Virginia's Health Insurance

Today's Market, Legislative Priorities, and the Power of the Employer to Drive Change

PRESENTED BY ROBIN FOUTZ & AMY MUTTER

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Agenda

- ✓ State of the Commonwealth's Insurance Marketplace
- ✓ National Trends
- ✓ Legislative Issues, Opportunities, Concerns and Administrative Actions
- ✓ Top Trend - Power of the Employer to drive change

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State of the Commonwealth's Insurance Marketplace

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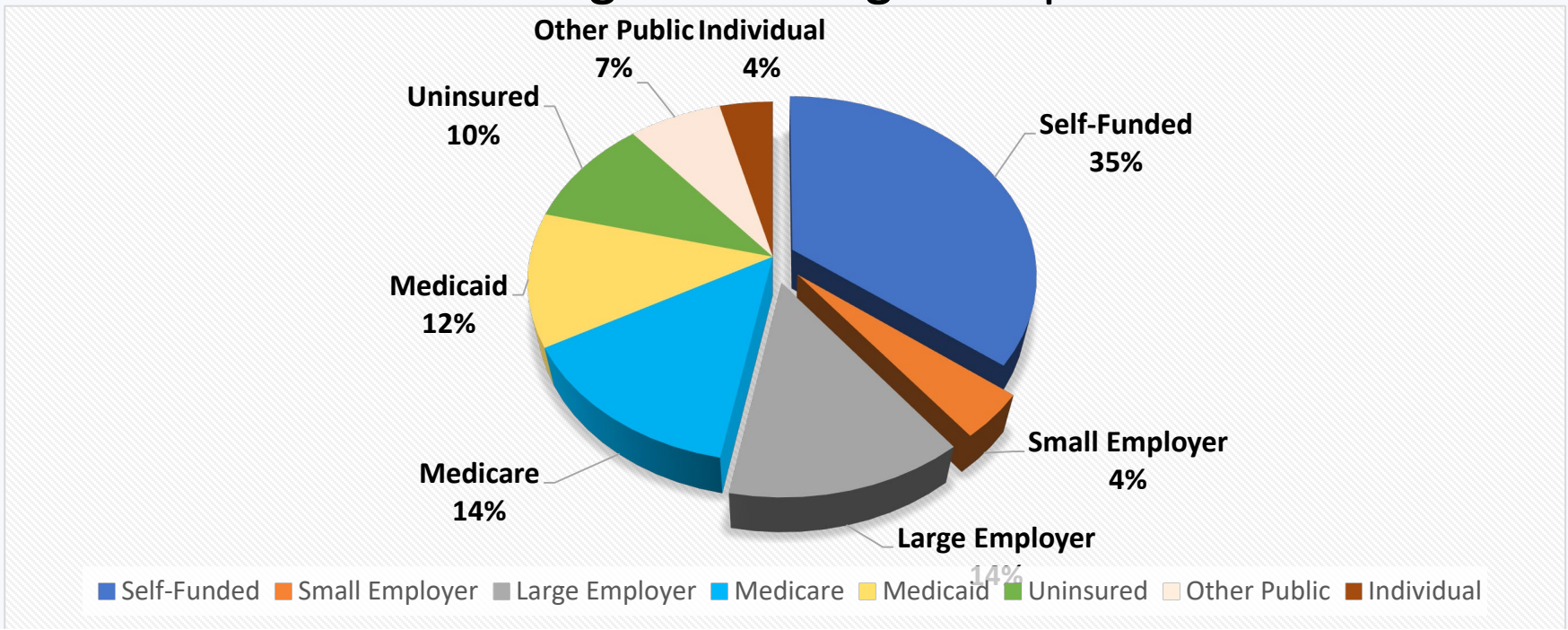
Health Care Coverage of the Virginia Population - 2018



Source: U.S. Census Bureau - Current Population Survey - Annual Social and Economic Supplements

Definitions

Medicaid: Includes those covered by Medicaid, the Children's Health Insurance Program (CHIP), and those who have both Medicaid and another type of coverage, such as dual eligibles who are also covered by Medicare.

Medicare: Includes those covered by Medicare, Medicare Advantage, and those who have Medicare and another type of non-Medicaid coverage where Medicare is the primary payer. Excludes those with Medicare Part A coverage only and those covered by Medicare and Medicaid (dual eligibles).

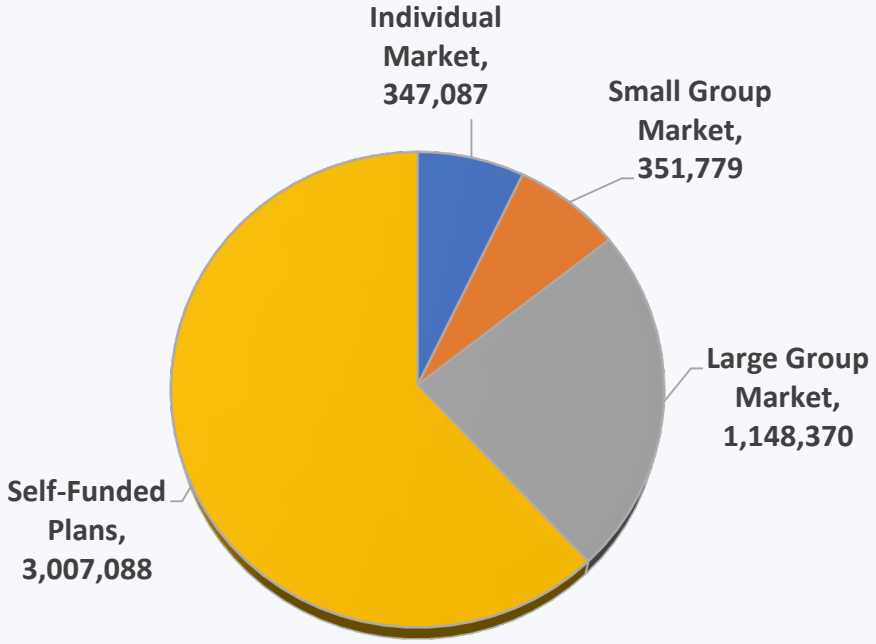
Employer: Includes those covered by employer-sponsored coverage either through their own job or as a dependent in the same household.

Other Public: Includes those covered under the military or Veterans Administration.

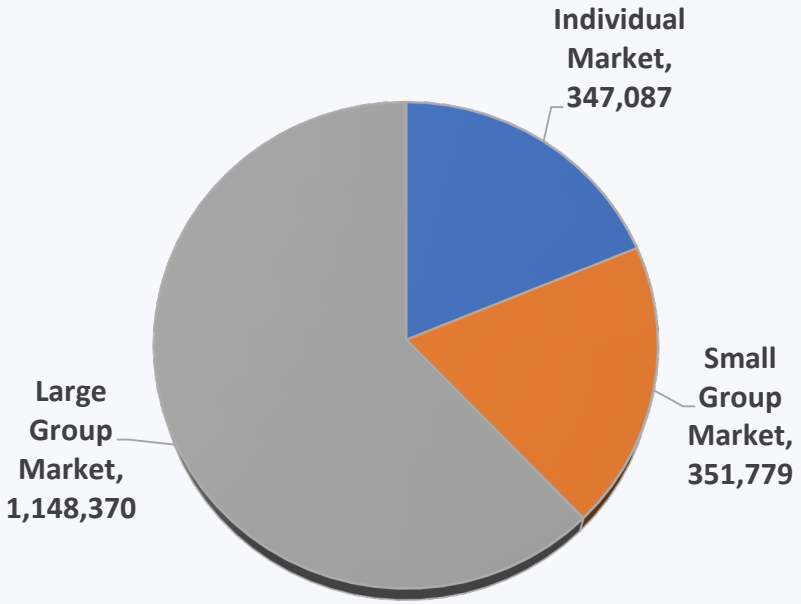
Non-Group: Includes individuals and families that purchased or are covered as a dependent by non-group insurance.

Uninsured: Includes those without health insurance and those who have coverage under the Indian Health Service only.

Enrollment in Self-Funded Plans and the Individual, Small Group, and Large Group Comprehensive Markets - 2018



Enrollment in the Fully-Insured Market – Individual, Small Group, and Large Group Comprehensive - 2018



Source: Company reported data found in the Annual Report - Supplemental Health Care Exhibit.

Health Care Coverage of the Virginia Population

	Employer	Non-Group	Medicaid	Medicare	Other Public	Uninsured
2018	53%	4%	12%	14%	7%	10%
2017	55%	5%	11%	14%	5%	9%
2016	55%	5%	12%	14%	5%	10%
2015	53%	8%	11%	14%	5%	9%
2014	55%	7%	9%	13%	6%	10%
2013	57%	4%	9%	12%	6%	12%
2012	55%	5%	11%	12%	5%	13%
2011	55%	5%	11%	12%	5%	13%
2010	55%	5%	10%	12%	5%	13%
2009	57%	5%	10%	11%	5%	12%
2008	59%	5%	9%	11%	4%	12%

Source: U.S. Census Bureau - Current Population Survey - Annual Social and Economic Supplements

Definitions

Medicaid: Includes those covered by Medicaid, the Children's Health Insurance Program (CHIP), and those who have both Medicaid and another type of coverage, such as dual eligibles who are also covered by Medicare.

Medicare: Includes those covered by Medicare, Medicare Advantage, and those who have Medicare and another type of non-Medicaid coverage where Medicare is the primary payer. Excludes those with Medicare Part A coverage only and those covered by Medicare and Medicaid (dual eligibles).

Employer: Includes those covered by employer-sponsored coverage either through their own job or as a dependent in the same household.

Other Public: Includes those covered under the military or Veterans Administration.

Non-Group: Includes individuals and families that purchased or are covered as a dependent by non-group insurance.

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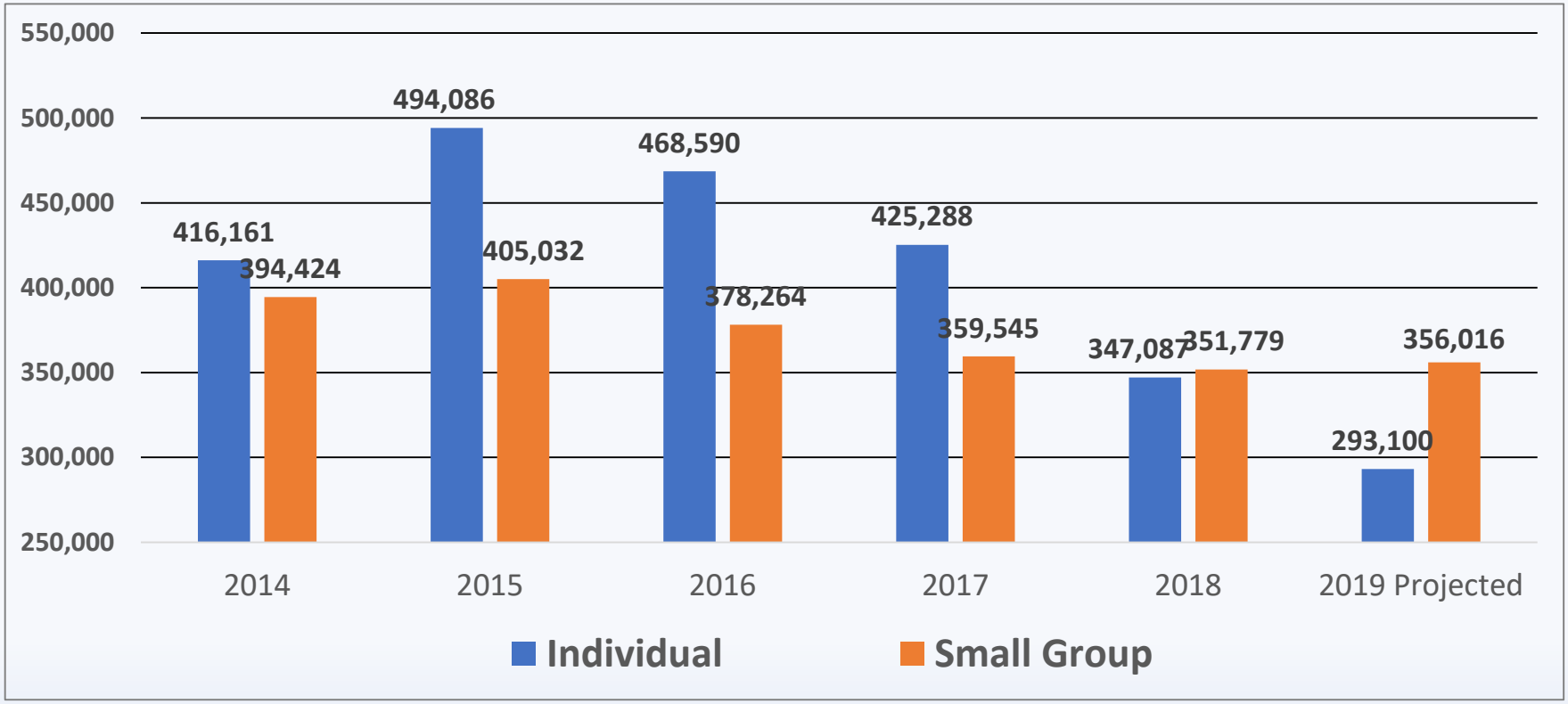
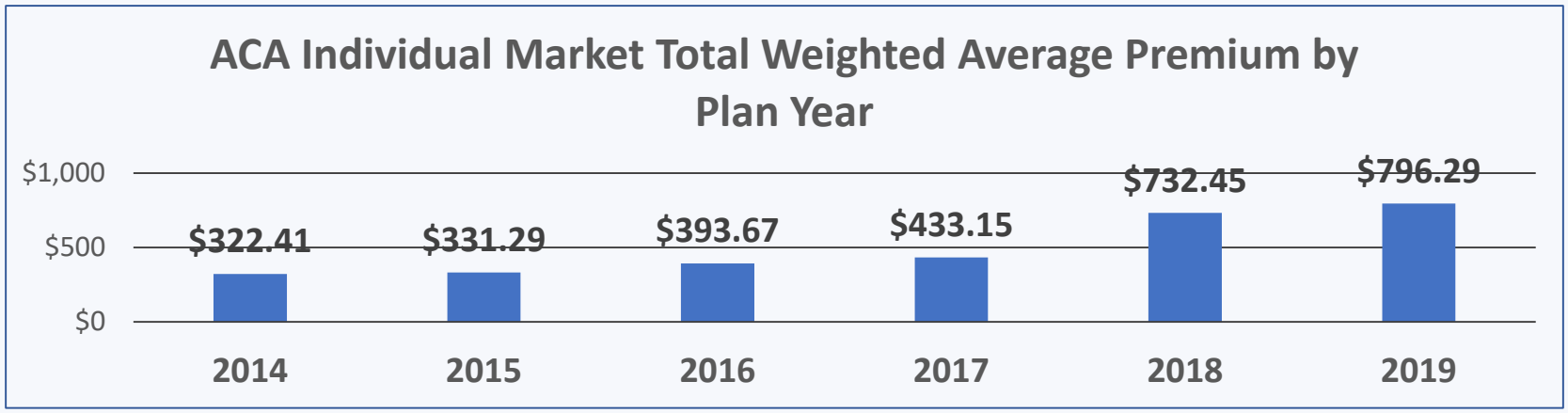
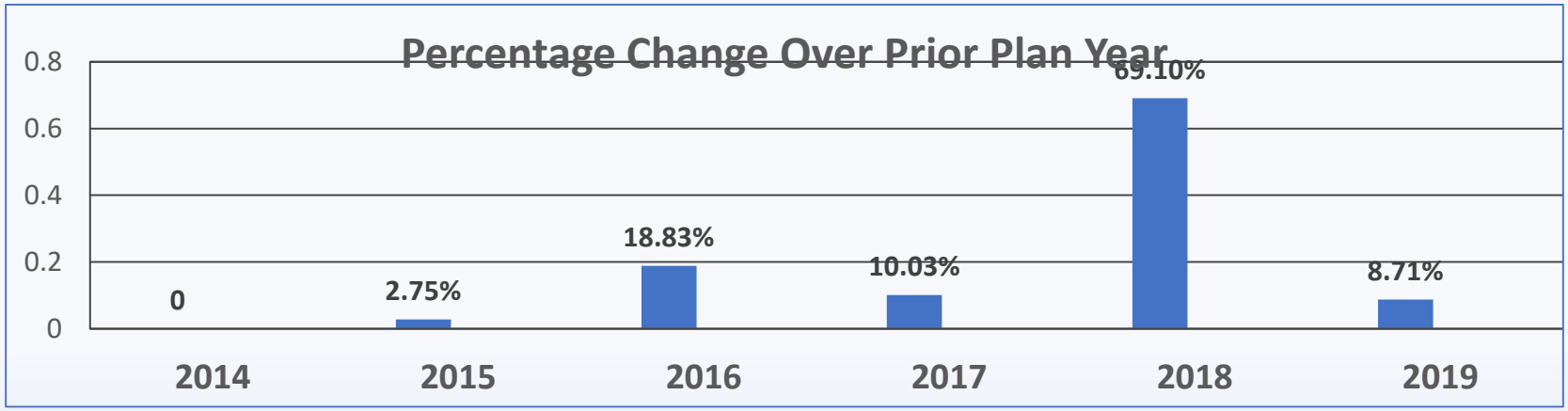
Individual and Small Group Comprehensive Markets
Total Enrollment 2014 - 2019



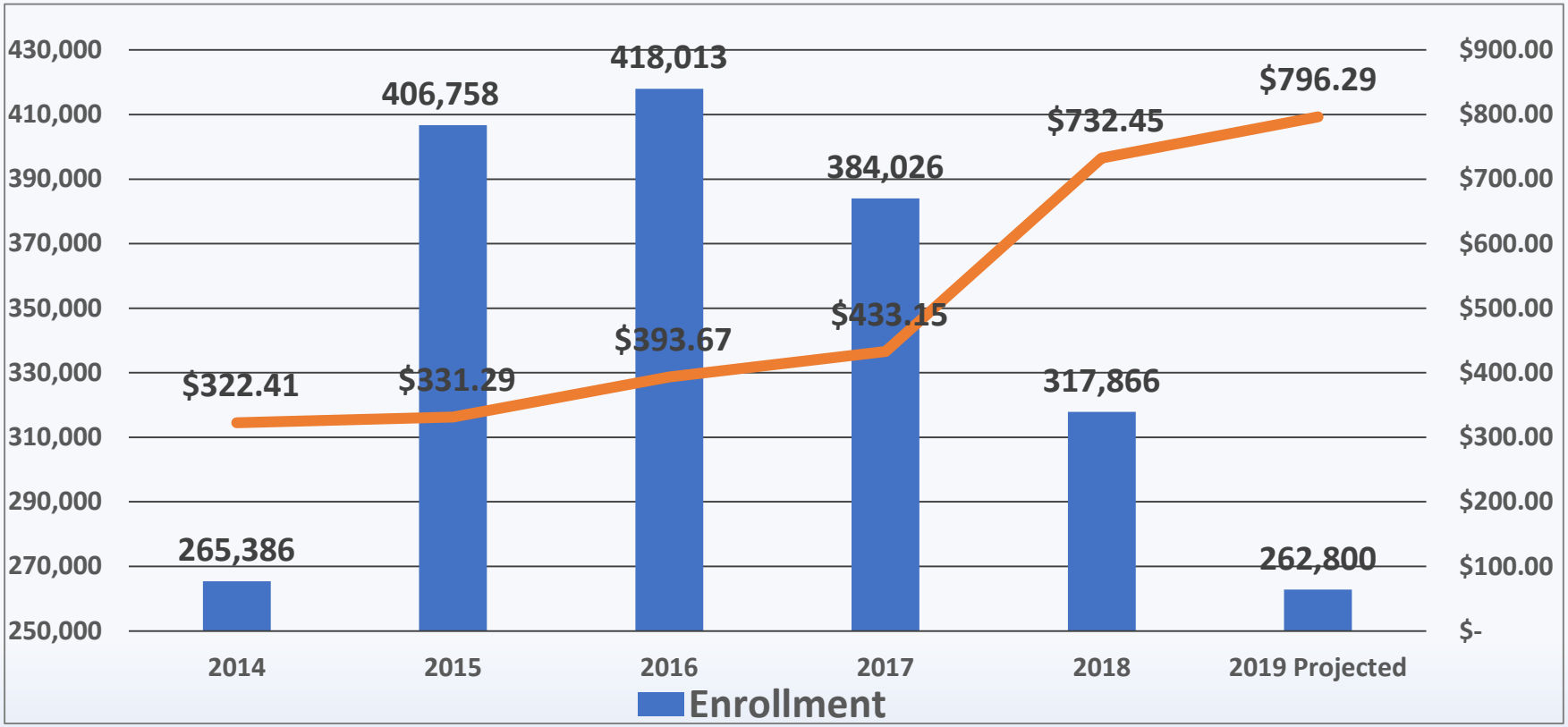
Sources: Annual Supplemental Health Care Report – Number of covered lives by market for 2014-2018. 2019 data derived from the 2019 rate filings and the report "Virginia – Individual Market Summary and Modeling Results – January 4, 2019" - Oliver Wyman. Funds for the study provided to the State Corporation Commission by the Federal Market Stabilization Grant.





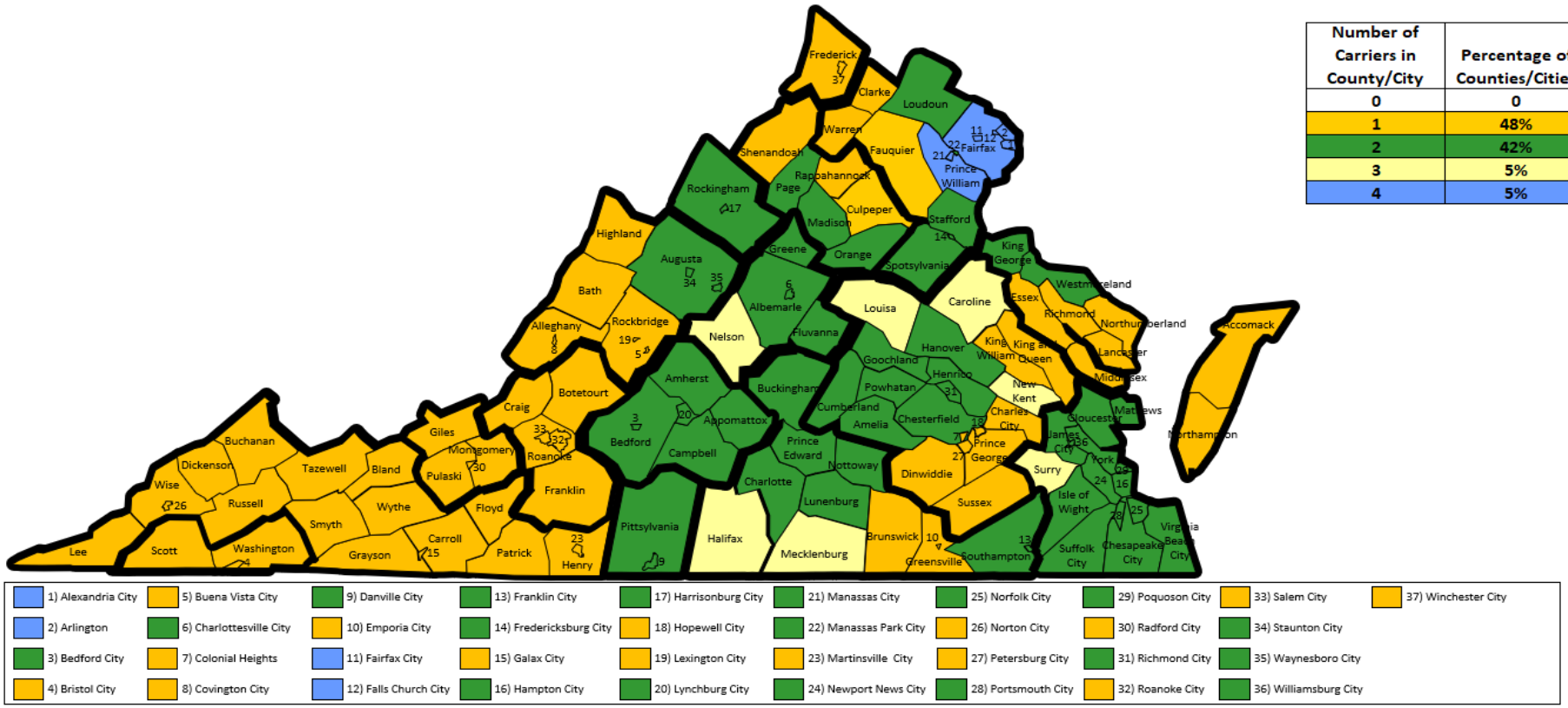
Total Increase of Weighted Average Premium 2014-2019: $473.87/mo. Total Percentage Increase of Weighted Average Premium 2014-2019: 147%.

Individual ACA Total Enrollment and Total Weighted Average Premium 2014 - 2019



Sources: 2014-2018 data derived from the rate filings. 2019 data derived from the report "Virginia – Individual Market Summary and Modeling Results – January 4, 2019" - Oliver Wyman.
Funds for the study provided to the State Corporation Commission by the Federal Market Stabilization Grant.

2019 Virginia Individual Market – Number of Carriers by County or Independent City



In an effort to provide the most accurate information available, the carrier count for the counties of Caroline, Louisa, Orange, and Westmorland includes a carrier that does not cover the entire county, but who offers coverage to a substantial population in those counties. The carrier count for the counties of Fairfax and Prince William include two carriers that do not cover the entire county, but who offer coverage to a substantial population in those counties. An additional one or two carriers offer coverage to a small population in partial areas of the counties of Loudoun, Culpeper, Fauquier, and Hanover. Those carriers are not counted in the total for these counties.

Summary of Markets – Recent Years

- Employer-sponsored coverage covers more than half of the Virginia population; the majority being self-funded
- Employer market steadily decreasing
- Medicare, Medicaid, Other Public increasing as a percentage of total Virginia population
- Uninsured decreased since ACA inception; expect that to decrease more with Medicaid expansion
- Individual market enrollment peaked in early years of ACA, but mostly subsidized individuals remain as the cost of coverage continues to increase; however, carrier interest has re-emerged

2019 KFF Employer Health Benefits Survey

September 25, 2019

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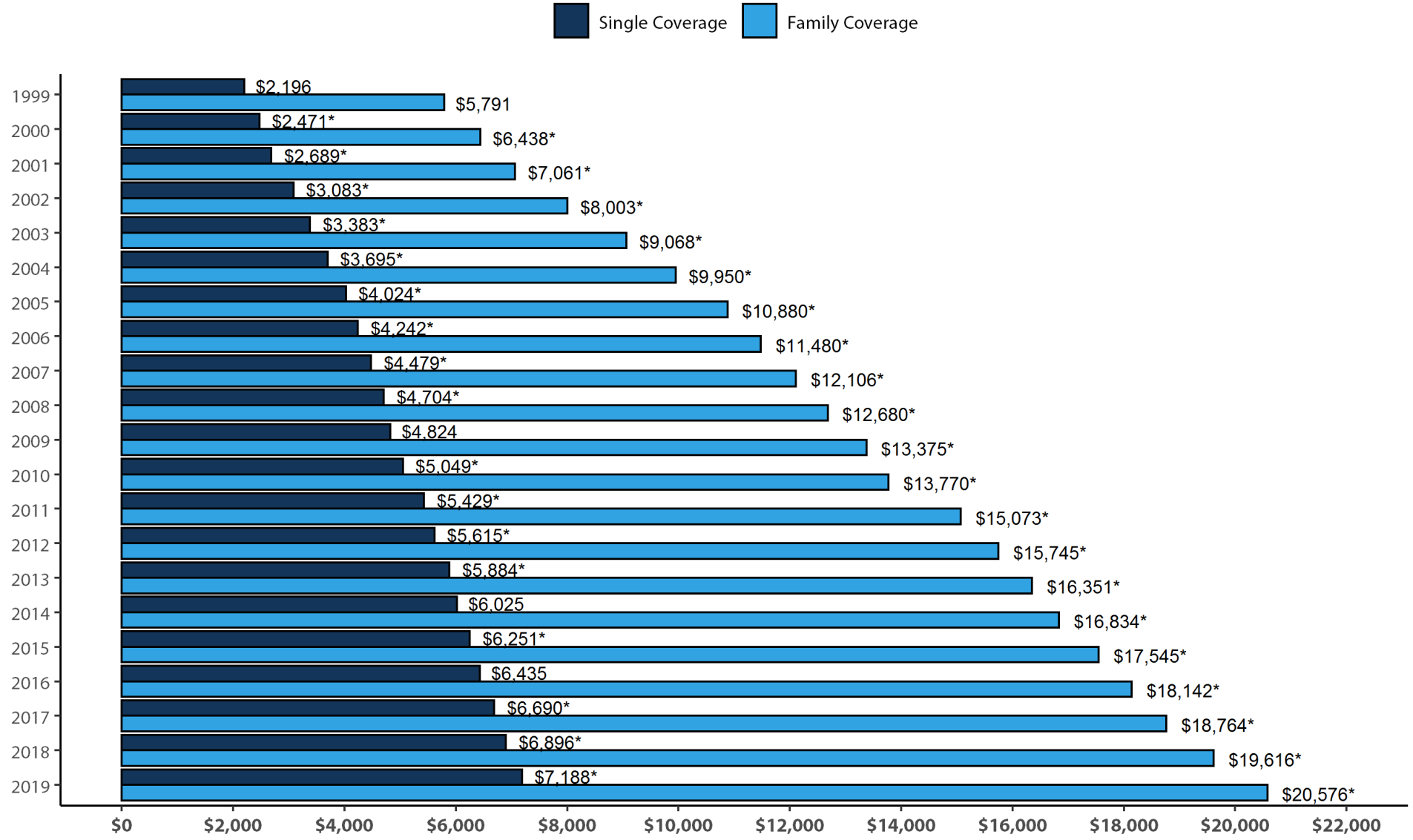
Filling the need for trusted information on national health issues.

Figure 12

Average Annual Premiums for Single and Family Coverage, 1999-2019



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2019; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

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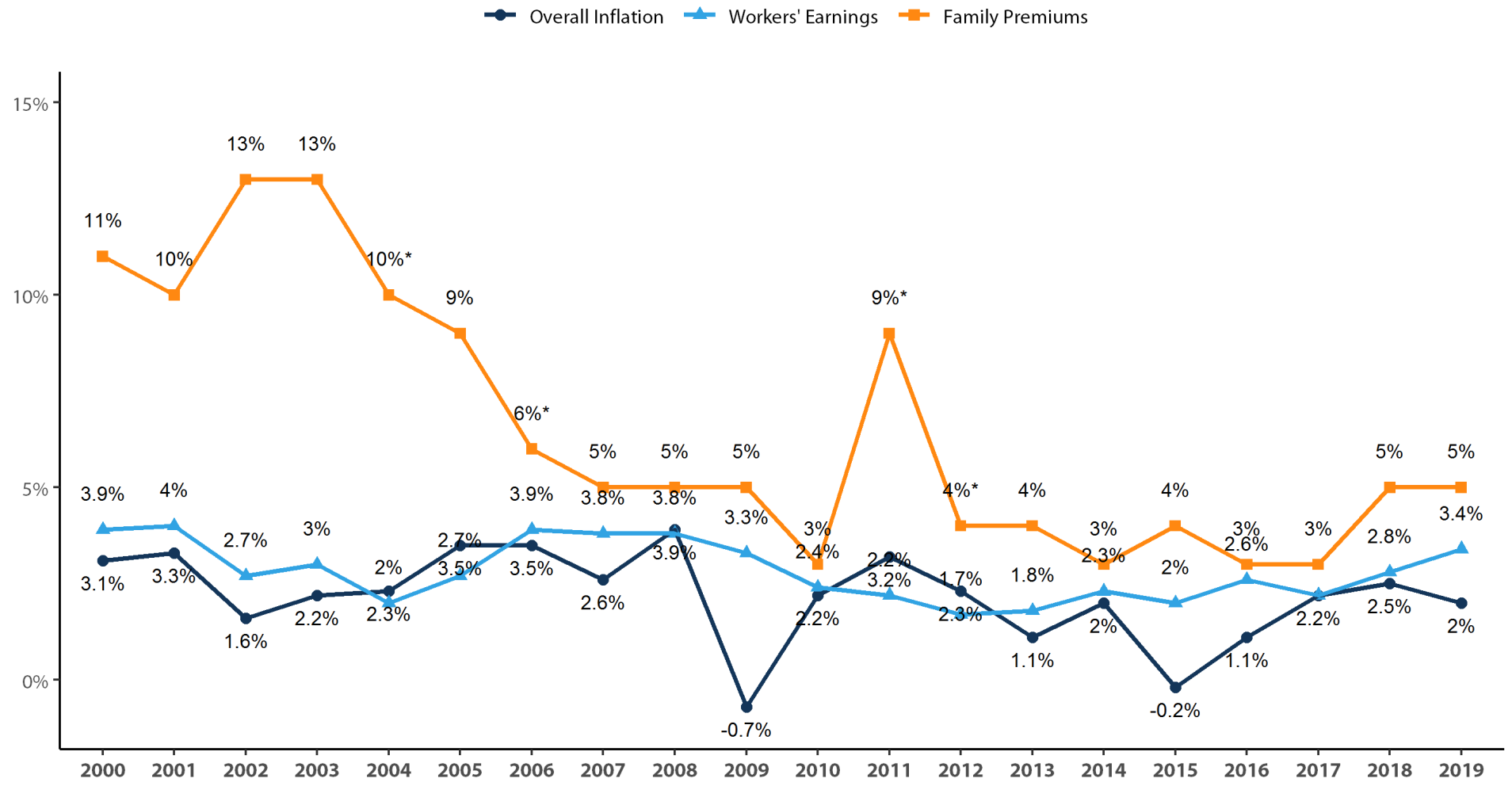
Figure 13

Average Annual Increases in Premiums for Family Coverage Compared to Other Indicators, 2000-2019



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2019; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2019; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2019 (April to April).

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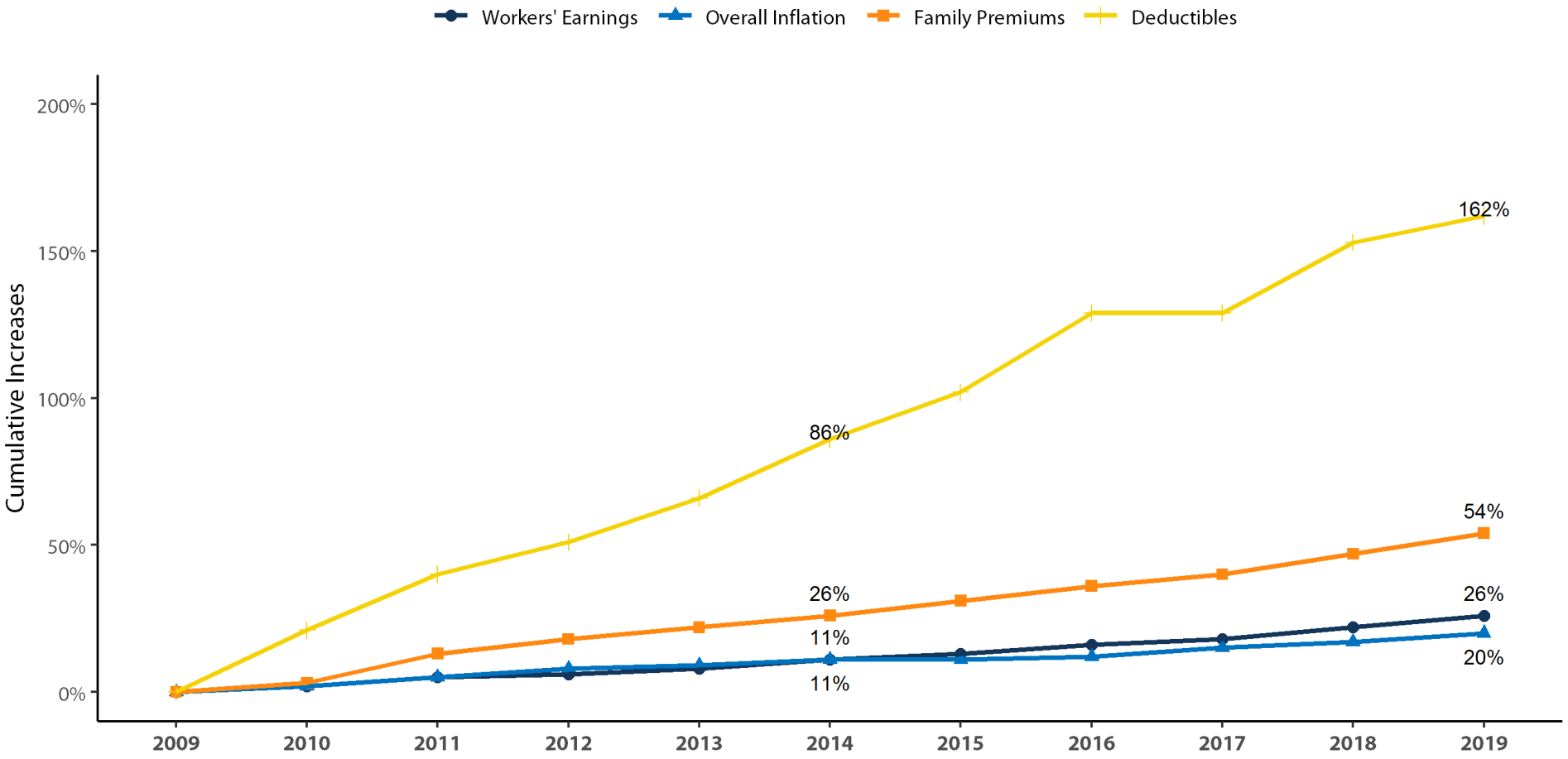
Figure 14

Cumulative Increases in Family Coverage Premiums, General Annual Deductibles, Inflation, and Workers' Earnings, 2009-2019



NOTE: Average general annual deductibles are for single coverage and are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

SOURCE: KFF Employer Health Benefits Survey, 2018-2019; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2009-2019; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2009-2019 (April to April).

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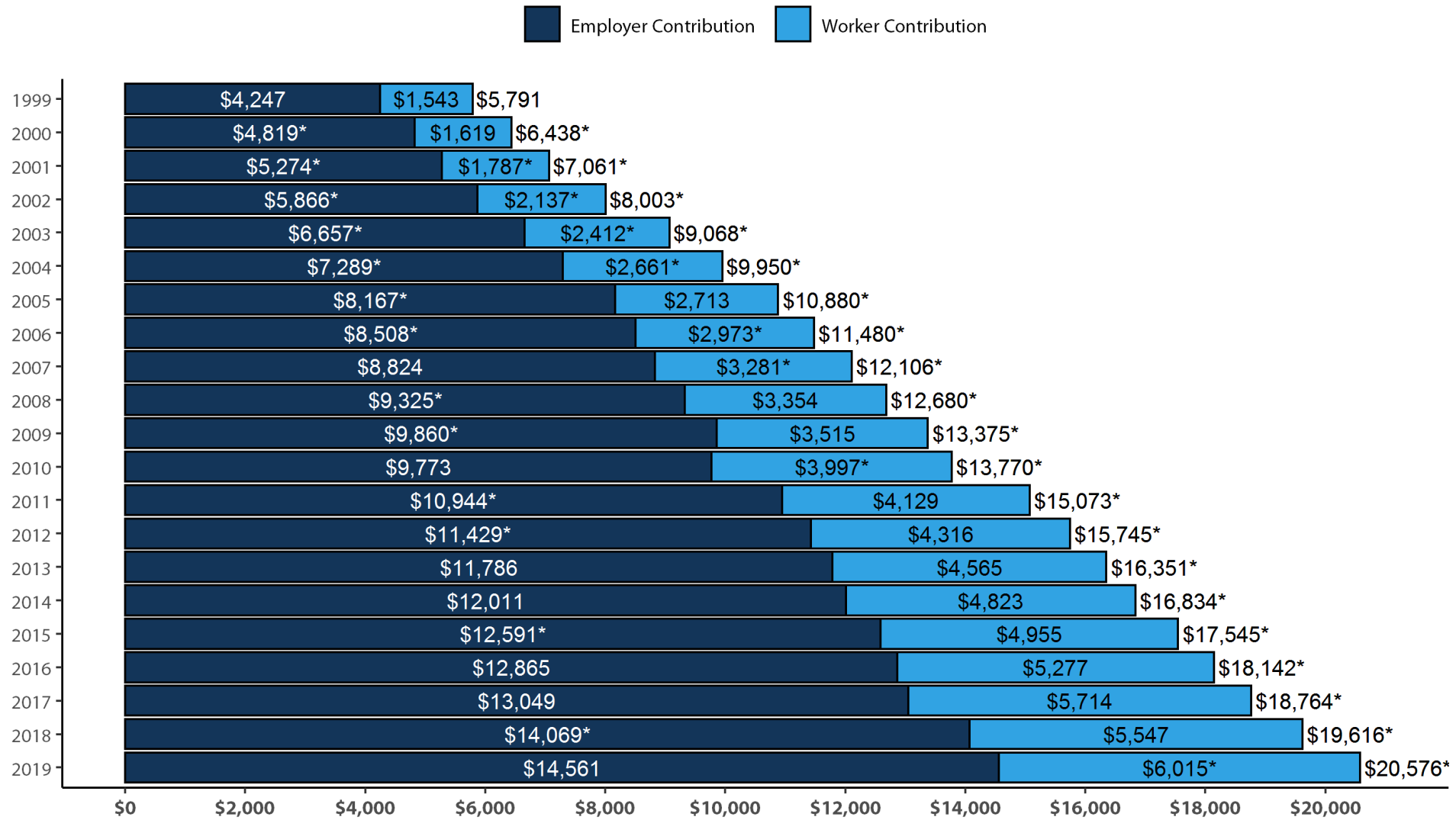
Figure 15

Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2019



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2019; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

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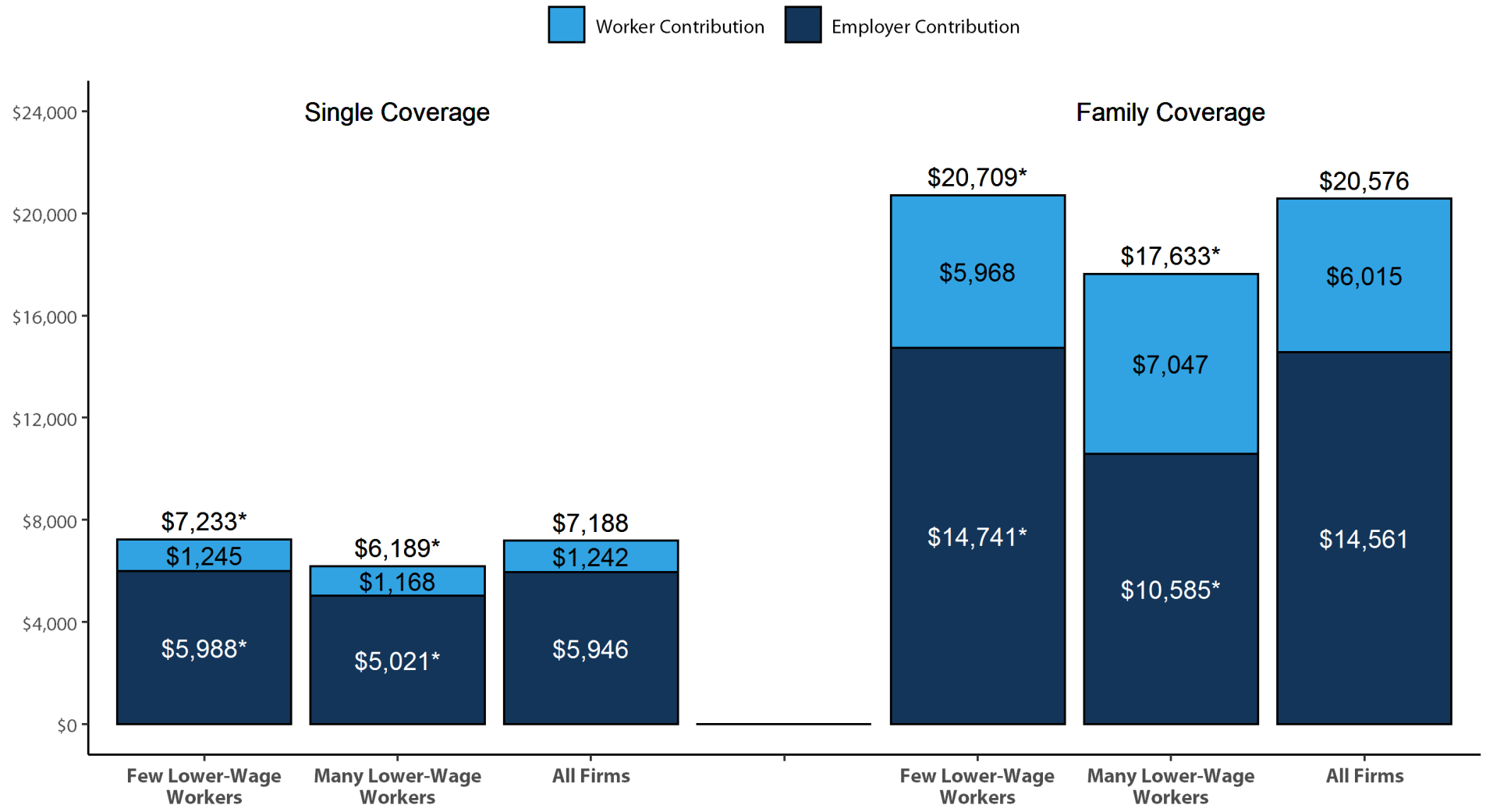
Figure 16

Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single and Family Coverage, By Firm Wage Level, 2019



* Estimate is statistically different between firm wage level categories ($p < .05$).

NOTE: Firms with many lower-wage workers are those where at least 35% earn less than the 25th percentile of national earnings ($25,000 in 2019).

SOURCE: KFF Employer Health Benefits Survey, 2019

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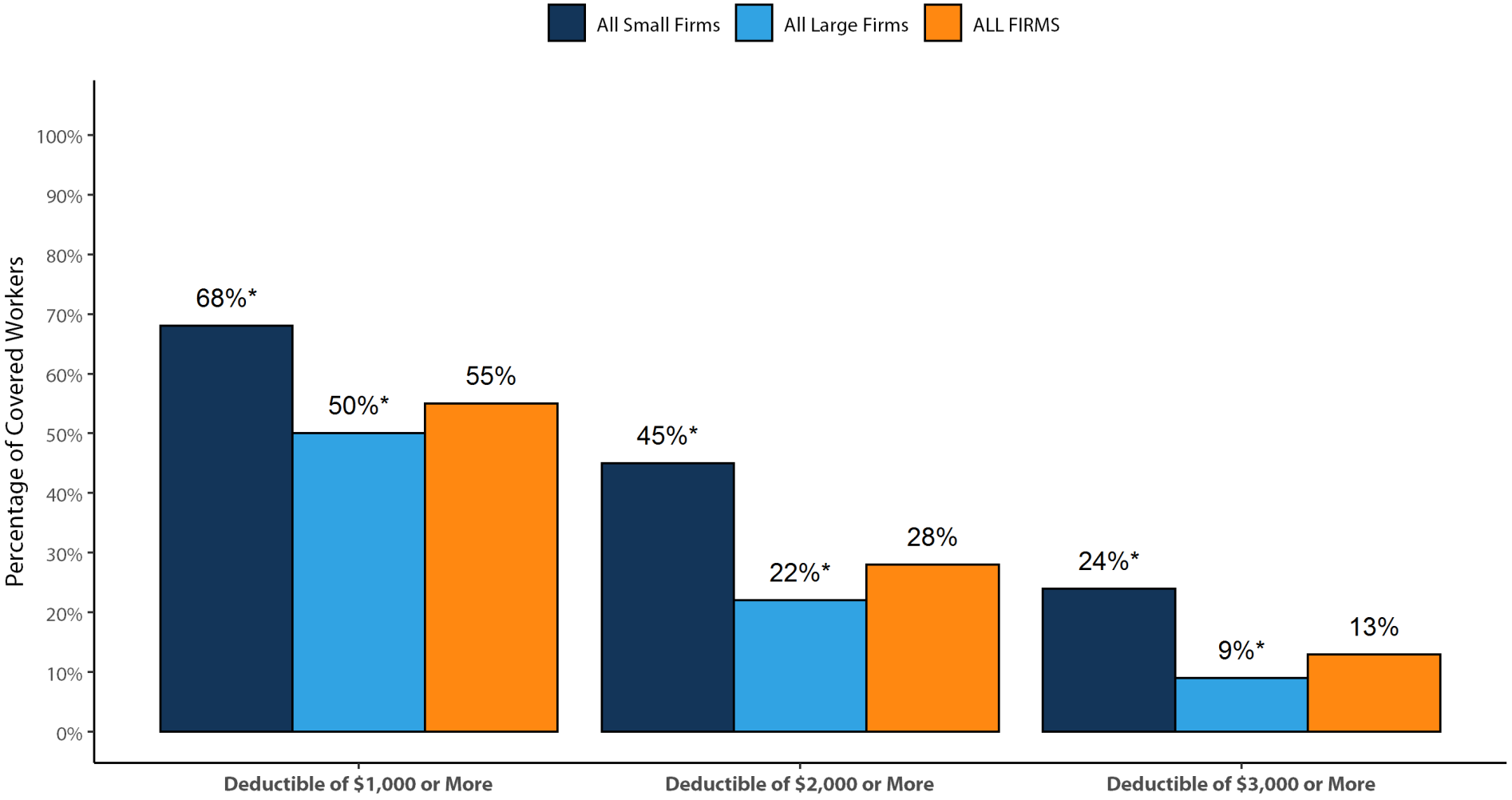
Figure 17

Percentage of Covered Workers Enrolled in a Plan with a High General Annual Deductible for Single Coverage, by Firm Size, 2019



* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: KFF Employer Health Benefits Survey, 2019

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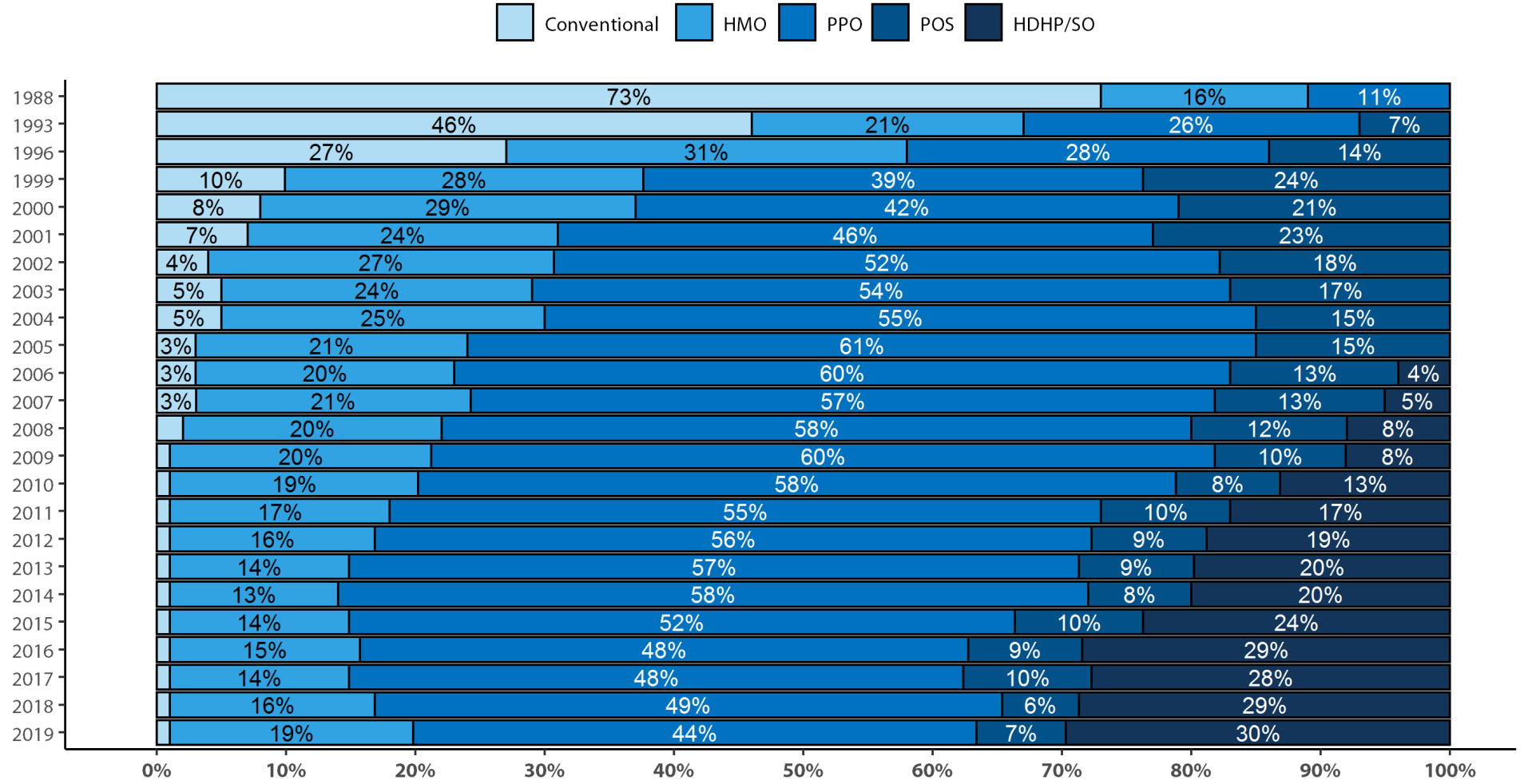
Figure 18

Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2019

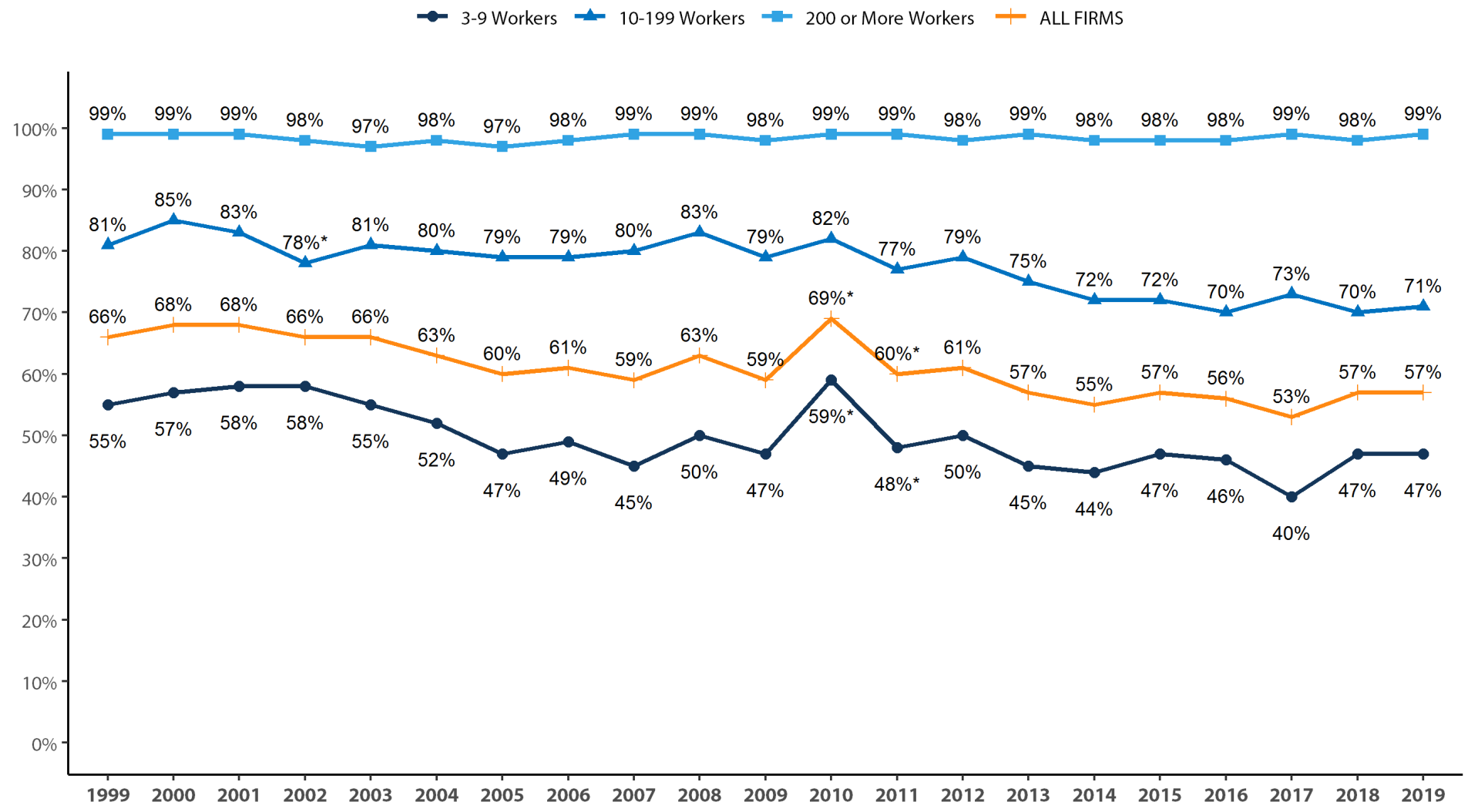


NOTE: Information was not obtained for POS plans in 1988 or for HDHP/SO plans until 2006. A portion of the change in 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey of Employer-Sponsored Health Benefits.

SOURCE: KFF Employer Health Benefits Survey, 2018-2019; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017; KPMG Survey of Employer-Sponsored Health Benefits, 1993 and 1996; The Health Insurance Association of America (HIAA), 1988.

Figure 19

Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2019



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

SOURCE: KFF Employer Health Benefits Survey, 2018-2019; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

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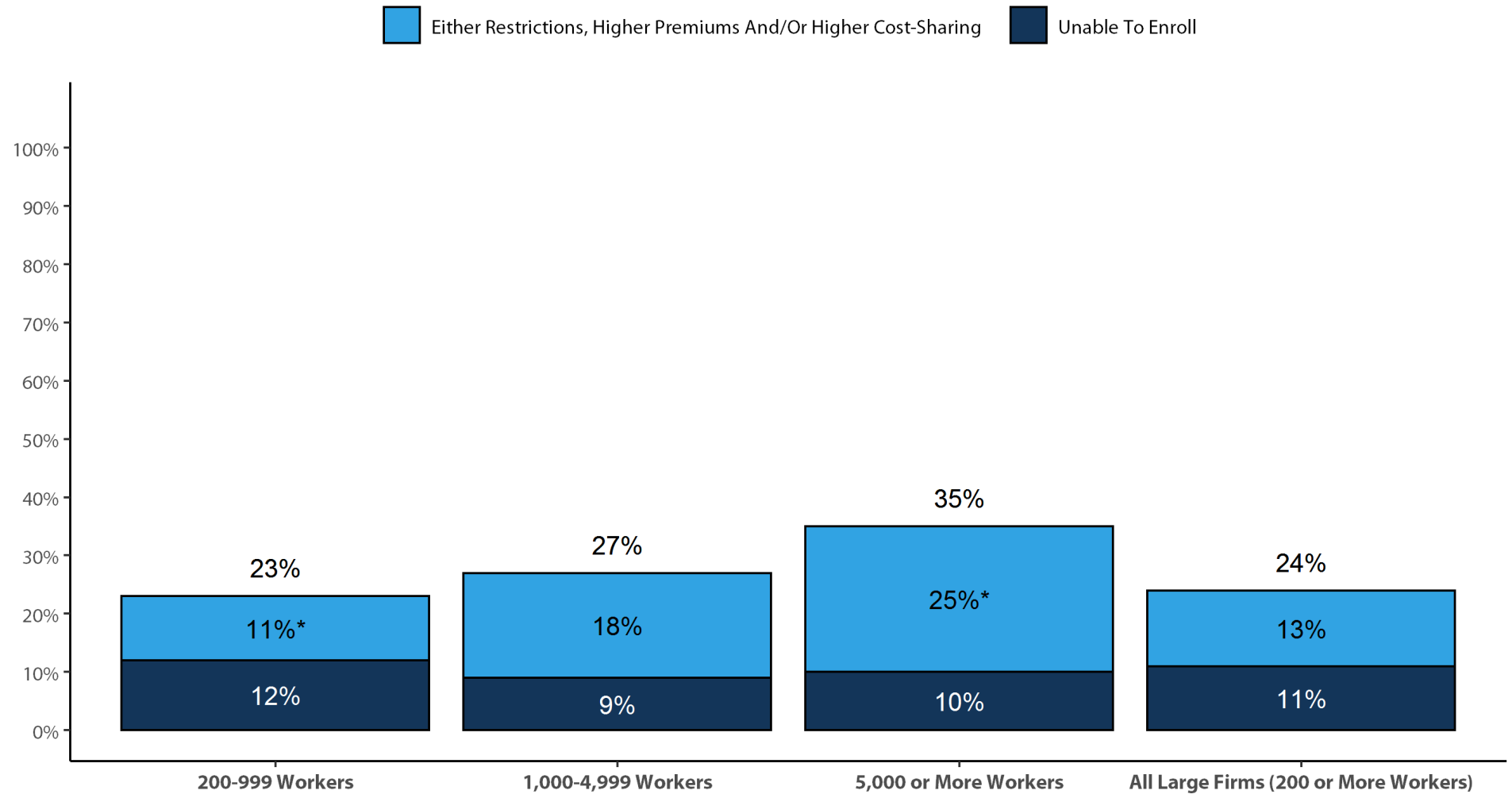
Figure 20

Among Large Firms that Offer Spousal Coverage, Spouses' Eligibility if They Have an Offer from Another Source, by Firm Size, 2019



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

NOTE: Large Firms have 200 or more workers. other restrictions may include requirements on the work status of the spouse, or the type of coverage they have access to

SOURCE: KFF Employer Health Benefits Survey, 2019

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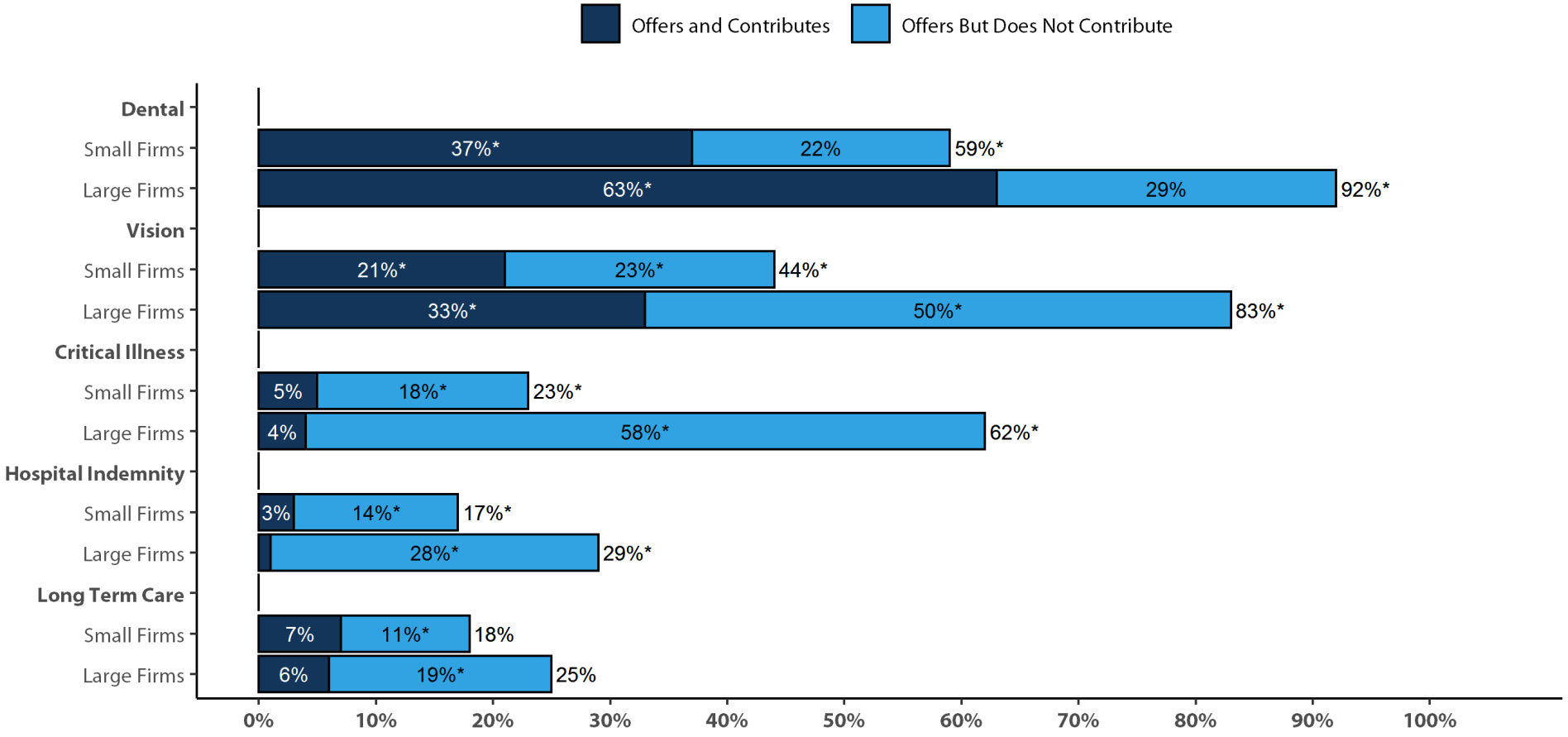
Figure 21

Among Firms Offering Health Benefits, Percentage of Firms That Offer Voluntary Insurance Benefits in Addition to Benefits Offered Through the Health Plan, by Firm Size, 2019



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Critical illness insurance provides a cash benefit when an enrollee is diagnosed with a specified condition, such as cancer. Hospital indemnity plans provide a cash benefit when an enrollee is admitted to the hospital or has a certain type of outpatient surgery. Long term care insurance covers assistance with daily living not generally covered by health insurance such as care from a home health worker or nursing home. The survey asks firms that offer health benefits if they offer or contribute to voluntary benefits that are separate from any their health plans might include.

SOURCE: KFF Employer Health Benefits Survey, 2019

Legislative Issues, Opportunities, Concerns & Administrative Actions

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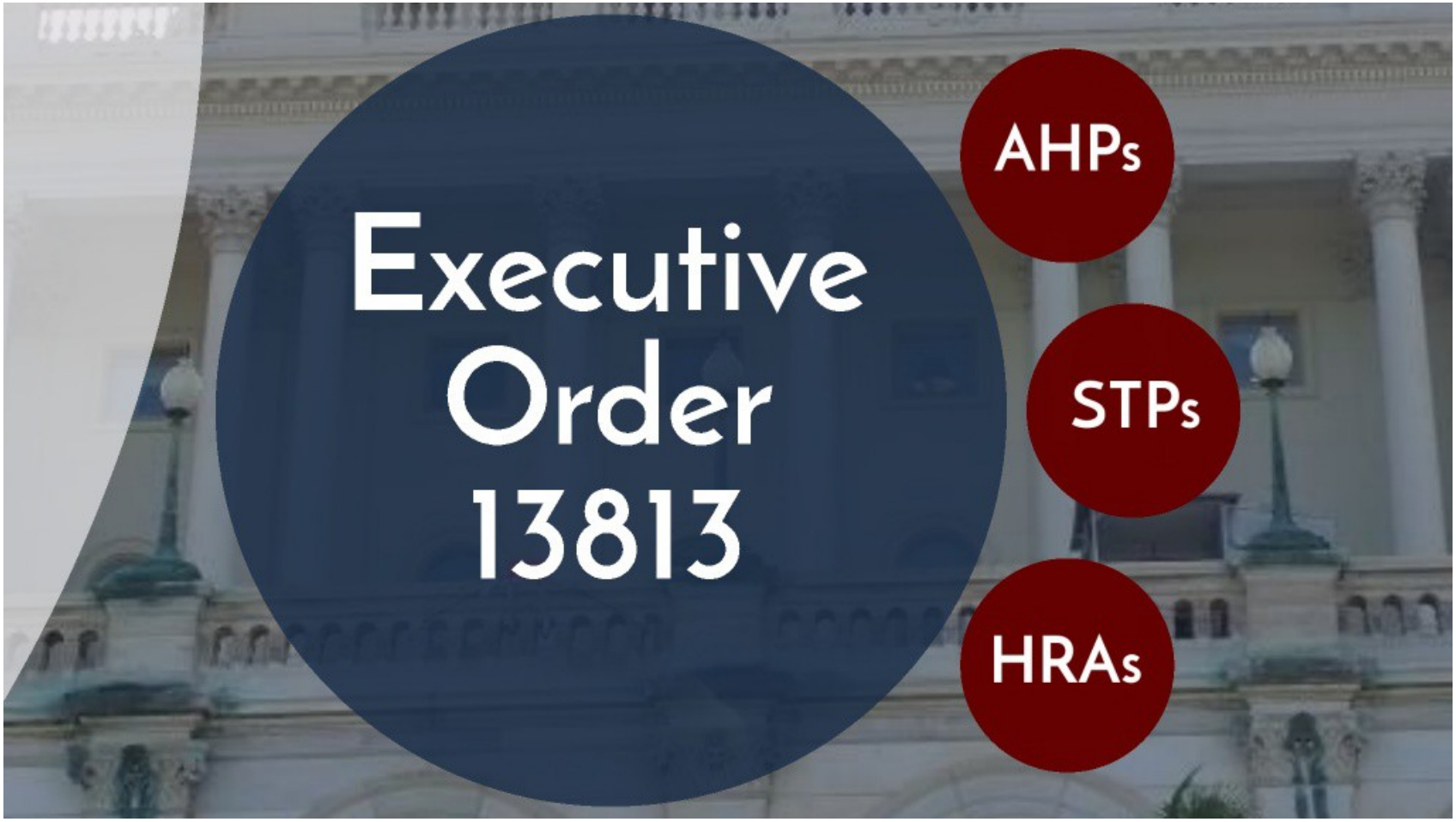
Regulatory
Priorities
New Rules


Executive Order 13813
AHPs
STPs
HRAs

Association Health Plans

- Changes the definition of a bona fide association, allowing an association to be created for the purpose of offering insurance
- It most offer at least one other service for members, besides insurance coverage
- May be formed not just with groups that share a common interest, but also groups whose members are in the **same trade, industry, line of business or profession**, regardless of location or alternatively, to be based on **location**
- All employer members of the group would be counted together as a large group – each small employer would not have to be counted based on their own size
- Individual employers, as well as any of their individual employees could not be rated based on health status.
- It allows working owners, even if they have no other employees, to be considered as both the employer and employee and participate in the AHP
- **State laws are not preempted**. States have regulatory authority today over both fully insured and self-funded MEWAs. Self-insured plans also aren't exempt from all ACA requirements and most have comprehensive coverage.

*Governor Northam chose not to enact legislation last session that would have allowed self-funded MEWAs as prescribed by this guidance.

Short-Term Plans

- The final rule effectively ends the policy established by the Obama Administration in 2016 restricting the length of time for Short-term limited duration insurance (STLDI), often referred to as short-term plans (STPs).
- It restores the maximum duration of STPs to **up to 364 days** as previously permitted, with the ability to renew for **up to 36 months** at the carrier's discretion.
- Includes increased consumer protections, specifically requiring insurers to clearly disclose the type of policy the individual is choosing and that these plans do not offer the same coverage as individual plans under the ACA.
- Defers to state regulators on the implementation of the rule:
    - States are permitted to adopt a definition with a **shorter maximum initial duration**, prohibit renewals or extensions of short-term plans, or require additional insurer disclosures.

Health Reimbursement Arrangements

- HRA *proposed rule* was published in October, comments sent December 28.
- Establishes new parameters to allow employers to offer an HRA to be used for the purpose of **purchasing individual health coverage in lieu of a traditional group health plan**.
  - Stipulates that an employer would not be permitted to offer both the option of a traditional group health plan and an HRA for the purchase of individual health coverage to the same class of employees.
  - An employee who is eligible for an ACA advanced premium tax credit (APTC) would be permitted to opt-out of an HRA, while the HRA sponsor would need to notify eligible participants that they would not be eligible for an APTC if receiving an HRA and enrolling in individual health coverage.
- Permits an **employer to offer employees an HRA for excepted benefits**, although employers are not permitted to offer employees both an HRA for purchase of individual health coverage and an HRA for excepted benefits.

Employer Reporting

Establish a new voluntary reporting system, reduce the number of individuals and amount of information that would need to be reported, and eliminate the requirement to collect dependent social security numbers.

Full Time Definition

Restore the 40-Hour Workweek; repeal the 30-hour threshold for full-time employee for purposes of the employer mandate in the ACA and replace it with 40-hours.

Cadillac/Excise Tax

Permanently repeal the "Cadillac Tax," which will impose a 40% excise tax on health plans that exceed certain cost thresholds beginning in 2022, following the delays passed in December 2015 and January 2018.

H.R. 748 | Representatives Joe Courtney (CT-2), Mike Kelly (PA-16), Suzan DelBene (WA-1) and Elise Stefanik (NY-21)

Concerns:
Employers may choose to cut or eliminate benefits to avoid tax.
Tax not properly indexed for inflation.
Employers may eliminate H.S.A. / H.R.A./ F.S.A., worksite products, and access for spouse. Impacts union and government-sponsored plans.

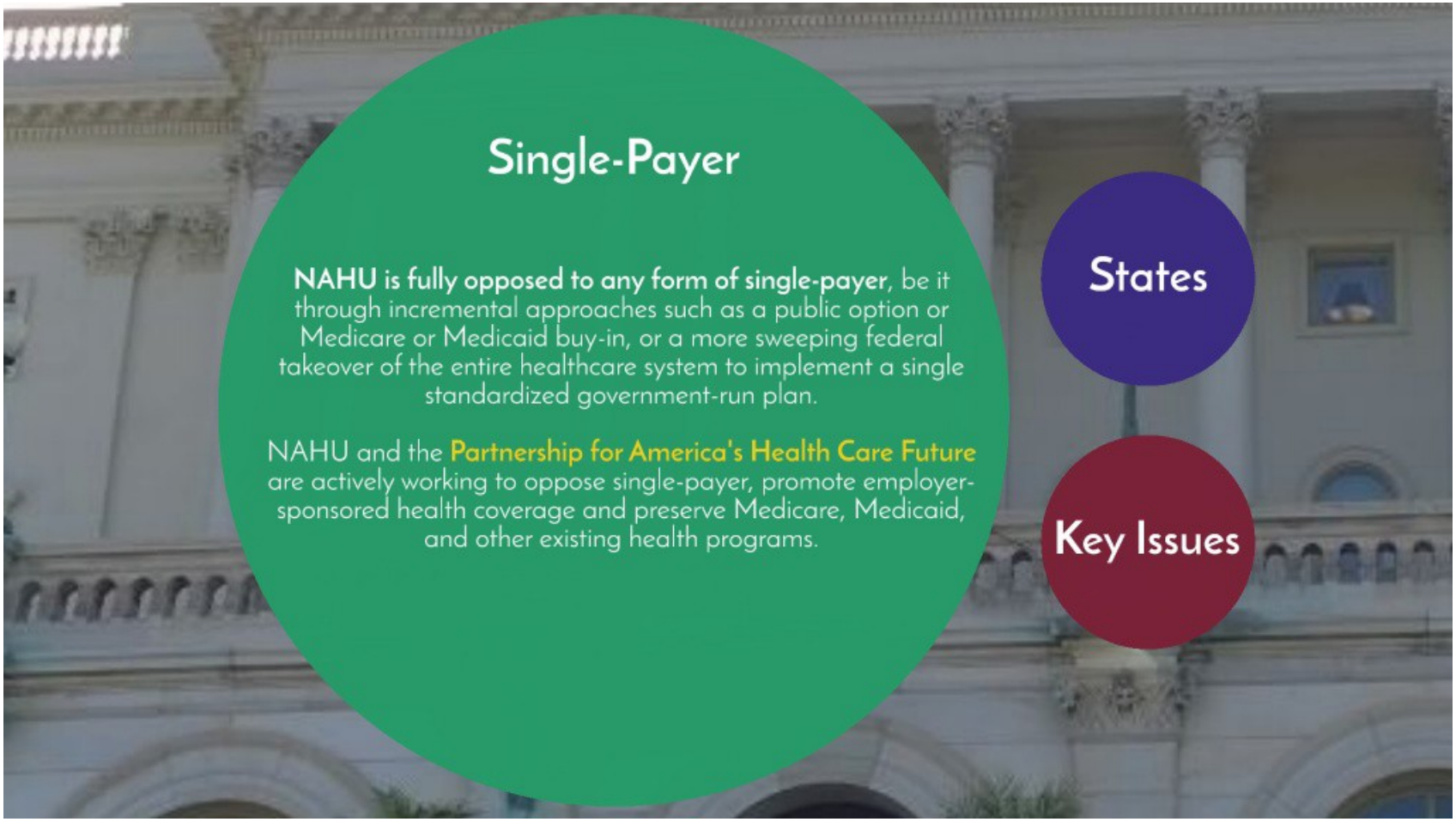
Annual Limit for coverage generally -
$10,200 for individual coverage / $27,500 for family coverage

Employer Exclusion

The employer-based system is highly efficient at providing American workers and their families with affordable coverage options through group purchasing and its associated economies of scale by spreading risk and avoiding adverse selection.

The success of this system is possible because of the preferential tax treatment of employer-sponsored insurance coverage, where employer-paid contributions for an employee's health insurance are excluded from that employee's compensation for income and payroll tax purposes.

Proposals that would cap the maximum value of the exclusion or eliminate it altogether would be detrimental to the stability of the employer-based market and would negatively affect middle-class Americans who currently benefit from this provision.

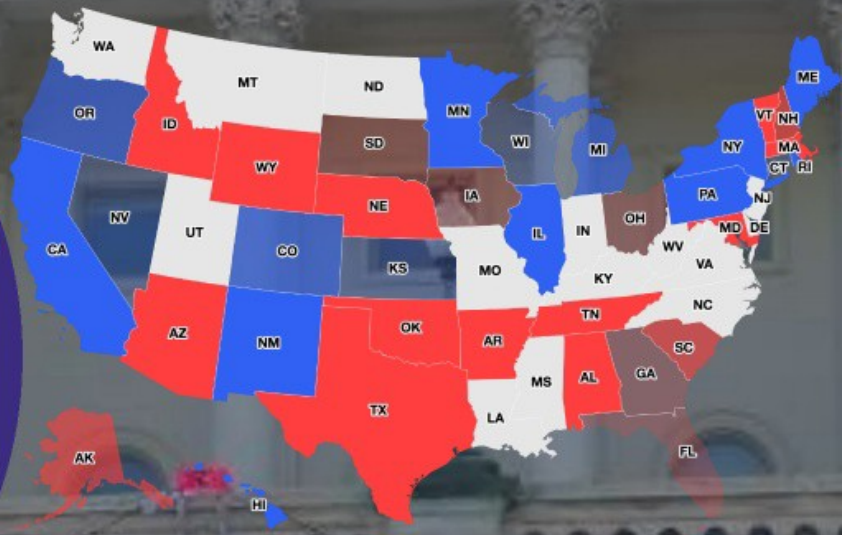

Single-Payer
NAHU is fully opposed to any form of single-payer, be it through incremental approaches such as a public option or Medicare or Medicaid buy-in, or a more sweeping federal takeover of the entire healthcare system to implement a single standardized government-run plan.
NAHU and the Partnership for America's Health Care Future are actively working to oppose single-payer, promote employer-sponsored health coverage and preserve Medicare, Medicaid, and other existing health programs.
States
Key Issues

States as Policy Laboratories

Single-payer concerns:
CA: Dems control gov, senate 28-12, house 57-43
CO: Dems control gov, senate 19-16, house 41-24
NY: Dems control gov, senate 40-23, house 107-43

Democrats now control 23 governorships
(+7 since 2018)

Democrats now control 37 state legislative chambers
(+6 since 2018)



Recent State Proposals


Recent State Proposals
• California - Goal of achieving universal coverage
• New Mexico - Public Option, Medicaid Buy-in
• Washington - Public Option
• New York - Single Payer

Health Insurance Tax (HIT)

Permanently eliminate the national premium tax (HIT) that will add more than $500 annually in costs to a typical family policy, with the total cost in 2016 of $11.3 billion. The tax is currently suspended for calendar year 2019.

S. 80 | Senators John Barasso (R-WY) and Kyrsten Sinema (D-AZ)

S. 172 (Delay through 2021) | Senators Cory Gardner (R-CO) and Jeanne Shaheen (D-NH)

Trump Administration Priorities

America First Prescription Drug Initiative

- Continued Focus on Roll Out of Pricing Blueprint
  - Direct to Consumer (DTC) Advertising, International Price Index Model, Importation

HHS/CMS are very focused on policies that promote Health Information Technology (HIT) utilization and interoperability

- awaiting proposed rule intended to create a "more accessible and interoperable health care ecosystem"

Potential Impact of *Texas v. U.S.* federal lawsuit

- If courts strike the ACA, Trump Administration would lose virtually all rule-making powers currently used for healthcare agenda on prescription drug reform, opioid response, provider reimbursement, value-based care and cost containment efforts

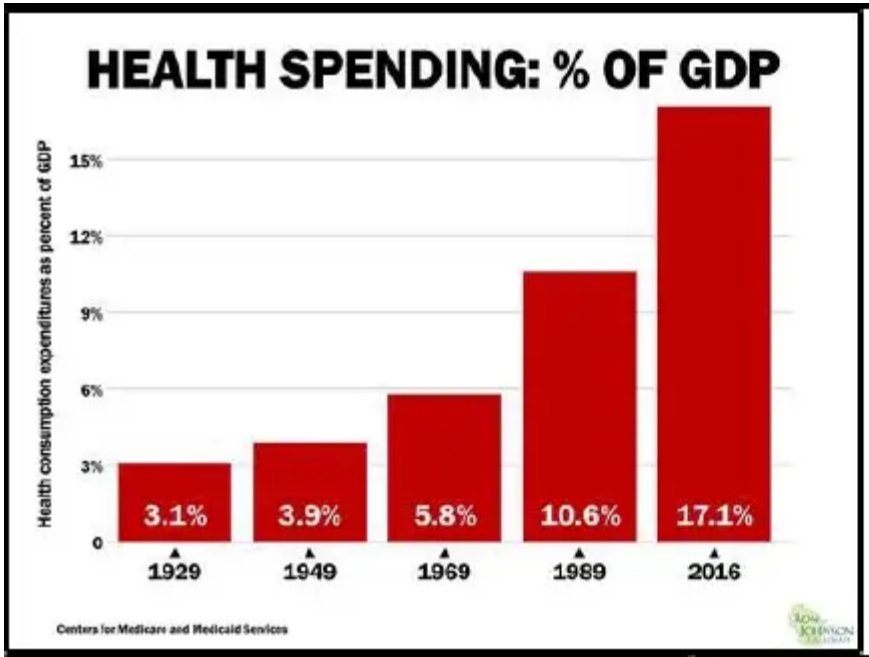
Texas v. United States

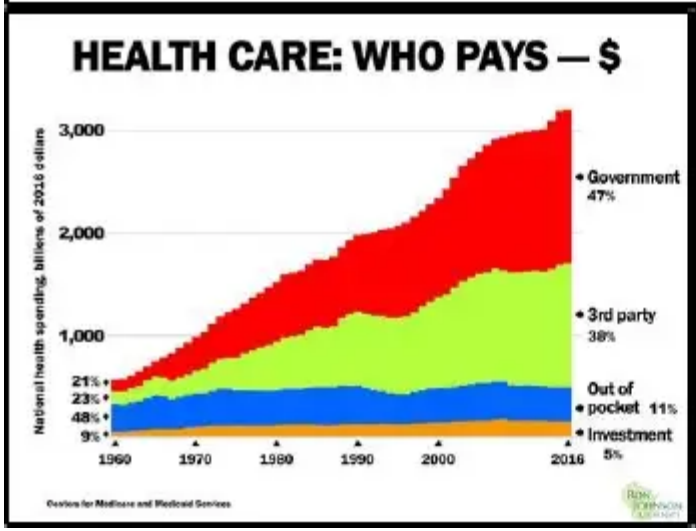
The Trump Administration and Republican-led states argue that while the individual mandate was upheld as constitutional in the landmark 2012 Supreme Court case *NFIB v. Sebelius*, on the basis that it complied with Congress's authority to levy taxes, that because the penalties have been zeroed out that there is no longer a tax being levied, and therefore, the mandate itself is not constitutional.

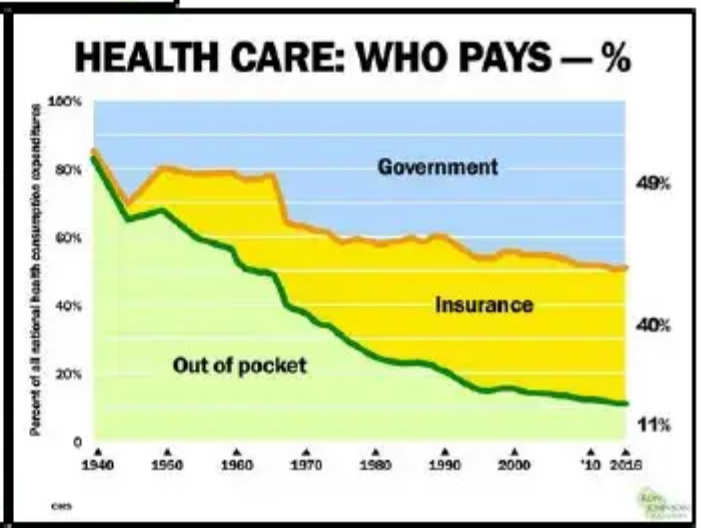
The Democratic states argue that the zeroing out of the penalty is akin to a suspension of the myriad of other ACA taxes, such as the Cadillac/excise tax and health insurance tax, and that it is not repealed but merely not generating revenue—a condition that is not required under the Constitution.

On 12/14/18, a federal judge ruled the individual mandate is unconstitutional, inseverable from the law, and that because it is such an essential part of the ACA and the law cannot function without the mandate in place, the entire ACA is therefore unconstitutional.

This ruling is not final and is expected to be engaged in appeals for the next several months which will likely culminate in a hearing before the Supreme Court. This means that the ACA continues to be the law of the land and compliance with the ACA is still being enforced. Coverage for the 2019 plan year remains unaffected by the ruling.

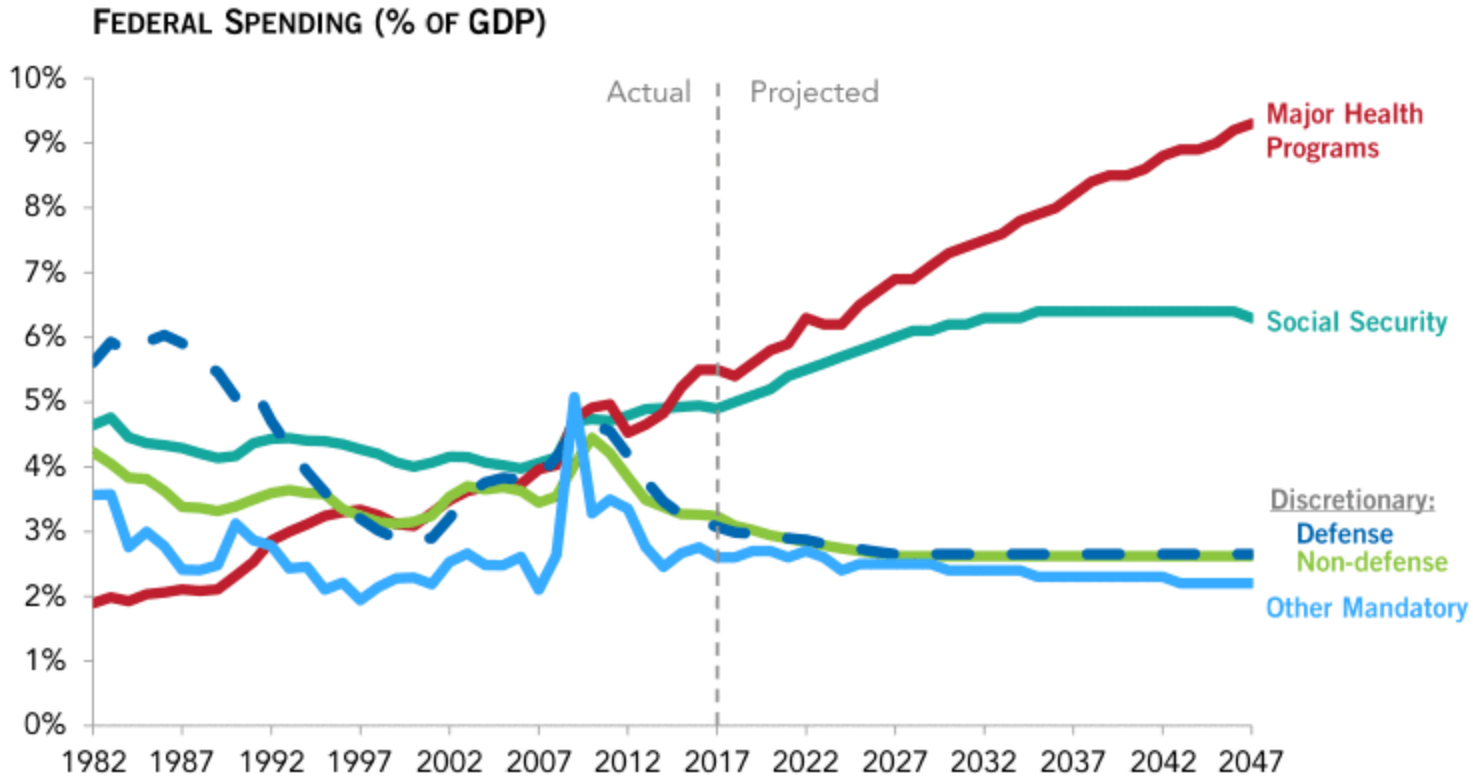

HEALTH SPENDING: % OF GDP
Health consumption expenditures as percent of GDP
15%
12%
9%
6%
3%
0
3.1%
3.9%
5.8%
10.6%
17.1%
1929
1949
1969
1989
2016
Centers for Medicare and Medicaid Services


HEALTH CARE: WHO PAYS — $
National health spending, billions of 2016 dollars
3,000
2,000
1,000
21%
23%
48%
9%
1960
1970
1980
1990
2000
2016
Government 47%
3rd party 38%
Out of pocket 11%
Investment 5%


HEALTH CARE: WHO PAYS — %
Percent of all national health consumption expenditures
100%
80%
60%
40%
20%
0
Government
Insurance
Out of pocket
49%
40%
11%
1940
1950
1960
1970
1980
1990
2000
'10
2016

PETER G. PETERSON FOUNDATION

Healthcare is the major driver of the projected growth in federal spending over the long term



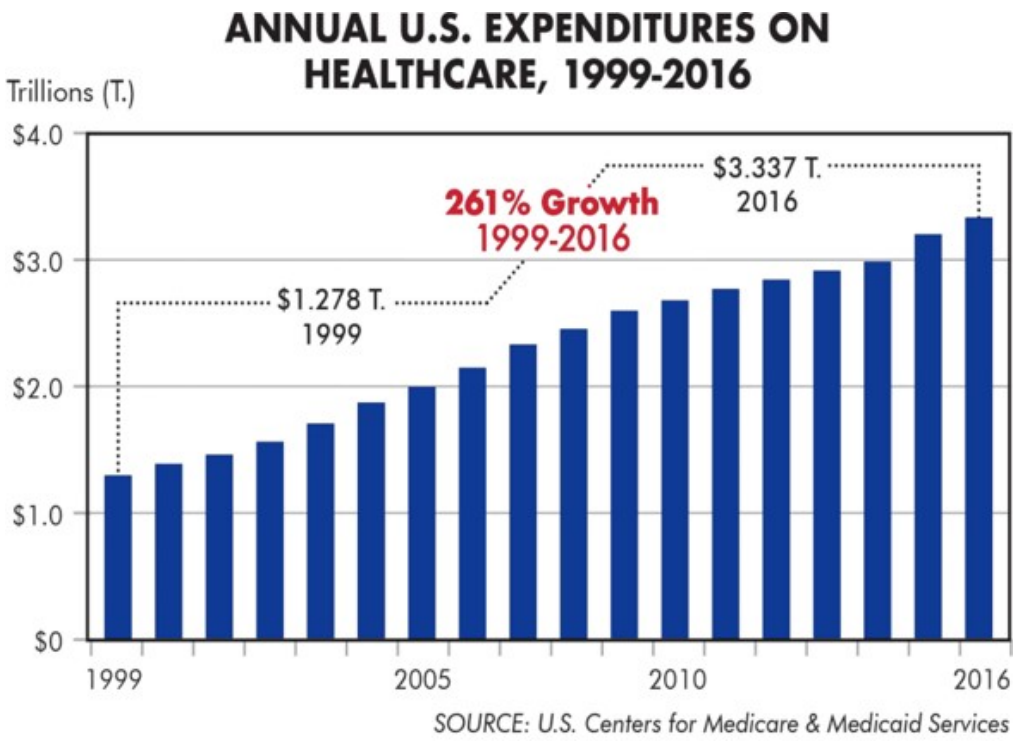
SOURCE: Congressional Budget Office, *The 2017 Long-Term Budget Outlook*, March 2017 and *The Budget and Economic Outlook: 2017 to 2027*, January 2017, and PGPF projections based on CBO data.
NOTE: Major health programs include Medicare (net), Medicaid, Children's Health Insurance Program (CHIP), and the health exchanges.

Top Trend - Power of the Employer to drive change

What they say you need

- Managed Care
- Wellness Programs
- Biometrics
- Incentives
- HSAs/HRAs/FSAs
- "Skin in the Game"
- Associations
- ACA

The Results




Humana

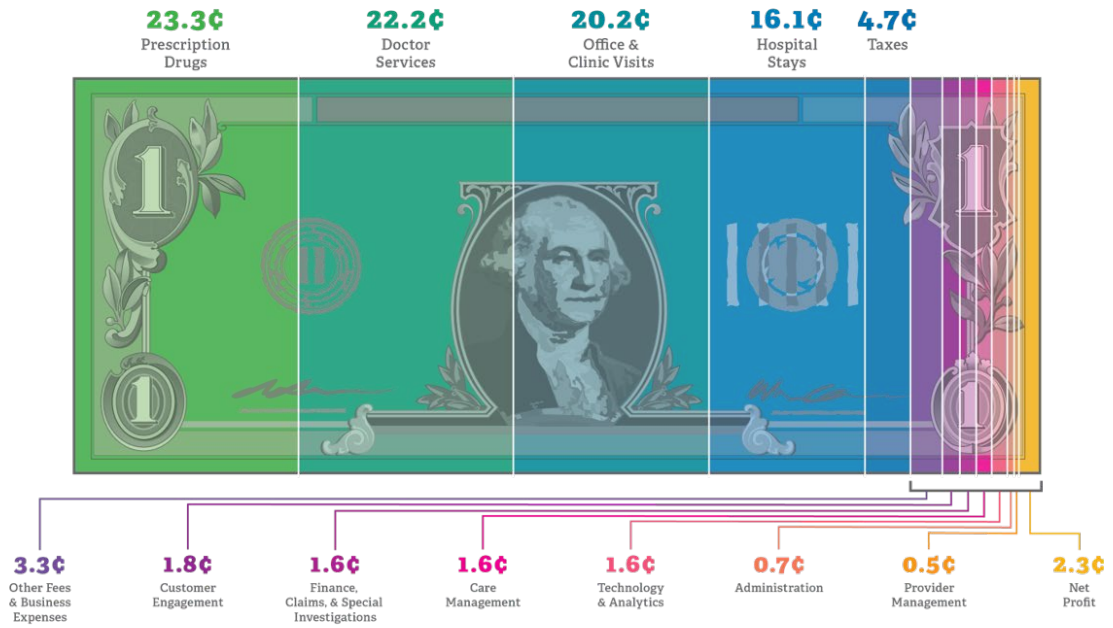

United
Healthcare


Cigna


BlueCross
BlueShield


Aetna

What they show you



While we are engaged in that conversation

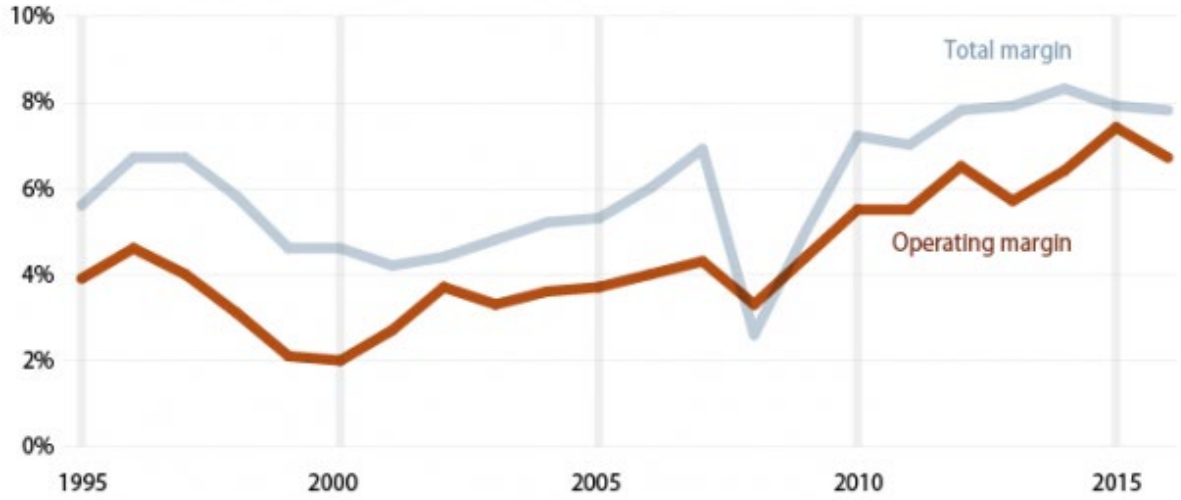
Insurers buying providers				
Buyer	**Provider**	**Type of service**	**Value**	**Status**
Optum - UHC	DaVita Medical Group	Primary and urgent care	$4.9 billion	Under FTC review
Humana, TPG Capital, and Welsh, Carson, Anderson & Stowe	Kindred at Home	Home health and hospice	$4.1 billion; Humana's share is $800 million	Finalized in July
Humana, TPG Capital, and Welsh, Carson, Anderson & Stowe	Curo Health Services	Hospice	$1.4 billion; Humana has a 40% minority stake	Finalized in July
Humana	Family Physicians Group, Orlando, Fla.	Primary care	Not disclosed	Finalized in April
Centene	Community Medical Group, Miami-Dade County, Fla.	Primary care	Not disclosed	Pending
Anthem	Aspire Health	Non-hospice palliative care	Not disclosed	Finalized in June
Source: Managed Care				

Health Insurance Carriers Stock Value

FIGURE 1

Hospital margins are at their highest in decades

Hospital operating margins, 1995–2016



Source: American Hospital Association, "Trendwatch Chartbook 2018: Table 4.1: Aggregate Total Hospital Margins and Operating Margins; Percentage of Hospitals with Negative Total Margins; and Aggregate Non-operating Gains as a Percentage of Total Net Revenue, 1995 – 2016" (Chicago: 2018), available at https://www.aha.org/system/files/2018-05/2018-chartbook-table-4-1.pdf.

CAP

• Hospital margins are higher than those in some other parts of the health care sector, though they remain well below margins for drug companies.

Healthcare Supply Chain Management

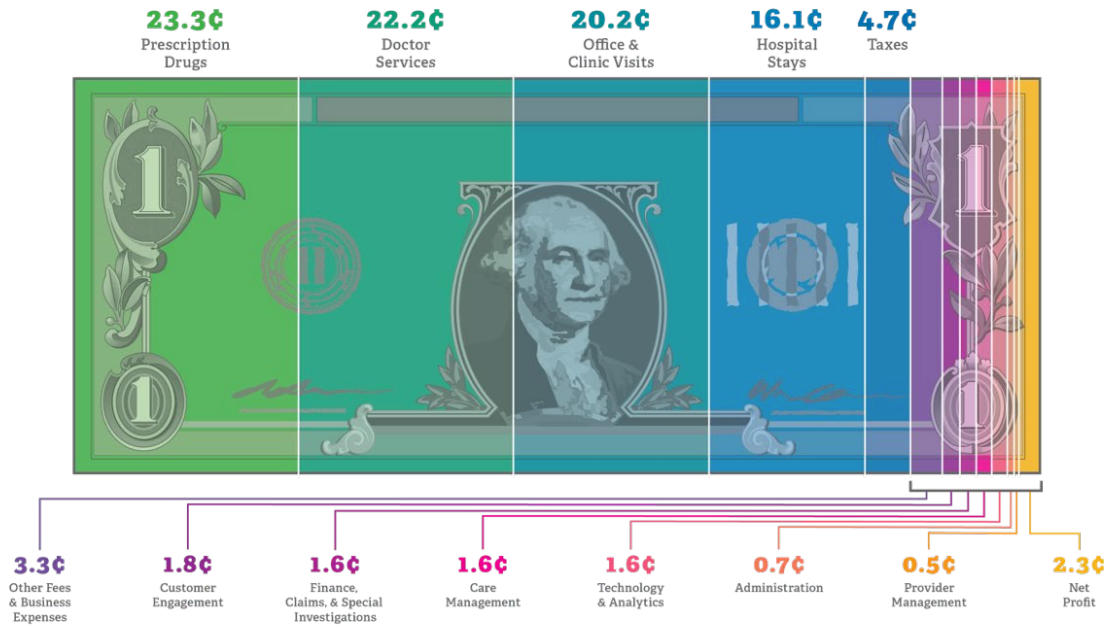
Gaining an Edge in an Unfair Game

Finding Opportunities

- Where we receive care
- How much we spend for it

A simple idea, however, we must "Train our Brains" to think differently

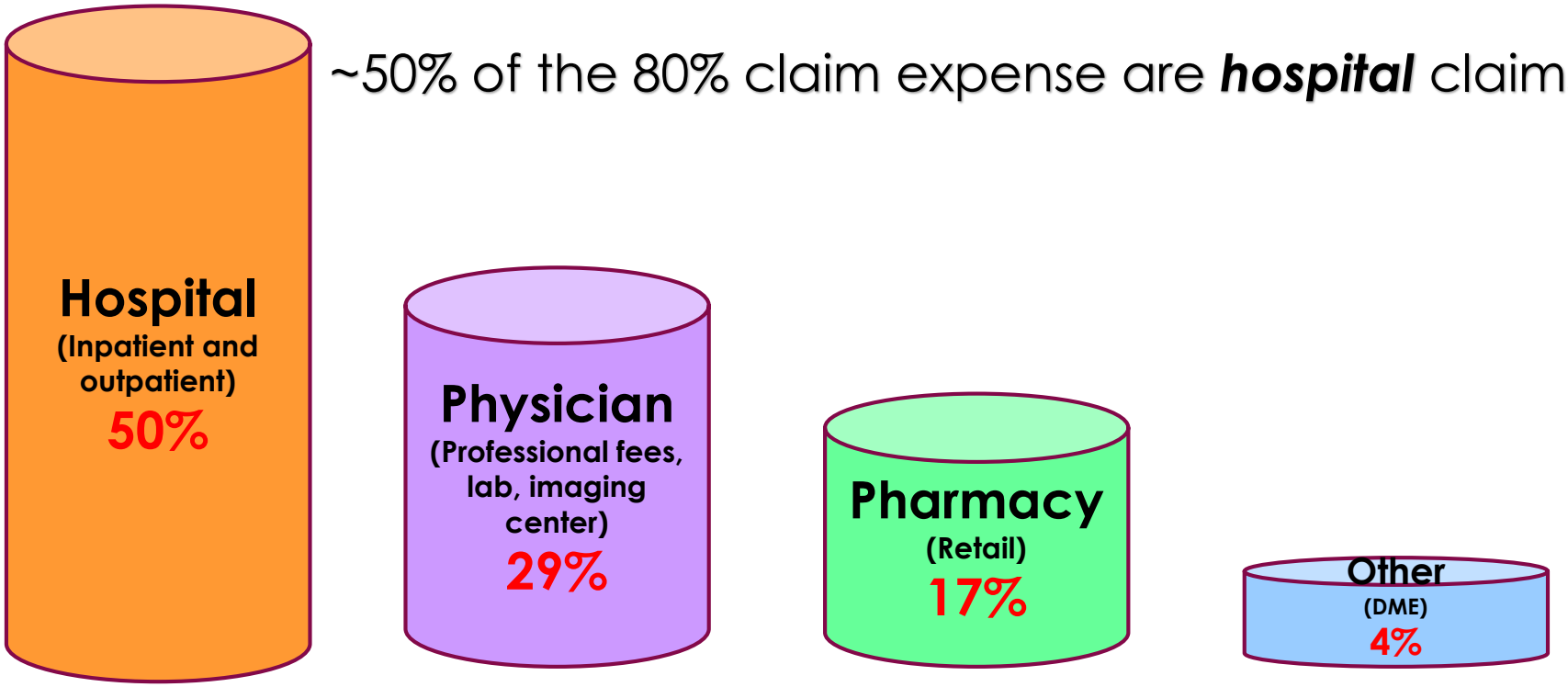
Let's Re-Think this slide

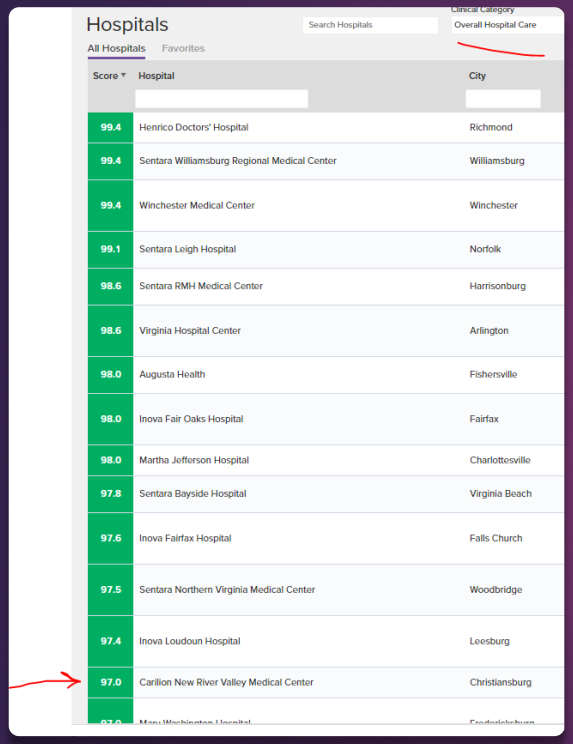


The Medical Plan Supply Chain

The Medical Plan Supply Chain
(2018 Milliman Medical Index)

~50% of the 80% claim expense are ***hospital*** claims

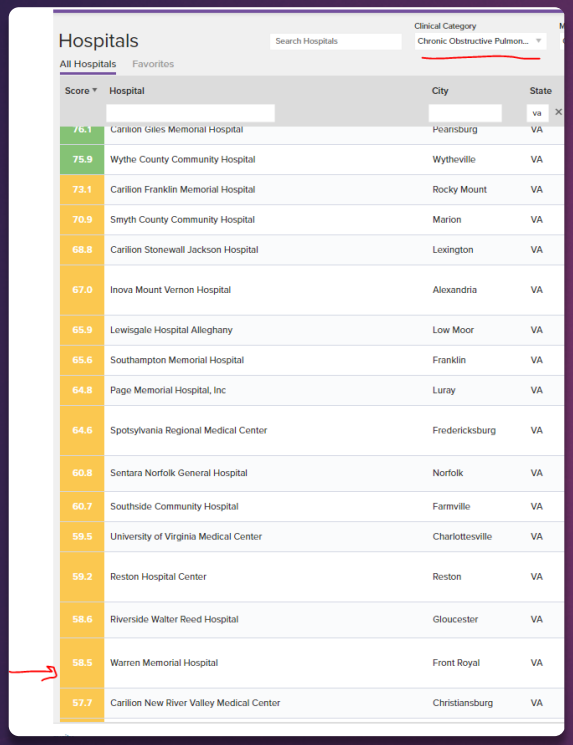




Carilion New River Valley Medical

Overall Hospital Care

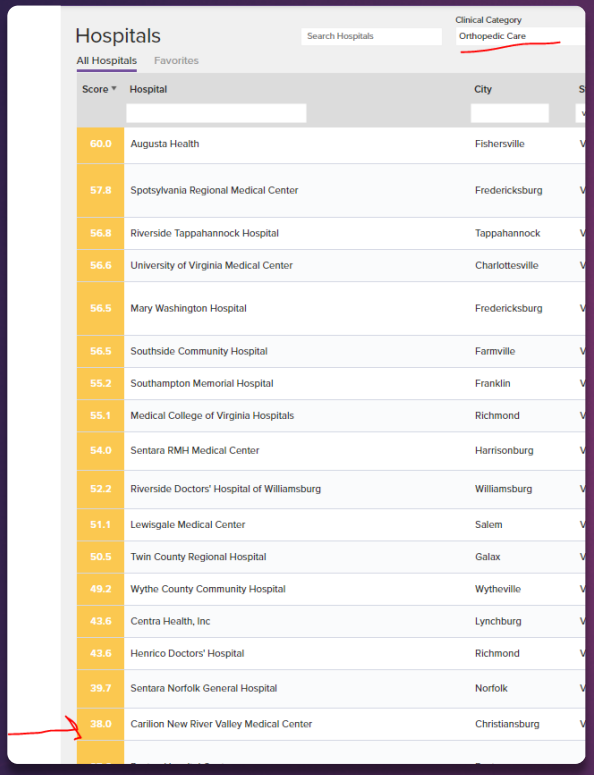
Score – 97.0



Carilion New River Valley Medical

Chronic Obstructive Pulmonary Disease

Score – 58.5

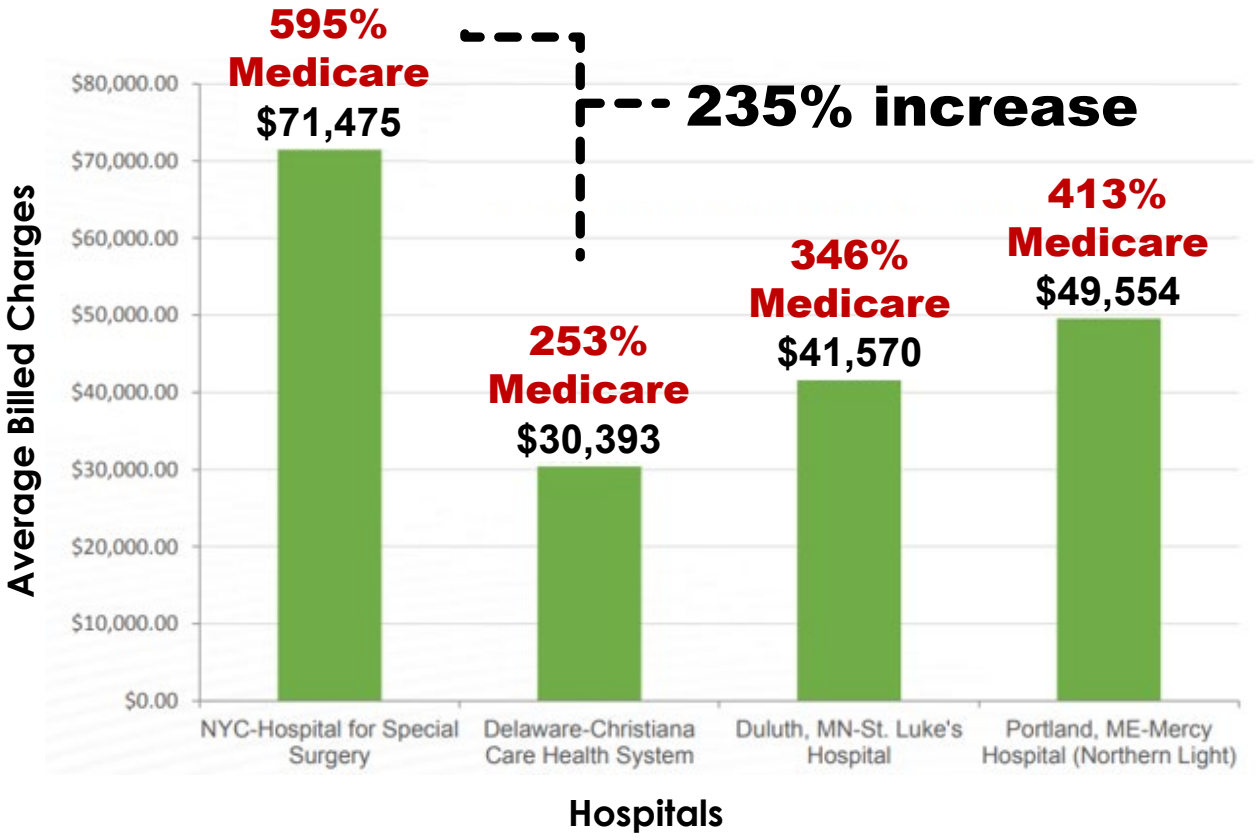


Carilion New River Valley Medical

Orthopedic Care

Score – 38.0

Average Billed Charges of Top 4 U.S. Hospitals for Total Knee Replacement *Based on Volume*




CPT-74177
January 3, 2019
Diagnostic Radiology
Procedures of the Abdomen
(Diagnostic Imaging)
$5, 981.12 - Highest Claim
$418.46 - Lowest Claim
$1,677.38 - Average Claim
$205. 62 - Sano Price

Consumer Reports

"Which Pharmacies Have the Best Rx Prices?"

SHOPPING BASKET

Five Generic Prescriptions

Actos Celebrex Cymbalta

Lipitor Plavix

HealthWarehouse.com

$66

CVS

$928

1,306%

Price Difference

Hepatitis C

U.S. PBM Cost

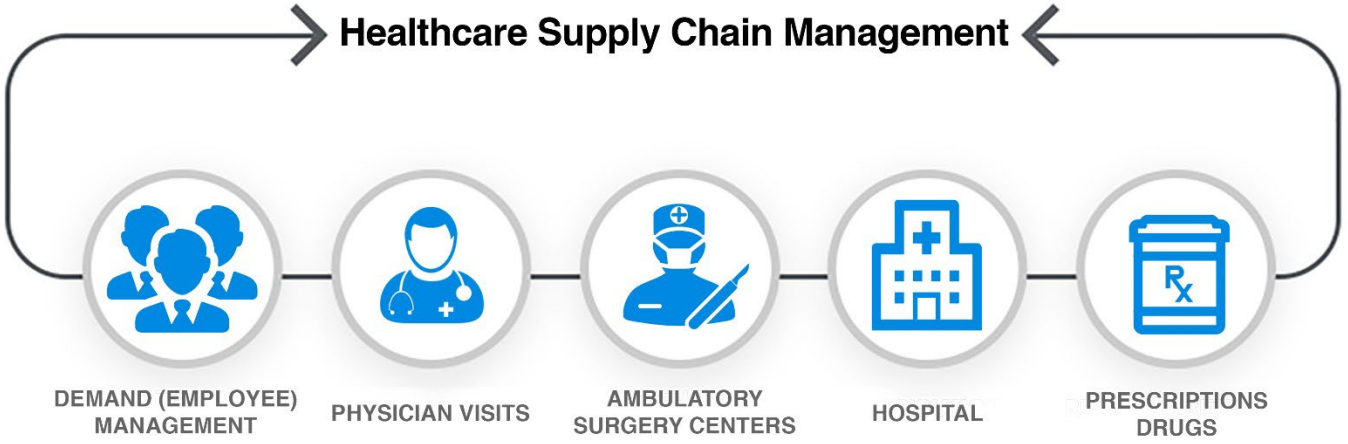
$96,411

Specialty Drug Cost Mitigation Program

$29,500

Employer Savings

$65,911



Train your Brain & Think Differently

- Focus on the ***COST*** of healthcare
- ***Embrace / Fight for*** transparency in Healthcare

Questions?

INNOVATIVE
INSURANCE GROUP