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Transcript of Hearing

Date: August 17, 2020
Case: INS-2020-00090

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1 COMMONWEALTH OF VIRGINIA
2 STATE CORPORATION COMMISSION
3 AT RICHMOND, VIRGINIA
4 CASE NO. INS-2020-00090
5
6 Ex Parte: In the matter of presentations of
7 premium rates in connection with health insurance
8 coverage issued in the individual and small group
9 markets
10
11 VOLUME I
12 August 17, 2020
13 CONDUCTED REMOTELY
14
15
16 PROCEEDINGS BEFORE:
17 The Hon. Mark C. Christie, Chairman
18 The Hon. Judith Williams Jagdmann, Commissioner
19 The Hon. Jehmal T. Hudson, Commissioner
20
21 9:30 a.m. to 12:16 p.m.
22
23 Job No.: 303506
24 Pages: 1-144
25 Reported by: Ruth A. Levy, RPR

1 APPEARANCES:
2 JULIE BLAUVELT
Deputy Commissioner of Insurance
3
DAVID SHEA
4 Health Actuary
5
Company Presentations:
6
7 TIMOTHY CONNELL
HealthKeepers/Anthem Health Plans of Virginia
8
9 PETER BERRY
CareFirst BlueChoice, Inc.
10
11 STEVEN GIORI
Cigna Health and Life Insurance Company
12
13 MARGARET CHANCE
Optima Health Plan
14
15 GRAHAM SUTHERLIN
Optima Health Plan
16
17 RYAN MORGAN
UnitedHealthcare Insurance Company
18
19
20
21
22
23
24
25

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1 P R O C E E D I N G S
2 BAILIFF: Today's case is
3 INS-2020-00090. The Honorable Mark C.
4 Christie, Chairman, presiding.
5 CHAIRMAN CHRISTIE: Well, good
6 morning, everybody. Trying to get my camera
7 on. There it is. We convene today's
8 proceeding by Skype for the annual rate
9 presentations on insurance plans to be
10 offered in the individual and small group
11 markets as of January 1st of next year.
12 As you know, under Virginia law, the
13 Commission must review and approve the
14 premium rates and forms for these health
15 benefit plans, whether they're sold on the
16 Federal Exchange for Virginia or whether
17 they're sold off the Exchange.
18 The Commission must also perform
19 plan management functions required to certify
20 participation in the Federal Exchange. This
21 is pursuant to Virginia law and there are
22 legal deadlines that govern our process. And
23 I'll mention a couple of them.
24 First, the US Department of Health
25 and Human Services requires that the

5

1 Commission's Bureau of Insurance complete its
2 review and recommendations of plans on their
3 rates for certification on the Federal
4 Exchange no later than August 26th of 2020.
5 Secondly, Virginia law requires
6 insurance carriers to notify their customers
7 of increases in annual premiums or
8 deductibles at least 75 days before the
9 proposed renewal of their health insurance.
10 The deadline for notifying customers this
11 year is October 16.
12 To meet these deadlines, insurance
13 companies recently filed their rates and
14 forms for insurance plans proposed to be
15 offered for use as of January 1. Now, given
16 the importance of the cost of health
17 insurance to Virginia's small businesses and
18 individuals, this Commission has
19 historically, for at least the past decade,
20 reviewed these health insurance premium rates
21 and increases in deductibles before approving
22 them for use in Virginia. We're very
23 sensitive to the effect of health insurance
24 premiums and deductibles on all of our
25 individuals and small businesses; it's very

6

1 important, particularly in these days.
2 Today's presentations are part of
3 that review. And they are designed to serve
4 as an overview of the range of rate impact or
5 changes for plans on the individual and small
6 group markets. We issued an order directing
7 presentations -- actually, we issued two
8 orders -- and we, among other things in those
9 orders, we, number one, instructed the Bureau
10 to coordinate presentations by insurance
11 companies for the Commission. The Bureau has
12 done this.
13 And today, we're going to be hearing
14 from insurance carriers in the individual and
15 small group markets who represent over 80
16 percent of the projected insureds in each
17 market.
18 The Bureau will also participate
19 today by providing background information and
20 presenting a summary of recent Bureau
21 activities in its review of the latest rate
22 and form filings for health insurance plans.
23 We'll hear first from Julie Blauvelt, the
24 deputy commissioner of insurance for life and
25 health. And after hearing from Julie, we

7

1 will hear from David Shea, the Bureau's
2 health actuary, who will discuss the Bureau's
3 review of these recent filings this year.
4 Afterward, the designated insurance
5 companies will provide presentations about
6 their proposed rate changes. The companies
7 provided presentation exhibits as part of
8 their rate filings. The Bureau has passed
9 copies of these documents to the Bailiff and
10 these will become part of the case record.
11 So they'll be in the record.
12 For each company presenting today,
13 I'd ask you to please be prepared to speak to
14 your rate filings for plans both on and off
15 the Federal Exchange and for plans in the
16 individual and small group markets.
17 Today's proceeding is being not only
18 Skyped but webcast, and it is open to the
19 public. So -- and I think a record's being
20 made, as well, of this Skype session.
21 Members of the public who wish to provide
22 comments on one or more specific filings may
23 provide comment, and they can provide comment
24 in writing. And the way you do that is you
25 can start by going to the Commission's

8

1 website, and you will see instructions on how
2 to submit your comments.
3 So for all today's speakers in this
4 Skype proceeding -- and we are in Skype, not
5 in the courtroom; I wish we were in the
6 courtroom, but we all know why we're not --
7 so this is a Skype proceeding, and so I'm
8 going to ask each presenter to, number one,
9 speak into your microphone, speak very
10 clearly, give your name and address for the
11 court reporter so she can record who is
12 making the presentations.
13 Hello? Actually, that brings up
14 another thing: If you're not presenting,
15 please turn your microphone on mute. And so
16 it's important, since we're in a Skype
17 session, that you speak very clearly so that
18 the court reporter can hear you, because
19 she's taking a transcript. Yes, this is
20 being recorded, but she's taking a
21 transcript, the court reporter is, and so
22 it's really essential that you speak slowly
23 and speak clearly so that she can get her
24 transcript right.
25 So begin your presentations with

9

1 giving us your name and address, just as you
2 would if were in the courtroom. And while my
3 colleagues, Judge Hudson and Judge Jagdmann
4 may have questions for the speakers, this is
5 not an evidentiary hearing and there will be
6 no swearing in of witnesses or
7 cross-examination.
8 Are there any other preliminary
9 matters any of the parties or presenters want
10 to bring up or Staff want to bring up? Okay.
11 Well, hearing none, we've been
12 successful with these Skype hearings so far.
13 Let's hope this one is also successful. When
14 I say successful, that's often been relative.
15 So we'll do our best and hopefully this will
16 go smoothly.
17 And with that, I'm going to call on
18 the Deputy Commissioner of Health Insurance,
19 Julie Blauvelt -- Deputy Commissioner of
20 Insurance for health insurance, Julie
21 Blauvelt. So Julie, can you come on up on
22 the screen.
23 MS. BLAUVELT: All right. Thank
24 you, Judge Christie. And I want to welcome
25 everyone, as well, to the 2021 plan year rate

10

1 presentations for the individual and small
2 group market for the ACAs. And thank you to
3 all of the carrier presenters who are going
4 to be participating today.
5 I just wanted to give a little
6 overview of what I'm going to present. We're
7 going to draw a picture of what the
8 individual and small group markets in
9 Virginia look like and how they've changed
10 since the inception of the ACA Marketplace
11 back in 2014.
12 We're going to look at a breakdown
13 of healthcare coverage in Virginia and
14 carrier participation in Virginia, both in
15 the individual and small group markets; and
16 look at the way that premiums have changed
17 over time in both of those markets; and look
18 at how rate changes this year will affect
19 subsidies in the individual market. And
20 we'll also discuss some of the effects that
21 COVID-19 has had and may have in the future
22 on the markets.
23 And then following my presentation,
24 David Shea, the Bureau's health actuary, will
25 be getting into a little more specifics about

11

1 the actual rate filings for 2021. So next
2 slide, please.
3 Okay. These slides show how the
4 breakdown of the healthcare coverage in Virginia
5 is currently and was in 2019 and 2018. So as you
6 can see from the 2018 slide, the big chunk is the
7 self-funded market, and add to that the small
8 employer and the large employer markets. So all
9 of that to say that half of Virginia's population
10 is covered by some sort of employer sponsored
11 coverage.
12 That employer sponsored coverage is
13 broken down with the small employer market
14 being a small chunk of that at 4 percent and
15 the large employer being a larger chunk. The
16 small employer market is made up of employers
17 with 1 to 50 employees in Virginia. And as
18 you can see, the self-funded market is the
19 largest chunk of any of the population in
20 Virginia. And that is a market that the
21 state does not regulate the benefits and the
22 rates offered.
23 Looking into the 2019 slide, you can
24 see some changes that have happened. We
25 don't have the break out of self-funded. We

12

1 don't have that information for 2019 yet.
2 But you can see that the individual and the
3 small employer markets were the same in 2018,
4 and now in 2019, the individual market has
5 decreased a little bit, but also, Medicaid
6 has increased 3 percent since 2018, and
7 that's the effect of the Medicaid expansion
8 that happened in Virginia in 2019.
9 Also, you can see as, I believe,
10 part of that effect is the uninsured market
11 from 2018 to 2019 has decreased from 10
12 percent to 7 percent, showing the effects of
13 the Medicaid expansion; that allowed for
14 nearly 400,000 individuals into the Medicaid
15 program.
16 One thing I wanted to indicate that
17 these slides don't show, but we do have
18 information that the individual market is now
19 at the smallest that it's been in at least
20 ten years. Medicaid is at its largest that
21 it's been in at least ten years. And in
22 fact, all the commercial markets, the
23 employer and the individual markets, are at
24 their smallest percentage of the population
25 that they've been in the last ten years.

13

1 COMMISSIONER HUDSON: Julie, this is
2 Judge Hudson. So are you saying that there's
3 a direct correlation to people who are going
4 more into Medicaid enrollment, which is thus
5 by reducing the individual market?
6 MS. BLAUVELT: Yes. We have seen
7 the -- from last year, we saw about 45,000 go
8 into the individual -- I'm sorry; the
9 Medicaid market from the individual market.
10 And from actuarial studies, we're showing
11 that eventually -- and possibly this year or
12 next year -- about 70,000 total will have
13 left the individual market that were covered
14 by individual insurance that we're moving to
15 the Medicaid market.
16 COMMISSIONER HUDSON: Thank you.
17 MS. BLAUVELT: Yes. Next slide,
18 please.
19 COMMISSIONER JAGDMANN: Julie, if
20 you could go back to the last slide, I just
21 wanted to ask a question. As most people are
22 aware, Virginia is moving to have the state
23 based exchange. When you're looking at this
24 pie chart -- I think this is just good
25 information for the record -- what portions

14

1 of the pie chart would be affected or would
2 go through the state based exchange?
3 MS. BLAUVELT: That would be the
4 individual market, mainly; that's the 3
5 percent. And then there is a small employer
6 health insurance exchange as well, so that
7 would be --
8 COMMISSIONER JAGDMANN: Is that the
9 one that's 4 percent on the 2018 chart?
10 MS. BLAUVELT: That's correct. But
11 we do know that, currently, there's a very
12 small portion, although I don't have the
13 exact numbers, but a very small portion of
14 small employer market that is actually on the
15 small employer exchange, currently, as far as
16 the Federal Exchange goes.
17 COMMISSIONER JAGDMANN: So are you
18 saying you would not expect the full 4
19 percent -- if the numbers stay the same,
20 let's say, from '18 -- or let's say from '19,
21 you wouldn't expect all 3 percent? What are
22 you saying? You don't have the small
23 employer broken out for 2019.
24 MS. BLAUVELT: Right. We didn't
25 have those figures for 2019, but --

15

1 COMMISSIONER JAGDMANN: Well, let's
2 look over 2018. Which pie charts would be
3 going through the state based exchange? And
4 if only a portion of them will be going
5 through the state based exchange, please tell
6 us what they are. I mean, I don't need to
7 know the numbers; just identify them.
8 MS. BLAUVELT: Okay. It's a portion
9 of the individual, so if you're looking at
10 the 2019 slide, the little blue bar, 3
11 percent at the top. And then a piece of that
12 orange slice in the 2019 slide. Or if you're
13 looking at the 2018, the smaller orange
14 slice, the small employer market, a portion
15 of that would be part of the small employer
16 state based exchange.
17 COMMISSIONER JAGDMANN: Okay. I
18 just think that's good for clarification for
19 people to realize that only those two
20 segments would be going through the state
21 based exchange. Thank you.
22 MS. BLAUVELT: Sure. Okay. Next
23 slide.
24 This slide is showing the level of
25 participation by carrier in the individual

16

1 market and how that's changed as we come into
2 our eighth year of exchanges. The yellow at
3 the top of the bar shows the number of
4 carriers that are actually -- were
5 participating on the marketplaces during
6 these years, and the blue at the bottom of
7 the bars are the carriers that were --
8 represents the off exchange market, the
9 individual market.
10 You can kind of -- you can see from
11 the graphs that the individual market did
12 increase in enrollment initially and then,
13 as -- and then fell. And that's pretty much
14 the same time that premiums began to pick up.
15 You can see the sharp decline from 2017 to
16 2018 of the carriers that were participating
17 in the markets during those times. There was
18 a lot of uncertainty in the ACA between 2017
19 and 2018.
20 At the end of 2017 is when the
21 federal government stopped providing cost
22 share reduction payments, and the carriers
23 had to absorb that cost and build that into
24 premium, and so premiums started rising
25 sharply. Add to that the loss ratios that

17

1 David will explain in some later slides; that
2 carriers were anticipating sharp rate
3 increases and a lot of carriers did exit the
4 market at that point in time.
5 But as you can see, the market has
6 tended to increase in the last few years and
7 seems to have, in fact, stabilized as far as
8 the number of carriers that are
9 participating. I do want to mention that
10 even though from the 2020 to 2021 we're
11 showing the same number of carriers in the
12 individual market and on Exchange, we do
13 actually have a change in carrier
14 participation from 2020 to projected 2021 in
15 that Virginia Premier, which was an HMO -- it
16 is currently an HMO that provides coverage in
17 the individual market, that they had an
18 ownership change, where it's now owned by VCU
19 and Sentara Healthcare with Sentara
20 Healthcare being the majority owner.
21 So Virginia Premier has not filed to
22 participate on the Exchange in 2021, but we
23 did get a new carrier that has filed for
24 participation in the individual market for
25 2021, and that is Optimum Choice, which is a

18

1 United HealthCare insurance company, a part
2 of that company. So that keeps us at the
3 nine carriers for 2021.
4 Next slide. All right. This map is
5 showing the concentration of the carriers in
6 the individual market in the counties and
7 cities in Virginia for 2021 as they have
8 filed. The blue portion, which is about 40
9 percent geographically of the state, still
10 has a choice of only one carrier in those
11 regions, and that represents about 20 percent
12 of the state's actual population, the blue
13 area.
14 CHAIRMAN CHRISTIE: Julie?
15 MS. BLAUVELT: Yes.
16 CHAIRMAN CHRISTIE: As I read your
17 chart -- and of course, it's -- and I hope I
18 read it correctly; it's good news -- we don't
19 have any uncovered counties this year?
20 MS. BLAUVELT: Oh, no. No. We have
21 no projected uncovered counties.
22 CHAIRMAN CHRISTIE: That's great.
23 Because a couple of years ago, we were
24 worried about some uncovered localities.
25 MS. BLAUVELT: Yes, that is correct.

19

1 That was a concern a few years ago. We have
2 a lot more of the area than we did last year
3 covered by two to five carriers. So we can
4 see that the highest concentration, the
5 purple and the green areas, where we've got
6 three to five carriers covering those areas,
7 in the Northern Virginia and the Richmond
8 areas. And those two areas, the Northern
9 Virginia and Richmond areas, represent about
10 half of the state's population.
11 And a quarter of the state is
12 covered by -- I'm sorry; Judge Christie, did
13 you have a question?
14 CHAIRMAN CHRISTIE: I was just going
15 to say it's a great chart, because it shows
16 the degree of competition.
17 MS. BLAUVELT: Yes.
18 CHAIRMAN CHRISTIE: So it's really a
19 good chart.
20 MS. BLAUVELT: Yes. So we've got
21 actually about a quarter of the state that's
22 being served by three to five carriers, which
23 is, like I said, better than we had in 2020,
24 where only 15 percent of the state was served
25 by three to five carriers.

20

1 So we are seeing more competition in
2 the individual markets. Carriers are
3 increasing their service area. We talked
4 about, in the last slide, Virginia Premier
5 that was leaving for 2021. And actually,
6 Optima Health Plan has filed to increase its
7 service area by 18 localities, which will
8 encompass the area that Virginia Premier --
9 the Richmond area where Virginia Premier will
10 be leaving in 2021.
11 COMMISSIONER JAGDMANN: Julie,
12 towards the blue area, which carrier is
13 covering the blue area where we have only
14 one?
15 MS. BLAUVELT: I believe it's mainly
16 HealthKeepers. It may be a different carrier
17 in some parts, but for the most part, it's
18 HealthKeepers. And I believe it's all
19 HealthKeepers.
20 COMMISSIONER JAGDMANN: Thank you.
21 MS. BLAUVELT: And the new carrier,
22 Optimum Choice, will be operating mainly in
23 the Northern Virginia area, in about 16
24 localities up in the Northern Virginia area.
25 We can move to the next slide, if there's no

21

1 questions.
2 All right. This graph is showing
3 the projected carrier participation in the
4 individual market again and the percentage of
5 market share that the carriers are projecting
6 themselves to hold. You can see that
7 HealthKeepers has the majority and they do
8 cover almost the entire state. They are
9 projecting 40 percent of the market share in
10 the individual market. The only portion they
11 don't cover is the Northern Virginia area
12 where, under the Blues Agreement, CareFirst
13 covers.
14 And the next most populated carrier
15 is Cigna Health Insurance -- Health & Life
16 Insurance Company with 27 percent. And so
17 there are basically four -- the four carriers
18 encompass 90 percent of the individual
19 market, Kaiser, Optima, Cigna, and
20 HealthKeepers.
21 COMMISSIONER JAGDMANN: Julie, if
22 you look at Care First Blue Choice, is that
23 predominantly in the beltway around the D.C.
24 area?
25 MS. BLAUVELT: Yes, that's correct.

22

1 (Indiscernible) as well, Group
2 Hospitalization Medical Services. Next
3 slide.
4 All right. This is a look at the
5 small group market and the carriers who are
6 participating on and off Exchange. And you
7 can see we haven't had as big of swings of
8 carriers over the years. And in fact, for
9 the last four years, it's been very constant.
10 You can also see the difference
11 between the carriers that are participating
12 in the small group market versus individual
13 market in that it's pretty much the reversed;
14 almost all the carriers in the individual
15 market were participating on Exchange, which
16 is the yellow in these slides, and in the
17 individual market, only one carrier was off
18 Exchange.
19 So in the small group market, almost
20 all of the carriers except for three are
21 operating only off the SHOP Exchange. And
22 the three carriers that operate on the SHOP
23 Exchange are just mainly in the Northern
24 Virginia area. So that's really the only
25 portion of the state that SHOP coverage is

23

1 available.
2 COMMISSIONER JAGDMANN: Say that
3 again. So you're basically saying, when you
4 say SHOP, that would be what, Virginia --
5 that's the Exchange; that's what it's called,
6 right?
7 MS. BLAUVELT: Yes.
8 COMMISSIONER JAGDMANN: So on the
9 Exchange, for small group, there are three
10 carriers?
11 MS. BLAUVELT: That's correct. And
12 their service areas are only in the Northern
13 Virginia area. So really -- so really, small
14 employers only have the option to purchase
15 coverage through the SHOP Exchange in the
16 Northern Virginia areas of Virginia
17 currently.
18 COMMISSIONER JAGDMANN: And it's a
19 requirement, if you're on, you also have to
20 be off, isn't that correct? Or it used to
21 be, if you're on Exchange, you also have to
22 offer off Exchange?
23 MS. BLAUVELT: Yes, that's correct.
24 Okay. Next slide.
25 Okay. This is the small group,

24

1 small employer group market slide of
2 Virginia. And it's not quite as colorful as
3 the individual market, but it actually does
4 have more carrier participation than the
5 individual market. The least amount of
6 participation is in the yellow, but that's
7 still ten carriers that are participating,
8 and ten carriers is the least amount of
9 participation that we have in any part of
10 Virginia.
11 And throughout Virginia, we've got
12 between 10 and 15 carriers participating in
13 every city and county. So this basically
14 reflects more competition in the small group
15 market than in the individual market. Okay.
16 Next slide.
17 And this is another slide showing
18 the share, the projected enrollment that
19 carriers have filed for 2021. So the top two
20 are Anthem and HealthKeepers. So together,
21 pretty much like in the individual market,
22 HealthKeepers or Anthem is projecting to hold
23 40 percent of the small group market. And
24 then we've got UnitedHealthcare projecting a
25 little more than 18 percent of the market

25

1 share. And between about five different
2 companies, if you put together Anthem and
3 HealthKeepers and CareFirst and Group
4 Hospitalization and Medical Services, about
5 five carriers have 90 percent of the small
6 group market as well. Next slide.
7 Okay. This graph is looking at the
8 enrollment numbers between the individual on
9 the top and the small group market on the
10 bottom. The blue bars are the ACA enrollment
11 for individual and the green portion of the
12 bar for the small group enrollment. The
13 yellow portion of both of those is the
14 non-ACA enrollment, so grandfathered plans,
15 the transitional plans that have been allowed
16 to continue on a yearly basis.
17 And as you can see, those yellow
18 bars, especially in the individual market,
19 have been shrinking, as grandfathered
20 coverage slowly has gone away. And we have a
21 very small portion of the transitional
22 coverage in the individual market and same
23 for small group as well.
24 COMMISSIONER JAGDMANN: So Julie,
25 just for clarification, this is on and off

26

1 Exchange together?
2 MS. BLAUVELT: Yes. That's the
3 total enrollment figure that you see at the
4 top of each bar is on and off and
5 grandfathered and transitional plans as well.
6 So if you just want to look at ACA, which
7 would still be ACA plans on and off, that
8 would either be the blue or the green bars.
9 COMMISSIONER JAGDMANN: And just
10 tying it back into your other charts, these
11 are those two pie slivers we talked about; I
12 think they were, like, 3 and 4 percent; I
13 can't remember.
14 MS. BLAUVELT: Yes, that's correct.
15 So you can see, in the individual market, the
16 large drop in enrollment from 2017 to 2018,
17 where we had a lot of carriers exit the
18 market as well at that point and a lot of
19 uncertainty about the ACA. And then the drop
20 from 2018 to 2019, as we talked about, where
21 a lot of the individual market moved to the
22 Medicaid population.
23 COMMISSIONER JAGDMANN: That would
24 have been what year? That would have been --
25 MS. BLAUVELT: That started January

27

1 1 of 2019. So these figures are at the end
2 of 2019. So that's showing the drop of about
3 70-, 75,000.
4 COMMISSIONER JAGDMANN: Let's look
5 at, like, 2015. We have the number of total
6 insured to 2021 projected. That's a big
7 drop. All of those -- do you think all of
8 those have gone to -- where do you think
9 they've gone? Or do we know or do you have
10 any idea?
11 MS. BLAUVELT: Well, we don't really
12 know where all of them have gone. The
13 uninsured market, you know, in those early
14 years to the later years has not changed all
15 that much except for 2019 when it shrunk a
16 lot when the Medicaid expansion began.
17 But really, you know, some have just
18 found other types of coverage possibly,
19 short-term limited duration plans or --
20 COMMISSIONER JAGDMANN: They haven't
21 all gone to Medicaid, when you look at the
22 chart?
23 MS. BLAUVELT: No. Because you can
24 see a large drop from 2017 to 2018, and that
25 was prior to the Medicaid expansion. And

28

1 even looking from 2016 to --
2 COMMISSIONER JAGDMANN: They've
3 either found coverage elsewhere or they're
4 uninsured?
5 MS. BLAUVELT: Yes.
6 COMMISSIONER JAGDMANN: Okay. Thank
7 you.
8 MS. BLAUVELT: And then we do know
9 in Virginia, some of the small -- or some of
10 the individual market may have moved --
11 although I don't think it's a large portion;
12 I think we projected about 25,000 maybe --
13 have moved to the small group market under
14 the law that allowed sole proprietors and
15 self-employed individuals to become covered
16 in the small employer market. So some have
17 moved from the individual market to the small
18 employer market based on that legislation
19 that happened in 2018.
20 Okay. Go to the next slide. This
21 slide is showing the inverse relationship
22 between premium growth and enrollment and
23 participation in the individual market. The
24 premiums down here, the yellow line, is an
25 average, basically, of each carrier's

29

1 weighted premiums. So it's not completely a
2 true picture of really what the weighted
3 average premium is in the individual market
4 because we do have -- most of the carriers in
5 the individual market, their weighted average
6 reported premiums for 2021 -- we're looking
7 at 2021 -- range from $541 to $672 per month
8 for premium.
9 But we do have one PPO that's in the
10 individual market, Group Hospitalization
11 Medical Services, Inc., and their premiums
12 for the last several years have been quite a
13 bit higher, you know, more than double of
14 what the premiums are of the HMOs and EPOs
15 that are in the rest of the individual
16 on-exchange market. And the PPO's premium
17 for 2021 is $1,727; that's the average
18 weighted --
19 COMMISSIONER JAGDMANN: If you threw
20 that one out, what would the average be --
21 MS. BLAUVELT: I'm sorry; could you
22 say that again?
23 COMMISSIONER JAGDMANN: If you threw
24 that one out --
25 MS. BLAUVELT: No. And that's what

30

1 is kind of skewing this average of it. But
2 right, if you threw that one out, it would be
3 lower because, like I said, the premiums,
4 other than that one, range from $541 to $672.
5 CHAIRMAN CHRISTIE: But Julie, I
6 wanted to ask you, you've got another chart
7 farther in -- at least the presentation I've
8 got, there's several pages later you've got
9 an individual total weighted average premium
10 and it's a bar chart. And this is a line
11 chart. And I assume it's the same; just a
12 different presentation of the same data; one
13 is a bar chart and one is a line chart.
14 But what is a weighted average?
15 When you say weighted average, what do you
16 mean?
17 MS. BLAUVELT: So that's when the
18 carriers will take their total premium and
19 they'll look at where most of the enrollment
20 is, and they'll -- so we'll look at what most
21 of the people are paying; they'll calculate
22 the weight of -- it's not a straight average,
23 so you're not just dividing by the number of
24 enrollment, but you're providing more weight
25 to, you know, if 40 percent of the

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1 individuals pay $600 and 20 percent pay $800,
2 you give more weight on that $600.
3 CHAIRMAN CHRISTIE: So it's weighted
4 by the individual carriers and it's also
5 weighted again by all the carriers; is that
6 by enrollment? Because, obviously, you've
7 got carriers like Anthem that have a lot of
8 people and then you've got the smaller niche
9 carriers.
10 MS. BLAUVELT: Right. How we've
11 done this calculation in the past is the
12 carriers provide us their weighted average or
13 we calculate their weighted average from the
14 carriers, but then it's a straight average
15 after that of each carrier's weighted
16 average.
17 And I think we're going to change
18 that going forward because that was kind of
19 determined that that's probably not the best
20 way to be doing that. And so I think we're
21 going to change that for other years. And so
22 we'll have to go back through all the years
23 and change that manner of calculating because
24 of the large difference of the one carrier's
25 premium. We want to show better, really,

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1 what is more the weighted average premium and
2 not let that carrier be skewing the premiums.
3 CHAIRMAN CHRISTIE: Well, it shows
4 the trend though.
5 MS. BLAUVELT: Exactly.
6 CHAIRMAN CHRISTIE: I mean, you can
7 play with it all you want, but it just shows
8 a trend.
9 MS. BLAUVELT: Right. I did want to
10 point out that we do have a very large
11 portion of the individual market that is
12 subsidized. Some reports have said 83
13 percent, some have said 88 percent, so we've
14 got a lot of people who, you know, are not
15 paying this premium in the individual market.
16 So, really, only about 12 to 17 percent are
17 paying the full amount of premium without
18 subsidies in the individual market.
19 COMMISSIONER JAGDMANN: And just a
20 refresher for us, these subsidies, where are
21 they coming from? Just a refresher.
22 MS. BLAUVELT: Those are coming from
23 advanced premium tax credits or premium tax
24 credits that the federal government provides
25 to individuals with incomes between 138 and

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1 400 percent of the federal poverty level. So
2 it's kind of a sliding scale of what a person
3 could afford to pay. I think they figure
4 between 8 and 9 percent of a person's income
5 is what they could afford to pay as far as
6 health insurance coverage.
7 So in another slide, we're going to
8 look at the change in the second lowest cost,
9 silver plan premium, which is what those
10 subsidies are based on. So we'll get to that
11 discussion in more detail in that slide.
12 COMMISSIONER JAGDMANN: Thank you.
13 CHAIRMAN CHRISTIE: What are the
14 income cutoffs? I remember the number 47,000
15 as being a cutoff for household income. Was
16 that for individuals or families? What's the
17 cutoff?
18 MS. BLAUVELT: That's a good
19 question. I'm not quite sure what the cutoff
20 is. It seems like that may be for a family,
21 because it seems like maybe -- I might have
22 to get back to you at the end of the
23 presentation.
24 CHAIRMAN CHRISTIE: I seem to
25 remember 47,000 being the cutoff, because the

34

1 person, you know, hanging Sheetrock and
2 making 50,000 is not getting subsidies.
3 MS. BLAUVELT: Right. Yes. I think
4 that would be -- I think that's a good guess
5 on what the 400 percent, the top level for
6 the population that receives subsidies is.
7 COMMISSIONER JAGDMANN: And I bet
8 some of our follow-up presenters may have
9 that data. This will give them an
10 opportunity to find that for us. That will
11 be great.
12 MS. BLAUVELT: Sounds good. Okay.
13 We can go to the next slide. Okay. So this
14 is talking about the subsidies, exactly what
15 we were just discussing. And this is another
16 map that was created by our rate and map
17 summary tool that we've got. It's showing
18 how the subsidies will change or are
19 projected to change from 2020 to 2021.
20 So most of the state is gray. The
21 gray and the blue is where the second lowest
22 cost silver plan premium will be decreasing.
23 And when that happens, subsidies will
24 decrease, because if a -- we just -- we are
25 cognizant that consumers will need to know

35

1 this information about subsidies decreasing
2 so they don't just stay on the same plan, you
3 know, not change plans, not look at their
4 options.
5 It's going to be very important for
6 people, especially where -- in the areas
7 where subsidies will go down, because the
8 premium of the second lowest cost silver plan
9 is going down. It's going to be very
10 important that they look at all of their
11 options and make sure that they know what
12 their final premium is that they're going to
13 be paying, because if they got $600 a month
14 in subsidies in 2020, you know, they may be
15 getting $400 a month in subsidies in 2021.
16 So they'll need to make sure that
17 they're choosing the plan and knowing what
18 their final premium is before they make their
19 final selection.
20 COMMISSIONER JAGDMANN: Julie,
21 that's a very important point. I'm so glad
22 you brought this up. So let's talk about
23 that just a little bit more. You're talking
24 about the second lowest silver plan. Is that
25 the second lowest silver plan offered in the

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1 individual market for the area --
2 MS. BLAUVELT: Yes.
3 COMMISSIONER JAGDMANN: -- or for
4 the whole state or for the area?
5 MS. BLAUVELT: It's just for the
6 city or the county.
7 COMMISSIONER JAGDMANN: Okay. So
8 let's look at this gray area. And let's say
9 that one carrier -- they don't use the lowest
10 because maybe somebody low-balled or
11 something, so it's the second lowest. But it
12 could be far lower than all the others and
13 that means the premium's going to go down
14 significantly. It doesn't mean that the
15 income level has changed for these
16 individuals, but it doesn't mean that the
17 premium that they used last year is going to
18 go down; it just means the benchmark for the
19 subsidy has gone down.
20 And if I heard you correctly, they
21 really -- they're going to really need to be
22 cognizant of that. And I'm sure, you know,
23 we get a lot of information, you know, when I
24 get my premiums stuff, it's hard to find the
25 time to look at it and go through all of

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1 that. I'm assuming that we'll be expecting
2 the navigators -- that's going to be a large
3 part of their job this year, is it not?
4 MS. BLAUVELT: That's correct, yes.
5 COMMISSIONER JAGDMANN: All right.
6 That's a huge point. I'm so glad you brought
7 that up.
8 MS. BLAUVELT: Yes. And the red and
9 the green areas are areas where the cost of
10 the second lowest cost silver plan will be
11 increasing. So subsidies will increase most
12 likely in those areas from what the
13 projections are that we've got.
14 COMMISSIONER JAGDMANN: Now I'm
15 looking at these gray areas. That's an area
16 a lot of times where -- is that an area where
17 we had one carrier?
18 MS. BLAUVELT: Yes. Like in
19 Southwest Virginia, Northern Neck, yes, we
20 have had one carrier.
21 COMMISSIONER JAGDMANN: But that
22 doesn't mean there's one plan; there can be
23 many, many plans, right?
24 MS. BLAUVELT: They still offer
25 several plans in the areas, yes.

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1 COMMISSIONER JAGDMANN: Okay. Well,
2 this is serious stuff. Thank you.
3 MS. BLAUVELT: Okay. We can go to
4 the next slide. Okay. This is just turning
5 to the small group market, and looking at the
6 same slide with the premiums, showing the
7 trend over time in the yellow line and the
8 enrollment showing the trend over time with
9 the green bars.
10 The trend in the small group market
11 has been an increase in premium every year
12 since 2015. So that's a little unlike the
13 individual market where we had the sharp
14 increases in premium in 2018, 2019, and now
15 it's decreasing and trying to level out. The
16 small group market premiums are continuing to
17 increase.
18 And you know, from what we've seen
19 since 2017, enrollment falling in the small
20 group market, we do show a projected amount
21 of the increase in the small group market for
22 2021, but that is a projection that is based
23 on each carrier's submission.
24 So that's not somebody who took a
25 look at the overall market and projected that

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1 it increased; that's just a total of each
2 carrier's projected enrollment.
3 Go to the next slide. We'll talk a
4 little bit about the effects that we've seen
5 and read about of COVID-19 on the health
6 insurance markets. Families USA reported
7 that nationally 5.4 million workers became
8 uninsured between February and May of 2020.
9 And the expectation is that the uninsured
10 workers are going to move into either the
11 individual market or Medicaid or become an
12 insured.
13 And it's anticipated in studies that
14 more people will move into Medicaid than in
15 the individual market, just because of
16 their -- the qualifications of being able to
17 be in Medicaid when they don't have the
18 income that they had previously.
19 COMMISSIONER HUDSON: Julie, quick
20 question: Due to COVID-19, are you seeing
21 rising unemployment and furloughs but a lag
22 in transition of coverage because most of
23 these individuals are still under their
24 current employer's plan?
25 MS. BLAUVELT: It's kind of hard to

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1 know what to say. I do have another slide
2 that's going to show that we have seen an
3 increase in people moving to the individual
4 market, but I think that would be correct;
5 that they're -- we know that, on this slide,
6 I talk about carriers making concessions for
7 small employer groups that are having a hard
8 time coming up with their premium payments
9 and providing them credits on their rates or
10 extending the deadline for when the grace
11 period begins to allow more time for the
12 employers to come up with premiums.
13 So I think it's true that a lot of
14 movement has not occurred yet because, like
15 you say, employers are furloughing people and
16 keeping them on their plan or carriers are
17 extending the ability of employers to wait
18 further into the year to pay their premiums.
19 So I guess it still remains to be seen what
20 effects will happen when all of this shakes
21 out.
22 COMMISSIONER HUDSON: Thank you.
23 MS. BLAUVELT: One thing to think
24 about and one of the statistics from these
25 studies that the Urban Institute presented

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1 was that, as we see people move from the
2 commercial markets, either the group market
3 or the individual market, and especially as
4 they move out of the group markets and into
5 more government plans or uninsured
6 population, providers are generally
7 reimbursed in those government program
8 segments of the market.
9 And so we're figuring out that group
10 commercial markets may be expected to pick up
11 that shortfall of the reimbursement that the
12 providers are not receiving. And we saw that
13 the group market was the largest of the
14 population, but that is most likely falling
15 because of coronavirus.
16 That covers that slide and we can
17 move to the next slide. Sorry. I don't know
18 if my system is hung up or the -- can
19 everybody else see the next slide or are we
20 still waiting to see that?
21 CHAIRMAN CHRISTIE: Is it loss of
22 MEC SEP Enrollments from the End of Open
23 Enrollment, a multi-colored bar chart?
24 COMMISSIONER HUDSON: Yeah, I see
25 that as well.

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1 MS. BLAUVELT: That's it. Then it's
2 just me that can't see it, I guess.
3 CHAIRMAN CHRISTIE: It's up there.
4 MS. BLAUVELT: So this is showing
5 the prevalence of the loss of coverage
6 minimum essential coverage special enrollment
7 period number on -- this is just from the
8 Federal Exchange and how that has -- it's
9 showing back through several years how that
10 changes over each month and the people that
11 enroll coming off of the loss of coverage
12 special enrollment periods.
13 So you can see that, in the graph,
14 that up until April and May of 2020, the
15 numbers were pretty much in line with how
16 they've been in the past couple years. But
17 then we see, April and May, a big shift in
18 people coming into the individual market
19 through the Federal Exchanges. This is a
20 national graph of states that are on
21 healthcare.gov.
22 So a lot of people were able to get
23 coverage, or change coverage; maybe their
24 income changed so they are able to change
25 coverage on the federal platform and

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1 healthcare.gov states. But we do know that
2 there are others that did have a loss of
3 coverage who lost their job and whose income
4 dropped and if they were uninsured when that
5 happened, they were not able to come on to
6 the Exchange through a federal enrollment
7 period. That was true for all healthcare.gov
8 states that they -- if they do not have
9 coverage prior to losing their job, that they
10 could not use the special enrollment period
11 to gain coverage with tax credits on the
12 federal platform.
13 COMMISSIONER JAGDMANN: Julie,
14 that's been a longstanding tenet of the
15 Exchanges. I think, was that primarily
16 because you can't have a situation where
17 people buy insurance the moment that they
18 need it; otherwise, talk about premiums
19 jumping. They will jump sky high.
20 MS. BLAUVELT: Yes.
21 COMMISSIONER JAGDMANN: That was, I
22 think, an accommodation. Well, it's always
23 been, if you lose your job, that's one of
24 those factors, I guess, one of those
25 extenuating circumstances under which you can

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1 go on the exchange; isn't that correct?
2 MS. BLAUVELT: That's correct.
3 COMMISSIONER JAGDMANN: It's really
4 not a change; just how it's playing out.
5 Now, this chart, I just want to ask
6 you a couple of questions. These are
7 national numbers or Virginia numbers?
8 MS. BLAUVELT: They're national.
9 Well, they're all of the states that use
10 healthcare.gov.
11 COMMISSIONER JAGDMANN: Right. So
12 you wouldn't want anybody to think these are
13 Virginia numbers; these are national numbers.
14 All right. Thank you. Very helpful.
15 MS. BLAUVELT: And I just wanted to
16 say one more thing, that there was a survey
17 done by the Commonwealth Fund. And they
18 found that, among people who lost their jobs
19 during the COVID crisis, most did not have
20 coverage through their job.
21 Okay. We can move to the next
22 slide, which is my conclusion slide. And as
23 I said, David's going to continue on after I
24 finish, but just to wrap things up, back in
25 the beginning, we saw that the percentage of

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1 the uninsured in Virginia is at its lowest in
2 ten years. And in the early years of the
3 ACA, the fully insured market as a whole was
4 at its highest enrollment in the ten years
5 prior to that. And now we've seen that all
6 of the commercial markets are at or near
7 their lowest enrollment in ten years.
8 And we talked about, as government
9 programs, commercial -- as government
10 programs increased, that the cost of
11 commercial insurance could potentially
12 increase to need to make up the shortfall for
13 provider reimbursement needs.
14 Medicaid expansion, along with other
15 options, like the sole proprietor
16 legislation, (indiscernible) the years out of
17 the individual market. And there are
18 probably other options, too, that are drawing
19 people out of the market; those are the two
20 big things.
21 The individual market has been
22 highly subsidized, what it was in 2019. But
23 with decreasing premiums, that could possibly
24 bring more unsubsidized persons into the
25 market. Right now, the unsubsidized

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1 population would probably be classified as
2 mainly not real healthy because of the high
3 premiums that have been in effect. So, you
4 know, if you really need the coverage, you're
5 going to pay that high premium. But if you
6 don't, you're probably going to find some
7 other kind of option.
8 So as premiums come down, that could
9 help the health of the individual market, and
10 hopefully it will continue to stabilize in
11 that manner.
12 But we still are only seeing about
13 one-fifth of the -- one in five persons in
14 the market has a choice of just one carrier,
15 although that has gotten -- the carrier
16 choice has gotten a lot better in the
17 individual market over the years.
18 And let's see. We talked about the
19 coronavirus challenges and the increasing
20 premiums and effects of the COVID on
21 businesses.
22 So I think that would conclude my
23 presentation. So if there are any more
24 questions on this portion from the judges,
25 then if not, I will turn it over to David

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1 Shea to continue on with more detail about
2 the individual rates for 2021.
3 COMMISSIONER HUDSON: I just have
4 one quick question. For the -- the last
5 bullet that talks about the small group
6 market, with these challenges, these new
7 challenges that are lying ahead, do you
8 believe that the increase in premium costs
9 will be minimal, will be great, or is it just
10 too early to tell at this time?
11 MS. BLAUVELT: We haven't really
12 seen large shifts in volatility for the small
13 group. So I don't expect them to be large,
14 although we really don't know what's going to
15 happen with coronavirus. But you know, I
16 wouldn't expect -- and we've seen the
17 projections for 2021. So those premiums, you
18 know, haven't increased hugely, although they
19 are increasing.
20 I think that the challenges will be
21 for each small employer as they try to make
22 it through the crisis, you know, with their
23 businesses and trying to pay their premiums
24 this year.
25 COMMISSIONER HUDSON: Thank you.

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1 CHAIRMAN CHRISTIE: Any other
2 questions? All right. Well, Julie, that was
3 a great presentation. And I've got a feeling
4 you've used that slide show before in other
5 contexts. Because if not, you should. It
6 really is a great summary of where we are,
7 where we've been, and previews of where we're
8 going. So it's really a great slide
9 presentation.
10 And with that, I'll thank you. And
11 we'll bring on Mr. Actuary, David.
12 MS. BLAUVELT: Thank you.
13 MR. SHEA: Good morning. Thank you
14 everyone. Thank you, Judge Christie. Again,
15 I'm David Shea, the Bureau's health actuary.
16 Now I'm going to be going through a bit more
17 detail about the rate filings that we saw for
18 the 2021 ACA rate filing season.
19 Before I get started, I did have a
20 quick follow-up for the federal poverty
21 level. Judge Christie, you were pretty close
22 in the annual income, where it's a cutoff.
23 It's actually, this year, the cutoff is a
24 little over $51,000. The federal poverty
25 level, a hundred percent of the federal

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1 poverty level for an individual in 2020, is
2 12,760. So four times that is at the 400
3 percent level, so 51,040 is the cutoff this
4 year for subsidies in the individual market.
5 Those numbers, obviously, will
6 change each year, go up a little bit. But
7 this year, it's about $51,000.
8 CHAIRMAN CHRISTIE: Right. Okay.
9 MR. SHEA: Just to give you-all an
10 idea of how relatively --
11 COMMISSIONER JAGDMANN: I just
12 looked --
13 MR. SHEA: -- compressed the rate
14 filing season --
15 COMMISSIONER JAGDMANN: Can I
16 interrupt, David? He was talking about
17 41,000. And we talk about the individual
18 market. And a lot of us, we've heard these
19 presentations and we're aware, but a large
20 reason for this is education for, of course,
21 for the Commission, but for everyone else as
22 well.
23 But when you say 51,000 in the
24 individual market, that doesn't mean that
25 only one person in the -- there's only one

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1 person in the family, does it? I mean,
2 that's not -- an individual plan does not
3 mean one individual.
4 MR. SHEA: Yes, that's for a family.
5 No, that's for -- the $51,000 is the cutoff
6 for an individual, one person per household.
7 CHAIRMAN CHRISTIE: Right.
8 COMMISSIONER JAGDMANN: One person
9 per household. But what about a family --
10 MR. SHEA: So if you want four
11 people -- pardon me?
12 CHAIRMAN CHRISTIE: Well, there's a
13 family income, as well, that if you're buying
14 for your family, it's a little bit higher,
15 right?
16 MR. SHEA: Yes. Absolutely. I was
17 just referring to a household of one.
18 CHAIRMAN CHRISTIE: Right. Right.
19 COMMISSIONER JAGDMANN: Well, I
20 guess what if it's a household of four?
21 MR. SHEA: The subsidies -- well, I
22 think it might be four times; I'm not sure.
23 I'd have to look that up. Let's see.
24 Here we go. For a family of four, a
25 hundred percent of the poverty level is

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1 $26,200. So you multiply that by four to get
2 400 percent. So that's a little over
3 $100,000.
4 COMMISSIONER JAGDMANN: So if you
5 make less than $100,000 --
6 MR. SHEA: That's where the
7 subsidies --
8 COMMISSIONER JAGDMANN: Thank you.
9 MR. SHEA: You can qualify for some
10 subsidy, yes.
11 CHAIRMAN CHRISTIE: And that's for
12 the silver plan. That's applicable to the
13 silver plan.
14 MR. SHEA: Okay. It is. That's the
15 benchmark plan, absolutely.
16 CHAIRMAN CHRISTIE: Right. Okay.
17 MR. SHEA: Our initial rate
18 submissions were due this year -- oh, I'm
19 sorry.
20 CHAIRMAN CHRISTIE: Go ahead.
21 MR. SHEA: Any questions? Okay.
22 Our initial submissions were due May 22nd.
23 And our deadline to submit our qualified
24 health plan recommendations is August 26.
25 Qualified health plans are those that are

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1 offered on the Exchanges. The ones off
2 Exchange are called non-qualified health
3 plans. Those reviews are done in concert
4 with the QHPs and we pretty much finish
5 everything either on or before the deadline,
6 and this year will be no different. So we
7 have to submit things to the federal
8 government by August 26th, next week.
9 We suspended public access to SERFF
10 on April the 1st, and it has been restored
11 today. So we've turned the lights back on
12 and everyone can review all the details
13 regarding all of our rate filings.
14 There was an interim date of July
15 22nd, and that was the deadline for carriers
16 to submit voluntary service area revisions
17 and voluntary rate filing revisions. After
18 that date, the only changes that carriers
19 could make to their rates, their actuarial
20 assumptions and things like that, were those
21 that were directed by the Bureau. So that
22 just gives you an idea.
23 Basically, it's a three-month time
24 frame, from May 22nd till the middle of
25 August, where all of this activity occurs.

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1 And believe me, it's a lot of activity that
2 goes on there.
3 Next slide. Okay. It's a little
4 slow. But let's see, here we go. Okay.
5 Every year presents pricing challenges for
6 the carriers in the ACA market. This year
7 was unique in that, truthfully, the biggest
8 challenge that all carriers had was to
9 determine the impact of COVID-19 on their
10 2021 rates. Now this is a good chance for me
11 to give everybody levels as to what carriers
12 are looking at when they develop their rates
13 for 2021.
14 The initial filing date was May
15 22nd. So when carriers submitted their rate
16 filings on May 22nd, it's best that carriers
17 look at -- in fact, they're required by law
18 to start with the most recent year of
19 completed historical experience.
20 Well, on May 22nd of 2020, the most
21 recent completed year is 2019. So carriers
22 are looking back at 2019. They see what's
23 emerging during 2020, so they do work very
24 diligently to try to factor in any changes
25 from 2019 to 2020, but by the time they have

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1 to set their rates and we have to put
2 everything on a bow and send it off, 2020 is
3 only halfway complete.
4 So they've got a full year last
5 year, they've got a piece of this year, but
6 they are projecting costs for next year. So
7 they've really got to look far ahead.
8 That presents a particular challenge
9 with COVID-19. Number one, as we've all
10 seen, the assumptions of the virus and how it
11 spreads and its impact on the economy has
12 been all over the place. So that's been a
13 big challenge. And frankly, this year, it's
14 not easy developing rates in the ACA market;
15 there always are challenges. But this year,
16 the sole challenge for carriers was to figure
17 out what is the impact of COVID-19 on my
18 rates for 2021.
19 So that's why it's real important
20 for folks to pay attention to, well, will
21 there will be a vaccine available? And how
22 widespread will it be available? And will it
23 be effective and safe? So that's the big
24 challenge for next year's pricing this year.
25 Next slide, please --

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1 COMMISSIONER HUDSON: David, I have
2 a couple of questions.
3 MR. SHEA: -- and I'll show you a
4 little detail on it. Yes?
5 COMMISSIONER HUDSON: So my first
6 question is, when you were talking about
7 challenges, what about a second wave of
8 coronavirus that could kind of delay more of
9 care? Do you think that has been factored
10 into as far as our rates and medical costs?
11 MR. SHEA: Well, I think the easiest
12 way to respond to that is to say that
13 whatever carriers assume as of the end of
14 last week is what's in their rates for next
15 year; there are no opportunities to change
16 their assumptions.
17 COMMISSIONER HUDSON: Okay.
18 MR. SHEA: So it's possible. And
19 you know, some of our carriers can -- our
20 presenters today can speak to that, on what
21 they assumed for their individual business.
22 I'm just going to give an overall of,
23 marketwide, what they assumed. And the
24 carriers can speak to whether they assumed a
25 second wave or not. But whatever they

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1 assumed as of the end of last week is in
2 their rates.
3 COMMISSIONER HUDSON: Okay.
4 MR. SHEA: And so if there's news
5 that comes out about a second wave, that will
6 not be able to be impact -- reflected in
7 their rates.
8 COMMISSIONER HUDSON: Okay. Thank
9 you.
10 MR. SHEA: All right. Any more?
11 COMMISSIONER HUDSON: No, we're
12 good.
13 MR. SHEA: Next slide, please. So
14 the summary of COVID-19 assumptions that were
15 included in the 2021 rate filings, we had 26
16 separate rate filings; that's for both
17 individual and small group.
18 As you're aware, quite a few
19 companies have multiple filings that they
20 submit; for example, United HealthCare has
21 three separate legal entities -- I'm sorry;
22 four separate legal entities in the small
23 group market. Of the 26 rate filings that
24 were submitted for the 2021 claim year, only
25 nine of those filings included an adjustment

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1 to their rates for COVID-19.
2 The others said that the large
3 unknown with respect to COVID-19, they had
4 decided that they would just leave their
5 rates as they are with no increase due to
6 COVID-19.
7 Initially, when the rate filings
8 came in on May 22nd, the rate increase due to
9 COVID-19 ranged from 2.4 percent to 8.4
10 percent. So, obviously, the carriers were a
11 little bit skittish in their initial
12 assumptions in their initial filings.
13 However, when all was said and done,
14 the final adjustments to carriers' rates for
15 COVID-19 ranged from two-tenths of a percent
16 to 3.7 percent. So carriers got a little bit
17 more optimistic about the impact of COVID-19
18 on their rates for 2021. But there are still
19 minimal impact.
20 And truth be told, the main reason
21 why our rate -- initial rate changes changed
22 from the initial filing to the final filing
23 was due to the fact that carriers got, like I
24 said, a little bit more optimistic about
25 COVID-19. And our individual presenters are

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1 welcome to speak to their assumptions.
2 Now, those assumptions kind of broke
3 down into numerous areas. It was mentioned
4 earlier about deferred care or pent-up demand
5 of services. Now, again, we have to
6 remember, this is now going into 2021. So it
7 really doesn't matter what happens the rest
8 of this year. What these assumptions are for
9 are 2021.
10 There was also assumptions about the
11 economic impact of job loss, not only in the
12 small group market but in the individual
13 market. There was also some concern about
14 the health status of the people that remain
15 in the market. Those who can't afford it are
16 probably the first to drop out and they are
17 usually healthier individuals.
18 There was some assumption about
19 changes in provider reimbursement; that
20 physicians and some hospitals have had, in
21 some cases, a dramatic drop-off in revenue.
22 And so there's a possibility that some of
23 those providers will go back to the carriers
24 that they participate with and try to work
25 out an arrangement where their reimbursements

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1 have increased.
2 And on a smaller scale, there's also
3 some COVID-19 direct costs that are built
4 into those assumptions. But again, the
5 presenters could speak better to their
6 particular assumptions and their rates.
7 Next slide. Okay. I'm not seeing
8 any difference on my screen, so I will just
9 speak to -- there it is. It's loading up.
10 I've got a summary of the COVID-19
11 assumptions that are built into the rates for
12 our presenting companies. And this is how
13 they ended up. In the individual market, the
14 changes ranged from nine-tenths of a percent
15 to 2.9 percent.
16 And in the small group market, for
17 those carriers presenting today, the changes
18 were anywhere from 0 to 3.7 percent. And
19 again, the companies could speak better to
20 what's built into those numbers.
21 Next slide, please. Julie had
22 mentioned this earlier, that some carriers
23 developed some premium relief programs.
24 These are applicable only to the small group
25 market. As you can see, Anthem and

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1 HealthKeepers provided a 15 percent reduction
2 to April premiums. CareFirst and GHMSI, a 10
3 percent reduction applicable to August. And
4 UnitedHealthcare provided a 10 percent
5 reduction applicable to May premiums.
6 Next slide. This slide shows the
7 pricing trends for our presenters in both the
8 individual and the small group markets. And
9 a good way to think of this is if you try to
10 take out all of the noise going on, for
11 example, with COVID-19 and other impacts that
12 are sort of out there in the environment,
13 take those away, and generally, where
14 carriers start making their projections are
15 with what's called pricing trends.
16 And what this shows is -- as you can
17 see, the places of service, in-patient
18 hospital, outpatient, physician, and
19 prescription drugs -- carriers provide
20 details on their expected changes in cost for
21 each of those places of treatment and changes
22 in the utilization of services.
23 If you look all the way on the
24 right-hand side of the column where those
25 trends are totaled up, you can see generally,

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1 even though all of these carriers are
2 different, they operate in different markets,
3 they have different blocks of business of
4 insureds, you can see that generally their
5 trends are pretty much in the same
6 ballpark.
7 And you can also see, when you look
8 at some of the details, for example, pretty
9 much every carrier assumes drug costs are
10 going to increase at a much faster rate than
11 the utilization of prescription drugs for
12 next year. And generally, that's the same in
13 pretty much every category, inpatient,
14 outpatient, physician, and prescription
15 drugs, is generally carriers are expecting
16 the costs of those services to increase
17 greater than the use of those services.
18 So this chart in health insurance
19 has been very important in the last, well --
20 since there's pretty much been health
21 insurance. This is the key where carriers
22 start to make their projections for rates.
23 The ACA, obviously, provides
24 different challenges and different
25 complications, but this is the baseline where

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1 carriers start. And you can see that they've
2 pretty much all coalesced around the same
3 general range.
4 Next slide, please. The next slide
5 that's coming up -- again, I don't see it
6 right away on my screen -- but the next slide
7 that's coming up shows historical loss ratio
8 experience for the ACA markets in Virginia.
9 Loss ratio is a simple measure in health
10 insurance. It's basically your claims
11 divided by your premium, and it represents
12 the percentage of premium that gets paid out
13 in claims every year.
14 And what's notable when you look at
15 this graph as it progresses from 2014 to 2021
16 is the blue bar is the individual market and
17 the orange is the small group market. And
18 you can see, there's considerably more
19 volatility in the individual market than
20 there is in the small group market.
21 One of the main reasons for that
22 goes back to the fact that, when the ACA was
23 introduced, it represented a dramatic change
24 to the individual health insurance market but
25 a fairly muted change to the small group

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1 market. There were not many changes that the
2 small group market experienced with the
3 introduction of the ACA. So for them, it was
4 more or less business as usual. So that
5 meant that there could be some predictability
6 and stability over time. And you can see the
7 small group loss ratios, the lowest has been
8 76 percent and the highest has been 81, 82.
9 Likewise, in the individual
10 market -- and you might recall Julie's graphs
11 that showed that big bump in average premium
12 from 2017 to 2018. Well, if you think about
13 it, when carriers were projecting their 2018
14 rates, they were looking at 2016. And that
15 year had the highest loss ratio collectively.
16 And so that meant carriers felt like they
17 were on the verge -- and this is true of some
18 -- they were on the verge of losing money,
19 which would be disastrous if they didn't have
20 enough money to pay claims. So they had to
21 adjust their rates accordingly.
22 Also, at about that same time in the
23 2016-2017 period, there was considerable
24 amount of news with respect to dismantling
25 the ACA, removing the individual mandate.

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1 And that's what Julie mentioned earlier, that
2 the federal government stopped providing
3 payments for cost-sharing reductions; that
4 was all in that period of time, while also
5 the carriers were seeing extremely high loss
6 ratios. So that explains why that average
7 premium shot up so much from 2017 to 2018.
8 As you can see in the individual
9 market, as you progress along, 2018 and 2019,
10 as a result of some of those high rate
11 increases, the loss ratios began to decline
12 quite dramatically. But for the '20 and '21
13 period, carriers are collectively projecting
14 to have a loss ratio in the individual market
15 in the 80, 81 percent range. So they're
16 trying to get back to some stabilized
17 normal.
18 Next slide, please.
19 COMMISSIONER JAGDMANN: Can I ask a
20 question, David?
21 MR. SHEA: Yes.
22 COMMISSIONER JAGDMANN: This is just
23 to clarify. I'm assuming that all of these
24 slides are -- it's Virginia data. And you do
25 have Virginia, I see it, ACA historical data

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1 in Virginia. I had skipped over that. But
2 all your slides are Virginia specific, unless
3 you specifically designate otherwise,
4 correct?
5 MR. SHEA: That is -- yes, that is
6 correct. And I'm pretty sure all of my
7 slides and a great number of Julie's slides
8 are Virginia-only experience. Yes, but we
9 try to be pretty clear in labeling so that
10 anybody who grabs this presentation and picks
11 it up and starts reading it at least will
12 know what data they're looking at.
13 COMMISSIONER HUDSON: David, I have
14 a question as well.
15 MR. SHEA: Yes.
16 COMMISSIONER HUDSON: So just for
17 the record, under the Affordable Care Act,
18 insurers must spend 75 percent on medical
19 cost. So what happens to the remaining 25
20 percent?
21 MR. SHEA: That 75 percent is a
22 Virginia standard. The standard at the
23 federal level is a little different; it's 80
24 percent. It's a different calculation.
25 But let's stick with the 75 percent

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1 in Virginia, because that's what we measure
2 carriers against; that's the standard we use.
3 The remaining 25 percent is used to pay
4 carriers' administrative costs, marketing
5 costs, salaries, taxes and fees. And the
6 remainder -- hopefully there is a
7 remainder -- is a carrier's profit on a
8 percentage basis.
9 Which, again, going back to the 2016
10 and 2017, if a carrier has a loss ratio of 96
11 percent, carriers' expenses are generally a
12 bit more than 4 percent of premium. So in
13 that year of 2016, there were carriers that
14 probably didn't have money to pay -- well,
15 certainly they have to pay taxes and fees;
16 there's a lot of givens there. Commissions
17 on sales, things like that, there's not
18 always a lot of wiggle room in a carrier's
19 expenses.
20 So that's why that year in
21 particular was quite drastic for carriers,
22 because they're sitting there trying to find
23 out, "All right. How am I going to pay all
24 of these expenses? I have to pay my claims.
25 I'm not going to have any left over."

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1 Therefore, that's when that got to
2 that big rate increase, because they knew
3 they would have to project to not have a 96
4 percent loss ratio in the future. Does that
5 help?
6 COMMISSIONER HUDSON: Okay. No, it
7 does. It does, a great deal.
8 So if an insurer does not spend 75
9 percent -- like I see, in 2018 and 2019, for
10 the individual market, it's 70 and 65
11 respectively -- what happens there? Does the
12 insured -- are they required to provide
13 rebates or credits back to the customers?
14 MR. SHEA: That's a great question.
15 And the answer is yes, at the federal level.
16 COMMISSIONER HUDSON: Okay.
17 MR. SHEA: The Virginia loss ratio
18 standard is for projections. So when we look
19 at a rate filing, we want to see, after all
20 of the carrier's assumptions and make sure
21 they've done all their calculations
22 correctly, we want to make sure that they're
23 assuming that they're going to pay out at
24 least 75 percent of their premium in claims.
25 On the federal level, that 80

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1 percent number, that is really a
2 retrospective look. So at the federal level,
3 carriers will submit all of their loss ratio
4 detail to the federal government and they
5 will base -- use 80 percent as that
6 benchmark. And when carriers don't hit that
7 80 percent, if it's below that, that
8 difference gets refunded to their insureds.
9 COMMISSIONER HUDSON: Perfect.
10 MR. SHEA: And that's what's called
11 the MLR rebate, the medical loss ratio
12 rebate. Yes, they do. They do have to
13 return some of that. Based on a federal
14 guideline, they return it to their insureds.
15 COMMISSIONER HUDSON: Okay. Great.
16 Thank you for the clarity.
17 MR. SHEA: Does that help?
18 COMMISSIONER HUDSON: It does.
19 Especially the Virginia distinction, that's
20 helpful. Thank you.
21 MR. SHEA: Okay. Sure. Next slide,
22 please. This slide kind of harkens back to
23 what we talked about earlier in one of
24 Julie's. And I like what you said about
25 this, Judge Christie, because even though the

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1 percentages may not have -- were not
2 calculated based on the number of members
3 which is kind of equal across all carriers,
4 the story is still the same.
5 This story shows that, in 2018,
6 there was a massive rate change in the
7 individual market in Virginia. And that was
8 based on all of those criteria we talked
9 about earlier, the very, very high loss
10 ratios, the constant hammering in the media
11 and in Congress at the federal level about
12 getting rid of the ACA, taking away some
13 payments that were supposed to be made. And
14 it got -- it just made the market incredibly
15 unstable. We had some carriers exit the
16 market. And so that increase were the
17 carriers that chose to remain.
18 Again, the percentages are
19 calculated based on a weighted average
20 premium. We are modifying that change. And
21 we're calculating it on the number of members
22 in each carrier and weighting the rate change
23 that way.
24 In particular, that last percentage
25 on --

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1 COMMISSIONER JAGDMANN: Will this
2 chart do that --
3 MR. SHEA: -- the right --
4 COMMISSIONER JAGDMANN: -- or will
5 it do it in the future? This chart is not
6 weighted by the number of -- this chart does
7 not take into account maybe that only one --
8 MR. SHEA: And you know it --
9 COMMISSIONER JAGDMANN: Let me ask
10 it my way, if I may. Does this chart take
11 into account that one person --
12 MR. SHEA: Okay.
13 COMMISSIONER JAGDMANN: -- may have
14 bought the most expensive premium or not?
15 MR. SHEA: I will say that it does.
16 However, I will also say that, in the past,
17 when you're looking at '15, '16, '17, and
18 generally '18 -- and again, there was a huge
19 amount of dislocation in the market
20 particularly in 2018 -- the calculation
21 really didn't make too much difference
22 because the premiums were generally within a
23 certain boundary. But as time went on, one
24 or two of the average premiums started to
25 really deviate.

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1 So we're going to make those
2 changes. And in particular, that very last
3 number on the right, that picked up the
4 weighted average premium. But when you base
5 it on the number of members, which is a
6 better way to represent the market -- for
7 example, if you've got two carriers in the
8 market and they each have 100 insureds, one
9 carrier files a zero percent rate change and
10 the other files a 20 percent rate change, if
11 you use members to weight those rate changes,
12 the average rate change in the market is
13 10.
14 Now, as all averages do, sometimes,
15 unfortunately, they don't represent any one
16 person or any one action; they represent an
17 average. So in this case, the average rate
18 change in the market is 10 percent.
19 However, if you start weighting them
20 by premium, if one carrier's premium is five
21 times greater than the other, you're going to
22 throw a lot more weight toward that carrier,
23 when that's not really representative of what
24 the market's going to see on average.
25 So in 2021, the collective

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1 expectation of the carriers that have
2 filed -- and we're going to make the change
3 before we put this presentation out on our
4 website -- the average rate change in the
5 individual market is around -7 percent, which
6 is really good news for consumers. Very good
7 news for consumers.
8 It also does speak to the fact that,
9 if you remove COVID-19 from the equation, the
10 individual market and all the swirl and noise
11 around it has really died down over the last
12 couple years. And what that does is it makes
13 carriers a little more confident and
14 optimistic about participating in the market.
15 And we see those results in the changes.
16 CHAIRMAN CHRISTIE: Let me just say
17 this, David.
18 MR. SHEA: Again, though, going back
19 to what Judge Christie --
20 CHAIRMAN CHRISTIE: Let me just jump
21 in here. In 2018, you're right, there was an
22 effort to repeal the ACA, but they did repeal
23 the individual mandate. And the rates --
24 interestingly enough, we were told the
25 individual mandate was critical to keeping

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1 rates down; in fact, rates have gone down
2 after the individual mandate was repealed.
3 Now, that could just be statistical noise and
4 probably is statistical noise.
5 But if this chart showed rates from
6 2010, they would be a lot higher increases.
7 Because we've been keeping the rate increase
8 since 2010, and they're a lot higher than
9 these, if you use that as a baseline. This
10 is from 2015, I notice, and not prior to
11 2015.
12 MR. SHEA: That's a good point.
13 This measures the rate changes for the ACA
14 market. Prior to that, carriers were all
15 over the place; they didn't offer the same
16 set of benefits. There were no essential
17 health benefits that they were required to
18 offer.
19 The rating requirements, the rating
20 variables like age and gender and health
21 underwriting, they were all over the place.
22 So it was virtually impossible to measure a
23 change in the average individual health
24 insurance premium prior to the ACA. There
25 were studies that did that, but you'd have to

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1 make a lot of assumptions and try to put a
2 lot of carriers on an equal footing before
3 you could get a real good measurement of what
4 those rate changes looked like. And as the
5 ACA was --
6 CHAIRMAN CHRISTIE: Well, but what
7 we as a Bureau have to do is to take the
8 popular plan --
9 MR. SHEA: -- introduced, pretty
10 much everything -- right.
11 CHAIRMAN CHRISTIE: And take the
12 most popular plan, you're right, it wasn't
13 community rating.
14 MR. SHEA: That's true.
15 CHAIRMAN CHRISTIE: And it wasn't
16 guaranteed issue. And those are both good
17 things. But they've come at a price. So
18 let's just be realistic about it. It's great
19 seeing rates --
20 MR. SHEA: That's true.
21 CHAIRMAN CHRISTIE: -- go down.
22 It's great seeing rates go down. I mean,
23 that's wonderful. It's a heck of a lot
24 better than going up 70 percent. But you
25 know, this only goes back but so many years.

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1 I mean, let's hope the trend continues, for
2 gosh sakes.
3 MR. SHEA: We certainly do. We
4 certainly hope the trend continues. And you
5 know, you have a good point about the
6 individual mandate. Prior to the
7 introduction of the ACA, an enormous number
8 of people, including many health actuaries,
9 believed that the linchpin, the keystone to
10 the individual market was the individual
11 mandate requiring people to purchase
12 coverage.
13 CHAIRMAN CHRISTIE: Right.
14 MR. SHEA: While that may be true to
15 a degree, the more powerful incentive to get
16 people and keep people in the individual
17 market was the subsidized coverage. That was
18 much more powerful than a government mandate.
19 CHAIRMAN CHRISTIE: Right.
20 MR. SHEA: And so, yes, the
21 individual mandate, probably not a great
22 thing that it's no longer there, but it
23 wasn't the doomsday scenario that everybody
24 had expected, because the subsidies were the
25 keys to keep people in the market.

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1 So carriers have managed to work
2 around that. And what we're seeing is the
3 result of all that work. And like I said, we
4 expect an average rate decrease in the
5 individual market in Virginia next year of
6 about 7 percent.
7 CHAIRMAN CHRISTIE: Well, the
8 biggest concern I've seen in this
9 presentation -- and in Julie's -- is that the
10 enrollment is the lowest it's been in ten
11 years. And you know, as you well know, the
12 only way you can have guaranteed issue and
13 community rating is with a large enough
14 enrollment of healthy people. That's the
15 only way you can have it.
16 Otherwise, it's just a matter of
17 arithmetic; the rates go up. If the
18 morbidity goes up -- and we haven't heard the
19 term morbidity -- but that's the claims and
20 the --
21 MR. SHEA: Right.
22 CHAIRMAN CHRISTIE: -- and what
23 we've heard for years in these presentations
24 is the concern that the morbidity -- and it's
25 been a lot more applicable, interestingly

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1 enough, in some of the Northern Virginia
2 carriers -- but the morbidity is the big
3 thing that drives rate increases. And if you
4 don't balance that out with young, healthy
5 people, that's when community rating and
6 guaranteed issue structure sees, you know, a
7 spiral of rate increases.
8 And so Julie's chart about the
9 lowest number in ten years of enrollment --
10 and a lot of them are going to Medicaid, and
11 that's fine; they can afford that -- but it's
12 pulling them out of the pool. To the extent
13 they're younger and healthier, it's pulling
14 them out of the pool that's necessary to keep
15 the rates down in the Exchange.
16 MR. SHEA: Yes. That's true. And
17 you know, part of it is, particularly moving
18 into the 2019, 2020, 2021 period, part of the
19 drop in the individual market is due to
20 Medicaid expansion. Certainly, another part
21 is the simple afford -- unaffordability for
22 some individuals of the premiums. You've got
23 to remember that anybody below that $51,000
24 FPL gets some portion of their premiums
25 subsidized. But after that point, it drops

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1 off.
2 CHAIRMAN CHRISTIE: That's right.
3 MR. SHEA: And while $51,000 is a
4 good income, health insurance premiums
5 potentially can take up a huge portion of
6 that. And so that's when you get at the
7 affordability.
8 And you're right. If those numbers
9 continue to drop over time, then some
10 carriers might have some serious
11 considerations about whether they'll continue
12 to participate in the market. So it's vital
13 that we all work to try to maintain a healthy
14 market with good competition and rates that
15 are stable over time. That would be -- that
16 would be the nirvana, really, is the
17 stability of rate changes over time.
18 Even though they're at a high level,
19 if they're predictable, it's easier for
20 people to plan. And so, as you can see in
21 the past, from the 2015 to 2018, rate changes
22 in the individual market were hardly what I
23 would categorize as predictable. But as
24 we're moving forward, with the Medicaid
25 expansion and the stability in the market,

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1 that if rate changes can be predictable, then
2 it will be easier for folks to decide whether
3 they want to participate.
4 Any more questions?
5 COMMISSIONER JAGDMANN: Yeah. Just
6 looking at this chart, just putting it in
7 perspective, in general, just from 2015 to
8 2021, which just looking at the numbers you
9 have here, basically, the trend is much
10 better because rates are going down. But
11 these individuals have seen over a 100
12 percent increase in their rates over this
13 time period. It's going back down, but I
14 mean --
15 MR. SHEA: Yes, that's right.
16 You're right. Cumulatively speaking, the
17 rate changes are pretty high.
18 COMMISSIONER JAGDMANN: And I just
19 want to say that. Because one individual
20 should know, we appreciate that. I'm
21 thinking people may be listening and they're
22 saying, "Okay, they're saying rates are going
23 to go down 2 percent, but it's eating me
24 alive." Well, you appreciate that when
25 you're looking at these rates from an

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1 actuarial pointed of view, I'm sure.
2 MR. SHEA: Absolutely. And you
3 know, it gets down to that old trope of
4 healthcare is expensive in the United States.
5 And to a large degree, health insurance
6 premiums reflect that level of cost. And,
7 you know, we're definitely cognizant of these
8 changes over time.
9 CHAIRMAN CHRISTIE: Well, and as you
10 know, in Virginia, health insurance carriers
11 often get blamed, but they have to buy from a
12 very concentrated hospital market in
13 Virginia.
14 MR. SHEA: True. Any more
15 questions?
16 COMMISSIONER JAGDMANN: No, I have
17 none.
18 MR. SHEA: Okay. Next slide,
19 please. I believe this next slide is the
20 same chart for the small group market. You
21 will not see huge swings in rate changes over
22 time.
23 And also, a point here, while we're
24 going to be basing these rate changes on
25 weight by number of members, in the small

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1 group market, there isn't a huge amount of
2 rate variation, as there is in the individual
3 market. So we're not going to see big
4 changes in these percentages, regardless of
5 whether you do it on premium or whether you
6 do it on members, because the premiums are
7 much more clustered together in the small
8 group market than they are in the individual
9 market.
10 And you can see we're expecting an
11 average of about 5 percent change, 5 percent
12 increase in small group rates in Virginia for
13 2021.
14 COMMISSIONER JAGDMANN: Now, David,
15 we certainly understand that there's --
16 MR. SHEA: And also, remember --
17 COMMISSIONER JAGDMANN: Go ahead.
18 You finish and then I'll ask my question.
19 MR. SHEA: And we also have to --
20 pardon?
21 COMMISSIONER JAGDMANN: I said, I
22 will have a question at the end. I think
23 it's easier if I wait, because of the delay.
24 I don't want to mess up your flow, but I have
25 a question at the end, when you finish this

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1 slide.
2 MR. SHEA: Okay. That's fine.
3 Okay. That's great.
4 And also, one minor little thing is,
5 as Julie showed earlier with the number of
6 carriers in the market, these percentage
7 changes were based on the carriers that were
8 in the market at the time.
9 So it's possible that a carrier or
10 two in 2017 who had substantially high rate
11 increases, say, in the small group market are
12 no longer here or left the market in 2018.
13 It still tells the same story of what
14 happened in that year though.
15 And like Judge Christie said
16 earlier, not focusing so much on the absolute
17 numbers but the trend over time. And
18 particularly, when you compare individual and
19 small group, you can see the individual of
20 the small group rate changes are relatively
21 stable compared to the individual ones.
22 Okay. Let's go to the next slide.
23 COMMISSIONER JAGDMANN: Well, I have
24 a question, if you're through now. When
25 you're looking at the percentage of increase,

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1 we don't have the -- you don't have the exact
2 premium, but that's okay. But just in
3 looking back over these presentations over
4 the years and being aware of the changes that
5 are proposed and have occurred, we are aware
6 that there's been, I would call it, the
7 flight or attempted flight from the
8 individual market to the small group market.
9 And I'm assuming that you don't have the
10 numbers here, but the premiums are lower in
11 the small group market than they are in the
12 individual market generally; is that correct?
13 MR. SHEA: That is very true.
14 Generally speaking, they are lower in the
15 small group market than they are in the
16 individual market.
17 COMMISSIONER JAGDMANN: And do you
18 know where we are -- where are we with these
19 issues? And what's going on with, I'd say,
20 options for individuals? Do we have -- I
21 know there were --
22 MR. SHEA: With respect to the plans
23 that are available?
24 COMMISSIONER JAGDMANN: Yes. No,
25 with respect to our individuals that --

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1 MR. SHEA: Is that with respect to
2 the plans that are available?
3 COMMISSIONER JAGDMANN: Yes. Well,
4 no, actually, I'm just saying are there --
5 MR. SHEA: The presenting carriers
6 can speak about that.
7 COMMISSIONER JAGDMANN: Okay. I'll
8 ask that then. Okay.
9 MR. SHEA: Yeah. And I would say,
10 generally speaking, the plans, the health
11 plans that are available in the small group
12 market are richer than those in the
13 individual market, if you think in terms of
14 deductibles, just deductibles. The average
15 deductible in the small group market is going
16 to be much lower than it is in the individual
17 market.
18 And likewise, with co-insurances and
19 co-pays. The plans will be richer in the
20 small group market than they will be in the
21 individual market.
22 And I think we can go to the next
23 slide. I have reached the end of the road
24 for me. I can at least see the title. Okay.
25 CHAIRMAN CHRISTIE: Any questions

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1 for David?
2 MR. SHEA: And these are the list of
3 our presenting companies today. Yeah.
4 CHAIRMAN CHRISTIE: Any other
5 questions for David? All right. Well,
6 David, thank you. As always, very
7 informative and interesting. And so I guess
8 we will move on to the actual companies.
9 MR. SHEA: Companies, yes.
10 CHAIRMAN CHRISTIE: We start with
11 HealthKeepers and Anthem. Tim Connell, you
12 can just come on up onto the screen and just
13 hit the high points for us.
14 MR. CONNELL: All right. Thank you.
15 Can you hear me?
16 CHAIRMAN CHRISTIE: Yes.
17 MR. CONNELL: Good morning. This is
18 Tim Connell. I'm with Anthem plans, located
19 at 2221 Edward Holland Drive in Richmond,
20 Virginia. I'll be here representing the
21 Anthem plans for individual and small group,
22 so that includes Anthem Individual
23 HealthKeepers as well as small group
24 HealthKeepers and small group Anthem Health
25 Plans of Virginia.

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1 I think we're starting here -- the
2 first slide you see is our rate increases for
3 the individual market. I thought I'd give a
4 couple comments, just some of the things that
5 were mentioned earlier in the call, just to
6 level set a little bit.
7 During the Deputy Commissioner's
8 discussion of participation in the market, we
9 have expanded our footprint in both 2019 and
10 in 2020. So we had a smaller area of
11 coverage in 2018, and it's a little bit
12 larger in '19. And in 2020, as well as 2021,
13 we are participating in what we call our full
14 participation market.
15 So we're in all the counties that we
16 are eligible for with the Blue Cross
17 Association agreements. So the other
18 counties in the northern part of the state
19 would be in the CareFirst regions. So our
20 participation is full statewide, both this
21 year and what we're proposing for next year.
22 CHAIRMAN CHRISTIE: And thank you.
23 Yes, thank you for that. Because the more
24 carriers participate in the more localities,
25 the more, obviously, consumers are better

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1 off.
2 MR. CONNELL: Thank you. So I'll
3 start with individual here. And I think it's
4 a pretty good story as far as what we're
5 going to say for the consumers. And the
6 bottom line that you'll see on the most
7 popular plan is about an 8.4 percent
8 decrease. So that's pretty close to our
9 average. I think we're in the neighborhood
10 of a -8 percent overall. And this most
11 popular plan is a silver plan that you're
12 looking at here.
13 Some of the components are broken
14 down there on the bottom half of the page,
15 where you can see what's driving the
16 increase. And I'll mention here that we
17 talked a little bit about morbidity earlier,
18 too. And there's sort of an interplay here
19 with morbidity and risk adjustment that I'll
20 just mention.
21 And that is when, say, in our case,
22 where morbidity improves in our population
23 but other carriers are seeing the same
24 morbidity, we'll actually have to pay some in
25 risk adjustment for that. So the risk

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1 adjustment, as it's used in the individual
2 market, is meant to normalize a little bit
3 for carriers that may be unlucky and get many
4 poor health risks and groups that happen to
5 get very healthy risks would have to pay into
6 it. So there's a little bit of interplay
7 with that.
8 And that's what's meant to be
9 reflected in the second and the fourth line
10 in our buildup, that we're actually expecting
11 some morbidity improvement in our population.
12 But on the other side of the equation, we'll
13 actually have to pay a little bit back into
14 risk adjustment.
15 The thing we really worry about in
16 the market is when the overall market
17 increases in morbidity. And I think that's
18 what Judge Christy was referring to earlier,
19 where we see, you know, people leaving the
20 market and they tend to be healthier people.
21 And you might see your morbidity increase,
22 but you wouldn't see any risk adjustment
23 compensation for that, because it's really
24 everybody's -- you know, all carriers seeing
25 the morbidity increase.

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1 COMMISSIONER JAGDMANN: And I'm just
2 going to jump in here for a minute. You've
3 had the, I guess, the luck -- or the
4 unluck -- of coming first. And a large
5 reason for this presentation is to make sure
6 that anyone who's listening to this
7 proceeding has an idea of why certain
8 premiums are going up or going down.
9 So if you would, in layman's terms,
10 explain morbidity. To me, I always think of
11 it is in terms of, you know, how sick is your
12 population, how much usage of the insurance
13 is there going to be, something along those
14 lines. But, you know, just define these
15 terms just a little bit so somebody who
16 hasn't been following this for five years can
17 understand what you're talking about here
18 with respect to morbidity and trend and go
19 through those, and the risk adjustment; you
20 did a little bit on that. But if you would
21 do that, that would be helpful.
22 MR. CONNELL: Sure.
23 COMMISSIONER JAGDMANN: And if you
24 do a great job, we won't have to ask anybody
25 else.

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1 MR. CONNELL: You're right. I am
2 the lucky one for getting to go first.
3 So yes, morbidity, I think, Judge,
4 you described it pretty well. It's really
5 meant as a measure. I do forget sometimes;
6 we get very technical in our definitions and
7 we use these terms a lot amongst ourselves.
8 But yes, the general public may not be as
9 aware of it.
10 COMMISSIONER JAGDMANN: You don't
11 have to die. You don't have to die. It
12 sounds pretty morbid, right?
13 MR. CONNELL: True. It may be a
14 little more dire than it really is. But it's
15 something we really pay attention to,
16 especially in the individual market where
17 there's a lot of turnover and you have
18 different membership from year to year and
19 you're really concerned about the general
20 health of that population you're covering.
21 It comes into play a lot more in the
22 individual rate setting than in small group,
23 you know, where we've expected maybe some
24 more drastic changes over time. So I would
25 say the way you characterize it is correct,

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1 that it's a measure of the health of your
2 population.
3 And if your morbidity is increasing,
4 if it's a positive number, it means you think
5 you're getting a somewhat sicker population.
6 Now, when you get that, if that's what you're
7 projecting to happen, it's possible, too,
8 that you might see risk adjustment compensate
9 for that. And such that, if your morbidity
10 goes up, you might see a negative influence
11 on your risk adjustment level, which is row
12 No. 4 there.
13 So it's typical that you see some of
14 those move together. I will give a little
15 counter example when we look at our small
16 group rates, where we really just perceive
17 some positive news happening on risk
18 adjustment that we hadn't had in there
19 previously. But those two measures are
20 interrelated; however, it is possible for a
21 carrier to say we think morbidity is causing
22 an increase in rates, but we may think that's
23 due to the individual market shrinking and
24 that we won't see any compensation from the
25 risk adjustment side.

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1 So there's just a dynamic in play
2 there that everyone should be aware of, that
3 there is a relationship, but at the same
4 time, we might also see some morbidity
5 increase just happening overall, which is
6 what we've really, as insureds, been trying
7 to get a handle on with the ACA market.
8 I think there was definitely a fear,
9 as we said earlier, back in 2018, with what
10 kind of morbidity increase we would see when
11 CSRs funding stopped, when the individual
12 mandate went away, when there was just lack
13 of support for the ACA; there was a fear
14 there that morbidity in the market would just
15 be increasing and we wouldn't see risk
16 adjustment compensating for that.
17 I do agree with David Shea's
18 characterization, too, though, that probably
19 the premium subsidies in the market have been
20 a good stabilizer, though, one that we
21 weren't sure if it was going to be stabilized
22 in the market back in 2018, but I think we've
23 seen that play out a little bit in practice.
24 CHAIRMAN CHRISTIE: What is the
25 number -- the big number you got there is

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1 Other/Favorable Experience, -13 percent.
2 That's the biggest driver to bring it down.
3 How would you describe that line?
4 MR. CONNELL: Yes. Most of that is
5 in the favorable experience. So I think
6 that's what we're trying to reflect there.
7 And that could be what we're seeing
8 through -- as David mentioned earlier, the
9 2019 experience is our primary experience
10 that we're using. We're also trying to look
11 at the early 2020 development, though it has
12 been a little bit difficult to get that,
13 especially with COVID-19.
14 CHAIRMAN CHRISTIE: But what's the
15 favorable experience? It's not morbidity
16 because you've got a morbidity line. It's
17 not trend. What is it?
18 MR. CONNELL: So it could be the
19 claim experience we saw for 2019. There
20 could be morbidity wrapped into it, in that
21 what we assumed in morbidity for 2020 was
22 higher than what we needed for an adjustment
23 like that. So I think it's related to prior
24 assumptions that we made in the 2020 rates.
25 And it's also related to how 2019 experience

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1 has come in and what we think that means in
2 the 2020 period.
3 COMMISSIONER JAGDMANN: Would you
4 say -- what I hear you saying is that there's
5 some stability in there. You're seeing some
6 stability in your facts and what's coming to
7 fruition. Is that what you're -- generally,
8 is that sort of it?
9 MR. CONNELL: I think so. I think
10 so. You know, this is the second year in a
11 row we're going to be giving a decrease in
12 the rates. So I think that was not where we
13 expected to be two years ago. I think we
14 were worried about the stability, and we are
15 seeing that it has stabilized a little bit.
16 Certainly, we're kind of keeping an
17 eye on new developments. And certainly, with
18 discussions on COVID-19, there's a lot of
19 uncertainty there. But we do see that
20 there's been some stabilization.
21 CHAIRMAN CHRISTIE: Okay. You can
22 focus on your most popular plan and -- well,
23 you've already done it, really.
24 MR. CONNELL: Yep. I didn't know if
25 we wanted go over any of the other -- I'll

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1 kind of hit quickly on some of the other line
2 items.
3 COMMISSIONER CHRISTIE: Not really.
4 We just want to stick to the most popular --
5 COMMISSIONER JAGDMANN: Well, I'd
6 asked him to go over the definitions of these
7 things so people --
8 CHAIRMAN CHRISTIE: Oh, yeah. No.
9 COMMISSIONER JAGDMANN: -- know what
10 we're talking about.
11 CHAIRMAN CHRISTIE: I'm just trying
12 to --
13 COMMISSIONER JAGDMANN: Move this
14 along, I know.
15 CHAIRMAN CHRISTIE: -- keep it from
16 being so long today.
17 COMMISSIONER JAGDMANN: Yeah, just
18 go down through there, just quickly, what you
19 think they mean.
20 MR. CONNELL: Sure. The trend is
21 more of a global item that we use in our
22 pricing. I think David Shea's presentation
23 had a line item for this as well. But it's
24 meant to cover what we just expect to happen
25 in the environment, to be cost per unit,

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1 utilization, provider increases that we have
2 to give, new technologies; it covers kind of
3 a wide variety of things. And it's generally
4 used for all the insureds in a similar way.
5 We did use this trend item as well
6 to cover the uncertainties with COVID-19. So
7 we can get into that a little bit, if you'd
8 like, but that's where we are keeping --
9 where we're assuming the COVID impact would
10 hit, for the most part.
11 COMMISSIONER HUDSON: Tim, I just
12 have a question, just to touch upon that.
13 I'm sure when you provided the information to
14 our Bureau of Insurance that there were
15 algorithms and models that you had to work
16 on. Do you think that the coronavirus
17 pandemic complicated the models that you had
18 to put together to set the prices for next
19 year's premiums and co-pays?
20 MR. CONNELL: Definitely, yes.
21 Yeah, we really -- and we kind of joke
22 internally that we needed to be economists
23 and clinicians and, you know, we certainly
24 relied on some of our experts within the
25 company to help us with that.

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1 But it was such an uncertainty. And
2 I think David Shea mentioned earlier that,
3 you know, we had some initial assumptions
4 back in filing this and trying to get it
5 ready back in April. You know, back then,
6 there were discussions that the pandemic may
7 cause insureds to go insolvent; that costs
8 may run out of control. I think there was
9 more worry back then about -- and there's
10 still a lot of uncertainty about what the
11 downside is.
12 So yeah, we had to really try to do
13 our best with what we thought the economic
14 situation would be. And it's so varied in
15 its implications. It's the cost of covering
16 COVID, it's the economy, it's groups and
17 members losing their jobs and losing their
18 coverage, and how will that impact our market
19 and how will it impact the individual market
20 versus the group market. You know, a lot of
21 complexities in there.
22 So I think we're -- and the other
23 part which was interesting was we knew in
24 filing that we really didn't have our final
25 answer at the time of filing. And even when

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1 we refiled according to the dates in July,
2 you know, we're putting our best estimates at
3 the time when we make each filing. I think
4 we're uncovering this as we go.
5 COMMISSIONER HUDSON: Sure. Sure.
6 And if you can just maybe touch upon
7 long-term impacts. Because I assume that
8 there's a significant degree of uncertainty
9 there that may impact premiums, such as
10 whether you're going to be required to cover
11 COVID-19 diagnostic tests and antibody tests
12 and whether people are going to return to do
13 more elective care. And I'm just making a
14 presumption there.
15 MR. CONNELL: Right. You hit on
16 some of the things we tried to consider. It
17 was -- I would say one of the primary things
18 was we knew utilization tapered off in the
19 second quarter of this year. And as people
20 had stay-at-home orders and doctors' offices
21 were closed, people weren't getting the
22 normal care that they would have been
23 getting.
24 So what we tried to project was,
25 when people that delay a service, it's

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1 possible that -- we assume some of those
2 services may never get done. But on the
3 other hand, we figure people might delay an
4 elective -- an elective surgery sounds like
5 it really might be optional, but I'm sure in
6 many cases, people are living with some
7 uncomfortable conditions and that elective
8 surgery is going to relieve that.
9 So we do expect a lot of this to
10 come back. So, really, one of our major
11 tasks was trying to figure out when would the
12 utilization start to -- we've referred to
13 internally as there's sort of a baseline
14 number. And for about three months, we were
15 below baseline, because people weren't
16 getting the services that they usually get.
17 And then we're trying to figure out when will
18 utilization return to baseline and then we
19 expect it to go over baseline as some of that
20 pent-up demand starts to return.
21 So that's where we really thought
22 that pent-up demand still might be delayed.
23 We think that's probably still a reasonable
24 projection at this point, especially now
25 that -- you know, when COVID numbers were

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1 dropping off, we were concerned; maybe it's
2 going to bounce back a little earlier. But
3 then COVID numbers bounced back up. So we
4 think that that return of utilization still
5 coming maybe in the fourth quarter and really
6 spilling into 2021 is reasonable.
7 Additionally, when people are
8 missing their services or maybe their visits
9 and check-ups, you know, there could be an
10 increase in health problems that result from
11 that. So that's really an unknown. And we
12 didn't put that in explicitly, but it was a
13 part of our thinking that, you know, this is
14 just an unknown impact that we're going to
15 see for the rest of this year and next year.
16 So there certainly could be pretty large
17 downside risks that comes from it.
18 So those are some of the things we
19 thought about. And then I guess the last
20 thing I didn't mention was just the expense
21 of treating COVID. And you touched on that a
22 little bit, too; that we have to -- we're
23 expecting to keep cost shares at zero for
24 members during the period. And we're also
25 expecting to cover these expenses that

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1 weren't in the system, you know, prior to
2 this year.
3 So that was a tricky one to project
4 as well. We actually called that one fairly
5 low. Now that we're seeing some rebound in
6 the cases, you know, that expense may really
7 continue into next year. And then some of
8 the downside risks might be, you know, will
9 there a vaccine? How expensive will that be?
10 We'd expect we'd have to cover that for
11 members.
12 There's also the possibility, like
13 you mentioned, of the testing. You know, I
14 think we're assuming at least where people
15 are sick and presenting, that we'll have
16 those tests to cover. We're not sure that we
17 would expect to cover antibody testing or
18 other, I think it's called, more surveillance
19 testing among members.
20 You know, we don't want to be
21 covering that for repeated episodes for the
22 same member over and over, but we do think
23 there's going to be some -- you know,
24 definitely some costs on the coverage of the
25 testing next year. And potentially, if all

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1 things go well, the vaccine would be a
2 potential cost for next year as well.
3 COMMISSIONER HUDSON: Thank you.
4 MR. CONNELL: Thank you.
5 COMMISSIONER JAGDMANN: We'll do
6 risk adjustment real quick. Quickly. You
7 hit on it lightly, so tell us briefly, what
8 is risk adjustment?
9 MR. CONNELL: Okay. Risk adjustment
10 is the federal program that was established
11 with the ACA to help probably try to
12 neutralize the effects of poor morbidity
13 going to a certain carrier. It tends to pay
14 back carriers who have a little bit sicker
15 population, and it tends to make carriers who
16 have a healthy population pay into that risk
17 adjustment pool.
18 And risk adjustment is determined
19 annually. And we just had the results come
20 out at the end of June -- or I guess it was
21 late this year; it was mid July -- where we
22 learned of what happened for 2019.
23 So the reason this estimate might be
24 a little bit influx is it tends to move a
25 little more quickly in the individual market,

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1 particularly like, in our case, where we have
2 expanded our footprint. We are seeing this
3 number move a little bit from where we had it
4 in 2019. But it is -- it's one of the risk
5 mechanisms built into the ACA. And in our
6 case, we're seeing it's causing an increase,
7 but we really think that's more due to
8 getting a somewhat healthier population,
9 where we see the decrease in morbidity
10 above.
11 COMMISSIONER JAGDMANN: So,
12 basically, you have a decrease -- let's look
13 at this most popular plan, of $12.83. So
14 let's just say, for example, that may mean,
15 among other things, that your insureds are
16 healthier and they haven't gone to the doctor
17 as much or they haven't been as sick.
18 But conversely, since your people
19 are healthier, other's peoples have been
20 sicker, let's say, other carriers, so you're
21 going to have to pay out -- it's just sort
22 of -- you undergird each other that way?
23 MR. CONNELL: Right. And we think
24 probably the net number of those two is
25 probably a reasonable way of what we think is

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1 going to happen to the market overall; that
2 there will be some slight increase to the
3 market overall due to just general attrition
4 that we see in the membership numbers, which
5 we've seen over time.
6 That reminded me, some of the
7 graphics, I think, that were shown earlier of
8 the market increasing in size in 2021, I
9 think, are a little optimistic. I think when
10 each carrier sets their own projections of
11 membership and then you put them together, it
12 probably looks a little higher. I would
13 probably expect 2021 to continue along the
14 decreasing trajectory that it's been on.
15 COMMISSIONER JAGDMANN: And the next
16 one is your income tax reduction, I guess,
17 the HIT, right?
18 MR. CONNELL: Yes. That's the
19 federal Health Insurance Tax. And that is a
20 number that has bounced around every year,
21 for those of us that have lived through the
22 last few sessions here. One year it's in;
23 one year, it's out. And it looks like it's
24 now on permanent -- it's permanently out. So
25 from 2020, where we had the health insurance

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1 tax in the rate, it is being removed in 2021.
2 Other non-benefit expenses really
3 relate to sort of administrative and other
4 changes which are fairly minor. And the
5 benefit changes would be, when we looked at
6 the specific plan design, there's a slight
7 change.
8 I do see, above the description of
9 the products, if you look higher on the first
10 half of the page, we did raise our
11 out-of-pocket maximum, which means the
12 member's responsibility on this plan, its
13 final -- I guess, highest liability a member
14 might absorb on this plan was raised a little
15 bit. So that probably caused some benefit
16 change that would reduce the plan.
17 COMMISSIONER JAGDMANN: Thank you.
18 I think you did a nice job of those
19 definitions, and nobody else will have to do
20 it. Unless their definitions are different
21 than yours, which they may be for, whatever,
22 benefit change, whatever. Thank you very
23 much.
24 MR. CONNELL: Sure.
25 CHAIRMAN CHRISTIE: Yeah, you did a

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1 good job on that.
2 COMMISSIONER JAGDMANN: Now on to
3 the rates.
4 CHAIRMAN CHRISTIE: Unless somebody
5 later wants to say you got it wrong, we'll
6 not ask them to do it again.
7 MR. CONNELL: Okay. Any other
8 questions? I think we can move on to the
9 next slide.
10 So, really, not much on the way of
11 changing our other factors in this market for
12 individual. You'll see a couple of those
13 numbers in the negative range, which is
14 related to a law that changed, I think it
15 was, back in December, such that tobacco
16 couldn't be sold anymore to people under 21.
17 And we did have a tobacco load at those ages,
18 so we've removed that load going forward;
19 that's the reason for the negative change
20 there.
21 Area changes are listed on the right
22 side. And really, there was no area change,
23 but we -- what we say in the trade is we
24 renormalized so that the average is a 1.0 for
25 the state. And as we saw our membership

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1 distribution by area, we just redistributed
2 that a little bit, and that caused a
3 slight -- just a slight bump in the factor,
4 but that was really not an area-specific
5 change; that was just kind of a getting the
6 regions back to an average of 1.0.
7 Any questions? We can go to the
8 next slide, I think.
9 CHAIRMAN CHRISTIE: Keep moving.
10 MR. CONNELL: I believe we'll be on
11 small group next. Okay. So I think this is
12 also a pretty good news story with our rate
13 increases. What you're seeing here is the
14 first quarter of 2021 relative to first
15 quarter 2020.
16 We also file quarterly step
17 increases for second through fourth quarter.
18 We do have a chance to revisit those and file
19 them at a later time if we want to revise
20 rates. But at this time, we're just
21 discussing the first quarter number.
22 And I think it's a similar -- kind
23 of a similar breakdown from what we're seeing
24 here. The morbidity is up slightly, which is
25 kind of what we expect to happen in the

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1 market. Trend is in the neighborhood of what
2 we had for individual, I think, between
3 around the 7-and-a-half percent range.
4 The risk adjustment, in this case,
5 is a slight favorable number. And this was
6 sort of a recognition of what we've been
7 observing in our most recent risk adjustment
8 results. I don't think this was necessarily
9 an offset to the morbidity, but we calibrated
10 where our risk adjustment was relative to the
11 market. And that caused a slight decrease in
12 the rates compared to where we had it in the
13 first quarter of '20.
14 Again, the health insurance tax
15 removal is about a -3. The admin and other
16 non-benefit expenses is similar to what we
17 saw in individual. For benefit changes, I
18 would say we also probably lumped into
19 benefit changes here the favorable experience
20 that we've been observing. So I think this
21 is a combination of both of those. The
22 reason I put that on a separate line here was
23 to call out the area factor change that's on
24 the next line.
25 But really, benefit changes, as a

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1 line here, includes favorable experience as
2 well as the benefit changes. And most of
3 that is probably in the favorable experience.
4 I would put probably about a three to four
5 percent favorable impact that came from claim
6 experience.
7 CHAIRMAN CHRISTIE: Let me ask you a
8 question, Tim. This relates to what you
9 think might be the COVID impact. So small
10 group is 1 to 50, correct?
11 MR. CONNELL: Yes.
12 CHAIRMAN CHRISTIE: So, obviously,
13 this is small business. This is the small
14 business market. And we know that, certainly
15 in March and April, small businesses took a
16 huge hit from COVID. Certainly, in certain
17 industries like restaurants and service
18 industry.
19 What have you seen -- and the
20 biggest scary thing about this is whether
21 these small businesses are just failing and
22 going away, in which case they're not paying
23 premiums because they're not even in
24 existence anymore. And of course, they had
25 the PPP, you know, the small business loans.

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1 But what are we seeing just in the last few,
2 couple months, I mean, since March, that
3 tells you about the trend and what's happened
4 in the small business market because of
5 COVID?
6 MR. CONNELL: Yeah, that's a tough
7 one to answer. And I'm not as close to the
8 front lines as some others in the company. I
9 would say we expected some losses. And with
10 the economy going down, we expected more of a
11 sharp decrease in membership. And we haven't
12 quite seen that so far.
13 Now we're wondering, is that in
14 part -- you know, we're also trying to be
15 accommodating, too, to some of these small
16 employers, in that, if they need extensions
17 on their premium or we may not be, you know,
18 terminating them in the normal process that
19 we would have before if they hadn't paid
20 their premiums.
21 But so far, we haven't seen the
22 membership maybe drop off as much as we would
23 have expected. So it's really hard to say if
24 that's representative of the economy or if
25 it's maybe just the industries that are, you

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1 know, most hard hit by the economy and may
2 not be ones that offer coverage. So it's a
3 tricky one to answer, and I don't really
4 think we're out of the woods yet.
5 But I think, you know, we haven't
6 seen the losses yet, but it's definitely
7 something we're trying to track and keep our
8 heads with.
9 CHAIRMAN CHRISTIE: Okay.
10 MR. CONNELL: All right. So back on
11 the favorable experience, as I mentioned, was
12 on the benefit changes. And the area factor
13 for our rates chosen actually went up 2
14 percent. And I think we'll see some of these
15 geographic factors here.
16 So a couple of areas, what we did is
17 a restudy of our area factors in small group.
18 And our approach has been to not --
19 especially with a small less-than-credible
20 area, not to react too much to an individual
21 year claim experience. We tend to look at
22 multiple years. We also tend to try to move
23 the factors a little more gradually rather
24 than have them swing from year to year. So
25 that's been sort of our methodology to keep

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1 the area factors relatively stable.
2 And in the Richmond area, we did
3 bump up the area factors this year, but we
4 did have, as you can see, some area factors
5 also went down.
6 COMMISSIONER JAGDMANN: I think just
7 the area factor, that's if you're .939 like
8 Charlottesville, that would be a slight
9 reduction, as you see, over there, .07; that
10 means it's slightly less. And who was the
11 benchmark for you again; was it Richmond?
12 MR. CONNELL: Yeah, the benchmark
13 now is in Richmond. Yes.
14 So you could also see from this, for
15 example, the Charlottesville would be one of
16 the lower area factors in the state. And the
17 highest one looks like it is in Blacksburg.
18 So if you're just kind of looking at those
19 relative to one another, which are relatively
20 less expensive and more expensive.
21 COMMISSIONER JAGDMANN: And that is
22 -- is this because the rates all were -- I'm
23 curious; in other years, these factors have
24 been more divergent. But has that change
25 already been factored into the rates and this

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1 is just a change from last year's benchmark?
2 Or are the costs really this similar across
3 the state?
4 MR. CONNELL: Yeah, these are pretty
5 representative of the costs across the state
6 for Anthem. And you know, I think it's just
7 a combination of things. It's the provider
8 cost in those areas. It could just be
9 provider practices in those areas that
10 diverge a little bit.
11 COMMISSIONER JAGDMANN: But they're
12 really not that different when you look at
13 those areas.
14 MR. CONNELL: They're not too far
15 apart in this market. Even in the individual
16 market, I don't think there's too wide of a
17 swing between areas. But it's something that
18 we try to keep track of.
19 And when we measure it, we also --
20 we try to factor out anything that's related
21 to health risk when we're looking at the
22 claim experience, too.
23 All right. Next slide. This will
24 be our other legal entity and small group.
25 So we can probably go through this fairly

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1 quickly. I think the results are similar to
2 what we saw in the HealthKeepers. And I
3 think actually our most popular plan is
4 sitting at the same increase as the popular
5 plan in HealthKeepers.
6 So I think we're -- I don't know if
7 there are any more questions on this one. We
8 can probably just move through and you can go
9 to the next slide and see if there's any
10 questions. I think it's probably similar
11 results in presentation to what we saw for
12 small group in HealthKeepers.
13 Some different area factors, but the
14 changes were -- we also kind of did the same
15 methodology to come up with the changes
16 there. But they were a little bit different
17 than what we saw on the HealthKeepers side.
18 All right. Well, I think that's my
19 last slide. I will pass it on, if you want
20 to go to the next presenter.
21 CHAIRMAN CHRISTIE: Okay. Next will
22 be CareFirst, I believe.
23 MR. BERRY: Yeah, my name is Pete
24 Berry. I'm the chief actuary for CareFirst.
25 The address is 10455 Owings Mills Circle,

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1 Owings Mills, Maryland, 21117.
2 Today I'm going to be presenting
3 rates for 2021 small group market for the
4 CareFirst BlueChoice entity. And when we
5 look at the slide, just going down to the
6 bottom there, to start, and then I'll do the
7 details. Overall, for our most common plan,
8 the rates are increasing by a half a percent,
9 so very modest.
10 CareFirst sells small group in
11 BlueChoice in the rating area 10, which is
12 Northern Virginia. We have approximately
13 43,000 members. This most popular plan, you
14 can see there, is about 8.7 percent of our
15 total membership.
16 So that relatively flat rate
17 increase, it's made up of several factors
18 which I'll go through. So trend from 20 to
19 21 is about 6.1 percent; risk adjustment, the
20 5.1 there basically says that we expect to
21 pay a little bit more to our competitors in
22 the risk adjustment program. And then you
23 see those two are offset by the HIT removal
24 of the -3-and-a-half. And then just going
25 down, right below the line there for base

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1 period index rate, similar to what Anthem was
2 talking about, that -5 is that we're seeing
3 emerging experience compared to what we had
4 in our '20 rates, coming in more favorably.
5 And so that means that our '21 rates need to
6 go up less.
7 So when you add all of those factors
8 together, that produces the .5 percent at the
9 bottom. So that's the overall story on the
10 rate increase before I talk about COVID and
11 other things. Any questions there?
12 COMMISSIONER JAGDMANN: Yes. I'm
13 just curious. Now, you offer all around the
14 D.C. Beltway and in the District of Columbia,
15 as well, correct?
16 MR. BERRY: We do. And we would
17 file under a separate entity in D.C., that's
18 right.
19 COMMISSIONER JAGDMANN: I'm just
20 curious, do you offer similar plans in the --
21 MR. BERRY: Yeah, so we do. Our
22 plans -- obviously, our service area is
23 Maryland, D.C., and Virginia for small group.
24 All our plans are very similar in those three
25 jurisdictions.

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1 COMMISSIONER JAGDMANN: That's all.
2 I was just curious.
3 MR. BERRY: Sure. So for COVID, we
4 were one of the plans that did not put an
5 explicit load or discount for COVID. We did
6 do quite a bit of analysis, much of it
7 similar to what Anthem described, what Tim
8 described for Anthem. So I won't cover that
9 ground.
10 But we do see deferred care in the
11 second quarter. We do expect a portion of
12 that to return. We do see COVID costs,
13 although I think, like many others, the
14 COVID -- the actual cost of COVID care, we
15 believe, will be -- that will be a smaller
16 factor than what we will see in the economic
17 impact.
18 And to answer the question regarding
19 the impact on the small group market, we have
20 not seen a reduction in membership yet. And
21 similar to what Anthem described, we
22 increased our grace periods for premium
23 termination due to premium defaults from 30
24 to 60 days. That was to the end of June. We
25 have been more flexible with our groups,

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1 working with them. And as David talked
2 about, we did do a premium discount in
3 August.
4 So we do expect, at some point, that
5 there will be economic impacts, but we
6 haven't seen them yet.
7 COMMISSIONER HUDSON: Peter, quick
8 question: So in your analysis, did you take
9 into account a scenario where people are
10 going to be doing less social distancing,
11 testing for infections and antibodies will
12 expand, and people no longer defer the
13 non-COVID care; did you guys look and see how
14 that would actually impact premium rates?
15 MR. BERRY: We did model it. And
16 like Tim was talking about, it is fairly
17 complicated. Like, for example, if there's a
18 vaccine next year, there's costs associated
19 with a vaccine, but then there's --
20 presumably, there's less costs associated
21 with COVID care.
22 A big part is how much people are
23 willing to return to the doctors' offices and
24 whether the personal protective equipment is
25 even available for that utilization. Now we

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1 have seen, in June, we do see care, by the
2 end of the month, returning to about 95
3 percent of the pre-COVID levels. One thing
4 we're tracking very closely is what is the
5 care each month as a percent of what we would
6 have expected. So, you know, we might be at
7 110 percent of what we would have expected as
8 the deferred care comes back.
9 So it's really going to be important
10 to track the expected care versus the actual
11 for the third quarter and into the fourth
12 quarter.
13 And then, of course, if there's a
14 second wave in the winter and deferred care
15 happens again, we have not -- we did not, you
16 know, explicitly model that. But it's
17 certainly something we're going to be
18 watching.
19 COMMISSIONER HUDSON: Thank you.
20 And thank you for touching upon the possible
21 second wave of coronavirus maybe next winter.
22 Thank you.
23 MR. BERRY: Yeah. Sure. If there's
24 no more questions on this slide, we can go to
25 the next slide.

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1 CHAIRMAN CHRISTIE: Okay.
2 MR. BERRY: So, as I said, we're in
3 a single rating area, so we don't really --
4 the geographic factors really don't come into
5 play. The only thing I wanted to point out
6 here was that the overall rate change when we
7 put everything together is a very modest 1.5
8 percent. So we're very pleased by that. And
9 we think it will improve our competitive
10 position and bring stability to our members.
11 And that was all I had, unless
12 there's any other questions.
13 CHAIRMAN CHRISTIE: Any questions of
14 Mr. Berry from colleagues or Staff?
15 COMMISSIONER JAGDMANN: No.
16 COMMISSIONER HUDSON: No questions
17 here.
18 MR. BERRY: Thank you.
19 CHAIRMAN CHRISTIE: Well, thank you
20 very much. Thank you, Mr. Berry.
21 So the next one is Cigna.
22 MR. GIORI: Good morning, everybody.
23 CHAIRMAN CHRISTIE: Good morning.
24 MR. GIORI: So here we've got the
25 same plan landscape, our most popular plan.

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1 We decreased the rate 10.7 percent.
2 Oh, yeah, let me start over. My
3 name is Steven Giori representing Cigna. I
4 live at 410 Cypress Road, Newington,
5 Connecticut.
6 COMMISSIONER JAGDMANN: It's a shame
7 you couldn't come down to Virginia, but maybe
8 next year.
9 MR. GIORI: Maybe next year. I was
10 looking forward to the trip, but you know,
11 things happen.
12 CHAIRMAN CHRISTIE: Well, if you're
13 going to give us a 10.7 percent decrease, you
14 don't need to come.
15 MR. GIORI: What? I don't get a
16 trip, too? Okay. I'll remember that next
17 year.
18 CHAIRMAN CHRISTIE: Give us an extra
19 2 percent. But we'll take it. Minus 10.7 is
20 very good. So I almost want to get you off
21 before you change your mind.
22 MR. GIORI: Okay. I mean, I think
23 it's too late, right?
24 CHAIRMAN CHRISTIE: I hope so.
25 MR. GIORI: So the most popular

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1 plan, the Cigna Connect 6500, the goal here
2 was to keep the plan as similar as possible
3 year to year, so we didn't change much from a
4 benefit perspective, hence the rate changed a
5 little bit higher than our average of 11.7
6 percent. This is -- the rating area used for
7 the comparison is Northern Virginia, by the
8 way. We do have a very similar plan in
9 Richmond.
10 Just kind of calling out some of the
11 big changes here. So we have a pretty
12 similar dynamic between morbidity and risk
13 adjustment that Tim mentioned. So you can
14 see morbidity took a dip, but risk adjustment
15 picked up to kind of cover that same ground.
16 So this is the dynamic that we see in the
17 individual market where, when you have
18 morbidity specific to your carrier relative
19 to the market decrease, you're going to end
20 up paying more money for risk adjustment,
21 which (indiscernible) that favorability. So
22 those two kind of cancel out.
23 We've got four percent trend for the
24 '20 to '21 time period. Other changes that's
25 been mentioned, like the HIT removal, has all

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1 been covered, I would say. Like I said, very
2 minor benefit changes. And kind of the
3 driving force of the decrease is this
4 experience period change, which I would say
5 is mostly driven by the fact that we expected
6 a lot more market morbidity increase from the
7 '18 to '19 period than we saw.
8 COMMISSIONER JAGDMANN: I'm just
9 going to ask a question for general
10 information.
11 MR. GIORI: Sure.
12 COMMISSIONER JAGDMANN: Now, you've
13 got your most popular plan and your minimum
14 rate change plan. And I'm looking at them to
15 see the premiums; they're somewhat similar.
16 But in your most popular plan you have a
17 deductible of $6,500, and in the minimum,
18 it's $1,500. So there must be some features
19 that are different in those plans because a
20 person would not pay more money for a higher
21 deductible. So just -- a lot of this is
22 educational as well.
23 MR. GIORI: For sure. So I'd like
24 to call out that the rating areas are
25 actually different. So we have lower

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1 premiums in Richmond than we do in Northern
2 Virginia, due to differences in the cost of
3 services in that area.
4 COMMISSIONER JAGDMANN: So these
5 plans are not offered in the same areas?
6 MR. GIORI: Well, they actually --
7 we do have the same -- we have pretty similar
8 plans offered in both geographies; they're
9 filed under separate HIOS plan IDs. So yeah,
10 it's just the way we file these plans.
11 COMMISSIONER JAGDMANN: So your
12 experience is different than Anthem's in that
13 we should -- when we go to the next page, we
14 should see that the rating areas, there will
15 be differences for your plan.
16 MR. GIORI: Correct.
17 COMMISSIONER JAGDMANN: Okay. But
18 that being said, so this most popular plan,
19 is this -- are you telling me that the most
20 popular plan and the minimum rate change plan
21 are for different rating areas?
22 MR. GIORI: Correct. That's why you
23 see a different premium. The premium is
24 actually lower on the -- yeah, exactly.
25 COMMISSIONER JAGDMANN: So most

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1 popular. Okay. So where is this most
2 popular plan?
3 MR. GIORI: This is in Northern
4 Virginia.
5 COMMISSIONER JAGDMANN: Northern
6 Virginia. Okay. And this minimum is in
7 Richmond; is that what you said?
8 MR. GIORI: Correct.
9 COMMISSIONER JAGDMANN: Okay. Well,
10 that's very helpful. Because -- okay.
11 MR. GIORI: Great. And it's also
12 probably worth calling out that the most
13 popular plan was actually the maximum rate
14 change, so we put the next lowest on the max
15 rate change. So that's why those numbers
16 look a little strange, if anyone's scratching
17 their head there, why it's a -10.7 versus
18 -10.8. That's a little complicated, maxes
19 and mins, when they're negative, but...
20 COMMISSIONER JAGDMANN: All right.
21 MR. GIORI: Any other questions on
22 this slide?
23 CHAIRMAN CHRISTIE: No. Keep
24 moving.
25 MR. GIORI: All right. Next slide

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1 please. Cool.
2 So not really a whole lot to call
3 out here. I would say I did want to mention
4 that we did expand our offering for '21. So
5 we're offering more plans. Mostly the same
6 geography. We did expand to Spotsylvania in
7 rating area 10, which is part of Northern
8 Virginia.
9 And then the rate for Winchester did
10 come down relative to last year a bit as we
11 started to see some experience. That was our
12 2020 expansion, was to that one county. So
13 we did see that some of our hospital
14 discounts were more favorable to what we
15 expected, slightly, so we were able to bring
16 those rates down.
17 COMMISSIONER JAGDMANN: Okay. I'm
18 looking at your geographic factors, and they
19 don't seem to drive the big change that we
20 saw on the other page.
21 MR. GIORI: Oh, no, the rating area
22 factors themselves are -- most have been kept
23 the same. We've seen experience kind of come
24 in pretty consistently year to year between
25 Richmond and Northern Virginia.

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1 COMMISSIONER JAGDMANN: Okay. So
2 what was driving the change on the page
3 before? I thought you said it was the rating
4 area factor.
5 MR. GIORI: No, no. It's the
6 experience.
7 COMMISSIONER JAGDMANN: It's the
8 experience. Okay.
9 MR. GIORI: So I think Tim mentioned
10 this, too, earlier. So when we talk about
11 morbidity, we're talking about morbidity for
12 the projection period, from '19 to '21. But
13 the period from '18 to '19, we saw much less
14 of a morbidity uptick than what we
15 anticipated.
16 As you recall from earlier, there
17 was a lot going on politically back then;
18 everybody was pretty scared back when we were
19 filing, you know, 2019. You know, that
20 was -- we didn't have a lot to really go on
21 in terms of where things were going to be
22 ending up so...
23 COMMISSIONER JAGDMANN: So let's
24 just say, if you're comparing Richmond to
25 Northern Virginia, is your morbidity higher;

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1 is that what's driving that? Because you
2 said one was for one area and one was for
3 another.
4 MR. GIORI: It's not morbidity. So
5 you can't rate for morbidity differences
6 between rating areas. It's more the delivery
7 of services. So the hospitals in Northern
8 Virginia, you can think of them as being more
9 expensive than the hospitals in Richmond.
10 COMMISSIONER JAGDMANN: Okay. And I
11 was just trying to get at what is the fact,
12 you know, that is driving the rates down.
13 MR. GIORI: Ah. Yes.
14 COMMISSIONER JAGDMANN: So it is
15 higher costs for services; is that what
16 you're --
17 MR. GIORI: Yes.
18 COMMISSIONER JAGDMANN: -- in
19 Northern Virginia?
20 MR. GIORI: Physicians and hospitals
21 would be the crux of it.
22 COMMISSIONER JAGDMANN: Okay. Thank
23 you.
24 MR. GIORI: Sure. Any other
25 questions?

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1 CHAIRMAN CHRISTIE: I hear none. So
2 thank you.
3 MR. GIORI: Thank you.
4 CHAIRMAN CHRISTIE: Okay. Our next
5 presenter is Optima.
6 MS. CHANCE: Hi. Let me just start
7 my video. Hi. This is Margaret Chance. I
8 am a principle consulting actuary with
9 Milliman, and I'm the certifying actuary for
10 this rate filing. Our address is 71 South
11 Wacker Drive, Chicago, Illinois, 60606.
12 So here we have illustrated the most
13 popular plan. So it was an average rate
14 increase. Optima Individual is at 7.7
15 percent, which a little bit less than trend.
16 One thing to note is that the past two years
17 we have had substantive rate decreases. So
18 the implication of a rate increase for 2021
19 is that, in 2020, the rates were sort of
20 level, set back to where we pretty much think
21 costs are, and so now we're increasing rates
22 to effectively be something close to trend.
23 So if we walk through the most
24 popular, one thing I wanted to mention was
25 sort of brought up in the last presenter,

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1 with having a very popular plan be a $6600
2 deductible, is that these are silver plans
3 and a number of members that have silver
4 plans are actually getting cost sharing
5 reductions. So in many cases, they're not
6 seeing $6,000 deductibles; they're quite a
7 bit lower, because those costs are
8 subsidized. So that's a driver of --
9 CHAIRMAN CHRISTIE: The deductible
10 is subsidized as well?
11 MS. CHANCE: Yes. So if you think
12 about a, quote, silver plan average claim to
13 premium, maybe it would cover 70 percent of
14 the premium; whereas, for a subsidized plan,
15 it could be as much as 94 is the max, or 93.
16 So it's significantly subsidized.
17 COMMISSIONER JAGDMANN: So the
18 premium is subsidized and is the
19 out-of-pocket subsidized as well?
20 MS. CHANCE: Yeah. So for cost
21 sharing reductions, I believe the threshold
22 is 250 percent of the federal poverty level,
23 where you can get -- in addition to premium
24 subsidies, you can also get subsidies for
25 your cost sharing. So that will be your

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1 deductible, your out-of-pocket max, your
2 co-pays. And they vary at different levels
3 of subsidy, depending on your income level.
4 And to have those plans, those are
5 silver plans only; whereas, the premium
6 subsidies can apply to any on-exchange
7 metallic plan.
8 COMMISSIONER JAGDMANN: And there
9 must be other features that are different,
10 because the price differential is not that
11 different, but the deductible is quite
12 different. So there must be features, richer
13 benefits, something that would drive you to
14 the more popular option.
15 MS. CHANCE: Generally, the more
16 popular option is significantly driven by the
17 subsidy. And this particular plan -- and I'd
18 have to go look at each plan -- but I suspect
19 that this most popular plan is the least
20 expensive silver plan available, in which
21 case they're sort of -- someone who's getting
22 their benefits subsidized and then they're
23 getting the maximum amount of -- the premium
24 subsidy that they can get, so yeah.
25 COMMISSIONER JAGDMANN: Okay. Yes.

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1 That makes sense. So in most cases, you
2 would expect the most popular plan to be a
3 silver plan because it has to be a silver
4 plan to get the subsidy.
5 MS. CHANCE: Correct. To get the
6 cost sharing reductions, correct.
7 COMMISSIONER JAGDMANN: Okay. Thank
8 you.
9 MS. CHANCE: Okay. Great. So the
10 line items are very similar to other
11 carriers. With respect to the other
12 morbidity line, this is reflective of the mix
13 of membership that Optima expects in its
14 individual plan relative to what we've seen
15 in 2020. So a slight improvement.
16 Skipping trend for a moment,
17 offsetting, that is the risk adjustment
18 piece. So as discussed before, when you have
19 a -- or expected to have a healthier
20 population, it's likely that you will receive
21 less in risk adjustment.
22 So the trend is M 8.9 percent; 1
23 percent of that is actually because the
24 trends had gone up since the prior year, so 1
25 percent of that is due to some additional

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1 trend based on last year's pricing.
2 The HIT, the health insurance fees,
3 so that reduced rates a little over 1 percent
4 by no longer having that to pay. Other
5 non-benefit expenses, a slight increase, just
6 general administrative costs.
7 One thing I want to point out, I
8 know we're focused on the more popular plan,
9 but I know there has been some review of the
10 plans next to one another. We did change our
11 methodology to do expenses on a per member
12 basis because that more accurately reflects
13 how they are -- the cost to the company.
14 So when that happens, rather than
15 having them as a percent of premium, that
16 caused -- for the bronze plan, it caused that
17 number to go up more on the max rate change
18 plan.
19 Did someone have -- I thought I
20 heard someone maybe had a question. Maybe it
21 was just not muted. Okay.
22 And then with respect to benefit
23 changes, just a small decrease in rates for
24 that factor.
25 COMMISSIONER JAGDMANN: With that

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1 said, what have we not asked that you thought
2 we might?
3 MS. CHANCE: What have you not
4 asked?
5 COMMISSIONER JAGDMANN: What are you
6 prepared to tell us that we haven't asked?
7 Is there something that we should -- I
8 mean --
9 MS. CHANCE: No. I mean, I think
10 that in looking at sort of the -- the
11 questions had come up about some of the
12 differences in the min and the most popular
13 related to regional issues. We had lowered
14 the -- you can see the area factor revision
15 line. So there had been a lowering in the --
16 Optima has sort of a rate in area 9 and then
17 a regional rate for the other areas in which
18 it offers plans.
19 And so due to some changes in the
20 networks and the negotiated rates, they were
21 able to lower area factors for the regional
22 rate. You'll see that on the next page. So
23 that's a big driver between, say, the min
24 rate change and the most popular plan. You
25 can see that.

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1 Other than that, I mean, the COVID
2 adjustment, very comparable types of thought
3 processes that we went through that seems
4 that other carriers went through. So I would
5 expect a modest increase for those issues.
6 Any questions?
7 CHAIRMAN CHRISTIE: No. Keep
8 moving, unless you hear anything.
9 MS. CHANCE: Great. Next slide. So
10 there's not much to say here. Similar to
11 what Tim Connell said, we changed the tobacco
12 load for under 21, so that's a change there.
13 And then as I mentioned previously, the
14 reduction in the rating area factor for the
15 regional -- we call the regional factor the
16 non-area 9 rate, as discussed previously.
17 COMMISSIONER JAGDMANN: So we see a
18 big drop in Charlottesville. I'm sure
19 they'll be happy. And in Harrisonburg and
20 Richmond, in the area factors. And
21 everywhere, it looks like, yeah.
22 MS. CHANCE: Other than area 9,
23 Optima presents sort of a regional rate and
24 just made a decision to do that. And that
25 was -- that started last year and that has

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1 continued into this year. So it's a variety
2 of changes for different regions within that
3 region.
4 Next. Okay. If nothing else, I
5 think we have a different presenter for small
6 group. I will sign off.
7 COMMISSIONER JAGDMANN: Thank you.
8 CHAIRMAN CHRISTIE: Thanks. So
9 we're going to move -- the next presenter's
10 doing the small group market, correct?
11 MR. SUTHERLIN: Yes. Can you see
12 me? I'm Graham Sutherlin. I'm with
13 Cedarview Consulting. Our address is 1151
14 Rosebud Road, Quipman, Arkansas 72131.
15 Our average increase for the small
16 group product, as you see on the next slide,
17 is 10.9 percent. For our most popular plan,
18 due to changes at the benefit level, is 18
19 percent. Making up the increase from this
20 most popular plan, we had trend at 7.2
21 percent.
22 In 2019, we had an increase -- or we
23 moved from a receivable in risk adjustment to
24 a payable. We had been receiving small risk
25 assessment. And in 2019, we ended up paying.

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1 We do have changes in place to improve that.
2 But that's what caused the risk adjustment
3 here to increase that 5.4 percent.
4 Not paying HIT tax lowers our rates
5 1.4 percent. We did move to the per-member
6 cost on admin, as Margaret just mentioned.
7 And for this plan, it improved the
8 non-benefit expense line. And Optima also
9 chose to reduce its profit, which is also in
10 this line for the -7.1 percent in the
11 non-benefit expense.
12 The region factor specific to the
13 Tidewater region was increased at 1.5
14 percent. The largest decrease was in the
15 Lynchburg region, which is our minimum rate
16 change plan of the -8.4 percent.
17 Shifting in memberships -- was there
18 a question? Shifting in membership caused
19 increase in demographics of 2.3 percent. We
20 did have a complete overhaul of our benefit
21 relativity model. And as a result, you know,
22 some plans went up and some plans went down.
23 And this was a plan that had an increase of
24 6.6 percent due to that change in our
25 model.

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1 As we've mentioned before in
2 different slides, the COVID load is 1 percent
3 for Optima Health small group plans. And
4 besides that, an additional 2.7 percent for
5 other factors.
6 COMMISSIONER JAGDMANN: I have a
7 question. Are you on the small group
8 exchange?
9 MR. SUTHERLIN: No, ma'am.
10 COMMISSIONER JAGDMANN: Okay. So
11 that would explain why your most popular plan
12 is a gold and not a silver plan, right?
13 MR. SUTHERLIN: Yes. If there's no
14 other questions, we'll go to the next slide.
15 There you can see the 10.9 percent overall
16 average increase. The majority of our
17 membership is in the area 9, which is in that
18 1.5. Besides that, the majority of our
19 regions are getting a decrease in the area
20 factor. That's everything I have.
21 CHAIRMAN CHRISTIE: All right. Any
22 questions?
23 COMMISSIONER JAGDMANN: There are
24 advantages to coming last. We've answered
25 all our questions.

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1 CHAIRMAN CHRISTIE: All right.
2 Well, the final speaker is Mr. Morgan for
3 UnitedHealthcare.
4 COMMISSIONER JAGDMANN: I spoke too
5 soon.
6 MR. MORGAN: Yes. Can you hear me?
7 CHAIRMAN CHRISTIE: Yes.
8 MR. MORGAN: Let me start my video
9 here. Good afternoon. Thank you to the
10 Judges and the Virginia Bureau of Insurance.
11 I'll try to move quickly through this. My
12 name is Ryan Morgan. I'm an actuarial
13 director with United HealthCare. My address
14 is 10701 Research Drive, Wauwatosa,
15 Wisconsin, 53226.
16 And so yeah, today I'll be primarily
17 talking about our 2021 small group rate
18 action for United Healthcare Insurance
19 Company, which we call our UHIC license. I
20 think it was mentioned earlier, United
21 actually does have three other small group
22 licenses, but the UHIC one is really the big
23 one that's about 80 percent of our total
24 block. So that's what we'll focus on.
25 As was mentioned, obviously we don't

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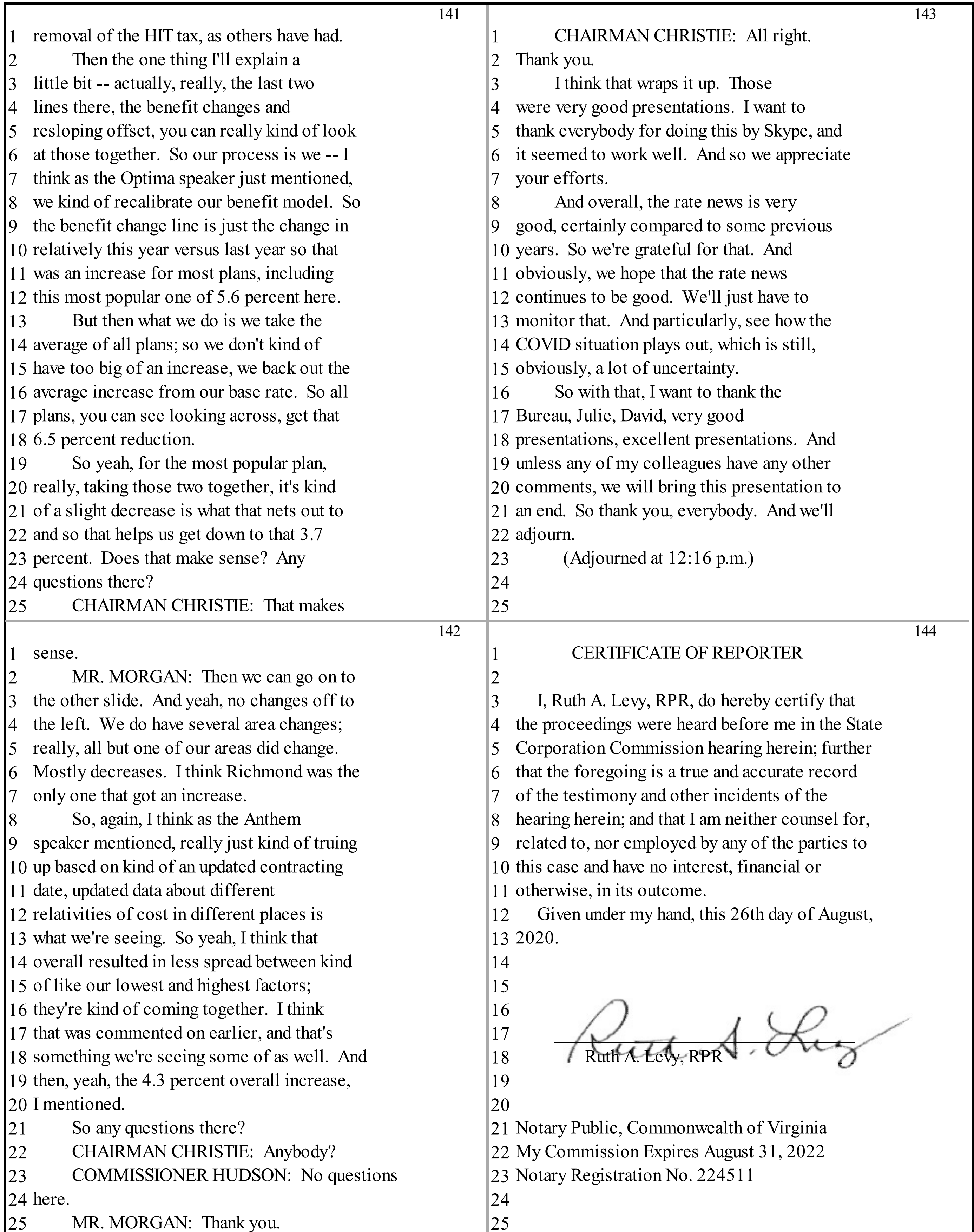
1 have any experience, so there's not much to
2 talk about. But yeah, as was mentioned
3 earlier, we are entering the individual
4 market under our Optima Choice Incorporated
5 license for 2021.
6 So maybe I'll talk about that then
7 in future years. But yeah, for today, for
8 the UHIC license, yeah, so you can see our
9 most popular plan. This is -- across the
10 board here, we're assuming the Northern
11 Virginia region, so that part is consistent
12 here.
13 So our most popular plan, UHC Choice
14 Plus Gold, $1500 deductible plan, is a 3.7
15 percent calculated increase. So yeah, the
16 components -- really, the trend is the big
17 upward driver, as has been mentioned, I think
18 true for most. So that's the 20 -- that's
19 actually last year's trend that's explaining
20 the increase from last year to this year of
21 8.1 percent.
22 But then some favorable items for
23 risk adjustment; we're a little bit less of a
24 payor this year than we were last year, so a
25 -1 percent there. Also, favorability and



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1 removal of the HIT tax, as others have had.
2 Then the one thing I'll explain a
3 little bit -- actually, really, the last two
4 lines there, the benefit changes and
5 resloping offset, you can really kind of look
6 at those together. So our process is we -- I
7 think as the Optima speaker just mentioned,
8 we kind of recalibrate our benefit model. So
9 the benefit change line is just the change in
10 relatively this year versus last year so that
11 was an increase for most plans, including
12 this most popular one of 5.6 percent here.
13 But then what we do is we take the
14 average of all plans; so we don't kind of
15 have too big of an increase, we back out the
16 average increase from our base rate. So all
17 plans, you can see looking across, get that
18 6.5 percent reduction.
19 So yeah, for the most popular plan,
20 really, taking those two together, it's kind
21 of a slight decrease is what that nets out to
22 and so that helps us get down to that 3.7
23 percent. Does that make sense? Any
24 questions there?
25 CHAIRMAN CHRISTIE: That makes

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1 sense.
2 MR. MORGAN: Then we can go on to
3 the other slide. And yeah, no changes off to
4 the left. We do have several area changes;
5 really, all but one of our areas did change.
6 Mostly decreases. I think Richmond was the
7 only one that got an increase.
8 So, again, I think as the Anthem
9 speaker mentioned, really just kind of truing
10 up based on kind of an updated contracting
11 date, updated data about different
12 relativities of cost in different places is
13 what we're seeing. So yeah, I think that
14 overall resulted in less spread between kind
15 of like our lowest and highest factors;
16 they're kind of coming together. I think
17 that was commented on earlier, and that's
18 something we're seeing some of as well. And
19 then, yeah, the 4.3 percent overall increase,
20 I mentioned.
21 So any questions there?
22 CHAIRMAN CHRISTIE: Anybody?
23 COMMISSIONER HUDSON: No questions
24 here.
25 MR. MORGAN: Thank you.

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1 CHAIRMAN CHRISTIE: All right.
2 Thank you.
3 I think that wraps it up. Those
4 were very good presentations. I want to
5 thank everybody for doing this by Skype, and
6 it seemed to work well. And so we appreciate
7 your efforts.
8 And overall, the rate news is very
9 good, certainly compared to some previous
10 years. So we're grateful for that. And
11 obviously, we hope that the rate news
12 continues to be good. We'll just have to
13 monitor that. And particularly, see how the
14 COVID situation plays out, which is still,
15 obviously, a lot of uncertainty.
16 So with that, I want to thank the
17 Bureau, Julie, David, very good
18 presentations, excellent presentations. And
19 unless any of my colleagues have any other
20 comments, we will bring this presentation to
21 an end. So thank you, everybody. And we'll
22 adjourn.
23 (Adjourned at 12:16 p.m.)
24
25

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1 CERTIFICATE OF REPORTER
2
3 I, Ruth A. Levy, RPR, do hereby certify that
4 the proceedings were heard before me in the State
5 Corporation Commission hearing herein; further
6 that the foregoing is a true and accurate record
7 of the testimony and other incidents of the
8 hearing herein; and that I am neither counsel for,
9 related to, nor employed by any of the parties to
10 this case and have no interest, financial or
11 otherwise, in its outcome.
12 Given under my hand, this 26th day of August,
13 2020.
14
15
16
17 ______________________
18 Ruth A. Levy, RPR
19
20
21 Notary Public, Commonwealth of Virginia
22 My Commission Expires August 31, 2022
23 Notary Registration No. 224511
24
25

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