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Transcript of Advisory Committee Meeting

Date: June 20, 2024

Case: Health Benefit Exchange Advisory Committee Meeting

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MEETING
HEALTH BENEFIT EXCHANGE ADVISORY COMMITTEE
Conducted Virtually
Thursday, June 20, 2024
2:09 p.m.

Job No: 542159
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Meeting of the Health Benefit Exchange Advisory
Committee, conducted virtually.

Pursuant to agreement, before Danny Terry, Notary
Public in and for the Commonwealth of Virginia.

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A P P E A R A N C E S

EX-OFFICIO MEMBERS:

JOHN LITTEL, Virginia Secretary of HHS

CHERYL ROBERTS, Director DMAS

JEFF LUNARDI, Chief Deputy Director DMAS

JAMES WILLIAMS, DSS Acting Commissioner

REBEKAH ALLEN, Bureau of Insurance

VOTING MEMBERS:

SABRINA CORLETTE, Chair

IKEITA CANTU HINOJOSA, Vice Chair

STARLA KISER, Dickenson County Behavioral Health Services

CRAIG CONNORS, VA Hospital and Healthcare Association

STAFF:

KEVIN PATCHETT, VHBE Director

HOLLY MORTLOCK, VHBE Chief Government Relations Officer

RACHEL M. BECKER, VHBE Senior Policy Advisor

LYNSEY STROHMINGER, VSCC Administrative Coordinator

GUEST SPEAKERS:

MARK SICKLES, Delegate, Virginia House of Delegates

SHELBY GONZALES, Vice President Immigration Policy CBPP

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P R O C E E D I N G S

Whereupon,

(The court reporter was duly sworn.)

CHAIR CORLETTE: Welcome, everyone, to our first and only in-person meeting of the Advisory Committee to the Health Benefit Exchange in 2024. I'm Sabrina Corlette, and I serve as your Chair.

Before we start the roll call, we'll do just a few housekeeping matters. First of all, please help yourself to coffee, water, refreshments. And thank you to our Marketplace colleagues for providing the very, very nice refreshments. This meeting is scheduled to conclude at four p.m. I am also hoping that those of you who are interested after the meeting will join us for a very informal happy hour just across the street at the -- what's it called? Tobacco Company? Tobacco Company. Thank you. Very appropriate for Richmond. Let's see. The restrooms are to the right and around the corner, if you need them.

And also, importantly, please refrain from asking questions of our presenters until after they've completed their presentation. This just helps us keep track of time. So just if you have questions during the presentation, just note them down and save them until the presentation is over.

A transcript of this meeting will be made available, along with any presentation materials online at

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1 the Marketplace website, and a link will be provided to
2 those of you in person and it's right there on your screen.

3 With that said, unless there's any questions,
4 we'll turn to the roll call. Secretary Littel?

5 SECRETARY LITTEL: I'm here. John Littel.

6 CHAIR CORLETTE: Director Roberts, I believe, is
7 on her way, but standing in for her for now?

8 COMMISSIONER LUNARDI: Jeff Lunardi, DMAS.

9 CHAIR CORLETTE: Welcome. Acting Commissioner
10 James Williams?

11 COMMISSIONER WILLIAMS: Here.

12 CHAIR CORLETTE: Great. I understand Commissioner
13 White is not available, but standing in for him?

14 MS. ALLEN: Rebekah Allen, present.

15 CHAIR CORLETTE: Great. Welcome. And Doctor
16 Shelton is not with us I don't think.

17 Okay. Turning now to voting members, Ikeita Cantu
18 Hinojosa is here.

19 VICE CHAIR HINOJOSA: Here.

20 CHAIR CORLETTE: I know Julie Bataille could not
21 be with us. Lee Biedrycki is not with us. Did he say he
22 was coming?

23 MS. MORTLOCK: Yes. Everyone who has a name tag
24 is --

25 THE REPORTER: I apologize. Who is speaking?

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1 CHAIR CORLETTE: I'm Sabrina Corlette. I'm your
2 Chair.

3 Let's see. We're waiting for Scott. We're
4 waiting for Liz. Liz is not able to join. We're still
5 waiting for Elizabeth Cunningham. We're still waiting for
6 Doug Gray. Starla Kiser?

7 MS. KISER: Present.

8 CHAIR CORLETTE: Lou Rossiter, I don't see his
9 name tag, so he's not coming?

10 MS. MORTLOCK: That's right.

11 CHAIR CORLETTE: Okay. And Craig Connors?

12 MR. CONNORS: Present.

13 CHAIR CORLETTE: Great. All right. Well, we will
14 go ahead and get started. And we are very, very lucky today
15 to have Delegate Sickles with us. I know, Delegate Sickles,
16 you are having a very, very busy day today, so really,
17 really appreciate that you're joining us for our meeting.
18 We wish you could be here in person, but I'm honored you're
19 here through Microsoft Teams and providing some welcoming
20 remarks. So take it away.

21 DELEGATE SICKLES: Well, thank you for inviting
22 me. I always love being in Richmond, which I'm there a lot
23 as most of you know. So I mean, the whole team should be
24 congratulated on this multi-year project getting this up to
25 speed. This is the way government ought to operate, I

1 think. I mean, it was really done without too many people
2 knowing about it, because it went so swimmingly well. And
3 everybody remembers the first state exchanges that were
4 stood up around the country got a lot of news. Some of them
5 got some good press, but a lot of them didn't. And I think
6 a lot of the problems that other states had you guys were
7 able to recognize and prevent from happening in the first
8 place.

9 So everybody associated with this, including my
10 Senate co-patron Congresswoman Jennifer McClellan, we're
11 very proud of what's happened. We're glad we've set up this
12 new department. We're the newest department and the SCC, I
13 think, and something new for the SCC to do and oversee this
14 project, and happy that 400,000 people are already using it.
15 I think our uninsured rate is as low as it's ever been in
16 Virginia, and part of the way we're going to keep it that
17 low is hopefully the federal government will continue with
18 the subsidies that need to be reauthorized next year. But,
19 you know, we need to tell everybody about this. And there's
20 a whole lot of people out there cheering you on. And when
21 folks are not eligible for Medicaid anymore, persuaded in
22 many cases to buy very highly discounted insurance, and
23 that's just good for everybody, good for the business
24 economy, good for people to want to leave their jobs that
25 are afraid of losing their insurance. They know they'll

1 have insurance here when they're not on Medicaid anymore.
2 So we've got a -- you've got a big job in front of you for
3 making sure Virginians have confidence in this program going
4 forward. The website looks great. You know, you're
5 providing an unbelievably good service to everybody, as I
6 said. And we can do things in the future to improve our
7 situation even more. And so, speaking on behalf of the 140
8 of us in the General Assembly, we're looking for good ideas
9 to help everything get better. So far, you know, I think
10 this is off to a great start, and we're always -- we have an
11 open door for suggestions on how we can improve it.

12 We probably haven't bragged about it enough. I
13 was, as some people know in this room, I was going to give a
14 talk on this on the floor during session. I never got
15 around to it for various reasons. And I think, you know,
16 when things go as well, as they've gone with this new
17 agency, it's kind of boring, you know. So I mean we want to
18 say it. I've been known to give a few boring speeches.
19 Last time I gave one they started waving the white flag at
20 me, and I was talking about something that I thought was
21 very important. But, anyway, they did not think it was that
22 important. And so when you're not really in the press like
23 this, that's a good thing. And, of course, we were able to
24 get a permanent fix. I know the agency was nervous about
25 the target reduction, you know, not having the General

1 Assembly approve the target reduction, I guess, each time.
2 So we know what it is now until we say otherwise when we
3 change it.

4 And that's another thing, you know, everyone would
5 love to know your opinion on over time can we get more than
6 a 15 percent reduction with the first year -- correct me if
7 I'm wrong, but in the first year with our 15 percent target,
8 we got more than that from many of the carriers. We got
9 more than 15 percent. But it will be 15 percent until we
10 change it in the code. So, you know, I think that's not
11 meant to be permanent forever and ever. It's just meant for
12 you to do your business until people think it's smart to
13 maybe change that, go down or up, depending on the current
14 situation and the economy and things like that.

15 So congratulations on all your good work, and
16 congratulations on working with so many people on the
17 outside so they know what you're doing and helping people
18 get insurance. So that it. Thank you for agreeing to be on
19 the advisory board.

20 CHAIR CORLETTE: Well, thank you so much Delegate
21 Sickles. If it weren't for you, first of all, none of us
22 would be in this room; and, second of all, Virginia would
23 not have control over its own State-Based Marketplace. So
24 it's really kudos to you and your vision for making sure
25 that Virginia could take control of its destiny when it

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1 comes to health insurance coverage and making sure we're
2 doing a good job for Virginians. So thank you so much for
3 being with us.

4 DELEGATE SICKLES: Thank you very much. Am I
5 allowed to listen in to your meeting, or you're going to
6 kick me off now? I really need --

7 CHAIR CORLETTE: I have no objection. All right.

8 DELEGATE SICKLES: I'll stay on for a couple
9 minutes.

10 CHAIR CORLETTE: Okay. Great.

11 DELEGATE SICKLES: Yeah. I've got to hear what
12 Secretary Littel says.

13 CHAIR CORLETTE: Well, we are going to deviate
14 just slightly from the agenda. We have a special guest
15 speaker today, Shelby Gonzalez, from the Center on Budget
16 and Policy Priorities, and we invited her here to talk to us
17 because just -- what's it now -- maybe a month ago the Biden
18 Administration finalized a very important rule regarding the
19 recipients of DACA, or Deferred Action for Childhood
20 Arrivals. And it's going to have a pretty important impact
21 not just for DACA recipients, but for the Marketplace in
22 terms of how they need to get ready for the change that's
23 coming for November 1. So Shelby is an immigration policy
24 expert at the Center, and has, I think, probably read and
25 parsed every word of the rule and its complexities and

1 nuances and is here to share a little bit with us about what
2 this rule means for the affected population and for the
3 Marketplace.

4 So, Shelby, thank you so much for joining us and
5 taking time out of your very busy schedule to help us out
6 today.

7 MS. GONZALEZ: Thank you, Sabrina, and thank you
8 to the whole committee. I also would like to echo some
9 things. I was born and raised in Virginia. I spent a lot
10 of my early career in Virginia, including working a decade
11 for Anova Health System. So I am very, very closely
12 connected and care a whole lot about the health and the
13 health coverage of Virginians. So kudos to all of you for
14 excellent work, and I'm super excited about this opportunity
15 to talk with you today about this new policy.

16 I figured that I would start by giving just a tiny
17 bit of background to make sure that we're all on the same
18 page. Under the Affordable Care Act, there is a more
19 liberal standard of eligibility for coverage so that people
20 can purchase health coverage in the Marketplaces compared to
21 Medicaid and the CHIP program, the standard Medicaid and
22 CHIP programs. So under the ACA Marketplaces, one has to be
23 lawfully present in order to enroll in Marketplace coverage.
24 And when I say enroll, I mean enroll. Like you can't even
25 purchase a hundred percent out of pocket with your own money

1 without meeting that standard. So one, you know, kind of
2 the first thing that you need to do is make sure that you
3 are lawfully present, and the way that lawfully present was
4 defined, it was -- one, I just want to make sure that -- can
5 you see my slides?

6 MS. MORTLOCK: No.

7 MS. GONZALEZ: Sorry about that. Let me just go
8 ahead and put that -- I forgot to share my slides, even
9 though we practiced this. Okay. Now it's coming up. Sorry
10 about that.

11 Okay. So the first kind of requirement is that --
12 Now can you see them?

13 CHAIR CORLETTE: Yes.

14 MS. GONZALEZ: Okay. Great. Thanks.

15 So the first requirement is that you have an
16 immigration status that is considered lawfully present as
17 defined in federal regulations that were issued by HHS. And
18 that was intended in the ACA to be a very, very broad --
19 basically, it was intended to say, if the US government says
20 that you are here lawfully, then you are here lawfully, and,
21 therefore, you have an avenue to be able to purchase health
22 coverage in the ACA Marketplaces. And what happened was
23 that the way that it was defined very technically left a few
24 people out of who the Department of Homeland Security says
25 is eligible based on -- who is -- who was here lawfully, who

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1 has recognized their status here in the US, but still did
2 not meet the standard that was defined within the ACA. And
3 the big group that everybody has been hearing about and when
4 we think about what we call, oftentimes, the ACA DACA rule,
5 we think about the individuals with Deferred Action for
6 Childhood Arrivals, also known as people with DACA. What
7 happened was when President Obama created the Deferred
8 Action for Childhood Arrivals program, immediately
9 afterwards they also created a emergency regulation, a
10 change in the lawfully present rule so that, even though
11 everybody else who has deferred action for -- just deferred
12 action, any type of deferred action, because that is another
13 status based off of immigration within our immigration
14 system -- even though they are lawfully present for the
15 purposes of enrollment in the ACA Marketplaces, strategic --
16 like very surgically they were saying people who have
17 Deferred Action for Childhood Arrivals, so only that subset
18 of people with deferred action were not going to be eligible
19 to purchase health coverage in the Marketplace. So that
20 meant that, even though people who, you know, have this
21 status otherwise were qualified Childhood Arrivals status,
22 no. And that was complicated, quite frankly, for the
23 federal government and then later on State-Based
24 Marketplaces to even implement, because, when you think
25 about an individual who has Deferred Action for Childhood

1 Arrivals, they believe that they are here -- you know, if
2 asked the question, are you here lawfully, are you lawfully
3 present in the US, they've gone through a very rigorous
4 process to be lawfully present in the US to be -- they have
5 acknowledged a lot of -- they've gone through a lot of
6 hurdles. They have a social security number. And it's
7 complicated, right? So it created quite a barrier and
8 confusion. But, nonetheless, so for a lot of us, we -- and
9 also, quite frankly, this is a young group of people, for
10 the most part, that are here working in the US trying to
11 make their lives here. They know no other home. Oftentimes
12 they've come, you know, so young in their lives they've
13 never been any other place. So it always seemed very
14 awkward and very kind of just not just to have this group to
15 be left out.

16 So I have right here kind of the -- these two
17 charts kind of show who today is eligible based off of the
18 lawfully present eligibility requirement. And you'll note
19 that, as I have this listed in both of these slides, these
20 groups we talk about who meets the lawfully present and
21 lawfully residing eligibility standards, and that's because
22 Medicaid has up to now, up to up to the change of this rule,
23 the lawfully residing program, which is very limited -- as a
24 state optional program very limited only to children and
25 people who are pregnant at the state's option, and Virginia

1 has taken up those options. And they basically can adopt
2 the same kind of more expansive eligibility standard that is
3 exactly as the lawfully present standard is today. So right
4 now these are two standards that are the same with the
5 exception of the way that Medicaid then also requires a
6 state residency requirement, which is slightly different
7 than the state residency requirements under the Exchange.

8 So what happens is that we have a new rule, and
9 that new rule -- and I'm going to open it up a little bit
10 larger on my screen because I realize I can -- it's this
11 big, so I can barely see the slide itself on my screen. But
12 so what the new rule does, it's only applicable in making
13 changes as of November 1 for individuals who are getting
14 coverage in the ACA Marketplaces. So this is not going to
15 happen. These changes are not going to be applicable for
16 Medicaid. These are changes that are only going to be
17 applicable to the ACA Marketplaces. And the first group
18 that's going to newly gain coverage is people with Deferred
19 Action for Childhood Arrivals, as I talked about.

20 Another group that's interesting to think about is
21 currently individuals that have special immigrant juvenile
22 status. This is a small group of children who, when they're
23 applying for this special status, they are eligible, they
24 meet the lawfully present requirements, and lawfully
25 residing under Medicaid. But then what happens is, is that

1 once they're awarded this status, they're no longer
2 eligible. And that doesn't make any sense, right? And the
3 reason why it doesn't make sense is because, once upon a
4 time, these individuals would also get their green cards or
5 lawful permanent resident status as they got this status.
6 So when lawmakers and policymakers and, you know, rule
7 makers were creating all of these standards, it was assumed
8 that they didn't need to list out this particular group
9 because they realize, Oh, they're going to be eligible
10 anyway because they have lawful permanent resident status.
11 So it's kind of an example of almost like a clarification,
12 right, like nobody intended to leave this group out once
13 they got the status. They were fixing a problem.

14 When you go down the rest of the slide, you'll see
15 some other groups that are similar in that same way, that
16 nobody was really intending to leave out these groups, but
17 they were left out in one way or the other because of the
18 way that rulemaking is done, sometimes in a vacuum from
19 what's happening elsewhere in immigration policy, right,
20 because we're adopting immigration policy within the
21 framework of health coverage policy. And guess what, it
22 doesn't work perfectly. All the puzzle pieces just don't
23 fit together as nicely as we would like them to, which isn't
24 that shocking if you think about it, because it is
25 complicated stuff.

1 So when we take all these things into
2 consideration, we now will have a new rule, a new set, a new
3 standard on the ACA Marketplace. This is not applicable for
4 the Medicaid program, but it -- and then when I show you the
5 updated slides that are now only applicable to the ACA
6 Marketplace coverage, the new technical changes are all
7 reflected here in those new slides. So I provided them
8 here.

9 I wanted to also just tell you, because a lot of
10 people were very, very concerned -- and to be clear, I
11 personally would love to see that the Medicaid regulations
12 around who is lawfully residing to resemble, to be exactly
13 the same as the lawfully present status standard. That is a
14 good goal, you know, and I think that that's what we should
15 hope for in the future. But that's not what's happening on
16 November 1.

17 The good news is that the way that the ACA was
18 constructed it knew that lawmakers that were writing the ACA
19 fully understood that there were going to be some people who
20 were lawfully present, a larger universe of people that are
21 lawfully here in the United States that were not going to
22 meet the very restrictive Medicaid immigration eligibility
23 standards, right? So for individuals who are ineligible for
24 Medicaid because of their immigration status, even though
25 they're lawfully present, they can have income either in the

1 Medicaid range, and that includes income below the federal
2 poverty line, so under 100 percent of the poverty line, and
3 still qualify for premium tax credits and cautionary
4 reductions as if their income was above the federal poverty
5 line. So it allows a pathway for affordable coverage for
6 individuals that are newly going to become eligible under
7 this rule, despite the fact that some of them might have
8 income below the poverty line, and despite the fact that
9 Medicaid is not going to have these rules applicable to
10 them. So that is important for folks to know. But I will
11 share that it's going to be complicated to get the right
12 eligibility determination for these folks, so it's something
13 that you want to keep in mind.

14 And then, finally, I just wanted to talk a little
15 bit about some considerations that you may want to make or
16 think about as you're thinking about how this is all
17 implemented to make sure you're really maximizing the
18 opportunity for coverage. And some of the things that we
19 oftentimes think about around outreach is that if you
20 think -- if you put your head into the space of where a lot
21 of these individuals might be, some of them may have applied
22 for coverage in the past and have been turned away, right,
23 because they were ineligible. It's a little bit more
24 challenging to get them to come back, right, and to explain
25 these technical changes. It is not necessarily super

1 intuitive to people. An important step to take is to really
2 work with partners that are trusted by these groups so that
3 they feel like, okay, there is a welcoming of me here, and
4 these are individuals that I trust, and, therefore, I'm not
5 going to be super afraid that they're trying to kind of
6 trick me into purchasing something that later on might
7 create problems for me. Language access is also a really
8 big deal. And, you know, the use of high quality
9 translations of all materials, and the use of skilled
10 interpretation services in all of the different ways that
11 people interact with the Marketplace, whether they're
12 calling to apply online, whether they're talking to a
13 navigator, whether they're talking to some other consumer
14 assistance provider that they can get access to telephonic
15 application assistance oftentimes is really important. And
16 that through your attempts in raising awareness about the
17 new coverage, partnering and doing what you can to utilize
18 the media that's relevant to the new audience. So, for
19 example, maybe Univision might be a better, you know, media
20 outlet than Fox News or NBC 4 News, right? Like that might
21 not be the best venue for folks, but maybe some of these
22 channels that -- and I'm just using TV examples, but
23 certainly thinking about in-language newspapers and
24 in-language radio, in-language social media that is
25 targeting groups that are newly going to be eligible, and

1 then utilizing reassuring messages that ensure that people
2 who are newly eligible are not fearful that enrolling in the
3 coverage will later on result in some kind of negative
4 immigration-related consequence for the family. And one of
5 those fears might be that they think that they might be
6 subject to a public negative consequence. So that's later
7 on when somebody in their family is changing their status
8 that immigration officers might look badly upon people who,
9 you know, got coverage. Indeed, people actually -- when
10 they go to that kind of immigration assessment, having
11 health coverage is actually a plus for them, and having
12 access to Marketplace coverage is not a minus. So,
13 ultimately, this is a good thing for people who are seeking
14 to change their status.

15 And with that, I'm going to pause and see if
16 there's any questions.

17 CHAIR CORLETTE: Shelby, thank you so much.
18 That's a really complicated rule, and you helped us parse
19 through it, so really appreciate that.

20 Does anybody have questions for Shelby?

21 MR. CONNORS: Craig Connors. I'm just curious.
22 Is there any way to estimate the number of people in
23 Virginia who will become newly eligible?

24 MS. GONZALEZ: That's a really good question. I
25 don't have the answer to that, and I suspect that it might

1 be challenging to find it. But I will ask both my friends
2 at -- I used to be the Chair of the Commonwealth Institute.
3 I will ask them if they have an assessment, if they've done
4 any kind of state assessment. I can also ask some of our
5 other partners that do a lot of support for individuals. I
6 don't recall if -- I don't think the rule would have put a
7 state-by-state estimate. Overall, there's an estimate that
8 about 500,000 people will be able to newly enroll in
9 Marketplace coverage, adults, and potentially up to
10 50,000 -- I'm sorry. It's about -- I'm sorry. I'm getting
11 the numbers mixed up with a different rule that happened, or
12 different policy that happened this week. So I think that
13 we're talking about 100,000 people for the ACA DACA rule,
14 but it could actually be more. It depends on like how
15 aggressive and effective the outreach is. But that's
16 nationwide. So I don't know if we have the ability to get a
17 very specific number for people with DACA. Even if we knew
18 how many people with DACA live in the Commonwealth, it would
19 be hard to then do the next piece of assessment to find out
20 of that group how many are uninsured and how many would be
21 eligible for Marketplace coverage, and then factor in like,
22 well, what's the -- what's the likelihood that they would
23 enroll, even if they are eligible and uninsured.

24 MR. CONNORS: Thank you.

25 CHAIR CORLETTE: Any other questions for Shelby?

1 Yes.

2 SECRETARY LITTEL: Hi. This is John Littell, and
3 this is information -- I could be off, but since you're an
4 expert it's a good time to ask it. If you are seeking
5 asylum but you have not had your hearing, is that considered
6 deferred action?

7 MS. MORTLOCK: No. It's a different kind -- some
8 people are implicated in this rule that are within the
9 asylum-seeking process. Those are children. So right now
10 an individual who's seeking asylum must wait until they have
11 work authorization to be able to then qualify, because the
12 asylum process could take a very, very long time, as you can
13 imagine. And for them, for adults and some children, you
14 must have work authorization in order to meet the lawfully
15 present status requirement. Okay? However, there's always
16 been a recognition that children -- getting work
17 authorization, it's difficult and expensive. So to get work
18 authorization for children during the application process,
19 it's not something that normally happens. So there was
20 always an understanding that there needed to be a different
21 kind of way to identify children and get them access without
22 waiting until they had work authorization. So there was a
23 180-day waiting period for those children. And so that's a
24 long time in the life of a child, as you can imagine, to
25 wait to get coverage, and especially when they're asylum

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1 seekers and they might have just gone through quite a
2 traumatic, you know, experience and they're trying to, you
3 know, get established within a community and enroll in
4 school and all of the things, right? So this rule also just
5 does away with the 180 days for the children, so the under
6 14, like I mentioned. Some children do still have to get
7 work authorization if you're over 14.

8 SECRETARY LITTEL: Thank you.

9 MS. MORTLOCK: No problem.

10 CHAIR CORLETTE: Any other questions for Shelby?

11 COMMISSIONER WILLIAMS: This is James Williams.
12 The DACA and then I think the Special Immigrant Juvenile
13 status, you can age or time out of those. And so how would
14 it work if you qualify under the status, you receive
15 insurance through the Exchange, and then you become
16 ineligible because you time or age out of the category?

17 MS. MORTLOCK: So two things. Those are great
18 questions. Okay. So for SIJ, for people with SIJ, which is
19 Special Immigrant Juvenile Visa status, the trajectory for
20 those individuals is generally a pathway towards a lawful
21 permanent resident status. That's generally what happens
22 for individuals who have SIJ. So when you obtain that
23 lawful permanent resident status, that will be what was
24 qualifying you, and that's generally what you would see
25 happen. So it's moving in that direction, not in the

1 direction of people losing it and being timed out.

2 For individuals with Deferred Action for Childhood
3 Arrivals, it's an ongoing kind of application process. So
4 every -- what is it -- two years, they have to re -- I'm not
5 a hundred percent sure about how many years it is. They
6 had --

7 COMMISSIONER WILLIAMS: It's two years.

8 MS. MORTLOCK: Yeah, two years. They have to
9 reapply for their status. And generally what we have been
10 seeing is that people are -- you know, it's extremely
11 helpful for people to be able to keep their status. And a
12 lot of the work has been done, you know. So, now, there
13 might be delays sometimes in renewing status, and that could
14 happen. But thinking about how consequential it is for
15 individuals, including the fact that they can't keep their
16 jobs, oftentimes, if they have a lapse in their status, it
17 doesn't -- you know, people are pretty on top of it in
18 keeping it. There's a lot of people who -- you know, we
19 started, what, about 800,000 people who have had DACA over
20 the years, and now we're at about 586,000, something like
21 that. That's generally because people have gotten status
22 through a different avenue, or left, or left the US, but not
23 generally because they decided like I'm just not going to do
24 this anymore.

25 The second thing I would say is that the ACA

1 requires individuals to reapply for coverage or renew their
2 coverage on an annual basis. Now, I understand enough about
3 the auto reenrollment rules to know that that could become a
4 little bit complicated because individuals may not be, you
5 know, reassessing their eligibility based off of all factors
6 during auto reenrollment. But even that, like, people not
7 touching the application for more than two years, it's
8 generally not a good thing. Like, generally, you want
9 people to come back into the application and provide new
10 information and take action versus being auto reenrolled
11 into different programs. So I think that there are ways.
12 And also there is a requirement -- and I believe that it's
13 part of the notification that's provided to individuals
14 that, if there is a change in their circumstances that would
15 make them ineligible, that they are required to -- or, you
16 know, a change of your circumstances, they're required to
17 report changes. So this would be something that people
18 would have to know that they should report on if they were
19 to lose their immigration status that qualifies them.

20 CHAIR CORLETTE: Thank you. And I'll just say
21 that I think this -- this question and response speaks to me
22 of how important it is going to be for the Marketplace and
23 other people who are interfacing with these individuals to
24 have really good, you know, FAQs and call center scripts and
25 website content so that -- because these nuances are just

1 so -- they're difficult for folks like us to understand.
2 It's really going to be something to have to translate it
3 for individuals going through this experience.

4 Okay. Any other questions for Shelby?

5 MS. MORTLOCK: Can I add one more thing on that
6 question in particular? This is not the only group that
7 meets the lawfully present or who will meet the lawfully
8 present requirement. Today there are people who meet the
9 lawfully present requirement who also have time-limited
10 immigration visa status. So there technically should be
11 processes in place already, including both the requirements
12 for reporting, as well as the -- you know, the ways to make
13 sure that you are taking into consideration in your auto
14 renewal processes at least not necessarily has to be every
15 year, but like of some type for specific individuals.
16 Because when you look at that list, there are other
17 individuals who also meet this requirement.

18 COMMISSIONER WILLIAMS: That's a great point.
19 It'd be nice to hear, Exchange, how that is done for the
20 other categories today and in the future.

21 MS. MORTLOCK: Yeah. And, you know,
22 healthcare.gov has -- I mean, I've had -- in addition to
23 immigration policy, I'm an expert in health coverage as well
24 and in Marketplace coverage. So I've had many, many years
25 working with the folks that run healthcare.gov, and these

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1 are conversations that we've had in the past as well. I'm
2 not saying that everything is easy, but it's not something
3 that hasn't been thought about. So your friends at
4 (indiscernible) might have some good ideas as well, and
5 they're another resource to tap into in addition to me. I'm
6 available as well.

7 VICE CHAIR HINOJASA: Shelby, does your
8 organization have -- Hi, my name is Ikeita Cantu Hinojosa.
9 I'm our Vice Chair. Your presentation was so informative,
10 so thank you for this. Does your organization have
11 communication toolkits or resources for this November 1
12 rollout in terms of talking with members of the community
13 and helping educate folks about what's coming?

14 MS. MORTLOCK: We are in the process of developing
15 information. So we run a program called Beyond the Basics,
16 and we do train navigators and other consumer assistance
17 providers. And, quite frankly, a lot of State-Based
18 Marketplaces come to our trainings as well. And we plan on
19 having resources available for -- we will be training on
20 different aspects of this.

21 VICE CHAIR HINOJASA: Thank you.

22 CHAIR CORLETTE: Thank you so much, Shelby. This
23 has really been a fantastic presentation and very, very
24 helpful.

25 I think we can turn now to our director's update.

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1 Do we have Kevin on the line?

2 Thank you Shelby.

3 Yes, I see Kevin. Wonderful.

4 DIRECTOR PATCHETT: All right. Good afternoon.

5 Can you all hear me okay?

6 CHAIR CORLETTE: Yes. We can hear you perfectly.

7 DIRECTOR PATCHETT: All right. Well, I'm really
8 delighted to be here, although I regret tremendously that I
9 couldn't make it in person today because of some
10 circumstances beyond my control. I will also say, though,
11 following up on some of the remarks that Delegate Sickles
12 made, I've never been happier to be the cause of boredom for
13 folks. It really was what we were aiming for as part of our
14 transition, let's make this as boring and uneventful as we
15 can. So a unique but useful measure of success.

16 And, James, I heard your question, and I will be
17 more than happy to provide some additional details on that
18 here towards the end of my remarks.

19 I wanted to start today, and take a little bit of
20 a step back. I think for a lot of the time that this
21 advisory committee has been meeting we've really been in
22 transition mode, and we -- you know, we had our first sort
23 of post-transition meeting last March. But I wanted to take
24 a step back and look at who the Virginia Exchange is at an
25 organizational and really kind of genetic level, and start

1 with what are our highest strategic priorities as we are
2 continuing to move forward into this our first year of
3 operations as we prepare for open enrollment in November.
4 As we thought about these things, we took the very useful
5 strategic priority recommendations that this advisory
6 committee gave to us and, you know, kind of consolidated
7 those and pulled back at a higher level.

8 And so we start from the importance to understand
9 and eliminate barriers to health coverage. We don't just
10 want to identify those barriers, and there's a lot of great
11 work going on in Virginia as well as nationally to help
12 identify what those barriers are, but we want to make sure
13 that we understand them, that we're doing our work in terms
14 of consumer outreach to learn, you know, what do these
15 barriers really mean to consumers so that we can begin to
16 figure out how do we do our part to eliminate those
17 barriers. And as we work to figure out how we can eliminate
18 barriers, we really have a wonderful array of tools at our
19 disposal. But those barriers are so varied. So, you know,
20 we think about really simple things like are the words that
21 we're using when we talk about health insurance coverage
22 helping, or are they, in fact, making it more difficult; do
23 we get stuck too much in jargon and industry lingo; are we
24 recognizing the different communication needs that different
25 consumers have. From there, you know, all the way up

1 through things like the functionality of our platform,
2 social determinants of health, the big cost and access to
3 provider factors. All of that are things that we think
4 about as we make big and small decisions around how we
5 operate as an Exchange, who we are, and where are we putting
6 the resources to the Commonwealth as we make some of these
7 decisions.

8 From there, we focus very much on continually
9 improving the consumer experience. There's a great deal of
10 time and effort that we spend on consumer outreach and
11 education to bring uninsured individuals into the
12 Marketplace, make sure they have the right coverage, make
13 sure those tools and assistance are available for them. But
14 if they have -- if they don't have a great experience, it's
15 going to reduce the number of them that we keep, and what we
16 really want is folks staying covered here in Virginia so
17 that, as Delegate Sickles mentioned, we can continue to have
18 the lowest number of uninsured we've seen in Virginia, and
19 to see that number continue to go down.

20 And then, lastly, we spend really a great deal of
21 our time thinking about and working to engage with our
22 stakeholders so that we can have their input on shaping what
23 is it that is going to make Virginia's Exchange meet the
24 needs of all Virginians. And we are so privileged to have
25 so many of our stakeholders represented here at this

1 meeting. Our insurance plans, our hospitals and providers,
2 our agents and brokers, our other state and federal
3 governmental partners listening and learning to what you all
4 have to say, your experiences, your perspectives we
5 recognize are critical input as we make these decisions
6 around what does Virginia's Insurance Marketplace look like.
7 You've all heard me say it a few times, but we take very
8 seriously the fact that we are building a Marketplace that
9 is by Virginia for Virginians.

10 All right. So in order to get there, there are
11 things that we really have to focus on internally as we are
12 developing those external strategies. We start internally.
13 And first is operational excellence. I wish I could convey
14 adequately to you all the quality of individuals that we
15 have working in Virginia's Exchange. In my 20 years of
16 experience, which are split almost evenly between the
17 private sector and the public sector, I have never met or
18 worked with a team that is more committed to their mission.
19 There is no hesitation to put in extra time, extra effort.
20 It really is remarkable, and very much the reason that we
21 had a boring transition. But we don't -- we don't stop,
22 right? We're not satisfied with where we are. We have to
23 continually get better. And it's not just about our team;
24 it's about the tools that we're making available to
25 consumers. It's about the way we manage the vendors that

1 help make our Marketplace possible, available and accessible
2 to consumers. And as we do that, we make sure that our
3 focus stays on being a customer service organization. It's
4 really interesting for us to be part of the State
5 Corporation Commission, which is the largest regulatory
6 agency in the Commonwealth. And at the Exchange, we have
7 some regulatory functions. We certify plans that they meet
8 the criteria to be a qualified health plan. We certify
9 insurance agents and brokers and provide training. And
10 there are other regulatory functions. But at our core, we
11 are a customer service organization. We are about
12 delivering to individual Virginians the tools and the
13 resources that they need to get and stay covered in health
14 insurance. And in order to do that, we have to be nimble
15 and deliberative decisionmakers. We as an organization are
16 often faced with the challenges of having to make decisions
17 in a timeframe that is much shorter than we'd like, and
18 often with imperfect or incomplete information. I think
19 also, you know, our DNA, especially my leadership team, we
20 are deliberative decisionmakers. But, you know, that's not
21 enough. We have to be nimble. We have to be flexible, and
22 then do what we can to rely on the data and the information
23 that's available, but also what we can -- what we can find
24 ourselves.

25 So those are some of the things that really are

1 part of the DNA of Virginia's Health Benefit Exchange and
2 are critical to what we are doing to make Virginia's
3 Marketplace a success for Virginians. We had a very
4 successful open enrollment this last year, and we're looking
5 forward to what we can do this year.

6 All right. Let me share a few of the things that
7 are on the horizon for our platform starting in this
8 November. So first, we're switching to an in-house provider
9 directory that is being built and driven by our vendor. We
10 were using last year a third-party commercial directory of
11 healthcare providers, and we heard feedback from many of our
12 stakeholders that it was just not great, and in some
13 specific localities it was worse than not great. So as we
14 engaged in some dialogues about what we can do to make it
15 better, we learned that our vendor for some other states
16 have started setting something up in house. There's some
17 tradeoffs to this. It's going to mean some more work for us
18 at the Exchange because we're going to be doing a lot of the
19 work to validate with our carriers the accuracy of the
20 information that they're uploading, but it gives us a lot
21 more flexibility to collaborate with our carriers in setting
22 the frequency with which they can update their provider
23 directories, working together to make sure that we have a
24 uniform taxonomy so that one carrier isn't designating a
25 facility that's really a mental health facility as a

1 hospital so that it's much easier for consumers, as they're
2 making their decision about coverage, to figure out whether
3 or not their providers are covered by the plans they're
4 looking at.

5 We are also in the middle of rolling out a
6 facilitated enrollment program. So this is a program that
7 is created by legislation and is targeted for this coming
8 tax year. On Virginia's state tax form, the Department of
9 Tax will be adding some language that allows consumers to
10 essentially check a box and say that they want more
11 information about the Marketplace. There's a similar box
12 right now for Medicaid, and so now we'll be adding the
13 Marketplace. What we want to do once we get that
14 information from those consumers who've requested that the
15 Virginia Department of Taxation share that with us is use
16 that information to pre-populate accounts for those
17 consumers so that when they do come to the Marketplace an
18 account's ready, as much information has already been
19 pre-populated into their application, and they can really
20 hit the ground running in terms of enrollment. We're also
21 looking at how this is going to line up with special
22 enrollment periods since we're going to get this information
23 really outside of the open enrollment period. But what we
24 have learned as we've talked with other states who have
25 implemented similar programs is that, when done right, they

1 really can be one of the most effective ways to reach
2 consumers who don't have insurance and aren't aware of
3 what's available for them in the Marketplace.

4 Lastly, I'll talk a little bit about our broker
5 mobile app. As you'll see in a minute, we have a very
6 healthy and active agent and broker community in Virginia.
7 It is well over a third of our consumers who are enrolled
8 with the assistance of either an agent, broker or navigator.
9 And so it was important to us to find and leverage the tools
10 that are available to make their work more efficient. And a
11 mobile app for our agents and brokers is one of the first
12 things we're -- first enhancements that we're bringing to
13 our Marketplace this year.

14 All right. So now I want to talk a little bit
15 about metrics. Last month we shared a handful of metrics
16 based on our open enrollment, and we've been working really
17 hard, especially our data analytics team, on expanding the
18 data metrics that we can validate and share. So it's a lot
19 of information. I'm going to just kind of move through the
20 slides. I'm not going to try to spend time talking about
21 many, certainly not all of these metrics. To take a look,
22 we've broken them down into a few categories. So we start
23 with what were our initial open enrollment metrics. Many of
24 these were related to things we were already reporting
25 publicly or had to report to CMS, but we have certainly

1 augmented them and we've listened to the recommendations
2 from this committee, as well as from other of our
3 stakeholders about what -- you know, what is most useful.
4 As we go through these -- and I'm not really sure the best
5 way to move through these, or how quickly to move through.
6 So we'll just kind of leave this here for a minute for you
7 all to consume, and I'll share just a little bit about some
8 of the challenges that we have. We have a wealth of data
9 available to us. There's a significant amount of work to
10 make sure that as we analyze that data that it is, in fact,
11 valid. And when I say valid, it really comes down to is
12 this data what we think it is or what it appears to be. So
13 there's an initial step that we go through of working to
14 validate the data that we have. Then we have to think
15 about, well, how are we going to present this information,
16 what are we going to label this. I talked at the beginning
17 about avoiding the tendency to just slip into jargon or
18 industry speech, but the intention, of course, is that many
19 of our consumers of this data are, in fact, going to be
20 industry folks, so how far do we want to deviate from
21 industry standard terms. So we are working to strike that
22 balance.

23 Let's go ahead and go to the next slide. And so
24 here we've -- this is our first step into some geographic
25 data analysis. We want to get even more deeply into

1 geography when we do our data analysis. So we're starting
2 here by rating area.

3 CHAIR CORLETTE: Did we lose Kevin?

4 MS. MORTLOCK: His video is frozen.

5 CHAIR CORLETTE: If he can rejoin.

6 MS. MORTLOCK: I'm going to reload everyone.

7 Okay. So Kevin's power and internet has gone down.

8 UNIDENTIFIED SPEAKER: Can you pick up where he
9 left off?

10 MS. MORTLOCK: I can. Surprise. Poor Kevin.

11 So I'll just add that for these metrics that we
12 are pulling together, I just wanted to share a little bit
13 about the process. So when we received the strategic
14 priorities from you all and the recommendations on the types
15 of metrics that would help us get to those strategic
16 priorities, we shared that information with -- the strategic
17 priorities package that you prepared, we shared that with
18 SHADAC, which is the State Health Access Data -- Sabrina?

19 CHAIR CORLETTE: I don't remember the full
20 acronym, but they're data and analytics --

21 MS. MORTLOCK: Yes.

22 CHAIR CORLETTE: -- Minnesota.

23 MS. MORTLOCK: Yes. Great. Thank you. And
24 they've been wonderful. And so they share -- so they took
25 that compendium of information, and helped us identify sort

1 of strategically how to start collecting this data, and then
2 reporting on it, knowing that, as we're getting used to this
3 massive data tool, you know, as we're validating that
4 information, that we are presenting it, one, to reflect sort
5 of what you all have asked for, and that it is meaningful
6 and useful to, you know, as Kevin had noted, sort of
7 industry partners, you know, and, of course, consumers and
8 our state agency partners and so forth. So this is where --
9 so one of the metrics, of course, was enrollees by region.
10 They provided us with a really great layout of how to begin
11 to report on these metrics and then build upon them in
12 future iterations of them. So that's what you're seeing now
13 what Kevin started with. So we are down on enrollees by
14 region. And so, as of the end of open enrollment on January
15 16, these were the number of enrollees by each of these
16 regions. And so I just wanted to give a sense of what that
17 looked like.

18 Go to the next slide.

19 MS. BECKER: I was looking for wise for Starla.

20 MS. MORTLOCK: Okay. And one of the --

21 Oh, great. Hi, Kevin.

22 DIRECTOR PATCHETT: Hey, I apologize to everyone.

23 My power went out along with my internet, so it took me a
24 minute to get joined by my phone. But, Holly, why don't you
25 go ahead and finish going through these data slides.

1 MS. MORTLOCK: Sure. So, of course, of key
2 interest is going to be sort of enrollment by income level,
3 because that tells us a lot of information about our
4 population, not only, you know, their needs, and gives us a
5 lot of insight into sort of the resources that they needed
6 and how they're impacted by our policy programs. So this
7 slide just goes by federal poverty level and some key slots
8 of -- the word is escaping me, but just slots of the way
9 that federal poverty level is measured and presented in
10 terms of enrollment demographics.

11 COMMISSIONER WILLIAMS: A couple of questions on
12 that.

13 MS. MORTLOCK: Sure.

14 COMMISSIONER WILLIAMS: The under a hundred
15 percent FPL and then the unknown categories, so I guess for
16 the unknown are those people just applying and they know
17 they're not going to receive any subsidy or tax credit so
18 they don't even bother putting in the information, and,
19 therefore, they're just enrolling and paying a hundred
20 percent?

21 MS. MORTLOCK: Yeah. That's probably a very key
22 reason as to why that's not known, because if they're not
23 applying for -- if it's not a financial application, then
24 they're paying full price for a plan, then that's not
25 contemplated. Of course, if they do report it, then we

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1 would have that information.

2 COMMISSIONER WILLIAMS: And then the under a
3 hundred percent, why would they not be referred to DMAS?

4 MS. MORTLOCK: There are some folks who are not --
5 who would not be eligible for Medicaid coverage that could
6 purchase a Marketplace plan, and that's why they would be --
7 they would be eligible to purchase a QHP with financial
8 assistance, but these would be people that would be not
9 eligible for Medicaid coverage otherwise.

10 COMMISSIONER WILLIAMS: -- examples?

11 MS. MORTLOCK: So certainly certain immigration
12 categories, and there could be -- I think that's the
13 predominant one.

14 VICE CHAIR HINOJASA: It's primarily the people
15 that have five-year bar.

16 MS. MORTLOCK: Yeah.

17 COMMISSIONER WILLIAMS: Okay.

18 VICE CHAIR HINOJASA: I'm not an eligibility
19 expert, but immigration and the five-year bar is what I was
20 thinking.

21 COMMISSIONER WILLIAMS: Yeah.

22 MS. MORTLOCK: And so this is our -- so what this
23 represents is we have -- there's enrollment -- as the end of
24 open enrollment concludes, you know, the Marketplace, you
25 know, serves people for a variety of reasons. You know,

1 some people come on for certain months of the year and they
2 rotate off. But this is our effectuated enrollment as of
3 March 31.

4 DIRECTOR PATCHETT: And so one thing I will add
5 here, as we are preparing to start reporting this, our plan
6 right now is that we are going to be posting this data
7 quarterly on HBE's website to make it widely available to
8 folks and easy to find. We've spent a lot of time thinking
9 about what frequency makes sense, but we've landed at
10 quarterly. And so, hopefully, our first public posting of
11 our data will happen here at the end of this month.

12 MS. MORTLOCK: And these are the same metrics that
13 were on the original slides, just updated to reflect the
14 effectuated enrollment as of March 31 of this year.

15 CHAIR CORLETTE: I know we're supposed to hold
16 questions to the end, but if we have questions about
17 particular data points, is it okay to ask them now, or would
18 you like us to hold --

19 DIRECTOR PATCHETT: I think now's a good time.
20 Yep.

21 CHAIR CORLETTE: Okay. I just have two questions,
22 and then -- one is, it looks like a majority of your
23 enrollment is in bronze, and I'm curious if you know how
24 many of those folks would be CSR eligible if they were in
25 silver.

1 MS. MORTLOCK: Yeah. So we could certainly tell
2 by -- we should certainly be able to have some indication by
3 the number of folks by the poverty level, right? So most of
4 them I would think would be -- if they're under 250 percent
5 would be eligible for CSRs.

6 CHAIR CORLETTE: Okay. I think that would be a
7 good --

8 MS. MORTLOCK: Very good observation.

9 CHAIR CORLETTE: -- data point to make available
10 for folks in an area for improvement.

11 The other thing I noticed was that the average --
12 is this your average call center wait time is 50 minutes?
13 Was that just during open enrollment, or --

14 MS. MORTLOCK: Can we go back to that -- the first
15 one. Sorry. Yes. That's 50 seconds.

16 CHAIR CORLETTE: Oh, 50 seconds. Okay.

17 (Crosstalk.)

18 CHAIR CORLETTE: You may want to clarify that.

19 MS. MORTLOCK: Yeah, we'll clarify that certainly.
20 Certainly, you know, around the December 15 deadline there
21 were additional -- it did take a little bit longer.

22 CHAIR CORLETTE: No. 50 seconds is fine. When I
23 saw 50 minutes, I just wanted to know how --

24 MS. MORTLOCK: Yeah. No.

25 CHAIR CORLETTE: -- a little bit. But 50 seconds,

1 that's pretty good.

2 MS. MORTLOCK: That's right. And the call volume,
3 to give that a little bit more context, so over the course
4 of open enrollment, there were 196,000 -- approximately
5 196,000 calls to the call center.

6 CHAIR CORLETTE: Any other questions? Starla?

7 MS. KISER: So I just maybe have an observation
8 for the future, but I'm also curious about the distribution
9 of carriers per geographic region because some carriers -- I
10 mean, some regions may only have health keepers as the only
11 option. I think if we're looking at consumer experience,
12 providing them a good product, the ideal Marketplace is an
13 actual marketplace. You have more than one vendor; they're
14 competing for your business and providing you good product.
15 So I guess it ideally -- like some of these people that have
16 health keepers number one, and all those people that have
17 bronze, that might have been your only option in some cases
18 because you're located in a rural area, for example.

19 MS. MORTLOCK: Yeah. That's an excellent
20 observation. I think in terms of sort of public -- you
21 know, for public consumption I think that would be
22 definitely something that we can explore the feasibility of
23 doing. I will just note that Virginia is pretty fortunate
24 in that we have -- I think in the last two years we have had
25 at least two carriers in every region available for

1 consumers. So that is a -- certainly we're glad for that,
2 and not every state is quite that fortunate. But I do think
3 that having for people to see visually what the carriers
4 that are in their regions and available to them, and then
5 how people enroll would be a good thing to explore.

6 DIRECTOR PATCHETT: Yeah. And one of the other
7 things that I was starting to speak about when I was cut off
8 by the power, you know, these are by rating areas, and one
9 of the things that we've recognized is that every rating
10 area is not homogenous. So there is real benefit to being
11 able to get down to, you know, smaller geographic units than
12 just the rating area. So we have the information to do it.
13 It's high on our priority list. So keep an eye out for that
14 in the hopefully not too distant future.

15 MS. KISER: One quick followup. The average
16 premium was somewhere on there. It was like 350. Is that
17 with CSRs? Is that what the patient's paying, or that is
18 what the -- like what is that?

19 DIRECTOR PATCHETT: That's the gross. That's the
20 gross. Yeah.

21 (Crosstalk.)

22 CHAIR CORLETTE: That's no gross. Without the
23 APTC, Kevin?

24 DIRECTOR PATCHETT: Yes.

25 COMMISSIONER WILLIAMS: We should have the with

1 financial assistance number on there as well. 119 sticks in
2 my mind for what the average premium with --

3 MS. MORTLOCK: Yeah. And that is -- that is per
4 member. So that would be -- consumers with financial
5 assistance is almost in the top of the middle there. That's
6 the numbers of -- sorry. That's the enrollment. There
7 is --

8 MS. KISER: 344.39?

9 MS. MORTLOCK: Yes, and that's per member per
10 month.

11 (Crosstalk.)

12 UNIDENTIFIED SPEAKER: That was actually going to
13 be my point is adding whatever the premium is, and then that
14 CSR amount.

15 CHAIR CORLETTE: Yeah.

16 (Reporter interrupts for clarification of the record.)

17 MS. KISER: We want to know what consumers are
18 paying.

19 MS. MORTLOCK: And this may not be the final
20 format that we post on the website. This was a lot of
21 information that we wanted to be able to share with you
22 today to show our progress and getting these available. So
23 we will certainly welcome your suggestions and happy to --

24 CHAIR CORLETTE: Yeah. This is great. And it
25 bears repeating that this is not data that -- I mean, we

1 have some of it, but a lot of this is data we wouldn't have
2 had without the State-Based Marketplace.

3 Did other people have questions on the data?
4 Ikeita?

5 VICE CHAIR HINOJASA: This is Ikeita. I'm just
6 wondering, as you were poring through all of these metrics
7 and putting it all together, what were some of your most
8 surprising findings or lessons learned?

9 MS. MORTLOCK: So I would say that the number
10 of -- so we did see quite an increase in youth enrollment.
11 And so for our first year as a State-Based Marketplace
12 having captured, you know, more individuals under the age of
13 I think it was 19 to 25 was really encouraging to us.

14 And then I think the other thing that really stuck
15 out too, but certainly, you know, aligns with sort of the
16 landscape of what's happening and what has happened in
17 healthcare over the last -- you know, since the pandemic is
18 really the increase in the number of older individuals,
19 older adults, you know, who have purchased Marketplace
20 coverage, so 55 to 64. Those are some of the key ones.

21 Kevin, did you have others that you've thought
22 about and wanted to share?

23 DIRECTOR PATCHETT: So it's difficult to pick a
24 metric that was most surprising, although it's -- it's
25 interesting. I'm not sure we are showing here today our by

1 age metrics. What I think has been most surprising for us
2 is as we've started to work with the data and recognize --
3 and, you know, we've seen some of it here today, but just
4 the different ways we can look at the data, the different
5 ways we can talk to you about the data, and small changes
6 that we make in a criteria here or there, how much it
7 changes -- how much it changes the outcome. So, you know, I
8 think for me, when I looked at the data, one of the things
9 that surprised me was the income distribution. It was
10 really very different than what I had expected. And I
11 think, James Williams, you pointed out the number that --
12 again, we reported it here is unknown. It really should
13 have been not reported. But, you know, the number of
14 individuals that are purchasing insurance above the four and
15 500 percent poverty level, the number of individuals who
16 aren't reporting income, and then the way that income
17 distribution plays out, especially between the 138 percent
18 up to 250 percent of the federal poverty level. I think
19 what really has been most important for me to take away is
20 just how much we have to learn about who our consumers are
21 and how we can help them, what issues might be confronting
22 them. And that's the value of a lot of the demographic
23 data, especially as we get to a point where we can start
24 doing some meaningful cross-referencing of that data.

25 MS. MORTLOCK: Thank you.

1 DIRECTOR PATCHETT: Any other data-related
2 questions?

3 Let me take a second here then and circle back to
4 the question again that James Williams had raised regarding
5 validating changes in the DACA status of individuals. It is
6 a process that we are still working through, and we've
7 learned that CMS is still working through it on their end.
8 But, generally speaking, we're going to be using the
9 existing processes that we have to not reinvent the wheel.
10 Right now twice a year after open enrollment we do what's
11 called a periodic data matching where we take our entire
12 consumer population and run their eligibility, or their
13 enrollment against federal and state databases, including
14 Medicaid, Medicare and a number of others to make sure that
15 our enrollment process, the integrity of it's being
16 preserved. So one of the things we'll do for the DACA
17 population is we will run those folks against the federal
18 immigration status databases that we have access to to
19 ensure the integrity of those enrollments.

20 All right. I'm going to pass it back over to
21 Holly who's going to do a brief summary of some operational
22 policy issues. I think, as many of you know, every year CMS
23 publishes a notice of benefit and payment parameters, which
24 are the annual CMS regulations. This year was a very
25 fruitful year for federal regulation, and some of those

1 require -- some of those require us to do what our federal
2 regulator tells us to do. Some of those are areas where we
3 have to make decisions. And even where we are required to
4 follow a CMS regulation, there are still decisions that we
5 make on how we're going to operationalize these. And so
6 Holly and her team have selected a few to talk about today.

7 So, Holly, back to you.

8 MS. MORTLOCK: Thank you. And so for the court
9 reporter, this is Holly Mortlock speaking. So as Kevin was
10 talking about our strategic priorities over this year and
11 years to come, I sort of took my -- I had to take a big
12 breath because I realized we're just over halfway to -- at
13 the halfway point this year to the next open enrollment. So
14 we are thick -- we are in the thick of our Special
15 Enrollment Period campaign, so individuals who may be
16 experiencing a qualifying life event and still coming to the
17 Marketplace to access coverage. So we're learning a lot
18 through that process of implementation and issues to be
19 worked on. And then at the same time, we are now in charge
20 of implementing new guidance and policy changes as we
21 prepare for November 1. So as Kevin had noted, there are a
22 number of policy changes. We got quite a few this year that
23 start at the end of this year and into plan year '25. And
24 so both of those -- I guess, both of the mandatory and the
25 discretionary changes provide a -- they present a wide range

1 of what I would say opportunity and some challenges for the
2 Marketplace and for our consumers. I just wanted to give
3 you a brief overview of some of these issues, some of the
4 key ones that we are operationalizing for your awareness.

5 So, of course, the first one is network adequacy.
6 So CMS in their 2025 notice of benefit and payment
7 parameters finalized that they are -- that starting January
8 of 2026, State-Based Marketplaces will be required to
9 establish quantitative network adequacy standards that are
10 aligned with the FFM standards. And so the Exchange, in
11 consultation with the Bureau of Insurance and the Department
12 of Health who lead these efforts, we have to work together
13 to create these standards and a process for conducting
14 network adequacy compliance reviews by 2026. And so this is
15 currently a partnership between VDH and the Bureau. And so
16 we are in that conversation with them, and working out how
17 to best implement this. But we are having those
18 conversations, and we will be prepared when the time comes.

19 DIRECTOR ROBERTS: (Indiscernible) network
20 adequacy too.

21 MS. MORTLOCK: Yes, it did.

22 DIRECTOR ROBERTS: Except yours was quicker.

23 MS. MORTLOCK: Yes. So we will be ready for that
24 in January of 2026.

25 The next requirement has to do with the offering

1 of telehealth services and the requirement for carriers to
2 provide information on their services that they offer
3 through telehealth. So this is a requirement by plan year
4 '26. And in order to operationalize that development, we
5 are working with the Bureau in updating QHP certification
6 requirements to ensure that we can collect that data and
7 report it accordingly.

8 The next big one I'll say is a failure to
9 reconcile. So some of you may be familiar with that issue,
10 I suspect. So prior to the end of the public health
11 emergency, or prior to beginning of the public health
12 emergency, the ACA and federal law required that individuals
13 receiving premium tax credits must file taxes and reconcile
14 their premium tax credits with the federal government that
15 they've used every year as a condition of eligibility for
16 premium tax credits. And prior to now, they were required
17 to do that on an annual basis. And if they did not
18 reconcile their tax credits annually, then they would lose
19 their eligibility for them. With the public health
20 emergency, the federal government paused the enforcement of
21 that requirement. And so the NBPP for 2025 requires
22 Marketplaces to resume the enforcement for this upcoming
23 open enrollment and stipulates a couple of things, but
24 exchanges may only deny tax credit eligibility for
25 individuals who have failed to file and reconcile for two

1 years, two consecutive years. And then it also requires
2 that Exchanges provide annual notification to consumers with
3 a failure to reconcile status for both one and two years.
4 And so it does require that we remove eligibility for
5 premium tax credits for consumers who have failed -- who we
6 verified have failed to reconcile for two years. CMS
7 does -- this is a requirement, but they do provide
8 flexibility to State-Based Marketplaces in how to meet those
9 requirements. This is a complicated process, and we are
10 working very closely with CMS and other states, especially
11 those who have experience implementing failure to reconcile
12 processes to get all of the lessons learned and suggestions
13 as to how we can best implement this for Virginia. There
14 are two things that we are working really closely on. One
15 is to ensure that our process, of course, is in compliance
16 with the regulations; and, two, that it's an opportunity to
17 support consumers to keep their coverage, to keep that
18 continuity, as well as educating them about how to maintain
19 their coverage year over year and use that opportunity to
20 engage with them on a yearly basis making sure that they've
21 provided their updated information and reconciled. And so
22 really that is one of the -- one of our key goals is to
23 really help improve that consumer literacy and how to manage
24 their health insurance coverage. So that is the opportunity
25 in that policy development.

1 The next item that we have is standardized plans,
2 and, of course, so for plan year '24 and '25 the requirement
3 generally maintains consistency with the approach that CMS
4 adopted for this year and for plan year '23. And beginning
5 plan year '25, the FFM is going to limit the offering of
6 carriers to two nonstandard plans per product type, metal
7 type and service area. To maintain consistency sort of over
8 our transition, the Exchange decided to align with the FFM
9 for plan year '24. As we recognize the importance of the
10 discussion about standardized plans, and also a consumer
11 choice and how to support them in decisionmaking, those are
12 some key priorities that we have. We know that there is a
13 lot -- we have a lot to learn about how to create a process
14 and a policy to best help consumers, and so we are taking
15 some time to learn as much as we can and to consult with our
16 stakeholder groups to get their recommendations and thoughts
17 about what is going to work best for Virginia. So for plan
18 year '25, we have made the decision to continue to adhere to
19 the plan year 2024 requirements and not move towards the
20 more aggressive -- aggressive is a poor choice of words, but
21 having the four nonstandard plans allowed versus two. And
22 so we will be discussing with our stakeholders over this
23 coming year, and we'll be providing information as soon as
24 we have made the decision available for the upcoming -- for
25 plan year '26.

1 The next one is the Special Enrollment Period
2 opportunity for individuals with incomes 150 percent of the
3 federal poverty level and below. So this SEP allows us to
4 make available a monthly SEP for individuals who are APTC
5 eligible. So we currently have implemented this SEP. We
6 did this as part of our strategy to help promote coverage
7 transitions during the unwinding. Individuals who are in
8 this income category will be able to switch plans monthly,
9 if necessary, although certainly some challenges with that.
10 We do see this as an essential component of reducing churn
11 between Medicaid and the Marketplace. And we will continue
12 to offer this SEP on an ongoing basis.

13 The next one is premium payment deadline
14 extensions. So one of the things we have learned is that
15 there are all kinds of extenuating circumstances that
16 individuals and even carriers can experience in making sure
17 that those premium payment deadlines are met. The NBPP
18 gives Marketplaces the discretion to extend those deadlines
19 in certain circumstances, and so we appreciate that
20 flexibility that allows for continuation of coverage. And
21 we are -- our policy is to -- you know, if carriers are
22 experiencing difficulty for a number of reasons, we will --
23 they make the request to us, and then we just evaluate that
24 request on a case-by-case basis, but, of course, with a lens
25 on helping consumers maintain their coverage.

1 And then the last two -- I know Shelby gave us a
2 lot of information about the new DACA rule. And what I will
3 just share with you all is that we will be ready for
4 November 1 for that implementation, and that we are working
5 closely with our vendor and also with other stakeholders.
6 We are in the midst of developing our marketing and outreach
7 strategies for open enrollment and preparing messaging to
8 help us realize that rule's full potential. And we will
9 place a special focus on addressing the effects related to
10 the public charge to make sure that people know about the
11 availability of that coverage for them.

12 And then I have one more, Kevin.

13 So CMS just recently issued guidance that gives
14 Marketplaces and Medicaid flexibility for unwinding
15 provisions. They did allow Marketplaces to extend the
16 unwinding SEP through November 30 of this year. And so, as
17 we are watching carefully to see what is in the best
18 interest of our carriers and our consumers, we have extended
19 our unwinding SEP to September 30 and will continue to
20 evaluate the need for any further extensions as we get
21 closer to the end of summer.

22 DEPUTY DIRECTOR LUNARDI: This is Jeff Lunardi. I
23 just wanted to publicly say thank you. I know I've said
24 thank you privately. But when we called Holly and Kevin
25 when this flexibility got opened up, they were ready to hit

1 send on it already, so we appreciate it.

2 MS. MORTLOCK: Of course.

3 Okay. Back to you, Kevin.

4 DIRECTOR PATCHETT: Yes. Thank you, Holly. I
5 wanted to take a minute and just add a little context to one
6 of these, because I think it's really illustrative of what
7 we do as an Exchange beyond providing a simple enrollment
8 platform and customer service center. So the failure to
9 reconcile is turning out to be a wonderfully complex and
10 challenging rule to implement. And one of the things that
11 has really surprised all of us is that this isn't something
12 that was new. There were lots of states who were doing this
13 prior to the pandemic. But, as we've talked to them, so
14 many of them are really going back to square one in
15 evaluating how they've worked their process, what's been
16 good, what hasn't been good because it presents a competing
17 set of challenges for consumers. So consumers who haven't
18 reconciled their income taxes but continue to receive
19 advanced premium tax credits run the risk of owing a
20 potentially significant tax liability to the IRS when they
21 do reconcile.

22 On the other side of that, it has been known for
23 quite some time that the federal databases that report on
24 consumers' tax reconciliation status are not great. They're
25 outdated. They're not updated as frequently as they could

1 be. So very often Exchanges are being put in the position
2 of making decisions to remove consumers' APTCs on less than
3 perfect information, and as -- I'm not sure we actually have
4 the numbers up there today. But as we talked about, there's
5 a significant difference between the average premium with
6 and without a APTCs. So a consumer who loses APTCs because
7 of bad information reported from a federal database may
8 determine whether or not that consumer keeps health
9 insurance coverage or not.

10 So how we operationalize this requirement has a
11 big impact on consumers, and so it requires us to really
12 think through how do we do this, how do we meet the needs of
13 consumers, how do we pair messaging with operations, how do
14 we think about supporting consumers while maintaining
15 compliance. And this is a lot about why it is that we are
16 happy to be here as Virginia's Health Benefit Exchange so
17 that we can create a solution that we and our stakeholders
18 and our partners and consumers think is best for Virginia.
19 And I can tell you it's -- we're not going to have a
20 situation where all 18 or 19 Exchanges are doing this the
21 same way. I think they're probably going to be at least
22 four different -- four different flavors of it. So I wanted
23 to share that as just one more detailed example of what it
24 means for Virginia to have its own Exchange and how we
25 consider all the many implications of these rules that we're

1 going to get updated every year.

2 And so, with that, I'll turn it back to you,
3 Sabrina, and any other questions from the committee.

4 CHAIR CORLETTE: Well, thank you, Kevin. Thank
5 you, Holly, for a great presentation. And I'm really
6 thrilled to see the rich data that we can use to not only
7 identify where things are going well, but also identify
8 areas where we can build and improve.

9 So I have a question. It's less of a policy
10 question and more of a like compliance operations question.
11 Some of you may have seen in the news reports about
12 fraudulent enrollments and fraudulent plan switching where
13 it sounds like it's mostly unscrupulous brokers for
14 commission, gain commission revenue are going in and
15 enrolling people who are not -- aren't even aware that they
16 are being signed up for coverage, or are signed up for
17 coverage and are not aware that somebody's going into the
18 system and switching them to a new plan. I'm told that this
19 is primarily a problem for the states that use
20 healthcare.gov and not for the SBM states. But I'd be
21 really curious, Kevin, Holly or anybody, like to what extent
22 are you seeing this kind of behavior in Virginia; and, if
23 you are, sort of what -- and this may also be a question for
24 the Bureau -- you know, to what extent are there, you know,
25 preventive measures in place or investigations going on to

1 try to curtail what really is, you know, a problem for the
2 consumers who are unknowingly put into this coverage when
3 maybe they don't want to be or shouldn't be.

4 DIRECTOR PATCHETT: Yeah. It's an important issue
5 and a good question, Sabrina. Fortunately, we are not
6 seeing this problem in Virginia, really not even on a small
7 scale. However, because we're seeing it at the federal
8 level on a pretty large scale, we're doing a few things.

9 First, we've created a policy and a process to
10 make sure that if this does happen in Virginia, whether it's
11 once or more, we are able to take the necessary steps,
12 including things like referring to agent regulation at the
13 Bureau to make sure that appropriate licensing action is
14 taken, that our own process for decertifying agents is
15 included, as well as what we can do in terms of retroactive
16 disenrollments to benefit consumers who are harmed.

17 The other piece of this for us and one of the
18 things that makes this a little challenging is that we still
19 don't have really good information from healthcare.gov on
20 what really are the underlying causes of this. But,
21 nonetheless, we've really gone back to square one in the way
22 that we do agent-facilitated enrollment in plans, which
23 is -- and really walk through the process to see, you know,
24 what can we learn, are there ways that we can do better that
25 we can, as you say, implement some of these preventative

1 steps. And, overall, I think we've got the right balance.
2 Part of what we're balancing thing is -- you know, we could
3 make this -- we can make this very, very difficult for a bad
4 actor to do. We could never make it impossible because
5 really to make it happen the agent or broker has to have a
6 pretty significant amount of consumer information to
7 validate their identity. But there are things that we can
8 do to make it virtually impossible, but that would also make
9 it really difficult for certain segments of our population
10 to work with an agent and broker. And so, you know, we
11 don't want to get the balance wrong there. And I think we
12 have come to a place where we think we're still striking
13 that balance properly, but we have identified a few things
14 that we can supplement in terms of controls, notice and
15 messaging to consumers that we think will help in the event
16 that there is unauthorized enrollments or plan switches.

17 CHAIR CORLETTE: Thank you. And it's great to
18 hear that it's not happening in Virginia the same way it
19 seems to be happening with healthcare.gov.

20 Other questions?

21 VICE CHAIR HINOJASA: This is Ikeita. So, first
22 of all, I just want to express enthusiasm and excitement for
23 how your team is moving forward on our advisory committee's
24 recommendations for strategic priorities. It's nice to see
25 how everything is taking shape. And so I was just

1 wondering, in terms of your leadership team, do you now
2 currently, or do you have plans in the future for developing
3 or creating a mission and vision statement now that your
4 organization is more fully formed?

5 DIRECTOR PATCHETT: Yes, absolutely. And thank
6 you for that question. One of the things we finally had a
7 chance to do for the first time in the late winter was to
8 sit down as a leadership team and really start focusing on
9 strategic planning and strategic priorities. You know, we
10 then looped in another two layers of the leadership team to
11 start developing the mission statement, a set of cultural
12 values. I really thought we would have those ready for you
13 for this meeting, but, as it turns out, there are a whole
14 bunch of other operational things that we're doing for the
15 first time as a Marketplace, you know, including
16 operationalizing failure to reconcile. So we are very much
17 in the middle of that effort.

18 One of the things that I will say that has been
19 extremely satisfying to me is to see the way that our team
20 is very quickly coming together and developing a culture
21 that is already customer service-centric. I wish I had a
22 way to show you all the reaction that really our entire team
23 from customer service to IT operations to policy, the way
24 they react when we learn that a consumer has had a wrong
25 outcome or has had a challenge with the platform. The just

1 immediate motion into action and hours committed to get that
2 right are really exciting to see and going to be at the
3 center of what you see in terms of our mission statement and
4 values.

5 VICE CHAIR HINOJASA: Great. Yeah. So whenever
6 that comes together, we're excited to see that.

7 And then my second question was, when you kind of
8 recapped the top-line strategic priorities you mentioned,
9 you know, continually improving the consumer experience.
10 And so I was just wondering what kind of consumer feedback
11 you've received to date.

12 DIRECTOR PATCHETT: So a couple of things.
13 Overall, the consumer feedback has been very positive. I
14 will say far more positive than I expected. One area where
15 we are receiving consumer feedback that has become the focus
16 of improvement for our customer service work right now and
17 over the last few months, we have found that there are
18 consumers who are not getting escalated to my internal
19 escalation customer service team that we've, unfortunately,
20 had consumers who have been told by our call center that,
21 you know, there's nothing that can be done for them, and
22 they hit a wall. And, to me, that's an unacceptable
23 outcome, and one of the areas that has been a priority for
24 us in terms of improving customer service. And that's been
25 a multi-pronged effort in terms of developing the right

1 processes and tools internally, the right training for our
2 customer service representatives, getting the right kinds of
3 metrics and levers in place with our vendor. So, you know,
4 that's -- that's one example of where our customer service
5 focus has been. Right now we've been able to be -- I think
6 we need to knock on wood somewhere. But in terms of the
7 escalations that have come to us throughout open enrollment
8 and since, we've been able to resolve all of those within 24
9 hours, which is an important metric to us.

10 VICE CHAIR HINOJASA: Thank you.

11 CHAIR CORLETTE: Starla?

12 MS. KISER: Yeah. I have a comment, not a
13 question, but I didn't mention earlier just thank you for
14 the data piece. I was very appreciative of that. I didn't
15 tell you it was beautiful, but, like I said, it was so, so
16 nice to see. I mean, I don't know if other states are doing
17 this, but I think the geographic piece is just so important.
18 And I think it's just beautiful to see -- you know, and
19 again we can dig into it more maybe, as Kevin mentioned, not
20 just by rating, but by geographic region, like smaller
21 regions. But I think I brought this up before. There's
22 such an opportunity to take this map and just, you know,
23 look at it and be like, which region is most impactible. So
24 if you compare this map to a map of all the uninsured in
25 Virginia being able to spark target, you know, we need to

1 look in central Virginia now, and like really call those
2 people and just have more aggressive outreach. So there's
3 such an opportunity, like I said, to pair that with other
4 data that's out there to figure out, you know, where's my
5 pool of eligibles that I need to go grab within the whole
6 state to reduce the uninsured rate as a whole.

7 But I would also say we do need more young,
8 healthy adults and individuals. So I think it's very
9 interesting. Kevin, you mentioned about the surprise, which
10 I think we heard that last meeting, and I was surprised as
11 well that these young people, presumably could have been
12 under their parents' insurance, that are actually signing
13 up, or even today where you mentioned the unknown, so people
14 that are paying without subsidies. It'd be great to have a
15 lot more of those. Right? So it's like to just know who
16 that group of people is, like who are these people so that
17 we could, again, target more of those. It'd be great if
18 these young adults, like why are you signing up, or like,
19 you know, what's common about that group so that more of
20 them can sign on to what we're doing.

21 And one other little follow up is just about
22 consumer experience. I feel outside of just talking to
23 agents and like trying to sign up, I would love to know,
24 ultimately, do our consumers think that we're giving them a
25 good product, do they like their insurance products. So

1 year to year when you have these people that do not
2 reenroll, why? Like I used to be -- when I had -- I was
3 self-employed -- I have my own business still, but when I
4 had my own clinic I had to go on the Obamacare Exchange a
5 few years ago, and, again, I only had health keepers as an
6 option, and it was like, I don't know, 400 bucks a month.
7 And I'm like I'm young and healthy. I'm not doing this, you
8 know, for a very poor plan. But I mean, a lot of -- and I
9 mean, I had, presumably, a better income than a lot of
10 people in my region. Right? So consumers everywhere are
11 very cost conscious. So that's also where the data of
12 understanding like the number of carriers per region, what
13 are their costs, because I would imagine it's going to be
14 greatly different throughout the state, because the state is
15 so heterogeneous. Anyway.

16 DIRECTOR PATCHETT: Yeah. I think you're exactly
17 right, and I -- you know, we're just a few months away from
18 the Bureau of Insurance publishing rates for next year. But
19 every time we look at those, there -- I mean, there really
20 is an amazing variance certainly from rating area to rating
21 area and perhaps within rating areas. One of the other
22 things that we're doing right now -- or so two things that
23 we're doing right now in response to those questions, one,
24 we are in the middle of developing both some better tools
25 and what we hope is going to be a more effective consumer

1 survey to get better feedback from our consumers. Right now
2 the surveys that we're doing are really focused around
3 overall customer satisfaction, and we want to do better than
4 that while figuring out how to strike the balance between --
5 you know, nobody's going to answer a 30-question survey, so
6 how can we minimize the number of questions, but get the
7 information we need.

8 The other thing that we're doing right now is
9 enhancing our data analysis tools. We had some good tools
10 at our disposal coming out of the gate. But one of the
11 things that we realized, in order to maximize the utility of
12 the data we have, we need to be able to incorporate outside
13 data to do some of these analyses comparing, as you
14 mentioned, uninsured data to, you know, some of our
15 enrollment and demographic data. Unenrolled is not part of
16 our system, but we have that data. There are lots of other
17 examples of where we can begin to pull external data that's
18 out there to really do some meaningful analysis. And so we
19 are almost finished standing up the tools that are going to
20 allow us to do that.

21 VICE CHAIR HINOJASA: Thank you.

22 CHAIR CORLETTE: Craig Connors?

23 MR. CONNORS: Craig Connors. Does the Marketplace
24 have its own process for consumer complaints if a consumer
25 has a complaint about either its plan or a issue they are

1 unable to resolve with the plan, or they go through the
2 BOI's consumer complaint system? Do you know what I mean?
3 BOI has a consumer complaint form. Do you go through that,
4 or does the Marketplace have its own pathway?

5 MS. MORTLOCK: It depends on what their complaint
6 is for.

7 MR. CONNORS: What about providers? The BOI has
8 recently posted a provider complaint form on its website.
9 Is there a pathway for providers with the Marketplace plan,
10 or is the only pathway if the provider has a complaint about
11 a Marketplace plan to go through the BOI's process?

12 MS. MORTLOCK: So I think that would just be part
13 of our evaluation process of the complaint. So certainly I
14 know providers are familiar with the Bureau process. If
15 there was a complaint that a provider wanted to make, I
16 think anyone could make a complaint with the Marketplace and
17 that would be evaluated in whether or not it was something
18 that should be addressed by the Bureau, you know, we would
19 work cooperatively with them to share the complaint to have
20 it addressed, I think, just depending on what the complaint
21 was.

22 MR. CONNORS: I guess I need to find that, though.
23 There is actually a specific place on the Virginia
24 Marketplace website for --

25 MS. MORTLOCK: For complaints.

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1 MR. CONNORS: -- to complain?

2 MS. MORTLOCK: Yes.

3 MR. CONNORS: Just complaints?

4 MS. MORTLOCK: Yes.

5 DIRECTOR PATCHETT: Yeah. And that's something
6 that we would be very interested in additional feedback. As
7 Holly mentioned, you know, there are some complaints that
8 really do go through the Bureau, but we work hard to make
9 sure that we're collaborating with the Bureau because many
10 of these things don't fit neatly into the Bureau or the
11 Exchange individually. There's a need to collaborate. But
12 if you go -- and I'm sure Holly can send you the link to our
13 consumer processes and our complaint processes. And if you
14 look and think, yeah, there's a gap here, there's some
15 benefit in, whether it's providers or whomever having access
16 to a complaint process, we're more than happy to talk about
17 that and see how we can make it better.

18 MR. CONNORS: Great. Thank you.

19 CHAIR CORLETTE: This is Sabrina. It sounds like
20 the original provider directory that you all had maybe did
21 not meet expectations, so that's the kind of thing, I would
22 imagine, as that rolls out that would be an Exchange sort
23 of -- the place to go for that would be the Exchange if
24 there's any issue.

25 MS. MORTLOCK: Yes. Yeah.

1 CHAIR CORLETTE: All right. Any other questions
2 for Kevin or Holly?

3 Great. Well, I think we're close to time. I just
4 had one small question, just a clarifying question. Kevin,
5 at the start of your presentation, you mentioned a few
6 things that are on the horizon. One was the provider
7 directory. I also think it's great that you're rolling out
8 an agent mobile app to make things easier for your agents.
9 I was curious, is that also going to be available for
10 navigators and other assisters, or is it only for the broker
11 or the assisters?

12 DIRECTOR PATCHETT: So right now it's just a
13 broker mobile app. We are expanding this year other tools
14 for navigators and assisters. One of the things we learned
15 in the middle of our implementation last year was that our
16 navigator and assister portal was not quite as robust as the
17 agent and broker portal, so we have done a number of things
18 to align those. But we are more than happy to look at ways
19 that we can take what we learned from the rollout of a
20 broker mobile app and apply that to navigators and
21 assisters.

22 CHAIR CORLETTE: Great.

23 DIRECTOR PATCHETT: I will just share one other
24 thing quickly. We're in the middle of doing some focus
25 groups to get feedback from a number of our stakeholders.

1 The one that we're in the middle of right now is actually
2 with our agents and brokers. And as my stakeholder
3 engagement team was meeting with some other states to find
4 out how they do -- what processes they use to get feedback
5 from various stakeholders, including agents and brokers, we
6 actually had a couple of states who said we don't because we
7 really wouldn't want to hear their feedback. And, you know,
8 that's -- that's not who Virginia's going to be as an
9 Exchange. So we really are leaning in to our stakeholder
10 engagement. We we want feedback. We want criticism. We
11 want to make this Marketplace the best for everyone in
12 Virginia.

13 MS. MORTLOCK: I will add to Kevin's point about
14 that. So that's an absolutely true story, and we did do --
15 we have done agent focus groups this spring. I know --
16 early summer now. There is one more, I believe. And really
17 the overwhelming message that we are getting from our agent
18 community for folks who have substantial numbers of
19 enrollments and participated in these groups is that they
20 have very positive reactions to the Marketplace, and they
21 came with also very good constructive feedback and
22 suggestions to how to help them and their consumers. So
23 we've really taken that under advisement and are looking
24 forward to reviewing that more closely and seeing how we can
25 strengthen that relationship in collaboration with them. So

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1 we're just very, very excited to see that happen.

2 CHAIR CORLETTE: Any other questions?

3 SECRETARY LITTEL: This is John Littell. I would
4 just maybe end by where we started, and just say from the
5 administration's standpoint this has really been very, very
6 positive. And, you know, we started in 2022 high up on our
7 (indiscernible) were the unwinding and the implementation of
8 State-Based Exchange, and they're obviously very connected.
9 And we're still not done with the unwinding, but both have
10 gone remarkably well. And I think the linkup between the
11 two has been really very positive. So really good work.
12 Now I have other things that have risen to the top of my
13 list, which if you'd like to take them, you may, but it's a
14 good thing.

15 CHAIR CORLETTE: Great. Well, with that, can we
16 move to adjourn?

17 SECRETARY LITTEL: Don't we have to do public
18 comment?

19 CHAIR CORLETTE: Oh, I don't think we have any,
20 but I'll ask.

21 MS. MORTLOCK: We did not have anyone sign up for
22 public comment today.

23 CHAIR CORLETTE: Okay.

24 (Indiscernible.)

25 CHAIR CORLETTE: Oh, yes. Here we go.

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1 Exchangedivision@sec.virginia.gov if you'd like to submit
2 any public comments. Okay.

3 MS. MORTLOCK: Next meeting is --

4 CHAIR CORLETTE: Thank you. Next meeting,
5 September 24. That will be virtual. And then our last
6 meeting of the year, December 12. Anything else, Holly,
7 before we adjourn?

8 MS. MORTLOCK: That's all that we have.

9 CHAIR CORLETTE: Okay.

10 VICE CHAIR HINOJASA: I'd just like to say, you
11 know, right now we don't have any active subcommittees, but
12 to the extent that your team identifies a need or something,
13 I mean, feel free to let us know, and we're happy to start
14 up a subcommittee again, or, you know, something like that.
15 And, you know, we can always consider that in our September
16 or December meeting. So you all can talk internally, and we
17 can get something going to the extent that your team needs
18 additional assistance or consideration from our end.

19 MS. MORTLOCK: Yeah. Thank you so much. We will
20 definitely, definitely do that.

21 CHAIR CORLETTE: All right. Well, thank you,
22 everybody. I'll move to adjourn.

23 MR. CONNORS: Second.

24 CHAIR CORLETTE: All right. We are adjourned.

25 (The proceedings adjourned at 4:01 p.m.)

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CERTIFICATE OF COURT REPORTER

I, Danny Terry, the officer before whom
the foregoing proceedings were 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.



Danny Terry, Court Reporter

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CERTIFICATION OF TRANSCRIPT

I, Nicole Mastrosimone, do hereby certify that the foregoing transcript, to the best of my ability, knowledge, and belief, is a true and correct record of the proceedings; that said proceedings were reduced to typewriting under my supervision; 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.

Nicole Mastrosimone

Nicole Mastrosimone

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