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Transcript of Advisory Committee Meeting

Date: December 12, 2024

Case: Health Benefit Exchange Advisory Committee Meeting

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COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

VIRGINIA HEALTH BENEFIT EXCHANGE
ADVISORY COMMITTEE MEETING

Conducted Remotely
December 12, 2024
2:05 p.m. to 3:40 p.m.

Job No.: 563589
Pages: 1 - 70
Transcribed by: Ruth A. Levy

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A P P E A R A N C E S

Voting Members:

- Ikeita Cantu Hinojosa, Interim Chair
- Keven Patchett, Director
- Lee Biedrycki
- Scott Castro
- Sheenu Kachru
- Doug Gray
- Kip Piper
- Louis Rossiter

Ex-officio Members:

- Julie Blauvelt, Deputy Commissioner, Bureau of Insurance
- Hope Richardson, DMAS

Also present:

- Holly Mortlock, Chief Government Relations Officer/HBE Liaison to Advisory Committee
- Rachel Becker, Senior Policy Advisor for the Exchange

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

2 INTERIM CHAIR HINOJOSA: It is only
3 2:06. So we will call this meeting of the
4 fourth quarter Virginia Health Benefit
5 Exchange Advisory Committee meeting to order,
6 taking place virtually on Thursday, December
7 12th, 2024. My name is Ikeita Cantu
8 Hinojosa. I am vice chair serving in the
9 position of interim chair of the Advisory
10 Committee. Welcome. Thank you for joining
11 today.

12 So open enrollment is under way for
13 the 2025 health coverage, and we're all very
14 excited to learn about the latest
15 developments for Virginia's Insurance
16 Marketplace. So let's go ahead and get
17 started.

18 So in terms of meeting etiquette,
19 only committee members should turn on their
20 cameras. The chat is disabled. So please
21 remain muted and use the raise hand function
22 to speak. Please refrain from asking
23 questions until speakers have finished their
24 presentations. And the transcript of this
25 meeting will be made available online at the

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1 link you see on the slide.

2 Okay. So let's go ahead and get
3 under way with roll call. So I'll first call
4 the roll of our ex-officio members:
5 Secretary Janet Kelly? Director Cheryl
6 Roberts?

7 MS. RICHARDSON: Hi there. My name
8 is Hope Richardson. I am at DMAS and
9 substituting for Director Roberts and Deputy
10 Director Lunardi today.

11 INTERIM CHAIR HINOJOSA: Great to
12 have you.

13 Commissioner James Williams?
14 Commissioner Scott White?

15 MS. BLAUVELT: Good afternoon. I'm
16 Julie Blauvelt. I'm substituting for Scott
17 White today.

18 INTERIM CHAIR HINOJOSA: Okay.
19 Dr. Karen Shelton?

20 So now moving on to our appointed or
21 voting members. I am here. All right. So
22 Lee Biedrycki?

23 MR. BIEDRYCKI: Present.

24 INTERIM CHAIR HINOJOSA: Scott
25 Castro?

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1 MR. CASTRO: I'm here as well.

2 INTERIM CHAIR HINOJOSA: Craig
3 Conners? I believe he has a conflict today.
4 Elizabeth Cunningham? Doug Gray?

5 MR. GRAY: Present.

6 INTERIM CHAIR HINOJOSA: Sheenu
7 Kachru?

8 MS. KACHRU: Present.

9 INTERIM CHAIR HINOJOSA: Kip Piper?

10 MR. PIPER: Present. Temporarily on
11 the phone, as I turn my camera on or trying
12 to get it to work.

13 INTERIM CHAIR HINOJOSA: And Lou
14 Rossiter?

15 MR. ROSSITER: I'm here.

16 INTERIM CHAIR HINOJOSA: All right.
17 Thank you all for being here. Okay. So now
18 that roll call is complete, before we move on
19 to the next item of our agenda, I will use
20 chair's privilege to just make a few remarks
21 before we move on to the next item of our
22 agenda.

23 So when the vice -- when our
24 Advisory Committee Chair's appointment
25 expired in October of 2024, I went from vice

1 chair to become our interim chair. And so
2 during the other business portion of this
3 afternoon's agenda, we need to actually hold
4 elections for our chair. So before we do
5 that, I just wanted to take a few minutes to
6 go over the duties of chair and just make
7 sure that we all feel comfortable with what
8 that's about so that we're prepared for the
9 other business portion of the agenda. So I
10 just wanted to take a couple of minutes
11 there.

12 Also, we'll also hold elections for
13 a new vice chair, since I technically only
14 have two more meetings for the Advisory
15 Committee after today, since my term expires
16 in June of 2025. I've been very honored to
17 serve and I'm appreciative of those of you
18 who wanted me to stay on in the leadership
19 capacity, but it is my time to pass the
20 baton.

21 So I'm just going to describe the
22 roles and responsibilities just very, very
23 briefly according to the Exchange bylaws.
24 And according to the Exchange bylaws, the
25 committee chair shall serve on the Committee

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1 as a voting member. So since ex-officio
2 members are nonvoting members, they cannot
3 serve as chair or vice chair.

4 The chair shall coordinate the
5 meeting agenda in collaboration with
6 Commission Staff; act as a liaison between
7 the Committee, the Exchange director, and the
8 Commission; submit recommendations of the
9 Committee to the Exchange director and the
10 Commission; and also coordinate the
11 collection, review, and storage of public
12 comments with the Commission Staff for the
13 consideration of the Committee. So those are
14 the committee chair responsibilities.

15 The committee vice chair shall act
16 as chair during the temporary absence or upon
17 resignation of the chair and shall work in
18 collaboration with the chair in fulfillment
19 of the chair's duties as needed. So that's
20 what the vice chair does.

21 So speaking personally, I've served
22 as both interim chair and as vice chair, and
23 I will say that the estimated time is minimal
24 in terms of the commitment; it's generally in
25 connection with the quarterly meetings. And

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1 so with that overview, I will just pause and
2 see if folks have any questions for me or for
3 SCC Staff just about the chair or vice chair
4 duties, with that brief summary and overview.

5 MS. KACHRU: I have a question; it's
6 Sheenu. I'm just curious: What's the term
7 for both of these roles? And then -- yeah,
8 what are the terms, in terms of span of time?

9 INTERIM CHAIR HINOJOSA: So that's a
10 good question. There isn't an SCC -- and SCC
11 Staff can jump in, interject, correct. There
12 isn't a length of time in terms of the
13 by-laws; it really has been, you know, with
14 our appointments, people tend to cycle off or
15 term out. So our previous chair was the
16 chair and then she termed out; her term
17 expired and so she was no longer chair.

18 And some people may decide that it
19 no longer works with their schedule. The
20 vice chair, for example, she termed out so
21 then I became vice chair. So that's how it's
22 happened up till now that we typically -- and
23 this is all very new -- but we typically have
24 very staggered appointment dates and times.
25 And so that's how it's worked up until this

1 point.

2 So people may have schedules or
3 lives that being chair or vice chair may just
4 no longer work, so people may cycle off that
5 way. Or they may term out in terms of their
6 appointments. But there's nothing set in
7 stone that says a person is chair or vice
8 chair for a certain period of time.

9 And Staff, please feel free to jump
10 in.

11 MS. MORTLOCK: Ikeita, this is
12 Holly. And I'll just say that, yes, so the
13 proceedings of the Committee have been upheld
14 informally as the statute allows us to do.
15 And so, yes, that is how it has worked. And
16 we are looking forward to working with the
17 new incoming chair to look at those processes
18 and see, you know, if they still meet the
19 needs of the Committee, just working with
20 you-all on that.

21 So certainly it is not -- if someone
22 wishes to be included in a nomination for the
23 chair, they certainly could take that and
24 would not be obligated to do so longer than
25 they would like to. So resigning is always a

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1 possibility and a new election could be held.

2 INTERIM CHAIR HINOJOSA: Yes. It's
3 not a lifetime appointment. No Supreme Court
4 issues here.

5 MS. KACHRU: Thank you. That's
6 helpful.

7 INTERIM CHAIR HINOJOSA: Any other
8 questions?

9 All right. So hearing none, I
10 believe we are ready to turn to the Health
11 Benefit Exchange updates. So I will turn it
12 over to Staff. Thank you so much.

13 MR. PATCHETT: Thank you, Ikeita.
14 And thank you all for having us here today.
15 It's always a pleasure. My name is Keven
16 Patchett. I'm the Director of the Virginia
17 Health Benefit Exchange. And we've got a
18 long list of things we want to share with you
19 today. I know the typical procedure is to
20 hold questions until the end, given the wide
21 range of topics. I'm comfortable if anyone
22 wants to interrupt me with questions along
23 the way.

24 So since we are a little over
25 halfway into open enrollment, I thought we

1 would start with an open enrollment update.

2 So we have some basic metrics to share.

3 Overall, open enrollment has gone very well;

4 this is our second open enrollment. And

5 while it has been still far busier than I

6 expected, I will say it has not been as

7 eventful and exciting as open enrollment

8 after our transition year, which is a good

9 thing, good thing for us.

10 So one of the things you can see

11 here in these initial metrics is, as of this

12 point in open enrollment, our enrollment

13 numbers are a little bit lower overall than

14 they were this time last year. However, what

15 is higher is the number of new consumers.

16 So overall, this is a positive trend

17 for us and, you know, we've got a little over

18 a month left in open enrollment. And I am

19 really interested and excited to see how

20 these numbers continue to develop over the

21 remainder of open enrollment.

22 Another thing that's different this

23 year than open enrollment last year, last

24 year we had December 15th as the last day

25 that consumers could select a plan and have

1 it be effective January the 1st. This year
2 we've pushed that all the way to December
3 31st. So that is likely to change consumer
4 behavior in that the last-minute
5 procrastinators may be coming on to the
6 marketplace towards the end of the month
7 instead of the middle of the month.

8 Now, before I move on to the next
9 section, I want to just take a minute; I
10 don't have any slides to talk about this, but
11 as many of you may be aware, a couple of days
12 ago a court in the Eighth Circuit issued an
13 order that temporarily enjoined a CMS DACA
14 ruling. When we say DACA rule, we're talking
15 about the Deferred Action on Childhood
16 Arrivals.

17 This was a rule that CMS promulgated
18 that expanded the definition of lawful
19 presence to include DACA recipients and a
20 couple of other immigration statuses for
21 those who are eligible to purchase qualified
22 health plans through the marketplaces. This
23 order is very new and we are in the middle of
24 reviewing it and working with CMS and our
25 legal counsel to understand the impacts from

1 a practical standpoint.

2 Currently, we have 49 individuals
3 who are enrolled under the DACA rule and 12
4 additional individuals whose enrollments are
5 in a pending status. So we will know more
6 here in the coming days, but I wanted to give
7 that brief update now.

8 All right. So the other thing that
9 is really top of mind for us and for a lot of
10 folks who are interested in state-based
11 marketplaces are the enhanced premium tax
12 credits, particularly the expiration of
13 those. And so earlier this week we were
14 asked to present to the Virginia Health
15 Insurance Reform Commission on the impacts of
16 the pending expiration, and we wanted to
17 share with you a little bit of what we shared
18 with that commission.

19 So to start out, let me just give a
20 little bit of background about what advanced
21 premium tax credits are; we don't want to
22 take for granted that everybody knows this
23 very specific area of healthcare policy.
24 When the Affordable Care Act was passed in
25 2010, it included these premium tax credits.

1 Like all other tax credits, they are based on
2 certain eligibility factors and also tied to
3 income. In the case of these premium tax
4 credits, the key factor for being eligible is
5 having purchased a qualified health plan
6 through a marketplace.

7 They are -- as I said, they are
8 income based. And more specifically, it is
9 the ratio between income and health insurance
10 premium that determines the amount of those
11 tax credits. So each individual consumer's
12 income is compared to the premium and there's
13 a sliding scale based on where that
14 individual falls or where that household
15 falls along the federal poverty level
16 spectrum. So the higher your income is
17 relative to the federal poverty level, the
18 greater percentage of your income you will
19 contribute toward your premium, which will
20 reduce the number of tax credits that you're
21 eligible for.

22 The most notable thing that makes
23 these different from other traditional tax
24 credits is they can be paid in advance of
25 filing your tax return, and they're paid

1 directly to your insurance carrier to reduce
2 your monthly premium. Initially, these tax
3 credits were capped to -- the eligibility for
4 these were capped for individuals whose
5 incomes were below 400 percent of the federal
6 poverty level. And that 400 percent, for a
7 long time, has been known as the subsidy
8 cliff.

9 So we're talking today about the
10 enhanced premium tax credits. In 2021,
11 Congress passed the American Rescue Act plan,
12 which expanded or enhanced these tax credits
13 in two ways: First, it removed that 400
14 percent federal poverty level cap so that
15 individuals earning above 400 percent of the
16 federal poverty level could now be eligible
17 for advanced premium tax credits. The other
18 thing it did is it reduced those percentage
19 income contribution levels to make the amount
20 of premium tax credits higher for most
21 consumers. These enhancements are set to
22 expire at the end of next year, December of
23 2025.

24 So then we talk about what are going
25 to be the impacts of this expiration if

1 Congress doesn't act between now and December
2 of next year, and some of these are difficult
3 to really get a handle on. But the first
4 thing we would take a look at is what is this
5 going to do to premiums across Virginia? And
6 on average, we will see about a 22 -- and I
7 say a 22 percent increase. And I say
8 premiums, but it's really the amount of
9 premiums the consumers are paying; the
10 premium itself won't change.

11 So we'll see a 22 percent increase
12 in the amount that consumers across Virginia
13 are paying for their premium. But when we
14 break it down by ZIP Code or rating area,
15 that ranges from 16 percent to 33 percent,
16 depending on which part of the state
17 consumers live in.

18 So the averages, as you'll see from
19 some specific examples that I'm going to
20 share, there will be individuals at certain
21 income levels who won't see any change. And
22 then there will be some who will see a much
23 more dramatic change in what they're paying
24 for their premiums.

25 So then we look at well, what is

1 this going to do to enrollment? And during
2 the time period since these enhanced premium
3 tax credits came into being, we've added
4 about 122,000 consumers to the marketplace
5 here in Virginia, which is roughly a 34
6 percent increase. The congressional budget
7 office released a report last week that
8 estimates nationwide we'll see about a 26
9 percent decrease in enrollments if these
10 enhancements expire, which result in about
11 100,000 people in Virginia no longer having
12 coverage through the marketplace.

13 On the flip side, the congressional
14 budget office estimated that if the
15 enhancements remain in effect, nationwide we
16 would see about a 25 percent increase in
17 enrollment, which would, again, represent
18 about 100,000 individuals in Virginia. So
19 those are the high level impacts. And now
20 let's look at what this will look like for
21 some specific scenarios.

22 So as we created these scenarios, we
23 wanted to do a couple of things to try to
24 keep them as consistent as we could. So all
25 of these scenarios look at the same plan. We

1 looked at four different rating areas across
2 the Commonwealth with that same plan. And
3 then we looked at a range of age, household
4 makeup, and then income.

5 So as you can see, where we started
6 with a 60-year-old couple. And at 300
7 percent of the federal poverty level, you can
8 see it's about a 25 percent increase in their
9 monthly premium. But when we move to that
10 400 percent level, which is where the subsidy
11 cliff will come back into being, this
12 couple's -- what this couple pays for their
13 insurance premium is going to double.

14 And what is really noteworthy here,
15 for me, if you total this up over a year, a
16 60-year-old couple making \$80,000 will be
17 spending about \$20,000 a year on their health
18 insurance premium, which is one-fourth of
19 their annual income, which is a little
20 shocking.

21 Now, if we look at the next
22 scenario, which is a 40-year-old couple with
23 two children at around 300 percent of the
24 federal poverty level, we see close to a 50
25 percent increase in their monthly premium.

1 And that is the same -- about the same at the
2 400 percent federal poverty level. So not
3 quite as extreme as the previous example, but
4 this is still an increase that a family in
5 this particular situation is certainly going
6 to feel.

7 And then our last scenario looks at
8 a 45-year-old individual. And if we look at
9 someone in the 200 percent federal poverty
10 level, again, we can see over a 50 percent
11 increase in that monthly premium. And when
12 we move all the way to 400 percent, there's
13 actually no change as a result of the
14 enhanced subsidies expiring, because at 400
15 percent of the federal poverty level, that
16 individual was already not receiving
17 subsidies.

18 So let me pause here and just make
19 sure we don't have any questions about these
20 scenarios before I move on to our next topic.
21 Okay.

22 MR. CASTRO: I've got a quick
23 question.

24 MR. PATCHETT: Go ahead.

25 MR. CASTRO: This is Scott Castro, a

1 member of the -- I'm not sure if this is part
2 of your overall presentation, but my
3 understanding as well, in addition to the
4 expiration of the enhanced subsidy funding --
5 and maybe we haven't asked this question
6 yet -- but looking into the fact that
7 Virginia is one of nine states with a trigger
8 law that would essentially do away with our
9 Medicaid expansion should the federal funding
10 fall below the 90 percent match, is that
11 incorporated into this at all or is that
12 something that the Commonwealth is looking
13 into?

14 MR. PATCHETT: So it's not
15 incorporated into this. It is separate. But
16 it is something that is certainly on the
17 radar, given what we've seen in the news
18 about proposals being considered at the
19 federal level for adjusting Medicaid funding.

20 MR. CASTRO: Okay. Yeah, because I
21 understand most of that is 100 percent to 138
22 percent. And I know we're looking at those
23 income levels above that that are receiving
24 those enhanced subsidies. But, yeah, just
25 something I want to kind of keep on our radar

1 as well, as we're thinking about how and
2 where people are purchasing their -- getting
3 their insurance and what they are and are not
4 eligible for.

5 MR. PATCHETT: Yeah, thank you. And
6 it's critically important to us, because one
7 of our statutory obligations as the Exchange
8 is to support the continuity of coverage for
9 consumers. So if the -- if that trigger law
10 goes into effect and we see a fairly
11 significant population losing Medicaid
12 coverage or losing eligibility for Medicaid
13 coverage, their next option is going to be a
14 marketplace plan.

15 And so it will be key to the work
16 that we're doing to make sure that we are
17 helping consumers in that situation
18 transition and get the coverage they need
19 through the marketplace, similar to what
20 we've been doing and are doing for Virginians
21 who are losing their Medicaid coverage right
22 now as part of the continuous coverage
23 unwinding.

24 INTERIM CHAIR HINOJOSA: And thank
25 you for providing these scenarios. It really

1 helps illustrate the real world impact.

2 MR. PATCHETT: Yeah, and we had seen
3 some similar scenarios that were prepared as
4 sort of nationwide estimates, and it really
5 was educational for us to dig in and prepare
6 these as Virginia-specific, based on the data
7 that we have of Virginia consumers.

8 And I think one of the things I
9 forgot to mention is the reason we picked the
10 plan and the rating areas that we chose or at
11 least one of the factors we were looking at,
12 we wanted to choose a plan and some rating
13 areas that had high enrollment levels so that
14 it wasn't, well, you know, this will affect
15 one or two consumers. These are really
16 scenarios that are on the margin; these are,
17 in fact, scenarios that had -- that will have
18 high impact here in Virginia.

19 All right. So with that, I will
20 move into talking a little bit about some of
21 our overall updates in the marketplace. So
22 there are a few things that have changed and
23 are changing in the near future that I just
24 wanted to spend a few minutes talking about.
25 The first, we've talked a lot over the last

1 year about the continuous coverage unwinding.

2 And as DMAS continues to work
3 through the tail end of that unwinding
4 process, we are continuing to extend a
5 special enrollment period to make sure that
6 Virginians who lose Medicaid coverage as part
7 of this have a special enrollment period that
8 is tailored to their circumstances. So that
9 previously was set to expire at the end of
10 December; we've now extended that till the
11 end of June of next year.

12 We will also be taking on
13 responsibility as part of some regulatory
14 changes at the CMS level. State-based
15 marketplaces are now going to be responsible
16 for doing the work of certifying that health
17 plans comply with network adequacy time and
18 distance standards, so we will be kicking
19 that work off in the spring of next year and
20 are building out our personnel and our tools
21 and our resources that will be necessary to
22 run that network adequacy work.

23 Right now, the CMS rules say that
24 states have to impose network adequacy
25 standards for time and distance that are at

1 least as strict as those at the federal
2 level. But states have flexibility to do
3 more. Here in Virginia, we are going to
4 stick with those CMS standards, especially in
5 the first year. As we begin to do these
6 analyses ourselves, I think over the
7 subsequent years, we will then be able to
8 take a look at are there ways that we can
9 begin to tailor these standards that make
10 more sense for Virginia and can be a better
11 fit for both Virginians and for our health
12 plans and providers.

13 Also, CMS has issued some new
14 standards for what are called standardized
15 plans. These standards are optional. And so
16 for us in Virginia right now, we are going to
17 stick with the standards that existed for
18 plan year '24. As we look next year into
19 starting to do some research and some
20 stakeholder engagement and focus groups
21 around what might make sense for Virginia in
22 terms of standardized plans, there's a wide
23 range of approaches that are taken across the
24 country, and it's important to us that we do
25 this with intention and based on research and

1 stakeholder feedback, again, to try to
2 produce what will be the best situation for
3 Virginia consumers.

4 So the other thing that actually has
5 changed, we have changed the default sorting
6 in our plan display. So one of the things we
7 talked about in a previous committee meeting
8 was the relatively high number of bronze
9 plans that had been purchased in Virginia.

10 And so we are testing out this open
11 enrollment period to see what the impacts
12 will be if we switch from the previous
13 default, which was plans were sorted based on
14 monthly premium; we've switched that default
15 sort now to total cost.

16 And so we're tracking our enrollment
17 numbers to see what if any impact this has on
18 consumer choice of plans and metal levels.
19 Consumers are still free to change those;
20 they have a number of different options that
21 they can choose for plan sorting and
22 filtering; this just changes that default
23 plan.

24 All right. So the other thing that
25 we've talked about a number of times at the

1 past few meetings has been our metrics. And
2 so this time I'm going to focus on -- or
3 we've been focusing on really what does the
4 visualization of those metrics look like and
5 how can we make those more consumable as we
6 continue to work towards building out some
7 dashboards on our websites and making this
8 data more accessible and more transparent for
9 individuals, for researchers, really, for
10 whomever's interested.

11 So we'll start with the quarterly
12 enrollment numbers. I think as of our last
13 meeting, we had the second quarter and so
14 now, of course, we have the third quarter
15 enrollment numbers. And when we look at
16 these enrollment numbers, it's important to
17 keep in mind that we're talking about what we
18 call effectuated enrollment as opposed to
19 enrollment at any given time. So effectuated
20 enrollment is someone who has come to the
21 marketplace, they've selected a plan, and
22 they've made at least one monthly payment.

23 So these numbers are going to be
24 higher than what the current enrollment is
25 because it doesn't take into account

1 terminations or cancellations. But we think
2 this number is useful in tracking how many
3 Virginians during the course of the year have
4 come and purchased health insurance through
5 the marketplace. And so you can see how it's
6 been a steady activity ever since the end of
7 open enrollment, which is a positive trend
8 for sure.

9 Okay. After these enrollment
10 metrics, we can take a look at our Medicaid
11 numbers. Again, a pretty steady trend here
12 with individuals who have been found either
13 eligible for Medicaid or what we call
14 assessed eligible for Medicaid, which means
15 that it's likely that they are eligible for
16 either Medicaid or FAMIS, but there's a
17 little more work that needs to be done.

18 To remind everyone, when we at the
19 marketplace make an eligibility determination
20 for Medicaid, those individuals are
21 transferred to DMAS and DMAS picks up with
22 the enrollment process. When we assess
23 someone as likely being eligible for
24 Medicaid, it means that there's a little bit
25 more work to be done, and the DMAS picks up

1 that eligibility determination, whether it's
2 gathering information from the individuals;
3 that's the point where DMAS picks up that
4 process.

5 We have a good percentage of
6 Virginians who are eligible for these premium
7 tax credits we were talking about before.
8 This shows here 86 percent. And if you look
9 at some of our marketing materials, you often
10 see that we say nine out of ten Virginians
11 are eligible for APTCs, so this number is
12 based on that same effectuated enrollment.
13 And that is individuals and families who have
14 actually purchased and enrolled in coverage.

15 The nine out of ten goes back to the
16 application level, so it happens that people
17 apply for coverage and then decide not to
18 actually purchase it. So I just wanted to
19 call out that distinction between the north
20 of 90 percent and the 86 percent that's shown
21 here.

22 We've also provided here the
23 regional breakdown. And as requested at the
24 last meeting, we've added in the percentage
25 of the population for each of these regions

1 that these enrollment numbers represent. We
2 also spent time trying to show these numbers
3 as a percentage of the uninsured in Virginia.
4 That turned out to be more difficult than we
5 anticipated because of the way that the
6 available data is presented on the uninsured.

7 So we had some numbers that just
8 didn't make sense when we ran it based on the
9 data, so we've got some work to continue to
10 do to try to normalize the data that we have
11 across these different categories from
12 enrollment to region to uninsured. And
13 hopefully we'll be ready to reflect that by
14 our next quarterly update.

15 It is interesting to see how
16 relatively consistent those numbers are
17 across regions, generally ranging from four
18 to six percent of the population.

19 MR. ROSSITER: Keven, is that
20 nonelderly population?

21 MR. PATCHETT: That should be the --
22 so we use census data for that population.
23 And that's a helpful distinction to point
24 out.

25 So I don't think we've been able to

1 determine on a ZIP Code or region the
2 population difference based on age; that is
3 another element that we're working on. And
4 that's a distinction that's made in the way
5 the uninsured population is reported as well.

6 So here's a breakdown of our monthly
7 premium, monthly premium paid after the
8 application of premium tax credits. And
9 this, again, shows really the impact that
10 premium tax credits have on what Virginians
11 are actually paying for their premiums.

12 We've also provided here a breakdown
13 of enrollments, I think, by carrier. I think
14 a number of you have asked to see that in the
15 past.

16 And then lastly, we have the
17 breakdown by metal level. And you can see,
18 as I was mentioned before, there is a higher
19 percentage of Virginians in bronze plans than
20 we expected. And so we're continuing to dig
21 into that data and looking at what we can do
22 to help consumers recognize the difference.

23 So I think one of the things that's
24 useful to say here is that the reason we are
25 interested in the difference between bronze

1 and silver or bronze and gold or bronze and
2 platinum, so bronze plans have the lowest
3 premium but the highest deductible. So one
4 of the things that we notice is that there
5 are individuals who purchase a bronze plan,
6 but with the application of premium tax
7 credits, they could purchase a silver plan
8 sometimes at the same price so have an
9 overall lower out of pocket that they pay,
10 which is one of the reasons we switched that
11 default display from premium to total cost to
12 try to provide Virginians with that
13 information as they're doing their plan and
14 comparison and their shopping.

15 All right. Go ahead.

16 MR. PIPER: This is Kip. Do we know
17 how the -- great information on this -- how
18 the distribution is, especially of the bronze
19 versus silver, by the difference of basically
20 the income cohorts? Are folks on the lower
21 end of the income or smaller families or
22 bigger families more likely to opt for the
23 bronze even though -- I'll show my bias --
24 even up out of the filter, you know, it's the
25 better deal overall, once you consider the

1 risk and out-of-pocket?

2 Whereas, if it were some folks that
3 were higher income and so on, I could see how
4 that kind of behavioral effect would be, just
5 in terms of the economics. Any thoughts on
6 that?

7 MR. PATCHETT: Yeah, so we've been
8 looking at just that. And I will say
9 generally that's true; it's not true across
10 the board, but it is generally true that
11 lower income brackets tend to have a higher
12 percentage of bronze plans. And that makes
13 sense when you're looking at the lowest
14 out-of-pocket cost.

15 But like I said, the thing that
16 really catches our attention is when that
17 out-of-pocket cost is going to be the same
18 for a silver plan or, in some situations,
19 even a gold plan, and then we know that those
20 individuals and families are missing out on
21 the opportunity to have an overall lower cost
22 of health insurance. And you know, I've got
23 theories about what's driving that, but we
24 are digging into that data right now.

25 MR. PIPER: Sure. And I suppose

1 age, too, because folks that are younger, in
2 terms of their own appreciation of risk and
3 their actual risk, is different than somebody
4 who's older and maybe risk adverse or know
5 that they're going to have out-of-pocket
6 costs and they're going to want those things
7 covered.

8 And I suppose there's also
9 experience -- I'll stop there -- but there's
10 also some experience level with this as well.
11 You know, it takes awhile for people to
12 understand when they're going into a -- this
13 isn't a new market, but when they're going in
14 and buying something new and under different,
15 new circumstances, there's a learning curve
16 involved. So...

17 MR. PATCHETT: Yeah. And we're very
18 interested in understanding the educational
19 needs for Virginians, because health
20 insurance, I think for all of us, is not
21 easy. Right. It's certainly not the
22 simplest thing that we purchase in our lives,
23 and especially for individuals who are making
24 transitions; whether it's from Medicaid to
25 the marketplace or it's from employer-sponsor

1 coverage into the marketplace, there is
2 certainly that learning curve you're talking
3 about and we view that as an important part
4 of our responsibility to help bridge that gap
5 and facilitate consumers moving along that
6 learning curve.

7 And if you're interested, I think by
8 our next meeting, we can show some of the
9 cross reference data on these metal tiers,
10 how it relates to income level, age, rating
11 area, if you think that might be useful to
12 look at from your perspective.

13 MR. ROSSITER: Keven, a related
14 question: I have a healthcare.gov account
15 and so I get a push e-mail that urges me to
16 go to healthcare.gov and sign up for health
17 insurance. And I went. It takes me to the
18 healthcare.gov site. So how does that work
19 for consumers in our state-based Exchange?

20 MR. PATCHETT: Yeah, so if you got
21 that e-mail and you went to healthcare.gov,
22 the first thing that should happen is they
23 ask what state are you from. And when you
24 select Virginia from the dropdown menu, it
25 will push you to our marketplace. And we do

1 similar outreach to Virginians. We have a --
2 and it's -- it's sort of a staggered plan,
3 but as we lead up to open enrollment, we're
4 sending out notices both by e-mail and by
5 paper.

6 And then as we move through open
7 enrollment, we continue to target those
8 e-mail outreach notifications, and this year
9 we are even employing some text messages for
10 Virginians who have given consent to use
11 their cell phone to get that message out that
12 it's time to enroll and time to re-enroll.

13 MR. ROSSITER: Great.

14 MR. PATCHETT: All right. Well, if
15 there are no further questions, I'm going
16 to -- and I will be available at the end as
17 well for other questions, but I'm going to
18 pass it over to Brionna, who is our marketing
19 manager, to talk a little bit about the
20 marketing efforts and campaign that's going
21 on for open enrollment, which I think is what
22 is driving the increase in new customers we
23 have this year compared to last year.

24 So go ahead, Brionna.

25 MS. JONES: Thank you, Keven. Good

1 afternoon, everyone. I'm Brionna Jones. I
2 am the marketing and outreach manager here at
3 the Health Benefit Exchange. So I'm going to
4 provide an overview of some of our marketing
5 and outreach starting with our open
6 enrollment campaign.

7 Our plan year 2025 open enrollment
8 campaign does use an integrated approach to
9 drive eligible Virginians to the marketplace
10 website to enroll in health insurance plans.
11 And our campaign has two objectives: The
12 first being to build awareness about
13 Virginia's insurance marketplace and open
14 enrollment period; and the second, to drive
15 eligible Virginians to enroll.

16 To achieve these objectives, our
17 marketing efforts use a combination of owned,
18 earned, and paid media strategies to reach
19 our target audience and deliver our messaging
20 and our creative materials. And these
21 strategies were chosen based on the results
22 from plan year 2024's open enrollment
23 campaign.

24 So starting with owned media
25 strategies, if we can -- thank you. Using

1 Virginia's insurance marketplace's social
2 media accounts, our e-mail marketing
3 platform, which, as Keven says, also include
4 texts messages and our website, we highlight
5 open enrollment, key deadlines, the different
6 types of coverages, financial savings, our
7 health center, etc.

8 We developed a new open enrollment
9 tool kit for our partners that's sound
10 loadable on our website. So social media
11 content and graphics can be downloaded as
12 well as our brochure and key flyers for
13 different demographics. We also captured
14 videos of real customer stories.

15 This summer we identified five
16 marketplace consumers and we went out across
17 the state into their communities and we did
18 interview them and we asked them what was
19 their experience using the marketplace. We
20 were able to film very compelling videos that
21 we currently use on our website, on our
22 social media accounts, and our pay channels
23 as well.

24 For earned media, we recently
25 completed our satellite media tour. It was

1 on November 14th and Keven interviewed for
2 quite a few hours with several media partners
3 across the state. Our results were ten
4 television projects, six radio broadcasts,
5 two online placements, and we were able to
6 reach 2.2 million listeners/viewers across
7 all regions in Virginia.

8 Our paid media campaign used a
9 combination of traditional and digital
10 advertising to reach our target audience and
11 drive them to the marketplace to enroll. We
12 did design our media plan based on what we
13 learned from last year's open enrollment
14 campaign. We invested our budget in channels
15 that were successful that had the strongest
16 performance. And then we also allocated a
17 percentage of our budget in testing out new
18 channels.

19 So listed here on this slide are
20 examples of some of the add channels that we
21 are currently using in this open enrollment
22 campaign. For digital adds, we are using
23 programmatic display and video ads. And you
24 typically see those when you're scrolling on
25 different websites, maybe at the top, on the

1 left, those types of ads.

2 High-impact display ads are similar.
3 They are typically more premium and more
4 active though. Digital out-of-home ads are
5 ones that you may see at a bus station or at
6 the gas station, in grocery stores, so these
7 could be a combination of print and digital
8 ads.

9 We also are advertising on social
10 media. Our social media platforms that we
11 currently have advertising is Facebook,
12 Instagram, and YouTube. And then we also are
13 advertising on Google search, so when
14 Virginians are searching for health related
15 terms, our ads will pop up on Google. Site
16 direct is an ad type that is paired with
17 specific websites so we work directly with
18 those websites to get those placements.
19 Streaming audio are going to be sites like
20 Pandora and Spotify, so you'll hear the
21 advertisements for the marketplace on those
22 platforms.

23 Connected TV is going to be your
24 Hulu, your Prime Video, your Netflix and
25 those commercials that show when you're in

1 between programming on those platforms.

2 Twitch is a new platform we are
3 testing this year. I'll go into a little
4 more detail about what Twitch is. Influencer
5 marketing is also a new platform that we're
6 testing out this year. And then our
7 traditional advertising channels include
8 broadcast television and radio, and our ads
9 are also available in Spanish as well.

10 I'm going to get into some of these examples and
11 highlight a few of our advertising channels
12 starting with our broadcast television
13 commercials. We filmed new commercials this year.
14 I really love our commercials. The theme was when
15 life happens, Virginia's insurance marketplace has
16 you covered. We did go with a humorous tone, and
17 we will play them for you right now.

18 (Video played.)

19 MS. JONES: Okay. Next one, please.

20 (Video played.)

21 MS. JONES: Thank you so much. So
22 those are our newest commercials. We will --
23 they're airing on broadcast television right
24 now. They'll be on connected television as
25 well, social media, so we'll use them in a

1 variety of ways.

2 So Twitch is one of our newest
3 platforms as well. It's a live streaming
4 service in the global community for content
5 like gaming, entertainment, music, sports,
6 and more. Twitch users are primarily between
7 the age of 18 and 34, so we're targeting a
8 younger demographic with this ad channel.

9 And we are targeting users whose online
10 behavior suggests that they are in the market
11 for health insurance. Our video ads are
12 incorporated into the Twitch live broadcast.
13 They're highly visible. They're non-skippable
14 and they're clickable.

15 And influencer marketing. So we're
16 excited to launch this ad channel probably in
17 the next week or so. So we are working with
18 social media influencers in Virginia on paid
19 partnerships where they will promote open
20 enrollment. They will create content that
21 will be posted on their pages as well as in
22 the form of stories, which are content that
23 deletes after 24 hours.

24 We're also going to share this
25 content on our organic channels and then

1 we're also going to promote some of the
2 influencer marketing content that is paid ads
3 on our social media channels as well. And
4 we're working with a variety of different
5 people, different ages, different hobbies, so
6 we're really excited to get this ad channel
7 started.

8 And then this just shows some
9 examples of our advertisement. We won't play
10 these videos, but these are our consumer
11 testimonial videos that I mentioned earlier
12 that we filmed this summer. We are using
13 these ads in a variety of different ways as
14 well on our different channels.

15 And these are more examples of our
16 advertisements, just gives you an example of
17 what our advertising looks like out in the
18 community. An example of our high impact
19 display ads, our programmatic display ads,
20 what a Google search may look like, what our
21 digital out-of-home ads look like, and then
22 social media ads.

23 And so far, our results are great.
24 As of December 5th, our paid media campaign
25 has resulted in 37.2 million impressions,

1 meaning our ads were in front of that many
2 people. We got 485,581 clicks to our
3 website; 342,540 website sessions. Our cost
4 per click, \$1.14, which is a 46 percent
5 decrease from last year. And our
6 click-through rate at 1.30 percent, and that
7 is a 293 percent increase from last year. So
8 it is costing us less to get more engagement.
9 So it just really shows the efficiency of our
10 campaign and how great our messaging is.

11 I'm going to move into outreach. So
12 these are some areas where we have seen
13 success in our outreach efforts thus far.
14 We've hosted several webinars for various
15 organizations throughout the state. We
16 conducted statewide college outreach. We
17 held statewide agent engagement meetings to
18 get agent feedback. We even gauged our
19 Native American communities. We've also
20 participated in their Powwow event.

21 We've participated in community
22 planning with the Department of Health and we
23 are supporting enrollment events currently.
24 Right now, during the open enrollment period,
25 we're working with our Navigator partners

1 throughout the state with those events.

2 We attend monthly meetings; usually
3 these are various community partner meetings
4 where we get together monthly to discuss
5 resources, so that's been a great aspect of
6 our outreach. And then we're also working to
7 distribute our marketplace educational
8 materials.

9 We have our main brochure, but we
10 have a lot of different niche, if you will,
11 flyers that may be for pregnant moms or young
12 adults, you know, small business employers.
13 So we have a lot of material and we may give
14 it out directly. And we will also do
15 mail-outs at requests of partners needing our
16 materials.

17 And we also have gained quite a few
18 healthcare partnerships in conferences.
19 Pictured here is the external fair staff at
20 the annual conferences for the Rural Health
21 Clinic Association, the Virginia Free
22 Charitable Clinic Association, and the
23 Community Health Workers Association. It's
24 been really great to connect with these
25 statewide organizations and just -- like I

1 said, being able to really connect on a
2 statewide level with these health-related
3 entities.

4 So some of our collaborations that
5 we've done thus far include podcast
6 interviews, newsletter articles, social media
7 posts being shared, event participation,
8 Webinars and a conference sponsorship.

9 And these are just more examples of
10 some of the outreach that we've done thus
11 far. I mentioned those enrollment events
12 that we're currently doing throughout the
13 state. Those have been successful thus far.
14 We have several more scheduled throughout the
15 open enrollment.

16 And then we did participate in the
17 State Fair of Virginia here recently -- what
18 was that, September, October? -- and we did
19 ten days of outreach to Virginians at that
20 event.

21 Celebrate Healthcare is one of our
22 sister partners who they have a really big
23 emphasis on health-related events so we
24 participate in a lot of their events. And
25 then we recently also participated in Senator

1 Warner's Women's Conference.

2 And then I will end on just some
3 website updates. We did recently work with
4 our website vendor to get 30 new
5 announcements for our website. The goal was
6 to just improve the look and feel of our
7 website. So we were able to implement quite
8 a few of these enhancements prior to the open
9 enrollment and we continue to enhance the
10 website.

11 We received several new widgets.
12 And a widget is just the way that our
13 information is displayed on the website to
14 the public, essentially, is the best way I
15 can explain it, black image scrolls and three
16 box callouts and text columns. We have some
17 new design elements that have helped improve
18 the website. We've updated our FAQs. We
19 have additional brand colors.

20 We've increased document storage
21 size so we can upload more things for
22 partners to be able to have and download.
23 And then we now have the automatic
24 translation to our Spanish side of the
25 website. We also were able to add our

1 testimonial videos and carry your logo on our
2 website as well.

3 Yes, I think that is the end of my
4 presentation. Thank you so much for
5 listening. I'll hand it back over to Keven
6 and happy to answer questions if there are
7 any.

8 MR. PATCHETT: Thank you, Brionna.
9 I think that's a fair amount of content
10 across this update today. So if there are
11 any other questions for me or for Brionna,
12 we're happy to take those.

13 MR. ROSSITER: Keven, it's Lou
14 Rossiter. This morning at 8:30, my
15 brother-in-law called from North Carolina,
16 which I believe is on the Federal Exchange,
17 right?

18 MR. PATCHETT: Correct.

19 MR. ROSSITER: And he said he had
20 just spent the last several days trying to
21 get his now 18-year-old son enrolled and he
22 was on hold for at least an hour each time he
23 called until he could talk to someone.

24 So that led me to ask you -- ask
25 what's our -- how are the call centers

1 working?

2 MR. PATCHETT: Our call centers are
3 working really well this year. So I had a
4 metrics slide I pulled at the last minute,
5 but our wait times right now are, on average,
6 less than ten seconds. So our call centers
7 are functioning very efficiently.

8 I think our average talk time is
9 around 14 minutes, which is a positive
10 indication that consumers are really engaged
11 with the representatives and got a very, very
12 low, I think, less than 1 percent call
13 abandon rate. And our first call resolution
14 rate, as I recall, was over 70 percent. So
15 really positive statistics this year on the
16 call center front.

17 MR. ROSSITER: Yeah, that's amazing.
18 Congratulations.

19 MR. PATCHETT: Thank you. If there
20 are no other questions, then I will turn it
21 back over to you, Ikeita.

22 INTERIM CHAIR HINOJOSA: I actually
23 did have two questions.

24 MR. PATCHETT: Okay.

25 INTERIM CHAIR HINOJOSA: Yeah. So

1 one question is what is kind of the most
2 popular question that you-all are receiving
3 from consumers? I know there was a mention
4 that FAQs had been developed and those kinds
5 of things. So it would just be interesting
6 to know, you know, what are some of the kind
7 of the most popular inquiries that you-all
8 are receiving from Virginians for the
9 marketplace? That's one.

10 And then second is just I know that
11 there was a mention of network adequacy, and
12 I know that our Advisory Committee Board
13 member Craig Connors, who was unable to
14 participate in today's meeting due to a
15 scheduling conflict, but he actually came
16 across Pennsylvania's network adequacy study
17 and he was curious about the direction that
18 they're heading, and he sent a little blurb
19 about it. And they're looking at marketplace
20 plans regarding provider directory
21 inaccuracies and consumer's ability to secure
22 a timely appointment with both behavioral
23 health and physical health providers and
24 going deep, right.

25 And so his question was is

1 Virginia's marketplace kind of currently
2 conducting or planning to conduct any kind of
3 evaluation like that? And so I just wanted
4 to be clear, based on your presentation, that
5 it sounds like you're currently sticking with
6 CMS's federal minimum standards of time and
7 distance in the first year, but something
8 like the Pennsylvania model could be a
9 direction for future years; is that accurate?

10 MR. PATCHETT: That is accurate.

11 The other thing I'll add is that -- so we've
12 already started the provider directory work.
13 We implemented this this year, a new provider
14 directory that is new -- it was really built
15 from the ground up, and we've been working
16 very closely with our carriers to get their
17 -- over the summer to get their content
18 uploaded, updated to make sure we have the
19 right lexicon in place so that when consumers
20 are looking for a certain kind of physician
21 or facility, that we're aligning our
22 directory to those inquiries and then we're
23 continuing forward to get those updated on a
24 regular basis.

25 One of the challenges we saw last

1 year was that the commercial third-party
2 vendor that we've been using for our provider
3 directory, we just had no visibility into
4 when, where, or how the information was being
5 updated. And in some regions of Virginia, it
6 was just very, very out of date. So I think
7 it's moving in a really good direction and
8 it's going to be an area of ongoing focus for
9 us.

10 We will just be kicking off the
11 spring, you know, incorporating the
12 information that we receive from the carriers
13 about their provider networks to do that time
14 and distance standard analysis. And that
15 will give us the opportunity to start moving
16 in a direction of what works for -- what
17 works best for Virginia and how do we account
18 for the differences between urban and rural
19 areas, for example. So it's a very fertile
20 soil for us to work in next year.

21 And then as for the top question, I
22 don't have that at my fingertips. I know the
23 last time I looked at it, you know, of
24 course, I think the top ones tend to be the
25 very routine: How do I reset my password?

1 INTERIM CHAIR HINOJOSA: That makes
2 sense, yeah.

3 MR. PATCHETT: But, yeah, we will
4 look into what's below those and how that may
5 be different this year from last year, and
6 I'll be happy to share that information.

7 INTERIM CHAIR HINOJOSA: Okay.
8 Yeah. Thank you for that.

9 Any other questions before we move
10 on to the next portion of our agenda?

11 MR. PIPER: One question for you,
12 Keven, if I may. This is going to be -- it's
13 essentially a pros, cons, whatever, with
14 changes inside the proverbial beltway, terms,
15 changes, and anticipations. Is there
16 anything that's on our radar? Since this is
17 the first time for a change in administration
18 at the federal level since the Commonwealth
19 created its own Exchange, is there anything
20 that's on our kind of wish list or things
21 that perhaps we should be thinking about?

22 Flexibility is what I'm getting at.
23 Things that, up to now, we wouldn't be able
24 to do or we would like to be able to have,
25 whether it's that dispensation or that

1 flexibility or whatever it is in terms of the
2 guidance, anything like that that would be on
3 our Christmas list, whatever you want to call
4 it, in terms of what we would want instead
5 of -- you know, because there's always going
6 to be pros/cons; there's always going to be
7 things on the policy side of things, but
8 there's often technical or administrative
9 process, guidance, things like that.

10 Anything like that that would be beneficial
11 that we haven't gotten traction on or just
12 been too busy on the federal side to look at?
13 Anything like that that's coming up?

14 MR. PATCHETT: So, of course, the
15 biggest one for us really is the extension of
16 these enhanced premium tax credits. We
17 recognize that that's a policy decision
18 that's going to be made at the federal level.
19 But we also appreciate the impact that it's
20 going to have to Virginians. And so
21 extending those would certainly be at the top
22 of our Christmas tree or wish list.

23 You know, generally speaking, one of
24 the key reasons for Virginia making this
25 transition to a state-based marketplace is to

1 take advantage of those flexibilities that
2 are already built in. I think -- I can't
3 think of one specific one that's at the top
4 of our priority list other than, really, you
5 know, maintaining the flexibility to make
6 this truly a marketplace that's by Virginia,
7 for Virginians, and tailored to what we need
8 and what we learn works best here in
9 Virginia.

10 MR. PIPER: Great. Thanks.
11 Appreciate it. It was more of one of those
12 open-ended, kind of curiosity questions.
13 Like is there anything there that, you know,
14 because it's always a -- yeah, it's always a
15 best game or whatever moving parts, and
16 sometimes there are things and sometimes it
17 gets in the positive and sometimes it's like,
18 oh, no, please don't change anything. You
19 know, it works both ways.

20 MR. PATCHETT: Yes. Understood.
21 And something that we really are paying very
22 close attention to.

23 MR. PIPER: And I was also asking in
24 the context of, without being misunderstood,
25 because obviously what you've done so far is

1 quite impressive, and you've been taking
2 advantage of those -- exactly as you put it,
3 taking advantage of those flexibilities.

4 And that's not a down on CMS, but
5 there are things that they can do and are
6 much more nimble at doing, and you know, when
7 one side does not cut off, just any of those
8 things. So, cool.

9 MR. PATCHETT: Thank you.
10 Appreciate that.

11 INTERIM CHAIR HINOJOSA: All right.
12 Any other questions or comments?

13 I'd just like to thank you all for
14 doing such an amazing job. This is so
15 exciting. We love to hear the update and we
16 look forward to our next conversation in the
17 spring.

18 And we'll go ahead and proceed to
19 our next agenda item, which is other
20 business. So the first topic on our other
21 business today is to accept nominations for
22 chair and vice chair.

23 So first we will consider any
24 nominations for chair and vice chair that
25 were submitted prior to the meeting in

1 response to Staff's e-mail request for
2 nominations. So prior to the meeting, we had
3 two nominations for chair. So one person
4 nominated me for chair, but as I mentioned
5 earlier, my term is scheduled to end two
6 meetings from now, in June, so I'm honored,
7 but I will politely decline the nomination.

8 And one person nominated Lou
9 Rossiter for chair. So congratulations, Lou,
10 and we will figure out in a few moments if
11 you accept the nomination.

12 And prior to the meeting, a person
13 did nominate an ex-officio member for vice
14 chair, but as we discussed earlier, only
15 voting members can serve in these positions,
16 so that nomination is ineligible. And we
17 didn't have anyone else nominated for vice
18 chair in advance of the meeting.

19 Okay. So heading into this
20 nomination process, the only name currently
21 in the mix is Lou Rossiter for chair. So now
22 we will open it up for our realtime
23 nominations for chair and vice chair. And as
24 a reminder, only current appointed or voting
25 Advisory Committee members are eligible. So

1 if you're nominating someone, just please say
2 your name, say the nominee's name, and just
3 share just a little bit about why you believe
4 the individual is a good candidate for the
5 role. And feel free to second a nomination
6 or add your support to a candidate, just in
7 terms of adding to the discussion.

8 So with that, I will open the floor.

9 MR. GRAY: Well, I nominated Lou.
10 And I think he'd be great. Lots of good
11 experience and knowledge about what we do.
12 So I second my own nomination.

13 INTERIM CHAIR HINOJOSA: Well, you
14 nominated, so...

15 MR. CASTRO: I can second Doug's
16 nomination for him. You know, Doug and I
17 don't usually agree on a lot, but when we do
18 agree, you know, peace in the valley. So
19 Scott Castro here, and happy to second the
20 nomination.

21 INTERIM CHAIR HINOJOSA: Okay. So
22 that was Doug for the nomination and was it
23 Scott for a second?

24 MR. CASTRO: Scott, yeah.

25 INTERIM CHAIR HINOJOSA: So doesn't

1 seem like we're going to have any fist fights
2 here, but would anybody else like to say
3 anything or any other comments or discussion
4 around it?

5 MR. CASTRO: Let's approve him
6 before he backs out.

7 INTERIM CHAIR HINOJOSA: So Lou,
8 first of all, do you accept the nomination?

9 MR. ROSSITER: Yes, I do.

10 INTERIM CHAIR HINOJOSA: Okay. That
11 would be good. So do we have any other
12 nominations for chair? Anybody else want to
13 put anybody else's name in the hat for chair?

14 Okay. Hearing none, let's go ahead
15 and move on to the vice chair nomination
16 process. Do we have any nominees for vice
17 chair? I'll go ahead and get it started.

18 Having served as vice chair, I will
19 go ahead and nominate Doug Gray for the role
20 of vice chair and just say that Doug has, you
21 know, been around the block for quite some
22 time. Not calling him old but calling him
23 very seasoned. He's got over two decades of
24 experience in working in Virginia with health
25 plans and their many, many partners, you

1 know, long before the Virginia Insurance
2 Marketplace ever opened its business.

3 He's known a lot of best practices
4 and lessons learned, seen a lot of what works
5 and what doesn't and has made a lot of
6 friends along the way and has been a very
7 active contributor on this body and has
8 served, understands the role, and I'm
9 confident that he's well suited to support
10 the chair and support the Staff and fellow
11 Advisory Committee colleagues. So I'm glad
12 to support his candidacy.

13 MR. ROSSITER: I second.

14 INTERIM CHAIR HINOJOSA: Okay. Any
15 other comments? So we have me for the
16 nomination and Lou for the second. Do you
17 accept, Doug?

18 MR. GRAY: Yes.

19 INTERIM CHAIR HINOJOSA: Okay.

20 MR. GRAY: I just want to reassure
21 everyone. I'm very aware that I represent
22 the plan, and so if anybody's ever
23 uncomfortable, just let me know.

24 INTERIM CHAIR HINOJOSA: Yes. And I
25 will just say, in terms of Lou, one of the

1 benefits of having Lou as chair, Lou is an
2 academia; he's a retired professor and it
3 kind of continues our informal tradition of
4 having our chair being associated with
5 academia rather than a particular sector so
6 no one gets the impression that our Advisory
7 Committee is privileging one sector of health
8 insurance over another because all sectors
9 are critically important. So that's one
10 advantage of having a retired professor at
11 the helm.

12 All right. So any other candidates
13 for vice chair?

14 Okay. Hearing none, we will proceed
15 to chair and vice chair elections. So thank
16 you both, Lou and Doug, for being willing to
17 serve.

18 I will now turn it over to SCC Staff
19 to explain the voting process and administer
20 the process and publicly announce the results
21 of the chair and vice chair elections.

22 MS. BECKER: Hi, everyone. Good
23 afternoon. My name is Rachel Becker. I am
24 the senior policy advisor for the Exchange,
25 and I'm hoping that this will be a quick and

1 painless process, especially since we've only
2 got two nominations.

3 So in a few moments, a poll -- it's
4 a Microsoft Teams poll -- is going to pop up
5 on your screen. We are going to begin with
6 the election for chair. Just so you know,
7 your responses are anonymous, so your
8 colleagues will not be able to see your
9 votes. So if you are not a voting member,
10 please select I'm not a voting member or just
11 don't fill out the poll. And then once
12 you've pressed your selection, click done and
13 it's in the lower -- please click done or
14 submit in the lower right-hand corner.

15 So we will now open up the poll for
16 chair. And please make your selection.

17 MR. GRAY: Mine says something went
18 wrong, please try again. So I voted for Lou.

19 MR. CASTRO: I also voted for Lou,
20 and when I did, I didn't see the number of
21 responses go up. So I just want to make sure
22 that my vote was recorded as well. Scott
23 Castro, voting for Lou.

24 MR. PIPER: And Kip Piper, voting
25 for Lou. I'm getting the same error.

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1 INTERIM CHAIR HINOJOSA: Yeah, it
2 says, "Failed to send."

3 MS. BECKER: Oh, okay. I think
4 maybe because you-all do not have SCC e-mails
5 is what we're realizing. So I apologize for
6 that. So I've recorded Doug Gray, Scott
7 Castro, and Kip Piper for Lou. Do you think
8 it's all right, Ikeita, to just do voice
9 vote?

10 INTERIM CHAIR HINOJOSA: I think
11 that's fine.

12 MS. BECKER: I'm sorry. We tried to
13 make it anonymous.

14 MR. PIPER: Madam Chair, if it was
15 appropriate, I would move that we elect Lou
16 as our chair by activation or what have you,
17 bypass the vote if necessary.

18 INTERIM CHAIR HINOJOSA: Does
19 somebody second that?

20 MR. GRAY: I'll second that.

21 INTERIM CHAIR HINOJOSA: All right.

22 MS. BECKER: So the results of our
23 election are unanimous for Lou.
24 Congratulations.

25 INTERIM CHAIR HINOJOSA:

1 Congratulations, Lou.

2 MR. ROSSITER: Thank you. I'll try
3 to do my best.

4 MR. PIPER: The one guy who gets the
5 whole web thing set up earlier and correctly
6 every single meeting, you know, obviously we
7 can't get a vote done, but there we go.

8 INTERIM CHAIR HINOJOSA: And it's a
9 benefit that our new chair is a health
10 economics professor. We'll get it all
11 figured out for us moving forward.

12 Okay. And then we'll -- and we have
13 the same agreement moving forward for
14 election of vice chair?

15 MR. GRAY: So moved by acclimation.

16 INTERIM CHAIR HINOJOSA: Do we have
17 ayes?

18 MR. PIPER: I have ayes.

19 MR. CASTRO: Aye.

20 MR. ROSSITER: Aye.

21 MS. KACHRU: Aye.

22 INTERIM CHAIR HINOJOSA: Aye.

23 MR. GRAY: I voted aye.

24 INTERIM CHAIR HINOJOSA: Any nays?

25 Okay. It's unanimous. We have a

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1 vice chair. Congratulations, Doug.

2 MR. GRAY: Thank you.

3 INTERIM CHAIR HINOJOSA: We have a
4 new chair in Lou and a new vice chair in
5 Doug. Congratulations. Thank you both for
6 your willingness to serve the people of
7 Virginia through these leadership roles. And
8 as the outgoing vice chair and interim chair
9 for a very brief period of time, please feel
10 free to reach out to me if I may ever be of
11 assistance to you. I will just finish
12 presiding over this meeting for these last
13 couple of minutes. But just know that I am a
14 resource to you.

15 Okay. So there's just one more --
16 before we move on to the public comment,
17 there is just one more item of -- we're in
18 other business right now. There's just one
19 other kind of other business item, I think,
20 other business that I just wanted to mention
21 before we go into other comment, which is
22 2025 meetings. And then to see if anybody
23 else has other business items for the good of
24 the group, since this is our last meeting of
25 2024.

1 So we have quarterly meetings for
2 the Virginia Health Benefit Exchange Advisory
3 Committee, because I know we have some new
4 members here. So we typically hold our
5 quarter one meeting in the spring, around
6 March, and our quarter two meeting is in the
7 summer, around June. Our quarter three
8 meeting is in the fall, around September.
9 And our quarter four meeting is in the
10 winter, around December. So four meetings in
11 the year.

12 And three of those meetings are
13 virtual. We try to meet once a year in
14 person. And so probably sometime after the
15 holidays in early 2025, SCC Staff will send
16 an e-mail to the Advisory Committee members
17 and they'll include a poll to figure out
18 which 2025 meeting dates work best for most
19 members to schedule and send out meeting
20 invitations accordingly so that we all have,
21 you know, those four quarterly meeting dates
22 on our calendars, with plenty of advanced
23 notice.

24 So we need to, you know, make sure
25 that we respond to their messages. They were

1 so good at reminding us and rerepeating us,
2 you know, really, really trying to get us to
3 respond. So I wanted to make a pitch on
4 behalf of the Staff: Please respond to their
5 messages in these poles because they really,
6 you know, are trying to give us as much
7 advanced notice as possible on that.

8 And then just for a bit of
9 historical context, in terms of that one
10 face-to-face meeting that we try to do per
11 year, you know, we try to go to Richmond once
12 a year, to go to the Exchange office and meet
13 face to face, just to have an opportunity to
14 build relationships with each other as
15 Advisory Committee members and also build
16 relationships with the SCC Staff.

17 For a bit of historical context, our
18 Richmond meeting was in March in 2023. So
19 that was the spring, you know, quarter one
20 meeting. It was in June in 2024. So that
21 was the quarter two meeting. We usually stay
22 away from the fall since SCC Staff is
23 consumed with open enrollment. We usually
24 stay away from the winter, since inclement
25 weather can get in the way. But you know,

1 just be mindful when that message goes out.
2 So I just wanted to give you that heads up,
3 you know, that message will be coming and
4 just to be aware of that.

5 So that's all we have for other
6 business for now. Just the elections and to
7 be mindful of the scheduling for the four
8 quarterly meetings.

9 Does anybody else have any other
10 items of other business they wanted to bring
11 up or discuss?

12 MR. GRAY: Ikeita, I wanted to say
13 what a pleasure it's been to work with you.
14 We worked on the subcommittee together which
15 you chaired. The rest of the Committee
16 should know that we are losing a heck of a
17 lot of talent with Ikeita going off. She not
18 only -- not only was she at the DC Health
19 Benefit Exchange; she's got a JD from the
20 University of Michigan, and she's just a
21 very, very nice person. So we are going to
22 miss you a whole lot and thank you very much
23 for serving on the committee.

24 INTERIM CHAIR HINOJOSA: Well, thank
25 you. You've got me for at least two more

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1 meetings. My term expires in June, so...
2 But I very much appreciate it. It's been an
3 honor and a pleasure. So thank you. And I'm
4 definitely around and absolutely a resource
5 to you and everyone else. So yeah, thank
6 you.

7 Any other items for other business?
8 Okay.

9 We'll move to our next agenda item,
10 which is public comment. And we have no
11 items for public comment that have come in.
12 So we can move on.

13 So just as a reminder, public
14 comments are accepted on an ongoing basis at
15 ExchangeDivision@SCC.Virginia.gov so we do
16 welcome public comments; everyone's thoughts
17 and ideas are very important to us.

18 And with that, this meeting is
19 adjourned. We wish everyone a safe and happy
20 holiday and we look forward to connecting in
21 the spring. Thank you so much. Bye bye.

22 MR. ROSSITER: Thank you. Thanks,
23 Ikeita.

24 INTERIM CHAIR HINOJOSA: Thank you.


25 (Meeting adjourned at 3:40 p.m.)

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CERTIFICATION OF TRANSCRIPT

I, Ruth A. Levy, do hereby certify that the foregoing transcript, to the best of my ability, knowledge, and belief, is a true and correct record of the State Corporation Commission meeting herein; 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.

Given under my hand, this 23rd day of December, 2024.



Ruth A. Levy
Planet Depos, LLC

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3 I, Joshua Tubbs, AAERT CER, the officer before
4 whom the foregoing proceedings were taken, do
5 hereby certify that any witness(es) in the
6 foregoing proceedings were fully sworn; that
7 the proceedings were recorded by me and
8 thereafter reduced to typewriting by a
9 qualified transcriptionist; that said digital
10 audio recording of said proceedings are a true
11 and accurate record to the best of my
12 knowledge, skills, and ability; and that I am
13 neither counsel for, related to, nor employed
14 by any of the parties to this case and have no
15 interest, financial or otherwise, in its
16 outcome.

17 Notary Registration No.: 7929796

18 My Commission Expires: 7/31/25

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22 Joshua Tubbs, AAERT CER

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