SILVER STATE HEALTH INSURANCE EXCHANGE

BOARD MEETING

TUESDAY, OCTOBER 15, 2024

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K. BLAGEN: Okay. I'll go make sure it's up in the conference room.

T. DAVIS: Madam Chair, just for your knowledge at this time, I know it's not quite 1:30 and we are waiting for a few other voting board members and other board members as well. We do have at least four board members with us currently.

V. CLARK: Okay. Thanks Tiffany. Okay. It's 1:30. Shall we call the meeting to order? And I'd like to welcome everyone that's joining us today. Let's see. Tiffany, can we do a roll call, please?

T. DAVIS: Yes, of course. Tiffany Davis, for the record, for the roll call. Valerie Clark?

V. CLARK: Present.

T. DAVIS: Jonathan Johnson? He has not joined us yet so I'll mark him absent. Ms. Lavonne Lewis?

L. LEWIS: Present.

T. DAVIS: Thank you. Dr. Sarah Friedman? I don't hear Dr. Sarah Friedman, so I'll mark her absent for right now. I do know that I believe Jonathan Johnson just joined us. Jonathan Johnson for roll call?

J. JOHNSON: Here.

T. DAVIS: Thank you. And, Mr. Quincy Branch?

Q. BRANCH: Present.

T. DAVIS: Thank you. And Ms. Amber Torres? Marking absent, not hearing anything. Mr. Sam Kumar?

S. KUMAR: Here.

T. DAVIS: Thank you. And Stacie Weeks? I'm not hearing anything. I'll mark absent currently. And then Scott -- Commissioner Scott Kipper?

T. RICH: Hi Tiffany, this is Todd Rich. I'm substituting for Commissioner Kipper.

T. DAVIS: Perfect. Thank you so much, Todd, for confirming that. And Jenny Hilton?

J. HILTON: Here.

T. DAVIS: Thank you. And if there's anybody -- any other board members that happen to join throughout the meeting, I will, readjust the roll call. But for right now, Madam Chair, we do have a quorum.

V. CLARK: Thank you. And, Tiffany, I believe, Sarah Friedman just joined as well.

T. DAVIS: Oh, excellent. Oh, Sarah Friedman. Thank you so much. Mark you as --

V. CLARK: Great. Thank you very much. It is now time for public comment.

T. DAVIS: Yes. Sorry, my -- I'm like a little distracted about all -- everybody who's joining right now. Tiffany Davis for the record. My apologies, Madam Chair. I'm happy to help facilitate with public comment.

Just as a reminder for those, who have joined us online, that when the time has come, if you would like to make a public comment, please raise your electronic hand feature if you've joined us through Zoom or indicate in the chat box that you would like to make a public comment and our staff will let you know when you may unmute yourself. For anyone who has called into the meeting, we will let you know when the time comes, when you may unmute yourself and provide your comment at that point. For right now, I'd like to start with our Carson City conference room, physical location. Kassie, do we have anyone in the physical location of the Carson City office that would like to make public comment at this time?

K.FUENTES: Hi, this is Kassie Fuentes for the record. There is no public comment here in the Carson City office. Thank you.

T. DAVIS: Great. Thank you so much for confirming that, Kassie. And then, online, if any of our attendees who have joined us through Zoom would like to provide public comment, you may raise your electronic hand feature on Zoom, and Kaitlyn will call your name, and you may unmute yourself to make public comment. Do we have anyone who has joined us who would like to make public comment at this time?

M. DENHAAN: I don't know where the raise the hand function is.

T. DAVIS: That's fine. Please -- please go ahead.

M. DENHAAN: This is Mike Denhaan with VSP.

V. CLARK: Thank you, Mike. Go ahead. Good.

M. DENHAAN: Well, thank you. Thank you for the opportunity to join the meeting today and provide public comment. Background, my

name's Mike Denhaan. I am with VSP and I'm the primary point of contact through the partnership with the Nevada Exchange and VSP. And, wanted to use the time to address the letter that we had provided for public comment and review that information. So if it's okay, I'd like to pop off camera and be able to read through that and I will come back on camera following completion of that. But I would like to take a moment to review the materials that were provided through public comment, if that's okay.

V. CLARK: Thank you. Yes.

M. DENHAAN: Good. Great. All right. Well, again, thank you for the opportunity. As just a little background and introduction, we wanted to take some time to walk through, the importance and background, of the value to Nevada consumers on offering the vision benefits through our partnership. We have reviewed the information provided to us in the email, dated October 8th. And our goal, is really to address -- I'm sorry, to address the partner hosting agreement, review the current operations model, as well as any other concerns the board may have regarding, the member support that is provided to Nevada consumers through this arrangement. So, just a little background on this partnership with VSP and the Exchange. Back in spring of 2019, VSP had contacted the Nevada Exchange to share how VSP was collaborating with other state-based Exchanges to offer an individual vision option for consumers that needed it. The Nevada Exchange at that time did not offer vision benefits, and it appeared there was an unmet need for Nevada consumers. So, in way of background, only state-based Exchanges are able to offer vision benefits on the Exchange. The Exchanges using the federal platform actually cannot.

And we were already, at that time, successfully partnering with several other state-based Exchanges using this same model that we have in place with you. And we were also in discussions with, several additional state-based Exchanges about supporting their consumers as well. And, we spent several months -- about 18 months working through the business model, the IT requirements, and the marketing and were able to launch the solution that's in place now, in November of 2020. And the model that we have in place, with the Exchange is really a co-branded redirect link, which appears very seamless to the members and brings consumers to VSP to complete the purchase of a fully insured vision benefit. Now, we've built this link with the member experience in mind and consumers can shop for a plan. They can compare pricing. They can find a doctor. They can reach out to a call center agent if they need it. And they can also use that vision benefit the next business day, all from the website purchase of this vision benefit that they had through VSP. And the team that we were working with back in, 2019 and 2020 felt that there was tremendous benefit for Nevada consumers to have access to a high-quality vision product through VSP. And the model that we had proposed required very little IT resource or human capital to implement. Additionally the model would be essentially cost neutral for the Exchange due to this hosting fee that we provide. And that is really in place to offset any operational costs that are incurred when adding the link, but also maintaining the link on the Exchange's website. And the smart link is really a turnkey solution that allows VSP to kind of be the expert and handle the billing, the renewals, communications, customer service, product compliance, and so forth. And

also, we work with several other state-based Exchanges, including California, Idaho, Colorado, obviously the Nevada Exchange, Maryland, Kentucky. And all of those Exchanges do use this VSP Smart Link redirect model as part of our partnership. And, you know, to address this, we do have the ability to implement an integrated model, similar to what you have in place with other health carriers on the site or the Smart Link model. And to date, all of our Exchange partners have really opted for that smart Link option, I think primarily due to its ease, it's lack of resources required, and the low cost to put this in place and implement. So if a integrated solution is ultimately, a preference, we can certainly support that. But it does require some additional contracting, completion of a security questionnaire and, significantly more resources to administer for both parties. But it is an option. So we wanted to clarify that in case that was of concern. We also understand that the board has some concerns regarding, you know, potential or lack of oversight of the vision plan offerings, as well as the consumer assistance activities that, surrounding that. And to address those concerns, we have provided an attachment to the letter. And it has some information that I'm hoping the board would find helpful, specific to things like growth of the program, the -- our summary of the reporting that we provide, compliance overview, information on member support and nurturing that we do as well, as well as satisfaction information. And, fortunately, vision benefits are much less complicated, than traditional health benefits and dental benefits. They are also very stable in both product coverage and pricing. So changes on our end are extremely rare as compared to health and dental benefits, which

certainly could require more oversight, than a vision product does. And a little background on the products, we do offer two vision plans on the Exchange for consumers, which include, very importantly, an annual well eye exam and materials. So that's the frames and lenses or contact lenses. And consumers get that every 12 months. Now, this not only helps consumers get the eye care and the eyewear that they need, but the well eye exam, can detect early onset health conditions such as hypertension, high cholesterol, or diabetes, and those aren't detected on a routine eye exam. And often the optometrists could be the first person to actually refer them to their PCP for treatment because they caught that early onset condition and progression through that well eye exam. Now, consumers not having access to vision benefits as a result of, potentially terminating this relationship, could ultimately increase the risk of missing an early detection of what we consider very serious pending medical conditions such as hypertension, high cholesterol, or diabetes. So that's, clearly an important part of what we do. A little bit about VSP, if you're not familiar with VSP, we have been in business for over 60 years. We cover over 80 million Americans and are truly in every aspect of healthcare, including employer sponsored benefits, government programs such as ACA, Medicare, Medicaid, as well as several other healthcare channels. VSP is also a not-for-profit organization, and we are focused solely on the quality of service and member satisfaction. I believe highly regarded in our healthcare industry. And as part of our onboarding with the Exchange, we did share some partner information with the Nevada Exchange so they could contact other state-based Exchanges as a reference and speak to

them about the success of the model and our partnership. So we wanted to provide as much transparency as possible. One of the questions was about service. And in the email we received, it did note thatthe Exchange is not aware of any consumer complaints regarding our services being reported to the call center or consumer assistance team. We were obviously pleased to hear that, and that information clearly aligns with our expectations of the quality of our products, the service, as well as the support for members who do purchase our individual vision products. It is also extremely consistent with our experience with the other state-based Exchange partners, who have been extremely pleased with the partnership andthe results of that partnership. So, one other piece to our partnership that I wanted to highlight was that we schedule an Annual Partner Review where we spend some time and we share results. We discuss service, member satisfaction, growth of the membership, et cetera. And the goal of this annual meeting and get together is really to address any concerns that the team might have and provide what we think is valuable information to the Exchange about our program. And to date, there have been no concerns expressed at all from the Nevada team, and the membership continues to grow, which demonstrates that access to a vision benefit really does help fill an unmet need for Nevada consumers. We would happily welcome the opportunity to have board members participate in those annual review meetings going forward, if that would be helpful. And Ibelieve this might provide some additional insight into how the program's performing and address some of the concerns that may have been expressed about the lack of oversight. So we welcome your thoughts on participating, in that in the

future going forward, and, would really enjoy spending that time together to address those concerns. So I know I'm running a little bit over time. In closing, we hope that the details shared in this letter that I'm reviewing and that you've been provided, as well as the attached information, will really address those concerns, that you may have about this model or maybe the service that's provided to your Nevada consumers. We look forward to continuing serving your members and providing this important vision benefit that your consumers need and deserve. And certainly, we thank you for the partnership and the opportunity to improve the lives of your consumers. So, with that, thank you very much for allowing my time with the public comment and I will now pop back on now that I'm not reading.

T. DAVIS: Thank you so much and, at this time -- appreciate your public comment. At this time, I'd like to see if there's anybody else on Zoom who has joined us who either, again, raising your electronic hand feature, if you're not able to do that, if you wanna unmute yourself and let us know that you would like to provide public comment. Kaitlyn, do you see any other hands or anybody in -- anything in the chat that indicates that someone would like to make a public comment at this time?

K. BLAGEN: Kaitlyn Blagen for the record. No, I do not see any hands at this time. Thank you.

T. DAVIS: Okay, great. Thank you. And then just, one more time for the phone lines. If anyone is joining us by calling in, you may go ahead at this point and unmute yourself and provide your public comment. Madam Chair, not hearing anything, I would like to say that that would

conclude public comment at this time if there's no other public comments. I would like to, state for the record that, Stacie Weeks did join us. So previously I had marked her as absent, but she is, online with us, has joined us, and so I'll mark her as, present.

V. CLARK: Thank you very much, Tiffany. Next on the agenda we have the Executive Director Report. This report provides updates on topics that cover operations of the Exchange. And with that, I'll turn it over to Mr. Russell Cook.

R. COOK: Thank you, Madam Chair. Are you able to hear me okay?

V. CLARK: Yes.

R. COOK: All right. I know I've been plagued by audio issues in the past. Just wanna make sure I'm coming through loud and clear. I will begin my report with some general comments. In the four-month interim since the June board meeting, the Exchange has completed a significant number of major milestones. In August, the Exchange's fiscal team completed work on our proposed budget for the upcoming State Fiscal Year, or SFY 2026 and 2027 buy-in. This budget, which was presented to the Governor's Finance Office on September 30th, reflected an average increase of 8.3% versus the Exchange’s budget for State Fiscal Year 2025. This increase was largely attributable to the combined impact of recent wage increases authorized by the Governor's Office, for which our staff is very grateful, the newly imposed cost of utilizing Equifax's Verify Current Income data service for income verification, which until July 1st of this year was covered by CMS, and the Exchange’s request for two new staff

positions, which we hope will bolster the Exchanges Plan Certification capacity, and provide the Exchange with a dedicated Tribal Liaison. In September, the Exchange successfully closed out two separate information security audits, one of which was conducted by Nevada's Legislative Council Bureau and the other of which was conducted by the IRS, with a small number of low to moderate severity findings. We anticipate that each of these findings, some of which require only minimal changes to existing policy or procedure documents, will be resolved within the first quarter of 2025. Also, in September, the Exchange submitted its annual suite of compliance related documentation to CMS in order to preserve the Exchange's authority to connect or ATC to the Federal Data Services hub. Collectively, these accomplishments represent several months of collaborative work between the Exchange’s Information Assistance Manager and technology vendor, GetInsured. During the same time period, the Exchange’s communications team worked tirelessly with marketing vendor, the Abbi Agency, to develop what I believe is poised to be our most effective fall marketing campaign to date. The messaging for this campaign was driven by numerous email surveys and focus groups conducted over the past year by research and analysis for Marketing for Change, and the campaign's television and radio spots feature a newly commissioned Nevada Health jingle, a first for the Exchange. Our team is grateful for the opportunity to share a preview of this campaign later in today's meeting. The Exchange's policy team, though operating at a reduced capacity due to staffing vacancies, completed its annual revisions to the Exchange's policy manual and issuer agreement, both of which were

updated to reflect the latest guidelines promulgated in CMS's Plan Year 2025 Notice -- I'm sorry, was I -- I thought I heard something, very sorry. I'll continue. The guidelines promulgated in CMS's Plan Year 2025 Notice of Benefit and Payment Parameters. Draft revisions of both documents were circulated for stakeholder review and feedback during August, and the final versions were released in September. On September 16th, the Exchange successfully completed its annual open enrollment readiness review with CMS, the final regulatory hurdle in preparation for the upcoming open enrollment period. This milestone represents the broadest collaborative achievement of the Exchange's annual operational cycle, requiring the combined efforts of the Exchange's policy, quality assurance, reconciliation, communications, broker, Navigator, and fiscal teams, truly all hands on deck, working under the coordination and guidance at the Exchange's operations manager. Lastly, but perhaps of the most immediate impact to the Exchange's existing consumers, the annual plan certification process was successfully completed in September with 100% of submitted plans comprising 148 -- 141 QHPs and 18 dental plans being approved for sale through Nevada Health Link for Plan year 2025. The statewide weighted average rate increase for Nevada Health Plans is 6.55% versus plan year 2024. I will now move to our four month look ahead. Annual passive renewals is the first item. Work on the annual passive renewals job began in August with a complete staged run that allowed the Exchange and technology vendor, GetInsured, to identify eligibility or data quality issues, which could potentially be resolved prior to the October production run. During this year's stage run, the Exchange achieved a renewal success rate

of 99%. The production renewals run began on October 11th, and although it's still in progress as of the date of this presentation, the Exchange anticipates similar results to the stage run. An overview of the passive renewals results will be provided during the December board meeting. Next is the plan year 2025 open enrollment period. The plan year 2025 OEP will begin on November 1, 2024. As with the plan year 2024 OEP, the Exchange will be providing extended call center hours to consumers and enrollment professionals, including staffing on Saturdays. In order to qualify for coverage beginning January 1, 2025, consumers or enrollment professionals must submit plan selections by midnight on December 31st. To secure coverage beginning February 1, 2025, applications for coverage must be submitted by midnight on January 15th, though the Exchange will allow an additional six days through midnight on January 21st to submit plan selections. And I did want to clarify that January 20th this year falls on Martin Luther King Jr. Day, which is, a holiday for the, call center. So we have adjusted our schedule, to allow one additional day. Usually, we have a five-day buffer period. This year, we will allow enrollments, and plan selections to be submitted all the way through midnight on January 21st. Next, we have been working to implement some DACA eligibility changes. On May 2nd rather, 2024, CMS finalized a rule that expanded access to healthcare by allowing Deferred Action for Childhood Arrivals, or DACA, recipients to be considered lawfully present with respect to enrollment eligibility for ACA qualified health and dental plans. The final rule allowed DACA recipients, to submit applications for marketplace coverage starting November 1, 2024 for coverage beginning December 1,

2024. On August 8, 2024, a group of 19 State Attorneys General filed a lawsuit in Federal District Court in North Dakota seeking an injunction to block the implementation of this rule. Oral arguments are scheduled to be heard on October 15th, today in fact, and a ruling is likely to come shortly thereafter. The Exchange, having already implemented the functionality required by the final rule, is prepared to extend lawfully present status to DACA recipients through the Nevada Health Link Marketplace, beginning with special enrollment period applications submitted during November 2024 for coverage beginning December 1st. However, in the event that an injunction is granted following oral arguments, the Exchange will have the ability to revert to the DACA, uh -- revert the DACA related changes, rather, to ensure compliance with the ruling. The next update is in regard to automatic voter registration. On September 24, 2024, the Nevada Secretary of State's office held a kickoff meeting to roll out the technical implementation requirements for Nevada's Automatic Voter Registration Program per the requirements of AB 432 from the 2021 legislative session. This meeting resulted in a number of policy-related questions being raised by SSHIX and DWSS staff, and the Secretary of State held a follow up discussion on October 7th to address these questions. Following this meeting, the Exchange believes that we will be able to implement the required reporting functionality and satisfy our statutory obligations by the target date of January 1, 2025. A status update and progress report will be provided during the December board meeting. The next item in the update is in regard to the RFP or technology platform and call center services. Following the special board meeting on September 17, 2024,

during which the Exchange provided an update on the RFP to the Board of directors, two events occurred which have further, shaped the contents of the RFP rather. The first was a meeting with members of the Nevada Association of Health Plans, or NVAHP, on September 25th. The board may recall that Shelly Capurro provided public comment during the September 17th board meeting on behalf of NVAHP, expressing concern about the timing of the Exchange's RFP in relation to the ongoing Medicaid NCORP. During the September 25th meeting with NVAHP, I was able to gather a great deal of additional insight into the concerns of the Exchange's insurance carriers, and these concerns resulted in a number of additions and modifications to the vendor requirements of the RFP. Of particular note, the requirements surrounding the onboarding of existing on Exchange insurance carriers in the event of a vendor change were strengthened to minimize the financial burden on carriers and decrease the potential need for technology changes. The second event impacting the RFP was the aforementioned meeting with the Secretary of State's office on October 7th. Although the Exchange remains confident that the requirements of the AVR program can be met without a reliance on vendor supported technology per se, the Exchange's technology platform must remain capable of producing a very specific type of reporting on a configurable cadence. And the detailed information provided by the Secretary of State, along with the resulting clarification to the vendor requirements and the RFP, has increased our confidence that the Exchange will be able to remain compliant with ABO requirements in the event of a vendor change. The RFP is currently undergoing a final internal review with

the goal of providing the completed scopes of work, project timeline, and evaluation criteria to the state purchasing division by October 16th. Despite these delays, the overall project timeline remains unchanged from the timeline that was proposed on September 17th, with the exception of a slightly shortened vendor response window. The next update is in regard to the Medicaid unwinding. August of 2024 marked the final month of Nevada's unwinding of the public health emergency. Although numerous technical difficulties were encountered over the course of the unwinding period's 16 months, the net result was a substantial improvement to the integration and interoperability of Nevada's Exchange and Medicaid and CHIP systems. And in my eight years of work with the Exchange, the strength of the collaborative working relationship with the DWSS team is at an all-time high. During the June board meeting, the Exchange reported the rollout of a direct-to-consumer SMS messaging campaign, which was intended to provide detailed guidance in both English and Spanish to Nevadans who lost Medicaid or CHIP coverage during the unwinding period. The SMS messages -- I'm sorry. The SMS messages themselves were relatively simple, but they encouraged consumers to visit landing pages on the Nevada Health Link website, which were created to provide customized instructions which were tailored to the date that a given household lost their Medicaid or CHIP eligibility. To date, the Exchange has sent nearly 77,000 SMS messages representing at least one message to each household that lost Medicaid or CHIP eligibility during the unwinding period and whose application contained an SMS enabled phone number. Over the course of this campaign, the Exchange logged over 11,000 views of the

landing pages, which were accessible only by direct hyperlink in the SMS messages. And even though some of these page views were likely to be duplicate views from the same user, we estimate that the overall click-through rate was at least 10%. Despite this apparent success, the SMS campaign was unsuccessful in significantly raising Nevada's conversion rate, or the percentage of consumers who enrolled in Exchange coverage following their loss of Medicaid or CHIP eligibility. Throughout the unwinding period, the monthly conversion rate hovered around 3.5 to 4%. At the end of August, the Exchange had logged approximately 129,000 individuals who lost Medicaid or CHIP eligibility during the unwinding, of which approximately 4,900 had subsequently enrolled in Exchange coverage, for a cumulative conversion rate of approximately 3.8%. Next, I'll provide an update on our Tribal Partnership Program. Over the last few months, the Exchange’s Tribal Partnership Program has gained momentum. We are pleased to be working with the team from the Reno Sparks Indian Colonies Tribal Health Center to provide aggregated monthly premiums for members of their community, one of the largest federally recognized tribes in Nevada, beginning of November. As mentioned above in the general comment section, the Exchange has also requested a full-time Tribal Liaison in our upcoming budget. Increasing workload demands on our existing part-time Tribal Liaison in recent months have convinced the Exchange that a dedicated staff resource will be integral to our continued efforts to build community trust and support within this historically underserved population. I will conclude my report with some personnel updates. The Exchange currently has two vacancies, both located on our

policy team. The first is our Policy Specialist position, which is responsible primarily for reviewing revisions to applicable state and federal regulations and identifying strategies for the Exchange to remain in compliance. This position, which reports directly to our policy team lead, has been vacant since August 12, 2024, and the Exchange completed interviews with all candidates on October 14th. A successful candidate has been chosen and we hope to have the position filled within the month of October. The second position is our Policy Team Lead, an integral leadership role within the Exchange. This position, which reports to the Executive Director, has been vacant since September 30, 2024. Although the recruitment for this position has not yet been open to applicants and -- and hot off the presses, I just got confirmation an hour ago that it has been opened. We hope to begin accepting applications the week of October 21st with the goal of filling the position by early November. And that concludes my Executive Director's Report. I would be happy to entertain any questions from the board.

V. CLARK: Thank you so much, Russell. Do we have any questions at all? Sounds like you're very busy, and congratulations on all the good reports. Appreciate all of you and your staff and your time.

R. COOK: Thank you, Madam Chair.

V. CLARK: If there are no questions, we will move on.

T. DAVIS: Madam Chair?

S. KUMAR: Chair, a question.

V. CLARK: I'm sorry, go ahead. I'm not seeing whose hand it is. I'm sorry.

J. JOHNSON: Sam.

V. CLARK: Oh, Sam, yes. Sam, I'm sorry. Yes?

S. KUMAR: Thank you, Madam Chair. Russell, quick question for you. You said with the unwinding period, the response rate was somewhere around 4% or so. Do we know the reasons why? Do people move out of town, out of state, what's the reason? Do we have an understanding of that?

R. COOK: Based upon our best educated guess, by looking at the enrollment data, and in particular looking at the consumers who have submitted applications and received eligibility determinations, and thus are aware of the, APTC that their household will qualify for, is that the net premium is the driving consideration, for the majority of the individuals. And the exact percentage, I don't have that handy at the moment. We have not actually calculated this particular metric in a number of months. But earlier in the year around the March/April timeframe, we were doing some investigative analysis, and it appeared that the majority of, households that had lost a Medicaid or CHIP, eligibility and then enrolled in Exchange coverage, were paying a net premium of $80 or less per month. So, it seems as though getting into that 80 or $100 per month range for a net premium, appear to be a determining factor for a significant number of households. That is an inference, of course. You know, we only have, limited amount of data, with which to, to make these kind of, educated guesses again, which is why we, you know, really, worked hard, to develop kind of a multi-pronged consumer outreach, report. Not only was our call center, making outbound calls, on a daily basis to households that had lost

their eligibility, but I mentioned also the SMS messaging campaign. So, you know, we know that the folks who are receiving these messages, we know that at least 10% of them or so, were actually clicking the links to the Exchange website, but it's very difficult to track, you know -- to follow a single household from SMS message to website visit to ultimate enrollment. So again, you know, we have to make a lot of inferences. I would say at a high level though, in summary, that, cost considerations were the number one determining factor.

S. KUMAR: That's good information. Thank you. And also, thank you for the excellent report.

V. CLARK: Yes.

R. COOK: You're very welcome.

V. CLARK: Stacie Weeks, did you wanna make a comment?

S. WEEKS: Thank you. I was just curious -- remind me, you mentioned a number, I think. How many people did you say during the unwind enrolled in the Exchange?

R. COOK: Approximately 4,900, I believe. It was just over 4,900 total of the 6,000.

S. WEEKS: Just so members -- so for folks to understand the size of the unwind, so our program was closer to over 900,000 people in Medicaid. We lost about 300,000 people during the unwind. About 150,000-ish have come back. We just finished the unwind, like Russell was referring to, this last month. So we probably will see some people come back on, because obviously they probably didn't get their paperwork back. But just to give you guys some context of about 150,000 people that were

on Medicaid that have not come back at this time.

V. CLARK: Okay. And, and so then Russell, you're saying that 49,000, were eligible for the Exchange -- and maybe I missed that. How many went onto the Exchange?

R. COOK: So we received -- excellent question, and I don't mean to get too far deep -- you know, deep down in the weeds here, but, the first discrepancy that I wanted to address, I reported that the Exchange received, referrals for approximately 129,000 unique individuals, throughout the unwinding period. Obviously, that's substantially lower than the figures, that Ms. Weeks provided. But I did want to clarify that we only receive referrals for a Nevada Medicaid for households who lost their eligibility due to a verified, excess of income about the Medicaid or CHIP eligibility threshold. There are other reasons including, what's known as a procedural denial, often referred to as a non-cooperation related denial, where, you know, a household may, fail to provide the required, documentation in order to complete an eligibility verification that will result in, loss of eligibility without a corresponding referral to the Exchange. Yeah. Yes, Ms. Weeks, Iwould appreciate any help you could provide.

S. WEEKS: Yeah. So some folks obviously had employer coverage. So in total, you know, over that time, people were on Medicaid. We weren't able to disenroll them during the unwind period. That was the federal rule, during the, pandemic, and that allowed the state to get increased federal funds during that time. So some folks got jobs, they made more money, they had affordable coverage. So as we're cleaning up

our roles, some of those folks were just already covered somewhere else. They were our low utilizers. So in total it was about 300,000 people. But like Russell's saying, a group of those folks were determined likely eligible for the Exchange on income, and so they were sent over. And, Russell of the ones sent over, how many did you say you enrolled again?

R. COOK: 4,900, actually not 49,000.

V. CLARK: Oh, I'm sorry, 4,900.

R. COOK: Yeah.

V. CLARK: Got you. Okay.

R. COOK: And -- yeah. So first point I wanted to make, you know, is that, we were not on the receiving end of every single household who lost their Medicaid or CHIP eligibility during the unwinding period. Of those approximately 129,000 unique individuals who were referred to the Exchange, only about -- oh gosh, I can pull up the number right now if you gimme just a second. Approximately 11,500 of those individuals actually submitted their applications for coverage through the Exchange. And that's an important distinction to keep in mind, because when we receive an account transfer referral from Nevada Medicaid, our system is able to extract the information from that electronic payload. We pre-populate an application. We actually go so far as to open a special enrollment period window, a 60-day enrollment window, automatically for the consumer. But the consumer really has to take the next step of submitting their application for coverage and receiving their eligibility determination. So of the approximately 129,000, about 11,500 of those individuals actually submitted their application and received, an eligibility determination. And

of those, 4,900, which is over 45%, actually did enroll in Exchange coverage. But to Mr. Kumar's point, to his question from a moment ago, it's that gap, the discrepancy between the 4,900 versus the 11,500 that, provided the basis for our inference that cost consideration, specifically net premium, were the primary determining factor for those households who received in eligibility determination, but then elected not to take the next step and actually enroll in coverage.

V. CLARK: Okay. Jonathan?

J. JOHNSON: Yeah, thank you. Thanks for the report, Russell. I really appreciate, the updates you provide every board meeting. Not to harp. Ihave two questions. Not to beat this question to death, but do we have any sort of benchmark or comparison? I know that this is, you know, specific to the state of Nevada, but is there any comparison to any other state that, you know, ended their, you know, emergency and had this massive influx from folks that qualified for Medicaid that no longer qualified, and either went to their state Exchange or to the federal Exchange, to kind of understand, you know, or gain any additional insight?

R. COOK: Sure. You know, the what comes to mind immediately, and I wanna acknowledge up front, Nevada was certainly at the low end of the conversion rate -- the, so-called conversion rate, for, you know -- compared to other state-based marketplaces. Now, we have been in contact, over the last 16 months with many other state-based marketplaces to compare notes on their methodologies. In my opinion, other states, were using methodologies to calculate their conversion rate, which might have given a falsely inflated impression of that conversion

rate. They , in some states, they were unable to distinguish, for instance, between consumers who actually lost Medicaid or CHIP eligibility versus other consumers who are not actually receiving Medicaid or CHIP benefits, but may have been listed on the, same application. And, you know, when the entire household enrolls, they were counting everyone as a loss of Medicaid that converted into an Exchange enrollment. We have, you know, deliberately designed our methodology to provide the most conservative calculation possible of our conversion rate. That being said, I don't mean to split hairs here. There were several states that exceeded a 25 or even 30% conversion rate. And I believe, that, Washington DC, in particular, was closer to, was even higher than 30%. And it's my understanding that they achieved this conversion rate, largely through the automatic enrollment of, consumers, who lost Medicaid or CHIP eligibility if they qualified for a $0 net premium. And I just want to mention that, you know, that is certainly, I think avery effective solution, to this problem, which remains even beyond, you know -- persists beyond the unwinding period, you know, that we still are on the receiving end of hundreds or thousands of, referrals from Nevada Medicaid each month. One of these, you know, potential solutions, which is in the works right now, is, something that we refer to as auto eligibility. It's not the same as auto enrollment, but what that would allow us to do -- and it would be dependent upon receiving a few additional data points, from Nevada Medicaid in these account transfers, and we have already defined the requirements. We already have aproject in place, which is being worked on at present, with, the DWSS technology vendor Deloitte. But that would allow the Exchange to bypass the

requirement for consumers to actually, actively submit their application of coverage in order to receive their eligibility determination. It would allow us to calculate their eligibility determination based on the household income that was previously verified by Nevada Medicaid. So instead of sending a notification to the household saying, hey, you know, we're aware that you lost your Medicaid or CHIP eligibility. Come to Nevada Health Link and see what you might qualify for. We can instead, issue their eligibility determination in that notification, and hopefully entice more consumers to actually take action and get enrollment coverage. Again, that's a steppingstone. It's not, the same as auto enrollment, but I believe that that would be, you know, a very, beneficial change, beneficial enhancement to the overall, integration process.

J. JOHNSON: Yeah. And look, I think the -- we're getting a lot of these questions around that, right, 'cause you hear all these people losing Medicaid eligibility, and we have this option for them to get subsidized coverage. And the whole purpose why we're here and to do this is to reduce the number of, Nevadans, that don't have access to medical care. And so when we hear these numbers, it's, you know, it's sad. It -- so the effort goes on. T he other question that I have is, you mentioned two, positions that are vacant at the moment, both of them on the policy team. How many people are in that department? Is that the entire department that we're missing, or,

R. COOK: And great question. That --

J. JOHNSON: Shed some light on what that department looks like. And I'm assuming their departures were, voluntary.

R. COOK: Yeah, their departures were actually the result of out-of-state residency. One of our, personnel, who was the Policy Specialist had been residing out of state for a number of years. He was approved by, human resources to move out of state, back in 2021. And as a result of policy changes, his employment ended on August 9th. More recently, and coincidentally, our former Policy Team Lead, who was, married to an enlisted man in the Navy, he was re stationed down to Southern California. So for, you know, essentially the same reason, she had to, vacate her employment as well. So it was coincidental and it was certainly amicable, but it definitely, left an impact on the Exchange's operations. To answer your first question, though, out of 27, full-time employees total at the Exchange, the policy team, comprises four of those positions. We have a Policy Team Lead, a Policy Specialist, our Plan Certification Manager is also on the policy team, and then we have an Appeal Specialist who processes, eligibility appeals.

J. JOHNSON: Thank you.

R. COOK: Ms. Weeks, Isaw your hand raised a moment ago. I don't know if we addressed your question. I wanna make sure we were able to, if you still have one.

S. WEEKS: Thank you. It was an accident. Sorry. Thank you.

R. COOK: Oh, no problem.

V. CLARK: Okay. Thank you. Great questions. Does anyone else have any questions for Russell? Okay. Seeing none, we will move on in the agenda. Then item number four is the Navigator program overview of goals, funding, and selective criteria. I don't -- is that something you'll be

presenting Russell or somebody else?

R. COOK: Yes. Ibelieve I just put it up on the screen share. You should be seeing, the introduction slide. Is that correct? Can you see that okay?

V. CLARK: Yes.

R. COOK: Okay, wonderful. So for context, this, presentation was requested by Stacie Weeks, during our September 17th special board meeting. And I am pleased to, be joined today by Rosa Alejandre, who is the Exchange's Navigator Program Coordinator. I will be walking through the presentation, and delivering these slides -- or presenting the slides rather. But Rosa has agreed to make herself available because she is the foremost subject matter expert on this topic. And, she and I will be more than happy to answer any questions, that are not addressed, throughout the course of the presentation. And, in terms of scope and content for this presentation, looking back at historical meeting agendas, it's been quite some time since the Exchange presented an overview of its Navigator Program to the Board of Directors. So I wanted to kind of balance some general information about the background and the regulatory framework of the Navigator Program, while also taking akind of forward looking perspective at the potential for, you know, future, enhancement, of this program and perhaps also future integration, with, Medicaid, eligibility, enrollment assistance, activities. So again, we'll move through the presentation. I will, try to be as expedient as possible, and then, we'll be sure to allow, time at the end of the presentation to address any questions that the board members might have. All right. So on the agenda,

we're gonna move through five topical areas. We're gonna start with a summary of Navigator and Assister functions. We're then gonna discuss the, Affordable Care Act regulatory framework that requires, states to implement a Navigator and Assister programs. We're gonna talk a little bit about a special type of a <inaudible> called a Certified Application Counselor. And I -- you know, Iwent back and forth as to whether or not that would be helpful to include in the presentation, but there are really three fundamental types of enrollment assisters, that are, defined in ACA regulations. And I thought it might be really helpful to present an overview of each role, as well as to define and distinguish between those roles. And then we're gonna move on to the training and the certification process for all three of these roles. It is a common, certification process. And we're gonna close with an overview of, current funding for the Navigator Program, as well as staffing levels for Plan Year 2025. All right. So we'll start with functions of Navigators and Assisters. So, Navigators and Assisters, which are also known as In-Person Assisters, or IPAs. These are licensed professionals who are paid by state marketplaces, not just Nevada, this is required of every state-based marketplace, to help consumers who require more assistance than can be offered through a website alone. In addition to one-on-one help, Navigators and IPAs can help consumers understand eligibility requirements for federal subsidies. Navigators and IPAs must provide advice regarding substantive benefits or comparative benefits of different health plans. But unlike agents or brokers, Navigators and IPAs are not authorized to receive payments from insurance carriers and/or consumers. So that's one critical, distinction,

right off the bat, is that Navigators and IPAs do not receive commission payments from insurance carriers the same way that brokers or agents do. And the Navigators and IPAs can perform the same functions, each of these roles can perform the same functions, but there are some subtle differences between the two, that I'll review on the following slide. Unlike Navigators, which operate under a standard set of rules across states, rules which are, defined in ACA regulations, there is more variation in the size, structure, and functions of IPA programs on account of the leeway that's afforded to state marketplaces. The ACA, when it was, in its inception, authorized grant money to assist states to plan and establish their own marketplaces. And states were authorized to pay IPAs using these grant funds. States were also authorized to use establishing grant money to plan and administer their Navigator programs, but Navigators could not be paid out of these grants, and that remains true today. States were authorized to use a staff -- oh, I'm sorry. I'm repeating myself. Navigators must be paid out of the operational budget of the marketplace, which in Nevada is funded by an assessment on monthly premiums for health plans sold in the marketplace. We also refer to that as our carrier premium fee or CPF. In practice, the Exchange typically refers collectively to the activities of its Navigator and IPA communities as its Navigator Program, even though there is technically a distinction between the two roles. Community partnerships are really an integral part of the Navigator Program. One of the primary goals of our Navigator and IPA Program is to foster collaborative partnerships with agencies, including state agencies and community health organizations throughout the state. Through these

partnerships, Navigators and IPAs can provide printed resources and free in-person assistance in a variety of languages to communities with limited English proficiencies. And I chose just a couple of examples to share, although there are many such examples throughout the entire state. But a few examples include the Asian Community Development Council in Las Vegas and Reno, who partner with the Exchange to provide printed materials and enrollment assistance, in a variety of, Asian languages. They can cover Filipino, Korean, Mandarin Chinese Tagalog, as well as the Consulate of Mexico in Las Vegas. We do have a Navigator staffed in the consulate who can provide, free, enrollment and eligibility assistance on a walk-in basis right there in the consulate. We're next gonna move on to the ACA regulatory framework related to the Navigator Program. The principal requirements for the establishment and operation of a Navigator Program are defined in, Title 45 of the, Code of Federal Regulations, Chapter 155.210 Navigator Program Standards. And I, the entire, chapter itself is quite lengthy. So what I've done is I tried to kind of pluck out what I thought were the most salient points, in a summarized format. But anyone who is interested, in delving into the details can, of course, just do a quick Google search for the applicable CFR, and, you can find a wealth of additional details. But at a high level, the general requirements are that the Exchange must establish a Navigator Program through which it awards grants to eligible public or private entities and individuals. And again, just to recap, those grant funds do need to come from the Exchanges operational budget. Those, are not, authorized to utilize, ACA establishment grant funds. Regarding standards of the Navigator Program,

the Exchange is required to develop and publicly disseminate a set of standards to be met by all entities and individuals to be awarded Navigator grants designed to prevent any conflicts of interest and to ensure appropriate integrity of Navigator activities. And these standards are defined in a document called our Operator Agreement, which every single Navigator entity as well as every single individual, Navigator, is required to sign, and I'm sorry, before they will be appointed, as a certified, Navigator. And then, standard number two, requires the Exchange to develop a set of training standards to be met by all entities and individuals carrying out Navigator functions. And these are encompassed, within our online training and certification program, which we'll talk a little bit, about later on in the, training certification, portion of the presentation. Regarding entities and individuals who are eligible to be a Navigator, in order to receive a Navigator grant, an entity or individual must have existing relationships or be readily available, able rather to establish relationships with employers, employees, consumers, or self-employed individuals likely to be eligible for enrollment in QHP. They must meet any licensing or certification requirements prescribed by the Exchange, and again, we'll cover those in more detail in few slides. They must not have a conflict of interest, during the term as a Navigator. We'll talk a little bit about that on the next slide, regarding prohibitions on Navigator conduct. And then they must also comply with the privacy and security standards adopted by the Exchange. Those, again, are defined in our Operator Agreement. Regarding prohibitions on Navigator conduct, the Exchange must ensure that a Navigator must not be a health insurance issuer or subsidiary, be an

association that includes members of, or lobbies on behalf of, the insurance industry. They must not receive any monetary consideration from an insurance issuer. They must not charge an applicant or enrollee for their services. They must not provide gifts of any value to an applicant or potential enrollee, and they must not use Exchange funds to purchase gifts, gift cards, or promotional items that market or promote the services of a third party. And we'll now conclude this section, with an overview of the duties of a Navigator. An entity that serves as a Navigator -- and an entity in this context just means a Navigator organization. They must carry out at least the following duties; maintain expertise in eligibility and enrollment, and conduct public education activities to raise awareness about the Exchange, facilitate selection of a QHP by providing information in a fair, accurate, and impartial manner, provide referrals to any applicable Office of Health Insurance Consumer Assistance or any other appropriate state agency that includes Nevada Medicaid, and they must provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange. And that's where these, community partnerships really come into play. Next, I wanted to change gears for a moment and talk about, a related, enrollment assister role known as a Certified Application Counselor. A different CFR, 155.225 this time, requires the Exchange to establish and maintain a Certified Application Counselor, or CAC, Program. As far as CAC standards are concerned, Certified Application Counselors must provide information to individuals and employees about the full range of QHP options and insurance affordability programs for which they are eligible.

They must provide fair, impartial, and accurate information that assists consumers with submitting the eligibility application. Obviously some overlap with, the Navigator duties here. They must clarify the distinctions among health coverage options, including QHPs and help consumers make informed decisions during the health coverage selection process. They must assist individuals and employees to apply for coverage in a QHP through the Exchange and for other insurance affordability programs. And they must help to facilitate enrollment of eligible individuals in QHPs and other insurance affordability programs. So, as I alluded to a moment ago, lots of overlap with Navigators and IPAs, but there are some differences as well. Although CACs are responsible for providing many of the same services as Navigators and IPAs, importantly, CACs do not receive funding from the Exchange. CACs are typically affiliated with third party organizations such as community health centers, for example, and they might work on a volunteer basis. And, per the CFR, the Exchange may designate an organization, including an organization designated as a Medicaid Certified Application Counselor Organization by a state Medicaid or CHIP agency, to certify its staff members or volunteers to act as Certified Application Counselors. In addition, if Navigators -- and this is something that Rosa asked me to include in the presentation. Just again, Imentioned at the top of the presentation kind of forward looking in terms of potentials for future collaboration with Nevada Medicaid. If Navigators and IPAs, are, you know, certified by the Exchange, could obtain access to the Medicaid Eligibility Verification System, that would improve their ability to support Medicaid CHIP enrollment and reduce duplication of

coverage. So, trying to come at that, you know -- the potential for future collaboration from a couple of different needs there. And lastly, wanted to introduce a new concept, which is gonna be, you know, important in the next section regarding training and certification, which is the notion of Exchange Enrollment Facilitators. Navigators, IPAs, and CACs are collectively referred to as Exchange Enrollment Facilitators, or EEFs, for the purposes of training, licensure, and certification, which is our very next topic. Regarding training -- and again, the information in this section is applicable to all three of those groups, Navigators, IPAs, and CACs. Prior to appointment by the Exchange, prospective EEFs must successfully complete the Exchange's online training curriculum. Following their initial appointment, EEFs are, then required to attend annual continuing education administered by the Exchange. And all EEFs receive extensive training on all insurance affordability programs, including Medicaid and Medicare as part of their training curriculum. Certification of EEFs in Nevada is defined in NRS 695J, which states that individuals who enroll qualified individuals, qualified employers, excuse me, and their employees in a QHP on the Exchange and who do not hold a producer license with the Nevada Division of Insurance, must hold an Exchange Enrollment Facilitator, or EEF, certification issued by the DOI. And to discuss those certification requirements in a bit more detail, individuals who are seeking appointment with Nevada Health Link as an EEF must first complete the following; a fingerprinting and background check, they must enroll in and successfully complete the Exchange’s online pre-certification course, they must schedule and pass the DOI's Nevada Insurance Exam, with a score of

80% or greater, and lastly, they must apply for DOI certification as an EEF, including the online application fee, which at present, I believe, is $185. I'll now conclude, with a brief summary of the current funding and staffing levels of the Navigator Program. At present, the Exchange's budget for its Navigator and IPA Program is approximately $1.5 million per year, which includes training, administration, and operational costs. And the reason why this will appoint -- include only Navigators and IPAs and not CACs is, again, because we are not authorized to use, to provide, funding -- grant funding to, to CACs, only to Navigators and IPAs. A total of seven entities will be providing Navigator and IPA services for Plan Year 2025. And these seven entities, together employ a combined total of approximately 40 individual Navigators and IPAs throughout the state. In addition, 12 CACs will be certified to offer enrollment assistance for Plan Year 2025. So that concludes my presentation, and at this time I'm happy to entertain any questions from the Board.

V. CLARK: Thanks, Russell. Do we have any questions? I know I have a question. I just wanna understand on the licensure -- so you've got the EEFs, which is comprised of the CACs and the Navigators. And on one of the slides there was, some requirements for training and then also to be licensed by the DOI. Is that correct?

R. COOK: That that is correct. It's essentially a collaborative training and certification process. The Exchange is primarily, responsible for training on, ACA standards and insurance affordability program eligibility in general, whereas the DOI is, primarily responsible for, the licensure aspects, of the process, which is similar to, but different in

certain respects from the licensure process for producers.

V. CLARK: Okay. And then those people are employed by outside entities?

R. COOK: CACs are employed by outside entities, but some of them do actually serve, on a volunteer basis. It just depends on the nature of the organization.

V. CLARK: Okay, but they don't -- they are not employed by the Exchange?

R. COOK: That is correct. If we consider the recipients of grant funding, Navigator grant funding to be employed by the Exchange, only Navigators and IPAs are in practice employed by the Exchange. CACs, either are paid by their employers or work on a volunteer basis.

V. CLARK: Oh, okay. Okay. Thank you.

R. COOK: You're very welcome.

V. CLARK: Jonathan.

J. JOHNSON: Thanks for the overview and update again. Is there any way to or does the Exchange track the volume or activity from the Navigator Program?

R. COOK: We do track it in a number of ways. I think the most relevant metric might be the share of Exchange enrollments, which are, for which the designated Assister, rather, is a Navigator or an IPA or a CAC, and at present that's around 3.5 to 4% of Exchange wide enrollments. I do want to clarify, though, that that is an underrepresentation of the role that Navigators, IPAs, and CACs play, throughout the state because, it is a very common outcome for a Navigator or an IPA interaction for the

Navigator or IPA to provide some basic coaching, introductory, explanations of eligibility criteria before referring, that consumer to an agent or broker for enrollment.

J. JOHNSON: Thank you.

R. COOK: Very welcome.

V. CLARK: And are these -- do these people carry, like errors and omissions insurance or how are they protected, you know, for basic -- you know, the potential of any mistakes, anything like that?

R. COOK: That's an excellent question. We have just exceeded, the limits of my expertise. So, if you don't mind, I'm going to phone a friend and ask Rosa, if you have any insight, to Ms. Clark's question.

R. ALEJANDRE: Rosa Alejandre, Navigator Program Manager, for the record. Yes. Actually, the EEFs do carry ENO, as part of their contract when they sign up with us every grant year.

V. CLARK: Okay. So the employers -- the people who employ them purchase the coverage?

R. ALEJANDRE: Yes, ma'am.

V. CLARK: Yeah. Okay, fantastic.

R. COOK: Entities is the term that we commonly use to refer to those employers -- those organizations, rather.

V. CLARK: I see.

R. COOK: Ms. Lewis, yes? Oh, I'm so sorry. I didn't mean to cut you off, Madam Chair.

V. CLARK: That's okay. That's -- oh, yes. Lavonne, yes?

L. LEWIS: Do you have any Navigator agencies that are

primarily in African American communities?

R. COOK: Again, I'm going to ask Rosa if she can, help provide some context there.

R. ALEJANDRE: All of our Navigator and Assisters provide assistance to any community, minority or not. We do have minorities as Assisters. We have African American, we have Asian, we have Hispanics, Latinos, but they do provide service to all communities throughout the state, whether it's virtually or over the phone.

L. LEWIS: Yeah, I recognize that they provide assistance to any communities. But sometimes the location, at least when this was first implemented back in the year '06, you know, there was some look to have, some agencies that were specifically located in minority communities who provided Navigator services. And I am wondering if you have any in African American communities specifically.

R. ALEJANDRE: Well, we do have Nevada Health Centers, for example. Nevada Health Centers has a location off of, MLK and Lake Mead area. So we have assistance there as well. We have assistance off of Eastern and, Flamingo area, minority service area as well. Let's see here. Now I have to figure out every single one of the entities. But yes, we do have 'em in the areas.

L. LEWIS: All right. Thank you.

R. ALEJANDRE: You're welcome.

T. RICH: Hey, Val, this is Todd. I just wanted to <inaudible> the discussion, if that's all right.

R. COOK: Absolutely.

V. CLARK: Go ahead. Yes.

T. RICH: And Russell, thanks for the, update on this. We work closely with the Exchange. In fact, this summer we, looked at our, Memorandum of Understanding between the two agencies, and we made some changes, made some updates. One was around plan management. We also looked at the EEFs, and made sure that, the DOI was in the right lane in terms of what we're doing. And I know I speak for Commissioner Kipper, we take, anyone that is speaking to consumers about their health insurance needs and, anyone that's speaking to anybody about what they should be choosing very seriously. And so we wanna make sure that all of these folks are licensed. Currently we have over 249,000 licensed producers in the state. And so this is something that we, look at. And then if there's a problem, we would certainly get involved. And then we do actually have a small, fund that is available if a licensed producer did do something, that was inappropriate and we could try to make that, consumer whole. So just wanted to let you know that there is some safety net out there. Hopefully we never have to use it. And we would expect that if there are concerns with any of the Navigators, Certified Application Counselors, et cetera, that we would hear about it and then we would, put that over to our enforcement team. They could take a look at it, and we could take any administrative actions including, taking that license away if we felt that was, in the best interest. So just wanted to give the Board that update.

V. CLARK: Thank you very much, Todd. Appreciate that. Stacie, did you have your hand up?

S. WEEKS: I just wanna say thanks Russell. This was really helpful. I think, this is one of the more, important roles that the Exchange plays is trying to get people engaged in enrolling in coverage, and really appreciate hearing more about what you guys are doing in the Navigator Program. I think, you know, some of the things that the governor's put out in his strategic plan, one of them really is about, you know, making the process easier for people. And so as we, you know, move forward in the future, I -- you know, coming from the Medicaid side, I would love us to consider ways to leverage some of our federal Medicaid funds, 'cause -- so if someone -- so for example, a little -- a lot of those communities that you're -- these Navigators are meeting with, many of them probably are eligible for Medicaid and ensuring that, you know, if someone is, that they're able to get that handoff in a way that's useful and helpful to them. And maybe a Navigator can be more supportive in that role so they don't only have to use outreach workers from DWSS, which they have their -- also, they have their own outreach, process. So I just think there's some alignment there, in the future, I would love us to think about and ways to leverage the 50/50 match that we can bring to the table and maybe expand some of the Navigator work that you're doing. So just wanted to bring that up and say thank you.

R. COOK: I'm very grateful for the feedback and that was, one of the specific goals that I had in mind when I put this presentation together. So looking forward to continuing this discussion in the future.

V. CLARK: Excellent. Thank you very much. Are there any other questions on the Navigator presentation? Seeing none, I think we are ready

to move on to the next agenda item, marketing and outreach update presented by the Exchange and marketing partner, the Abbi Agency.

K. CHARLESON: Hi. Good afternoon, everybody. My name is Katie Charleson. I'm the Communications Officer, Nevada Health Link.

V. CLARK: Hi, Katie. You know what? Your voice is really muffled. I personally cannot hear you.

K. CHARLESON: Oh, no. Can you hear me any better now?

V. CLARK: Yep, much better.

K. CHARLESON: Yeah, is that -- okay. Sorry about that.

V. CLARK: Thank you.

K. CHARLESON: My name is Katie Charleson. I'm the Communications Officer at the Exchange. Just in the interest of time, I'll be giving a high-level overview of our marketing and outreach report, mostly talking about what we've been doing recently, and it'll be followed up by a presentation by -- with our marketing partner Connie at the Abbi Agency. So over the past several months, Nevada Health Link's communication team and marketing partner, the Abbi Agency, have been hard at work in developing and strategizing a new open enrollment creative advertising campaign for the Plan Year 2025's open enrollment period. Our approach is to message Nevadans from October 1st to the 31st to encourage them to window shop for health insurance plans in preparation of open enrollment. Starting November 1st, the creative campaign and messaging will switch to a more extensive open enrollment campaign. This year's campaign increase -- is to increase brand awareness and foster trust with the Nevada community. Over the past few years, our research has consistently

highlighted a significant hurdle, knowledge. Despite being in Nevada's official health insurance marketplace for the last five years, we're still working to improve Nevada's understanding of Nevada Health Link, and our goal is to make Nevada Health Link a household name, whether you need it or not, recognized just as readily as Medicaid or Medicare. So this year our campaign focuses on building brand recognition with a straightforward message. We are Nevada Health Link, Nevada's official health insurance marketplace, your link to savings, selection, free assistance, and name brand health insurance. To compliment the clear messaging, we are introducing animation into our campaign. The concept showcases different areas of Nevada with a ton of fun Easter eggs. Connie will share the commercial during our marketing presentation. There's lots to see to make sure you're watching out for all different areas of Nevada, whether it's through the cities and the rurals. On October 1st, we sent out a press release explaining the benefits of window shopping and announcing the on rate average increase, and the plans available for 2025. Last week we co-hosted a community resource brunch in Elko, Nevada to share insights and resources with the rural Nevada community. We had about 60 attendees, there. And Russell presented along with Nevada Respite Care to inform, local Elko, about what resources are available to them. We also have a new broker grantee in Elko named <inaudible>, who was able to attend as well. This week we'll be going to have, uh -- this weekend and next we're having our annual prep rallies in Northern and Southern Nevada. The prep rallies intend to join together in Nevada Health Link staff, enrollment professionals, and other community partners to learn about the important

updates of the upcoming open enrollment period. For the kickoff of open enrollment, we are having a press conference of the Cleveland Clinic, Lou Ruvo Center for Brain Health in Las Vegas. The press conference will be live streamed and available to be viewed on Facebook. We are also celebrating Nevada Health Coverage Day on November 1st, which last year was established as a holiday by Governor Lombardo. And this year we are introducing a fun initiative called Hats for Health Coverage. To accompany this strategy, we ordered beanies with the Nevada Health Link logo and sharing of partners for posting with the hashtag Hats for Health Coverage. If you'd like to participate, please let me know. If you don't come to the Prep rally, I'm happy to get you a beanie. We are committed to reaching Nevadans from all backgrounds and communities. Nevada communities are more diverse than ever. The 2025 open enrollment media plan integrates highly effective tactics to reach historically underserved communities and the remaining communities throughout Nevada. Overall, the Abbi Agency has allocated the <inaudible> broadly across a diverse range of media channels to ensure we reach Nevadans on the platforms that they frequent. On a broader scale, the campaign aims to increase brand awareness and increase favorability within the Nevada community. We want Nevadans to associate, access to affordable health coverage with Nevada Health Link. As continued, community engagement strategy throughout the window shopping and open enrollment, the Exchange has established new relationship with organizations including Family Respite Care, and they're out in Elko as well as Reno, the Children's Cabinet, and the Tahoe Night Monsters. Navigators remain the primary staff

representing Nevada Health Link at statewide outreach events, and we have participated in 199 events this year. Abbi Agency has completed an audit to improve our, website, nevadahealthlink.com, ADA compliance by addressing major accessibility issues. And we are proud that we have increased our accessibility score by over 20%. We have also conducted many general updates on our website for the open enrollment period in both English and Spanish to improve the consumer's journey throughout the website. And now I'm going to pass the mic over to Connie to go through the presentation, and some of the optics.

C. ANDERSON: Wonderful. Good afternoon. My name is Connie Anderson, Chief Strategy Officer with the Abbi Agency, for the record. Katie, thank you so much for the great introduction. Let me share my screen very shortly. Let's go to – okay, slide show mode. Can everyone still see that? Perfect. Okay. As Katie mentioned, in the interest of time, we often go through, quite a few tactics, that will be integrated on the marketing efforts, and you have, quite a hefty presentation in your board packets that you can look at. But I'll be briefly going through some of these high-level tactics, sharing with you some exciting additions this year. Russell mentioned earlier the jingle. Katie mentioned, the animated approach. So we'll be showing those to you and we look forward to, hopefully everyone on this call, seeing them in action starting November 1st. Briefly touched on earlier in, Russell's presentation was the amount of research that has gone into, developing these creative concepts and these messaging. Most recently, in summer of 2024, our team, along with Marketing for Change, surveyed over 600 Nevadans, specifically with

uninsured as well as self-insured individuals in Nevada, as those are individuals that we want to target to enroll them through the Exchange. And we found that some things continue to remain true. One of those is that price messaging, highlighting the low plan premiums, are very relevant and very motivating. But as Katie and Russell have both mentioned earlier in the call, there is still a knowledge gap about what Nevada Health Link is and who can use Nevada Health Link. So at a high level, we wanna make sure that we're really providing awareness of Nevada Health Link and then following up with retargeting messages, and more conversion based tactics -- digital tactics that highlight, the price messaging. With that in mind, our team is really focused on two creative campaigns that are very complimentary. One of which is very awareness-based, highlighting who Nevada Health Link is, how it can help Nevadans, and its four unique value propositions. And those are -- will be delivered on tactics such as TV, billboards, things like that, that we would consider awareness-based tactics. And then, as I mentioned earlier, really focusing on digital and conversion tactics, highlighting that price premium messaging, highlighting the assistance that Nevada Health Link provides, financial assistance specifically as that is something that is very motivating to individuals. Here's examples of what those messaging will look like as I shared. The awareness messaging is focused on what we consider Nevada Health Link's four unique value propositions, the four things that Nevada Health Link can provide that no one else can. And that is we can provide savings, we can provide selection, we can provide free assistance, and then of course, name brand health insurance. Following up here, specifically when we get

to enrollment and conversion messaging, as I've mentioned, we're focused on best prices, best plans, ensuring that individuals know that our premiums, are quite low, and that 9 out of 10 enrollees through Nevada Health Link are receiving financial assistance. Here's a little preview, before we get to the commercial and all the campaigns, of what this, new animated style will look like. We're very much leaning into the purple color of the Nevada Health Link brand and logo. It's something that is very bold. It stands out in the media market. It's something that we've highlighted in previous campaigns. And then you'll see here we're focused again on some of those, four unique value propositions that I just talked about, savings, selections, free assistance, and of course, name brand health insurance. And here is, the 30 second commercial. This is like 99% done. There's a couple things that we are going to tweak and change, but we are very excited to share this with you at the end. In the last five or six seconds, you will hear the new jingle that was mentioned, in the Executive Director's Report. (Video of commercial played. Video link here: Nevada Health Link Open Enrollment November 1st 2024 - January 15th 2025) I hope everyone was able to hear that. Wonderful, I see some nodding heads. We were very excited to come up with that, focusing on some of these awareness and enrollment messaging. As all of us are consumers of advertising every day, you have to make things fun. You have to make things engaging. And that's why you'll see throughout this ad. There's a unique storyline of, something that I think perhaps all of us as can relate to your dog, your cat, something your child maybe kind of runs away and you're running after them. You're like, hey, come back. Right? And then you're able to travel through Nevada. You

align with some of these great unique scenes that Katie mentioned earlier. I think, and I hope, most of us have done some road trips through the state, but it's absolutely beautiful. And we wanted to show off that scenery in some of this fun animated way. We also wanted to have some of those Easter eggs. So you'll see throughout there that, you know, maybe the birds pulling the dollar sign, there's insurance logo carriers -- or the insurance carrier logos are on the hot air balloons, bales of money, some of those signs in that running scene, talk about some misconceptions. People maybe don't know about the 10 essential health benefits, such as the fact that all of these plans cover pre-existing conditions. We also think this animated approach allows us to continue to build on it, to come up with new scenes, to come up with new ideas and related story angles. You'll see a lot of big brands are also moving into this animated direction. So we're excited to bring Nevada Health Link into that direction. And hopefully, as Russell said, it can be the most successful marketing campaign. A little bit of pressure there, but of course, our goal is always to bring more consumers into Nevada Health Link and get as many Nevadans insured as we can. Okay. With that, here's some examples of the digital ads that, you may see throughout open enrollment. These will be HTML 5 ads, so animated ads, as well as social carousel frames. Some of these have just slight, differences in how they're designed, some of the messaging. We always do AB testing throughout all of our campaigns so that we can see how are consumers engaging with the different creative, how are they consuming, engaging with the different messaging, and we'll optimize towards those variations. With time, I'm just gonna keep moving on. You

can take a look at all of this. Katie has mentioned this as well. This four months of the year is our most busy time of year, most important time of year, obviously. The previous eight months of the year, we're always preparing for these four months. You'll see here that, just as in general, here's where our efforts will be focused as far as how we are talking to consumers, and how, as we get closer to that deadline, we're shifting a little bit further away from awareness and really focusing on conversion. Here are some of the large marketing tactics that are undertaken in these months. Our team, it's conducts fully integrated marketing, making sure that we're covering messaging across PR, social media, website, blog, newsletters, events, and then advertising as well. Katie mentioned earlier Nevada Health Coverage Day. Here's an example of those beanies. The Nevada Health Link team put together, these really exciting kind of, beanies with, the ribbon and directions on how to use them. As Katie mentioned, we'd love to see, support and social posts on November 1 to recognize Nevada Health Coverage Day. We're very excited and appreciative of the governor who declared that last year and wanna continue the momentum this year. As mentioned also, we have completed 199 community events. These are the Navigators out at these events. This is just a sampling of some of the events that they go to. Our team works very close with Rosa and Katie to make sure that we are covering as much of the state as we can, as well as the diverse, populations that, call this state home. Additionally Katie mentioned, some of these improvements, but we are always looking to ensure that the landing page is optimizing people to conversion. That, depending on the individual, means enrolling

themselves. Others, it means finding assistance through a broker or a Navigator. So we make sure that all of those options are very prominent to an individual when they get to the landing page about open enrollment. Our team was also very happy to complete the ADA improvements. Making sure that our site is accessible to individuals is very important and increasing that to over 80%, almost 90%, is great. And we will continue to make sure that we are optimizing the site for ADA accessibility. New this year -- oh, I went too fast -- is we'll be adding partner content to the blog partner and guest content. That helps to bring in fresh new voices to the blog and provide more information. Social media, our team will focus on engagement and growth of the channels overall. We continue to bring in new human centric, photos. People really engage with people. They like to see people on social media, so we'll make sure that we're doing that. We're gonna be going to a lot more of the community events, this year to make sure that we're highlighting the communities that Nevada Health Link serves. So we're very excited for another open enrollment. Our team loves working with Nevada Health Link, and our partners, Erica Avilles and Marketing for Change too as well. So I'm happy to answer any questions that you may have.

V. CLARK: Thank you so much, Connie. That was a great presentation.

C. ANDERSON: Thank you.

V. CLARK: We appreciate it. As always, you guys do a great job. Does anyone have any questions?

S. KUMAR: Madam Chair, this is Sam Kumar. I have a couple of

questions.

V. CLARK: Yes, Sam, please.

S. KUMAR: Thank you. First of all, thank you Katie and Connie for, taking the time to give us an overview of, what's coming up. So a few questions. I'm going to reference the document that Tiffany sent as part of the meeting package. This is probably -- the first one is a question probably for Russ. What is the total budget and how much of that -- I would assume a hundred percent is spent as part of the total, of the -- a hundred percent of budget is sent -- spent on open enrollment? Is that fair to say?

R. COOK: I'm sorry, could you maybe restate the question? I'm not sure I followed what you were getting at, the

S. KUMAR: No problem. So, two components. First is, what is the total budget? Second one is how much of that is spent during the open enrollment period?

R. COOK: The total agency budget?

S. KUMAR: No, for advertising.

R. COOK: So the advertising budget is a subset of our, vendor budget for the Abbi Agency. Katie, are you able to shed some light on that? Okay. I really would appreciate it. I just don't have the figures in front of me, Mr. Kumar. Katie's a lot more familiar than I'm.

K. CHARLESON: Yeah. Katie Charleson for the record. So our budget, yearly is 3.2 million for our marketing and advertising. And then Connie, would you say it's about 75/25 on open enrollment compared to, special enrollment? We also increased it for like the public health

emergency, so that took a bigger chunk last year. But usually about 70/30, I would say. Connie?

C. ANDERSON: Yeah, I would say about 70% of the budget is focused on open enrollment at times, especially this year. In previous years it had been higher. It the split had been a little bit more even because we had had ARPA funding coming in, we had -- the deadline had extended due to IRA, the PHE ended, and so there was more messaging and advertising needed outside of the open enrollment period. This year it's about 70% focus on open enrollment. 30% of the budget is spent in the other part of the year for advertising around special enrollment period, doing brand awareness, Navigator Outreach events happen year-round so that the trust is built with different communities.

S. KUMAR: Okay. Thank you. My --

R. COOK: Sorry. Sorry, Mr. Kumar. I just wanted to add that that split between SEP versus OEP, it can also be impacted by the quantity of, traditional media buys, i.e. television advertisements. In presidential election years like this one, we tend not to focus so much on media buys in that kind of late October, timeframe leading up to the election. So that can actually, reduce, the kind of the split, relative to the special enrollment period, for considerations like that.

S. KUMAR: Great, thank you. My next question, I'm again referencing to the other document. Idon't know if you have it in front of you, if not, totally understand. You are -- in Page 2, you're referencing quantitative research with key audiences. Can you expand a little bit on that?

C. ANDERSON: I believe you're, just to make sure I understand, you're referring to the PowerPoint presentation, correct? Not the --

S. KUMAR: No, it appears to be a, word document, I'm guessing Marketing and Outreach Report October 15, '24.

C. ANDERSON: Okay. The quantitative surveying discussed in that, written report is referring to the 620 surveys -- or 624, I think it was, surveys that were sent out. That was Page 2 of my presentation, today.

S. KUMAR: Got it. Okay, that makes sense. And the -- jumping over to Page 3, you are referencing, under media strategy, first paragraph, highly effective tactics to reach these historically underserved communities. Can you give us a sense of those tactics please?

C. ANDERSON: Yeah, so for paid media tactics, we do partner with a lot of traditional media vendors. So we do partner with Hispanic speaking magazines, magazines that focus on African American communities. We target -- or work with traditional media and rural communities. We do partner with, on TV and radio, we partner with, Telemundo, Univision, Spanish speaking radio outlets, and things like that. And then as much as we can on digital mediums, we'll work with individuals, outlets that, again, are targeting those low income, and/or historically disadvantaged communities.

S. KUMAR: Thank you. Jumping into page four, you are talking about out of home advertising and digital out of -- OOH, I'm guessing out of home. Can you expand on what that is?

C. ANDERSON: Yes. So out of home is what we would most

often see as, billboards. So you're driving down the 215 in Las Vegas, or you're driving down maybe 8580 in Reno. We have some rural billboards in Minden this year. So those are your traditional out of home. Your digital out of home is, we actually partner with different vendors, who can place advertising on ATM machines in 711s. So that's considered out of home. It's not in your house. You're maybe not thinking you're gonna engage with it, but you're getting cash out at a 711, ATM for instance. So we will find and target those areas. We do also gas station advertising. So if you're getting gas, we're targeting gas stations that are in, local areas. You know, we don't wanna buy the gas stations by Harry Reed Airport in Las Vegas because that's probably a lot of tourists, not as much locals. So we'll find different neighborhood communities where a lot of locals will be at and target again them in those, kind of, out of home areas, like I said, gas stations, 711 ATMs, for example.

S. KUMAR: Interesting. Things that I don't normally think about, so thank you for sharing that. And jumping to the next page, escape content, what exactly is that?

C. ANDERSON: Absolutely, great question. So, escape content, is maybe you're on ESPN and you're looking up, scores for a game. You're curious, you know how UNLV did, maybe you're curious how the University of Nevada did, maybe you're looking on Pinterest, you know, you're like, how do I wanna redo my child's room? And so we're placing advertising in those areas, not necessarily just, if somebody is googling how to buy health insurance.

S. KUMAR: Got it.

C. ANDERSON: We do buy those terms as well. But knowing that there's a lot of information coming down to individuals right now with the election inflation is still, I think prices are high, right? We all feel that pressure. We wanna make sure that some of this advertising is a bit more jovial and reaches people in places they may not be looking for it.

S. KUMAR: Got it. Thank you. And, you are referencing opportunities for free place bonus placements and PSAs. What kind of a monetary value do assign do you assign to that? Do you even have a guess?

C. ANDERSON: I don't have the guess off the top of my head. That's a great question. But the end of every open enrollment period, we provide what the monetary value for the PSAs, is. So I will have that in January, February. I can see if, we can pull some of that information though ahead of time and what we think it'll be based upon what we've negotiated so far and provide that as follow up. But, you will most definitely see it in February as we do our full open enrollment report recap.

S. KUMAR: Yeah. And I'm also looking at your public relations strategy where, in the first paragraph you're talking about Nevada Health Link's goal of getting more Nevadans enrolled in health insurance. That's great. One thing I'm very curious about, I don't know it's part of the mission or not -- perhaps, Russell, we can discuss this offline. How about improving the quality of life through usage of, the Exchange? So that's something that we should look at. One, it increases quality. It lowers cost. And, you know, we should all be in favor of increasing the quality of life. So just to file that away. And I think you had a reference to , something

like Maxi something. Is that AB testing or is that something totally different from that?

C. ANDERSON: We did do Max Diff testing?

S. KUMAR: That's correct, yes.

C. ANDERSON: And so Max Diff is looking at a variety of messaging. I think we had had 9 to 10 messages and having people rank them. And so just finding the difference -- the maximum difference in how people aligned with the different messaging or favored the different messaging.

S. KUMAR: Is that similar to focus groups or how's that different?

C. ANDERSON: That was done quantitatively via the survey. It can be done via focus groups, but this was done, in a survey.

S. KUMAR: Great. Thank you so much for your responses. Appreciate it.

C. ANDERSON: Absolutely.

V. CLARK: Thank you, Sam. Are there any other questions for Connie? All right. Thank you so much. We appreciate your time and all the good information. All right. Next on the agenda, we have marketplace stabilization program update presented by Stacie Weeks, Administrator of DHCFP. Stacie?

S. WEEKS: All right. So I'm gonna share my screen if that's okay. Real quick, let's see -- make sure I've got the right deck. There we go. All right. Can you guys see that okay? Let's start from the beginning. All right. So I know we're probably -- it's getting close to the end of time,

so I wanna be mindful of people getting tired, but if you can't hear me, let me know.

V. CLARK: Stacie, we can hear you, but we can't -- I'm not -- maybe you -- there we go. Now I see it. That's very -- Thank you. Okay. Okay?

S. WEEKS: Yep. Okay. Yeah, I've been having some issues today, so hopefully everyone can see. All right. So can you guys hear me? I feel like the gods are working against me today. Can you hear me now? Okay, let me try it one more time. Maybe, Tiffany, if you wanna share it. Do you have it handy? I don't know if it's my computer or what's going on. I'll try share it again.

T. DAVIS: Stacie, yes. Tiffany Davis for the record. I do have it handy if you do need.

S. WEEKS: I think so. It feels like every time I bring up a PowerPoint today, I've been having issues, so I apologize. Thank you.

T. DAVIS: Would you prefer the PowerPoint or the PDF version? Does it matter?

S. WEEKS: PowerPoint is fine. Thank you. Thank you. Sorry about that. All right. As Tiffany's pulling that up, I just -- this is a reminder. This is an update on the request from members about the public option, which we're calling the Battle Born State Plans, and the waiver that the state is seeking for that operation of the program and the federal funding. Also part of this PowerPoint will be the governor's, portion of the plan to implement this program under state law and mitigate any impacts to the market, and so that's why it's called the Market Stabilization Plan.

V. CLARK: And just for the record, there is -- I don't see a -- I'm not seeing a PowerPoint yet.

S. WEEKS: Yeah.

T. DAVIS: I'm working on it.

V. CLARK: I just didn't know if you thought it was up and it wasn't or --

T. DAVIS: I'm having a few --

V. CLARK: Thank you.

T. DAVIS: You're welcome. You able to see that?

V. CLARK: That's the marketing report.

S. WEEKS: Sorry, Tiffany.

T. DAVIS: No, you're good.

V. CLARK: I'm glad I'm not the only one that has these kind of problems.

S. WEEKS: No, it's been one of those days.

T. DAVIS: Okay, all able to see that?

S. WEEKS: That's the Abbi one.

V. CLARK: That's the marketing one.

T. DAVIS: Sorry.

S. WEEKS: I'm sorry, yeah.

T. DAVIS: I'm not sure why that showed.

S. WEEKS: I mean, it's definitely prettier than my PowerPoint and it has jingles in it, so I'll give Abbi that.

T. DAVIS: I'm sorry. Let me --

V. CLARK: There we go.

S. WEEKS: Yeah, our state government ones are less pretty, so we'll get started. All right.

R. COOK: And, Stacie, sorry, I didn't mean to step on any toes. I had this pulled up and all ready so I just went ahead and shared it.

S. WEEKS: Thank you, Russell.

R. COOK: I'll be happy to walk you through it.

S. WEEKS: Yeah, sorry. Thank you. Teamwork. Next slide, please. All right. So the agenda real quick. We're gonna walk through the background, kind of ground some folks in what this program is, the state law, look at the new plans and kind of how they differ from the current plans in the Exchange, and then talk a little bit about the 1332 waiver that the state is currently waiting, for federal approval or decision on, and then also the savings that come along with that, and then how the governor, looked at the law and decided to implement it under the 1332 waiver to stabilize the market. Next slide, please. So just a little grounding here. So Senate Bill 420 in 2021 -- I'm going back here, it feels like a long, long time ago -- is the state establishing authority, for the public option. It requires the Department of Health and Human Services, which has been delegated to our division at DHCFP, to leverage the purchasing power with Medicaid managed care contracts and carriers to require these carriers to offer new state contracted qualified health plans. So they're the Exchange plans on Nevada Health Link along with other QHPs. These new state contracted plans, which we're calling the Battle Born State Plans, are procured through a new state procurement, which just started, a couple weeks ago. We, the state dropped the RFP for the Battle Born State Plans and the MCO

procurement will soon follow. These two have to be aligned under state law. And there's also requirements in, both of those referring to each program. On the right here, I just wanted to note the size of the market we're talking about and which market we're in. So as you can see, the group market, which is not the Exchange market, is the largest payer. The employer market is the largest payer in the state. About 40% of the market is employer coverage, individuals. The second largest is Medicaid at 25%. The part over there, it says -- the box that says individual market, that's 3%. That is the Exchange market and it's roughly about a hundred thousand people a little bit more 'cause there are some folks outside of the Exchange that get coverage in the individual market and they purchase coverage on their own. And as you can see, Medicare is about 7%. And then there's a large group, which is the fully insured market, which is 11%. Next slide, please. And just to remind folks, so this product would operate in that 3%, so that's kind of where this product is going. It's not operating in any other portions of the marketplace. So state law also requires the department to seek a 1332 Waiver Request to implement the new state contracted QHPs or the BBSPs and to capture any federal savings resulting from the program. And I'll walk through in a little bit about how savings, is produced under the waiver and the program. And I'll kind of walk you guys through that here soon. The waiver was submitted and -- as required by state law on January 1, 2024. And we are currently still awaiting final decision from CMS, which is the secretary of HHS and the Department of Treasury. And so hopefully, you know, we'll hear something by the end of the year. We just recently reposted the application with updates, during

our negotiation process. Those -- those changes have been posted for a 30-day public comment period, which ended about -- I think about a week or two ago. And the couple things in the waiver that have changed is some of the stuff we talked about before. The CMS is really wanting to promote the Exchange as an online shopping, resource to consumers. And so really promoting some of those consumer shopping activities during open enrollment, so all consumers can find the most affordable option, whether it be a BBSP or whatever product is that they can see that they have affordable options available to them. Also we are looking at -- oops, sorry. Sorry, Russell. Yeah, you're good. Premium rebates, because there's about 24% of the enrollees that are anticipated to enroll in the program who may see a small increase in their premium. These are the folks that enroll in our -- usually our $0 bronze plans, or low cost bronze plans that have the higher deductibles. The folks will be seeing about $2 $5, premium increases. So under federal law we cannot have any increases. So there will be a premium rebate program for those individuals if they cannot find a more affordable product. Okay, next slide, please. Thanks. So how does all of this generate federal funds for the state? So on the right here is a graphic I tried to put together, but essentially really what it is, is right now the federal government, funds what we call a premium -- advanced premium tax credits in the Exchange to lower the cost of the silver product for consumers. So those plans are subsidized down to a certain percentage of certain populations and their income, so ensures that they have affordable product if someone purchased that silver product and they are up to, I think it's 200% of poverty. Is that right Russell? Or is it 400%? I'm

going blank right now. The subsidies? I think it's four.

R. COOK: I just put myself on mute, too. In light of the expanded subsidies under our IRA, it's actually a little bit over 400, but pre it was at 400,

S. WEEKS: Right, so those are the subsidies we're talking about. And so when you lower the second lowest silver, which this product is required to do under state law, this product will be lower. So if the products are lower, the feds have to pay less to buy those premiums down. And so that difference between what they would've paid versus what they will pay now with the BBSP products in the Exchange is the money that we capture. So, as you can see here, Nevada's anticipating, based on the numbers that we've been able to project with CMS, about -- receiving about 279 to 310 million in the first five years in new federal funds. And then over the 10 years it's about 760 to about 844 million. There's two factors really driving that. The one I mentioned earlier is that premium reduction target in state law that requires all these products -- the plans to meet a certain target and that will lower our silver plan. It's over about 15%, over four years. And then there's the reinsurance program, which is the governor's proposal to really stabilize the market in response to the BBSP. And the reinsurance program we'll talk about here in a second that really is really lowering those premiums even further, but also spreading that across the market and helping all individual market plans lower their premiums. Next slide, please. So how is the plan different? So this is the bullseye, I guess is what we're gonna call it, but it's the best visual I could come up with. So in the middle is what you might think of today when we

talked about that of the pie, the 3% of our market. This is what we consider individual market plan, right? This is a product someone goes out and buys on their own, either directly from a carrier or today on the Exchange. Now the individual market, if you're purchasing it on the Exchange, there's additional requirements that what we call qualified health plans must meet. And that's that little bit of a middle blue-gray color in the middle there. That second ring is what we consider the requirements for the QHPs. They still have to meet all the individual market rules including network standards, solvency standards, rate review, a DOI, but they also have to meet all of the other, requirements that Exchange plans -- qualified health plans have to meet. And so there's some other things here I've listed that fall under the Affordable Care Act, including paying the issuer fee, being certified by the Exchange, and all of the other consumer protections under the ACA. The third ring is what you might consider the BBSP plan. So it's an additional layer of requirements for these products. They're still offered in the individual market. They're still in the Exchange. They meet all the individual market rules. They meet all the standard Exchange plan rules for QHPs, but they have an additional layer of rules. And those rules are the premium reduction target, which I mentioned earlier, that they have to meet over the first four years of the program. And then they have to also ensure that they do not pay any rates any lower than Medicare. The reason that's in there is 'cause if we are lowering the premiums, right, in this product, the concern was is that, you know, the healthcares would just offset that completely and go below Medicare for providers. So there is a floor in state law to protect

providers. There's also other contract requirements that we can talk about a little bit later, but it's about value-based payment design is in there and aligning any of those operations between Medicaid and the Exchange product, so that way it's a streamlined experience for the consumer. And so, as I mentioned earlier, Medicaid managed care must offer these new products. Anyone who offer -- any carrier that offers a Medicaid managed care plan must agree and offer a good faith bid to, to offer this new BBSP plan. Now the one thing to note is that, today, all of the managed care plans are required in our contracts already to offer silver and a gold. And all of them, I think as of today, have met that or will be hopefully by the end of the year, Russell. But it has been a progress, but we have already been moving in that direction. And I think the real difference here and kind of the sticking point is that it requires them to have a separate contract with us on these products and it requires them to meet that premium reduction target, which has really been, I think, some of the friction and conflict, over this. The other piece here is that it's only, available in individual market, which is about a hundred thousand people. And right now, we're looking -- the waiver is estimating that about 83,500 people will be enrolled in the new plans by year five. It is a slow take up over time, and then by year 10 89,000. Next slide, please. So the governor's approach to looking at the waiver and ways to take that new funding and ensure that it's reinvested in the market in a way that's gonna really balance the market is what we're calling the Market Stabilization Program. And this is what we put in the 1332 waiver and we're asking for federal approval. So in following state law, if we're gonna implement the BBSP,

what can we do with that money was the first question to ensure that the market's stable and providers are not, you know, gonna see a huge rate cuts? So a couple things were done. The first one is really, in year two, ensuring that we have a fully funded reinsurance program. We will be the first state in the country, if approved, to have a reinsurance program that is not funded by the state and is fully funded by the waiver. And so that is unique to us and it's a pretty, I think -- hopefully this piece is approved. It's a very important piece of the program and it's something I think many folks have wanted in this market for a long time to really help lower costs for all individual market plans, and it will apply to all individual market plans. And the program will operate like a waterfall funding. So in year one and two -- we really won't have the funding in year one. Year two, we will have the funding, and we will pay for the reinsurance program. Year three there will be additional money left over and that will go to what we're calling a Quality Incentive Payment Program and possibly, depending on how much money is left over, a Workforce Investment Program. The Quality Incentive Payment Program is essentially like a quality bonus payment for carriers, who participate in different quality programs with the state under the contract or meet certain, metrics that we have set and standards for the private market, including pushing forward value-based payment design and aligning that with the efforts that we're already doing in Medicare and -- Medicaid nationally and Medicare, but also some of the stuff we're doing at Medicaid. And then really we're gonna be looking at trying to ensure that carriers are sharing some of the savings with their providers that are participating in these quality initiatives. Then the

workforce investment piece is a couple years out, but this is, I think, the pieces that we really do need to work on. I think this is a broader thing that the governor has been very clear on is that workforce is the challenge. We can cover people all day, but if they can't get in to see a doctor, then what are we, you know -- there really isn't going to be an impact until we do that. So part of the, program and the waiver is seeking that we use some of this funding for what we're calling a loan repayment program in our where we really have our workforce shortage areas, some of our more drastic areas that are affecting our network adequacy for products. That's where we'll be focusing on and looking at a four-year commitment for any provider who gets the loan repayment that they live and work and stay in that community for at least four years. Next slide, please. The other piece that the governor is really wanting to ensure that the waiver and the funding would look at is ensuring that we can mitigate any impact on the provider. There is going to be obviously impact to the market 'cause if you lower premiums, the money's not free. Nothing's free, right? So if we're reducing money in the market, it's gonna come out somewhere. So when we looked at that, reinsurance was one of those options to really help offset those losses. It really is gonna be, reducing some of that hit to the market. The other mechanisms that are part of the governor's Market Stabilization Plan are the bonus payments to carriers. We talked about that, sharing that with their network providers. Also, there is a waiver process in state law that if a provider, you know, is -- in state law, they have to take a public option enroll the -- or BBSP enrollee or patient to the same extent that they're accepting other patients or enrollees in the public

employee benefit plan and Medicaid. And so there is a waiver from that participation if needed. And we're looking at putting out more guidance around that once the waiver approve -- is approved, but really looking at if someone is really substantially finance -- you know, substantially financially harmed by the public option and having more of their patients in a public option product, then they could be exempt from participating. The other option here is that ensuring in our contracts, which is in the RFP that's posted, is that carriers must share the losses in meeting the premium reduction target. They cannot just shift all of that 3% in the first year onto their provider reimbursement rates. A certain percentage of that must come out of their profits in their overhead. We are putting language in there that did, I think, say that that could not be the brokers and other important pieces. But I do know that there is gonna be some of that sharing, of some of these losses with the carriers. Next slide, please. And then this slide, real quick is just showing you the breakdown of that funding that we're projecting. Obviously, you know, everything will be on actual. So in year one, whatever really happens and the money, you know, that -- that is really is going to impact these numbers. But reinsurance, like I mentioned, would not be occurring until 2027. If all the plans do meet their targets, we're -- you know, at least one or two hit that, second lowest silver, we are ensuring that we will get the reinsurance program fully funded. The reinsurance model uses a $60,000 attachment point with a $1,000 cap and reduces the 15% premium reduction about in half. Now that varies for each plan, depending on where they are in the market today according to their premiums. But the reinsurance really does subsidize, the

-- the money that the carriers are gonna have to take out of the market for the premium reduction. So essentially that's what this program is doing is subsidizing that market loss. On the side here, you can see over time there is money left over each year and how that money rolls forward. On average in the first two years, you know, the reinsurance program is roughly 55, $58 million, which is a big portion of money. If we were going to pay for a part of that ourselves as a state, that would've been really hard to fund. So it is -- I think that is a big piece of this is for the reinsurance program. Next slide please. So I was putting this together and I kind of got sad. I was like, the star is not -- not at the end of the rainbow, but it's very still at the beginning. It feels like we've been working on this for a while in the state. But we -- you know, like I mentioned, we are still in this procurement and waiver waiting process. So, we're hoping to wrap up all of the awards for the contracts in March, and hopefully the MCO contracts as well soon after. And then we have the, BBSP carriers, whoever, you know, got the awards, will be able to submit their rates just like they would for all -- any of their other QHP products for rate review and for certification in 2025. And they would be available for open enrollment and online for Plan Year 1 in 2026. And then at the end, obviously every year there's something that we're doing around implementation, but I think this is the bigger picture, of all of the things that we are working on with the Department of Insurance and Exchange. I think that's it, Russell. Maybe there's -- I think that's -- yep, that's questions.

V. CLARK: Wow. Thanks Stacie.

S. WEEKS: Yeah.

V. CLARK: Um, does anyone have any questions right now?

J. JOHNSON: Sarah raised her hand.

V. CLARK: Oh, I'm sorry. Sarah, yes, please.

S. FRIEDMAN: Hey, Stacie. Thank you so much for that presentation. That was really interesting. When you showed the pie of how different -- how Nevadans are insured, you said we're talking about the 3% in the Exchange plans, and I'm wondering to what extent is it also the uninsured chunk, which is 6%? Is it -- we're just talking about switching basically from one type of Exchange plan to another?

S. WEEKS: Yeah, so today -- right now it's been, you know, 3 to 4% over the last few years has been the covered market for individual market. Now that 6% that we're showing, which I would just note is pretty low for Nevada. I think typically, if you ever looked at Kaiser Family Foundation, it's usually 10% or 11% in the last few years, so I think Department of Insurance just put out that data. So that's exciting news that we're now down to 6%. So I just think that's a win we probably -- I should have mentioned earlier for the state. So that's exciting. But a good portion of those we do anticipate are actually eligible for Medicaid. Gwen, Center did a study and found about 44% of the uninsured were Medicaid -- likely Medicaid eligible. There are a lot of reasons for why people may not be enrolling in Medicaid. That's something -- that's why I-I've been -- I wanted to talk about the Navigator Program and look at that Medicaid Express Option through the Exchange, trying to make it easier for people to get coverage. But I do think there is a portion of those folks that could come over depending on their eligibility for coverage. But that's a good

question.

S. FRIEDMAN: Thank you.

V. CLARK: Stacie, I have a question, um.

S. WEEKS: Yeah.

V. CLARK: So who is your, well maybe this was answered today in the presentation. Who would be the sales arm of a program like this? Is it, the Navigators and the --

S. WEEKS: No.

V. CLARK: Are brokers involved in any way, or who would be the sales arm?

S. WEEKS: So the carriers get to decide. Now, in the RFP, there is requirement in the contract with them that they will market the products similar to their other products, right? So they could use brokers or they could use other marketing tools. We are asking them to put together a market plan, and really trying to focus in on how they're gonna get to the uninsured, right, and if that really is the goal of this product, are we gonna market appropriately? So that's part of the plan, but really it's like what we do with Medicaid when we contract with them, we ask them to do the outreach a lot of times to people to get them enrolled in the product.

V. CLARK: Okay, so you don't, you're not setting up any rules on that. You're looking --

S. WEEKS: No. Thank goodness.

V. CLARK: You're looking for them to come to the table with their ideas. Very good. Okay. And then I had one more question, and it

went right outta my head. I'll think of it in a minute.

J. JOHNSON: Sam has his hand raised as well, and I have a question.

V. CLARK: Oh, I'm sorry, Sam. Yes, Sam?

S. KUMAR: Thank you, Madam Chair. Stacie, thank you for taking the time to walk us through this. As you are certainly aware, there's a very complex space and I'm trying to wrap my arms around it, so I have a bunch of questions. So, looking at your slide, you are talking about the new state procurement that aligns with the state's Medicaid. How often do we do this? Is it every three years or five years? I'm trying to remember.

S. WEEKS: It was four, but now we're doing five years for our managed care contracts. So this will be on a five year or longer, depending on the next time. But yeah, five years is typical.

S. KUMAR: Got it. And the 1332, Waiver Request, you already answered that question. It's only for the, Exchange. And, the other question, you already answered APTC, Advanced Premium Tax Credit, I wasn't sure what that was. That same slide, how does this generate federal savings, the second bullet point, you're talking about premium reduction target of 15% reinsurance program. Do we need to meet those criteria, how do we get to that, number of , in terms of the, money, we'll be getting the -- from the feds.

S. WEEKS: So right now, the plans are going to bid and obviously they're gonna give us preliminary rate proposals, which is challenging 'cause they're not typically putting their rates together till next year. But if they hit the target, which we -- you know, the 3% in state

law and over time is supposed to be 15%, so we're letting them kind of move that target around as much as they need to hit the 15 in four years. If we hit the target, we get the funding. Now, if come in a little higher than the target, right, and we don't hit it completely, we get less of the funding. There is another unknown element here, and maybe Russell knows more about the tea leaves than I do at the federal level on this, but there are the ARPA premium subsidies. So if those get extended, we get even more federal funding. So that would -- it really -- it adds a couple hundred million on top of that. So it'd be really great for the state, you know, in many ways for everyone, consumers, but also the funding piece. But the reinsurance is -- really relies on those targets being hit or we can't fund the full -- you know, the full amount, and we'll have to change the reinsurance, program a little bit to adjust for the funding.

S. KUMAR: So just to summarize, us meeting the 15% premium reduction, we'll get the funding, which will then use it for reinsurance program. Is that how I should read it?

S. WEEKS: Yes.

S. KUMAR: Perfect. Thank you. And, scrolling down, you are talking about the new state requirements, when you're talking about how is this plan different?

S. WEEKS: Yes.

S. KUMAR: Can you expand a little bit on that? I think you touched upon that during your presentation, but I'm trying to get a little bit more detail.

S. WEEKS: Yeah. So today, a carrier can offer QHP and all they

have to do, right, is meet state law on individual market and the ACA. What we're adding to it is additional requirements. So in state law, the big one -- I will say the biggest -- or big two requirements that do not apply to the other products would be you have to come up with that annual premium target in the 15 over four years. And that's, I think, the sticking point, right? The other ones are good things that we all probably wanna work on together, I would say, you know. Maybe the private market plans are not as used to doing that with the state, but the things that we do in Medicaid now with carriers, which is value-based payment contracting with our providers and quality metrics and all the things that we're adding into those contracts, for the first time ever, those will be in the private market and the state will be holding that contract to monitor it. So I think that's the difference, right? It's giving the state a little more of a lever. Yeah.

S. KUMAR: Are you setting some kind of a threshold for VBC or, is that flexible? How are you -- what kind of an approach are you taking with VBC?

S. WEEKS: Oh, with the value-based payment design?

S. KUMAR: Correct.

S. WEEKS: Yeah, so we're looking -- the land -- you know, the land framework, maybe we should do a whole deck on that, maybe -- sometimes, Sam, 'cause I -- that's a big one. But I, um --

S. KUMAR: Yeah.

S. WEEKS: We're aligning that with the work we're doing in Medicaid. So right now, we are doing a huge, value-based payment collaborative with hospitals and all four major carriers that we work with

to get all the big systems aligned in doing some of the basic pay for performance. And over time we wanna move them to upside downside risks, shared savings, right, where we're actually getting at the cost of total cost of care. But that takes time and we wanna align what we're doing there with these products in the private market 'cause of the same carriers and hopefully the same provider network. So that actually helps the providers do better under those arrangements. So it's a lot of alignment and activity, but, that's the stuff I think we're most excited about. You know, the day-to-day implementing of a -- this has been really a lot of work, but the value-based payment design I think is more exciting.

S. KUMAR: Yeah, that'll be an interesting journey, so eager to see how that goes. And very few have succeeded. Even those who talk about it, it's only a small portion of their overall contract, but we won't get into that.

S. WEEKS: I know.

S. KUMAR: You were talking about, the second bullet on that same slide on, slide six, average provider payer mix. Iknow the payer mix part of it. What do you mean by average provider payer mix?

S. WEEKS: Which slide was that?

S. KUMAR: Slide six, second bullet point, under how is this plan different?

S. WEEKS: Oh, sorry, I was on the wrong one. How is this plan different? Sorry, for some reason,

S. KUMAR: Second bullet.

S. WEEKS: Oh, sorry. It's so -- it's like the end of the day when

my brain stops working, so I'm sorry.

S. KUMAR: That's okay.

S. WEEKS: Yeah, yeah, yeah. So it's insurance market and average provider mix. You know, I don't know why I put that in there now I'm looking at it. I wrote this for one of the life insurance ones, but I can't remember why that's in there. But basically, it's only available in that market is really the point. It's not the whole market and -- oh, oh, oh, oh. There was a study around the impact on the providers. And because providers, you know -- most providers -- now I'm not talking about your typical smaller provider, behavioral health providers, but the average large system provider, individual market makes up a very small portion of their payer mix. And , the study that was done with Milliman showed about 3 to 4% would be this product for those large payers -- or for large providers and hospital systems.

S. KUMAR: Got it, thank you. I was --

S. WEEKS: Sorry.

S. KUMAR: No, no, that makes total sense. And you already answered the next question is waiver specific to the individual market, the answer is yes. Going to the next slide, governor's proposal for new federal savings, you're talking about, cost shifting, on the left-hand side of the bottom of the reinsurance area. What exactly is -- what cost shifting are you talking about, from who and to who?

S. WEEKS: So both provider -- so the carrier to the provider, right? So if we reduce the amount of money that they have to reduce in their premium by subsidizing it, that reduced that cost shifting onto the

providers.

S. KUMAR: Got it. Makes total sense. And you know, this is not specific to the, Exchange, but overall Medicaid. As you're well aware, reimbursement, at least the numbers I'm seeing, is about 40 to 45 cents on the dollar. So that's a significantly lower amount than what it actually costs the providers.

S. WEEKS: Well, we were -- on this one, we're talking Medicare rates, so not Medicaid. Just wanna be clear and --

S. KUMAR: Oh.

S. WEEKS: Yeah.

S. KUMAR: Good to know. That's good to know. Yeah.

S. WEEKS: Also, I will just note, because I run Medicaid, so I feel like I have to give it a shout out for a hot minute, but Medicaid now pays the hospitals the average commercial rate on inpatient and outpatient through supplemental payments 'cause they -- the provider tax program that just started this year. And it pays up to the, Medicare upper payment limit for fee for service program. So we've maxed out under Medicaid, at least on inpatient/outpatient hospital services. In physician services, we pay close to 95 to 98% of Medicare.

S. KUMAR: Can you repeat that one more time?

S. WEEKS: 98%. There's a Kaiser study, I'll send it to you guys. It's like 95 to 98% of physician services, we pay that 95% to 98% of Medicare rates. So --

S. KUMAR: Medicare rates?

S. WEEKS: <inaudible> the lowest in the country. Yeah.

S. KUMAR: Yeah, that's interesting. Okay. And --

S. WEEKS: Sorry, I just always felt like Medicaid gets a bad rep. I'm not gonna say it shouldn't always, but it's not always -- like, not all of our rates are bad. There are some though. But go ahead. Sorry, Sam.

S. KUMAR: Yeah, that'll be an interesting conversation, but, we won't go there now.

S. WEEKS: Okay.

S. KUMAR: You're talking about quality metrics. Have you already determined that or is that TBD?

S. WEEKS: So we have some stuff we're doing in the Medicaid side we probably will align with. That's something the carriers have given us feedback on. The big piece is, obviously in -- in Nevada the big areas we lack is the maternal health populate. Like, maternal health is a huge issue for our program and Medicaid as well as, you know, I think statewide, behavioral health. But some of the HEDIS metrics that we use already, and Medicaid will be aligning with that as well.

S. KUMAR: Okay, that makes sense. And the last question on that slide is the arrows, that are going from reinsurance to quality incentive payment and workforce investment. Should those arrows be coming from the new federal waiver funds? I'm trying to understand.

S. WEEKS: So the money -- I was trying to do a waterfall because the money acts as a waterfall. So the money comes down, hits reinsurance. What's left, bounces into quality.

S. KUMAR: Got it. Got it. Got it. Okay. That makes sense.

S. WEEKS: I'm not the best at visuals always, but that's what

we intended.

S. KUMAR: No, no. Yeah, now that you're explaining it, it makes total sense. And you are talking about provider impact mitigation, future mechanisms. What criteria should be met for the sharing to take place?

S. WEEKS: You mean the last one?

S. KUMAR: The provider impact mitigation, the first bullet. First <inaudible>.

S. WEEKS: Oh, we still are -- we haven't defined those fully yet. We're waiting till we get the bids back. The -- we've asked carriers for feedback on all of those.

S. KUMAR: Okay. And my second bullet, my question is, why would a provider need a waiver?

S. WEEKS: Well, it's in state law that a provider -- so right now state law requires if a provider -- 'cause one of the things that happened in Washington was that the hospitals and other providers did not want to take or even participate in the networks for these products. Obviously every state that has a public option is very different. So I wouldn't compare it to that, Washington. But because of that, my understanding is there is a provision in the state law that says if you participate in Medicaid or take, you know -- have a Medicaid contract with the state to, you know, serve Medicaid enrollees and get payments, or you participate in the public employee benefit plan and you're a network provider, you have to treat these folks the same. And so it's a waiver from that if they're financially harmed.

S. KUMAR: No, that makes total sense. And the last bullet there, carriers must share the losses in meeting the premium reduction target. Are we talking about MLR or is it something different you're referencing?

S. WEEKS: So when you think of the premium, right, there's the non-benefit and the benefit pieces. So non-benefit is typically your salary, profits, and then your benefit is the provider rates. They can't just put the whole enchilada on the provider rates. They have to share it with the non-benefit, which would be their salaries and their overhead and those types of things. Yep.

S. KUMAR: So that's a medical loss ratio of 85% for large ones and 80% for the small ones.

S. WEEKS: Yes.

S. KUMAR: Okay. That's what I thought you were talking about, so that's good to know. And the next slide, which is my last question. So you're going from 60,000 to a million cap. At about a million, is there some kind of a, different insurance that the providers go through or how does that work? Do you have any insight into that?

S. WEEKS: No, this would be the only reinsurance that would be offered. So if it goes -- it hits that point, we would pay the -- the pieces of the claim. It helps offset those high cost, for carriers.

S. KUMAR: So say for example, we have someone where 2 million was spent, at 60,000, this kicks in up to a million. From the 1 million to 2 million, do they have a secondary insurance outside of what we are providing? How does that work?

S. WEEKS: I don't know if they do. I mean, I would probably call on my friends at Department Insurance, but my understanding is there's probably not another program out there like --

V. CLARK: I would assume the carriers have their own reinsurance.

S. WEEKS: Yeah. But, yeah, this would be for the whole market that the state's paying for. Yeah.

S. KUMAR: Okay.

S. WEEKS: This is similar to a couple other states. I mean, this was modeled and looking at other state programs that have reinsurance programs.

S. KUMAR: Okay. Thank you so much for your time and thank you for patiently answering my questions.

S. WEEKS: No problem, happy to.

V. CLARK: Thank you, Sam. Great questions. Jonathan, did you have some questions?

J. JOHNSON: Yeah, can I ask a couple of questions as well? One -- and this is more -- this kind of came up as you were talking and going through this, Stacie, just the zero cost bronze plans, you know, folks that, at a certain income qualification, I don't know what that level is. But it just kind of begged the question, you know, if they go it's my understanding if they go with a bronze plan as opposed to a silver plan, they forfeit cost share reductions. Is there an education gap there? Is there a way that we can identify those folks and give them some education that, for just the little bit out of pocket, the benefit of doing so is drastic. So that was one

observation that stood out. I don't know what the opportunity is there, but I know that that can make a big difference in, their lives.

S. WEEKS: Yeah, on that point, I mean it's -- maybe I shouldn't say this. I will say it 'cause I always speak -- say what I think, but I used to call it the bronze trap plan, right, because it is a kind of a trap. You -- it's really affordable, but you don't know you're gonna get hit with that high deductible and if you were, you know -- but it kind -- I mean, Russell probably knows better than I do about this market in, you know, Nevada, shopping on that Exchange. But I think a lot of people look at that, you know, monthly sticker shock and even with the subsidy paying a premium, still, you know, reduces their income for the month. But I don't know. I know, Russell, you guys probably do a lot of education in that space and, so I don't know if you guys are -- the marketing team has any thoughts on that piece, but I think that is an area that needs a lot of help for consumers.

R. COOK: It's definitely something we emphasize, in particular in terms of our training materials for our Navigator and Agent Brokercommunity, is really emphasizing the end of year out-of-pocket cost as opposed to the cost of the monthly deductibles. And you're exactly right. Now, given the lowest gross premiums associated with these bronze plans, they're the first ones that are gonna, you know, qualify household for $0 net premium each month, not realizing that, you know, it's really not free insurance. At the end of the day it's a safety net, perhaps and certainly, you know, light years better than no insurance. But you know, you mentioned the word trapped, which I think can be an apt descriptor,

when you're hit with those, especially high deductibles and max out of pockets.

J. JOHNSON: It's I don't know. I think there's probably a lot of strong opinions, with the folks on this call, as with respect to that. But if we're in this for the consumer and those protections, gotta figure a better way, with those situations. And I get it. You know, sometimes even if it's $25, it's just not possible. But if they end up spending that in, in terms of out-of-pocket costs, to me that's more heartbreaking than, right, than the trap itself. And then the other question, these are plans that are gonna be offered both on and off Exchange. Is that correct?

S. WEEKS: In the individual market.

J. JOHNSON: In the individual market.

S. WEEKS: So that means like a -- someone could go to the carrier and directly purchase it.

J. JOHNSON: Sure, sure. And so, I guess, what would make -- with respect to the Exchange, right -- I get kind of outside of the Exchange, someone just buying it privately. Maybe they don't qualify for, subsidies, things like that. To me, that makes a little bit more sense. But as it re-relates to the Exchange, why would consumers choose, BBSP over an-another plan, given that the portion that they pay is tied to their income, not necessarily the premium?

S.weeks: So the premium plan -- the premium reduction target, the way it will work, if it does work -- I mean, that's always the experiment, right? So if plans do hit that target and it ends up being the second lowest cost silver, they will be the more affordable subsidized

product -- just naturally some of the most affordable products on the Exchange 'cause we're not seeing other plans lower their premiums, right, much ever. You don't see a 3% reduction in a year. So it really will set that target and set the subsidy.

J. JOHNSON: Okay. And then the other question is in terms of the funding that's going to the reinsurance and all of those things, how did you arrive to some of those calculations and those estimates? And if enrollment were to fall short of target, what does that do to the whole program? What does that --

S. WEEKS: So, the target doesn't need to be the enrollment. The key is whether or not we lower the second lowest cost silver and how much the feds would have otherwise paid. So as long as we reduce that trend in our premium spend, the state gets the savings to the feds. So that's the target. I didn't set that number. We worked with actuaries, who did actuarial science. There's a whole, I can send you guys the whole actuarial report if you'd like to see it. It's several hundreds of pages. But, they looked at the trends in the market and if you set it to three, you know, what does that mean in terms of who might enroll? There were a lot of assumptions that went into this and back and forth with the actuaries at CMS as well.

J. JOHNSON: So it's safe to say that the goal is really for these plans to meet that second lowest cost silver plan because that's where subsidies are going to be --

S. WEEKS: Maximized.

J. JOHNSON: -- based on. That's where the federal funding is

coming in, regardless of what consumers choose beyond that

S. WEEKS: Yes.

J. JOHNSON: Okay.

S. WEEKS: That drives the -- that drives the funding, right? Yeah.

J. JOHNSON: Yeah. Perfect. Thank you.

S. WEEKS: You're welcome. Sorry, I know that everyone's probably tired and it's almost four o'clock, Russell. Thank you, guys.

V. CLARK: Thank you so much, Stacie. That was very informative. I'm not seeing any other hands. Am I missing anything? All right. Let's move on. Thank you again, Stacie. Appreciate your time on that. The next agenda item, number seven, is discussion, consideration, and possible adoption of Silver State Health Insurance Exchange bylaw amendment as proposed by the subcommittee. And, the subcommittee met today to discuss and develop a recommended evaluation process, which we are going to discuss under agenda item eight today. However, as part of that process, it does require a change to the Exchange bylaws to accommodate the evaluation of the Executive Director. Thus, the subcommittee is now recommending to the Board that the amended language to bylaws state the following, which we did vote on in our subcommittee meeting this afternoon. So, in reference to Article IIII, currently it states pursuant to NRS 695i-380, the Board shall appoint an Executive Director who is responsible for the administrative matters of the board this afternoon. This afternoon the subcommittee met to attach the following language to that in section -- in Article IIII. So we would -- that

first sentence would still apply. And then we would add the Board shall establish a procedure for an annual evaluation of the Executive Director. So that is what we did vote on, earlier today. And I believe at this point in time, we are making that recommendation to the full board, to adopt that, amended bylaw language that was, approved by the subcommittee earlier today. So, at this point I would take a motion to approve that language as we are bringing forward to you.

Q. BRANCH: Madam Chair, this is Quincy Branch. I motion that we adopt and accept the language as submitted by the subcommittee.

V. CLARK: Thank you, Quincy. Do I h--

J. JOHNSON: Jonathan Johnson, second. Yep.

L. LEWIS: <inaudible>.

V. CLARK: Ye-yes, uh, Lavonne?

L. LEWIS: I second the motion.

V. CLARK: Oh. Oh, thank you. I didn't quite hear that. Okay. Thank you very much. Is there any further discussion on that? Okay, seeing none. All in favor, please say aye.

MULTIPLE: Aye.

V. CLARK: Anyone opposed? Anyone abstaining? Okay. Motion carries. Thank you very much. And then agenda item eight, discussion, consideration, and possible implementation of, recommended Executive Director evaluation process as proposed by the subcommittee. So we did also, approve in the subcommittee the process that we would like to bring to the Board for their approval for the evaluation of the Executive Director. Jonathan, do you wanna go through that or would you like me to?

I don't mind doing it, but you -- since you being the Chair of that committee, I didn't -- I thought you might want to, except now I can't see your face anymore.

J. JOHNSON: Yeah, sorry. I had to, disconnect from the computer. I'm on my phone now.

V. CLARK: Oh, okay.

J. JOHNSON: But yeah, happy to talk through that, just real quick. Let me -- gimme just a -- just to --

V. CLARK: And I have my notes in front of me if you need --

J. JOHNSON: Yeah, if you can take that and --

V. CLARK: Sure, sure.

J. JOHNSON: -- and walk through the notes from our meeting, that'd be great. Thank you.

V. CLARK: Okay, yeah. So what we had agreed to is that the Silver State Health Insurance Exchange subcommittee will work in conjunction with the State Department of Human Resources Management to formulate a confidential 360 assessment. The questionnaire will be distributed to appropriate stakeholders who interact or have interacted with the Executive Director. The, Silver State Health Insurance Exchange and the committee will develop the list of stakeholders that will receive the survey. The responses of the survey will go to and be compiled into a report by the State Office of Human Resource Management. And the report will be delivered to the subcommittee who will evaluate it and bring it, to -- and present it to the Board of Directors for review and follow up. So that's what we agreed, in our, subcommittee today and voted on and

approved. So we are bringing that forward to you, the full board, for your questions consideration, and potential vote. Are there any questions I can answer?

S. KUMAR: Madam Chair, Sam Kumar. I think we discussed this at length, either in the previous meeting and the one before that, so I'm totally comfortable with the approach.

V. CLARK: Is that a motion, Sam?

S. KUMAR: So moved.

L. LEWIS: Lavonne, second the motion.

V. CLARK: Thank you, Lavonne. Are there any -- is there any additional conversation about that? Okay. Seeing none. All in favor, please say aye.

MULTIPLE: Aye.

V. CLARK: Any opposed? And is there anyone abstaining? Okay. Motion carries. Thank you very much. Mr. Detmer, are you still on? Did I miss anything there? I just wanna confirm that you feel that was all, I've included all the language that was appropriate at that time.

M. DETMER: It sounded complete, Chair.

V. CLARK: Thank you very much. Okay. Next on the agenda -- we're almost done, people. Item nine, review and discussion of continuance of existing agreement with VSP Individual Vision Plans. And this is for possible action.

R. COOK: I did not mean to interrupt you, Madam Chair. I just wanted to provide a brief introduction to this agenda.

V. CLARK: Thank you, Russell.

R. COOK: All right. So this, item is intended to provide the Board of Directors with an opportunity to review the Exchange's existing contractual agreement with VSP Individual Vision Plans and consider the future status of that agreement. To provide a summary, of the background of this agreement, in 2020 the Exchange entered into a contractual agreement with VSP Individual Vision Plans to host a link on the nevadahealthlink.com website in exchange for an annual hosting fee. This link would direct consumers to VSP's website for the purchase of enrolling in op Exchange vision coverage. And the relevant page on our website, I provided a link to in the, agenda item here. This agreement, as was mentioned in the public comment, followed a pattern which had previously been established by other state-based marketplaces, including California and Idaho, wherein the state marketplace would partner with one or more vision carriers by driving traffic to their respective websites. The Exchange's contract with VSP was amended in September of 2021, and again in March of 2023. These amendments merely increased the annual fee that VSP would pay the Exchange and <inaudible> for hosting the link. The obligations of both parties appear not to have been modified by the amendments. And although the contract was set up to automatically renew each year, at least in the most recent amendment, it does include a severability clause indicating that either party may terminate this agreement without cause upon 90 days prior written notice. So at present, it is within the Board's purview to either continue the existing relationship with VSP, in which case no action would be required, or to terminate the relationship with 90 days' prior written notice. I did want to mention also

that, representatives from VSP have prepared a slide presentation. And, you know, even though, we did hear from them, during the public comment at the beginning of the meeting, I did review the slides I have prepared. And in my opinion, there was additional information in the slides, particularly some metrics about, enrollment numbers that was not included in the public comment. And that is why I'm recommending that the Board consider, reviewing this presentation right now. I'm very mindful that we're, just now reaching the two-and-a-half-hour mark. So if, the board is okay with this presentation, I will ask our partners at VSP to please be mindful of their time and to move as, expediently as possible through the slides, which I'll share in a moment, upon your approval, Chair.

V. CLARK: Thank you very much. Is everyone okay with that? I think it would be good to hear this out if we can. And it is for possible action, so we do need to keep our quorum. So please hang in there with us if you can.

R. COOK: Okay, wonderful. And I should have mentioned this very brief bit of context up front. When this, discussion was requested for the meeting agenda, had discussed this with you, Madam Chair, as well as with Mr. Detmer. And we decided to split the discussion into two separate agenda items. This one is specifically to do with the existing agreement, with VSP. The next agenda item will be a more general discussion about, whether or not the Board wishes to implement a formal policy, which would apply to any vision carrier seeking a partnership with the Exchange.

V. CLARK: Okay.

R. COOK: All right. And, I will now invite, our, representatives

from VSP to, come off mute. And, I'm happy to, walk us through this slide deck. And again, I would just ask that you please be mindful of our time.

M. DENHAAN: Of course. Thank you, really appreciate the time today. And really this was just to supplement what was discussed. Obviously, I just reread a letter that you guys had access to and thought this additional information may be helpful and also maybe addresses a few of the questions that you might have that were not covered in that. So, I have already covered the partnership solution, which was that redirect link. This is kind of a summary of that. It also shows that, we have grown to over 400 active subscribers with an active policy. And also, this last, open enrollment, which led to January 1 enrollments was the largest enrollment in a month we've had since the inception. And we tend to see that, as it becomes more familiar with consumers, the numbers continue to grow. So, Russell, if you wouldn't mind going to the next slide. This is just a two-year snapshot. I couldn't squeeze in a longer one. But this started at zero growth at time of launch and has grown to over 400. And we see a very consistent pattern of sort of a slow airplane taking off that continues to grow year over year, and this includes additions as well as terminations. So, we see a very consistent pattern. This is also consistent with our experience with other Exchanges that, year over year, they tend to grow. And it's been a very successful program. Russell, if you wouldn't mind going to the next one. We do provide access to a reporting portal, which gives you some key metrics, including things like policy start dates, memberships, whether they're buying it for themselves or dependents, whether they've selected our month or annually, as far as payment models,

which products they've suggest -- or, selected, and then we do provide, you know, sort of information on active versus canceled and what some of that churn looks like. So that reporting is available to you through a reporting portal, and you have administrative rights to provide that to whomever would like to see that. And that's an ongoing piece. That's real-time data. And then a very blurry slide, which I did not put together, on compliance. And that's -- I'm a salesperson, not a compliance person. So this, is not my purview, but we do have -- obviously, we cover 80 million members. We're in every imaginable aspect of healthcare. So compliance and oversight at every level is just part of what we do, because we work with state agencies and so forth, so this is some of the detail on that. I obviously won't take the time to read through those bullets, but I just wanna assure you that compliance is there, and significant oversight is being done by our organization as well as our partners. And I think one question about, the customer support or what's the member experience and experience with us on, are we managing them, are they happy, these are just a few of the bullet points on our touches throughout the year. We consider, what we do a member nurturing, where we want them to see the value. We want them to use the benefit. As I mentioned, the well eye exam is critical for, not only their eye health, but their personal health. So we do a lot of touches throughout the year to make sure that they're using that, provide information about the value or the savings that they get by buying a fully insured vision product, and so forth. So there's a lot of touches. We manage that ourselves and it's critical to, the outcomes that we get as well as the member satisfaction survey results that we generally

get. And this is the sort of 12-month protocol where we, onboard them, we nurture them, we remind them that their renewal is coming, and then we manage that renewal through this system. So they're only tied in for a 12 month program, and at the end of that 12 months, they can move on if they so chose. But, we do a lot to inform them. There's no surprises. It's very important that we communicate well with them, and that is all built into the program. And as we had mentioned, if the preference is to move to a different model, that's outside of what we're doing with the other Exchanges, we can do that. There's some pieces that go with that, but it does require some additional work and, some additional resource to do that. But we wanted to make that, available should you, choose to move forward as the only way to keep this together, we would certainly welcome revisiting that. But so far, the smart link model has worked exceptionally well. And, just wanted to let you know there's some flexibility for us, should you choose to go that route. And finally, I'll let you guys get out at 4:05 here. Member satisfaction is a hallmark of what we do. We're not-for-profit, focused a hundred percent on their experience, and the quality of our services. And our member satisfaction's outstanding, year over year consistently by line of business. And I just wanted to share that with you, just about what it means to the actual consumer buying our products. So hopefully that alleviates some of the concern about not kind of keeping, eyes on it, that it's performing well, members are happy, and that's been sort of the VSP experience, consistently year over year. And that's it. Thank you very much for the time.

V. CLARK: Thank you, Mike. Yes, thanks. Idon't know that, I

have any questions about the product. I think it's a quality product. I personally have worked with VSP my entire career, you know. As you know, I'm an insurance broker, so we sell vision plans constantly. I think where questions come into play are the fact that there is -- I don't believe there is any other vision carrier on the Exchange, so where do we get that competitive, you know, how do people shop when they only have one option? Um --

M. DENHAAN: Right, right.

V. CLARK: Are we -- and I don't know, Mike, that that's your issue as much as our issue.

M. DENHAAN: Right.

V. CLARK: What have we done as an Exchange to promote competitiveness, you know, a competitive, dynamic so that people are assured, you know, a variety of different rates and benefits, and network access because there are different networks. So that's what -- I think my personal concern is that why are we not having other carriers competitively, priced against your product so that they're, you know, keeping you guys in check, giving people options. You know, there are lower cost options on the marketplace, but most people like VSP because of the network size. And so I don't know that that's your problem to solve, Mike. I think that's our problem to solve.

M. DENHAAN: I did wanna share that, on the Exchanges, we do have Exchanges where there are multiple carriers.

V. CLARK: Yeah.

M. DENHAAN: And we are on some state-based Exchanges

where we are the solo choice.

V. CLARK: And we don't have an exclusive agreement between us, do we?

M. DENHAAN: Correct, no.

V. CLARK: Okay.

M. DENHAAN: We do not.

V. CLARK: Any other thoughts, questions? Sam?

S. KUMAR: Yeah. Thank you, Madam Chair. I'm -- to kind of add to your question, we don't want to be accused of preferential treatment. So, Russell, that's something we should keep an eye on. If others have reached out to you, we have reached out to others, VSP competitors, that'd be really good. And, going back to Mike, a couple of questions. You're talking about potentially, VSP folks detecting hypertension, high cholesterol of that and all of that. How often do you see that happening?

M. DENHAAN: Idon't know statistically, how that comes up, but I know historically that optometrists, through the well eye exam, often catch some of those early onset conditions through a well eye exam. So I don't have those numbers. I apologize. That's not something I have access to because we're in so many aspects of healthcare, but almost all of our plans do have that annual well eye exam, and that's such a great opportunity to catch early onset condition. And we hear the story all the time about how their optometrist was literally the first person that got them in to see their PCP, and they've caught -- there's all kinds of stories about people catching, all kinds of conditions. So there -- it's -- and I bring that up strictly as the value added on top of the eye exam that's specific to

the eyecare. It's just sort of an altruistic additional benefit of offering vision and the value offering vision to consumers.

S. KUMAR: Yeah. If you can, track that down and send it over to Russell, that'll be great. I'm just curious. So, great. Thank you.

V. CLARK: Mike, do you --

M. DENHAAN: Yeah, happy to answer questions.

V. CLARK: Yeah. Do you operate off of an MLR for -- or a loss ratio for a group like this? Do you look at a group like this in a form of what it's generating versus what is being paid out in terms loss?

M. DENHAAN: Right. We -- in general, the underwriting is done, on an annual basis. The the rates are revisited, more in aggregate. We don't do, customer specific MLR unless we get into things like our group business. The, rates rarely change. They're actually state based, so, we have underwriting assumptions for different states because the, provider payment varies by market. So it's really a state-based. We rarely have rate changes. And as you know, in ancillary services like vision and dental or other chiropractic and things like that, the cost of the benefit as compared to the administration of it, that -- the MLR is pretty different because you get into a health plan product that's 400 or $500 a month versus $12 a month.

V. CLARK: Right.

M. DENHAAN: The MLR looks vastly different 'cause there's just not much margin. So --

V. CLARK: Yeah.

M. DENHAAN: So that has not changed much to be frank.

V. CLARK: Okay. I'm just trying to understand how you judge these relationships in terms of profitability.

M. DENHAAN: Yeah.

V. CLARK: And if we have access --

M. DENHAAN: It's really done in aggregate.

V. CLARK: -- to that.

M. DENHAAN: Yeah, it's really done in aggregate. Ihard to do it. We don't wanna rerate based on, group. We have really done it for the individual product in general because we're in so many different aspects of individual vision and we sort of look at individual in total.

V. CLARK: Sure. I understand. Any other questions?

S. WEEKS: Just real quick. Sorry, Valerie, real quick. I know we're tired. Just wanna say thank you. I think something worse we always see in Medicaid, obviously adult dental is not covered, but children is, and pregnant women is covered. I think, if we can move to covering that adult dental Medicaid, it could help the whole market. I will say that, you know, there are some contracting strategies that we might wanna consider with our DBA contract. Just like we require MCOs to offer products in the Exchange, we could do a similar thing for our dental benefits administrator, Russell, so you could get other products, back to Valerie's point around competition and options and choice. So I just throw that out there as something for folks to consider. But Mike, I really -- obviously the mouth is part of the body and I think it's just really -- thankful that you guys wanna offer some coverage. But, you know, to Valerie's point, making sure we have a healthy market I think is something we can consider. And

Russell, we can maybe talk offline about options on that.

V. CLARK: Yep.

M. DENHAAN: Yeah. Thank you for including me. I really appreciate it. You, you've been --

S. WEEKS: No, thank you.

M. DENHAAN: -- a valued partner and we really appreciate it.

V. CLARK: Thank you very much. And we don't want you to feel that you're not valued, you are. We just --

M. DENHAAN: Yeah.

V. CLARK: I think we all wanna make sure it's fair and competitive --

M. DENHAAN: Sure.

V. CLARK: -- because of course that's what generates the best consumer experience, so.

M. DENHAAN: Sure, understood.

V. CLARK: Great. So do we need to vote on this? I'm sorry. I'm formal policy -- let's see. Review and discussion of continuance of existing agreement. So, I guess, do we need to vote on this? Do we wanna vote on continuing this agreement?

M. DETMER: Mike Detmer for the record. You know, I was thinking about it just now. If you were not to vote on it and it would just be a discussion item, the status quo would be maintained. But if there's some action that you wanted to take, that you could vote on it.

V. CLARK: Okay. So I guess I would open the floor to anyone who might wanna make a motion.

S. KUMAR: Madam Chair, Sam Kumar. Just a quick comment. Since we are planning on continuing anyway, no action is needed.

V. CLARK: I would agree. Okay.

L. LEWIS: Same.

V. CLARK: Lavonne, I'm sorry, I didn't quite hear you.

L. LEWIS: Oh, I agree that no action.

V. CLARK: Okay. Yep. Okay. So we'll just let that one go. We don't need to take any action on that. And then the next item, consideration and possible creation of a formal policy related to vision carrier partnership. I think we could maybe take some action there. In terms of -- I mean, my personal recommendation would be that we need to put -- maybe include other vision carriers in an RFP type of a process or procurement process, just to open up the doors for competition and choice. I don't know how anyone else feels.

S. KUMAR: Madam Chair, Sam Kumar. I think that can be done offline. I don't know if it's an RFP basically, and you know, a little bit of recon to see if anyone else is interested. And if they are, I would imagine there should be some kind of a vetting process by the state supply chain before --

V. CLARK: Yeah,

S. KUMAR: -- they can include it. So, if -- Russell, if you're okay with that, can we assign that to you? You have your hands full with everything else, but, thought I would float that.

R. COOK: Thank you, Mr. Kumar. Can you clarify a little bit, what the ask is? This is, by the way, precisely the type of dialogue, that we

were hoping to encourage with these two agenda items. I was just hoping to gain some additional clarity regarding the, the specific, ask.

S. KUMAR: Yeah. You know, like, Valerie said we'd like to have a competitive marketplace for, vision plan as well, and also, fairness in terms of offering others the opportunity to participate, not just VSP. If we can do some background research to see if anyone is interested, and send them through the vetting process and include some links there for others as well, if they're interested.

R. COOK: Okay. Well, you know, for reference, we did put together a very brief attachment for this agenda item. The language that I had repaired, which is very brief, stated that ACA regulations, do not have provisions for Nevada Health Link to sell vision plans directly, through the marketplace. But numerous state-based Exchanges have entered into partnerships, with vision carriers, by way of the host referral link that we discussed earlier. So, part of what we were proposing is that the Board might consider the implementation of a, policy which defines a process, potentially including selective evaluation criteria or formal guidelines for application, including a potential timeframe for application, perhaps on an annual cycle, by which vision carriers might express interest in a partnership with the Exchange. That would be a little bit more passive of an approach versus an active recruitment like an RFP. But again, we'd be more than happy to, you know, do some research in the meantime. Perhaps even prepare a draft policy or, you know, our suggested course of action based on experience. For context, Mr. Kumar, because the discussion that sort of precipitated, you know, today's agenda items occurred back in June

at our board meeting before your appointment to the Board. And I had delivered in my Executive Director's Report, a recounting of an incident which occurred last fall where we were actually approached by another vision carrier besides VSP. And over the course of reviewing, a number of criteria, you know, we made the judgment call at that time, that, you know, we weren't comfortable, you know, issuing a tacit endorsement of that carrier services, specifically citing concerns about their customer service track record. So, they're out there. There's definitely interest in partnering with the Exchange. And the reason why I mentioned that in June was specifically to bring the Board into the fold of that process, and, you know, sort of solicit, opinions and suggestions for how we might, you know, better foster, you know, a competitive, you know, relationship or, you know, competition within the marketplace. Just wanted to make sure that we were getting out ahead of the Board in terms of, steering, what that, selection process or those criteria might look like.

S. KUMAR: That context is extremely helpful. Thank you, Russell. And, if you don't mind coming up with a draft proposal, that would be great. Nothing that has to happen right away, whenever you have some time. You know, you have your hands full right now.

R. COOK: We'll shoot for getting that on the agenda, for the December board meeting barring any, unforeseen, you know, circumstances in the meantime. I think that should be doable. If, you know, if we do run into trouble though, certainly we'll reach out and let you know and we'll seek advice by email if that sounds okay.

S. KUMAR: Sounds good. Thank you.

V. CLARK: Excellent. Thanks, Russell. It'll be nice to see what's out there. Okay. Discussion and possible action of creating various advisory committees for proper oversight and support of the Exchange.

S. KUMAR: Madam Chair, Sam Kumar again.

V. CLARK: Yes.

S. KUMAR: That's an item that I had asked to include. Given that we are nearing the three-hour mark, I don't want to be public enemy number one, so we can probably punt that to the next meeting. And what I would also do is I can put together a document and share it with you, or with Tiffany, that way we can make it part of the pre-read for the next meeting so that we are all better prepared.

V. CLARK: That sounds excellent, Mr. Kumar. Thank you. Okay. Topics, dates, times, and agenda items for future meetings. Sounds like we have a couple already that we've discussed. Anything else anyone would like to see on the next agenda? Okay. With seeing none, we'll move on to public comment. Tiffany?

T. DAVIS: Madam Chair, thank you so much. Tiffany Davis for the record. And for public comment, I'd like to say that anyone who has joined us on Zoom, if you would like to make a public comment, that you may raise your electronic hand feature or indicate in the chat box if you would like to make a public comment, and our staff will let you know when you may unmute yourself. For those who have called into the meeting, we'll also let you know when you may unmute yourself to provide your public comment. At this time, I'll go ahead and go directly to our Carson City conference room. Kassie, do we have anyone in the physical location

of Carson City office who would like to make a public comment?

K. FUENTES: This is Kassie Fuentes. There is no public comment here in the Carson City location. Thank you.

T. DAVIS: Thank you. And then, let's see, online again. If any of our attendees would like to provide public comment, you may now raise your electronic hand feature on Zoom, and Kassie will call your name and then you may unmute yourself for public comment. Kassie, do we see anyone with their hands raised for public comment?

K. FUENTES: This is Kassie Fuentes and there are no hands and no comments.

T. DAVIS: Excellent. Thank you so much. And then on our phone lines, just, one last time, if anyone calling in would like to go ahead and unmute yourself at this point and provide public comment, you may do so. Not hearing anything, Madam Chair, I believe we have no public comments. If I may add just one thing, right at this moment, our next regularly scheduled board meeting is for December 17th.

V. CLARK: All right. Thank you so much, Tiffany. Appreciate your help and I appreciate everyone that was here today. Thank you very much. Do we have a motion to adjourn the meeting?

S. KUMAR: So moved. Sam Kumar here.

V. CLARK: Do we have a second?

L. LEWIS: Second the motion, Lavonne Lewis.

V. CLARK: Thank you. Thank you, Levonne. All in favor?

MULTIPLE: Aye.

V. CLARK: Thank you, everyone. I hope you have a really great

evening and appreciate your time and participation today. Take care.