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# Transcript of Meeting

**Date:** September 15, 2022

**Case:** Health Benefit Exchange Advisory Committee Meeting

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COMMONWEALTH OF VIRGINIA  
STATE CORPORATION COMMISSION

VIRGINIA HEALTH BENEFIT EXCHANGE  
ADVISORY COMMITTEE MEETING

Conducted Remotely  
September 15, 2022  
2:06 p.m. EST

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Reported by: Ruth A. Levy, RPR

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

2 Voting Members:

3 Sabrina Corlette, Chair

4 Keven Patchett, Acting Director

5 Julie Green Bataille

6 Lee Biedrycki

7 Scott Castro

8 Heidi Dix

9 Ikeita Cantu Hinojosa

10 Kenn Penn

11

12

13 Ex-officio Members:

14 James Williams, Deputy Secretary of Health  
15 and Human Resources

16 Colin Greene, Acting State Health Commissioner

17 Cheryl Roberts, Acting Director of DMAS

18 Gena Boyle, Department of Social Services

19 Bradley Marsh, Bureau of Insurance

20 David Shea, Bureau of Insurance

21

22 Also present:

23 Holly Mortlock, Chief Government Relations

24 Officer/HBE Liaison to Advisory Committee

25 Whitney Thomas

1 P R O C E E D I N G S

2 MS. MORTLOCK: We have an  
3 action-packed agenda today, so I want to make  
4 sure that we have enough time to get through  
5 everything. Can everyone see the  
6 presentation?

7 CHAIR CORLETTE: Yes, I can.

8 MS. MORTLOCK: Sabrina, I will have  
9 you go ahead and take it away.

10 CHAIR CORLETTE: Thank you, Holly.  
11 And it's my pleasure to welcome everybody to  
12 the third Advisory Committee meeting of 2022.  
13 As Holly indicated, we do have a lot to cover  
14 today. And I'm particularly eager to hear  
15 from Kevin and the other Exchange folks on  
16 our progress as we manage this transition as  
17 well as from our subcommittee on  
18 communications.

19 So we'll dive right in. Holly, it  
20 sounds like we have a quorum so we can go  
21 ahead and get started with the roll call.

22 So in the place of Secretary John  
23 Litell, I believe we have James Williams; is  
24 that correct?

25 MR. WILLIAMS: Correct.

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1 CHAIR CORLETTE: Great. Welcome.  
2 Cheryl Roberts, are you with us?

3 MS. MORTLOCK: I expect that she'll  
4 be joining us shortly. We've spoken with  
5 her.

6 CHAIR CORLETTE: Great. Colin  
7 Greene? No Colin Greene. Danny Avula?

8 MS. BOYLE: Good afternoon,  
9 everyone. This is Gena Boyle. I'm the  
10 deputy commissioner over policy and  
11 administration at DSS, and I'm filling in for  
12 the Commissioner today.

13 CHAIR CORLETTE: Welcome, Gena.  
14 Commissioner White? Okay. Do we have  
15 anybody from the BOI that's filling in for  
16 Commissioner White today?

17 MS. MORTLOCK: Sabrina we have David  
18 Shea and Brad Marsh who are here to do some  
19 presentations for us, and I believe  
20 Commissioner White is traveling.

21 CHAIR CORLETTE: Great. Well, for  
22 non-ex-officio members, we have Julie  
23 Bataille.

24 MS. BATAILLE: Hi there. Good  
25 afternoon.

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1 CHAIR CORLETTE: And Lee, I saw your  
2 smiling face earlier.

3 MR. BIEDRYCKI: Good afternoon.

4 CHAIR CORLETTE: Hi, Lee. Scott  
5 Castro?

6 MS. MORTLOCK: I believe Scott is  
7 with us.

8 MR. CASTRO: Yeah, I'm here. Can  
9 you guys hear me okay?

10 CHAIR CORLETTE: Yes. Hi, Scott.  
11 Liz Cunningham? Do we have Liz? Maybe no  
12 Liz today. How about Doug Gray; do we have  
13 Doug Gray? Ikeita?

14 MS. MORTLOCK: So I think Heidi will  
15 be joining us in just a moment.

16 CHAIR CORLETTE: Heidi...

17 MS. MORTLOCK: Heidi Dix. So she  
18 will be with the -- she's with the health  
19 plans.

20 CHAIR CORLETTE: Okay. So she's  
21 subbing in for Doug?

22 MS. MORTLOCK: Yes.

23 CHAIR CORLETTE: Okay. And Ikeita,  
24 I think I saw you.

25 MS. HINOJOSA: I'm here. Yes.

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1 CHAIR CORLETTE: And I know Starla  
2 is traveling out of the country, and I think  
3 Kenn is also not available; is that right?

4 MS. MORTLOCK: That's right.

5 CHAIR CORLETTE: Okay. Do we have a  
6 quorum if we don't have Liz, Starla, and  
7 Kenn?

8 MS. MORTLOCK: We will have Heidi in  
9 just a moment.

10 CHAIR CORLETTE: Okay. Well, let's  
11 go ahead and dive in at least with our SCC  
12 updates. I think we're going to start with  
13 Kevin Patchett, our acting director, for the  
14 Exchange director's update.

15 MR. PATCHETT: Thank you, Sabrina.  
16 Happy to be here. Happy to share some of our  
17 recent updates and goings on here at the  
18 Virginia Health Benefit Exchange. I will try  
19 to move through this pretty quickly because I  
20 realize that we all have a packed agenda  
21 today.

22 So some of our key milestones and  
23 things that -- we list them as milestones,  
24 but they are all ongoing activities. We've  
25 made really good practice, thanks largely to

1 our deputy director for outreach and  
2 notification, Jennifer Krupp, on getting our  
3 marketing plan developed and ready to  
4 implement. And we're very excited as we're  
5 approaching this upcoming open enrollment  
6 period, that we've got that ready and are  
7 preparing to execute it.

8 We've made some really great staff  
9 hires in the recent months, as we have  
10 continued to build out our division. We  
11 hired a new deputy director for  
12 organizational governments and program  
13 management; her name is Susan McCleary.

14 We have hired a manager for  
15 marketing whose name is Brianna Johnson. And  
16 we are in the process of conducting  
17 interviews for a call center services manager  
18 and a manager for finance and audit. So our  
19 staffing up efforts continue and we really  
20 are feeling great about the team that we've  
21 built and the capabilities that we have as  
22 we're moving forward.

23 We've successfully submitted our  
24 blueprint application to the Centers for  
25 Medicare and Medicaid Services. This is a

1 critical and required step as part of our  
2 transition. CMS has instructed us that this  
3 year they're treating the blueprint as  
4 something of an iterative process, so we will  
5 continue to work with them and update that  
6 application as we move through our various  
7 transition gates and milestones.

8 And lastly, we have awarded our  
9 Navigator program grants for the upcoming  
10 year. We have two Navigator entities that we  
11 awarded grants to, the Virginia Poverty Law  
12 Center and Boat People SOS. And as I think  
13 many of you know, these Navigator  
14 organizations play a critical role in our  
15 outreach opportunities and reaching  
16 individual consumers to help educate and  
17 facilitate their enrollment in insurance.

18 As we look forward to plan year  
19 2023, we're really very excited about what we  
20 see and very optimistic about what the  
21 landscape looks like. And I think a lot of  
22 what we see here really is the culmination of  
23 lots of different efforts both at the federal  
24 and the state level, different organizations,  
25 but bringing together key components that

1 really do support the admission of the  
2 Exchange.

3           So as you see, Virginia will be  
4 kicking off its reinsurance program this  
5 year. We have a couple of folks from BOI who  
6 will talk a little more about that later.  
7 But the most notable impact that we are  
8 already seeing as a result of Virginia's new  
9 reinsurance program was a 17 percent  
10 reduction in insurance rates in the  
11 individual market. And that's nothing but  
12 good for us as we work to fulfill our  
13 objectives in the Exchange to reduce the  
14 number of uninsured in Virginia, one of our  
15 primary statutory obligations and guiding  
16 principles.

17           We saw the extension of advanced  
18 premium tax credits and other subsidies on  
19 the federal this year, which again, reduces  
20 the cost that Consumers will have to pay for  
21 insurance in the individual market. And for  
22 this year, the last year, we'll remain on the  
23 healthcare.gov platform for open enrollment  
24 before we transition to Virginia's platform  
25 for next year.

1           As I mentioned earlier, one of the  
2 really big pushes that we've been making, and  
3 again, led by Jennifer Krupp this year, has  
4 been our marketing and outreach efforts. As  
5 I said, one of our main statutory obligations  
6 is to reduce the number uninsured in Virginia  
7 and also to help facilitate a continuity of  
8 coverage among those who already have  
9 insurance.

10           And one of the ways and one of the  
11 tools that we have to do that is through our  
12 marketing and outreach efforts. And so we've  
13 worked closely with other state agencies,  
14 with other states, with our marketing vendor  
15 to put together this plan and to really focus  
16 on how can we reach individuals throughout  
17 Virginia.

18           And to do that, we're going to  
19 leverage a lot of help. We're going to  
20 leverage our Navigator entities. We're going  
21 to work with existing community  
22 organizations. One of the guiding principles  
23 of our marketing and outreach plan is to make  
24 sure that we're reaching people where they  
25 live, where they work, where they worship,

1 and to make as much of this tailored to  
2 individual needs.

3           One of the things I didn't mention  
4 from the previous slide was that we now have  
5 in Virginia two carriers in every region of  
6 the Commonwealth. This is a really big  
7 milestone for us. And we want to make sure  
8 that our outreach and education activities  
9 are robust and tailored so that our messages  
10 reach folks from Northern Virginia to  
11 Tidewater to Southwest Virginia and  
12 everywhere in between.

13           And we recognize that we've got a  
14 diversity of population that we need to  
15 reach, that we need to be able to communicate  
16 with. And so our marketing and outreach  
17 effort, like I said, leverages a variety of  
18 tools, everything from digital advertising to  
19 in-person events; we get our Navigators to  
20 try to make that happen.

21           The other thing that, of course, I  
22 can't ignore right now is our procurement for  
23 our platform and call center services. And  
24 we had hoped that that would be on our list  
25 of milestones. And we are very, very close,

1 I will say imminent to being able to show  
2 that as a milestone and to make our public  
3 announcement, but we're just not quite there  
4 yet. We've got a little bit of work to do,  
5 but I do want to take a minute and just  
6 acknowledge and thank all those who have  
7 helped out through this procurement, through  
8 the evaluation process.

9 We had seven committee members from  
10 three different agencies plus over 22 subject  
11 matter experts that have participated  
12 throughout the procurement process. And  
13 we're really looking forward to being able to  
14 bring it to conclusion and announce our  
15 vendor and really take the training wheels  
16 off our transition.

17 So with that, I'm going to pass it  
18 over to Holly to talk a little bit about some  
19 of the key policy initiatives that either  
20 intersect directly with or relate to our  
21 activities on the Exchange.

22 MS. MORTLOCK: Great. Thank you,  
23 Keven. So everyone, I know that you are  
24 probably very well aware of some of the  
25 exciting developments that have happened over

1 the summer. As you know, in August, Congress  
2 passed the Inflation Reduction Act, which  
3 included a three-year extension of ARPA  
4 subsidies and also continues capping the  
5 maximum expected contribution to eight and  
6 half percent of income for all enrollees and  
7 also continues the extension of advanced  
8 premium tax credits to individuals with  
9 incomes above 400 percent of the federal  
10 poverty level.

11 On another front, there is a  
12 proposed rule on closing the family glitch,  
13 which we had talked about at our last  
14 meeting. There was a public hearing that the  
15 IRS held on June 27th, and we do continue to  
16 monitor for finalization. We know that the  
17 state Exchanges across the nation are eagerly  
18 awaiting news about this. It does seem as  
19 though there is an expectation that this  
20 could be finalized before open enrollment,  
21 but again, we continue to monitor that  
22 closely.

23 And another important development is  
24 that in August the Health and Human Services  
25 issued a new proposed rule on Section 1557,

1 which reapplies and strengthens the  
2 non-discrimination provisions of this  
3 section. We are in the public comment  
4 period, so comments are due on or before  
5 October 3rd. And if you're interested in  
6 that, there's also additional information and  
7 a fact sheet here on the Federal Register.  
8 So feel free to check that out if you're  
9 interested.

10 And we also wanted to offer Virginia  
11 Medicaid an opportunity to provide an update  
12 on the public health emergency. I'm not sure  
13 if Cheryl has joined us yet. Cheryl, are you  
14 here?

15 So we can put a placeholder there,  
16 and when they're able to come back -- come to  
17 the meeting, we can circle back and have  
18 Cheryl share that update from Virginia  
19 Medicaid.

20 So now I'd like to invite Brad Marsh  
21 from the Bureau of Insurance to talk with us  
22 about an update on the reinsurance program.  
23 And so if you-all would bear with me for just  
24 a moment, I'm going to switch the slide deck  
25 over to Brad's.

1 CHAIR CORLETTE: Holly, while we're  
2 waiting for you, can I just mention something  
3 that I forgot to mention during my opening  
4 comment?

5 MS. MORTLOCK: Yes, please.

6 CHAIR CORLETTE: Yeah, I'm sorry; I  
7 completely forgot to just flag for folks that  
8 our colleague, Jane Kusiak, who was our vice  
9 chair, folks may have noticed that she was  
10 not on the roll call, and that's because her  
11 term as an Advisory Committee member has  
12 expired. That is a seat that is a  
13 gubernatorial appointment, so we are awaiting  
14 for information about that.

15 But Jane passes on her regards to  
16 all of us and just wanted me to tell all of  
17 you that she really enjoyed working with us.  
18 And I know we all wish Jane the very best.  
19 So sorry for forgetting to mention that at  
20 the top. Take it away, Holly.

21 MS. MORTLOCK: Thanks, Sabrina.  
22 Brad, are you ready?

23 MR. MARSH: So my name is Brad  
24 Marsh. I'm the health insurance policy  
25 advisory for the BOI. I'm also the lead on

1 the Commonwealth Health Reinsurance Program,  
2 as we get that up and running for its first  
3 year in 2023.

4 So as a little bit of background,  
5 reinsurance is a mechanism for spreading the  
6 cost of expensive claims, pooling them  
7 together, and paying for them with a separate  
8 financing system so those costs aren't  
9 included in the standard premiums. And the  
10 SCC was directed by statute to apply for a  
11 state innovation waiver with CMS under  
12 Section 1332 of the Affordable Care Act to  
13 permit and help fund the reinsurance program.

14 And that "help fund" is really the  
15 main reason for applying for a Section 1332  
16 waiver as we receive pass-through funding  
17 from the feds that covers a large proportion  
18 of the program costs. And I'll get into a  
19 little bit more of that later.

20 The waiver application was submitted  
21 on December 30, 2021. And on May 18th, 2022,  
22 we were approved for our Commonwealth Health  
23 Reinsurance Program. There was a 30-day  
24 delay in the statute between the time that  
25 the approval occurred and when the laws

1 actually came into effect. So on July 17th,  
2 2022, the rest of the laws under 32 that  
3 govern the Commonwealth Health Reinsurance  
4 came into effect.

5 Virginia joins 15 other states that  
6 have received federal approval to do these  
7 reinsurance programs, so we're not the first  
8 to do this, and I think that's going to be  
9 very helpful as we move forward, just being  
10 able to lean on some of the things that other  
11 folks have done and hopefully not make those  
12 sort of bleeding edge mistakes that sometimes  
13 you have to make if you're the first one to  
14 do something.

15 As a part of our agreement with the  
16 feds, there are special terms and conditions  
17 that lay out our responsibilities, which  
18 include required reports, how do we go about  
19 amending or adjusting waiver terms, and some  
20 other elements of just how we run the  
21 program, but mostly it's just a reporting,  
22 and if we ever want to change anything about  
23 the program, there are procedures that we  
24 have to follow to do that.

25 So this is just -- I wanted to go

1 over a little bit of how reinsurance works in  
2 general, because there are a few terms that  
3 are used here that you may not be familiar  
4 with if you haven't been involved with  
5 reinsurance in any way before. But there's a  
6 reinsurance cap that is the -- over that cap,  
7 the insured's carrier would be responsible  
8 for all the claims. There's an attachment  
9 point. Under that attachment point, the  
10 insurers are going to be responsible for all  
11 the claims.

12 And then in between those two points  
13 is the co-insurance band that will be  
14 reimbursed at the co-insurance rate, where  
15 the issuers pay a portion of the claims cost.  
16 And then if we go to the next slide here, so  
17 these are the approved reinsurance payment  
18 parameters we moved forward with this year.  
19 It has an attachment point of \$40,000 and a  
20 reinsurance cap of 155,000, and the  
21 co-insurance rate of 70 percent.

22 So that for an individual that a  
23 carrier covers, if their annual costs fall in  
24 between this band, there will be a claim --  
25 I'm sorry; fall in between or exceed this

1 band, they will be eligible for reinsurance  
2 payments, but reinsurance payments will only  
3 occur up to cost, annual cost of 155,000, and  
4 anything after that would then be covered by  
5 the insurer.

6 MR. WILLIAMS: Just a quick  
7 clarifying question: So is that 30 percent  
8 that the carrier pays or should I say 70  
9 percent?

10 MR. MARSH: Well, there will be --  
11 so yes, the 70 percent is what the program  
12 will pay and 30 percent would be what would  
13 be left that the carrier would pay. Now the  
14 carrier's going to pay all this out of the  
15 pocket at the beginning and then be  
16 reimbursed at a later point in time, after  
17 making a claim for what claims fall into that  
18 reinsurance band.

19 MR. WILLIAMS: Thank you.

20 MR. MARSH: No problem. The  
21 reinsurance program impact, well, the main  
22 impact of the reinsurance program is it's  
23 going to lower the cost of premiums. And  
24 we'll get into a little bit more of that at  
25 the end of the presentation here as to the

1 specifics of what's occurred as a result of  
2 the program this year.

3 But in terms of what individuals who  
4 are being covered or who are getting covered  
5 on the Exchange or off the Exchange will see  
6 as an impact to them, your individuals who  
7 are subsidized by those advanced premium tax  
8 credits that were discussed a little bit  
9 before, the ones that were enhanced and  
10 extended through the Inflation Reduction Act,  
11 they're going to see minimal difference in  
12 their out-of-pocket cost because their  
13 premium tax credits from the federal  
14 government will be reduced in line with the  
15 reduction in those premiums.

16 And that's actually how the program  
17 is funded, so that the feds are going to give  
18 us that money that they would have spent on  
19 premium tax credits and fund our reinsurance  
20 program through that.

21 So the folks that are getting those  
22 premium tax credits, they're going to pay the  
23 same out of pocket, but the feds will be  
24 giving them a smaller premium tax credit to  
25 go along with, so the net is essentially the

1 same.

2           Unsubsidized individuals will  
3 benefit from the premium reduction because  
4 they're going to face the entirety of the  
5 premium cost themselves and won't be  
6 receiving premium tax credits. With the  
7 expansion of the advanced premium tax  
8 credits, that is a smaller group than it  
9 would have been because the original premium  
10 tax credits, I believe, are for a smaller  
11 group of individuals, a lower financial  
12 threshold there to get those credits. But  
13 there still are folks that will be  
14 unsubsidized and that will see benefits from  
15 this.

16           CHAIR CORLETTE: Brad, can I just  
17 ask a question about the impact on subsidized  
18 individuals? One thing that we've at other  
19 states that implemented a reinsurance program  
20 is that because the APTC is coming down in  
21 areas where the benchmark plan price has come  
22 down, that, for many subsidized individuals  
23 in those areas, they actually saw a net  
24 premium increase as a result of the  
25 reinsurance.

1           And so I think it's maybe more of a  
2 question for our -- for Jennifer and others  
3 with the Exchange, but it does present a bit  
4 of a communications issue, because if these  
5 folks don't come back and shop for a new  
6 plan, they will get a spike in their premium.  
7 And at least in some states it resulted in  
8 some backlash. I just wanted to flag that.

9           MS. MORTLOCK: Sabrina, thank you  
10 for raising that question. And we will  
11 certainly take that into consideration as  
12 we're thinking through how we will be  
13 messaging to our consumers and helping them  
14 sort of with that shopping decision.

15           MR. MARSH: I appreciate that.  
16 That's helpful to think about.

17           I think we're on the next slide  
18 then. So I'm going to put this slide up and  
19 I'm going to say a quick caveat right now  
20 that none of these funding amounts are  
21 correct anymore, but they're really just up  
22 there as to contrast with what we will see  
23 for next year.

24           We do not have, at this point, the  
25 projections for five years with the new

1 enhanced premium tax credits. We only have  
2 an estimate for that number for next year.  
3 We did anticipate this and have our actuaries  
4 prepare two scenarios for the program, one if  
5 the ARPA subsidies were continued and one if  
6 they were not continued. So we do have those  
7 estimates for our costs for next year.

8           So these numbers were what our  
9 original application had in them there. It  
10 looked to be around \$70 million in 2023 in  
11 state funding that was going to be needed to  
12 cover the state cost of the program. And the  
13 state would be covering 20, 25 percent of the  
14 costs under this regime.

15           Because of the enhancements -- and  
16 we'll look at this on the next slide here --  
17 that number has changed because of the  
18 passage of the Inflation Reduction Act; those  
19 numbers have changed fairly drastically,  
20 actually.

21           Because of the larger federal dollar  
22 amount put forward for the premium tax  
23 credits, that means that the benefit to the  
24 feds of the lower premium cost is a much  
25 larger dollar amount, which means that they

1 will actually cover a much more substantial  
2 percentage of the cost of the program. And  
3 our costs will be less than 20 million based  
4 on our actuarial analysis to cover the state  
5 cost of the program there.

6 Helpfully, the General Assembly had  
7 included \$20 million in reinsurance. I'm not  
8 sure if that was in anticipate of this coming  
9 down if that was just what they were willing  
10 to put forward at this point in time, but  
11 that 20 million in 2024 now does result the  
12 full state's share and will allow us to  
13 access the federal funding as soon as it's  
14 released next April.

15 So I want to just go over a couple  
16 of quick things, some high level areas that  
17 we're going to be working on that we're  
18 currently working on in terms of establishing  
19 the program and the processes that need to be  
20 in place for us to start to collect  
21 information from carriers on claims and begin  
22 to take on claims and pay them out and review  
23 them, those sorts of things.

24 So each year -- and this has already  
25 been done as a part of our application --

1 we'll need to set parameters with our --

2 (Interruption.)

3 MR. MARSH: Each year we'll need to  
4 set the parameters of the program. Those  
5 parameters being the attachment point, the  
6 reinsurance cap, and the reinsurance rate,  
7 and we will announce those by May 1st. So  
8 we'll work with our actuary to figure out  
9 what we can do with the funding that the  
10 General Assembly is going to provide for the  
11 program in that year and what sort of  
12 reduction we can look for.

13 We're limited by statute to aiming  
14 for a 20 percent reduction in premium rates,  
15 with the extended -- with the enhanced  
16 premium tax credits and the cost being much  
17 lower now, I'm not sure exactly, but I think  
18 the financial decisions on it will be very  
19 different when we're talking about costs that  
20 are from 15 to 20 million rather than from 70  
21 to 90 million from a general fund standpoint.

22 And I would mention one thing as far  
23 as funding of the program, is that unlike a  
24 lot of the Section 1332 reinsurance programs  
25 in other states, we are funding ours with

1 general fund monies. So, many other states  
2 utilize a fee on their Exchange, added to  
3 their Exchange, for the reinsurance program.  
4 And as a result, the full impact of the value  
5 of the program is passed on premium  
6 reduction.

7 In other states, because the  
8 carriers have to anticipate that they will  
9 also pay additional money for the program, it  
10 actually ends up sort of muting the effect to  
11 some degree of the reinsurance program. And  
12 because we're not funding this through that  
13 assessment, it's just a straight-up funding  
14 from the General Assembly that we placed into  
15 this reinsurance fund.

16 So each year -- and this rate review  
17 has also been done already, and we'll show  
18 you what the results of that have been. But  
19 carriers will submit rates based on the  
20 parameters that we've set forth and in  
21 anticipation of receiving reimbursement for  
22 claims of falling in that reinsurance band  
23 and those -- we expect that those would be  
24 lower than they would have been absent the  
25 program.

1           We're working on quarterly reports  
2           that we'll have to get from carriers where  
3           they will report on which members they had or  
4           which individuals they have that have pierced  
5           the reinsurance -- the attachment point and  
6           who they anticipate they will be requesting  
7           reimbursement for those funds for.

8           I talked about this a little bit  
9           already, but the funding for the program,  
10          once the state has provided full funding, the  
11          federal share of the program funding will be  
12          released. I think this was more of an issue  
13          when we were not sure that the funding was  
14          going to exist in the current budget.

15          These funds won't actually be  
16          expended till FY 2025, but we've funded it in  
17          2024 so that we can access those funds and  
18          use those for administrative purposes as well  
19          as for paying off the claims.

20          We're also working on the carrier  
21          reinsurance claim filing which is a little  
22          bit different from the quarterly reporting.  
23          The quarterly reporting is done for us to  
24          keep track of sort of where we stand and what  
25          we anticipate seeing at the end of the year.

1 But the actual claims for reimbursement won't  
2 come from the carriers until after the year  
3 has been finalized, and they will need to  
4 then get those to us by the end of April.

5 So, once again, we're working on the  
6 format that we're going to use for that,  
7 working with some other states and looking at  
8 what they have and how they go about getting  
9 that information so that we have enough  
10 information that we can verify based on the  
11 federal data that we have that those requests  
12 are accurate, that they represent real  
13 expenditures, those sorts of things.

14 That's what the next bullet point is  
15 at there, that the BOI will, between that  
16 April 30th deadline and September 30th, when  
17 we'll need to notify carriers of what we will  
18 be paying out in claims, we'll be assessing  
19 those claims and ensuring that we're -- that  
20 there's some integrity to the payments that  
21 are being made out of that program, that they  
22 match up, once again, with the data that we  
23 get from the feds, the data that the carriers  
24 submit to the feds that they will then be  
25 passing down to us so that we can use it to

1 verify those claims.

2           And then lastly, the funds will be  
3 disbursed with a deadline of November 15th of  
4 the year following the benefit year. So in  
5 2023, so for benefit year 2023, we'll make  
6 those payments out by November 15th, 2024.

7           And here's where the rubber meets  
8 the road here, is what has this actually done  
9 this year for the program, the impact on  
10 premiums in the individual insurance market.  
11 Carriers originally submitted rates that did  
12 not take reinsurance into account because of  
13 the fact that the program did not go into  
14 effect until July 17th. Prior to the  
15 adjustment for reinsurance, carrier-submitted  
16 rates were, on average, about 2.0 percent  
17 higher than for 2023 over 2022.

18           On July 17th carriers were requested  
19 to revise their rates and take reinsurance  
20 into account and resubmit those rates with  
21 documentation. Because of the lower expected  
22 claim cost for insureds under the reinsurance  
23 program, we saw a 17.2 percent reduction in  
24 premiums from 2022 to 2023. That is a  
25 weighted average premium of \$495.80 as

1 reduced from, prior to that, a weighted  
2 average premium of \$598.66.

3 And so the actual impact is -- and  
4 if we go to the next slide here. And if you  
5 look here -- and this is really just an  
6 exercise in contrast here because the small  
7 group market doesn't have the reinsurance  
8 program. The reinsurance program is only  
9 applied to the individual market here. So if  
10 you see how the individual market, you  
11 know -- sorry; the small group market, the  
12 premium cost went up 3.1 percent and the  
13 individual market, they went down 17.2  
14 percent.

15 So the impact of the reinsurance  
16 program is actually greater than that 17.2  
17 percent. It's probably an additional 2  
18 percent on top of that, based on the premiums  
19 that were filed prior to the program being in  
20 place. So it's around a 19 percent reduction  
21 from what the trend line would have been or  
22 where the prices would have been absent the  
23 program.

24 MR. WILLIAMS: Just a question: Can  
25 you clarify the experience versus trend,

1 differentiate those two a little bit?

2 MR. MARSH: And you've just touched  
3 on why I put this at the end of my slides  
4 right before Mr. Shea, who is also at the  
5 BOI, who is an actuary and can explain those  
6 things better than I can. So that's the  
7 reason I moved these to the end of the slide  
8 here, so that I can seamlessly flow into him  
9 and he can answer those questions for  
10 you-all.

11 MR. WILLIAMS: Thank you.

12 MR. MARSH: And he'll go into more  
13 detail on that. He's got some more things as  
14 he presents more broadly on the rates for  
15 2023.

16 Do you-all have any more questions  
17 for me that aren't actuarial related, I can  
18 certainly answer those. Or if not, I can  
19 pass on to David and I will be here to answer  
20 questions if more arise.

21 CHAIR CORLETTE: Yeah. Just a quick  
22 question. Thank you. That was a great  
23 presentation. Do you know roughly the number  
24 of folks that remain unsubsidized in the  
25 marketplace as a result of the ARPA APTC

1 enhancements, like what proportion remain  
2 unsubsidized?

3 MR. MARSH: I don't think I have  
4 those numbers since the enhanced premium tax  
5 credits. Because when we ran the numbers for  
6 the program originally, which would have been  
7 where we would have had that, I think the  
8 data we used was prior to that, to the  
9 enhanced premium tax credits, so in terms of  
10 the change since then. But let me look into  
11 that, and I'll see if I can get back to you  
12 with a number on that.

13 CHAIR CORLETTE: Great. Thank you  
14 so much.

15 MS. HINOJOSA: This is Ikeita. I  
16 also just have a quick question for you,  
17 Bradley. Thank you for your presentation, by  
18 the way; that was very informative.

19 At the outset of your presentation  
20 you mentioned that Virginia joins 15 other  
21 states to establish state-based reinsurance  
22 programs and you also discussed how our model  
23 here in Virginia for reinsurance is that we  
24 utilize the general fund, not a fee on the  
25 Exchange.

1                   And I was just wondering if you know  
2                   how many other states utilize this similar  
3                   model and if you know which ones.

4                   MR. MARSH: I am not aware -- I'll  
5                   have to look, but I'm not aware of any other  
6                   states that do that. It seemed that most  
7                   that I looked at, there may be -- there are a  
8                   few very small states that I didn't really  
9                   dig into because I didn't think they were  
10                  particularly comparable to us. But I don't  
11                  believe they do as well.

12                  I think most of these programs are  
13                  meant to be funded through an assessment.  
14                  But I'll take a look and see if we are truly  
15                  the first one to run the program that way.

16                  MS. HINOJOSA: Yeah. We're always  
17                  interested to know if we're innovating or the  
18                  first to do something. So yeah, if we're the  
19                  first to do that, that would just be  
20                  interesting to know.

21                  MR. MARSH: Absolutely. I'll look  
22                  into that and get back to you. Thank you.

23                  If that's all, I'll go ahead and  
24                  pass on to David then. And hopefully  
25                  possibly in his presentation he'll answer the

1 questions you had before, but certainly he  
2 can answer those questions after his  
3 presentation or during.

4 MS. MORTLOCK: Brad, thank you so  
5 much for such a comprehensive presentation.  
6 Just bear with me, everyone, and I will get  
7 the rate slides up.

8 CHAIR CORLETTE: While we're  
9 waiting, it looks like five that used general  
10 fund monies to finance their reinsurance  
11 programs.

12 MS. MORTLOCK: Can everyone see the  
13 next slide titled Number of Carriers? David,  
14 are you ready?

15 MR. SHEA: I am, Holly. Thank you  
16 very much. And good afternoon, everybody.  
17 I've got to take a few minutes and just kind  
18 of go through what the Virginia individual  
19 market looks like from a historical  
20 perspective and what we have this year going  
21 forward.

22 This year we had -- it was a net  
23 increase of one carrier in the market  
24 compared to the prior year; however, we had  
25 two new entrants, an Aetna entity. Aetna is

1 already in the individual market but another  
2 one of their entities, an Aetna PPO, entered  
3 the individual market. And Anthem entered  
4 the off-Exchange market.

5 And being a prior employee of Anthem  
6 for many years, I knew why they did this.  
7 They've got a lot of grandfathered plans that  
8 were age rated. And those folks are getting  
9 up in age. And it would probably be  
10 beneficial to them to enroll in even an  
11 off-Exchange plan if they don't qualify for  
12 subsidies, given the fact that their rates  
13 are probably higher than what's out there  
14 today.

15 But anyway, you will see as we go  
16 through this pretty brief presentation what  
17 the result of increased competition looks  
18 like in Virginia in the individual market.

19 Here are our players in the  
20 individual market. HealthKeepers -- which is  
21 also Anthem; HealthKeepers is their HMO --  
22 they enroll about half of the total  
23 individual market in Virginia. Cigna and  
24 Kaiser, when you take those three  
25 collectively, they represent about

1 three-quarters of the individual market in  
2 the state. Kaiser is notable because they  
3 primarily operate only in Northern Virginia.  
4 But again, we have lots of choices in  
5 Virginia.

6 And as Keven mentioned in his  
7 presentation earlier, this is the first time  
8 in the State of Virginia where a person  
9 located anywhere in the state has at least  
10 two carriers to choose from. Many, many  
11 times there have been just one carrier, a  
12 couple of times maybe zero, but another  
13 carrier would step in. So this is, again, a  
14 sign of a good, healthy, and thriving market.

15 And this was also mentioned in parts  
16 of Bradley's presentation. We've had several  
17 years of rate decreases, as you can see on  
18 the top line, and as a result, we've seen  
19 some subsequent increases in enrollment over  
20 the last few years. So, obviously, the drop  
21 in premiums in addition to recent -- the  
22 recent ARPA subsidies.

23 Now the original ARPA subsidies will  
24 not be represented in really any of the  
25 actual numbers that you see. That 307,000

1 number members in 2022, that was as of March.  
2 So kind of like right at the start. And you  
3 can see that, collectively, the carriers are  
4 increasing a slight -- or projecting a slight  
5 increase in enrollment for 2023, and there's  
6 that \$495 premium that Brad mentioned in his  
7 presentation earlier.

8           You asked about consumers who  
9 receive subsidies. Prior to the ARPA, which  
10 would obviously increase the numbers -- the  
11 key takeaway on this slide is about 90  
12 percent of consumers in Virginia receive a  
13 subsidy. So that number will probably do  
14 nothing but go up with ARPA being in place at  
15 least for the next three years. And 90  
16 percent's pretty high. So it's only going to  
17 go up from there.

18           In this year, the average premium  
19 paid before subsidies was about \$550.  
20 Afterwards, they paid an average of \$80. So  
21 the average subsidy received by about 90  
22 percent of the population -- the average --  
23 was about \$470 a month. And I hope that  
24 gives you an idea; like I said, these numbers  
25 are prior to ARPA, so they will go higher.

1           Next slide, please. This is just  
2 kind of a summary of what we've all been kind  
3 of talking about. The individual market in  
4 Virginia is showing signs of a healthy  
5 market. We've got increased carrier  
6 participation, so competition always helps;  
7 two carriers in every area of Virginia;  
8 lowest rates since 2017, primarily driven by  
9 reinsurance; ARPA subsidies.

10           Not sure about the end of public  
11 health emergency and Medicaid unwinding; that  
12 was not a factor in any of the carrier's rate  
13 filings that they considered to be a dramatic  
14 impact. The small group market may be facing  
15 some challenges. Nothing of an emergency yet  
16 but we shall see.

17           Next slide, please. Bradley  
18 mentioned this and I will make a little  
19 clarifying statement. The difference between  
20 the experience and trend is collectively what  
21 the carriers in the individual market were  
22 saying is, as I looked in the past to look at  
23 what my claims were compared to my premiums,  
24 my claims got, on average, about 7 and a half  
25 percent higher than they would otherwise, and

1 so that drives about a 7 and a half percent  
2 increase, looking at the rearview mirror.

3 And then looking forward, I'm  
4 expecting the average, my claims will go up  
5 about 5.6 percent. Basically, it's looking  
6 in the past versus looking into the future.  
7 And under the small group heading, the small  
8 group carriers chose to split theirs up a  
9 little bit and said that morbidity or the  
10 health status of my population got a little  
11 worse and so did my experience; they're kind  
12 of one and the same. But their trend was  
13 also the big driver in small group rate  
14 increases as well.

15 MR. WILLIAMS: So just a quick  
16 follow-up there. So why would they expect --  
17 it's real interesting that, in the individual  
18 market, they expect the trend to be lower  
19 than it was for the last year but higher in  
20 the small group market.

21 MR. SHEA: And you know, those two  
22 things, if you look at it in a macro sense  
23 and you look at it over time -- I mean, being  
24 an actuary, that's kind of what I did for a  
25 long time -- those trends are within

1 historical ranges. Nobody really cares too  
2 much about the fact that trends in the small  
3 group market may be higher or lower than in  
4 the individual market. As we all know, rates  
5 have changed doesn't always mean higher  
6 rates; it just means that it's going up at a  
7 faster rate.

8           So the fact that trend is a little  
9 higher in small group than it is in  
10 individual, so many different things can  
11 drive that. They're both within ranges that,  
12 to an actuary and to a lot of folks that look  
13 at this kind of thing, they're within the  
14 ranges that go that's within a certain  
15 historical range. If that trend was on the  
16 order of 12 to 14 percent, that would be  
17 highly unusual. Does that help?

18           MR. WILLIAMS: Yeah. Thank you.

19           MR. BIEDRYCKI: Yeah. I would just  
20 like to make a comment that regarding the  
21 small group trend, it's important to  
22 acknowledge that the small group products are  
23 completely different when compared to the  
24 individual. The individual uses micro  
25 networks; small group generally is going to

1 be statewide.

2 The small group market is currently  
3 getting cannibalized from two ends: One is  
4 level funded plans pulling small employers  
5 out of the ACA pool. And then with the  
6 extension of the ARPA subsidies, that is also  
7 taking individuals who weren't formally  
8 subsidy eligible out of the small group  
9 market and into this differing individual  
10 market.

11 So I agree that 12 is a much bigger  
12 number to be more concerned about; however, I  
13 would personally have concerns about how the  
14 pools with the small group market will be  
15 able to maintain a positive health status  
16 with these changes.

17 And one other comment relative to  
18 the off-Exchange carrier: Those  
19 grandfathered policies are being canceled,  
20 but it's important to note that those  
21 grandfathered policies were national network  
22 PPO policies, where the consumer could go to  
23 any physician in network and there was also  
24 an out-of-network benefit.

25 The proposed replacement policy is

1 an EPO, wherein consumers will no longer be  
2 able to go to an out-of-network provider.  
3 They will be able to go outside of Virginia  
4 but only to providers contracted with that  
5 carrier. So there is a dilution in the  
6 benefit with their new option relative to  
7 what they had.

8 MR. SHEA: Okay. Thank you. Next  
9 slide. This is sort of the inverse of the  
10 line that you saw earlier. This simply  
11 shows -- turns those rate changes into  
12 percentage changes over the last (inaudible).  
13 And as you can see, this is the fourth year  
14 in the individual market where rates have  
15 gone down.

16 Now, it's notable, to echo one of  
17 the things that Brad mentioned, that 17.2  
18 percent decrease for 2023 would have been a 2  
19 percent increase in the absence of insurance.  
20 2 percent increase is historically quite low,  
21 particularly in the individual market. But  
22 certainly 17 and a half percent and hopefully  
23 following the next year, we could expect at  
24 least rates that are lower than they would  
25 have been otherwise.

1                   Next slide. As mentioned, the rate  
2 changes for individual and small group are  
3 pretty consistent with historical ones.  
4 Pricing trends are also within historical  
5 ranges. And the individual market in  
6 Virginia appears to be doing well.

7                   I think that might be the last  
8 slide. Or is there one more, Holly?

9                   MS. MORTLOCK: It looks like that's  
10 it.

11                  MR. SHEA: All right. So are there  
12 any other questions?

13                  MR. BIEDRYCKI: I just have one more  
14 comment. I'm sorry, but I think it's  
15 important. Two slides back, when we were  
16 talking about the ACA premiums going down, I  
17 think it's also important to note that the  
18 out-of-pocket maximum in 2018 was only  
19 7,100-ish, and for 2023, the maximum allowed  
20 out-of-pocket for the ACA is \$9,100 for an  
21 individual and \$18,200 for a family, which is  
22 a huge number, regardless of the premium  
23 difference.

24                  CHAIR CORLETTE: Yeah. Thank you,  
25 David. Thank you, Bradley. And thank you,

1 Keven. Sorry. Lee, you look like you were  
2 about to --

3 MR. BIEDRYCKI: I wanted to ask a  
4 question of Keven. I didn't know we were  
5 changing gears so quickly, so if now is cool  
6 or I could wait till later.

7 CHAIR CORLETTE: No. Go ahead.

8 MR. BIEDRYCKI: Hey, Keven. There  
9 was a joint signed letter by the Virginia  
10 Association of Health Underwriters,  
11 Independent Insurance Agency of Virginia, and  
12 the Virginia Association of Health Plans  
13 regarding the direct enrollment and enhanced  
14 direct enrollment integrations with the  
15 Virginia Health Benefit Exchange so that  
16 agents -- 1,400 of us -- could continue to  
17 use the systems that we have used to enroll  
18 people on the Exchange, in my case, for  
19 nearly the last decade.

20 The question has not been answered  
21 as of yet, and I was wondering if there is  
22 any firm resolution on whether or not the  
23 Virginia Health Benefit Exchange will allow  
24 direct enrollment and enhanced direct  
25 enrollment integrations.

1           MR. PATCHETT: Yeah. So we got the  
2 letter, and we've had a number of  
3 discussions, internally and externally. I  
4 think one of the challenges for us was that  
5 the letter asked us to amend our solicitation  
6 and made some assertions that, you know, if  
7 this was functionality, that we couldn't get  
8 it unless we had built it into our  
9 requirements; you know, those were steps we  
10 couldn't take and we didn't take.

11           But the assertion that we couldn't  
12 get the functionality without building them  
13 into RFP requirements was not entirely  
14 accurate. So one of the things that we have  
15 done as we've gone through this process, as  
16 we've talked with others and I think some of  
17 our colleagues, Lee, about our commitment to  
18 continue to explore and investigate how we  
19 can work towards enhanced direct enrollment,  
20 what the implications are, one of the big  
21 challenges for us has been to figure out how  
22 do we follow the consistent advice that we've  
23 gotten from every other state that's done  
24 this recently.

25           Well, just to keep it simple and to

1 focus only on the core requirements that are  
2 required by CMS in order to make the  
3 transition happen so we don't wind up in the  
4 position where several other states have  
5 found themselves in having a transition that  
6 failed and had to go back and retry some  
7 years later.

8           And so enhanced direct enrollment is  
9 one of those things that provides a pretty  
10 significant expense and a great deal of  
11 complexity. So we, throughout the  
12 procurement process, have been working with  
13 vendors to learn more about what options they  
14 can provide, how can we have that  
15 functionality available, whether a near one  
16 or potentially down the road.

17           And so we will have more to share  
18 once we finish the procurement process here  
19 in the coming weeks on where we landed on  
20 that.

21           MR. BIEDRYCKI: Well, the assertion  
22 that it needed to be integrated was given to  
23 me personally by one of the individuals that  
24 was going to submit.

25           Secondly, I would just say that of

1 the states that stood up exchanges thus far,  
2 all but one have been heavy left-leaning  
3 states, which is fine. But none of them have  
4 allowed the integrations yet. And all of  
5 them saw a decrease in enrollment.

6 Last year, agencies such as my own,  
7 submitted over 50,000 enrollments through  
8 these direct enrollment and enhanced direct  
9 enrollment platforms. In the last ten years,  
10 my agency has submitted over 21,000  
11 applications using our direct enrollment  
12 platform.

13 And the information that was given  
14 to me was that the expense and the hurdles,  
15 if you will, associated with integrating  
16 direct enrollment and enhanced direct  
17 enrollment didn't really exist, that the tech  
18 providers already had them built and they  
19 could be stood up.

20 So the thing that is very concerning  
21 to me about not having these integrations  
22 firmly announced yet is that we have an  
23 entire organization's policies, practices  
24 built around using a direct enrollment  
25 platform that we had up and running before

1 healthcare.gov was. And the ten years of  
2 consumer data that are in that are going to  
3 make it very difficult for us to transition  
4 to a new system without any of the arc or  
5 historical data associated with our clients  
6 that is already contained in our existing  
7 environment.

8           So the thing that I would just like  
9 to, I guess, ask in the clarifying question,  
10 is that for the 1,400 agents that certify,  
11 and one of which has a brick and mortar  
12 location in every county in Virginia and will  
13 be participating in enrolling as they have  
14 shared with me, they too use a direct  
15 enrollment platform, does the state currently  
16 plan on making the DE and EDE integrations  
17 available for the first year of the Exchange?

18           MR. PATCHETT: Yeah, so we're still  
19 working through that. It's a challenging  
20 issue. And we recognize and we absolutely  
21 hear the concerns that are coming from our  
22 agent and broker stakeholders. We've spent a  
23 great deal of time working through these  
24 issues, getting input from consultants from  
25 other states.

1           You know, one of the -- just to  
2 present sort of the other side, not to  
3 discount or to forecast any decisions in any  
4 way, but just to sort of flush out the  
5 discussion here, there are, I believe, nearly  
6 50 different direct enrollment platforms used  
7 by carriers. And so one of the challenges is  
8 to figure out, well, how can we afford, from  
9 a cost but also from a resource standpoint,  
10 to do 50 additional integration points during  
11 implementation? If we do less than 50, how  
12 do we pick whose platform to use and whose  
13 not to use?

14           Today, I don't believe that any  
15 other state has successfully implemented an  
16 enhanced direct enrollment platform as part  
17 of their Exchange. And I'm not sure what  
18 left-leaning means in terms of the states who  
19 are implementing marketplaces, but the recent  
20 data that I looked at has actually shown  
21 several states that have seen an increase in  
22 enrollment during transition.

23           But these are part of the  
24 challenges. How do we balance all of these  
25 competing interests? And how do we figure

1 out, right, what's best for consumers in  
2 Virginia? I think, additionally, we've heard  
3 some folks raise some concerns about how  
4 these get implemented and integrated? How do  
5 we maintain transparency? Because one of our  
6 statutory obligations is that our marketplace  
7 be transparent and competitive.

8 And so then in order to do that, we  
9 have to have a pretty robust audit and  
10 enforcement regime in place, because the  
11 potential exists in an enhanced direct  
12 enrollment platform for, you know, a platform  
13 provider to essentially only show the plans  
14 that they want, right, because users aren't  
15 seeing the Marketplace; they're seeing  
16 something in between.

17 So all of those are the factors,  
18 along with those on the flip side that you've  
19 laid out here, Lee, that we've been working  
20 through. And like I say, not only internally  
21 but with lots of external stakeholders, lots  
22 of consultants and professional  
23 organizations, as well as the vendors who  
24 participated in the procurement.

25 MR. BIEDRYCKI: Well, I would say

1 that, to my knowledge, the only state that  
2 saw an increase of enrollment was New Jersey,  
3 and that's because they had a second state  
4 supplemental subsidy on top of the federal  
5 subsidy.

6 The five systems I'm talking about  
7 are the five biggest ones used by the  
8 majority of the agents operating in this  
9 space. And I just think that,  
10 philosophically, it is difficult to expect an  
11 increase in enrollment when you reduce the  
12 number of entrance points for the consumer.

13 You know, Amazon, Kayak, Grubhub,  
14 all of these web-based entities have learned,  
15 as demonstrated by healthcare.gov, that you  
16 have to meet the consumer where and when  
17 they're willing to purchase. And these  
18 direct enrollment platforms, I'm certain,  
19 would all comply with a mandate to show all  
20 carriers, because to my knowledge, they all  
21 do.

22 But for Virginia to reduce the  
23 number of places where consumers can be  
24 enrolled, I just don't see how we can  
25 reasonably expect to see an increase in the

1 enrollment numbers with fewer options for  
2 agencies like my own.

3           You know, these are very expensive,  
4 very laborious enrollments that are done.  
5 Our system, for example, the person puts in  
6 their ZIP Code, their doctor, their hospital,  
7 and their drugs, and it identifies by carrier  
8 which ones have those three critical items in  
9 network.

10           I would just like to say, again,  
11 that many of the states that have stood up a  
12 state-based Exchange have been a single  
13 carrier state, where there wasn't a need to  
14 contrast the network of carrier A versus  
15 carrier B. And I submit to you, in Virginia,  
16 without performing that due diligence of  
17 contrasting the networks of the carriers,  
18 there can be dire consequences for the  
19 consumer.

20           So, again, Virginia is a very  
21 different marketplace for most of the ones  
22 who have stood up Exchanges before, and it  
23 would be my hope and the stakeholders in the  
24 insurance and brokers community's hope that  
25 we would be able to continue to assist in

1 these enrollments as opposed to be forced to  
2 making a hard business decision if all of our  
3 tech and all of our resources were stripped  
4 from us.

5 CHAIR CORLETTE: Lee, thank you.  
6 This sounds like a really important  
7 discussion. Ikeita, I know you've had your  
8 hand up for a while. I don't know if it's on  
9 this particular topic. But it sounds like  
10 Lee's raising something that's worth further  
11 conversation.

12 So we'll put a pin in this, and  
13 Ikeita, I want to just give you an  
14 opportunity to speak, and then we really need  
15 to move to the subcommittee reports.

16 Keven, I don't know if you wanted to  
17 add anything, so I don't mean to cut you off.

18 MR. PATCHETT: No. I just  
19 absolutely agree and recognize Lee's  
20 concerns. And these are definitely things  
21 that we have been working through and trying  
22 to figure out the right solution for.

23 MR. WILLIAMS: Keven, I just had a  
24 follow-up. If you wouldn't mind just sharing  
25 some of the enrollment figures for other

1 states that have made the transition, that  
2 would be really helpful for everyone. You  
3 mentioned several other states that saw  
4 increases in enrollment?

5 MR. PATCHETT: Yeah, I don't have  
6 those numbers at my fingertips, but I'm happy  
7 to share them.

8 MR. WILLIAMS: Okay. Thank you.

9 MS. HINOJOSA: Yeah, just as a  
10 follow-up, I had a couple of questions for  
11 the directors' update. So my questions will  
12 be quick.

13 But it was mentioned that there were  
14 at least two carriers in all areas of  
15 Virginia, so I was just wondering how we're  
16 defining the areas of Virginia, because I  
17 know that, you know, sometimes it's broken  
18 down to the five regions of Virginia and then  
19 sometimes it's defined by other ways.

20 So how are we breaking down the  
21 areas of Virginia when we make that update  
22 that there are at least two carriers in all  
23 areas of Virginia?

24 MR. PATCHETT: I think that's a  
25 great question for David Shea. He had a good

1 graphic that showed it.

2 MR. SHEA: Yeah. In this particular  
3 case, we are defining area as every  
4 individual city and county in the State of  
5 Virginia. And I believe there are 132  
6 separate independent cities and unaffiliated  
7 counties in Virginia.

8 So that's pretty -- that's a pretty  
9 fine distinction. It doesn't get too much  
10 finer than that. Obviously, when you look at  
11 a county like Arlington or Bedford County or  
12 Pittsylvania County, those are big areas.  
13 But that's how far we go down as far as  
14 defining what an area is.

15 MS. HINOJOSA: Okay. That's really  
16 level, the level of granularity in terms of  
17 areas at the specificity; that's really  
18 helpful on that.

19 And then just in terms of marketing,  
20 is there a particular timing for the rollout  
21 of the Virginia Marketplace, you know, name,  
22 slogan, tag line, you know, any information  
23 like that, just in terms of branding, just so  
24 that consumers can just get more familiar  
25 with who we are?

1 MR. PATCHETT: That's a great  
2 question. And we actually spent some time  
3 speaking with Julie Bataille about this  
4 recently. So we're in the process of  
5 developing that and trying to balance, you  
6 know, the various messages that we have. And  
7 we're finalizing those naming, branding  
8 efforts. So we don't have a defined timeline  
9 right now.

10 But one of the key considerations is  
11 how do we balance all the kinds of messaging  
12 that we want to do in a way that's impactful  
13 and not confusing and doesn't turn into kind  
14 of background noise for consumers. So for  
15 the next month or so, our focus, in terms of  
16 our messaging, really is going to be around  
17 open enrollment and then figuring out how to  
18 better --

19 (Interruption.)

20 MR. PATCHETT: Figuring how to best  
21 roll out the naming and branding in  
22 conjunction with our transition are really  
23 key considerations that we're doing as we're  
24 putting together that timeline.

25 MS. HINOJOSA: Okay. So maybe by

1 the December meeting we'll have a little  
2 firmer hold on that?

3 MR. PATCHETT: Absolutely.

4 MS. HINOJOSA: Okay. Great. And  
5 then just the last question regarding that  
6 update. There was mention about comments on  
7 Section 1557, and I was just wondering if, as  
8 the Virginia HBE, if there were plans to  
9 provide comment or if that was just an  
10 overall update on the fact that that whole  
11 process is happening?

12 MR. PATCHETT: Just an overall  
13 update. We don't have plans to participate  
14 in the federal comment process.

15 MS. HINOJOSA: Great. Thank you so  
16 much.

17 MR. PATCHETT: You're welcome.

18 CHAIR CORLETTE: I see that Cheryl  
19 Roberts from DMAS has joined us. And Cheryl,  
20 we had -- as part of the update, we were  
21 hoping to hear a little bit about your  
22 planning for the end of the public health  
23 emergency and the Medicaid continuous  
24 coverage requirement. Are you able to say a  
25 few words about that?

1 MS. ROBERTS: Hi. Yes. Well, the  
2 easy answer is it's been extended until  
3 January at least. So it will not affect your  
4 open enrollment; that's the easy answer.

5 CHAIR CORLETTE: Okay.

6 MS. ROBERTS: And second, I met with  
7 Dan Tsai yesterday. Actually, we were in  
8 Seattle, which Holly, I think, is still  
9 there. And he said he was not at liberty to  
10 talk about it. And the things he talked  
11 about implied that we were going to go beyond  
12 January.

13 CHAIR CORLETTE: Wow. Okay. You  
14 heard it here first, folks.

15 MS. ROBERTS: Yes. So that's what  
16 we can give you. So when we come back in the  
17 next quarter, please put us back on the  
18 agenda if you want. That's going to be  
19 our -- but yes.

20 So no, the answer is we're working  
21 very diligently on it anyway. We're taking  
22 the attitude that January is going to come.  
23 And so we have done a lot of the system  
24 enhancements that we have with our partner,  
25 DSS; Gena's on the call so she knows that we

1 have worked very hard to do that.

2 We have a monthly meeting with  
3 James. In fact, we have one next Wednesday,  
4 in which we have like a task force and a team  
5 meeting in which we talk to multiple people  
6 about where we are in terms of that work.  
7 And one of the challenges -- and Gena can  
8 bring it up -- will be the locals and making  
9 sure that they have the right staffing. And  
10 we're doing some joint discussions on how to  
11 do the outreach and education piece.

12 Obviously, you're going to play a  
13 big roll in this, because we're planning to  
14 do -- and that's why I'm glad -- I was  
15 actually glad to be on the call and hear that  
16 every county has sufficient access in terms  
17 of being able to have options, because  
18 obviously, we're going to be telling people  
19 that there is an option and we want to make  
20 sure that there's a place to land. So I was  
21 glad to be on the call for that piece.

22 CHAIR CORLETTE: Thank you, Cheryl.  
23 Does anybody have any other questions for  
24 Holly, for Keven, for our DMAS or BOI folks  
25 before we move on to the subcommittee

1 reports?

2 Great. So I'm going to turn it over  
3 to Julie, who's been leading our consumer  
4 outreach and education subcommittee. Julie,  
5 do you want to give us an update on what  
6 you-all have been up to?

7 MS. BATAILLE: Sure. I will give a  
8 quick high-level overview and just say thank  
9 you to the subcommittee participants. Over  
10 the course of the summer, we have been  
11 communicating via e-mail to share some ideas,  
12 thoughts, recommendations to pull together to  
13 share with the full HBE.

14 And where we are now is that we've  
15 got about nine draft recommendations, all  
16 within the umbrella of providing some  
17 suggested strategies based on things that  
18 folks are aware of that have worked and been  
19 best practices for other marketplaces when it  
20 comes to enrolling consumers.

21 And I won't go through all nine of  
22 those, but I will just say I think many of  
23 them fall in three categories. One is  
24 following, I think, the last presentation  
25 that we had about data was really useful in

1 that a lot of our recommendations are really  
2 encouraging a data-driven approach to  
3 outreach and enrollment, knowing that that  
4 will continue and need to be evaluated as  
5 information changes.

6 And also making sure that we are  
7 taking advantage of evolving consumer media  
8 consumption habits and then what that means  
9 in terms of channels that are available to  
10 reach consumers. So I would say one comes  
11 under this sort of data bucket.

12 Another common theme is really the  
13 importance of equipping those who are  
14 providing in-person assistance to consumers  
15 with the tools that they need to be able to  
16 do their jobs. So that's certainly  
17 navigators, community organizations,  
18 encouraging those who are often trusted  
19 sources of information for communities around  
20 the state to be involved in the process and  
21 understand what is happening.

22 And then a third bucket is really a  
23 need to be mindful of the consumer needs  
24 across Virginia and to really apply a  
25 consumer-centric lens to the standup of the

1 Exchange itself. And I think that is  
2 everything from making sure that outreach  
3 occurs in ways that are linguistically and  
4 culturally relevant and appropriate, but also  
5 being mindful of what individuals' own  
6 experiences are and have been with insurance  
7 and with the Exchange and making sure that  
8 that's taken into account so that things can  
9 continually evolve as new information is  
10 available and as consumers contribute to the  
11 conversation.

12 So again, I won't go into all of the  
13 specific recommendations. I welcome anyone  
14 from the subcommittee to provide any  
15 additional context or feedback. I think  
16 where we are in the process is seeing if any  
17 members of the subcommittee have some  
18 additional suggestions to those  
19 recommendations. And then we look forward to  
20 sharing them with the full committee and  
21 having a full conversation and vote on them  
22 at that time.

23 CHAIR CORLETTE: Do any members of  
24 the subcommittee want to add to Julie's very  
25 concise and helpful summary?

1 MS. HINOJOSA: I just want to thank  
2 you for that summary. It was really  
3 difficult to get everybody to meet over the  
4 summer; it was not for lack of trying, Julie.

5 MS. BATAILLE: I figured sometimes  
6 e-mail is best.

7 MS. HINOJOSA: That was a very  
8 helpful summary of the feedback that folks  
9 gave over in writing. And once we do find  
10 the opportunity to actually convene, I think  
11 that we will be able to continue to flush things  
12 out. So thank you for your leadership,  
13 Julie.

14 MS. BATAILLE: Yep.

15 CHAIR CORLETTE: So Julie, in terms  
16 of timing -- oh, sorry, Lee, go ahead.

17 MR. BIEDRYCKI: I was just going to  
18 say the references to educating the community  
19 are among the most important that we deal  
20 with in the broker agency, right, because a  
21 lot of this is just so foreign and over the  
22 head of your normal, working Virginian just  
23 trying to figure things out.

24 And the fractional networks, the  
25 speak chasms between where another carrier

1 will play and where another one will not have  
2 historically seemed to occur in some of the  
3 communities that need the assistance the  
4 most.

5           And I would just like to say that,  
6 you know, in the beginning, we had a slide  
7 about the outreach and the navigators and the  
8 grant, but Virginia does not have the  
9 resources for brick and mortar everywhere it  
10 needs. We've got high-speed internet issues.  
11 And quite frankly, I don't know that you  
12 could ever hire enough call center people to  
13 deal with the Medicaid benefits  
14 redetermination audits that are slated to  
15 begin at the conclusion of the public health  
16 emergency.

17           So I think it's just important to  
18 note that there are a lot of resources  
19 available for the Commonwealth to be able to  
20 take a measured approach and do this the  
21 smartest way possible. And I think it is  
22 important that we do so. And I, too, thank  
23 you, Julie, for spearheading that  
24 committee.

25           MS. BATAILLE: Thank you. I think

1 those are important things to make sure that  
2 we lift up. And I would say this is probably  
3 not something consumers always want to do  
4 either.

5 CHAIR CORLETTE: No. So Julie, in  
6 terms of timing, when do you want -- for  
7 folks on the committee that want to get you  
8 feedback, let's give them a hard deadline.

9 MS. BATAILLE: Yeah, if folks --  
10 especially just knowing that the Exchange is  
11 moving full steam ahead for this open  
12 enrollment and really to inform their  
13 planning efforts, I think it would be great  
14 if the subcommittee could give me any  
15 feedback in addition to the recommendations  
16 that you've got by the end of next week, and  
17 then I can revise accordingly and get that to  
18 you, Sabrina and Holly, to go to the full  
19 committee for a conversation and public  
20 meeting and vote.

21 CHAIR CORLETTE: Great. Thank you.  
22 That sounds good to me.

23 Okay. We're going to -- unless  
24 anybody else has questions for Julie or the  
25 subcommittee members about those

1 recommendations, I'd like to move us along,  
2 since we're very far behind, to our other  
3 business, which is a discussion of  
4 communication strategies.

5 And for this, we're going to hear  
6 from Julie Bataille, who -- I think many of  
7 you already know this -- but is a  
8 communications expert at the form of GMMB and  
9 also shepherded the healthcare.gov  
10 communications when she was previously at  
11 HHS.

12 So I'm going to turn it over to  
13 Julie. And then after Julie, we're going to  
14 hear from the Reingold team about their  
15 survey results. And we were -- we're about  
16 25 minutes behind, so I don't want to cut you  
17 guys short, but if we can make it snappy,  
18 that would be great so we can make sure we  
19 have enough time to wrap up any final  
20 discussion.

21 MS. BATAILLE: Sure. So I'm happy  
22 to -- oh, sorry, was there a question?

23 CHAIR CORLETTE: Nope. Go right  
24 ahead.

25 MS. BATAILLE: I will speak quickly

1 but happy to answer any questions, so I'll  
2 look for hands as we see them. What I wanted  
3 to do today, at Holly's request, was really  
4 just share some things that we have learned  
5 over the last decade in terms of messaging  
6 that works to really drive enrollment. And a  
7 question that I get asked a lot is, "What can  
8 we do new and different this year? And how  
9 can we message things that haven't been done  
10 already?"

11           And one thing that I just want to  
12 reinforce is, while the times have changed  
13 and the tone in which we communicate may  
14 change, given the surrounding environment,  
15 what we continue to see in terms of audience  
16 research and what really resonates with  
17 consumers tends to be some things that have  
18 really been tested, especially as the  
19 marketplaces have taken hold and there are  
20 consumers who are really understanding the  
21 value of the coverage and being able to use  
22 it themselves.

23           So we will dive in. And if we just  
24 go to the next slide. Quickly, I'm going to  
25 talk about some of the barriers to coverage

1 that I don't think are going to be new to any  
2 of you; a little bit about what we know in  
3 terms of marketplace awareness, and it would  
4 be great to see if you have any Virginia  
5 specific data here, too, to supplement this;  
6 some of the messaging that drives enrollment;  
7 and then give you a sense of some things that  
8 we are seeing as marketplaces start to plan  
9 for the unwinding of the public health  
10 emergency.

11 So if we go to the next slide here.  
12 Some of the barriers to coverage, you know,  
13 cost remains at the top of the list. And I  
14 think especially today, this year, given  
15 inflation, given increasing amounts of  
16 medical debt that consumers are facing, this  
17 is just really top of mind.

18 As Lee mentioned, you know, with the  
19 increasing cost of deductibles, while premium  
20 is still the main driver, increasingly, as  
21 consumers are more savvy about how to shop  
22 for coverage, they're looking for their  
23 out-of-pocket expenses and what does that  
24 mean for them, too.

25 The other thing that I would just

1 say is we have definitely seen over the last  
2 decade that consumers really do want health  
3 insurance, they value it, they understand  
4 that it is important. But it is often a cost  
5 calculation in terms of what they can afford  
6 at the end of the day in their monthly  
7 budget.

8           You know, confusion, lack of  
9 awareness -- we were just talking about this  
10 a little bit -- the reality is the process  
11 can be complicated. There's jargon, there's  
12 a lot of terminology that isn't well  
13 understood, there are questions about what  
14 are the programs that I'm eligible for, how  
15 did things change, and really just not a lot  
16 of awareness about who's eligible for what  
17 and when somebody needs to take actual  
18 action.

19           And then the complexity of the  
20 process and the need for assistance. This  
21 isn't something that people often want to do.  
22 It is daunting to them. They often need and  
23 really want a lot of questions to be answered  
24 throughout the process to help them not only  
25 understand and get through, but really make

1 the decision that's the best plan for them  
2 and their family.

3 So if we go to the next slide, just  
4 some information that has come out in the  
5 last couple of years, as we've all been  
6 dealing with the pandemic, is an ongoing  
7 recognition that many people still lack  
8 awareness about the marketplace, especially  
9 if you're uninsured. And the thing that we  
10 continually need to reinforce is that the  
11 marketplace is the one destination that  
12 people can go to get financial help.

13 The reality is there's just a lot of  
14 lack of knowledge for those who haven't had  
15 to shop for their own coverage about where to  
16 go and how to do it. So the differentiator  
17 for the marketplace is -- thankfully, with  
18 the ARPA subsidies, this is great -- is that  
19 the value proposition that they offer for  
20 consumers is that financial help piece and to  
21 continue to reinforce that.

22 If we go to the next slide, this  
23 gets into the messaging sections. And we can  
24 go one more slide. I think you'll see -- I'm  
25 just going to show you some examples of how

1 other marketplaces have implemented some of  
2 these things over time. But I think these  
3 are things that you likely have seen in the  
4 works that many of you have done.

5 I think because Virginia has been a  
6 state that has seen healthcare.gov  
7 advertising in messaging, over time these  
8 things may be familiar to you. And what I  
9 think will be important for us all to think  
10 about in terms of Virginia is how do we start  
11 to make these Virginia centric and within the  
12 context of what will be important to  
13 Commonwealth consumers.

14 I think the first thing that I would  
15 just say in terms of, you know, tone and  
16 themes is we have definitely seen over time  
17 that consumers think about health insurance  
18 as something that they have to do, not  
19 necessarily something that they want to do,  
20 in that they really don't want things that  
21 are stale, and they appreciate information  
22 that's straightforward, it's matter of fact,  
23 it's giving them what they need to know to  
24 then make an informed choice.

25 We have definitely seen ways that

1 you can insert humor over time, but at the  
2 end of the day, it's health insurance that  
3 people are buying and they understand what  
4 that is.

5           And then in terms of messaging, you  
6 see this long list here, and we'll go through  
7 some of the examples, but all of these are  
8 really meant to overcome some of those  
9 barriers that people have to accessing  
10 coverage, give them a reason to look at the  
11 plans, and make sure that they understand  
12 what's available to them to, again, make a  
13 choice that's right for them and their  
14 family. So we'll go through some of these  
15 examples so you can just see practically how  
16 some folks have brought these things to life.

17           If we go to the next slide,  
18 affordability is certainly key and top of  
19 mind. And you can just see some of the  
20 examples of how exchanges have brought this  
21 to use. It's not just talking about the  
22 subsidies but how many people have been able  
23 to take advantage and get those savings.

24           You know, we heard earlier in the  
25 conversation 90 percent of Virginia consumers

1 are getting APTC. That's great; you know, 9  
2 out of 10 Virginians are able to access that  
3 kind of help. Making analogies to things  
4 that consumers are buying in their everyday  
5 life -- you know, less than a pack of gum,  
6 you see here, is one example -- is just  
7 something to keep in mind. But always  
8 emphasizing low cost, the availability of  
9 financial help, and doing that in a few  
10 different ways to make it clear that this is  
11 something that consumers today, you know,  
12 that I know in my neighborhood and my state  
13 are able to take advantage of is really  
14 important.

15 And while premium is certainly the  
16 biggest decider in terms of what people look  
17 for, as we've mentioned in this conversation,  
18 you know, doctor network and deductible are  
19 quickly other things that folks are looking  
20 at in making their overall cost calculation.

21 If we go to the next slide, another  
22 thing that is really important, and again,  
23 something that is really a hallmark of the  
24 marketplaces is giving consumers the  
25 information that they need to put them in

1 control of making a choice that's right for  
2 them and their families.

3 So this is something that it's great  
4 to know there are going to be choices for  
5 everyone in Virginia based on the previous  
6 presentation and really make that top of mind  
7 so that the marketplace is seen and  
8 understood and known as a destination that  
9 people can go to shop, compare, choose the  
10 plan that's right for them.

11 We can go to the next slide here.  
12 And something that is important -- we've  
13 talked about this a bit -- is just the need  
14 to reinforce the availability of consumer  
15 assistance. This can certainly be language  
16 help. This can be help over the phone. This  
17 can be online chat. This can be in person.  
18 But emphasizing that you've got people who  
19 are trained to have these conversations and  
20 equipped to be able to help people through  
21 the process.

22 Covered benefits and services, you  
23 know, people understand they need health  
24 insurance, they understand that it is  
25 something that is important for them and

1 their families, but giving them specific  
2 references to some of the benefits and  
3 services that are actually covered is really  
4 resonant.

5 One thing that (technical  
6 difficulties) the specifics that you see here  
7 on this slide is that over the last year and  
8 a half, we have really seen an evolution in  
9 what people are really interested in knowing.  
10 And something that is really of interest over  
11 the last year is mental health services and  
12 telehealth in particular. Those are things  
13 that consumers are looking for actively so to  
14 the extent that they are available, we would  
15 encourage people to call those out in  
16 particular.

17 If you go to the next slide,  
18 something that is interesting is just knowing  
19 that, you know, we're all human, we're busy,  
20 we have 12 different things to do all at  
21 once, but continually reinforcing when  
22 someone needs to take action and when a  
23 deadline is approaching in terms of  
24 enrollment has really tended to be a consumer  
25 forcing option.

1                   And this is something that we  
2                   questioned a little bit with all of the  
3                   special enrollment periods that happened over  
4                   the course of COVID; it seemed like people  
5                   could continually enroll. We still have seen  
6                   that reinforcing when the deadline to get  
7                   coverage is for the following year continues  
8                   to be important. So just know that those  
9                   deadlines still matter and use them as an  
10                  opportunity to remind them when they need to  
11                  do something.

12                  Piece of mind, financial security,  
13                  certainly, given the climate that we are in  
14                  right now with inflation, with concerns about  
15                  medical debt, you know, sending people  
16                  information and giving them messaging that  
17                  reinforces how health insurance is going to  
18                  help them, it's going to protect the economic  
19                  security of their families, it's going to,  
20                  you know, prevent them from accidents and the  
21                  cost of things that they wouldn't be able to  
22                  otherwise afford is something that is  
23                  definitely resonant with a lot of consumers  
24                  right now; just reminding them what health  
25                  insurance will bring to them and their

1 family.

2 And then let's go to the next slide.

3 Plans and prices change each year, this is  
4 something, you know, we really want to  
5 encourage people to actively shop and  
6 (technical difficulties) be in terms of  
7 whether or not the plan that they have is  
8 still the right one for them. What's new?  
9 Have you had circumstances in your life or in  
10 your family that have changed over the past  
11 year? But really encouraging them to make an  
12 active decision and take a look at the plan  
13 that they've got so they're not just  
14 automatically getting something is really  
15 important and I think probably something to  
16 keep in mind in Virginia in particular, just  
17 given the conversation we were having about  
18 reinsurance.

19 And then let's go to the next slide.

20 I think this is starting to get into some of  
21 the things to be mindful of. As you think  
22 about different groups of consumers and what  
23 information they may need because of their  
24 circumstances.

25 In the example of special enrollment

1 periods, have people just had children, are  
2 they newly married, have they lost a job;  
3 those are all things that you can include in  
4 messaging so that consumers understand, "Oh,  
5 this is meant for me; I'm one of those  
6 people; I should really see if this is  
7 something that I need to take advantage of or  
8 do right now." So I think just thinking  
9 through who some of those consumer  
10 populations are is something that I would  
11 really encourage.

12           And then we can go to the next  
13 slide. I think this starts to get into  
14 planning for the unwinding of the public  
15 health emergency, but really building on that  
16 point of who are the groups of consumers that  
17 we need to reach specifically and have them  
18 understand what they need to do or steps they  
19 need to take or what's at stake for them are  
20 some things that we are actively thinking  
21 through right now.

22           And I think certainly understanding  
23 the need to coordinate that, you know,  
24 handoff between Medicaid and the Marketplace  
25 for those who are no longer eligible for

1 Medicaid is going to continue to be really  
2 important. And making sure that people have  
3 updated contact information; I think many of  
4 us can probably appreciate the things that we  
5 see in our daily lives, if you're calling  
6 your credit card company or you're calling  
7 the utility company, usually that  
8 conversation includes, you know, "Do I have  
9 the right information for you? Is this still  
10 where you can be reached?" And thinking  
11 through taking some of those steps so that  
12 our agencies are then able to communicate  
13 directly with their consumers over time is  
14 something that's going to be really  
15 important.

16 I think that is my last slide. I  
17 know that was really quick. I was trying to  
18 intentionally talk fast. So I'm happy to  
19 take any questions if folks have them.

20 CHAIR CORLETTE: That was great,  
21 Julie. Thank you. Anybody have questions  
22 for Julie?

23 I have a question; it's kind of a  
24 small thing, but I noticed some of the  
25 state-based marketplaces have either a .gov

1 or a .org or a .com as their landing page.

2 MS. BATAILLE: Their URL, yes.

3 CHAIR CORLETTE: Sorry; URL, yeah.

4 And I was just curious; do you have a sense  
5 of, like, for Virginia, is one better than  
6 the other in terms of what consumers will  
7 trust? I mean, I do worry sometimes; there's  
8 much of these short-term plans and, like,  
9 fixed indemnity that's inundating with  
10 similar messages. So, like, is it helpful to  
11 have a .gov then or is it --

12 MS. BATAILLE: It's a great  
13 question, and you can see different exchanges  
14 have answered it for themselves in different  
15 ways. I will say some of the research that  
16 we've seen, and I know in the case of  
17 healthcare.gov, what we really saw was using  
18 (technical difficulties) an established  
19 program, it gave people the comfort and piece  
20 of mind that this was something that had been  
21 created for them. And it was definitely seen  
22 as helpful in terms of just building that  
23 credibility that is needed.

24 I will say I think the states that  
25 have .com and .org have also seen success, so

1 at the end of the day, I think it's the  
2 overall brand of awareness that matters. But  
3 I do think that consumers, especially just  
4 because so many more are shopping online, if  
5 you think about consumer patterns that have  
6 changed over the last decade, a .com is  
7 definitely seen much more as a for-profit and  
8 a commercial entity than a .gov for sure.

9 CHAIR CORLETTE: Well, this might be  
10 a nice segue then to the Reingold team,  
11 because I think they've got some survey  
12 results to share, and they may be able to  
13 tell us a little bit about what Virginians  
14 think about this and the messaging that  
15 Virginians might want to hear.

16 Do we have the Reingold folks on the  
17 call?

18 MR. ORRISON: We do. This is Greg  
19 Orrison with Reingold.

20 CHAIR CORLETTE: Great. Hi, Greg. Take  
21 it away.

22 MR. ORRISON: Great. So we're  
23 Reingold. We're the agency that's supporting  
24 the SCC in communicating to audiences to  
25 encourage them to sign up for the Exchange.

1 Julie's presentation was a great preface  
2 because we do have data on Virginians from a  
3 survey that we conducted that I think really  
4 reinforces some of the principles that she  
5 mentioned.

6 So we'll talk a little bit about the  
7 background of the survey, we'll talk about  
8 who responded, some key takeaways from that  
9 research, and then how we're going to apply  
10 them to our audiences when we, in turn,  
11 communicate to different audience groups.

12 So we were able -- I think we  
13 presented a couple months back. We also ran  
14 focus groups in Virginia among broad range of  
15 Virginians and we were able to supplement  
16 that with a more quantitative survey of 833  
17 Virginians; 117 of whom are primarily Spanish  
18 speakers.

19 So our goals for the research,  
20 really wanted to understand our audience's  
21 attitudes, their motivations, and their  
22 barriers related to purchasing health  
23 insurance so that we can, in turn, create  
24 messaging that meets them where they are,  
25 acknowledges those values, and will resonate.

1           So in terms of the survey responses  
2 we captured, we did get representation from  
3 across the Commonwealth in these sort of five  
4 regions you see here. The percentages of  
5 response you see on the right should index  
6 pretty closely to the populations of the  
7 state in those regions.

8           And we do have a good representative  
9 and diverse mix across things like  
10 urban/rural geography, race and ethnicity,  
11 gender, obviously. On the left-hand side  
12 there, you'll see our audience segments which  
13 I'll talk to in a minute. But that's how  
14 we're sort of clustering our audiences so  
15 that we can craft messaging and creative that  
16 is intended to most resonate with them.

17           We also have good representation and  
18 diversity in health insurance status. So we  
19 did screen for people who are eligible to use  
20 the Exchange or are in sort of insurance  
21 situations where they could become eligible  
22 to use the Exchange in the future. So 26  
23 percent of our respondents were uninsured, 15  
24 percent using healthcare.gov, and the rest in  
25 situations of sort of underinsurance or sort

1 of precarious insurance situations.

2 So with that, we'll get into our key  
3 findings. So to start, people's attitudes  
4 towards health insurance, we do have some  
5 good news, in that 93 percent respondents  
6 believe it's either very or somewhat  
7 important to have health insurance. So they  
8 acknowledge, you know, even if I don't have  
9 health insurance, it is of value; it's  
10 something that is important. That does vary,  
11 of course, by some of our subgroups, so  
12 younger respondents, also rural respondents  
13 were less likely to say that having health  
14 insurance is very important. So closer in  
15 the low 60s there.

16 Most people, 73 percent, after  
17 learning about the Exchange also said they  
18 would be willing to use it. Of course, with  
19 variances by subgroups, so again, younger  
20 people, lower income people, people on our  
21 lowest income bracket had the least  
22 likelihood of saying they're very likely to  
23 use the Exchange at 13 and 17 percent.

24 So barriers to insurance, as Julie  
25 said, really cost is the primary driver here.

1 So 50 percent of all respondents located that  
2 as the most significant barrier to insurance;  
3 particularly true, as you'd guess, among  
4 older people, those who are in potentially  
5 difficult financial situations, approaching  
6 retirement, for example, response is lower  
7 incomes and the unemployed.

8 Behind that, in terms of barriers,  
9 we found that 17 percent of people cited job  
10 uncertainty. That could be I just started a  
11 new job; I'm not eligible for insurance yet,  
12 for example. And then the complexity of  
13 navigating the insurance process, as Julie  
14 spoke to, was the third factor that we found  
15 to be the biggest barrier.

16 The next slide. And then  
17 motivators, in turn, so the flip side of cost  
18 being a barrier, 41 percent of people  
19 identified lower cost as a motivation to get  
20 health insurance and an additional 19 percent  
21 said they would be most motivated by  
22 financial assistance.

23 When we asked people the most  
24 important features they look for in health  
25 insurance, again, affordability at the very

1 top, 73 percent of people saying it's the  
2 most important feature; 15 percent cited  
3 quality; and 49 cited reliability. We also  
4 asked about the features or the services they  
5 most want to be covered. So sort of the  
6 bread and butter coverages that people  
7 identified, 50 percent identified doctor  
8 visits, 37 percent, hospitalization, 37  
9 prescriptions.

10 And then again, these are even --  
11 that was even more so the case for  
12 individuals ages 50 to 64 and those with  
13 incomes from 25 to 35 K.

14 Great. So how can we use this  
15 information to communicate to our audiences?  
16 We'll speak a little bit about how we plan to  
17 segment those audiences. So I'll introduce  
18 that on this slide. So obviously messaging,  
19 communications, it's not one size fits all.  
20 Virginia is a very diverse state  
21 geographically, demographically. So we want  
22 to tailor our communications so that they  
23 resonate with specific sort of segments of  
24 the population that have sort of shared  
25 characteristics.

1           We will use desegmentations and what  
2 we know about these audiences to shape our  
3 messaging, shape our creative, so if I get an  
4 ad, for example, it's likely to be someone  
5 who looks like me and may share my values.

6           We can also use this information to  
7 prioritize our audience groups. Some groups,  
8 based on their demographics or their  
9 insurance statuses, have greater need to be  
10 motivated to use the Exchange than others.

11           And then with that information, you  
12 know, we can use that prioritization to run  
13 as efficient as possible a campaign so that  
14 we're using our advertising budget to  
15 advertise to the right people sort of in the  
16 right places, those that need the most  
17 motivation to sign up.

18           So this, we started with a  
19 geographic segmentation, which will be most  
20 sort of appropriate for broadcast  
21 advertising, where we're advertising on radio  
22 and TV and to a large geography, for example.  
23 We use census bureau to look at all the ZIP  
24 codes in the state; that's the narrowest  
25 level of geography we have good data on.

1                   And then within those ZIP codes, we  
2                   looked at characteristics, including  
3                   insurance status, racial composition, income  
4                   and education levels, language spoken at  
5                   home, and internet connectivity. And then we  
6                   supplemented this demographic information  
7                   based on that census data with our  
8                   attitudinal data from this survey.

9                   We can just show you kind of what  
10                  the segments looked like that we've developed  
11                  on the next slide. Oh, just a recap of how  
12                  this sort of process works. Again, nearly  
13                  900 ZIP codes in Virginia.

14                 Within those ZIP codes, people often  
15                 will have common characteristics, by  
16                 insurance status -- you know, 40 percent of  
17                 the people in the ZIP code may be uninsured,  
18                 for example. Also, often, similar  
19                 racial/ethnic composition; and then we also  
20                 mapped onto those the attitudinal  
21                 characteristics from the survey.

22                 So we can then cluster those ZIP  
23                 codes together into larger geographies with  
24                 roughly similar populations that will get  
25                 similar types of advertising.

1                   So here are the audience segments  
2                   that we've developed on the basis of that  
3                   demographic and attitudinal data. These are,  
4                   in our order of sort of priority as we're  
5                   looking at prioritizing budget, based on the  
6                   population size of eligible populations,  
7                   eligible individuals within these  
8                   populations.

9                   So the first one we're calling  
10                  diverse low coverage, large population, high  
11                  rates of almost 15 percent uninsured. This  
12                  is a large -- among our segments, it's the  
13                  largest percentage, black; I believe it's  
14                  about 40 percent black. It's sort of  
15                  centered in the southeast along the coast  
16                  there around areas like Norfolk and also in  
17                  the south of the state along the border.

18                  Our second priority audience we're  
19                  calling cosmopolitan. This is a quite large  
20                  audience but lower rates of uninsurance.  
21                  This is our most diverse group, averagely  
22                  centered in the urban centers of Northern  
23                  Virginia, Richmond, etc.

24                  Our third segment, what we're  
25                  calling rural low coverage; this is, I

1 believe, greater than 90 percent white, high  
2 rates of uninsurance, almost 15 percent  
3 uninsured. This group is largely located on  
4 the western edge of the state in that sort of  
5 Shenandoah region.

6           And this fourth group here is  
7 primarily the audience we'll be serving our  
8 Spanish language media to; we're calling  
9 these Spanish speaking enclaves. We did set  
10 a pretty high threshold on Spanish speaking,  
11 just so that we're not sending English  
12 populations Spanish ads, for example. So  
13 this is upwards of 15 percent Spanish  
14 speaking, relatively small population, but it  
15 will be a high priority population, seeing  
16 greater than 20 percent uninsured.

17           And then our lowest priority group,  
18 what we're calling affluent suburban,  
19 relatively small population, predominantly  
20 white, truly suburban, low rates of  
21 uninsurance. So they'll receive our sort of  
22 our lowest media weight.

23           And then maybe I can just give an  
24 example on the next slide of how we're using  
25 some of the survey data to inform our

1 messaging. So this is just one example of  
2 those segments. So for each of these  
3 segments, we've identified what other sort of  
4 top concerns, what are their biggest  
5 motivating factors, what are the coverages  
6 that they most value, and then at the bottom  
7 here, these differentiators, what was really  
8 salient in the data that we can use to craft  
9 messaging.

10           So for this audience, for example,  
11 they actually had the greatest willingness  
12 among these segments to use the Exchange.  
13 They had the great interest in financial  
14 assistance, for example. That had the  
15 greatest -- we asked about where are you  
16 likely to learn about information about  
17 health insurance? How the greatest rate  
18 among these different groups of learning is  
19 by a TV ad. So we in turn, you know, when we  
20 looked at channels to advertise, TV could be  
21 a good solution in the mix here.

22           So that's an overview of how we were  
23 able to survey eligible Virginians and how we  
24 can use these insights to, in turn, inform  
25 our messaging and our campaign. I'm happy to

1 answer any questions.

2 CHAIR CORLETTE: That was great,  
3 Greg. Thank you. Really, really important  
4 work.

5 Any questions for Greg? Ikeita, I  
6 think you've had your hand up; I'm not sure  
7 if that's from before or if you --

8 MS. HINOJOSA: I think it was from  
9 before. I just have to say, I'm extremely  
10 excited just to see the diversity of these  
11 campaigns and how we're really building  
12 something that just reflects the diversity of  
13 the people of Virginia so that we can really  
14 build a state-based Exchange and marketplace  
15 that, you know, really helps serve all  
16 Virginians. So this is just really, really  
17 great work. So I'm very excited about the  
18 path forward, so thank you for that.

19 CHAIR CORLETTE: Any other questions  
20 for Greg or Julie?

21 MS. BATAILLE: Sabrina, I've got one  
22 quick question.

23 Greg, this is great. And I'm so  
24 glad that you guys have recent consumer data  
25 to inform everything you're doing. A quick

1 question in terms of whether or not this is  
2 part of your thinking for the marketing plan  
3 that was referenced for this coming open  
4 enrollment period, in addition to what will  
5 be put in place once the Exchange has its new  
6 brand. I assume this is going to be for  
7 both, but if you could just clarify that.

8 And then for this coming open  
9 enrollment period, are you sending consumers  
10 to healthcare.gov or to some other  
11 destination?

12 MR. ORRISON: I know that these --  
13 well, I will say, Julie, this geographic  
14 segmentation -- so for digital advertising,  
15 we have more fine grain ways of targeting, so  
16 we can actually target people who have a  
17 likely -- on digital, have a high likelihood  
18 of being uninsured, visitors to  
19 healthcare.gov, for example.

20 So I think those two approaches will  
21 be layered. But I may defer to Keven to  
22 speak to timing and sort of call to action.  
23 I'm happy to respond based on my knowledge,  
24 but I know that that's been under discussion  
25 at SCC.

1 MS. BATAILLE: If there isn't an  
2 answer, that's fine, too, right now.

3 MR. ORRISON: So our latest guidance  
4 from SCC is we will be directing to  
5 healthcare.gov and do not want to create  
6 brand confusion at this stage during the  
7 federal open enrollment period.

8 MS. MORTLOCK: Yes, that's right.

9 MS. BATAILLE: In terms of  
10 preventing consumer confusion, that makes a  
11 lot of sense. So that's terrific.

12 CHAIR CORLETTE: Any other questions  
13 for Greg or for Julie? All right. Well,  
14 those were two fantastic presentations.  
15 Thank you to the Reingold folks and thank you  
16 to Julie.

17 Turning now to, I think, our last  
18 agenda item. I'm told there are no public  
19 comments. So we can jump right to just sort  
20 of wrap up and some housekeeping matters.

21 The first is just to remind folks  
22 that we have our fourth quarter meeting on  
23 December 1st from 2 to 4 p.m. I do want to  
24 ask or do a straw poll of folks to see if  
25 there would be interest in meeting in person

1 in Richmond at the SCC.

2 As I understand it, Holly, there's  
3 not a budget for travel, so that is something  
4 that folks should take into account. But I  
5 think there's some interest in -- I certainly  
6 would like to meet many of you who I haven't  
7 met in person. So we can either do this  
8 offline or just take a quick straw poll now  
9 to see if folks would be willing to head to  
10 Richmond to meet in person. Does anybody not  
11 want to do that, I guess, is the question.

12 We don't have the whole --

13 MS. HINOJOSA: We should probably do  
14 this offline, because a lot of people are  
15 absent.

16 CHAIR CORLETTE: Yes, we do have a  
17 number of folks absent. So I will send an  
18 e-mail around and I'll just ask you to  
19 respond with your interests and not put  
20 anybody on the spot.

21 The last thing I just want to  
22 mention is, because we've lost Jane, we do  
23 need a new vice chair. So we will be seeking  
24 nominations and we'll need to hold a vote at  
25 our December meeting to elect a new vice

1 chair. So I just want to put that on folks'  
2 radar screen.

3 So if you're interested in serving  
4 in that capacity, Holly, should they reach  
5 out to you and me or how should we handle  
6 that?

7 MS. MORTLOCK: Sure. So please,  
8 feel free to send an e-mail to Sabrina, and  
9 you can CC me and just let us know if you're  
10 interested in serving as the vice chair or if  
11 you would like to nominate someone to do so.

12 CHAIR CORLETTE: Thank you. I think  
13 Lee, you have your hand raised?

14 MR. BIEDRYCKI: Yes, ma'am. Thank  
15 you. I wanted to clarify a comment that I  
16 made while talking to Keven. The comment  
17 about the reduced enrollment was relative to  
18 the percentage increase on the federally  
19 facilitated Exchange. So New Jersey was  
20 still inflated because it had an additional  
21 state subsidy, but Nevada and Kentucky did  
22 have a drop last year.

23 Secondly, there are 15 EDE and DE  
24 web providers certified and listed under  
25 healthcare.gov. The 50 number, probably

1 insurers, includes insurance carriers. Of  
2 the 15 a couple of those are white labeled,  
3 so the number is actually less.

4 And then last but not least, the  
5 federally facilitated Exchange requires that  
6 web brokers using DE and EDE display all  
7 plans available, regardless of whether or not  
8 that broker wants to sell it.

9 So I know that this may sound like  
10 I'm beating an annoying drum, but I have been  
11 doing Exchange enrollments for ten years, and  
12 I will say that, having built our own as a  
13 development partner, I'm a little concerned  
14 about the timeline relative to A, the tech,  
15 but B, a number of the agents that  
16 participate in this business segment are on  
17 the older more experienced end of the life  
18 span continuum, and new tech is just  
19 proportionately more difficult for them.

20 As we looked to the rollout of the  
21 Exchange, on October 1st, 2013, I was  
22 standing in a hotel room conference area  
23 proudly pulling up our Exchange and how it  
24 interfaced with healthcare.gov. And many of  
25 you will remember that that first year's open

1 enrollment, healthcare.gov wasn't operational  
2 until late November, maybe early December.

3           The thing that I want to point out  
4 here is that prior to healthcare.gov being  
5 operational, they opened the doors and  
6 allowed our system to begin to proceed  
7 processing enrollments because they needed  
8 the enrollments. It is one thing to assert  
9 the importance of these platforms for brokers  
10 to continue to enroll as is. But I think  
11 it's also very important to acknowledge the  
12 safety backstop that multiple systems provide  
13 in the event that one system has an issue.

14           So with that, I just wanted to make  
15 sure that the context was correct on the  
16 percentage change in enrollment. We are  
17 willing and available to meet and provide  
18 whatever assistance we can. But I really  
19 think that this component is vital to the  
20 success of Virginia, especially relative to  
21 the complexity of the marketplace.

22           CHAIR CORLETTE: All right. Lee, I  
23 think you're going to get the last word here  
24 today, because we are over time. But it does  
25 sound like you've raised some really

1 important issues, and it sounds like you and  
2 your colleagues are talking directly to the  
3 Exchange staff about that.

4 But if there's anything that we as  
5 an Advisory Committee can do to foster a  
6 discussion or dialogue on these issues, I'm  
7 certainly happy to help facilitate that.

8 We do need to close and be  
9 respectful of folks' time. So Holly, I'm  
10 going to turn it back to you. Do I need to  
11 make a motion to adjourn; is that how this  
12 works? I can never remember.

13 MS. MORTLOCK: Yes, if you can go  
14 ahead and do that.

15 CHAIR CORLETTE: All right. I would  
16 like to see if anybody could move to adjourn  
17 and we'll need a second.

18 MS. HINOJOSA: I'll move to adjourn.

19 CHAIR CORLETTE: Do we have a  
20 second?

21 MS. BATAILLE: I second that.

22 CHAIR CORLETTE: All right. We are  
23 adjourned. Thank you all so much. Pleasure  
24 to see you, as always.

25 (Meeting adjourned at 4:03 p.m.)

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CERTIFICATE OF REPORTER

I, Ruth A. Levy, RPR, do hereby certify that the proceedings were heard remotely before me in the State Corporation Commission meeting herein; further that the foregoing is a true and accurate record of the testimony and other incidents of the meeting herein; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

Given under my hand, this 27th day of September, 2022.



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Ruth A. Levy, RPR

Notary Public, Commonwealth of Virginia  
My Commission Expires August 31, 2026  
Notary Registration No. 224511

Transcript of Meeting  
September 15, 2022

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