

**IDAHO HEALTH INSURANCE EXCHANGE  
DBA YOUR HEALTH IDAHO**

**YOUR HEALTH IDAHO BOARD OF DIRECTORS  
MINUTES**

**FRIDAY, SEPTEMBER 15, 2017**

**1. BOARD MEMBERS PRESENT**

- Mr. Stephen Weeg, Chair
- Mr. Kevin Settles, Treasurer
- Mr. Tom Shores
- Ms. Karen Vauk
- Dr. John Rusche
- Mr. Dave Jeppesen
- Mr. Fernando Veloz
- Dr. John Livingston
- Ms. Margaret Henbest
- Mr. Jerry Edgington
- Ms. Janice Fulkerson
- Senator Jim Rice
- Rep. Mat Erpelding
- Director Dean Cameron
- Director Russ Barron

**2. OTHERS PRESENT**

- Mr. Pat Kelly, Your Health Idaho
- Mr. Layne Bell, Your Health Idaho
- Mr. Jeff Hull, Your Health Idaho
- Ms. Karla Haun, Your Health Idaho
- Ms. Alanee DeRouen, Your Health Idaho
- Ms. Frances Nagashima, Your Health Idaho
- Ms. Stephanie Mathiesen, Your Health Idaho
- Ms. Wanda Smith, Your Health Idaho
- Ms. Mandi Shawcroft, Your Health Idaho
- Ms. Meghan McMartin, Your Health Idaho
- Ms. Megan Bauer, Your Health Idaho
- Ms. Briana Colton, Your Health Idaho
- Ms. Cheryl Fulton, Your Health Idaho
- Mr. Mike Stoddard, Hawley Troxell
- Ms. Moriah Nelson, Idaho Primary Care Association
- Mr. Weston Trexler, Department of Insurance
- Mr. Mitch Toryanski, Regence Blue Shield of Idaho
- Ms. Julie Hammon, Department of Health and Welfare
- Ms. Lori Wolff, Department of Health and Welfare
- Ms. Shannon Brady, Department of Health and Welfare
- Mr. Josh Tyree, Harris & Co.
- Ms. Marnie Packard, SelectHealth

- Mr. Norm Varin, PacificSource Health Plans
- Ms. Emily Patchin, Risch Pisca
- Mr. Mike Reynoldson, Blue Cross of Idaho
- Mr. Bret Rumseck, Blue Cross of Idaho
- Ms. Tresa Ball, HR Precision

### 3. CALL TO ORDER

Following proper notice in accordance with Idaho Code §74-204, the Board of Directors meeting of the Idaho Health Insurance Exchange (Exchange) was called to order by Mr. Stephen Weeg (Chair), at 9:01 a.m., Friday, September 15, 2017, at the State Capitol Building, Room WW55. In accordance with Idaho Code §74-203 (1), the meeting was held in an open public forum and was streamed in audio format on the Idaho Public Television web site.

### 4. ROLL CALL

Representative Erpelding called roll and determined that the Chair, Mr. Settles, Mr. Shores, Ms. Vauk, Dr. Rusche, Mr. Jeppesen, Mr. Veloz, Dr. Livingston, Ms. Henbest, Mr. Edgington, Ms. Fulkerson, Senator Rice, Director Cameron, and Director Barron were present, resulting in a quorum.

Mr. Kreiling, Mr. Erstad, Ms. Sweigart and Representative Packer were absent.

The Chair introduced Dave Jeppesen, a new Board member taking Charlene Maher's seat representing Blue Cross of Idaho.

### 5. PUBLIC COMMENT PERIOD

There were no public comments.

### 6. PRIOR MEETING MINUTES

**Motion**: Dr. Livingston moved to approve the meeting minutes from the June 16, 2017, Board meeting as presented today. **Second**: Ms. Henbest. **The motion carried.**

### 7. REVIEW OF AGENDA

The Chair noted the two main topics of today's meeting: the FY 2017 Audit and the PY 2018 Plan Certification. In addition, we will discuss the latest updates out of Washington.

### 8. CUSTOMER EXPERIENCE

Mr. Kelly said the customer experience remains the priority at YHI. Improvements to the Customer Experience continue as a result of up training. While overall call volume is down due to being outside of Open Enrollment, the results of targeted training can be seen. This training includes soft skills, such as customer de-escalations and coaching sessions, paired with weekly accountability reports. We have used the opportunity to interact more with customer advocates while they are on calls to solve problems in real-time. As a result, efficiency and quality scores have both increased.

Mr. Kelly said in looking at the numbers, overall call volume is down 75% since the last Open Enrollment. While it's common to see a decrease, this was the largest to date. The number of times a customer had three or more contacts with YHI is actually up slightly – about 8%. This is due to the new requirement of SEP validation documentation coming to YHI.

However, we have improved the number of days it has taken to resolve an inquiry, with 86% now resolved in three days or less. We also looked at the customer experience while on the phone, and it too has improved. The Average Handle Time has gone down 20% since January. Total handle time includes time on hold, as well as time spent documenting the call. We do expect that number to increase during the next open enrollment.

Mr. Kelly said appeals are down significantly year-to-date. While the reasons for appeals remain consistent with enrollment date changes and reinstatements, a new category emerged related to the QLE and SEP validations. YHI has been able to resolve the majority of appeals, and this year there were only two that ended in a hearing, compared with nine last year. Drivers behind these improvements include a strengthened relationship with DOI and DHW and improved clarity around policy requirements to address the main issues for appeals.

Mr. Kelly said we seek to ensure that all 1095-A tax statements are delivered by January 31 and we are in excellent shape to see that through. Earlier this year, YHI implemented the reconciliation workbench and this automated the reconciliation process, but more importantly it provided detailed reports for those items that needed work manually. As such, we began analyzing the effectiveness of Carrier reconciliations and the impact this new work stream specifically has on Idahoans 1095-A's. As of today, more than 98% of required 1095-A tax statements are ready to be sent.

Mr. Kelly said getting tax statements right the first time is not the only customer experience issue we are looking at improving. We have learned that consumers simply do not want to leverage traditional channels to contact Support Centers. They want more self-directed access, they want mobility, and, of course, they want it now.

This brings us to the measured use of artificial intelligence. A “Bot” is an application that performs automated tasks, such as the ability for an Idahoan to reset their HIX password without ever calling the YHI Support Center, leveraging technology such as smartphones. Another area we looked at is an automated request for a resend of a 1095-A tax form. We expect to deploy Bot technology for consumer password reset by the beginning of open enrollment.

Mr. Kelly moved on to YHI's most recent technology release, which was released on September 13<sup>th</sup>, focused on four key areas of improvement. Those listed under APTC application based eligibility dates include alignment of the APTC eligibility dates and enrollment dates, and more importantly having the ability to change those dates retroactively up to sixty days. This is expected to reduce the number of appeals as well as cancellations for non-payment. The second piece that is included in this section is the ability to resolve complex customer issues that previously required a referral to GetInsured. This will speed up that process and puts control in YHI's hands to quickly resolve that issue.

Mr. Kelly said another item in this release is the 834 transactions which are the electronic reports and updates used by YHI and the carriers to communicate. These enhancements increase the

automation of that reporting which was a pinch point last year. It won't be visible to the customer, but will improve the customer experience through more accuracy and timeliness in resolution. We also expect this to reduce the overall workload for both YHI and the carriers.

Finally, on the technology release, is the carrier crosswalk. In June, we discussed the possibility of one of the carriers leaving the marketplace. It created a number of risks, both for consumers in terms of potential gaps in coverage, as well as financial risks to Your Health Idaho from an enrollment perspective. YHI implemented automated technology so that any cross-carrier renewals, which will be needed this year with the departure of BridgeSpan, will happen via an automated process. These cross walked plans will affect about 18,000 lives.

## **9. OPEN ENROLLMENT READINESS**

Mr. Kelly noted that open enrollment is just 8 weeks away and open enrollment readiness involves everyone at YHI and our partners as well. The redetermination and renewal process is well underway with our partners at DHW, DOI, and GetInsured. Internal to YHI, the first step was determining our workforce planning. We vetted our call volumes from last year using the Erling-C model, which is an industry standard for support centers. This basically verifies that we have the right number of customer advocates in the right place and at the right time.

We have started to fill the pipeline with seasonal workers in preparation for increases in customer inquiries, and our first training class just ended today. Our training of new temporary workers involves a buddy system – pairing new hires with seasoned staff. We also reduced the training time needed to two weeks and incorporated a module system to break up the training into simultaneous sessions when needed. Feedback from our first group of trainees has been exceptional and we are excited to get them on the phones early next week with that buddy.

We are also well underway with training for our Consumer Connector partners. Online certification, coupled with live trainings throughout the state are addressing changes and questions that agents and enrollment counselors may have. Just yesterday, we held a webinar for those who were unable to travel due to unique circumstances.

## **10. ENROLLMENT ENTITY CONTRACTS**

Mr. Kelly said that each year, YHI has issued its request for applications for enrollment entities. This year, we received three responses to the RFA.

Our proposal evaluation team met and recommends two of the organizations: IPCA and St. Luke's. As a reminder, these entities do not recommend individual plans, they are directed to assist Idahoans with their application and eligibility questions, and then refer them to an agent for plan selection. Many of these customers lack a computer to directly enroll or may have limited English-language skills.

If the Board approves these two entities, the contracts would total \$272,000 - slightly less than what we spent last year, and well within our approved budget.

Rep. Erpelding asked who will be serving the underserved communities in Northern Idaho. Mr. Kelly stated that he doesn't have those maps with him today, but it was a critical item during the selection process that we have coverage across the state. For reference, St. Luke's is primarily

centered in Southern Idaho while IPCA is across the state. Last year, St. Luke's assisted about 1,000 people and IPCA assisted about 17,000. Of the \$272,000 in contracts awarded, about \$18,000 goes to St. Luke's and the remainder to IPCA.

Mr. Jeppesen asked what types of controls are in place to ensure these enrollment entities don't step outside their realm of training and into the area that licensed agents and brokers while in the process? Mr. Kelly said first they are trained on the system, what documents they might need and what questions they might need to answer. The training does state that they cannot recommend plans and at that point, they will need to refer them to a licensed agent. YHI has worked over the years to increase the relationship between enrollment entities and the agents to ensure that handoff is seamless. In terms of reporting and oversight, with each invoice we receive, they report on how many people were assisted, where were they assisted, some high level demographic information. But those are just aggregate numbers. In terms of making sure they don't step out of bounds, there is no reporting for that. If a complaint arose, YHI would certainly look into that.

Mr. Jeppesen asked if YHI could provide some sort of oversight to ensure they don't overstep their bounds. Mr. Kelly said YHI is always happy to look at options for oversight, but the challenge in that is implementing the right kind of oversight. Mr. Kelly said that the challenge in this space is that if more self-reporting is implemented, it is highly unlikely that someone would report going outside their swim lane. In terms of secret shoppers, that becomes problematic in that customer PII may be exposed. Mr. Kelly said he is open to ideas and will even ask the enrollment entities themselves, but at this point we do not have a solid plan to ensure the entities remain in their swim lanes. The Chair added that it might be good to think about a way that at least would be some type of simple audit process. Mr. Jeppesen said he and Ms. Fulkerson, along with input from Mr. Kelly, will take this offline to work on a plan.

Dr. Livingston asked for some clarity on the dollar amounts of the contracts. Mr. Kelly said the contracts that are being proposed today are \$272,000 in total. St. Luke's is approximately 1,000 people served with a contract total of about \$18,000 and IPCA is about 17,000 served with a contract total of about \$254,000. Dr. Livingston added that he is concerned about the possible conflict of interest between St. Luke's and the co-op that they contributed \$15M to and also to SelectHealth. We need to make sure that no one is steered in the wrong direction in that regard. Mr. Kelly said the financial relationship St. Luke's has with both Select Health and the Mountain Health Co-op is something we discussed in the Marketplace Committee and Mr. Edgington addressed personally as he is a representative of SelectHealth on the Board and is also employed by them. St. Luke's contract value of \$18,000 in an overall revenue stream of \$2B is immaterial and the enrollment entities are so far removed that they might not even be aware of the financial relationship. More importantly, the training for them to not steer a customer to a particular plan also gives us some comfort there. It is something that we need to be aware of and any oversight that Mr. Jeppesen and I are able to implement will help us with this.

Dr. Rusche asked if YHI, who has been utilizing these enrollment entities for several years, has ever received any complaints that the enrollment entities have swam outside their swim lanes? Mr. Kelly said as far as he recalls, there has only been one complaint that went to DOI, and that was several years ago.

Mr. Shores added that the agent community reaches out to the entities and has had great successes there. But as the connectors become more proficient at helping people thru the enrollment process, they begin to develop opinions as to what might work best and it becomes more difficult for them to not recommend. It is important to train them properly about the handoff. In addition, the ACA requires YHI to have two entities. Many of these first contacts occur when a customer is seeking care and these connectors assist them in finding coverage. As a carrier, you would be recruiting customers that may end up costing the most.

Senator Rice added that this conversation shows that YHI should have some plan in place to audit. It's important that this is in place because if not, that potential conflict of interest becomes more obvious.

Director Cameron asked if YHI knows who each carrier is enrolling, does YHI have the statistical data that shows who they enrolled with. Mr. Kelly said the reporting that we get from the enrollment entities is aggregate. We would see that they assisted 60 people, but we don't know who those 60 people are. Director Cameron asked if it would be possible to have the entities report as part of their contract how many people they saw, but also who they recommended them to for plan selection or who they chose to be insured by. Mr. Kelly said this would be a manual process and he will need to go back to the team to see if this is possible. Another complication would be that some of these areas might only have one or two plans to choose from, and looking at that in aggregate, you could have somewhat of a red herring if you were garnering conclusions from that. This is a great opportunity to find some oversight, but find one that is fit for purpose for Your Health Idaho.

## **11. OUTREACH & EVENT RFP**

Mr. Kelly said Your Health Idaho has a need to expand its reach to all corners of the state. Our current efforts are often limited to the Boise area.

We would be seeking a vendor to identify and manage events and other opportunities for YHI to sponsor or participate in. This could include a booth at a health fair in eastern Idaho, a community event in Coeur d'Alene, or a family fun run in Caldwell.

In addition, this vendor would develop the appropriate materials for such events, from promotional to educational materials. They would also be needed to identify key influencers and utilize speaking opportunities, social media and community presence to build strong relationships and alliances. YHI would also benefit from that grass roots effort of Idahoans talking to Idahoans in the form of testimonials, which requires community engagement.

This is one of those rare instances where it's more economically efficient to engage a vendor. They can put multiple resources on the ground in a very concentrated period of time, compared to a full-time team member.

This RFP would supplant the coordinator position vacated in June, and would therefore fall within the FY18 budget.

**Motion**: Mr. Edgington moved that the Board approve the Enrollment Entity contracts and authorize the Executive Director and the Board Chairman, Vice-Chair or Treasurer to execute the Enrollment Entity contracts at an amount not to exceed \$272,655 collectively. This amount falls within the FY18 approved budget. **Second**: Dr. Rusche. **The motion carried.**

**Motion**: Mr. Edgington moved that the Board approve the release of the Outreach & Event RFP and authorize the Proposal Evaluation Team (PET) to select the vendor and authorize the Executive Director and the Marketplace Committee Chair to execute the Outreach & Event contract at an amount not to exceed \$50,000. This amount falls within the FY18 approved budget. **Second**: Dr. Rusche. **The motion carried.**

## **12. COMPENSATION POLICY**

Mr. Kelly noted that the Governance Committee discussed this topic and asked Ms. Henbest to present this topic. Ms. Henbest said the Committee reviewed the Compensation Policy and noted a couple of changes to the policy including how often we conduct market reviews on compensation. We also updated our variable pay program with Directors at 5%, Managers at 4% and 3% for the remaining positions. The last time this policy was reviewed by the Board was in April 2015, pre-integration of the support center and pre-consolidation of the Personnel Committee into the Governance Committee.

**Motion**: Ms. Henbest moved that the Board, as recommended by the Governance Committee, approve the revisions to the Compensation Policy as presented today. **Second**: Ms. Fulkerson. **The motion carried.**

## **13. CMS AND POLICY UPDATES**

Mr. Kelly said the administrations funding of CSR's on a month-to-month basis adds uncertainty to the marketplace. These subsidies are critical for those lower income individuals' ability to use their coverage.

In terms of the specific activities in Washington, that intensive pace of congressional activity has really slowed. There are two primary items YHI is watching. First is the Cassidy Graham bill, which is primarily a block grant funding to the states, was introduced Wednesday. We will continue to monitor that, but the clock is ticking on repeal and replace. The Senate Parliamentary Rule are the reconciliation rules that allow a simple majority vote in the Senate, or 51 votes will expire on September 30, 2017. After that, it would require 60 votes in the Senate to pass any legislation.

The second item that is being monitored are the HELP Committee hearings that are bipartisan and finished up yesterday. These hearings were primarily focused on stabilization and are relatively narrow in its goals compared to previous bills and discussions. They are really centered on four primary areas. First is CSR funding, that has a resounding consensus that they need to occur. Second is the expansion of copper plans, in terms of the ages they may be available to. There is also discussion on non-compliant ACA plans. And finally, and most important for Idaho, and other states, is state flexibility. Those are the four primary areas of the HELP Committees work and they are also under the same deadline to get these out so we expect to see those ramp up next week.

Mr. Shores asked if something passes, how quickly will we be able to implement those changes. Mr. Kelly said when the decision is made is critical and will be discussed following the next slide.

Mr. Kelly added that CMS extended plan finalization for FFM states. That will not affect Idaho. We are also waiting for 2019 proposed payment rules that were expected in mid-September or later. Important items coming from that include dates for next year's open enrollment, changes to plan structure, and other policy guidelines.

Finally, inter-carrier crosswalks are critical to those customers to avoid gaps in coverage and potential financial risk. YHI updated policies, received buy-in from carriers and created automation to enable that.

***a) Cost Share Reductions***

Mr. Kelly said the CSR funding is murky at best and month-to-month. DHW, DOI, YHI and GetInsured have worked together to develop these contingency plans, and essentially parallel tracks. The current plans today that were submitted and that we will review for certification assume CSR funding won't continue. These plans are the ones that will be used for redeterminations at DHW, and renewals at GetInsured.

If there is a formal indication that CSR's will be funded, this same group of partners will get together and are prepared to shift to different plans. Those plans are in the wings and are something we can switch to fairly quickly.

The important thing is *when* this formal indication occurs. If it occurs before redeterminations and renewals start, the customer impact is nil. If it happens after that has started, in the November/December timeframe, consumers would get another set of notifications, a revised APTC, renewed in a new plan, and then shift to that second set of plans. If the change happens in 2018, it becomes much more difficult, but can be done.

Director Cameron added that the biggest concern is the impact to the customer experience. That being said, DOI hopes congress will fund CSR's because it is lower cost for everyone involved, including the federal government.

***b) Enrollment Goal Discussion***

Mr. Kelly said based on the conversation this morning, there is much uncertainty in the market. Preliminary rate increases and confusion over the mandate are just two of the things that may cause confusion within the marketplace. We are proposing to change our current goal which assumes a 3% year-over-year increase, to a more reasonable goal of the enrollment levels remaining flat year-over-year. The retention goals remain the same.

Ms. Henbest said the uncertainty around the CSR's is outside our control. And although the team would like to see growth, it may not be realistic given this uncertainty.

Dr. Rusche asked about the potential impact to YHI's budget. Mr. Kelly said that despite the lower goal, we are projected to be favorable because of the rate changes.



**Motion:** Ms. Henbest moved that the Board approve the changes to the enrollment goal as discussed today. **Second:** Rep. Erpelding. **The motion carried.**

**c) Dual Waivers**

Mr. Kelly noted the dual waivers include Medicaid waivers, or an 1115 waiver and a 1332 or an ACA waiver. The goals of this dual waiver approach are to provide coverage for medically frail Idahoans, market stabilization with lower premiums in the individual market both on and off exchange, and to reach more citizens by creating an eligibility pool for those with incomes of less than 100% of the federal poverty level.

YHI is actively working with lawmakers and our partners to move these forward. We are meeting with Idaho stakeholders and lawmakers and will continue to do so as we move forward. Next steps include continued education within the state and at the federal level, as well as finalizing the waiver application themselves. If approved, implementation is targeted for plan year 2019.

Mr. Shores asked if part of the waiver includes those under 100% to qualify for APTC and CSR. Mr. Kelly said currently in the ACA, lawfully present non-citizens qualify for APTC under 100%, but citizens do not. The 1332 waiver would waive that restriction allowing 0% to 100% citizens to receive an APTC.

Mr. Shores asked if there will be a list of conditions that qualify for the waiver. Mr. Kelly said yes, the specifics of what conditions would be required will be defined.

Director Cameron said the concept is two-fold and quite unique and no other state has approached it this way. The concept is that the DOI and YHI would together apply for a 1332 waiver to enroll citizens below 100% of the poverty line in the same APTC structure that we enroll citizens above 100% today, and in the same structure that we enroll non-citizens below 100% today. This is a unique approach to address those individuals that fall into the gap. The requirements for them to enroll, is that they have to have an earned income and file taxes.

This waiver in and of itself would not solve the market stability issue. The instability of the marketplace is driven by the policies of the ACA, the actions and inactions of congress, and a lot of other factors.

Prior to the ACA, Idaho had 91,000 people enrolled in individual health insurance (not counting group plans). Today, Idaho covers 124,000 people. Claims totaled \$140M in 2009, while today claims total \$601M. In 2009 premium minus claims was a positive \$33M, today it is a negative \$59M. In 2009, the average cost per insured was \$159 dollars, while today it is \$363 dollars. The market is completely upside down now.

Director Cameron said the 1115 waiver acts as a stabilizer. And there is no way to address the 1332 waiver effectively without first stabilizing the market. The 1115 waiver addresses the high cost individuals. We do know that about 2% of the enrolled people in Idaho are driving about 40% of the costs. That 2% needs to be addressed.

The concept would be if an individual has one of the pre-defined illnesses, that person would have the option (not mandated) to move over from private coverage to Medicaid. The downside is that if they become eligible for Medicaid, they become ineligible for an APTC. This acts as an incentive to move over to Medicaid. If they beat the condition, go into remission or something like that, they then can move back into the private marketplace. That will result in about \$125M in medical claims being paid at Medicaid rates and split between the federal government and the state on a 70/30 split. The state will pick up about \$22M if approved by the legislature. This would result in approximately a 20% reduction in premiums and would help reduce rates significantly. It is not the only answer to fixing our healthcare problems. But this becomes a win-win solution where we can address the gap population and help stabilize the market.

Finally, Director Cameron said this all needs to be approved, of course, so it is not a foregone conclusion. If it is approved by the state legislature, we will then take it to our federal partners for approval. The timing is 2019 because it first needs to be approved in this next legislative session, and then carriers file their rates in June or July of 2018 for the 2019 plan year. If by the time rates need to be finalized, we don't have approval from the federal government, the length of time becomes longer.

Senator Rice made a couple of observations. He said it is not advisable to have Mr. Kelly advocating at the legislature for this. It probably is advisable to have Mr. Kelly available to answer questions that legislators have. In addition, this concept should be seen as a long shot with the legislature because it is a shuffling of the expense and is not an elimination of an expense. It would appear to require a waiver of statutory requirement rather than regulation and it doesn't seem likely that CMS would be able to waive the federal statute. There are several potential stumbling points in order for it to be a success.

Director Cameron noted that this is not yet a formal plan at this point. He looks forward to having a full presentation on this matter at a later date.

Mr. Shores said one of the problems of going from an individual plan to Medicaid is the issue of network availability. People end up having to change doctors. He also wondered if the high-risk pool could be used in these cases so that the APTC wouldn't be changed or recalculated. Director Cameron said the high-risk pool is being revamped but is on hold until these waivers are figured out.

#### ***d) Scenario Analysis***

Mr. Kelly said given all the uncertainty, Your Health Idaho is always looking at scenarios. We look at it not only from an operational and policy perspective, but also how it affects the bottom line. Given that, we looked at many different scenarios for fiscal year 2018, each mutually exclusive, but can be added together depending on the outcomes.

### **14. COMMITTEE SELF-ASSESSMENT**

Mr. Kelly said there are two elements of YHI's annual committee review. The Governance Committee requires an annual review that is twofold in nature. The Governance Committee

looked at the overall Committee structure as well as their own Committee in terms of effectiveness. The other Committees looked at the effectiveness of each of their Committees. In terms of effectiveness of the individual Committees, cadence of meetings, alignment with functional areas, the Governance Committee confirmed the structure is appropriate. They also noted the consolidation of the Committees in December of 2016, added a measure of efficiency, centralized governing and, eliminated cross-committee oversight.

In terms of individual Committee effectiveness, each of the Committees had their own internal discussions around these core questions: Are the frequency and length of meetings appropriate; do they have agendas and materials received ahead of time; do they incorporate the significant decisions; what improvements can be made and what did we do that really helped this past year. In regard to frequency, relevancy and the ability to get materials beforehand resulted in a resounding yes. The agendas, the topics were all considered very relevant to the charters. The one suggestion for the coming year would be to share discussions that may be relevant from one Committee to another. This could be a challenge due to the timing and order of meetings, but we will see what we can do in this regard.

Ms. Henbest said the Governance Committee felt the changes of the overall structure was good. Mr. Settles added that from the Finance Committee side, a reminder that in regard to compensation, there does need to be conversation back and forth in relation to budget.

***The Board took a break at 10:50 a.m. and reconvened at 11:00 a.m.***

## **15. FINANCE AND BUDGET**

Mr. Settles said the Finance Committee receives regular updates from Mr. Bell and we are running ahead of revenue projections and below in expenses and the financial become clearer as we have now utilized all our grant funds. This year, YHI had the cleanest financial audit we've seen in all our years, both on the financial side as well as the programmatic side.

Mr. Kelly said Low Cost Promise, is a measure of one of our variable pay goals on cash balance. We did have a carrier that was late on 3 months of payments and, unfortunately that check arrived one business day late. I discussed this with Chairman Weeg and decided that 12 months of effort on the part of the team should not be negated by one business day, and so the goal was paid out.

### ***a) Financial Analysis***

Mr. Kelly noted that unrestricted grant funds have all been utilized. As a side note we utilized \$102M in grant funds which was the lowest of any fully functioning state-based exchange. Fully functioning means, we have our own technology that works and we run our own operations.

Effectuations were just under 95,000 as of June month end. We have seen a slight decline since then, and with our tighter SEP validation requirements, we aren't seeing much growth. Revenue for assessment fees was \$150K favorable, driven primarily by higher than expected effectuations. We do expect to close out the last grant by October 31, 2107.

Operating income was \$1M favorable for the year driven by \$850K in grant revenue as we were able to extend the grant longer than anticipated and also \$150K in assessment fee revenues.

Operating Expenses, also favorable for the year, were driven by four primary areas. First is employee & related costs and temporary & seasonal workers by about \$900K in favorability. Outreach and Education saw \$300k in favorability in primarily due to automation of noticing. And favorability in professional services and facility costs of about \$150K in each of those areas. We did see some unfavorability in Eligibility and Shared Services but that budget was set prior to the integration of the customer support center. The important thing to take away from this for this coming financial year, we did adjust for the cost allocation model and we don't expect any ongoing unfavorability.

Finally, the project income statement, which will go way in the next fiscal year since we have exhausted the grant funds, shows \$1.5 in unfavorability centered on technology enhancements which is fully funded by grant funds.

***b) Financial Audit***

Mr. Tyree, Harris & Co., said the two items that were different from prior years were the integration of the call center and exhausting the grant funds. Harris & Co. goes through a risk-based process to issue the audit and we issue three separate opinions. The first opinion is the Management Discussion and Analysis, or the MD & A, which we don't audit. The second is the basic financial statements, which are covered under Government Auditing Standards (GAS) as well as making sure the statements are in accordance with Government Auditing Principals (GAP). That opinion is an unqualified, or a clean, opinion. That is exactly what this Board would want to see and expect.

The last part of the report is the Single Audit which contains the reports that we issue based off our compliance testing for the federal expenditures. It is also our internal control report that we issue based on our control testing on cash disbursements, cash receipts, payroll, and other control areas. Both of those opinions are unmodified, or clean, opinions. All three opinions are clean opinions and exactly what this Board would expect.

***c) Programmatic Audit***

Mr. Tyree said the Programmatic Audit, or the CMS report, was the first year that we went through all the CMS reporting and had no findings. Everything checked out, all the compliance testing was clean and we were able to issue a clean opinion. Lastly, we issue a SAS 114 letter which is required communication that if we had identified any fraud through our audit, or any disagreements with management or difficulties in performing our audit. The letter states none of that existed.

**Motion:** Mr. Settles moved that the Board, as recommended by the Finance Committee, approve the Financial Audit as presented today. **Second:** Dr. Rusche. **The motion carried.**

**Motion:** Mr. Settles moved that the Board, as recommended by the Finance Committee, approve the Programmatic Audit for the financial year 2017 and additional information contained in the report as presented today. **Second:** Senator Rice. **The motion carried.**

## **16. PLAN CERTIFICATION**

Mr. Wes Trexler, from the Department of Insurance, said on top of normal review of all plans on and off the exchange, there are additional certification standards that we review as part of the process for recommending them for certification by this Board. Those QHP Certification Standards include numerous items and one to call out that changed from 2017 to 2018 is the actuarial value. This year, the federal regulations changed to allow plans to have a wider actuarial value, or how much on average a plan cover every dollar of medical costs. For example, if a plan has 70% actuarial value, that qualifies as a silver plan and covers about 70 cents of every dollar of medical costs. Federal regulations changed it so there is a wider range of silver plans, rather than 68% to 72% it can now go from 66% to 72% actuarial value. They also expanded the bronze range with what's called an Extended Bronze which allows an even greater range of actuarial value.

Ms. Henbest asked if essential community providers, or networks, are looked at in every area of the state. Mr. Trexler said each plan has to have within their service area at least 30% of the available essential community providers and the DOI reviews this to make sure that requirement is met.

Mr. Veloz asked if the ACA compliant plans still need to maintain an actuarial value of 60%. Mr. Trexler said 60% is the bronze plan criteria and it has a 2% de minimis. CMS expanded that this year with a lower end of 56% and expanded it on the upper end to 65% and so it has a broader range at the bronze level as well.

Mr. Trexler said in 2017, 225 plans were introduced and there are now 299 plans for 2018. This includes 30 more plans in the individual market, 45 more plans in the small group market, and in dental market, plans remain the same in numbers.

Mr. Trexler reviewed the Individual Market and stated that in 2017 YHI had five carriers, and for 2018 it will be only four carriers because BridgeSpan dropped from the exchange. Blue Cross increased the number of plans for 2018 from 54 to 81. BridgeSpan went from 8 plans to 0. Mountain Health Co-op increased plans from 12 to 21. PacificSource decreased the number of plans from 10 to 6. And SelectHealth from 9 plans in 2017 to 13 plans in 2018.

There are six different rating areas for 2018. The rating areas changed slightly for 2018 and are now by county level instead of a zip code level. Each rating area does have a decent number of plans available and each area has representing all carriers except for two that have only three carriers in those areas. This shows there is adequate coverage in all counties in Idaho, unlike some other states that have counties with no coverage. As for metal levels, there are an adequate number of each in every county in the state.

Mr. Trexler said in Small Group Medical, Blue Cross went from 43 plans in 2017 to 81 plans in 2018. Mountain Health Co-op went from 12 plans in 2017 to 24 plans in 2018. PacificSource

reduced their number of plans from 24 in 2017 to 20 in 2018. And finally, SelectHealth remained the same at 14 small group plans.

Mr. Trexler said for 2018, all carriers submitted the same number of On-Exchange Dental plans. Best Life and Health has 10 plans, Blue Cross has 4 plans, Delta Dental has 6 plans, PacificSource has 15 plans, Willamette has 4 plans, for a total of 39 plans for certification in 2018.

Mr. Trexler said in review, we had 225 plans in 2017 to 299 plans for 2018.

Ms. Henbest said in looking at what's happening across the nation as compared to Idaho, it appears we are running counter to trends across the nation in terms of reduction of the number of plans, network adequacy, and available choices in certain counties. What is unique about Idaho?

Mr. Trexler said there has been some difficulty this year for other states to maintain plans in every county. On a broad sense, a lot of those are driven by some of the larger carriers that have a nationwide presence. Idaho's carriers are more regionally-based that are committed to providing service in Idaho in the individual market. They share some of the same risks and the department has worked hard to have discussions with the carriers regarding their concerns.

**Motion:** Rep. Erpelding moved that the Board accept the recommendation of the Department of Insurance and approve and certify the 299 plans as presented today as qualified health plans for plan year 2018. **Second:** Dr. Rusche. **The motion carried.**

Mr. Trexler touched on the crosswalk plans and reminded the Board that BridgeSpan is no longer participating in 2018 and SelectHealth pulled out of a couple of areas. The exchange maintains an obligation to help those individuals to maintain their coverage. As a result, DOI is providing mapped plans (cross walked) county by county for 2018, same metal level, same metal tier, then assigned those to the most similar existing plans. This will happen electronically during the enrollment process.

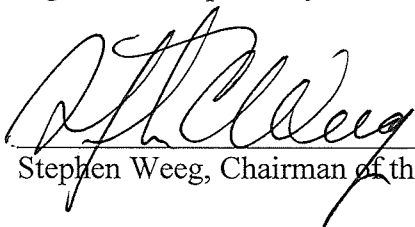
## **17. NEXT MEETING**

The Chair said the next meeting is tentatively scheduled for December 15, 2017.

## **18. ADJOURN**

There being no further business before the Board, the Chair adjourned the meeting at 11:55 a.m.

Signed and respectfully submitted,

A handwritten signature in black ink, appearing to read "Stephen Weeg", written over a horizontal line.

Stephen Weeg, Chairman of the Board