reduction plans that further limit cost shares for people in the individual market who are between 100 and 250 percent of the federal poverty level.

And ARPA increases the amount of financial assistance for people at lower income levels, as

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we talked about, who are already eligible for these reduced cost share plans under the ACA.

Under ARPA, the second lowest cost silver plan will be fully subsidized for people earning up to 150 percent of federal poverty level. As a result, low income people can now qualify for premium for these silver plans with smaller deductibles for covered health benefits.

Next slide, please.

So, at this time, our reviews of these filings are essentially complete but not yet finalized. So, the information in these slides could change but, based on the applications we received, looks like we'll continue to have 12 carriers participating in Virginia Exchange in 2023.

This number remains for a second year at the highest number of carriers that we've had on the exchange in Virginia since the exchange began in 2014.

Even though the total number of carriers participating on the exchange is the same, there are a couple changes in the carriers that plan to participate for 2023.

Bright Health, which currently

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participates on the Virginia Exchange, submitted their intentions to exit the individual market in Virginia after this year, 2022. Their service area is mainly in the Richmond and Northern Virginia Areas, and Bright Health enrollees will be notified that they'll be automatically enrolled into the most popular similar plan of another exchange carrier for 2023.

Coming into the market is an Aetna affiliated carrier, Aetna Health, Inc., an HMO. They're re-entering the exchange for 2023 following their exit in 2017.

Under Virginia law, a carrier that exits a market completely has to stay out of that market for at least five years. Aetna Health service area is going to mirror the service area of Aetna Life Insurance Company which currently provides coverage on the exchange.

Also, over the years, you'll see that we've only ever had one off-exchange carrier in the individual market, and you may notice we have an additional off-exchange carrier for 2023.

Anthem Health Plans, Anthem's PPO, filed to provide coverage solely off the exchange for 2023, and we're going to hear from Anthem later in

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the presentation, and we'll talk to them about their reasoning for entering the off-exchange individual market during their presentation.

Next slide, please.

These enrollment projections are from the individual carriers for 2023 without them having the benefit of knowing what new carriers are entering the market or who will be increasing their service area because, in Virginia, we don't make our ACA form and rate filings public until today, the day of the rate presentations.

We instituted a process a few years back for ACA form and rate submissions where those submissions are not publicly available until today. It's mostly so that when a carrier submits their rates, they're submitting their best and final offer without the knowledge of who may or may not be their competition and what the competitors' rates are in that region. And, so, we think the prospect of competition should keep the rates true.

Carriers, as well as the public, haven't been able to see any competitors' rates until today or know who's participating alongside of them in the market.

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So, these presentations also -- I'm sorry. Those projections also assume that ARPA subsidies will terminate at the end of 2022, and we asked carriers to file with that assumption back in May. So, with the ARPA subsidies are extended, we probably will see increased enrollment.

HealthKeepers is showing the highest market share. And behind them, the next four carriers project themselves to be a lot closer to each other in 2023 as far as their projected enrollment than they are now in 2022.

I think the largest changes in this slide from those 2022 projections are that Optimum Choice, which is a United HealthCare company that serves the Northern Virginia and Richmond Areas, projects to be one of the top five largest in the individual market by enrollment for 2023.

The other change I notice is that Innovation Health Plan, which is an Aetna company serving the Northern Virginia Area, was one of the top five, and by their 2022 projections, and they now expect their membership to increase from what it is currently, but the projections are significantly scaled back from what they projected in 2022.

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Again, though, this is without knowing what other carriers are participating and where, but it does somewhat match the actual market share for 2022 that we're seeing.

Next slide, please.

We're very happy about this slide. This slide is a great demonstration of the proposed increased participation by carriers on the Virginia Exchange and in the individual market.

2023 is going to be the first year since the marketplace began in Virginia that at least two carriers plan to provide exchange coverage in every city and every county of Virginia. And these will be two unaffiliated carriers in every city and every county.

Currently, in this year, 2022, there is about 20 percent of the state that still only has one choice of carrier on the exchange.

I think as -- I think something behind this is that both Optima Health Plan and Piedmont Community Healthcare HMO submitted significant expansions for their service area for 2023, and Optima Health Plan actually plans to cover almost the entire state except for a handful of counties and cities.

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The Northern Virginia and Richmond Areas, as you can see, are especially well-represented and we show five-plus carriers there but, actually, it's in the neighborhood of about eight to nine carriers serving those areas.

Carriers right now can't voluntarily change their service area at this point, so the projection of service area to be covered would only change if a carrier exits the exchange fully or if they're not approved to participate on the exchange or in a particular area.

Next slide, please.

Another success story is the premium amounts on this slide, and these amounts represent the average total premium for the plans that enrollees actually selected or are projected to select.

As we'll see in a later slide, in most cases, the premium amounts shown here are not the actual cost to the enrollee in the individual market because of the federal subsidies that are available.

We'll look at some information about the premium that most individuals actually pay in a later slide.

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So, the projected 2023 premium number is, thanks to the Virginia's reinsurance program that takes effect in 2023, the average rate per member per month is projected to be at its lowest since 2017.

Carriers are also estimating the highest enrollment in the last five years for 2023, and these estimated enrollment numbers were assuming lower premiums for the reinsurance program, of course, but the projected enrollment also assumed that ARPA subsidies would end for 2023, which now it appears probably will be unlikely.

As we look on the dip in enrollment in 2019, we are reminded that effective January 1 of 2019, Virginia did expand Medicaid to adults up to 138 percent federal poverty level. So, over 2019 and 2020, we think about 70,000 individuals newly eligible for Medicaid left the commercial individual market.

You'll also note, of course, that premiums were at their highest in 2019. And enrollment hit a low point in 2020, but in 2021 and '22, ARPA subsidies took effect and enrollment, you can see, starts to increase.

At some point, this market will see a

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large influx of people coming from Medicaid back to the commercial market. This is because during the COVID-19 public health emergency, states were required to maintain enrollment of almost all Medicaid enrollees and not terminate their enrollment.
So, when this public health emergency expires, state Medicaid offices will have to have about a year to return to normal operations.
Given that states will have about a year to unwind those no longer eligible for Medicaid and because the public health emergency continues to be extended, we really didn't see carriers making any adjustments to rates as a result of the expected change.
And the current public health emergency is set to end October 13 of this year, but HHS has said it will provide 60 days' notice if it doesn't intend to extend the public health emergency. So, that means that if we don't hear anything pretty much by the end of this week, that should signal that the public health emergency will again be extended.
And we would definitely be remiss to talk about enrollment growth and not acknowledge the

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great work of Virginia's navigators, who are Enroll Virginia and Boat People SOS, and they work very hard to inform consumers of the existence of subsidies for health insurance and to help enroll individuals on the exchange.
Their work and their increased presence in Virginia has been made possible through increased grants that the Virginia, as a state-based exchange, has been able to offer since 2020.
Next slide, please.
So, enrollment in the small group market is projected by carriers to almost exactly match the size of the individual market. The premium rate in this market, however, tells a very different story.
The average premium for the plan selected is higher this year and as projected for 2023. Even though the percentage change in premium from 2022 to projected '23 is along the same lines as it's been trending for the last few years, it will be the largest percentage increase in average premium per member per month in at least the last five years in the small group market.
Even so, enrollment is expected to remain steady at what it's been the past few years, and

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we'll take a look at what might be behind the larger increase during the carrier presentations portion. We've asked a couple carriers in the small group market to try to address these trends.
Also, the Bureau of Insurance plans to use actuarial consultants for a couple of projects, using funds through a federal grant to increase market stabilization and flexibility in the small group market.
The Bureau plans to do a scan of the small group market to get a better picture of the makeup of who's in the market to be able to assess any potential initiatives that the General Assembly may want to consider.
Also, we plan to create some educational materials that highlight the existence of some recent federal tax advantage tools to help small businesses afford to provide health benefits.
Next slide, please.
All right. So, switching back to the individual market, I wanted to spend some time looking at what the cost of insurance is for most individuals on the Exchange in Virginia.
On an earlier slide, we saw that the average premium as of March 1st of this year was

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$566. And that's in the ballpark of the average premium shown on this slide, using data from the open enrollment period for 2022, but as you can see by this chart, most people don't pay that full premium.
In fact, about a third of individuals on the Exchange pay a monthly premium that is $10 or less. And around 82 to 92 percent of individuals receive subsidies in the form of advanced premium tax credits or APTC. That reduces their monthly premium, on average, by 453 to $521, so that the actual average premium paid by people who receive tax credits was 67 to $91 per month.
Next slide, please.
In this slide, we're taking a look at the types of enrollment that make up the individual market for those who hold comprehensive health insurance coverage and how the two initiatives that we discussed before, the state reinsurance program and federal ARPA, are expected to change the makeup of the individual market.
You might notice that the presence or absence of the initiatives creates big changes in the subsidized versus unsubsidized portions of these bars.

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These numbers are based on modeling that Oliver Wyman did for the Bureau in the fall of 2021. And in the bar on the left, they estimated that during 2022, total enrollment in the individual market will be right at 300,000, which seems right on point based on enrollment figures carriers filed with us.

You'll see that the majority of the enrollment is orange, representing subsidized enrollment through the Exchange.

The next three bars all model how enrollment in the individual market could be expected to change in 2023 depending on what occurs with ARPA and state reinsurance.

So, as we know, we will have a state reinsurance program that did reduce premiums for 2023 by almost 20 percent from what they would have been without reinsurance for the unsubsidized individuals.

So, you can see the dramatic growth in the blue unsubsidized portion of the bar in the second and third bars, and these estimates represent how the subsidized orange portion shrinks without ARPA and the unsubsidized blue portion will grow without ARPA, but the subsidized portion moving to

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the unsubsidized if ARPA is not extended.

We expect that most individuals who have subsidized insurance in 2022 would have remained in the market for at least another year even without reinsurance. However, with reinsurance, the total number of insureds will grow to even more in 2023 than in 2022 with about 16,000 unsubsidized individuals expected to come into the market as the price point that resulted from our reinsurance program that the payment parameters that were set.

Also, you can see how the orange subsidized market is unaffected by our reinsurance program in the middle two bars but drastically affected when ARPA subsidies are available, which are the outside two bars.

And the last bar, the bar on the all the way right, is a scenario where we have both ARPA and reinsurance, and that brings up the most total enrollment in the individual market and is also the most likely scenario for 2023.

Next slide, please.

We spent a lot of time discussing the individual market and how it seems to be on a good track with increasing competition, the success

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story of all areas of Virginia having a choice in carriers on the exchange. We see decreasing premium rates for the unsubsidized population through the reinsurance program and ARPA subsidies increasing subsidized enrollment.

With the continued extension of the public health emergency, we didn't see carriers adjusting their rates for an expected Medicaid unwinding for 2023.

In the carrier presentation, we hope to hear from some small group carriers who might be able to discuss what changes they're seeing in the small group market. Also, the Bureau of Insurance plans to use actuarial consultants to do a couple of projects using funds through a federal grant to increase market stabilization and flexibility in the small group market.

So, are there any questions on this portion of the presentation from Alexander before I turn it over to David Shea, the Bureau's health actuary, to look at a deeper dive of the ACA rates?

CHIEF HEARING EXAMINER SKIRPAN: I did have a question. You talked a few times about the legislation extending things. Can you go through

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just how that's worked into the planning or into how you're dealing with that, if that's appropriate?

MS. BLAUVELT: David is going to get into that in his slides.

CHIEF HEARING EXAMINER SKIRPAN: Okay. Well, then I'll just wait for him.

MS. BLAUVELT: Okay.

CHIEF HEARING EXAMINER SKIRPAN: Okay. Thank you.

MS. BLAUVELT: Sure. Anything else?

CHIEF HEARING EXAMINER SKIRPAN: That's it.

MS. BLAUVELT: Okay. Come back to me if David doesn't answer your question.

CHIEF HEARING EXAMINER SKIRPAN: Okay.

MS. BLAUVELT: All right. Thank you. I'm going to turn it over to David Shea now.

CHIEF HEARING EXAMINER SKIRPAN: Thank you.

MR. SHEA: All right. Thank you, Julie.

And good morning, everybody.

We can go onto the next slide, please.

Every year the federal government releases what's called the "Notice of Benefit and Payment

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Parameters," and these usually include quite a few changes, not necessarily directly affecting rate filings.

This year, in particular, there were a couple. They -- all carriers are now required to have standardized plan offerings. For every network type, metal level, and service area where they offer nonstandardized plans, they've got to come up with two sets of standardized plans for every metal level, bronze equivalent, and silver CSR variation.

So, what this means is a local HMO that's in one service area offering a silver and a bronze plan has to offer two more silver and two more bronze plans and six more silver CSR variations to fulfill this requirement. And, obviously, there are several sets of standardized plans across the country based on specific state laws with respect to designs of those plans.

The jury is still out as to whether these standardized plans will become popular enough and have enough substantial enrollment, but we shall see.

These two plans, in fact, will be highlighted on Healthcare.gov, so consumers' eyes

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will be directed towards these in some way.

The other sort of behind-the-curtain change is changes in the de minimis ranges of the actuarial value. So, the actuarial value is the platinum, gold, silver, and bronze percentages that represent the generosity, the relative generosity, of plans.

When the ACA came into existence, for example, the silver plan has an actuarial value of 70 percent, and when the companies run these plans to figure out exactly what those values are, that 70 percent could be 2 percent higher or 2 percent lower and still be certified as a silver plan.

Over time, those ranges expanded for several reasons, and, in fact, a silver plan could go from a 70 percent plan all the way down to 66. So, the ranges were not exactly symmetrical.

Bottom line is they, more or less, returned to the plus or minus two around each one. However, for silver QHPs, it's plus two and zero.

What this does, in effect, is the actuarial value calculator where the plan values are determined, this, more or less, forces silver QHP plans to be a little bit richer than they would otherwise. So, that plus two minus zero,

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what this means is you can't have a silver plan that has a 68 percent actuarial value. It has to have 70 to 72.

This increases the generosity of silver plans and, therefore, will increase the amount of premium tax credits available to consumers who enroll in those plans.

Next slide.

So, the headline in Virginia this year for the ACA market is our successful 1332 waiver application which allowed us to introduce a reinsurance program. Julie mentioned quite a few of those details earlier.

What we asked carriers to do to support these adjustments is to send us what's called a "claim probability distribution." What that is is a listing of claims by dollar amount, so how many people had claims between 0 and $100, how many had claims between 100 and 200, so forth and so on.

And carriers can construct these tables either from their own claims data or from other data from consulting firms or so forth and so on. We asked them to submit the claim probability distribution table that supported their reinsurance adjustment.

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And the results of this, carriers adjust their rates for reinsurance anywhere from about a 10 percent decrease to a 33 percent decrease. This was based on individual carrier experience.

And as Julie mentioned, the reinsurance program resulted in rates that are 19 percent lower than they otherwise would have been.

So, what they would have been in the individual market in Virginia this year -- the average rate increase was about 2 percent prior to reinsurance. After reinsurance, it's about a minus 17 percent. So, that's a 19 percent drop in rates because of the existence of the reinsurance program.

And Julie mentioned earlier what the average rate in the market will be, the lowest it's been in probably forever, and those are the average rates that -- it would have been about $600 without the reinsurance program. It's a little under $500 with the program.

Next slide, please.

We took a look in both markets to try to see what were the main premium drivers. Now, the winner by far in the individual market was the reinsurance program.

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And other than that, in the individual market, carriers indicated that their worsening experience, claims coming in a little bit higher than they thought they would, added a bit to that rate, and an average trend of about 5.6 was another driver in the individual market.

When we get down to the small group market, an average rate increase of 3.1 percent, a sort of similar to historical averages, the main driver there was a trend increase of about 7 percent.

The small group market also experienced some morbidity changes. What that means is the health status of the populations that the carriers are insuring are changing and, so, that drove about a 4 percent. And their experience was at least a little better than the individual sign. That drove about 2 percent.

There were lots of little -- obviously, when you look at these numbers, you're, like, "Well, how do you get to 3.1?" There were a lot of little negatives that really would take up the whole page that caused the average rate for the small group to be about 3.1 percent.

Next slide, please.

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This is a slide that we have been including in our presentations each year to see how pricing trends for carriers compare. And we take a look at a little bit more detail than just an overall trend number.

What you see here are changes in the cost of services and changes in the utilization of services by inpatient, outpatient, physician, and prescription drugs. These are the trends that the presenting carriers today used in their pricing, and they are very consistent and within a historical range of trends over the last few years.

It's been quite a while since we've seen pricing trends approach double digits.

And, again, you see in the individual market, Kaiser's trends are lower. They've got a different business model, but that's consistent with their historical trends. And in HealthKeepers and Piedmont, those are certainly within the range of historical trends.

Next slide, please.

Julie had mentioned how the experience has changed over time. This shows the loss ratio experience of the individual and small group

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markets. And as you see over the last three years, the actuals and expecteds are pretty much stabilizing around in the low eighties.

In Virginia, the minimum loss ratio requirement in the individual and small group market is 75 percent. And the federal loss ratio, medical loss ratio, is 80 percent.

The difference is, in Virginia, the loss ratio minimum is for carrier's projected experience. On the federal level, the loss ratio applies to actual experience. So, carriers have to look back and see were they above or below the federal 80 percent. And if they were below the 80 percent, they're required to refund premiums to their consumers.

But you can see here that it doesn't appear that, at least on average, carriers aren't expecting to refund premiums, at least on the federal level.

Next slide, please.

This is somewhat of a success story. Even without the reinsurance adjustment for 2023, the rate change would have been 2 percent. So, that's pretty low on a historical basis, and it's been negative for the last few years. So, that is

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certainly beneficial to consumers and is indicative of the increased competition in the Virginia individual market.

Next slide, please.

So, some key takeaways from this information is 2023 rate changes are consistent with the historical ones for both individual and small group. For individual, even prior to reinsurance, the rate change is consistent with historical ones. Pricing changes are also within historical ranges.

And Julie mentioned this, and I'll just drive it home again. Year-over-year average rate decreases, increasing membership and increasing competition, it points to an individual market that is thriving, really, in Virginia, and we hope that continues into the future.

I've got a couple more slides to cover. Next slide, please, before we turn it over to our presenting companies, and there they are.

The companies that are going to be presenting today are Tim Connell with Anthem and HealthKeepers, James Chu with Kaiser, and Katie -- I've forgotten your name. Am I getting that right? -- and Lydia, possibly, with Piedmont.

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And they'll just be tossing off the presentations to each other when we get to them.

I've got one more slide, and then I'll turn it over to Tim. Next slide, please.

These are some questions that we provided to the presenting carriers prior to the presentations today. I'm not going to read through all of these, but the first stop point we'd like all of them to address is how did COVID-19 impact their experience and projections. And you can see we've got some questions for individual carriers. We've also got some specific carrier questions.

One thing I want to wrap up with respect to ARPA before we turn it over to the carriers, when -- we had directed -- at the beginning of the ACA pricing season, we had directed our carriers to assume that ARPA would expire at the end of 2022, which was where the political winds were blowing at the time. There didn't seem to be any appetite to extend the subsidies.

Well, roll forward three months and things have somewhat dramatically changed. And along these lines, we felt like we really should give carriers an opportunity to adjust their rates, if

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they so desire, now that it is fairly certain ARPA subsidies will be extended at least for the next three years.

We had one carrier accept our offer to request a resubmission. They will be filing no later than the end of the day today. They have previewed their changes to us. No guarantee of approval, but we did allow carriers -- and, again, we had one carrier take us up on that offer. So, we said, you know, if ARPA seems like it's going to be a certainty, this will be your opportunity to adjust your rate filing.

Now, I have a couple of other questions for carriers that we'd like for them to address in their presentation beyond the ones that are shown on the screen.

If you could just give us a general sense of, over time, how your cost-sharing elements have changed, how much, you know, deductibles have gone up, generally; co-pays usually don't change too much; and have you -- are you moving toward less rich coinsurance and out-of-pocket maximums. Just give us a general sense of how your plan offerings have been evolving over time.

And, in particular, when you get to

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discussing the elements that impacted your rate change, we noticed in a few cases that reinsurance was somewhat of a drive -- I'm sorry -- risk adjustment reinsurance was certainly a driver. Risk adjustment was somewhat of a driver in some of the rate changes, and we would like for you to go into a little bit more detail about what's driving your risk adjustment change, either positive or negative, and what that means for your book of business.

So, with that, are there any questions?

Alexander, in particular, did I answer yours?

CHIEF HEARING EXAMINER SKIRPAN: Yes, I think so. You covered it, as to what you're doing. It does raise questions about those carriers who didn't want to change their rates given that there's going to be more subsidy but --

MR. SHEA: Well, let me go into a little bit of detail about what type of impact ARPA has on a carrier's book of business.

Generally speaking, those subsidies, as we've seen, serve to increase enrollment. Now, if a carrier assumes that, "Oh, now that ARPA is coming in, I'm going to get 2,000 more members,

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but it's really not going to change the profile of my book of business," there's really no reason for a carrier to refile because the rates won't change. They'll simply have more members.

The things that a rate will -- that will cause a rate to change, particularly if you're bringing in a different group of people than you have had before, it may change the health status of your population compared to the state.

So, what we ask carriers to do is, if you're going to request a resubmission, we'd like for you to tell us how much it's going to impact enrollment and how much it's going to impact the morbidity of either your population or the population as a whole and how that change will affect rates.

Again, increasing membership without a change in rates at all is probably not a real good reason for a carrier to refile just to change an enrollment number. We were more interested in things that would impact rates.

Most carriers also indicated early on that, while they were pretty sure ARPA had increased their membership, they really had no way of telling who came to them because of ARPA. And,

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so, they really had no way of knowing the health status of that population compared to who they had.

So, the vast majority of carriers simply said, "I really didn't have a good handle on what those people looked like before so, I know that you're offering me to refile, I'm really not going to be able to make a good assessment on that." And, so -- but we did have one carrier say that they could, so they're going to resubmit again by the end of the day today.

Does that help?

CHIEF HEARING EXAMINER SKIRPAN: That was very helpful. Thank you.

MR. SHEA: Okay. Well, thank you.

Are there any other questions?

And if not, I am going to turn this over to Anthem and HealthKeepers and Tim Connell to do our first carrier presentation.

Tim.

MR. CONNELL: Hi. Good morning. Can you hear me?

MR. SHEA: Yes.

CHIEF HEARING EXAMINER SKIRPAN: Yes. Good morning.

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MR. CONNELL: Good morning. My name is Tim Connell. I'm a director and actuary with Elevance Health. And if that name sounds unfamiliar, that's the new name of our holding company, and I'll refer in the presentations to us as "Anthem," what we're known here as in the local markets. Our address is 2015 Staples Mill Road, Richmond, Virginia.

And I'll start with just kind of some general remarks before getting into some of the specific slides. We'll probably come back to these a little bit, too. And I think one of these is kind of the questions that were in the lead-up asking about some of our rate changes and how they've moved up a little bit.

I did want to kind of emphasize that we are seeing more cost pressures in recent times, and we expect that some of this in 2021, with, you know, the COVID pandemic initially had a great suppression on claim experience, and we knew that was temporary. We knew things were going to kind of return after that.

And probably later in 2020, they started to return. I think -- I think we saw quite a rebound in 2021, even a higher extent than what we

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expected. And I think we're expecting that -- you know, I would say we expect that to continue with the inflationary pressures that are out there. I think everyone is pretty well aware of how inflation is running.

We see that pretty strongly correlated to the medical and pharmacy field. Probably can understand that, you know, the pandemic has put a strain on providers. Right now we're hearing quite a bit of pressure on that side, as far as provider reimbursement.

So, we think this inflation pressure might be part of what we're seeing in our experience and, also, it doesn't look like it's going to abate any time soon. And, so, that's kind of an ongoing effect that we're trying to reflect in the overall pricing.

I also understand that, even on the Medicaid side, I think there's some changes maybe happening on the reimbursement there. I heard that statement yesterday, but I'm not quite as familiar with that. So, just the general environment right now, I think, is we're seeing this inflationary pressure.

And I did want to also -- I'll kind of

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play back what Mr. Shea mentioned earlier, too, that it's going to be a part of our -- part of my comments on some of these, especially on the slide that shows specific plans.

It's somewhat of an obscure concept, this idea of the actuarial value, the AV, de minimis changes that were mentioned. And we see it -- I think I'll just use an example of our individual silver plans. There was an actuarial value that used to be from 66 to 72, which allowed for some -- a little wider variation in benefits. And instead of going down to 66, the minimum now is 70 percent.

So, what that did was, as David mentioned, that's going to enrich some of the benefits on our plans, really by CMS guidance. That's what they wanted us to do. But that will actually increase the premium for those plans. Those plans that were maybe below the de minimis, the new de minimus range, now have to move up to meet that new minimum range for benefits.

I believe CMS did this to make plans more comparables because silver plans could look pretty different from the bottom and the top of that range, as far as benefits go. And, so, that's

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something that's kind of influencing, you know, some of these plans' specific rates.

I'll probably draw on that comment again, where we had to -- where we had been lower on the range, we had to move those plans up to meet the new range, which they gave us the guidance on that pretty late, which that will probably be a comment I make again when we talk about ARPA.

So, that's one of my general comments. And, of course, when we go through the slides, I think reinsurance, as we mentioned, is going to be a pretty beg -- you know, probably the number jumps off the page a little bit more than the other impacts. So, we'll probably talk about that and get into that a little bit, too.

All right. So, now, this is our first slide. It's a new offering. We're making an individual EPO plan available, off-exchange only. And, so, this was a bit of a new -- you know, we made this new offering thinking of -- we have some business that's still -- under the old ACA rules, it's called a "grandfather plan." And these are people that have been on the plans for, I think, about 12 years now, at least, some longer.

And these grandfather plans are a block of

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business that people are not out to join this kind of plan now, but if they have those plans and they want to keep them, you know, the ACA has allowed that if carriers can still offer them, they can keep these grandfathered plans.

What we see over time, though, is people leave these plans over time. The block has been shrinking. And we think that this EPO offering is a way that might attract some of those members to -- you know, this network being very similar to the network offered on these grandfather plans, it might offer a path for these members to leave and also get an ACA product that might look and feel a little similar to the ones they have today. So, we're kind of thinking about that grandfather population.

Sometimes as plans -- you know, as the number of members in a product get very small, you know, we have to make a decision to say that maybe we can't sustain this product anymore because the membership is so slow. So, we've had a few plans like that over the years that we've closed. And having this product available might be an offering that could help attract those members to stay on an Anthem plan.

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So, that was kind of our rationale for entering here. There is some risk, I think, you know, the fact that it's a little different network, it's a little broader network, than typically carriers offer in this market. You know, we're trying this off-exchange only, but we want to kind of see how that working -- you know, how that offering works with those customers and any potential take-up that we might get.

All right. So, I'm kind of looking at my notes here. So, I'll probably talk more about some of the other specific questions as we get into some of the other slides. So, could we page down, please.

And these show our area factors and which these are, of course, new offerings, so you can't see current and prior, but these are new area factors, which align closer to our -- actually our PPO network, which is very similar to this one in our small group market.

You can page down again.

And, so, here we have our Anthem small group plans, and this is our PPO offering, and I think there might be a HealthKeepers slide below. Probably most of my comments are going to apply to

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both, so I'll just kind of try to mention most of them here, and we might skim past that slide when that comes up.

So, I think what we're seeing in this market is a more of a return to the kind of premium trends we might have seen a few years ago. I think we had a pretty good run of low increases for a while, but I think one we've stopped and seen while those trends have really accelerated in 2021, and with the inflation, you know, it seems pretty lucky that we expect those to continue going forward.

And, so, you know, we're not talking real high increases, I think, compared to some we've seen historically, but back from, you know, relatively flat rate changes for a couple of years, to maybe in the, you know, 7 to 9 percent range. And I think what we have here is the 9 percent for the first quarter of 2023.

And getting into some of the comments -- some of the numbers below, I think one thing I mentioned was the benefit changes. I believe those ones that have both our most popular and our maximum change were influenced by that minimum AV change that had to be made. So, that's why

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there's slight increase there.
I will say the experience and model changes, the other changes, generally, we saw a slightly unfavorable experience in the market. So, I think we probably, you know, are in that 1 percent range unfavorable, and it just might have varied a little bit between, you know, that and the other -- we reevaluate the plan through an updated -- what we call a "relativity model" between plans.
So, sometimes there's some fluctuation in that modeling and how that comes out, but most of that is probably -- I would relate to experience.
I did want to comment, too, that sometimes it's hard to put a specific number on one category like this because I think a lot of these components that you see on the page here interact with one another.
And I'll mention an example that we tend to look at this internally is maybe looking at experience along with risk adjustment together because, where our experience was higher and we saw a higher claim experience, we actually did get a -- with the CMS publishing risk adjustment results for 2021, we actually did observe that our

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risk adjustment, our position in the market, improved.
That means that we are more of a receiver from the risk adjustment program. That does mean that we have usually higher risk people in our population. So, while we saw the claims that went along with that, we did get some -- you know, we got some, looks like, appropriate compensation from that from the risk adjustment program.
So, this will be a comment I will return to in individual, as well, but we -- so, when we look at it together, the experience with the favorable risk adjustment, you know, we were kind of tracking close to -- you know, close to expected results in our experience but, again, we kind of think those, you know, with the trends going up where they are, that there's still that risk in the market.
I think I might just touch on -- I think I touched on one of David's last questions about the risk adjustment. So, we really base this change -- you know, we had been monitoring our risk adjustment position from prior years. We had been a receiver in the market in small group, and I think when the 2021 results came through, we

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were just -- that's when we found out that we were a little bit more of a receiver than we had expected to be.
So, that was a change we decided to make with our refiled rates. It wasn't in our initial rates, but it came through on the refile.
So, we made that assumption that we think that our risk adjustment position will remain relatively stable over time.
I think David also asked about plan designs and our approach to that. I think we take a slightly different approach in the individual and small group markets. I think with our small group employer population, we might leave plans relatively stable over time.
I think our group customers like to have the same kind of benefits from year to year, if we can offer that. So, we tend not to make drastic changes, you know, for multiple plans in a given year.
One thing we will look at is that out-of-pocket number. If there's an opportunity to look like the out-of-pocket can move up -- you know, every year the CMS gives us guidance on what the maximum out-of-pocket can be, so we will

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sometimes look at those plans and say, "Well, you know, maybe to get a little lower price, the customers might be willing to take an out-of-pocket that's a little bit higher."
But you can see here that these out-of-pockets are pretty well below the minimum. So, we do see a lot of customers that, you know, maybe take plans in that gold range. Those are a pretty popular range. And, actually, our most popular is a platinum in this case. So, our customers still kind of like the benefits slightly on the richer end.
We tend not to change them, unless, you know, like the AV range had to be changed this year, or if, you know, sometimes we'll relook at plans if we think it's appropriate and we don't think there will be must disruption.
In the individual market, which I don't want to jump too far ahead, but we might take a slightly different approach there with benefits, where I feel like the market there is so cost-sensitive, price-sensitive, that we want to make sure we're competing as best we can, and probably there's a more regular look at, you know, keeping the plan that's going to be attractive and staying

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within the AV range but also might, if there are changes that increase the cost share from year to year, we tend to take those, one, thinking that the customers, they prefer the lower price, if they can get it, and, also, when, as Ms. Blauvelt mentioned earlier, many of these members are on a cost-sharing plan. They get a cost-sharing reduction with their benefits.

So, when we might, say, raise a cost share on a silver plan, those would be impacting only the members that don't get any cost-sharing reduction. Those that get the cost-sharing reduction would still see a relatively small cost share that they would have to meet.

So, I think it's a slightly different approach for each market, but I think just because the individual is so price-sensitive, that's why we -- that's kind of how our thinking is there.

Any questions so far?

No.

I'll get into a little bit to COVID-19, which was a question. So, I think we underestimated COVID-19, how long the duration would last. And our approach was sort of a minimal approach, I guess you could say, which we

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said -- and we tend to think of COVID-19 kind of together with any, perhaps, you know, suppressed or delayed utilization for other services.

And, so, if a patient -- if hospitals are filling up with their beds for COVID patients, it means likely they're not available if a patient with maybe something else or to go in for another service in the hospital, that the COVID still might be blocking other potential utilization.

So, we kind of look at that together. And, so, we really left the assumption of whatever -- we took the COVID that was in the experience and we said, "Let's just project that number going forward."

One thinking was we don't know how long this pandemic will last. You know, there will be new drug treatments. There will be new cases, perhaps new variants. Even when we submitted the first time, it looked like COVID was, you know, falling off, and then, sure enough, a new wave kind of hit again in the summer.

And, so, yeah, I think there's the belief that this could still continue and we have new variants into the next year. There will still be -- I think there are added costs to the system

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no matter what, with vaccines, with boosters being available, new treatments there.

And then the other side is that we -- even if there's a chance, which we think, you know, may happen, that the COVID experience will drop off in the future period, we think there's probably some suppressed utilization from other services that would cut -- would fill in.

That's a bit of an unknown and it's a bit of a risk out of there, that people that are delaying services, you know, how serious do their conditions get, are there treatments that are missed or that could have headed off a more severe episode.

So, that's one thing that's a bit of a risk, and we don't build in any -- as David Shea referred to, the morbidity increase, we didn't build morbidity for COVID-19, but we do see some risk there that people could be coming back sicker or people could have long COVID that might hit down the road and more severe episodes or a sicker population could be the result.

Anything questions on COVID-19?

All right.

CHIEF HEARING EXAMINER SKIRPAN: No, I

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don't think so.

MR. CONNELL: All right. Next slide, please.

And I'm having a hard time reading these on the screen, but they're relatively unchanged on our age and area factors here.

So, you can go to the next page, please.

So, HealthKeepers Individual. So, I think some of the comments I made earlier will come back here. Like, our most popular plan is the silver plan that had been on the low end of the actuarial value scale from 2022, and that new de minimis range is causing us to enrich their benefits.

So, if you look at the deductible, for example, the out-of-pocket actually did go up with the allowable maximum, but we did reduce the deductible and the coinsurance, which have a bigger impact in bringing the premiums up. So, that's a theme that we'll see throughout, that some of these plans that had that de minimus change are seeing a little bit of benefit increase for that.

But the number that probably jumps off the page is the reinsurance and the 18.3 reduction for that. So, it is a good timing for this program.

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We were looking like, similar to small group, looking at kind of a -- maybe a normal trend or, you know, high, single-digit kind of increase prior to that, and the reinsurance is definitely -- definitely helping bring the rate down.

So, this -- as we saw earlier, that's, I think, the fourth year in a row of decreases that Anthem has also had but I think the whole market has seen.

I'll also mention ARPA quickly. Where we reflected ARPA in the line called "Other Morbidity," so that's about a 1.2 percent increase, and that's one that, as we saw ARPA come on and more people being eligible for subsidy, our assumption was that those would be relatively healthier people.

And we use the morbidity assumption to more reflect what we think is going to happen marketwide. There is an interaction between risk adjustment and morbidity, that if you get healthier people but your competitors do not, you might see a decrease in morbidity but you might see an increase in risk adjustment.

So, really, our increase in morbidity, we

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did not have any offsetting adjustment in risk adjustment. The risk adjustment of minus 3.4 was really due, similar to small group, of what we saw with the results of the CMS marketwide results for 2021.

But we did build in the 1.2 for ARPA, with the assumption that -- it was also a very similar assumption we made when ARPA came in, when the ARPA subsidies began. We thought we'd see a mix of healthier people coming in, worth about that 1 percent, and with the ARPA subsidies that had to expire, we had put that 1 percent back in, back into the premiums.

So, yeah, we also elected -- it was kind of -- this is where we love the federal government's timing on things. They've done this before with the Health Insurance Acts and other things that come very late or too late for us, but, yes, we did see the message that there was an opportunity to change.

I think, given some of the risks out there in the market, and Ms. Blauvelt mentioned one of them that's kind of on our minds, when the public health emergency is declared over, there is -- what we're calling internally is we're calling

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this Medicaid redeterminations will happen. People that had been staying on Medicaid for an extended time will maybe not be eligible anymore. They may look to the individual market to continue their insurance.

And usually when there kind of a process happens, we would expect some anti-selection to happen there, too.

We did not build anything in for that explicitly, one reason being we're not sure when the public health emergency will be over and that's -- I don't think anyone wants to take a guess at when that will be.

But it is a risk out there, that if it happens, you know, within six months or so, there will be a time next year where that Medicaid population will be looking at our -- you know, looking at the individual products, and I think that does present some risk of morbidity change that we had not yet reflected.

So, I think having some other risks out there was one consideration we made to not elect a change. I think we also were thinking is this bill, you know, ready to pass or for sure to pass. I think most people agree that it probably is, but

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just having that pass into law was one consideration, too.

I'm thinking. All right. I think that's -- those are most of my comments. And I will mention just quickly here the risk adjustment that David Shea had asked about before.

This was a result that we did change a little more significantly than we thought from a risk adjustment perspective. We were expecting to be a payor in this market, which we had been in previous years, and when we got the results at the end of June, we're actually very close to the market average, just slightly above market average, on the morbidity measured by risk adjustment.

So, that means, instead of paying at the risk adjustment, we were, you know, not -- you know, maybe a slight -- just a very slight receiver. So, we did change that assumption with the idea that we'd expect that market position to remain relatively stable going forward.

That was another negative that we brought into the race here.

Next slide, please.

I think that might be it. These are our

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area factors and age factors.
Next slide.
And I think I covered most of our comments for small group. We combine these two books of business when we do our analysis for -- we combine the two legal entities together. And, so, typically, we tend to have the rate increases be very close to one another. And I think most of the comments I said earlier on small group would apply to this, as well.
All right. I think that's it.
Next -- you can just slide through the next couple slides. I think that probably will wrap up mine.
All right. Any other questions?
CHIEF HEARING EXAMINER SKIRPAN: No, I don't have any. I think you've covered everything well. Thank you.
MR. CONNELL: All right. Thank you.
CHIEF HEARING EXAMINER SKIRPAN: And, I guess, go ahead.
MR. CHU: Okay. Hey, everyone. My name is James Chu. I'm a director within Actuarial Services at Kaiser, and I'm the certifying actuary for 2023 ACA Virginia rates, and our company

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address is 2001 -- 2101 East Jefferson Street, Rockville, Maryland, 20852.
I'll address some of the questions that we had on the top. So, the first one was around COVID. So, in 2021, COVID was around 5 to 6 percent of our costs. So, this reflects both the COVID treatment costs, as well as the cost for COVID testing and COVID vaccination.
I think, like Tim was saying before, it's really hard to say how we think COVID will change going from 2021 to 2023. I think we can all expect that COVID is largely here to stay. A lot of that 5 percent of the cost will be around, but we can probably expect some sort of modest decrease in that, but we wouldn't expect that to have a huge impact on trend.
On the flip side, COVID, while in 2021 there was a return on a lot of the deferred care that was put off in 2020. There was probably still some sort of care suppression in 2021, and we expect, as that comes back, that will also put some upward pressure on rates going into 2023.
There was also a question about ARPA subsidies and reinsurance for the individual market. So, like Julie mentioned, based off of

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guidance, we assume that ARPA subsidies wouldn't be extended.
Between ARPA subsidies not being extended, which would lower enrollment expectations for 2023, and reinsurance implementation, which would increase enrollment expectations for 2023, we thought that they would largely trade off. So, we expect the market size to be roughly constant going from 2022 to 2023.
However, as best as we can -- sorry.
Subsidies were extended through 2025, ARPA subsidies were, and we estimate -- again, it's really hard to identify who exactly is joining because of ARPA subsidies versus just joining. We estimated that ARPA subsidies would increase enrollment by around 10 to 15 percent. I think that's slightly lower than what Oliver Wyman was expecting.
Even if the market is growing, it's hard to understand the risk of the specific numbers that are staying on because of ARPA subsidies. We probably would expect them to be slightly lower risk, given that they are on the margin of purchasing coverage, but with the ARPA subsidy extension, we think the market risk might have a

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modest decrease of 0 to 3 percent, and should that happen, that would probably offset Kaiser's negative margin within the individual market.
Any questions about those three topics?
CHIEF HEARING EXAMINER SKIRPAN: I don't have any. Thank you.
MR. CHU: Great. Let's talk about the individual market.
So, Kaiser's rate increase is minus 12.3. So, the biggest driver in that, again, is reinsurance.
To estimate the impact of reinsurance, we utilized the claims probability distribution that David described before. The impact of the reinsurance receipts themselves are probably only going to be 11 percent for Kaiser.
That's a combination of a lot of things. It's a little bit of Kaiser's risk provides, a little bit of the fact that the data system used to calculate those reinsurance payments does not fully capture Kaiser's cost structure the way that we deliver care and, also, driven by the way that Kaiser manages costs. But, yeah, you can see that reinsurance line item as at minus 11 percent there.

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The other morbidity line, the minus 6.2, that reflects the lower morbidity going from 2020 to 20 -- that number reflects -- sorry. That reflects our morbidity assumptions going from 2021 to 2023. A lot of that was driven by Kaiser's rate decrease in 2022.

So, last year, we submitted a minus 13 percent rate increase, and that increased our enrollment by 30 percent. And a lot of those members that we brought on were very low risk. So, that did bring down our morbidity assumptions that we're using for 2023.

Trend, we're assuming 2 percent. Risk adjustment, in general, the impact of it is relatively flat. Risk assessment is a pretty complicated beast, but this is colored by a lot of things. I mean Kaiser's risk is going down, but so is the market. So, that was sort of a trade-off.

The statewide average premium has always gone down quite a bit, as we've seen in this slide before, and that's also going to provide some favorability in risk adjustment.

Regarding the other non-benefit expenses, that will -- that mostly reflects admin, and that

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reflects a slight increase in admin costs. That was largely due to 2021 admin costs being a lot lower than expected, and we expect a rebound on those going into 2023.

For the benefit changes, we're showing a minus .2 for the first plan, and that reflects the increase of the out-of-pocket max going from 69.50 to 72.50. For the next point on the catastrophic plan, it's a minus 1.7, and that's both the deductible and out-of-pocket max going from 8700 to 9100. And then, finally, for the last plan, the gold virtual four plan, the plan did get slightly richer. The generic drug co-pay went from $10 after deductible to $5 after deductible.

The next driver is the base experience change, and this reflects the changes in morbidity, the change in experience from 2020 to 2021. Again, I don't think that anyone really expected that big rebound in cost that we saw in 2021, and that's what that 2 percent reflects.

The market change reflects our change in margin target. For 2023, we are assuming -- we are projecting a loss ratio of around 95 percent with a margin of 97 percent.

And the last item is model changes. So,

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every couple years, we do utilize a third-party model, and we update it to the newest version of that model. And based off of the version of that model, it did say that -- it did estimate that our deductible plans should be priced lower and our nondeductible plans should be priced higher, and that reflects how our gold plan has a 4 percent increase relative to the catastrophic plan, which had an 8 percent decrease.

And the last factor is a catchall. Just given the fact that -- given the way that all these factors interact, it's not really fully able to -- it's not really possible to fully isolate the impact of any of these one specific drivers. And that covers the balance to get us to the rate increases for each of these specific plans.

Any questions there?

CHIEF HEARING EXAMINER SKIRPAN: No. Keep attacking.

MR. CHU: Next slide.

So, we aren't changing any of our tobacco or area factors. So, our tobacco factor is 1.2, and we don't vary or our rates based off of geography.

Next slide.

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So, now I want to talk about small group rates. So, sort of for our small group is -- I mean it's pretty different, just like the prior speakers have noted. While the individual market has been growing and is going to become additionally robust because of the reinsurance plan, but the small group market is slightly struggling.

And for Kaiser, especially, going from 2020 to 2021, the story was pretty rough. So, the small group claims jumped pretty significantly, again, due to the claims rebound after COVID.

But on top of that, while other carriers benefitted from more favorable risk adjustment changes, Kaiser's risk adjustment became less favorable. So, it's sort of a double whammy. You wouldn't necessarily expect claims to increase and to pay more in risk adjustment, as well, and that was surprising to us, as well. That is partially driven by the increase in the market risk, which has increased faster than expected.

Yeah, so, given all those factors, we are filing a rate increase of 9 percent.

Going to the specific drivers, so, the other morbidity -- that reflects the morbidity

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expectations going from 2021 to 2023. Again, I think that we're slightly more pessimistic about how the risk will change, and we think that the overall risk will go up in this market.

Regarding risk assessment, that captures a lot of the unfavorability in risk adjustment that we saw, especially going from 2020 to 2021 and the potential unfavorable changes in the market risk going forward.

For non-benefit expenses, this had downward pressure on our rates. This was a combination of a couple factors. First of all, because the small group rates are increasing, because our admin costs are relatively fixed, because the rates themselves are increasing, admin, as a percentage of total rates, will go down.

We also moved some costs from healthcare quality expenses to medical expenses just to better align with the medical loss ratio definitions as set forth by the MBPP. And then we've also lowered our commissions.

For benefit changes, a lot of the minus .2 percent rate impact, that largely reflects the increase in the out-of-pocket max going from 6,000

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to 6,600.

The margin change reflects an improvement in our margin target just to allow us to reach a more sustainable margin, although we are still projecting a minus 13 percent margin in 2023 with a loss ratio of 99 percent.

The underlying morbidity change reflects that increase in cost going from 2020 to 2021, and, then, again, that other changes the balance factor.

Next slide.

And, again, like the individual market, we don't vary our rates by geography, and we don't charge a tobacco factor for small group. Right now it does say that the current tobacco factor is 1.2, but that's an error. We've resubmitted this form online.

Any questions for me? Otherwise, I'll pass it off to the next presenter.

CHIEF HEARING EXAMINER SKIRPAN: I don't have any questions. We can move to the next presenter.

MR. CHU: Thanks.

MS. TOLMAN: Hello. Can you hear me?

CHIEF HEARING EXAMINER SKIRPAN: Yes.

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MS. TOLMAN: I'm Lydia Tolman from Wakely Consulting Company presenting on behalf of Piedmont Community Healthcare HMO and Piedmont Community Healthcare, located at 2316 Atherholt Road, Lynchburg, Virginia.

My colleague Jackie Young, also from Wakely Consulting, and Ryan Ziemann from Piedmont will also be presenting.

I will cover the individual rate presentation and first three questions for the individual HMO plans. My colleague Jackie will cover the small group rate presentation and question for both the small group HMO and PPO plans. And, finally, Ryan will address the question around service areas expansion for the HMO products and decision to reenter the small group market for the PPO products.

So, for individual, Piedmont will be offering five renewing plans plus CSR variations in 2023. The most popular plan is expected to be their bronze 7500 plan, which currently has about a third of their membership.

The maximum rate change is a 14.9 percent decrease for our gold plan. And the minimum rate change is a 20 percent decrease for our silver

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5800 plan.

For all plans, we assumed a slight morbidity improvement due to ARP from 2021 experience in our 2019 manual, which was used to develop the rates.

For trend, we assumed a change in our trend of about one point. So, trend improved slightly from our 2022 filing, which is what is represented here.

And then for risk adjustment and experience, which is in the yellow section below, we saw from 2020 to 2021 experience that our claims increased quite a bit but our risk adjustment receivable was much, much higher in 2021.

For our 2023 filing, we needed that, slightly, but we still expect to be in a receivable position. So, these two offset.

The biggest impact to the filing is, like the other carriers, the reinsurance program, which is decreasing our rate 17 percent.

Our other non-benefit expenses reflects a slight increase in our administrative cost that we think is appropriate for the expected improved competitive positioning and additional members.

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And then, lastly, in the bottom section, we have the change in our paid to allowed ratio of 6.1 percent, which reflects a mix change. So, this is showing that we're going to have a lot more bronze members in our total population.

And then the change to benefits for each specific plan is included in the other change.

COVID, specifically, was included in 2022 in our other morbidity line. And then for 2023, we have moved that to the other line.

For COVID, specifically, we assumed that there was pent up demand in 2021 experience. Piedmont has a growing population and is not fully credible when we went to do a COVID study, so we relied on the SOA, Society of Actuaries, COVID model results for both the individual and small group lines of business, assuming the impact of pent up demand in 2021 will not be present in the 2023 projections.

One of the questions we received from the BOI was what Piedmont experience could also justify, and we found that even though it was not fully credible, it was consistent with the 20 -- or the COVID model results from the Society of Actuaries.

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And then the next question was what was the projected effect of reinsurance on enrollment and morbidity. Piedmont did not assume an impact to their specific enrollment morbidity for reinsurance.

We did model the expected reinsurance receivable on the Wakely ACA data that we have. We have a large proprietary database and modeled what we thought the paid receivable would be, included that in the rate buildup.

And although premiums will be lower, we don't think this will translate to lower premiums for subsidy-eligible members. So, we didn't think there should be a specific adjustment to Piedmont's enrollment.

And then, lastly, does the impact of the elimination of ARPA -- what is the impact of elimination of ARPA on enrollment and morbidity. Again, we assumed no large impact to Piedmont for enrollment changes, but we assumed a slight decrease in morbidity from our 2021 experience period and a larger but still small decrease in morbidity from our 2019 and manual experience.

We anticipated improved morbidities for members that joined in 2022 due to ARPA, which is

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not reflected in our 2021 experience, and that not all new members joining from April 2021 when ARPA passed to December 2022 would leave if ARP enhanced subsidies were discontinued.

Any questions?

CHIEF HEARING EXAMINER SKIRPAN: Can you go over with having ARPA extended, how do you see that impacting things.

MS. TOLMAN: Sure. So, we looked at what would happen if ARPA was extended, but as we noted, we are assuming a slight decrease in our morbidity assumption from 2021 to 2023 because we assumed a lot of the members who joined due to ARPA would stick around even with the loss of the subsidies. Part of that was driven by just lower premium rates, as well, with the introduction of the reinsurance program.

So, when we went back to our model and switched over to ARPA continuing, we saw a very, very, very immaterial change in our morbidity assumption, and since we didn't explicitly add or decrease any enrollment for ARPA, we didn't think anything had changed to our filing was necessary.

CHIEF HEARING EXAMINER SKIRPAN: Okay. Thank you.

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MS. TOLMAN: All right. Next slide.

So, this shows our tobacco load. We did want to point out that we have removed the tobacco load going into 2023. I believe there's some legislation on the table to get rid of the tobacco load or significantly minimize the tobacco load. And after some internal discussions and review of tobacco members, we decided that, just for ease of operations, we would remove the tobacco load entirely.

The geographic areas we are significantly expanding this year and, so, to develop our geographic area factors, we looked at the 2022 contracts versus the 2023 contracts. We also considered the geographic cost factor that is used in the risk adjustment program. And we reevaluated our area specific factor and re-normalized, which results in the rates shown over to the right.

Any questions?

CHIEF HEARING EXAMINER SKIRPAN: No.

MS. TOLMAN: Okay. Next slide. And with that, I will pass it to my colleague Jackie.

MS. YOUNG: So, my name is Jackie Young. I'm also from Wakely Consulting Group presenting

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on Piedmont Community Health Plan's behalf here.
So, moving on to the presentation of small group rates, we'll start with the HMO.
As an overview, under the HMO entity, Piedmont has 18 HMO plans, as well as 18 POS plans, 14 of which are renewing and 4 are new for both plan types. So, all plans are offered off exchange. The HMO is still only offered in rating area 6, Lynchburg, while the POS has expanded, similar to an individual, across the rating areas now -- a quick overview.
Now, referring to this first slide, the overall rate change for this segment was a 0.2 percent decrease, so very little change overall. The most popular plan is the Piedmont Choice POS silver, and it has a 23.50 deductible, approximately 250 members as of Q1 '22.
We had a relatively small range for the rate change across all plans here. The minimum rate change was a 3 percent decrease for that Piedmont Choice POS silver HSA. The maximum rate change -- and apologies for not catching this sooner -- was actually a 2.2 percent increase, which was the POS plan ending in 15 here, so HIOS 40015, state benefit design is listed, so the

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54.50 deductible and the 89.50 moot.
So, focusing on the rate change components, I'll go through these and then maybe I can stop and answer any questions you have.
So, to start, we are showing a 3.5 percent decrease for morbidity. This is driven by changes in the COVID impact and the way in which we allocated it, so it's similar to individual. Where last year we were expecting increases based on 2020 morbidity shifts, we're now expecting decreases from COVID impact due to the impact of pent up demand that we saw in 2021, which is now, in part, included in the other category. And I'll touch on this further after presenting the remaining slides.
We had a slight decrease in our trend assumption, which is shown here, again similar to individual, .7 percent represents the change in our trend assumption.
For risk adjustment, based on the current risk of our members that we saw at the end of 2021, and then our assumed mix changes going into 2023, we are actually expecting slight increases to our risk receivables. So, in 2023, we anticipated closer to $40 PMPM rather than the $30

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from last year, again just looking at the risk of our current population, just assuming a slight mix change so that we have more gold membership to increase that expected risk receivables, what's happening there.
Offsetting these negative changes, non-benefit expenses increased slightly, same as individual. Piedmont is now investing slightly more for upcoming expansion efforts, so a slight change there.
Change in underlying experience minus trend was actually pretty small. We did see a small increase to cost of about 1.7 percent from 2022 to 2023, so pretty minimal in the scheme of things. And similar to points made, this is pretty in line with the adjustment to risk adjustment amounts. So, if you see there that negative 1.9 percent that we assume for that risk adjustment change goes hand in hand with the expected claims we're going to assume in 2023, which is the 1.7 percent we have for the change in underlying experience.
We have a small change in the paid to allowed, which, again, here represents a small change in mix anticipated for 2023 with slightly

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more gold membership.
And with that, I think that really covers our explicit changes. The other change includes our actual trend, some COVID impact, PBM savings, and clean edit savings. So, that's what lumped into that other category.
But I just went over a lot, so I'm going to stop and take a second to ask for any questions.
CHIEF HEARING EXAMINER SKIRPAN: Just as a general, how is inflation reflected in this?
MS. YOUNG: Yeah, so, I think, in general, we did think about that when going through trend and COVID. So, we made sure when looking at our trend assumption, we were going off of publicly available sources for what was considered reasonable healthcare trend going from 2021 to 2023.
You know, I think, on average, you know, we could have gone lower. So, I think we sort of did consider it to try to be more conservative there. You know, I think, in total, the trend probably doesn't look as high, too, because we're considering the COVID impact and the deflating of the pent up demand in 2021 going from 2023. That

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impact is coming down some.
So, when you combine the two, I think, in total, it doesn't seem like much impact, but I do think we have been more conservative in our overall trend amounts to try to take into account the expected inflation going to 2023.
And just to add to that, we looked at several studies on trend, and we found that 2021 looked like it had the biggest impact from inflation, still some drivers for sure in 2022 and 2023, but most of that is already covered in our 2021 experience, the additional inflation.
CHIEF HEARING EXAMINER SKIRPAN: Okay. Thank you.
MS. YOUNG: All right. If we can go to the next slide, not too much to report here. We have no changes to the tobacco factors from the prior year. We're still not applying any tobacco load.
And similar to individual, Piedmont is expanding into these new areas, so we had to renormalize and redistribute the rating areas after thinking through the contracting, the GCS where current experience lies, to get from the original rating areas in 2022 to the factors in

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2023.
Any questions there?
CHIEF HEARING EXAMINER SKIRPAN: No. Thank you.
MS. YOUNG: All right. So, we can go ahead and move on to the PPO. All right. And I'll give a quick overview of the new PPO product.
So, under the new PPO entity, Piedmont is offering, again, 18 plans across the same 8 rating areas as the HMO. On this slide, we're only showing the one plan since this is a new line of business, and we're showing our most -- anticipated most popular, which is the Piedmont PPO gold with the $2,000 deductible.
So, not much more to report here without reaching, but for reference, the buildup of our PPO pricing was very much consistent with that of our HMO products. We just adjusted AVs for additional anticipated utilization for out-of-network cost.
In a second, I'll pass it over to Ryan to get more of the business decision as to why we started this new product again, but for now, I'll move on to the next slide.
And with that, again, not much reported.

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Same rating area factors as were shown for the HMO product. And same as the HMO product, we are not adding a tobacco load. So, same old/same old.
Any other questions there?
CHIEF HEARING EXAMINER SKIRPAN: No, no questions. Thank you.
MS. YOUNG: All right. And I'll, just before I pass it over to Ryan, I do want to more explicitly address the questions posed by the group.
So, to address the COVID-19 impact on experience and projections, I know we already touched on it briefly, but due to the pent up demand from COVID, Piedmont did see noticeably higher medical PMPM costs in early 2021 for the small group business, as well as what we saw for the individual, which have since leveled off slightly.
And, again, Piedmont has a growing population. Small group is not fully credible for a full-on COVID study, which is why we relied on the SOA COVID model results for both lines of business. So, assuming the impact of pent up demand in 2021 will not be present in the 2023 projections, we're assuming a slight decrease.

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To address your other questions, I think, for the most part, we went through risk adjustment, again, assuming a slightly higher PMPM based on our current numbers but a slightly different mix, assuming more gold membership, which is for that higher receivable amount.
And then for cost sharing, no major cost sharing changes since we don't have the standardized benefits like individual. There were some slight increases in deductible and moots but nothing all that notable in terms of cost sharing changes.
Any other questions before I pass to Ryan?
CHIEF HEARING EXAMINER SKIRPAN: I don't have any. Thank you.
MS. YOUNG: Great.
All yours.
MR. ZIEMANN: All right. Thank you.
Good morning. I'm Ryan Ziemann, chief financial officer of Piedmont Community Health Plan, which I'll refer to generally as "PCHP."
PCHP is the owner of both Piedmont Community Healthcare, Inc., and Piedmont Community Healthcare HMO, Inc. PCHP acts as the administrator for both of subsidiary and insurance

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organization. I'll talk a little bit about the expansion rationale.

So, in 2021, PCHP, with the support of our owner, which is Centra Health, underwent a project to overhaul the technology stack upon which PCHP sits. This project included the replacement of our claim administrator, connecting to a new claim processing platform, replacing our phone, CRM eligibility, invoicing portals, and several other systems.

That project left us with a foundation of scaleable for future growth with a need to achieve scale in order both to offset the investment costs, as well as provide greater stability to the company, having membership levels at around 10,000 for a health insurance company just doesn't provide the predictability that we need as an organization for the long term.

Health insurance, as you know, is a business that's subject to significant volatility and claims expense and has considerable overhead cost. So, the best opportunity to thin those overhead costs, reduce volatility, and improve the predictability and profitability is by achieving scale through growth.

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So, furthermore, we believe that PCHP provides a unique high-touch local-based community-focused approach at providing insurance for our members and providers. It's also our belief that there's a desire for such an approach outside of the Lynchburg Areas that we've traditionally served.

So, finally, there's many areas of Virginia that have product segments with little to no competition, at least historically, obviously. From the earlier presentation, that's beginning to change in 2023, and we're glad to be a part of that.

Our mission statement is Piedmont exists to help others by improving health in the communities in which we serve. So, we know that health can't be improved without the financial access to healthcare.

The markets that were active and cross our various product lines, we've seen a demonstrable impact in a reduction to the cost of insurance to local employers, local individuals, whether by moving business to our paper or by encouraging more competitive rates from our peers, some of whom are on this call.

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We are always disappointed when we can't move new business to Piedmont, but as a community-focused organization, we still feel like we've successfully fulfilled our mission by helping keep rates lower for Virginians.

In terms of the small group expansion, in 2023, Piedmont Community Healthcare, Inc., will be reentering the small group market and doing so with a PPO product.

In assessing the markets that PCHP serves, we determined there's a strong general familiarity with the PPO benefit design, as well as the desire for broader national network access. The structure already exists, essentially, within PCHP to administer similar designed benefits through our HMO POS products.

So, PPO offering was a natural extension for those groups that are really looking for a traditional PPO and also desire the security and availability of national network access.

Any questions for myself or the rest of our actuarial team?

CHIEF HEARING EXAMINER SKIRPAN: No, I don't. Thank you.

MR. ZIEMANN: Thank you. I think that

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concludes the Piedmont presentation.

CHIEF HEARING EXAMINER SKIRPAN: Okay. Well, that also, I guess, concludes the presentation today for everyone.

I want to thank the Bureau and for all the participants that have been in today.

And I also want to provide that, you know, for those listening to this, members of the public, if you wish to provide written comments on what you've heard today, you may do so by visiting the Commission's website and following the instructions on how to submit your comments.

With that, if there's nothing further to come before us, I'll give anybody a chance, if there's anyone that needs to say anything at this point, this is your chance.

Hearing none, I thank everyone for their participation, and we're adjourned. Thank you.

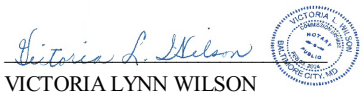
(Off the record at 11:23 a.m. ET.)

CERTIFICATE OF SHORTHAND REPORTER-NOTARY PUBLIC

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 16th day of August, 2022.

My commission expires February 3, 2024.



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