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Transcript of Meeting

Date: September 15, 2022

Case: Health Benefit Exchange Advisory Committee Meeting

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1 COMMONWEALTH OF VIRGINIA
2 STATE CORPORATION COMMISSION

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6 VIRGINIA HEALTH BENEFIT EXCHANGE
7 ADVISORY COMMITTEE MEETING

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12 September 15, 2022

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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

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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 CORLETTÉ: Yes, I can.

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

10 CHAIR CORLETTÉ: 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 CORLETTÉ: 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 CORLETTÉ: 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 CORLETTÉ: 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 CORLETTÉ: 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 CORLETTÉ: And Lee, I saw your
2 smiling face earlier.

3 MR. BIEDRYCKI: Good afternoon.

4 CHAIR CORLETTÉ: 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 CORLETTÉ: 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 CORLETTÉ: Heidi...

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

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

22 MS. MORTLOCK: Yes.

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

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

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1 CHAIR CORLETTÉ: 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 CORLETTÉ: 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 CORLETTÉ: 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

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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,

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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 reappplies 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.

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1 CHAIR CORLETTÉ: 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 CORLETTÉ: 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 CORLETTÉ: 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 --

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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 CORLETTÉ: 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 CORLETTÉ: 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.

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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,

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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

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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 CORLETT: 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?

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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

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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?

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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 CORLETTÉ: 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 CORLETTÉ: 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

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

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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 able to continue to flush things
12 out. So thank you for your leadership,
13 Julie.

14 MS. BATAILLE: Yep.

15 CHAIR CORLETTÉ: 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

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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 CORLETTÉ: 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 CORLETTÉ: 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 CORLETTÉ: 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 CORLETTÉ: 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 CORLETTÉ: 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 CORLETTÉ: 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 CORLETTÉ: 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

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1 answer any questions.

2 CHAIR CORLETTÉ: 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 CORLETTÉ: 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 CORLETTÉ: 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 CORLETTÉ: 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 CORLETT: 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

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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 CORLETTÉ: 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 CORLETTÉ: Do we have a
20 second?

21 MS. BATAILLE: I second that.

22 CHAIR CORLETTÉ: 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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1 CERTIFICATE OF REPORTER

2

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

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

14

15

16



17

18 Ruth A. Levy, RPR

19

20

21 Notary Public, Commonwealth of Virginia

22 My Commission Expires August 31, 2026

23 Notary Registration No. 224511

24

25

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