Transcript of Advisory Committee Meeting

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Case: Health Benefit Exchange Advisory Committee Meeting

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COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

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A P P E A R A N C E S

VOTING MEMBERS:
SABRINA CORLETTE, CHAIR
KEVEN PATCHETT, ACTING DIRECTOR
SCOTT WHITE, COMMISSIONER
IKEITA CANTU HINOJOSA, VICE CHAIR
JULIE GREEN BATAILLE
LEE BIEDRYCKI
SCOTT N. CASTRO
DOUGLAS GRAY
ELIZABETH CUNNINGHAM
LOUIS ROSSITER
STARLA KISER

EX-OFFICIO MEMBERS:
JAMES WILLIAMS, DEPUTY SECRETARY OF HEALTH AND HUMAN RESOURCES
CHERYL ROBERTS, ACTING DIRECTOR OF DMAS
SARAH HATTON, DMAS
GENA BOYLE, DEPARTMENT OF SOCIAL SERVICES

ALSO PRESENT:
HOLLY MORTLOCK, CHIEF GOVERNMENT RELATIONS OFFICER/HBE LIAISON TO ADVISORY COMMITTEE
WHITNEY THOMAS

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P R O C E E D I N G S

MS. CORLETTE: Okay. Well, welcome everybody to our first Advisory Committee Meeting of 2023. It is great to see so many of you in person that I've been looking at in a box on a screen for a few years now.

For our addenda today, we have a lot to talk about. We're going to hear from Kevin, our executive director with an update as well as from DMAS on the Medicaid unwinding. Ikeita is going to share an update from the Strategic Priorities Subcommittee that has gotten revived and under Ikeita's leadership and so I'm excited to hear about that progress. And then we have some celebrity guests from our assister Exchange in Pennsylvania, the folks from Penn. I think it's -- is it Devon and David is that --

A Yes. That's right.

MS. CORLETTE: Who is coming. They're going to talk to us about some innovative things that they are doing to try to reduce coverage loss during the unwinding. And then we'll have other business and public comment.

So let's start with our roll call.

MS. MORTLOCK: Sounds great. Would you like me to go ahead and do that?

MS. CORLETTE: Yes, because I don't have a

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list of all of the members. Will that show up on the screen?

MS. MORTLOCK: Yes.

MS. CORLETTE: Yeah. Why don't you go ahead and do the roll call.

MS. MORTLOCK: Sure. Okay. So Secretary John Latell [ph] I understand has sent a proxy. Is Deputy Secretary James Williams here?

MR. WILLIAMS: Present.

MS. MORTLOCK: Thank you. Director Roberts from Virginia Medicaid.

MS. ROBERTS: -- Medicaid.

MS. MORTLOCK: Thank you. Good afternoon. Commissioner Avula from the Department of Social Services.

MR. Avula: -- hello.

MS. MORTLOCK: Hello. And Commissioner White with the Bureau of Insurance has sent a proxy. Mary Ashby Brown, are you with us?

MS. BROWN: Yes, I'm here.

MS. MORTLOCK: Good afternoon. I see Sabrina here. And in the room we also have Julie Bataille.

MS. BATAILLE: Hi, everyone.

MS. MORTLOCK: Lee Biedrycki.

MR. BIEDRYCKI: Hi.

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MS. MORTLOCK: And we have Ikeita.
MS. HINOJOSA: Here.
MS. MORTLOCK: Hinojosa.
MS. HINOJOSA: Ikeita Contu Hinojosa, yes.
MS. MORTLOCK: Thank you. And Lou Rossiter.
MR. ROSSITER: Greetings.
MS. MORTLOCK: And then also on the line I want to ask Scott Castro.
MR. CASTRO: Yep. I'm here.
MS. MORTLOCK: Liz Cunningham.
MS. Cunningham: Yes, I'm here.
MS. MORTLOCK: Good afternoon. Starla Kiser.
MS. KISER: I'm here.
MS. MORTLOCK: And is Doug Gray with us virtually? Okay. I think Doug will probably be joining us at some point.
MS. CORLETTE: Okay.
MS. MORTLOCK: All right. So I think we are good to go.
MS. CORLETTE: Yeah. I think we have a quorum. Do we need a motion to begin? I can't remember.
MS. MORTLOCK: I don't think so.
MS. CORLETTE: Okay.
MS. MORTLOCK: We can be mostly informal.

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MS. CORLETTE: I think we can just dive right in. All right. Let's go ahead and start. Is Kevin on the line? Yes.
MS. MORTLOCK: Kevin are you with us?
MR. PATCHETT: I am. Can you all hear and see me?
MS. CORLETTE: We can hear you.
MS. MORTLOCK: We can hear you. We can't see you.
MR. PATCHETT: Okay. One second here.
MS. MORTLOCK: I don't know if it will work the way that the computer is set up in the room Kevin. So you might just have to go ahead and --
MR. PATCHETT: Okay. All right. Well, let me apologize to those who are in the room. I was really looking for an opportunity to seeing you in person and to meeting some of you in person for the first time, but circumstances were not in favor of that this week.
So I want to start out and give you all an update of where the Exchange is. Which and really where we've been over the last quarter or two which is we set out on this endeavor. I realized how difficult it was because of just how much we've accomplished. This time last year, we were pretty laser focused on getting an RFP released which happened right about this time last

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year. Then we really went into our evaluation mode and it was the fall when we awarded our contract, and we moved from what felt like a pretty fast pace to a whole different universe of speed and workload. And it's been really exciting for us to just see how the work has evolved, how our progress has evolved, how we as a team have evolved. And so I wanted to just share a little bit of -- of what we've done.
And on this first slide of status updates, you can start to get a sense, because on the left-hand side, we have the -- almost a half year's worth of events and then the right-hand side is filled up with things from a month. Some of which are the culmination of past work. And a lot of these things are really difficult to express just what was involved, but one of the things you'll see for instance, is product orientation sessions. We made a decision when we built our RFP this time last year that the significance and complexity of this project warranted a robust set of functional and technical requirements. Our selective vendor Get Insured continues to give us a hard time about the fact that we have over 800 requirements. But as part of that, that meant we went through this product orientation phase that lasted about three months where we sat for three and sometimes four days in a week for

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most of the day walking through exactly what Get Insured's platform did and how it satisfied those requirements which ultimately culminated in us doing a traceability of our requirements to the solution. And a lot of good things came out of that.
We got to know the platform, its functionality. Where we needed to make decisions. Where we needed to push for improvements and innovations early on and in a way that just did not come out of a procurement or evaluation process. And that, you know, that really built a foundation for us moving into design, development, making critical configuration choices for how we want to take a technology platform that five or so other states have implemented and make it Virginia's platform.
I will say that a couple of weeks ago I was talking with one of our KPMG representatives. The Exchange has required KPMG to help us in the testing process which has already kicked off. But he was telling me how excited he was to open our requirement spreadsheet and see a set of robust requirements so that they could actually take all of their test cases which are close to 300, I believe, and have some actual requirements to map them back to, and he said I wish every state would do it this way. So that was some

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gratifying feedback for me and for our team.
And then, so the next slide you'll see how our pace and the amount of work rooms [ph] that we're tackling continues to grow as we look at February and March. I think one of the areas for us that continues to be a wild card is the interaction with CMS. Some of you are getting to meet Susan today, and I frequently hear from Susan that CMS is asking us for something that's not on the schedule, that's not on the list, but they have oversight of our transition, and so we just get to roll with those requests and adapt.
One of the things you see there under March, for example, is the safeguards and security report. That was a 600-page document that we got to work closely with our vendor to make sure -- it doesn't do it justice to say that every T was crossed and I was dotted. And our chief of security and IT operations Amy Mears really, really dug in and did some extraordinary work to get that -- that ready for us.
One of the other things I will say that has come out of our interactions with CMS, we learned from -- from somebody who's kind of outside the process that CMS has begun asking other states who are beginning to work towards their transition and ask their vendors whether or not they're going to meet the Virginia

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standard. And also right, that was rewarding for us, because we're not just doing a lot of work. We're not just moving at -- at a really fast pace, but we are continuing to push everybody that we work with for a higher level of quality, a deeper level of engagement, and it's getting recognized and noticed externally, and that's a -- hugely rewarding for us.
I do want to take a second since I mentioned the safeguard and security report and just talk a little bit about security. I think you all have probably seen in the news the report of the data breach in Washington, D.C. A couple of things, we're not using the same technology platforms that they're using. But we are nonetheless viewing this as an opportunity to find lessons learned.
One of the things I've mentioned over and over, some of our most valuable resources are the other states who have already done this, who have gone before and we take every opportunity to -- to learn and adheres on the -- on sort of the other side of that, another opportunity for us to learn our vendor Get Insured has put together a multistate team to really sit down and dig into lessons learned and I will say re-reevaluate [ph] the security measures that are in place to make sure that -- that we are doing everything that we can

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to -- to as they say harden the security controls.
All right. So from status updates and progress, let's move to our timeline. I'll pick just a couple of things to point out. Actually, the first of them is not even on here, but at the end of May we will have one of our first operational readiness reviews with CMS where we will begin the -- the process of demonstrating our operational readiness for -- for going live in the fall.
The -- the one that's on here in early July is significant because that's one of the operational readiness reviews where we'll actually demonstrate the effectiveness of our collaboration and coordination with DMAS and DSS as we demonstrate our ability to do account transfers back and forth. The other thing that jumps out here is our August 4th -- this is a -- what CMS calls the go no go date. This is the point by which CMS is going to make a decision that we've done everything they think is necessary to be ready to go live with our first open enrollment in November.
A couple of other quick observations on the timeline front. You'll see that in some areas, the timeline goes forward and then jumps back a little bit. This is our attempt to show how some of these, a lot of these tasks in fact, are overlapping and you can see

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just how exciting our lives are going to be in the fall as we move into account migration and data testing and opening up the books of business for our agents and brokers with our soft launch of the platform and the call center. And we start our reenrollments all -- all coming pretty quickly together as we prepare for that critical November 1st open enrollment date.
So one of the things that's making all of this work possible for us is our staff. We have come a very long way in who we are and a lot of you have been around the Exchange since the beginning when it really was a -- something like a skeleton crew. We're up to 18, and you can see from the list here the -- the folks that we have brought on since the fall and a list of those that are currently in process. We've still got a ways to go as we move into the summer and next fall, but I will say, I could not have asked for a better set of professionals to work with top to bottom. We are today in my opinion as strong as the Exchange has ever been. One of the things that's really, really exciting to me is that in terms of staffing, we have finally moved from a place where we're trying to figure out how to tackle this challenge of growing a small organization quickly, how to identify where we -- we need resources to the place now where -- and -- and I can't say that, you know, we

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feel fully staffed, because we're not, but we now at least recognize where -- where we need more staff. And our staff and planning our staffing model is in a place that, I mean, even four or five months ago I was kind of scratching my head about. And it's exciting, because we've really, we've tried to, again, take advantage of learning from what other Exchanges have done, but that -- that saying that Exchanges are fond of, if you've seen one Exchange, you've seen one Exchange. Everybody does it differently. And -- and we learned that, yeah, we were going to have to be staffed and structured in a way that was uniquely Virginia. And so that's -- that's where we are and that's where we're going.

All right. Stakeholder engagement. Another little -- what may seem like a minor victory, but has been -- was really exciting for us when we recent ly presented our stakeholder engagement plan to CMS which is far more detailed than what you're seeing here. Their reaction was something along the lines of wow. And our stakeholding engagement plan I think was one of those things that we weren't expecting CMS to ask for it when they asked for it, but it was gratifying for us that we were able to -- to deliver something that exceeded their expectations.

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And I know I've said this before, but stakeholder engagement for me really is one of the most critical functions that we are going to do as an Exchange both now during our transition and in our forever future operational state. In order for Virginia's Exchange to meet our statutory obligations to accomplish things like support the reduction of the number of unenrolled in Virginia. Support continuity of coverage for folks moving from Medicaid to the market from employer based coverage to the individual market and in sort of all directions. All of these activities, they take a community. The overall objective as I see it of -- of our division is to build an Exchange that's by Virginia and for Virginia which again, that's going to require engagement with a broad range of stakeholders.

You can see here that some of our stakeholders get a couple of different blocks showing just the -- the level of engagement that we have going on with folks like our agents and our carriers. What we have listed here in a lot of ways is really the tip of the iceberg, because stakeholder engagement is going to be something that is going to continue to grow. We've of necessity, focused on those stakeholders that we -- we need their participation and input now and they need to be involved

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and engaged as we are going through the development and transition, but that's where you see about our engagement in the community and the more we are looking forward to building that into something that is much more expansive than what we have now. But it is one of those things that we have to tackle with what I will say is deliberate speeds. Sometimes it feels like we are deliberately running at breakneck speed, but wherever possible, we are being deliberate in making our choices about how to expand our resources, how to prioritize, and -- and focusing right now on the things that are most critically necessary, and most useful to accomplish -- this transition.

So I'm going -- I'm going to pause here for a second and actually pass it over to Holly to talk with you about a topic that gets a lot of attention, and that's the continuous coverage unwinding and how we as an Exchange are going to be working to support that continuous coverage unwinding. Holly, you want to take it away?

MS. MORTLOCK: Sure. Thanks, Kevin. As so, good afternoon, everyone. So I am excited to share with you some of the work and planning that the Exchange has been involved in, in regards to the continuous coverage unwinding. The Exchange was really created for a couple

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of reasons, and the first was to support the continuity of coverages Kevin had mentioned. And second, is to reduce the number of uninsured Virginians. And the work that we're doing to fulfill that mission is really just going to be magnified during this period of unwinding. And that's the core of the work that we're going to do now and into the future, so we really see that collaboration and continuity as really the core of what it means, you know, to be the Virginia Exchange.

So when we talk about what we're going to be doing, addressing people that are -- determined ineligible for Medicaid and transitioning them into marketplace coverage. It really is the same work. It's -- it will be about accelerating the pace and the volume and putting that focus on continuity. So prior to 2020, when Virginians became ineligible for Medicaid, they were sent to Healthcare.gov to find coverage. And when they -- when they went there for assistance, they were served by a call center that is also servicing 32 other states at the same time. And so just nationally that data is showing a really dismally low uptick in coverage when a person has to transition from Medicaid to the FFM.

So as an Exchange transitioning to a state-based Exchange, we will have a vast array of tools

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available that will help to change these outcomes. First, we are going to adopt the Federally Facilitated Marketplace unwinding special enrollment period. So we will continue that throughout our transition year without any interruption.

Our strategies for how we are going to specifically impact the unwinding will be substantially increased investments and marketing outreach in education, direct consumer assistance tailored to Virginians and using consumer-level data to inform specific outreach and policy decisions to improve the Exchange's reach of consumers.

So, first we'll start with the first strategy on marketing and outreach. So we do have an unwinding marketing and outreach plan. We have -- it will begin in April of this year and run through July of 2024. And we are applying our research strategies as we have been working with our vendor over the last year -- year and a half to identify and best target individuals based on a wide variety of demographic and geographic information including areas of high concentrations of Medicaid enrollees. And what we learned from our collaborative partners as well. And we will have a messaging framework that's tailored to our six key audience segments that we have also developed with our vendor and

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their research.

So examples of the types of outreach and education that we are able to do while we are in the process of transitioning will be digital marketing and advertising. State-wide radio and streaming audio advertisements, Google search ads, digital display ads, and through our social media posts, Facebook, LinkedIn and Twitter.

We also will have components of direct consumer assistance. So Virginia assisters. They work year round and ongoing, not just during open enrollment. We have 35 navigators and 34 certified application counselor designated organizations, and 1,400 agents, licensed and certified to sell in the Virginia Exchange.

So outside open enrollment, they will be able to inform consumers about the unwinding, their redetermination letters, you know, to be expecting them. Direct them to the appropriate site and assister place for coverage. And focus on -- and they can focus their efforts outside of open enrollment on individuals who are eligible for special enrollment periods, and support them to transition to marketplace coverage.

In terms of outreach, we are working to develop community partnerships to work with our local communities, with hospital systems, health clinics,

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small businesses, other -- other community partners to help us target locations and populations of Medicaid enrollees that are uninsured, underserved and -- and help them to -- incentivize them or help them to want to conduct that outreach and form them of the Exchange and the assister opportunities, and help them -- have them help us identify people that we can support into getting into coverage.

As part of this, we are going to be conducting ongoing assister education in the summer and the fall of this year. We will be providing technical assistance for assisters and agents. We will have assister tool kits available, community partner tool kits, social media tool kits. We are currently conducting and will continue to conduct monthly town hall meetings, and provide answers to frequently asked questions during those meetings, and then list them on our Exchange website.

We also will have consumer information about the unwinding with links to assister programs and appropriate redirects to Healthcare.gov on our existing website. And making sure that people have the appropriate information that they need and just amplify and support our partner messages into getting them to the right assister and to the right place for coverage.

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And in the fall of 2023, we will have a Virginia consumer assistance call center that will be staffed by people that are trained specifically for and entirely focused on the needs of Virginians. It will provide some technical assistance for agents and brokers to support, assist, you know, the assistance of consumers. And will ensure that consumers are getting connected to the appropriate place and obtaining coverage.

And finally, as we are making our transition, and in the fall of 2023, and beginning November 1st, Virginia -- the Virginia Exchange will have account transfer data from all current Healthcare.gov enrollees, and these current enrollees will be auto-renewed unless they choose different coverage.

We will also begin to get Medicaid account transfers starting on November 1st. And so we will begin accepting most account transfers for individuals who were just redetermined and found ineligible for Medicaid as well as new Medicaid applicants that were found ineligible.

Our system will be able to provide automatic notices and prepopulated applications, beginning on November first. And so for account transfers, we'll have the ability to automatically e-mail a person to

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help them get conducted to coverage and provide a partially prepopulated application for them. An individual would then just log in and be able to choose a plan.

Application and enrollment reports. So we will know -- will be able to know when an application has been started, but not completed or when an individual has shopped, but not completed a plan selection. And so we will be able to pull those reports and conduct outreach to consumers at the appropriate place in their application process. So I'm reflecting sort of where they actually are. And then again, people will just need to log in and submit their prepopulated application for eligibility and marketplace coverage.

So that is how the Exchange is planning to provide support and assistance through the unwinding and we are also just very happy to be partnering with our other agency partners and community partners as well. And so now, I just wanted to -- go ahead Sabrina.

MS. CORLETTE: -- question.

MS. MORTLOCK: Yes, please.

MS. CORLETTE: Thank you. It was really great. Exciting to see all the things that you can do once you have a little -- you have the -- have the reins. I just have a timing question just thinking

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about like the marketing and like consumer facing you have to do. Like you're obviously doing digital and other marketing for folks who may face a Medicaid termination directing them to Healthcare.gov, but at some point, you have to start building brand awareness.

MS. MORTLOCK: Yes.

MS. CORLETTE: For whatever --

MS. MORTLOCK: Absolutely.

MS. CORLETTE: -- we're going to call ourselves. So I'm just -- how are you thinking about that timing issue, and like is there like a date at which maybe it's something else and is -- are you, I don't know. How have you thought that piece through?

MS. MORTLOCK: Yeah. So we have been doing a lot of thinking about this, all the time, every -- everyday. These are sort of where we live and breathe these discussions, I know Susan, you know, has been, you know, a huge part of that discussion as well. And Brionna, Brionna Jones our outreach and marketing manager who is here with us today too.

So yes. So this is one of the nuances of transitioning this year. So --

MS. CORLETTE: Lucky Virginia.

MS. MORTLOCK: So what we want to make sure that we are doing, you know, first and foremost is, is

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one, using the opportunities as we have as an Exchange to be able to support individuals and our community partners amplifying their message to help get people to the right place to get coverage for plan year 2023, if that's what they need. And then also to help, you know, continue them in coverage in plan year '24.

So we are working with -- with our Medicaid friends and with our other partners to amplify existing messages. So CMS has put out a lot of information and tool kits and messaging so we are using those to the best of our ability and you know, putting those forward, you know, in terms of just amplifying those messages, making sure that people are not confused about where they need to be going, because our -- you know, we -- again, you know, we see this as our -- our ongoing mission, you know, to make sure that people are getting to the right place and getting coverage. So we're being very mindful of that in all of these -- in all of these strategies that we're using.

The next thing that I will say is that -- is that we will, you know, we are working with CMS very closely on sort of how we are going to roll out that specific brand awareness and start to build that with consumers. So we are in ongoing discussions with them. It will not be earlier this year that we're going to do

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that. And the reason is, because we have this, you know, particular thing, you know, this particular rollout with the -- with the unwinding. We are going to, you know, like I said, we will have information on our existing website, you know, that will not be promoting our brand right away, but we will be establishing those connections with people, you know, and that awareness that the Exchange is here and making sure that they get to the right place.

So again, we recognize that this is part of, you know, what we need to be focusing a lot of our attention on and being very deliberate about, but these are conversations that we are having with CMS, and will be very careful about that. I expect that over the next couple months we will have more information to share with you about what exactly what that will look like. You know, we do have, you know, plans that we're working on, but again, I think we want to be really careful about how we're providing that information to consumers, but just know that that is top of our minds everyday. And we are working very closely with CMS. And so I guess, Kevin, do you have anything that you wanted to add to that?

MR. PATCHETT: Yeah, I'll say a couple of things, and -- and while you mention that, we're working

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closely with CMS, because they have some ideas about how we should and should and can and can't be doing some of this brand rollout and -- and some of the different communication strategies that we've had or that we have. I will say that Holly mentioned earlier the -- the sort of abysmal take-up rates from Medicaid to Exchange coverage in the past. We -- we are determined to do better, and we're confident that we can do better. We've heard a lot from other folks about, you know, the challenges of us adding this extra complexity to our transition, but for us, it's -- it's an extra opportunity, and we wouldn't miss the opportunity to lean in on the unwinding.

I had an opportunity to speak with Alan Monset at CMS recently about the importance of coordination between the federal platform, and our Exchange. The importance of properly timed and coordinated messaging and communication. So it's -- the detail with which we are looking at these states and these strategies is getting heightened scrutiny which makes an interesting process, but it's -- for me, it's increasing my confidence in our readiness and our ability, like I said, to do better than what -- what we've seen in the past.

MR. BIEDRYCKI: Is that workflow -- at this

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point?

MS. MORTLOCK: What specific workflow?

MR. BIEDRYCKI: When an individual in the quote process is tagged as being potentially Medicaid eligible?

MS. MORTLOCK: I'm not sure that I -- that I know exactly what part of the flow process you're referring to.

MR. PATCHETT: Yeah. So let me -- so the interesting thing is the -- the flow really is multidirectional. And one example of that is the, you know, the expanded special enrollment period that CMS has given during the unwinding where it's really almost a continuous year and a half long special enrollment period except that once consumers go to the marketplace and begin shopping for a plan and have submitted that application, they then get a 60-day period to -- to make their -- their final plan selection. So you know, those -- those kind of trigger dates, they -- they are outlined, and the -- the flows for instance, where we have, you know, reenrollment starting in October. We have open enrollment starting in November. We have folks who will be coming off of Medicaid in say, November and looking for retroactive coverage, but they might not have to select until January of 2024. All of

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those things, Lee, yes. We are tracking and outlining and planning for.

MR. BIEDRYCKI: I just like to share that in '19 with the expansion before the public health emergency, when we would go in to do a quote, and Healthcare.gov or the enrollment platform would indicate that the individual or individuals were Medicaid eligible, one of two things happened. The individual's income was then resubmitted at a higher number to avoid all of that or the individual was told that they would be notified about their Medicaid eligibility. And this is where the consumer friction came about in that that consumer then had to wait for a letter from their state's Medicaid office as to whether or not they were eligible or not. And then that letter of ineligibility was the only thing that they could use to reenter into the marketplace and in that timeframe of waiting for letters to be sent and received, you are still dealing with individuals who would have prescription drugs that they need to fill, and doctor visits that they need to see.

So one of the things that was a very avoidable component to the chain of custody, if you will, is that the individual who helps them initially in the Federally Facilitated Marketplace or the enrollment platform was

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never notified whether or not the Medicaid eligibility was effectuated. So there was no way to follow up with that consumer in order to make sure that their coverage was actually effectuated. Now, once we went through the public health emergency, all of that changed; right. But we only had one year-ish of the Exchange and Virginia Medicaid interacting and that first year was very problematic for some individuals. We saw individuals artificially inflate their income to avoid the Medicaid eligibility, because they did not want to deal with the disruption of receiving their medications and their care.

MR. PATCHETT: I think that's one of the benefits we are looking to achieve as part of standing up a Virginia-based Exchange. We ought to be able and again, we are determined to do much better at coordinating with DMAS. We are just across the -- just across Capital Square. So that -- that disconnect that exists and you know, in some ways still exist between the FFM and Virginia Medicaid we're going to close that gap if not eliminate it altogether.

So again, one of the benefits of transitioning to state-based Exchange and a state-based Exchange that's maintaining Virginia as a determination state. So we should have a lot more flexibility and

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capabilities in that regard. Holly.
MS. MORTLOCK: All right. Thank you. Were there any other questions about that?
MR. ROSSITER: For Medicaid managed care companies that are both in the Exchange and Medicaid managed care, are they going to work to keep that enrollment continuous?
MS. MORTLOCK: Yes. So I believe that there are -- I think that sounds like a great segue to our next person who's going to speak with us this afternoon. So I'm going to see if Sarah Hatton is on the phone.
MS. HATTON: I am. Can you hear me Holly?
MS. MORTLOCK: Yes, I can. Thank you, Sarah. Would you like to go ahead and then maybe address Lou's question as you're -- as you're speaking.
MS. HATTON: Sure. I sure can. So we are officially in month one of unwinding here in Virginia where we're all really excited to start down this road and feel like we've done a lot to prepare for what's to come in the next 12 months. On March 18th we ran two very large batches of our renewals for month one. Those were pretty successful, I would say, so it was about 121,000 cases. So that contained about 200,000 members, went through our ex parte process. We did see that about 68.9% of those overall renewed for another year.

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That's a really good success rate for us and shows that a lot of the hard work that the DMAS teams and the DSS teams did to approve our systems have paid off.
Prior to the public health emergency, we saw about 50% of the overall population renew through the ex parte process, so this is -- this is a big improvement for us. So that means that about 36,000 individuals or households, rather were mailed paper renewal packets on Monday, March 20th, so a little over a week ago. And in Virginia, of course, like everywhere else, our first closures won't occur until April which will be April 30th for us.
We have not really seen any uptick right now at our call centers, and I don't believe at the local agencies that I'm hearing, so we know that folks are probably just getting these packets in the mail and aren't actually reacting to those quite yet. We do expect that later this week and into early next week we're going to start seeing those call volumes increase.
Another area that is -- a lot of hard work went into for us Cover Virginia is expanding and opening up a new redetermination call center and processing unit. That's our statewide call center, so that's actually going to go live on April 3rd. This is a temporary operation that we're standing up to help with

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the unwinding process. They're going to be assisting with all of the data entry pieces for our Magi only Medicaid only populations which is about a third of our populations after -- after ex parte runs and then our local agencies will be taking the remaining applicants that are ADD or those who have other benefit programs.
Let's see, so one of the areas where I know there was a question about that outreach and transition, so one of the areas that we focus on a lot that I know we've talked about a little bit here are our outreach plans for our individuals once we entered into the unwinding period. We do have a plan in place that is internal for our fee for service members which those numbers are pretty low, but then also, of course, our health plans have been great partners for us, so each month the individuals who receive a paper renewal packet, all of those individuals will be reached out to by all modalities regardless of whether or not they're fee for service or in managed care to let them know that a packet has been mailed and to remind them to complete their information.
For individuals who do not complete their packets, so they're going to be closing for a procedural reason, those individuals will receive a second round of outreach letting them know that they're going to lose

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their coverage if they don't call in. And of course, we strongly encourage those individuals to complete their renewal packets so they do get that referral over to the marketplace. So that -- that part is important.
And then our Phase 3 outreach plan does include our health plans actually working with the individuals who are losing coverage for a nonprocedural reason, so those individuals, for example who are over income, our health plans will be working with those individuals to help them transition into other coverage. So to answer your question, I think that was Lou that asked that question. Yes, our plans will be performing outreach to those folks and then helping them.
And I think that's all I have. I'm happy to answer any questions or if there's anything I didn't touch on that you're curious about, we should have some -- of course, we'll have a lot -- a lot more data and numbers to report out to everyone the next time we get together.
MS. MORTLOCK: Okay. Well, Sarah, thank you so much. We really appreciate that. And thank you for all your hard work.
MS. CORLETTE: Yes, thank you. Do we have the folks from Pennie on the phone?
MS. MORTLOCK: Yes. David Thomson and Devon

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Trolley, are you with us?
MS. TROLLEY: Yep, we're on.
MS. MORTLOCK: Wonderful. So we'll just take a break from our slide show and pull up your slides. Just bear with us for just a moment.
MS. CORLETTE: Yeah. I'll just take a minute and introduce our Pennsylvania friends. So thank you Devon and David for joining us today. I had invited our colleagues from Pennie to come and present, because I had the opportunity to hear about some innovative things that they're Exchange is doing to try to ease that friction as consumers transition from Medicaid into a marketplace plan and I thought you all were doing such cool stuff, we should hear about it here in Virginia.
So I don't know, Devon or David, did you guys want to take it away? It looks like Holly has your slides up.
MS. TROLLEY: Great, thank you. It's been -- introduction. And yep, we'll just talk through our approach. I thought it might help at the beginning to just -- so for those who don't know, I started with Pennie earlier this month, so about three and a half weeks in, but not new to the Exchanges. I was over Get Covered New Jersey before that, and our early days was at Healthcare.gov. But I thought it might be helpful

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to -- before we get into what we're doing, set some context for what we've seen other Exchanges do and because I think this is a place where state-based Exchanges really can demonstrate the value and through the coordination with -- with Medicaid and CHIP. So you might be familiar that Healthcare.gov, you know, they've struggled with the -- the quality of data that they get from states, and so they're -- when people come over to them, they will basically have to start a new account, start a new application from scratch and kind of go through the whole process to determine that was sort of the -- the most appropriate approach given the variation and data quality that they receive.
A lot of Exchanges including the one I just came from, New Jersey have, you know, I think a little -- a little bit ahead of that where there are sort of welcome letters and some information prepopulated or an account initially created for the consumer sort of trying to take away some of those steps to again, every step you can take away increases the likelihood that someone's going to complete the enrollment process. So I think there's a really concerted effort around that, and you know, we're seeing efforts across state Exchanges to do that.
And what we're going to talk about here is

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that Pennie with the GI -- system was really able to take even one more step further for a lot of people who are coming over from Medicaid and CHIP, and that is to actually take that application information and have the application submitted into the system for the consumers. So when they come over they just have to use their unique account access code. They'll receive a letter with that code and with their eligibility determination that will have their financial health already in there. And then once they come in the system they go basically straight into being able to select a plan. So that cuts out a lot of the steps as some of you who may be familiar with the application, since it is thorough, it also can take a while to get through. So for -- in order -- and of living up to the spirit of single streamlined application and -- we already have all this data from the Medicaid and CHIP agency in areas where that the data is complete and allows us to really kind of skip up ahead that step on the application, and drop people right into picking a plan.
And so this has been in place -- David can correct me what the exact timing is -- but in place for -- I think it went in place last year. And what has been seen so far is that about 75% of people coming from Medicaid and CHIP are able to get to the step where the

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information is complete enough to be able to skip them right to that step of selecting a plan. So we are seeing that it is, you know, the complete enough information for a lot of consumers.
Now, again, the influx from Medicaid and CHIP has been a little bit lower given that it has been the continuous coverage requirements so these are applications that are more going directly to Medicaid and CHIP and then coming over. So, you know, we'll see if that percentage stands as we get into this -- this broader redetermination population, but I think you know, our -- just about the ability to again, reduce as many steps as possible to get consumers into coverage.
Another item we're doing is that we did extend the special enrollment period to 120 days. That is in my mind primarily for people who maybe don't know that they're losing coverage, so it kind of gives them the extra time to realize that -- still have a window to enroll before open enrollment. We do have the system automatically line up and offer a consumer a date to align with their Medicaid coverage, the end date of that Medicaid coverage that we receive on the account transfer, so that there is no gap in coverage. And that's available if the -- they come over in the first 60 days. So we've really been emphasizing to -- in our

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communications to consumers that that first 60-day window is really key.

And I'll just mention in case there's -- we are an assessment state, so we assess -- assess eligibility for Medicaid not determination, so I just wanted to call out that difference in our processes. We are sort of account transfer based.

And then David was going to provide a little bit more detail and exactly what that looks like just so people can kind of wrap their mind around the consumer experience of this, and then we're happy to take questions.

MR. THOMSEN: Sure, thanks Devon. My name is David Thomsen, I'm the director of policy at Pennie. I've been at Pennie for a little over three years now. And while, you know, we've been planning for this for a while, since we've been in existence, you know, we've been under a continuous coverage requirement Covid state for the duration of our existence. So this will -- the redetermination process will be totally new for us as well.

So if you could just click through all of the slides, I think -- yeah. It would probably make more sense, yeah, that's good. Thank you. So what I'm going to do is kind of walk through how this is all going to

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look for the, you know, for the person who is currently on Medicaid or Medical Assistance in Pennsylvania, and how they come over to us. So the first thing is, okay, the -- the Medicaid enrollee responds to the request for -- to renew the Medicaid coverage from our Department of Human Services which is our state Medicaid agency. They submit their information on time and in this instance they're to -- you know, in this situation they're determined as not eligible for Medicaid or CHIP. In that instance, their Medicaid coverage will be terminated and, you know, a Medicaid worker will, you know, will assess that they are likely eligible for QHP with financial assistance. At that point, they get -- this person will get account transferred over to Pennie.

When they do come over because they have already submitted their information to our Medicaid program and that -- and the Medicaid program has already verified their information, that negates anything we have to do on our side to verify their information. So when the account transfer comes over, we get their eligibility application, we can run their eligibility determination from the account transfer file. And then -- and so -- which includes eligibility for QHP and also APTC and cost sharing reductions.

So essentially, the information comes over, it

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gets mapped to the Pennie application. We submit the application on the customer's behalf, and then during the unwinding, we'll also -- we've also created a new special enrollment period specifically for those losing Medicaid or CHIP. So when we get the account transfer file with someone losing Medicaid or CHIP, Medicaid or CHIP that end -- that coverage end date will be programmed for the end of the month in which -- in the month that the individual comes over to us. And that qualifying life event will be selected for the customer already.

When we do that, we then generate a customer notice with all of this information and also contain an account access code for them to claim their new Pennie account. When they claim their new Pennie account, they get right to plan shopping. They can skip the application, the eligibility determination and the qualifying life event and get -- and skip right to plan shopping. They shop for a plan, they pay their binder payment and if they have one, and they're off. So as Devon mentioned, we've had the ability to do an auto-eligibility determination for several months now. It has improved our conversion rate, but you know, important to remember, the Medicaid denial itself is not a qualifying life event, so you know, you still need

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a -- another QLE in order to be eligible for a special enrollment period. With the unwinding, that will no longer be the case, people will be able to have that special enrollment period automatically generated for them and we expect that to improve our conversion rate significantly. So this is kind of how that process works, and some samples of kind of the customer language that they will see.

Next slide. So of course, we kind of have -- we have as an assessment state, we kind of have two populations of focus during the unwinding. The first one is what we just went through which is those who -- who do submit the renewal packet, they are determined as ineligible for Medicaid, they come over to us. That's kind of the happy path scenario. There are, of course, those who do not respond to the renewal request. They don't submit information, and they -- and they're Medicaid coverage -- and they lose their Medicaid coverage.

So in that instance, because we're an assessment state, we're unable to do the eligibility determination. An application is not -- will not be sent to us, but we will be able to -- we are getting information about the household that's lost coverage from our state Medicaid agency in the form of a secure

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file. This will have kind of their household -- their contact information and e-mail address, maybe a phone number hopefully, so that we can conduct outreach to them. We will be, you know, providing information about how to enroll in Pennie, you know, 30 days after they lose their Medicaid and then we'll be able to follow-up with them, but through outreach communications and not financial notices.

So what is the common feature for both populations is that they're both eligible for the loss -- the new loss of Medicaid or CHIP SEP which provides 120 days special enrollment period as well as an opportunity to enroll with an effective date, first of the month after losing coverage within the first 60 days of their special enrollment period. So but that -- but for the procedural determined population, the customer will need to report that SEP.

For the procedurally terminated, if they -- if we assess that they're still Medicaid eligible we will account transfer them back to Medicaid, and then if they're -- and then they can actually pick up their existing Medicaid account, and so that they maintain coverage and don't have that gap. So if someone comes in to us and they're still Medicaid eligible, we want to get them back so that they can get back into their

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Medicaid account as if nothing had ever happened.

MS. CORLETTE: Thank you, David and Devon. So I have two questions. This is Sabrina, one for you all and then one for our Virginia friends, but so you guys, are you able to skip I.D. proofing, because you're getting it -- the person through an account transfer that enables them to skip over the I.D. proofing step?

MR. THOMSEN: Yeah, so -- yeah. Because Medicaid agencies already verified their information, we can skip that.

MS. CORLETTE: Okay. But -- okay. That's not the case with Healthcare.gov though; right? I thought they -- you were basically starting a whole new application including the I.D. proofing. Or maybe I'm wrong on that. Do you know?

MS. TROLLEY: Yeah, that's -- my understanding of Healthcare.gov is that they're starting people all over at the beginning, but they also -- and I mean, I haven't worked there in -- years, but I know there are always challenges, but the type of information received from Medicaid agencies since they're receiving it from so many different states, all that have different processes, so it's very difficult for them to assume something has been done or not done and to vary their system accordingly based on that. So I don't -- I --

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speak for them, but based on my earlier years of experience there, you know, I think -- and from what they've said about their unwinding plans, I -- I imagine that would continue to be a challenge today.

MS. CORLETTE: Yeah. I -- the reason I ask it is I was surprised to see how many people don't even make it through the I.D. proofing step. So the fact that you guys -- that people don't have to do that is -- is really good to hear.

And then my question for the Exchange folks is, the Virginia folks, will you all be getting any files on the procedurally terminated or are you only receiving account transfers for folks who are potentially QHP eligible because of income or household changes?

MR. PATCHETT: So our hope, and you know, these are ongoing coordination and activities with DMAS and DSS, our hope is that we would -- we would get the procedurally terminated folks as well. One of the benefits of Virginia being a determination state is that if -- if those people have kind of fallen off Medicaid's radar, we can pick them up and we can do that Medicaid eligibility determination and if they are in fact eligible, then we can transfer them back to -- to DMAS for enrollment and a Medicaid plan. And if not, if

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they're procedural determination was coincidental with some other, you know, income eligibility issue then we can move straight into helping them shop for plans. So we're -- we're helping to be able to -- to figure out a way to make that work smoothly for -- for the all three parties involved.

MS. CORLETTE: Great. Thank you.

MS. MORTLOCK: Any other questions for Devon or David?

MS. HINOJOSA: I have a question for Pennie. Hi, this is Ikeita Cantu Hinojosa. Could you speak a little bit to your efforts to educate the organizations like community-based organizations and providers, the people who work with individuals on Medicaid just about your overall activities and how that outreach and education is going and what you've done to date, please?

MS. TROLLEY: Sure. So we're -- just sort of -- all darts on the dart board type of -- so all of the sort of existing channels that we have with the Exchange so the agents and brokers and the assisters, the insurers, a lot of the other organizations that we connected with over the past couple of years, you know, leveraging those relationships, but also continuing to look everywhere we can for other channels to communicate the message. So you know, potentially exploring whether

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different provider board, you know, like better certified by the state if we can get in front of them to increase the word or we're also doing a lot of joint sessions with the Department of Human Services so that's it's sort of co -- presenting a united front about how there's options for -- for Pennsylvanians. So they also have a lot of sort of outreach channels that are also getting the same messages, and we sort of cobranded and coordinated a lot of the messaging across the board have been, you know, tried to do legislative outreach so they can get the message out to their constituents, so I think we're really try to hit every front we possibly can. Dave, I don't know if anything else is coming to mind for you besides that, but you know, really try to take a comprehensive approach to it.

MR. THOMSEN: Yeah, and we've -- we've been coordinating closely with our Department of Human Services for about a year on the unwinding, and our preparations, we have a lot of cobranded materials, our communications offices are in constant contact with each other, so we are trying to articulate the same message. We have regular touch points with stakeholders where we review kind of our material -- our outreach materials in our efforts to -- to spread the word. We're engaging our -- our Congressional representatives. We're

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engaging our state legislators and committees of, you know, jurisdiction in order to spread the word there, and we're trying to do as much jointly as we can to present a united front.

MS. CORLETTE: Great. Thank you so much.

MS. BATAILLE: I just have a question for the Virginia folks here at Pennie. I think the connection between the cobranded information for these consumers is really critical and in Virginia even more so just to give them the education that needs to happen. Has that been a part of your conversations?

MS. MORTLOCK: Yes. We have had -- we have been thinking back through in terms of how we might operationalize that and no, we did convene an unwinding group and included some of our friends from Medicaid and Social Services and the carriers. I think those conversations are continuing to happen and we will see how we can best coordinate those efforts. But yes, that is -- that has been on our minds.

MS. BATAILLE: Great.

MS. MORTLOCK: Thank you, Julie.

MS. CORLETTE: Yeah, because did I -- so the notice that David, you were talking about that -- that's cobranded both Pennie and your DHS?

MR. THOMSEN: So our system generated notices,

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just a Pennie notice.

MS. CORLETTE: Okay.

MR. THOMSEN: It's a get insured system notice, but we do -- so but the procedurally terminated will be getting a cobranded letter --

MS. CORLETTE: Okay.

MR. THOMSEN: -- from all the -- from -- from Medicaid, from us, from CHIP, basically saying, hey, if you've lost Medicaid or CHIP, you have other options and kind of tell them to come to Pennie.

MS. CORLETTE: Great.

MS. TROLLEY: And just to add to that. So when someone is -- loses Medicaid or CHIP because they're over income, they're receiving a letter from Medicaid saying we are transferring you to -- to Pennie, the Pennsylvania Exchange, so they sort of have that indicator of what to expect to look for a letter from Pennie, and then we follow up with a Pennie letter. So those are not cobranded because they're both sort of coming directly out of the systems, but I think to the population that didn't respond to Medicaid and didn't update their application, and may be have more confusion maybe about the process of what's going on or sort of who's outreaching that one is cobranded and we thought -- and that's, I think really important to kind

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of establish a connection between the program so that if they did lose coverage maybe without their knowledge or they weren't, you know, realizing that that had happened when it did, they get this message from both entities and they can kind of figure out what option works the best for them. Since it's more of a cold outreach.

MS. CORLETTE: Yeah. Any other questions? Well, David and Devon, thank you. I know you're incredibly busy and we're very grateful to you for sharing what you're doing with us and it makes me certainly very excited about all the possibilities that come with owning our own platform and having the two organizations just across the street from each other. So thank you very much, really appreciate it.

MS. MORTLOCK: Yes, thank you very much.

MS. HINOJOSA: Thank you thank you.

MR. THOMSEN: Thanks for having us.

MS. CORLETTE: Holly or Kevin, anything more from you all?

MS. MORTLOCK: Yes.

MS. CORLETTE: Okay.

MS. MORTLOCK: We were just going to do a quick overview of just some federal state policy updates.

MS. CORLETTE: Great. Okay.

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MS. MORTLOCK: Yeah. Then we'll be -- then I think we'll finish up.

MS. CORLETTE: Yeah. Well, thank you for being so flexible and letting the -- letting the Pennsylvania folks slide in so we didn't have to have them hanging on the line. So yes, please.

MS. MORTLOCK: Absolutely. So just first, we just wanted to acknowledge, you know, that as you all know, sort of the -- on December 12th, CMS released its draft or proposed notice of benefit and payment parameters for plan year 2024. You know, we have reviewed that and continued to review it and see it, you know, as it, you know, offering opportunities to further increase our enrollment and our collaboration of agencies in the service of Exchange consumers. We are looking at it in its entirety and considering how those new requirements and options can support our enrollment efforts.

For this year, we do intend to follow the FFM as closely as possible, so when that -- so when the NBPP is finalized, that is our intention. And we are continuing to review the additional options and as we move forward and we'll certainly keep you updated. I imagine we will have more information to share with you about that particular piece of our update in June.

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MS. CORLETTE: So, okay. So that's really interesting. So if the FFM decides, for example, to limit the number of plans, I think they're talking about two -- two per meta level. That's something Virginia will do that for 2024?

MS. MORTLOCK: For 2024, we will -- we will follow the NBPP.

MS. CORLETTE: Okay.

MS. MORTLOCK: As it's finalized.

MS. CORLETTE: Okay.

MS. MORTLOCK: That's right.

MS. CORLETTE: Okay.

MR. PATCHETT: Yeah and just -- Sabrina, part of our thinking is during the transition, we want to reduce the amount of burden and change and you know, sort of uncertainty for everyone from consumers to plans so we're -- we are going to stay consistent and then for this first year, and then afterwards, we'll be very deliberate and these are the kinds of topics that we will look forward to engaging with our advisory committee friends, you know, as we -- as we make these decisions going forward, but for the sake of continuity and consistency, it makes sense to -- to simplify everyone's lives and not, you know, throw a curveball right in the middle of the -- of the change.

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MS. CORLETTE: Makes a lot of sense.

MS. MORTLOCK: Okay. And I'll just mention a few other things. So a few other issues that certainly touch the Exchange. So this year, the Virginia General Assembly decided to develop a process for which Virginia would select its essential health benefits benchmark plan. So I think there may be a number of states that were also in this somewhat of a predicament in that we did not have -- Virginia did not have a specific process in terms of who was going to select the benchmark plan. And so -- so as, you know, policy decisions were made by the General Assembly in terms of, you know, what they're -- what they would like to see covered in these plans, either, you know, a few mandates passed, so they decided to kind of take the bull by the horns this year and really lay out that process for what it was going to look like here in Virginia. And basically, what it -- what it does is the bill sets out a five-year cycle and review process, and that's so that we can better reflect the policy decisions of the General Assembly, you know, such as state mandates that they pass from time to time. The two mandates that have -- that they have approved going forward have to do with covering -- nutrition and prosthetic devices, and so this places the authority of the General Assembly to actually select the benchmark

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plan with the incidence of the Bureau of Insurance, you know, who are directed to convene a work group, conduct actuarial analysis and make recommendations to ultimately have the General Assembly consider those recommendations and make a -- and make a -- introduce legislation that will again, direct the Bureau to make the selection based on all of the input and the actuarial analysis and recommendations that they have given them.

So that's roughly what it will look like in Virginia. And they did direct the Bureau to select a new benchmark plan for 2025 to include those two particular mandates that have -- that have been passed.

MS. CORLETTE: And so it's the Bureau that has to do the actuarial analysis to determine how much of a defrayal --

MS. MORTLOCK: Yes. That's right.

MS. CORLETTE: Okay.

MS. MORTLOCK: That's right. So they will -- they will do that. There will be work group input as required by the statute. They will make recommendations too. There's an interim commission called the Health Insurance Health Commission in Virginia, so they really vets all of these mandates and the actuarial analysis, and they will ultimately make a recommendations to the

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General Assembly in the form of a bill, and then the General Assembly will hear that bill and, you know, make they're judgments to it as they see fit, and then come back. Their bill will ultimately direct the Bureau to select a plan based on the criteria that they've put forth in the bill. So it is a really robust -- really is a robust plan. But -- but that is how -- that is how Virginia has decided to do it. It is a very -- it's a -- includes a lot of -- a lot of stakeholder and players in the process and that is a -- so that's how we will do it moving forward. So it -- I think we're fortunate that we have now a process -- a clear process in place to be able to --

MS. CORLETTE: But for plan year 2025, you'll need to have it submitted by like May 7th of this year?

MS. MORTLOCK: That's right. Yes. And the Bureau -- so the Bureau is convening there. They are -- they are working through that process now.

MS. HINOJOSA: Now how similar or different is this Virginia process to other Exchange processes?

MS. MORTLOCK: You know actually, I don't -- I don't know for sure. I did here from -- I think in some states it's a little clearer, you know, that they -- you know that the governor can select the plan. In some states, it's you know a secretary level --

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MS. CORLETTE: If you've seen one state, you've seen one state.

MS. MORTLOCK: That's right. That's right. And I have just moved from -- I was just on a call and had heard that Minnesota, that they also do not have a particular -- or you know, process in place, and they were asking what Virginia was doing. So we, you know, shared, you know, the legislation that passed with them. So anyway, so yes, you've seen one state, you've seen one state. But I guess we're fortunate that we're learning from one another, so. Yes. So that's the EHB, the benchmark plan and bill.

This year the General Assembly also passed a bill that would eliminate the authority of carriers to -- to provide a tobacco surcharge for tobacco users. So under current law, a carrier can vary its premium rates based on tobacco use by up to one and a half times higher than for nontobacco users. And consumers are not able to use their premium tax credits to pay or to put towards the tobacco surcharge. So this -- this bill does eliminate the authority of carriers to do that in Virginia. And it does direct the SCC to provide a report on how that is impacting enrollment and marketplace rates. And the bill does have a sunset clause for January of 2026. So we will -- we are

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keeping our -- I imagine we will be involved in some of those discussions, and we'll keep our eyes on that.

And then finally, I'll just touch briefly on reinsurance. I know we've talked about that in committee before. So this year was our first year implementing our reinsurance. It is a program that is administered by the Bureau of Insurance. They have developed the -- the plan and the program. But you may know that our waiver was approved in 2022 for a period of five years. Our -- under statute we can request a target premium reduction of up to 20%. I think this -- in this first year, we targeted a 15% decrease, but in the actual rate reductions I think it's somewhere around 17, 17 and a half percent, and the -- so you're going -- plan year '24 will be our second year and the Bureau is expected to announce the reinsurance parameters on May 1st. So they have their ACA teleconference today, and let carriers know that. So that is required by statute. So they will be providing that shortly. And so we will just be watching to see sort of how that -- how that turns out.

So that is basically kind of a light load on the -- on the state side, but I think we have plenty to do with our transition, so our -- moving forward with that.

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MS. CORLETTE: Grateful for a relatively quiet legislative session.

MS. MORTLOCK: Yes.

MS. CORLETTE: I -- do we have somebody from the Bureau on the phone?

MS. MORTLOCK: Mary Ashby.

MS. CORLETTE: Oh, Mary.

MS. MORTLOCK: Mary, are you still there?

MS. ASHBY BROWN: Hi.

MS. CORLETTE: Actually, maybe this is a question for Lee.

MS. ASHBY BROWN: Yes, I'm here.

UNIDENTIFIED SPEAKER: You're right next to her.

MS. CORLETTE: Yeah, but I'm also curious what the Bureau thinks about this. So one concern that I've had is that QHP carriers have often paid higher commissions for open enrollments, and lower commissions outside or none for enrollments outside of the open enrollment season. I'm curious of what carriers are telling you for the unwinding because I -- I've been hearing some -- some states' interest in making sure that at least through the unwinding the commissions are reasonable enough so that brokers are incentivized to help people.

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MR. BIEDRYCKI: Well, the Commissions have stabilized, but reasonable, I guess is a somewhat ambiguous question.

MS. CORLETTE: Well, I just mean not nothing.

MR. BIEDRYCKI: To ease the burden.

MS. CORLETTE: Or enough so that it's worth your time to sit down with somebody and help them through the process.

MR. BIEDRYCKI: So to quote the largest insurance agency in Virginia, you don't do Exchange enrollments for profit. You do it for community service. And the per employee per month commission is one thing, but the churn rate especially relative for those who have premium for nonpayment, and for those who have a medical procedure in the early part of the year ends up meaning that the number of hours that you're investing in the conversation, it's almost impossible to recoup that, because there's not a stability with that product. And that is the main reason that out of the 1,400 agents that take the test every year, a fraction of those actually participate.

This is my tenth open enrollment. And it's kind of funny, because there's something different every year. Whether it is a particular physician group, whether it's a particular hospital group,

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geo-demographics, but the most common thing that we dealt with and heard this year was confusion on why there was a 17% premium reduction, yet many of our customers with the exact same income as they had the prior year ended up incurring 100- to $150 or more increase in their net --

MS. CORLETTE: Yeah.

MR. BIEDRYCKI: -- out of pocket premium. And one of the things that gets very concerning for our organization and others is that when you have a product that operates on micro networks where aligning the individual with their physician and their hospital group is the most important part of the conversation, but the only thing they want to talk about is try and understand why they're paying more when they thought they were going to be paying less. And the suspicion that comes from that quite frankly, a number of the calls got elevated to me, because they thought that some of our employees had to be wrong or we're making a mistake or keyed the data in inaccurately. But I submit to you not even considering the conversation about integrations, the compensation on its face relative to the exposure, the time it takes and the turn rate means that many of the agents and agencies who do participate in the space do so to support a primary market, i.e. group, wealth

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management, property and casualty.

MS. CORLETTE: So you're saying that even if you were to try to make, accept enrollment commissions equitable to -- open enrollment commissions, they're still not -- still not covering your costs.

MR. BIEDRYCKI: And then you have to remember that with two weeks notice, in '16, the entire industry was told you will not be paid. And with the average age of health and life insurance agents in Virginia, they're not quick to forgive or forget, and there are some pretty complex historical moments that bring us to this points where the agents who do participant enthusiastically have found a way to do so through efficiencies, in order to make sure that wasn't a total case of loss revenue.

MS. MORTLOCK: Okay. I'm sorry, can I just jump in? I just wanted to say, I know there are some people on the phone -- on the line that have their hands raised.

MS. CORLETTE: Oh, okay.

MS. MORTLOCK: So I just wanted to invite people to jump in the conversation when they're -- when they're ready. So I just wanted to invite everyone to do that. Do you want to go ahead? Yeah. Doug, I know that Doug may have his hand raised.

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MR. GRAY: I can wait.

MS. ASHBY BROWN: Mary Ashby Brown. I -- Sabrina, I will take your question back to the Bureau. I actually am here -- I work at the Office of General Counsel and so I am not -- the subject matter on that particular question, but I will take it back to the Bureau and -- and give you our perspective.

I also just wanted to quickly chime in and let everyone know related to what you were saying, Holly, about the -- the updated EHB benchmark plan that the -- that has been posted -- the new plan has been posted to the SCC website on the Essential Health Benefit Benchmark Plan page which is the subset of the ACA page. And we are accepting public comments on that EHB benchmark plan through April 12th and the application is due to CMS on May 3rd. Thanks.

MS. MORTLOCK: Thank you for that update Mary Ashby.

MR. BIEDRYCKI: Just to put a bow on that. One carrier I know of is offering a trip, which I have not seen in this business for 14 years. It used to be commonplace, now not so much. There are some other carriers incentivizing enrollment, but thought to the level that you see on let's say a Medicare supplement or a Medicare Advantage product which is also one of the

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social products that are primary focused for those --
MS. CORLETTE: When you look at the profit margins on Medicare Advantage and that might explain why, but anyway. I digress.
MR. BIEDRYCKI: Well, I digress there with you.
MS. MORTLOCK: I think we can -- raised hands.
MS. CORLETTE: Yeah. Are there other folks on the line that would like to chime in?
MR. GRAY: Yeah. This is Doug. Sorry I didn't make it there in person. I intended to, but got caught up. The -- I -- I did check with the plans on the question of paying commissions during the special enrollment period and they've all moved to restore them to some extent. I would remind you that the reason they stopped paying them was because there was rampant abuse of the special enrollment period. And there was a refusal by HHS to do anything about it. After a while, they did come to a meeting of the minds and tighten up some of the requirements, but the practical reality is that a commission is paid for bringing something of value.
At the time, agents were bringing folks who had refused to enroll, gotten sick, and then wanted to enroll. And so that is fundamentally in contradiction

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to the basic principle of the ACA. So that's why commissions stop being paid. They are restored in this case, because everybody is on the same page. We're trying to keep people enrolled, trying to keep their -- their continuity in the right direction. And so that's why we're at the situation that we're at now. Everyone is interested in trying to keep people enrolled.
MR. BIEDRYCKI: I'd just like to counter the good gentleman from across the street to say that agents were facilitating enrollments from consumers who contacted them in accordance with the special enrollment period guidelines then controlled by Healthcare.gov. And that we may have been unintentional fire in that situation, but --
MR. GRAY: I agree with you.
MR. BIEDRYCKI: Okay.
MR. GRAY: I wasn't intending to say that you were abusing it. The -- this was a policy disagreement that HHS was slow to move on.
MS. CORLETTE: Anybody else with their hands up? Okay.
MS. MORTLOCK: Okay. So I am now going to pass the baton back to Kevin. Kevin, are you ready?
MR. PATCHETT: I am.
MS. MORTLOCK: Okay.

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MS. CORLETTE: Drums.
MR. PATCHETT: So this is -- this is actually a little nerve-racking, because we're, you know we're -- we're finally ready to show our brand name and our logo and one thing I said at the beginning as we were working through this that, you know, brand names, and logos is one of those things you ask ten people and you get 15 different opinions and wow, did that ever prove to be the case. So we really tried to focus on what did our research tell us? What did our consumer focus groups say about was meaningful and what was memorable? And so you know, here you go without further adieu.
So we went -- we didn't go with a creative or fanciful name. We wanted it to be descriptive. We wanted it to give consumers an idea of what we're doing. We chose the -- the dogwood flower for the logo to reinforce the connection that this is -- this is Virginia's insurance marketplace. Again, by Virginia, for Virginia, and unique to Virginia.
We got input from lots and lots of different sources, and have a number of approval processes that we had to follow. So this is where we are going and we're -- we're excited to be at this stage now that we -- we actually have a name that we can start sharing that's -- that's meaningful. And you know, we're -- we're happy

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to hear thoughts and feedback.
MS. CORLETTE: But not too much feedback.
MR. PATCHETT: But there's nothing we can do about it, so --
MS. HINOJOSA: I just have -- will you accept questions? Just in terms of your -- your process?
MR. PATCHETT: Of course.
MS. HINOJOSA: At this point?
MR. PATCHETT: Of course.
MS. HINOJOSA: Yeah. First of all, thank you for sharing, because we're all with bated breath. So you're -- the colors, blue is obviously associated with -- with health and health care. So it's -- it's interesting that you chose blue. But I was just curious about the choice of blue and if there were other reasons besides health care blue that you chose the -- the kind of dark blue and then, you know, transitioning to kind of a lighting blue as you go around that.
MR. PATCHETT: Yeah. So one of the things that we did want to do is make sure that there was some connection between Virginia's insurance marketplace and the SCC where it lives. So some of what you see in the color scheme is an effort to -- to bring all of those pieces together, healthcare blue, the color scheme that the SCC uses, a gradient that is both attractive without

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taking away from the legibility or readability. We wanted it to be -- we wanted a color scheme that was more calming than loud. So this was -- this was our work with our -- our marketing vendor, Ryan Gold who I have to give props and kudos to them, because the number of versions that we sent back to them was -- yeah. We went round after round after round before we were satisfied.

MS. HINOJOSA: And then just also curious that the word health isn't in there in terms of Virginia's health insurance marketplace, and you know, usually, you know, there's a tie in to like D.C. Health Link or Healthcare.gov. You know, we see health mentioned a lot and so this says insurance, but doesn't amplify that people come here for health insurance. And so just in terms of confusion, I just -- that I'm curious about that -- that piece.

MR. PATCHETT: Yeah. So another really difficult decision, and you've seen, as you mentioned a lot the -- a lot of the state marketplaces followed Healthcare.gov in focusing on the word health. Virginia's health insurance marketplace, we thought was just too long as to the -- our marketing vendor, and in fact we -- even with Virginia's insurance marketplace, we're running into character limitations in certain

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settings, so -- so we had to pick, and some of that comes from the research we did with our consumer focus groups, and some of it on really just a decision about where -- where we put our marketing emphasis. So for instance, Healthcare.gov, when you look at it on its face, it doesn't say anything about insurance. So is this a place where you go to find providers. So you -- you're always going to have a question to answer. Of course, you look at Pennie, and it doesn't say anything about -- which like which Starbucks doesn't say anything about coffee. And Food Lion doesn't say anything about groceries. So there is a -- there is an education component and we realized along the way that whatever our brand is, it's going to be what we make of it. So we recognize that we've got a lot of work to do in terms of consumer education, and for better or for worse, like I said, based on some of the things that our -- our consumer surveys pulled back, we decided insurance marketplace was more valuable in the name and then the health component we will deal with in taglines and in our -- our marketing outreach efforts.

MS. HINOJOSA: That was going to be my next question. Is there a tagline? I'm done with the questions.

MS. MORTLOCK: Well, and I'll just --

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MR. PATCHETT: So the --

MS. MORTLOCK: -- to add to that. So we also have done a lot of thinking in looking into taglines and sort of the different opportunities that we will have with those and have been looking into so how other states have creatively used them and absolutely see that is a big opportunity to help really refine and name our brand, so just -- let you know that's still part of the process, and want to come on that.

MR. PATCHETT: Yeah. So -- so we've got a number of taglines and one of the conversations -- Holly's point we're having is, we're not convinced that there has to be one tagline to rule them all, that there may be circumstances where we want to use different taglines with different consumer groups. It, you know, it was one of the interesting things for me that came out of the Hix [ph] conference this last year was research -- I think at DePaul University, around different ways to message to different consumer groups and how differently those consumer groups react to different messages. So on our -- on our long list of to do's is the tagline, but we -- we should have more to come on that, hopefully, well, certainly, by our next meeting.

MR. ROSSITER: Yeah, this is Lou Rossiter, I

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wanted to ask what happened to the other half of the dogwood flower?

UNIDENTIFIED SPEAKER: It's -- tagline.

MR. PATCHETT: I lost that. I lost that -- I was -- I was a big advocate of the whole flower, but I -- I lost that battle, so I think for --

MR. ROSSITER: The nice thing is you'll be able to put the Medicaid cardinal on your --

MS. CORLETTE: On the flower.

MR. PATCHETT: Now, I can't -- I can't promise this, but I think you can expect to see the emergence of the other half of the flower when we create things like our icon that goes in the upper left side of the -- of the web browser address bar. We're -- we're contemplating something like the whole dogwood flower with -- so -- so you may see -- you may see the whole flower --

MS. BATAILLE: I just want to say I did have those questions, but I appreciate the amount of work that went into this, and thank you for sharing this. I think there is a lot that will be really helpful about this, the fact that you have Virginia in the name, the fact that you have something that represents the state, the fact that you're using marketplace which has been research tested for years, I think is going to be really

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important as you're launching this just to establish the official nature of this entity and give it the credibility that's going to be necessary with so much consumer confusion especially given the unwinding. I fully appreciate the questions, and I think the other thing just to consider in terms of taglines to your point about not necessarily having one is that I think there's an opportunity to consider those in the context of different campaigns themselves, and would suggest that that be something that is thought about.

MS. CORLETTE: Yeah. Absolutely. That is something that we are thinking through and working on. -- health is a big topic with us in terms of using -- how to -- how to incorporate that into a tagline. We are -- we have been looking at that. We have, you know, options. I think we're still deciding yet on what exactly those will look like, but again, I think as Kevin mentioned, we will have much more to share with you in the coming months and we'll certainly do so and -- and hope that that will just, you know, further underscore so the -- the mission of the marketplace and what it does.

Also, you know, we did hear a lot that the marketplace has been research tested in terms of its association with health coverage. So there's another

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factor in our -- in our decision.

MS. BATAILLE: Yeah. I will also just say insurance is a word more and more that is much more universally understood across multiple languages than words like coverage in particular. So if you have to pick and choose, that's useful to know.

UNIDENTIFIED SPEAKER: Those three words are very clear. Yeah.

MR. ROSSITER: I'll commend Kevin on his preparation. He was ready for all those questions. Because no matter what you do you're going to get criticized, and you know it. I mean, that's just part of the process. You do the best you can with what you've got, and I think you've, you know, focused on what matters. And that's the most important thing.

MR. BIEDRYCKI: I just would wonder how it will impact search engine optimization, because there are 15 agencies with Virginian insurance in the first two words. Is that something that you'll have --

MS. MORTLOCK: Yeah, that's all part of our -- our marketing vendor's process, you know, when they look through -- think they look at -- they look at SEO scores. This did come out with a favorable SEO score, you know, it was absolutely something that we took a look at when they finalized that decision. And this --

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this really was a strong recommendation of theirs, so -- so definitely --

MR. PATCHETT: And --

MS. MORTLOCK: Go ahead.

MR. PATCHETT: No. I was going to say and part of that is -- part of that is our use of Marketplace.Virginia.gov as our domain. Making sure, so you know, some other Exchanges have gone the route of using .coms. In Virginia, our initial consumer research indicated a favorable response to the -- the connection to government, so we are leveraging that. We're leveraging the search engine optimization that already exists for Virginia.gov and so we're -- we're confident that the pairing is -- is going to work well for us.

MS. MORTLOCK: Any other questions about the logo. Congratulations, guys.

MS. HINOJOSA: Yeah, congratulations.

MS. CORLETTE: Yeah. Very, very exciting. It feels real. Anybody's hands up or --

MS. MORTLOCK: I'll just invite anyone else that's on the -- that's with us virtually, if you'd like to say anything else or ask any questions before we move onto our subcommittee report.

MS. CORLETTE: Okay. I guess everybody loves the logo. All right. Ikeita. You want to take it

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away.

MS. HINOJOSA: Okay. I'm up. Yes. All right. So as mentioned in our last meeting, we've reprised the Strategic Priority Subcommittee. We're very excited about that. And just by way of reminder, the mission of the Strategic Priority Subcommittee is members of the subcommittee will identify a set of critical outcomes that would help demonstrate to Virginians the value of our transition to a state-run Exchange. The subcommittee will further recommend the metrics and data needed to monitor and assess the Exchange's performance on those critical outcomes.

So the members of the Strategic Priority Subcommittee, it's comprised of six members. And those six members are Julie Bataille, Doug Gray, Starla Kiser, Lou Rossiter, Scott White, and me. And I serve as chair of the subcommittee.

So I just want to take a moment to extend my sincere gratitude for the subcommittee's members' willingness to serve. We are very, very fortunate to have their expertise and their experience. It's a really, really great group. And as a starting point for our work, our subcommittee revisited the slide deck titled, Thinking Ahead, the Importance of Exchange Monitoring. And that was presented to the Advisory

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Committee back in June of 2022. And that deck was by the State Health Access Data Assistance Center or SHADAC. And thanks to Professor Lou Rossiter, our subcommittee has secured the research assistance talents of Hannah Garfinkel. So Hannah attends William and Mary. She's a second-year master and public policy student interested in health and after graduation, Hannah will work for the Joint Legislative Audit and Review Commission or JALARC.

So Hannah's initial project was to research the current landscape of strategic priorities utilized by other state-based marketplaces as well as the Federally Facilitated Marketplace to help the subcommittee glean best practices and lessons learned for Virginia. So she presented her findings to our subcommittee during our kickoff meeting on March 22nd. And during the meeting we had a vibrant discussion and came to a consensus on several items regarding our next steps. And among them was to focus on securing the starting point of reference for the metrics of where we are now in Virginia. As represented by the Federally Facilitated Marketplace. And the deliverables were required through our Get Insured vendor. Now, once we've established a baseline for Virginia, we can measure what we accomplish in Virginia in the first

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three to five years of our state-based marketplace against the FFM baseline and the services Virginians received as part of Healthcare.gov.

While it's interesting to learn about other state-based marketplaces, at this early phase, it's not an apples to apples comparison to compare, yet to launch Exchange to more mature Exchanges that have been in existence since marketplace launch. So right now, what we want to do is make sure that we remain focused on the needs of Virginia and Virginians with particular attention to service areas and the geographic diversity of our state and then once we have a strong sense of our needs, we can incorporate the best practices and lessons learned from other states.

So we're setting up our next subcommittee meeting for April. And we look forward to engaging in a thorough process of data collection and knowledge sharing. And we'll provide additional updates as our subcommittee continues to meet, and we'll flush out recommendations for strategic priorities as we move forward.

So that is our brief update for now. Our subcommittee members are all here, I believe. So if anybody wants to add on to that, I'll open the floor to the rest of our subcommittee members. Okay.

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MS. MORTLOCK: Yes. Very --

MR. GRAY: This is Doug. I just wanted to share that I thought that we had a really good conversation about how to measure, and I really think it's a great resource to have the assistance of a graduate student who's assumed to end up at JALARC. She did a good job of getting us started and looking at what's happening in other places, and thank you to Lou for helping out.

MS. HINOJOSA: Yes.

MS. CORLETTE: Yeah. Well, thank you. Sounds like you guys are off to a great start.

MS. HINOJOSA: Yeah.

MS. CORLETTE: I'm just curious, how -- how do we go about identifying the sources of the data that we might need? Once you identify the, like targets, I mean, I think there's often things that you want to be able to measure, but you can't because the data is not great or -- so it's not something that you guys are thinking about -- we -- how like somebody -- sort of done an environmental scan of -- of that. Or is that something your student could do?

MS. HINOJOSA: Yeah, that's exactly what Hannah is --

MS. CORLETTE: Going -- okay.

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MS. HINOJOSA: -- working on, yeah.

MS. CORLETTE: Okay.

MS. HINOJOSA: Yeah. Absolutely.

MS. CORLETTE: Oh, that's great.

MR. ROSSITER: Kevin, maybe you can comment on this. What -- you understand CMS has 189 measures that they already collect.

UNIDENTIFIED SPEAKER: That you're required to report.

MS. MORTLOCK: They are required to report.

MS. HINOJOSA: Right. Yeah.

MR. PATCHETT: Yeah.

MR. ROSSITER: The --

MR. PATCHETT: Yeah. And this is, you know, this is one of the -- this is one of our opportunities and -- our staffing plan, what we are -- we're going to be building an internal data analytics team because we recognize the -- the need and the value for data, and this is an area where -- and honestly I don't know what I don't know, but I do think there are opportunities where we can contribute to improving the quality of data that the -- some of the challenges with available data out there has to do in large part with what's being directed, who's collecting it, how much attention they're paying to it. So it's some -- where I hope we

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can as an Exchange find some synergies and some improvements and some of that is going to tie back to our relationship and collaboration with -- with DMAS and DSS and our other stakeholder. But I think -- I don't know if you all have seen the -- the list from our contracted required reports --

MS. HINOJOSA: Yes.

MR. PATCHETT: That Get Insured has to be able to --

MS. HINOJOSA: That's part of what we're going through.

MR. PATCHETT: Yeah. We're -- we're well on our way.

MS. CORLETTE: Well, it's great that the thinking is happening now as opposed to trying to retrofit it in later. So kudos to the subcommittee for getting this work going.

MS. HINOJOSA: Thank you. We'll keep you posted.

MS. CORLETTE: Any questions for Ikeita or subcommittee members? All right. I think next on our agenda is other business. Is that right?

MS. MORTLOCK: That's right.

MS. CORLETTE: So first of all, if there are other topics that folks would like to raise --

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MR. BIEDRYCKI: Yes, ma'am.

MS. CORLETTE: Yes. Okay. Lee.

MR. BIEDRYCKI: So this -- forgive me, all of you -- was my first advisory committee posting, I guess if you will, and I don't know if I have understood the function and role that it was supposed to be throughout nearly two and a half years, I guess that's where we are now.

In my organization we have a book called Radical Candor which my employees hate every time I pull it up.

MS. HINOJOSA: I like that book.

MR. BIEDRYCKI: It's got a big orange cover, but it is important for organizations and teams and relationships to be able to communicate. And if you can't communicate clearly, no matter what it is, then you're not going to get anywhere.

From the very beginning on this committee, I had enjoyed a great deal of excitement. As I mentioned, this was my tenth open enrollment this past year. The first open enrollment, we were on an enrollment before Healthcare.gov even opened up. And that Exchange cost a mere 1.25 million dollars.

One of the things that I struggle with is that one of our first meetings a now retired committee member

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mentioned that there were members of the committee that had built Exchanges and that might be able to help with RFP in the procurement process. Especially relative to what things could and should cost. As I looked through the earliest four years of the exchange, I mean, there were just a lot of ugly potholes in the road that could've 100% been avoided, but everybody was trying to figure it out; right. So whenever you're doing something new for the first time, there's things you thought of that you caught, things you didn't think of that you didn't catch, and then the surprises that come along the way. And as leaders, it is our role to try and mitigate the impact of all of those things to the greatest extent possible. And for me, data, best practices and experience are the only things that really exist. And you have to combine the three, because the data as we just discussed is not always, is forthright as one would assume.

For two years, I spoke to this committee, served on subcommittees, and spoke in favor of integrations for the tools that agents use. And I've gone back and pulled the minutes from each of the advisory committee meetings to make sure that I wasn't crazy. And I -- I feel very frustrated that the conversation relative to integrations was never

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reciprocated or engaged prior to the RFP being released. Because getting back to the data, there are all kinds of misrepresentations floating through the health marketplace in general. And all too often, individuals can find themselves unknowingly repeating bad data that they thought was good.

So one example of that is we've heard frequently that state-based Exchanges that have stood up in a closed marketplace model have enjoyed greater broker participation and greater enrollments that know the FFM. And that is true when you consider that that data originated during the Trump administration when the advertising for Healthcare.gov was completely gutted. So one of the things that I think is a positive, and I don't want this to all be negative, is that by Virginia standing up its own Exchange, the citizens of the Commonwealth will no longer have to ebb and flow with awareness about health insurance depending on which party sits in the White House; right. The FCC largely recognizes an independent organization of great integrity should be able to make sure that the messaging to the consumer each and every year is the same and instead of some years it's all over Facebook, Instagram and the news, and some years, you don't hear anything.

With that said, the enrollment data for this

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last year was released in two segments, Healthcare.gov released -- segment data. And then the states released theirs later. Those that offer state-based Exchanges. And in case any of you don't have that data, it shows that the Federally Facilitated Marketplace last year enjoyed a 13% growth in enrollment. And the state-based Exchanges incurred a net 3% loss in enrollment over the prior year.

The thing that I think is important to contemplate is that 71% of enrollments based on the data from Healthcare.gov came through agents. 44% of agents use an enrollment platform. They use that platform because I had mentioned earlier, this is a very lean line of their business. Not only is a very lean line of business, but there's a great deal of exposure relative to errs and omissions. It is a very uninformed population, not always, but in general. And most importantly, the open enrollment for the individual marketplace sits right on top of the group, the federal SEP and Medicare. Leaving not a lot of time for this market segment to be addressed and as we've somewhat discussed, it is the least in compensation to the individuals who afford the enrollment.

I don't know how to say any other way than I do not understand how we believe that we can extract all

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of the enrollments that were formerly provided by the insurance carriers who are marketing in the Commonwealth on top of the enrollments by the large producing agencies that use tools of efficiency that direct quote they have to have in order to participate in the space. And expect that Virginia will be able to maintain or grow its enrollment, because that laughs in the very face of a traditional supply and demand business conversation.

I don't say this out of spite or adversity, I've actually enjoyed my conversations with Kevin and Holly. This is the first time I've ever disagreed with people and not gotten mad, which is odd for me. But when I sit on the phone with individuals who can't understand why their health insurance premium went up when their rates were supposed to go down, that is a problematic conversation. And whether Virginia should open or operate a closed marketplace or an open marketplace, I think is a decision that should've been made formerly, a little bit earlier down the path so that employees of the SCC and the VHBE wouldn't be in a position to be responsible for big fluctuations and enrollments and rates.

I'm happy to participate. I'm happy to help, but as an individual who has done this for ten years, I

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don't know how we're able to expect rate stability, stability with carrier participation when we have dramatically restricted the number of enrollment sources that exist and the capacity of those who remain to process enrollments.

MS. CORLETTE: Lee, thank you. I know you have -- you've raised these issues at a number of our -- our meetings, and I -- I appreciate the -- the work that you've done to bring this data to the table and the conversations that you've had -- Exchange staff and with all of us. I, you know, I don't want to speak for Holly and Kevin, but I'm not sure -- I mean, I understand that the -- the outside enrollment platforms are maybe not in the cards for this launch, but it's -- it's my understanding you have not have slammed the door shut on that for future years; is that correct?

MS. MORTLOCK: Yes, that's right. So --

MR. PATCHETT: Yeah.

MS. MORTLOCK: Go ahead, Kevin, if you want to speak to that.

MR. PATCHETT: Oh, no. Yeah no, that -- that's absolutely correct. And you know, and we've -- I can't speak to the processes of the committee over the entire four-year life with the Exchange, but I do feel that we as an Exchange at least as long as I've been

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here really work to engage on this issue, and I just in -- in part one of the things we've to consider and one of the things I think this -- this committee should consider is how do we reconcile some of this data, because there's a lot going on in the numbers that -- that Lee has referenced, you know, you -- we shouldn't expect to see growth in numbers of state-based Exchanges in states that have made it blow 3% of the total unenrolled population, right. You're just not going to see that. So where -- and this is one of the things that state-based Exchanges have done a better job of, is closing that gap. And we also see a connection between Medicaid expansion and the growth of states. But even there, none of that data is consistent. So we are, as an Exchange, we -- we continue to be open to the idea of -- of integrating with -- with other platforms and, you know, the more data, the more -- you know, and the more this committee can do to help, we absolutely welcome that.

MS. CORLETTE: Well, we are at time. And I -- I want to make sure if we do have public comments -- or do we have anybody on the line who wants to make public comments?

MS. MORTLOCK: No. Actually, there was no one that signed up to make public comments.

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MS. CORLETTE: Okay. All right. Great. Anybody else want to ask Lee a question or raise any other business? Okay. I think we did it in our two-hour timeframe.

MS. MORTLOCK: We did.

MS. CORLETTE: I will make -- seek a motion to adjourn.

MS. BATAILLE: So motioned.

MR. ROSSITER: So motioned, second.

MS. CORLETTE: Okay. We're -- we're adjourned. Thank you all very much.

MS. MORTLOCK: And thank you for everyone who joined us virtually, and hopefully we will continue to improve our virtual capability processes. But thank you for bearing with us and we're just glad you could join us.

MS. CORLETTE: All right. Thank you. We did it.

(Off the record at 4:02 p.m.)

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I, Daniel A. Terry, the officer before whom the foregoing deposition was taken, do hereby certify that said proceedings were electronically recorded by me; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set My hand and affixed my notarial seal this 28th day of March, 2023.

Notary Registration No.: 7748549
My Commission Expires: 2/28/2025

Daniel A. Terry, Notary Public
for the Commonwealth of Virginia

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I, Janine Thomas, do hereby certify that the foregoing transcript is a true and correct record of the recorded proceedings; that said proceedings were transcribed to the best of my ability from the audio recording and supporting information; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

Janine Thomas
April 2, 2023