

VERBATIM PROCEEDINGS

CONNECTICUT HEALTH EXCHANGE ADVISORY COMMITTEE

JUNE 13, 2012

LEGISLATIVE OFFICE BUILDING
300 CAPITOL AVENUE
HARTFORD, CONNECTICUT

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 . . .Verbatim Proceedings of a meeting of
2 the Connecticut Health Exchange Advisory Committee held
3 on June 13, 2012 at 1:06 p.m. at the Legislative Office
4 Building, 300 Capitol Avenue, Hartford, Connecticut. . .

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8 CHAIRPERSON TANYA BARRETT: So, good
9 afternoon everybody. We'd like to get the meeting
10 started. I think today we have a pretty full agenda, but
11 we'd like to start with introductions. So, if we can kind
12 of go to the right. I'm Tanya Barrett with United Way of
13 Connecticut 211.

14 CHAIRPERSON VICKI VELTRI: I'm Vicki
15 Veltri. I'm the state healthcare advocate.

16 MS. JENNIFER JAFF: Jennifer Jaff,
17 advocacy for patients with chronic illness.

18 MR. JOHN ERLINGHEUSER: John Erlingheuser,
19 advocacy for AARP.

20 MS. ARLENE MURPHY: Arlene Murphy,
21 Fairfield, Connecticut.

22 MR. GERALD O'SULLIVAN: Gerald O'Sullivan,
23 State of Connecticut Insurance Department.

24 MS. CHERYL FORBES: Cheryl Forbes, Small

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 Business for a Healthy Connecticut.

2 MR. ANDREW WOOD: Andrew Wood, Mintz and
3 Hote.

4 MR. CHRIS KNOPF: Chris Knopf, Mintz and
5 Hote.

6 MS. KATHY MORRELLI: Kathy Morrelli of
7 Mintz and Hote.

8 MS. NELLIE O'GARA: Nellie O'Gara, your
9 facilitator.

10 MR. ROBERT CAREY: Bob Carey, consultant
11 to the Exchange.

12 MS. TIA CINTRON: Tia Cintron, acting CEO
13 of the Exchange.

14 MR. JASON MADRAK: Jason Madrak, the
15 director of marketing and communications for the
16 Exchange.

17 MR. ROBERT SCALETTR: Bob Scalettr,
18 Exchange Board member.

19 MR. SHELDON TOUBMAN: Sheldon Toubman, New
20 Haven Legal Assistance Association.

21 MS. CEECEE WOODS: CeeCee Woods, I'm a
22 member of the Health Insurance Exchange.

23 MS. SARA FRANKEL: Hi. I'm Sara Frankel,
24 I'm with the National Alliance on Mental Illness of

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 Connecticut.

2 CHAIRPERSON BARRETT: Great. So, we'll
3 start with the review and approval of the minutes. Can
4 we get a motion to approve?

5 MS. JAFF: So moved.

6 MR. ERLINGHEUSER: Second.

7 CHAIRPERSON BARRETT: Great.

8 MS. MURPHY: I have a question about the
9 minutes? Are we okay for discussion?

10 CHAIRPERSON BARRETT: Discussion.

11 MS. MURPHY: Okay. Thank you. The
12 minutes for the previous meeting made basically just some
13 cursory reference to the concerns about the KPMG
14 assessment of consumer -- the consumer assistance
15 program. And there were a number of concerns that were
16 listed from that presentation. And I know that there is a
17 list under development, but my question about the minutes
18 is will those concerns be entered into the formal record
19 once we have them to make sure that they are addressed
20 because they were significant.

21 MS. CINTRON: Yes, we can -- I mean we
22 need to look at that. They're not here so I'm not sure
23 the status of answering those, but we can get back to
24 you.

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 MS. MURPHY: Yes, I'd appreciate that.

2 MS. CINTRON: Okay.

3 MS. MURPHY: Because I was -- the one
4 thing I was worried about was that very often the key
5 observations from a technical report will then lead into
6 the contracting requirements and I know they were moving
7 -- I don't know fast that was moving forward, but there
8 were -- I wanted to make sure that whatever their
9 recommendations were that something didn't wind up going
10 into the Request for Proposals or something that was not
11 consistent with the concerns.

12 MS. CINTRON: Okay. We'll look into that
13 and loop back with the Chairs.

14 MS. MURPHY: Thank you, that's great.

15 MS. CINTRON: Yes.

16 MS. WOODS: Also, CeeCee Woods, I was here
17 with the exception of five minutes for the last meeting
18 so if the minutes could note that, yes.

19 MS. O'GARA: Okay, so with those changes I
20 think, Tanya, you could take a vote.

21 CHAIRPERSON BARRETT: Great. So, I think
22 we had someone with a second. Great. So all in favor?

23 ALL VOICES: Aye.

24 CHAIRPERSON BARRETT: Nays? Abstentions?

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 Great.

2 So, next is the Mintz and Hote update.

3 So, I'm not sure who is leading that.

4 MR. KNOPF: Thank you. I'm delighted to
5 report that virtually all the content is going to be
6 handled by my colleagues today. So, I'm privileged to be
7 able to introduce them and then step back and let them do
8 the work. First off, well, we'll be going through the
9 stakeholder discussions to give you an update on that,
10 which is quite far along the way. We'll give you an
11 overview of the consumer research with some preliminary
12 directions that have already come out of that, and then
13 an update on our bridging communications. So, we'll start
14 with the stakeholder discussions and Kathy Morrelli, an
15 account executive at Mintz and Hote who is overseeing
16 that effort, will give you a report.

17 MS. MORRELLI: Good afternoon everybody.
18 I believe that most of those in the room here today are
19 familiar with the stakeholder discussions that we've been
20 holding. For anybody who is not up to speed on those,
21 we've been conducting these activities since February
22 through the present. These have really been focused on
23 allowing Mintz and Hote to speak directly with
24 stakeholders involved with the Exchange, and by

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 stakeholders I mean consumer advocates, small employer
2 advocates, healthcare providers throughout the state,
3 insurance carriers as well, and agents and brokers. Our
4 aim has been to ask them to project, for the constituents
5 who they represent, current perceptions of the healthcare
6 industry and health insurance industry, specifically, of
7 health reform, identify any concerns or confusion that
8 there is so that that can help us focus some of our
9 messaging as we develop it, and so that we can better
10 identify vehicles to communicate this information and
11 educate consumers throughout the state about the health
12 insurance exchange.

13 So we've been conducting a series of in-
14 person dialogues, one-on-one phone interviews and at
15 times in-person interviews as well. And more recently we
16 conducted a series of Webinar discussions, five to be
17 exact, focused on these areas. They've been going quite
18 well. We've spoken with a total of 114 stakeholders
19 throughout the state. Those are unique stakeholders, so
20 we've actually had additional discussions. At times we've
21 had follow up conversations with stakeholders. So, in
22 some cases we're having multiple touch points with
23 people.

24 What you can see on the bottom of the

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 screen here is that it's a quick chart to give you an
2 idea of the amount of people that we've talked to and how
3 that's broken out. So, you can see the heaviest amount of
4 activity is focused on consumer advocates as well as
5 small employer, consumer advocates and healthcare
6 providers, excuse me, as we feel that these are the
7 people who have the closest connection with the people
8 that we're trying to speak with.

9 We've also undertaken a primary consumer
10 research effort. This has included a series of focus
11 groups as well as one-on-one interviews. We've been
12 focusing specifically on speaking with people who are
13 currently uninsured. So they're not on state programs.
14 They're not insured through their employers. Maybe
15 they're working part time or they're unemployed for
16 various reasons they don't have insurance. We've been
17 focusing on the folks who can benefit the most from the
18 Exchange through the financial subsidies, so that 139
19 percent to 400 percent of the federal poverty limit
20 range, and people 25 to 64 years old.

21 Many of the groups that we've done we've
22 juxtaposed them in different ways. For instance, we've
23 had focus groups with males and then females. We've had
24 focus groups with younger audiences and older audiences.

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 And we've had focus groups with people who are
2 individuals and people with families so that we can start
3 to see some themes and differences in their feelings and
4 reactions to some of the test stimulus or test materials
5 that we've shown to them. So far we've spoken to a total
6 of 77 consumers. Yes?

7 MS. JAFF: I didn't know if you wanted me
8 to wait till the end with questions or if you wanted me
9 to interrupt.

10 MR. KNOFF: Whenever you wish.

11 MS. JAFF: Since I've interrupted you, so,
12 in terms of the first bullet I get why you're looking at
13 that population, but I was reading an article this
14 morning about the Massachusetts Exchange and the issues
15 they're having getting the Exchange to be solvent because
16 they've really done a very good job of recruiting people
17 who need subsidies and who can't afford insurance and all
18 that. But they haven't been able to do as effective a
19 job with people who are fully paying and small
20 businesses. So, I'm -- so along those lines I would be
21 concerned if you didn't, at some point, perhaps not now,
22 and maybe you plan to do this, but to widen that out to
23 people who would not be eligible for subsidies and also
24 small businesses in terms of, you know, what will bring

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 those consumers to the Exchange because in order for the
2 Exchange to be successful and solvent we need those
3 people to be part of the Exchange.

4 MR. KNOPF: Yes, we definitely agree with
5 that and we will be expanding out.

6 CHAIRPERSON VELTRI: I have sort of a
7 follow up question too based on a discussion I had with
8 somebody who was on one of the calls, I think it was a
9 small business call. And it's more on what the actual
10 focuses of the calls are. There was some concern raised
11 that maybe the call was maybe more about what the
12 Exchange should look like instead of how we get
13 information out to people. And so maybe if you could just
14 like backtrack and tell us, again, exactly what the focus
15 is of your work visa a vie the Exchange. Is it to
16 educate people about the existence of the Exchange and
17 what their opportunities are, or is it about more than
18 that? Just to clarify for --

19 MR. KNOPF: -- yes, I think it's three-
20 fold. It's to educate about the Exchange. It's to provide
21 the opportunity for the stakeholders to give their input
22 into what's happening and what they'd like to see. And
23 that was really -- I would say that's really the primary
24 purpose. The education part has evolved as people have

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 asked questions and as we have more we can educate with.
2 And then the third fold is to link us back out to broader
3 constituencies. So, if you, for example, if you have a
4 small business advocate that person can then put us in
5 touch with key people within the sort of small business
6 community that they're working with. So that also has
7 evolved as we've gone along. And those are the primary
8 purposes of these.

9 Since this is a work in progress and since
10 we've, things are developing and evolving and progressing
11 as we've gone along, it's become much more of a richer
12 educational experience than it had been at the beginning.
13 It was more of an input effort. So that's in a nutshell.

14 MS. MORRELLI: In the upcoming weeks we
15 will be focusing on -- so, as you can see, we've spoken
16 with people from four out of eight counties in
17 Connecticut. So we still have some work to do. We're
18 going to be focusing our efforts on making sure we have
19 representation from the other areas of the state, the
20 other counties of the state as well as we want to focus
21 on some of the folks in the state who represent people
22 living with chronic illnesses, mental illness, as well as
23 people who better represent a more diverse ethnic
24 background. So, please know that we are working on

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 recruiting, identifying, with your help if you can, folks
2 who we may be able to benefit from speaking to who represent
3 those groups.

4 MR. KNOFF: And I think the next time we'd
5 be discussing upcoming, after we've gone through that
6 group, small business was our next up. We've spoken to a
7 lot of small business, but nowhere near as much as we
8 need to. Mostly it's been advocates of small business not
9 the business owners themselves. But since this is an --
10 process meaning with every group that we do we refine our
11 message and with our core audience make sure that's
12 covered appropriately that gives us a much more
13 creditable and a more effective basis on which to talk to
14 the subsequent audiences. So that's why we're staging it
15 the way we are.

16 CHAIRPERSON BARRETT: Danielle, did you
17 have a question?

18 MS. WARREN: Yes. With finding these
19 consumers is it a possibility or is it being thought
20 about to go through the Medicaid system for those folk
21 who are found ineligible or who are put on spend down
22 because they, at that point, are uninsured? And it would
23 give us a bigger range of different ethnicities. Also by
24 going that route because I kind of skipped ahead and I

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 looked at your chart and I'm like who did they talk to,
2 you know, and there were very few from the Hartford
3 county, where I live. but I do know that we do have
4 people who slip through the cracks when they don't
5 qualify for Medicaid because they're low working, low
6 income working folks, or they're put on a spend down and
7 have to generate let's say \$3,000 worth of bills before
8 Medicaid will kick in. So, it's a really good resource
9 to use.

10 So I don't know if within the Medicaid
11 system we have advocates who are there working closely
12 with that system to be able to reach those folks to say,
13 okay, do you know that this is available, that is
14 available. You know, what's happening to those or are
15 they in limbo. And a lot of times, through my work, I see
16 that they are in limbo and they're trying to just
17 generate the bills. They're worried about generating the
18 bills because it's like they have to get the bill. It has
19 to be sent to them for labs, or doctor visits, and things
20 like that. And on the same token physicians, or these
21 institutions, facilities are a little leery because it's
22 like, okay, we want to get paid too. You know what I'm
23 saying. So, and what we do is we say, well, just give
24 them the service so that it can kick in and then be retro

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 hopefully once the Medicaid kicks in. But those folks --
2 and there is a good many that are in limbo because they
3 don't qualify for Medicaid at the time of application.

4 MR. WOOD: Hi, I'll address that. We
5 picked up several people within that group who are on
6 Medicaid primarily through recruits from the Community
7 Health Centers. The core of the research, at this point,
8 is around that 139 to 400. But actually to Jennifer's
9 point and your point, we are, through our stakeholder
10 interviews and various meetings with the Committee,
11 identifying sort of smaller groups or micro groups that
12 we do need to talk to. And we're quite willing to step
13 out and facilitate those that would be invited by, I'll
14 mess the acronym up, the American Civic Association, and
15 they're going to help us facilitate a group with their
16 folks. Now that's a small community within the
17 demographic of the state, within the target, but I think
18 it would be very valuable for us to get out and
19 understand the cultural nuances, differences that exist
20 there.

21 The same can be applied to your audiences
22 and I'm happy to cite those details and go back and fill
23 some of those interviews in. And we will cover who we've
24 spoken to in the various counties and I'll think you'll

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 find Hartford has been, and will be, pretty well covered.

2 MR. KNOFF: The other thing that's
3 happened in the natural process of the recruitment
4 process is the net sometimes brings in people who
5 absolutely float between Medicaid and uninsured. So
6 what's happened is some people are currently uninsured,
7 but they were on Medicaid so they can speak to that and
8 vice versa. So, it's -- even if we didn't target that
9 group we've been getting them as individuals as we've
10 gone along.

11 We've also spoken -- we also had a very
12 productive group, meeting with social workers who are
13 advocates for the Medicaid population actually down in
14 Middlesex county. So that's not -- they're part of our
15 stakeholder effort, but it really gave us some good start
16 in terms of getting closer to that Middlesex county world
17 because that's where we took, we did that interview. So
18 we've gotten insights along the way and as Andrew said
19 when we get to -- when we get near the end of this
20 process we can go back over and the Committee can give us
21 guidance as to where we need richer information.

22 MS. MORRELLI: This is just a very quick
23 look at the research schedule that we've been working off
24 of. This is not comprehensive. As new interviews and

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 opportunities for focus groups are identified they will
2 be added to this. It's just a quick snapshot.

3 I think we can move forward to the next
4 slide. I know Andrew wants to share just a quick look
5 into some of the activities or some of what we've been
6 learning so far.

7 MR. WOOD: Yes. Thank you. It's actually
8 been a privilege to step out and deal with such a
9 meaningful message. These are general themes that are
10 occurring throughout the research. General themes, there
11 are -- and we've been joined and there has been a
12 terrific process with our colleagues at Basser, a
13 multicultural agency. They've been conducting interviews
14 also. So what -- most of these are the general themes
15 I'm going to discuss very quickly. There are absolutely
16 cultural nuances that can be dealt with at various phases
17 during the communication process.

18 But there are also consistent themes and
19 that's the good news, consistent themes occurring through
20 groups and interviews. And first, you're looking at the
21 group we've been talking to, there are two particularly
22 important groups that set distinct, very distinct
23 communication challenges. Firstly, people with
24 dependents. People with loved ones and dependents become

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 a very different audience. They're acutely aware that
2 their family needs insurance, but they don't believe it's
3 affordable. The good news is there. We are not out there
4 in communications having to sell the need for healthcare.
5 We're not out there having to sell the need for
6 insurance. They know they need it. It's access and
7 opportunity that's the problem, and primarily the problem
8 is they don't believe it's affordable. Those are the
9 issues we have to address there. And we will need to
10 overcome a good deal, a great deal of skepticism and
11 bitterness around that. There are people out there who
12 have had insurance that no longer have it and are quite
13 bitter. And people skeptical they can ever be affordable.

14 Alternatively, a very different
15 communications challenge are single men. They've been,
16 quote, invincible and they are a valuable audience, but
17 they're a distinctly different audience. They just don't
18 want it. They don't believe they need it and they don't
19 want it. So, the challenge from communications will be
20 very different.

21 We've been using various communication
22 stimulus to find this out and it's been fascinating.
23 There are many phrases, terms, words, visuals that
24 actually can quite quickly generate hostility, and in any

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 process like this is it's often about what you -- there
2 are plenty of things you don't want to say, and you can't
3 say rather than what you do say. For example, things I
4 would have thought would have been attractive, financial
5 assistance. People find that extremely offensive. Saying
6 it's easy, and the Exchange is an easier way for people
7 to start accessing insurance. That is not a good word.
8 People are skeptical and they don't believe any insurance
9 can be possibly easy. The word insurance is loaded and
10 creates a whole to do.

11 So what does that mean to us? The good
12 news is there. Healthcare coverage can cover with that.
13 So we're starting to find the words, and the stimulus,
14 and the visuals that are most attractive. And, frankly, I
15 should have included in there telling people it's the law
16 and that they're legally obliged is a no-starter. I mean,
17 at some point, we're responsible to have that somewhere
18 in the communications, but that is not the way to lead
19 this campaign.

20 The category noise, by that I mean all the
21 advertisements on TV, in print, wherever you go category
22 noise has created a lot of misconceptions. You think
23 about Montel Williams with the pharmaceutical folks, you
24 think about all the insurance company ads out there, if

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 we look like that and sound like that we will fail, no
2 question. We need to distance the program from the "To
3 Good to be True" commercials. That skepticism I spoke
4 about is very real, very tangible, and that's the
5 reaction. This is "To Good to be True" surely.

6 Everything -- so when you start to
7 consider the message hierarchy, the kind of message that
8 you want to tell, and the support messages you want to
9 tell, you won't get to tell any message unless you deal
10 with that first question and that first issue. Everything
11 starts with affordability. That might not be surprising,
12 but affordability is a very frightened loaded word. It
13 has to be dealt with very carefully. It can suggest, on a
14 positive side, opportunity, access, and choice, which are
15 wonderful things. But it can quickly create a good deal
16 of skepticism unless it's made tangible and meaningful to
17 all audiences. So there are premiums, there are co-pays,
18 there are all sorts of facets that go into healthcare
19 insurance costs. People want proof very quickly, or
20 they'll look at, and they'll move on and move on in a
21 fairly hostile manner quite honestly.

22 Finally, and I thought this was
23 fascinating, we tested with and without. People want the
24 State of Connecticut involved, but the role of the state

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 seems to be oversee, to sort of manage, curate if you
2 like, the insurance companies. They're always oversee
3 and provide funding not manage the program. Lots of
4 references to various Medicaid issues, various Husky
5 issues. If this comes up they don't want the state to be
6 managing the programs, they want the state to be
7 overseeing it. So we are -- people want the coverage
8 private plans provide.

9 We must avoid the perception that the
10 private plans are offering a compromise, in any way, if
11 provided through a state program. So many people said,
12 yes, okay, but is this insurance company light. Am I
13 getting a plan that is a light version of what people
14 with private insurance are getting? We need to avoid
15 that perception. There is lots of ways to fall into
16 that, but we think we know how to avoid that.

17 And, finally, outreach will need to
18 quickly educate and drive to a resource to find out more.
19 It's not surprising. I talked about people's need to
20 understand affordability in a tangible manner. So we
21 need to think to continue, or the communications from the
22 initial outreach be it advertising leaflets, brochures,
23 and how to tie in effectively with the website being
24 created. All those things will need to work in harmony,

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 and that's the perfect word there. The role, without
2 doubt, the role of informed, and I say well equipped
3 community leaders, will be vital to the creditability and
4 vital to enrollment figures.

5 So, Vicki, I think you asked about the
6 small business discussion group the other night. A large
7 part of the focus for us was understanding what type of
8 materials those stakeholders, those people in the front
9 line need to take the message to the small businesses. So
10 understanding how we can equip them, the messages, and
11 the material they need will be vital. This program will
12 be won on that one-to-one stakeholder to constituent
13 level.

14 Thank you.

15 MS. O'GARA: I think Sheldon has a
16 question.

17 MR. WOOD: Sure.

18 MR. TOUBMAN: There is -- thank you for
19 that summary. I think there is a bit of a conflict in
20 two of the themes though. One is, as you said,
21 everything starts with affordability. People are really
22 skeptical about that. That's a really huge issue. I
23 think it's the primary issue. As you said, people
24 already recognize the need to have coverage. But the

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 other thing is when you were talking about, which of
2 course I work mostly in the Medicaid program so I know
3 the certain perceptions and stigmas and all that, you're
4 saying that people don't want it to be state administered
5 or whatever. If we don't get a basic health program then
6 it will not be affordable for the lower end people. So
7 you're going to have a really hard time with your
8 messaging that it's affordable if when people see what
9 the premiums and the companies are they say, they throw
10 up their hands and say, I can't afford that. It's going
11 to completely undercut your message.

12 MR. WOOD: Yes.

13 MR. TOUBMAN: If we get the basic health
14 program it should be affordable. So it won't be
15 misrepresenting that to call it affordable, but in that
16 event it would most likely be administered through the
17 state somehow, perhaps most likely through Community
18 Health Network, the administrative service organization
19 that we now went to as of January for Medicaid. But it
20 would be administered by the state and so that runs into
21 a conflict with your other theme, which is that people
22 don't like to hear that. Do you know what I'm saying?

23 MR. WOOD: I do.

24 MR. TOUBMAN: Yes.

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 MR. KNOFF: Well, we wouldn't be overtly
2 saying the state is not administering, the state is only
3 curating or whatever. I think that has to be implied. I
4 think if you -- as long -- and, again, these are
5 preliminary, but I think -- and it depends on -- these
6 audiences' reaction to the state vary a lot from audience
7 to audience. So it's not a monolithic feeling at all. I
8 think if -- the point is that this is good quality,
9 honest to gosh insurance that my well-off neighbor down
10 the street gets through his private employer that will go
11 a long way toward -- and that the insurance companies are
12 involved in this thing. See people dis insurance until up
13 and to the point when the products are out there and they
14 go, I don't like these people but I want what they sell.

15 So, there is a little bit of a dichotomy there too in
16 people's mind. But I think if that comes across that will
17 go a long way toward maybe satisfying that issue, if I
18 answered that correctly, clearly.

19 And you're right though, excuse me, you're
20 right though the program has to -- I mean as
21 communications people we're going to tell you what we
22 think the message has to be. But the program people are
23 going to -- it's going to come down to the product itself
24 and it needs to be affordable.

POST REPORTING SERVICE
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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 MS. WARREN: I have a question, because
2 I'm learning here so I just need clarification for
3 myself, you said one of the messages that are kind of --
4 it's kind of resisted is being told that it's -- that you
5 have to have this. So it is a law that you need to be
6 insured or -- because I know that was a part of this
7 whole thing from the Obama and that it would be law that
8 you must have medical coverage. So that is in place, it's
9 the law?

10 MR. WOOD: I believe it is ultimately
11 going to be in 2014 you are legally obliged to have
12 health insurance. That's a fact. I know we are fairly
13 diligent about learning from other states and from
14 Massachusetts and Maryland's experience, they too found
15 the same thing, you tell someone you are, it's the law,
16 you must get covered it's not an attractive way to
17 introduce the program to anyone, to say the least. And we
18 have tried that. We did feel obliged to step out and do
19 it and very, very quickly we just ran into a complete
20 brick wall on that one.

21 MS. WARREN: So, if it's the law then it
22 becomes your right. So maybe --

23 MR. WOOD: -- it's actually the law, I
24 believe.

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 MS. WARREN: It becomes your right to have
2 affordable insurance coverage. If it's the law does it
3 become a right? Do you understand what I'm saying?

4 MR. WOOD: I do understand what you're
5 saying.

6 MS. WARREN: And if that's the case then
7 that is a different take on it. It's an empowerment
8 statement, like this is your right, as opposed to you
9 have to. Do you understand what I'm saying?

10 MR. WOOD: Yes, I do actually. Yes, I do.
11 And that's an interesting thing that actually emerged
12 last night was the idea of empowerment. It's a different
13 take on it, but I thought the question was we did try
14 things where we're warning people of their legal
15 obligations, that's what I meant. So when we say it's
16 your legal obligation to get healthcare insurance, it's
17 the law that didn't work.

18 MS. WARREN: Right.

19 MR. KNOPF: It's even worse than that
20 because we took it out because I think we proved that it
21 wasn't going to work, but what it also did is it just
22 ruined all the other messages. People's brains just shut
23 off and they didn't even want to look at anything after
24 that. So, it's just -- it's a non-starter.

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 MS. MORRELLI: One last slide, just a
2 quick update on the bridging communications program that
3 we've been providing progressive updates on, again, to
4 keep stakeholders informed as we move forward and make
5 progress with the Exchange. A lot of this hinges on
6 launching the website which we're aiming for a target
7 date of June 21st to be able to share an actual
8 interactive look at the site on line with real content in
9 place. With that said, postcards and the beginning of
10 the email campaign, or email updates will start very
11 shortly thereafter. They just hinge and require that the
12 site would be in place for us to start pushing those out.

13 MS. O'GARA: Thank you, folks for being
14 sensitive to the time.

15 CHAIRPERSON VELTRI: And before we move
16 on, we need to dial in because there is somebody who has
17 been trying to get in and has not been able to access the
18 phone thing. So before we move onto the next discussion -
19 - thanks, Amy. Go ahead, ask a question while we're
20 dialing in.

21 MS. MURPHY: One of the things we talked
22 about previously, Kathy, was the ability to do maybe some
23 sort of two-way communication that once you do the launch
24 website and send out the postcard that there is some way

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 to loop people back in that once -- it's not just a one-
2 way communication, but there is some way that they can
3 then turn and link in somehow. Has there been any further
4 discussion of that? Maybe linking people together from
5 different communities, you know?

6 MS. MORRELLI: I think you may be
7 referring to what we discuss as a feedback form that
8 would exist on the website, which would allow people,
9 anybody really to write in questions, comments, feedback
10 and that gets delivered to the Exchange team. That is
11 still planned for the website. So that will be an
12 opportunity.

13 MR. KNOFF: And an encouragement for
14 people to express their opinions and sort of -- alter the
15 content.

16 MS. MURPHY: I think that having the
17 possibility of saying, you know, once you have people who
18 have questions or concerns that there is a possibility --
19 because I think that one of the ways to make this
20 effective is to have people in various localities
21 throughout Connecticut kind of connect with one another
22 to start working towards this and doing outreach that
23 once you have these names and ask, maybe one of the
24 questions would be would you be willing to be put into a

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 list of local people who are willing to work to improve
2 insurance in your community. Something like that, an
3 action step so that maybe those lists might be available
4 to improve outreach.

5 MR. KNOPF: That's a really, really,
6 really good idea. I really agree with what you're saying
7 and I think we should take that seriously and work on
8 something that way. And I think maybe social media is one
9 place where that can facilitate that.

10 MS. MURPHY: I didn't even think about
11 that.

12 MR. KNOPF: It's kind of a natural. And we
13 have -- that's a whole another thing that we're done --
14 we have a report ready. We have to -- we're just wrapping
15 that up, so we're getting closer where we can launch some
16 social media activities.

17 MS. MURPHY: Okay, thank you.

18 CHAIRPERSON VELTRI: So before we go on,
19 can we introduce -- the person on the telephone, can you
20 introduce yourself, please? Kevin, are you there? Have
21 we got somebody joining us?

22 MR. KEVIN COUNIHAN: Yes, it's Kevin
23 Counihan.

24 CHAIRPERSON VELTRI: And, Kevin, are you

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 joining as a member of the public?

2 MR. COUNIHAN: Yes.

3 CHAIRPERSON VELTRI: Okay. We were just
4 getting on with the major part of our agenda, so if we
5 can close up on the Mitz and Hote presentation and move
6 into the EHB discussion. Bob is going to take us through
7 this and I'm going to turn it over to you.

8 MR. CAREY: Thank you. So this is the
9 second -- this is a follow up to the meeting we had in
10 May with regard to the essential health benefits. Just to
11 sort of level set what we're talking about with regard to
12 the essential health benefits are the package or is the
13 package of benefits that will be provided starting in
14 2014 for plan years 2014 and 2015 at a minimum for the
15 individual and small group market. It is not cost
16 sharing. It is not medical management. It is not prior
17 authorization. It's not all of the things that go into an
18 insurance coverage. It's the underlying base package of
19 benefits that will be available to every one who
20 purchases coverage through the Exchange or outside the
21 Exchange in the individual and small group market.

22 So if folks start to go down a path of
23 cost sharing issues I'm going to steer you back onto the
24 path of essential health benefits cost sharing. And how

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 the packages are structured will be a subsequent decision
2 made by or recommendation made by the Advisory Committees
3 and then forwarded up to the Exchange Board.

4 Another point to make is that the lead
5 committee on this issue is the Qualified Health Plans
6 Committee, but there are sort of doing this in tandem
7 with the Consumer Outreach and Education Committee
8 because we felt it was critical to have the voice of the
9 consumer outreach and education group having their say in
10 the recommendation that would be promoted up to the
11 Exchange Board. So we met on Friday with the Qualified
12 Health Plan Committee. We went through all the materials
13 that we sent to you. This is the exact same materials we
14 sent to the Qualified Health Plan Committee. They had
15 some follow up issues that we are chasing down. And I
16 thought that perhaps rather than prejudice the discussion
17 going forward we would go through this discussion, have
18 your feedback, and then at the end sort of update you on
19 where the Qualified Health Plans Committee is moving in
20 terms of the direction that they'd like to take with
21 regard to next steps. So if that's okay with the
22 Committee we'll structure the discussion that way.

23 So we went you, you know, a package of
24 information. Hopefully you had a chance to go through

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HAMDEN, CT (800) 262-4102

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 it. We've also provided it to you at your desk here.
2 There were some revisions to the table in terms of
3 services covered. I believe we've highlighted those in
4 the package of materials. I would suggest it was not sort
5 of major line items in terms of what's covered and what's
6 not covered, but of a bit more refinement in terms of the
7 level of detail.

8 So, sort of a roadmap of the agenda for
9 this part of the meeting is, you know, an overview of the
10 process for making recommendations to the Board of the
11 Exchange. Clarification of a few EHB requirements that
12 came out of the last discussion that we had, a discussion
13 of state mandated benefits in these essential health
14 benefits package, some sort of guiding principles and
15 decision criteria of the guiding principles of the -- the
16 guiding principles that you have already agreed to with
17 regard to the Committee's guiding principles. And then
18 we've added some suggested decision criteria with regard
19 to the essential health benefits package just for
20 discussion purposes, then to go through the benchmark
21 options and the next steps. So we have quite a bit to go
22 through. My preference is that we have questions as we go
23 along as opposed to waiting until the end. So, if, you
24 know, something that we talk about you'd like to discuss

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 further just interrupt.

2 So the process itself sort of May, June,
3 early July we have advisory committee meetings to review
4 the options that are available to Connecticut and to come
5 up with a recommendation. It's our proposal that the
6 final sort of recommendation from the advisory committees
7 be done in a joint meeting with the Qualified Health
8 Plans Committee so we get everyone around the table to
9 hopefully they'll be, at that point, sort of a consensus
10 about which benchmark option to chose and we can move
11 that forward to the full Exchange Board hopefully in time
12 for the July meeting. We'll see at the end of this
13 meeting whether you feel comfortable with that timeframe.

14 Just so you know, the federal government
15 in the bulletin that it issued with regard to EHB
16 indicated that states would need to make a decision by
17 the third quarter of 2012 or the feds would make that
18 decision for the state. We had our gate review a few
19 weeks ago and talked about this issues, as you might
20 imagine, and when we indicated that we were looking for a
21 September 2012 decision they said, well that, you know,
22 that might not be soon enough. So, you know, we may issue
23 our decree sometime before then. I don't think that's
24 going to happen, but I just wanted to let you know that's

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 the message that they gave us. I'm sort of just passing
2 along that message.

3 So the current thinking is we would have
4 it in time for either the July or hopefully no later than
5 the August Board meeting of the Exchange. That
6 recommendation then would go up to the state in the form
7 of the Governor's office and the Commissioner of
8 Insurance because, again, it affects not just the
9 Exchange and while we think that this is the proper venue
10 to vet these issues and to come up with an option, the
11 Exchange isn't empowered to make a decision on behalf of
12 the state. So I think we talked about the last time. I
13 think that there are enough stakeholders and the Exchange
14 is made up of, obviously, the insurance department and
15 the Lieutenant Governor and other key stakeholders, and
16 so we're thinking that it probably will be consistent
17 with the recommendation. But it's just with regard to the
18 letter of the law and with regard to the guidance from
19 the feds they're assuming that the decision on an EHB for
20 a particular state will come from either the Executive
21 branch, the Governor's office, or perhaps the
22 Commissioner of Insurance, so just a level set on that.

23 So there are a few issues we wanted to
24 clarify. One was the issue of prescription drugs. So, as

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 you know, prescription drugs must be covered as part of
2 an essential health benefits package. Most health plans
3 in the State of Connecticut sell the drug benefit as a
4 rider. So that means that someone can purchase the
5 medical benefit and not purchase a prescription drug
6 benefit. Or they could purchase from the same company,
7 from United, or Connecticare, or Anthem they could
8 purchase a combined package, but the drug benefit is sold
9 as a rider. That's important because the way that the
10 federal guidance has come out it has -- CCIIO's current
11 position is that if a state selects a benchmark option
12 for which drugs are sold as a rider you can't combine
13 that carrier's drug rider with that carrier's medical
14 benefit. You have to go to another of the essential
15 health benefit options.

16 So when we looked at the ten options that
17 are available to Connecticut most of them sell the
18 prescription drug benefit as a rider. So if we selected
19 a benchmark plan that doesn't include prescription drugs
20 there are essentially two options available to us under
21 the current guidance. And I stress current because these
22 are sort of a fluid situation and CMS is sort of
23 constantly revisiting issues. But as it currently
24 stands, the state would need to pick from either the

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 Oxford PPO, which is one of the small group options that
2 are available, and base its prescription drug benefit on
3 the Oxford PPO drug benefit, or the federal employee
4 health benefit plan prescription drug benefit.

5 I can tell you that looking at the Oxford
6 drug benefit and looking at the federal employee drug
7 benefit in terms of the openness of the formulary they
8 were relatively comparable. There is not, you know, a
9 significant difference between the breadth of the
10 formulary for the Oxford PPO and the breadth of the
11 formulary for the federal employee health benefit plan.
12 So, it may be a difference without a distinction, but I
13 just, for our purposes, if we were to select a plan other
14 than Oxford and the federal employee plan for the base
15 medical package we would have to then pick either Oxford
16 or the federal employee plan for the prescription drug
17 benefit. And not in terms of the exact formulary, but
18 rather in terms of the types of drugs and the categories
19 of drugs that would be covered. And the feds are coming
20 out with additional guidance on this as well.

21 CHAIRPERSON VELTRI: Bob, could I just ask
22 you to maybe -- many of us are used to a lot of these
23 abbreviations, but everybody may not be. So, when you're
24 using one, even PPO, you may just want to explain to

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 people what it is.

2 MR. CAREY: Good point. So, yes, a PPO is
3 a preferred provider organization plan. It essentially
4 provides -- it allows an individual who is enrolled in
5 the PPO to seek care from what's called in-network
6 providers. So that would be providers who have actually a
7 contractual relationship with the carrier. But if someone
8 wanted to see a provider, a doctor, a hospital that
9 wasn't part of the network they could access care from
10 outside of the network. They would pay more for that
11 ability to access care, but they could access care from a
12 non-network provider as opposed to a HMO or a health
13 maintenance organization where you don't have access to
14 non-network providers other than if the in-network
15 providers aren't able to treat a given condition there
16 might be some access provided. But in general you have a
17 limited network or you have a network of providers in a
18 HMO whereas in a PPO you have that network and you also
19 have the ability to seek care outside of the network.

20 So that's the drug benefit issue, just
21 sort of for us to think about when we're going through
22 the options.

23 The second question or issue came up with
24 regard to drugs is on specialty drugs and whether the

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 options available cover specialty drugs. I can report
2 that both Oxford and the federal employee health benefit
3 plan cover specialty drugs. They may be on a separate
4 tier again for cost sharing purposes, but because we're
5 not sort of dealing with cost sharing purposes I want to
6 make sure that, you know, we don't view it through that
7 lens but rather does the drug benefit include coverage
8 for specialty drugs. And you can see so this is the
9 FEHBP, the federal employee health benefit plan,
10 description of what's considered a specialty drug. And
11 they put it on a specialty tier where there is additional
12 cost sharing for those, but, again, because cost sharing
13 is not an issue right now both Oxford and the federal
14 plans include specialty drugs.

15 A second issue came up with regard to
16 supplementing the essential health benefits package. So,
17 the last time we went through the ten categories of
18 services that must be covered as part of the essential
19 health benefits package. Sort of two and a half of those
20 categories aren't typically covered in a commercial
21 health plan. Habilitative care as opposed to
22 rehabilitative care, and we'll talk about that, and then
23 pediatric dental and pediatric vision.

24 So there will be typically some limited

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 pediatric dental or some limited dental and limited
2 vision, but in terms of a relatively comprehensive
3 package of care cover under pediatric dental and
4 pediatric vision most commercial insurance doesn't cover
5 these types of services. You have to buy a dental plan or
6 a vision plan. But because it is a category, these are
7 included in the ten categories of care, the feds have
8 identified these three benefits as potentially ones that
9 would need to be supplemented. So when we go through the
10 ten options we'll point out that there is sort of a
11 deficiency in habilitative, pediatric dental, and
12 pediatric vision and we'll talk about how we might
13 supplement those categories with additional types of
14 benefits.

15 So, habilitative as opposed to
16 rehabilitative it generally deals with learning new
17 skills or functions as opposed to rehabilitative which is
18 you were able to do something, you were in an accident or
19 had a condition that does not allow you to do things that
20 you did before, and so you're rehabilitating yourself so
21 that you can perform those functions. Habilitative is
22 you never were able to do certain things. So, it might
23 be a child who doesn't know how to speak, who hasn't
24 developed the ability to speak. There wouldn't be a

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 rehabilitative benefit, but there would be a habilitative
2 benefit.

3 And so, the -- has recognized this and in
4 the guidance that they put out they basically put forward
5 two options that would be available. Right now the
6 thinking is, at the federal level, that the carriers
7 could decide what those -- how best to cover habilitative
8 services. The first is that they would cover it on par
9 with their benefit for rehabilitative services. So, if
10 there was a speech therapy benefit of 20 visits per year
11 or, you know, 30 visits per illness or condition for
12 rehabilitative then you would apply that same criteria
13 for habilitative services. So that's one option that they
14 have on the table.

15 The second is for the plans to decide
16 individually which habilitative services to cover, and
17 then report that coverage to HHS. Again, we were in
18 Washington a couple of weeks ago, we suggested that they
19 may want to rethink this and they may want to put some
20 ability for the state or the Department of Insurance to
21 have a role in whether or not the plan meets the criteria
22 for habilitative services or not. They are sort of taking
23 that under advisement and may come out with further
24 guidance. But those are the two options on the table

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 right now from the federal perspective.

2 With regard to pediatric dental, the two
3 options that they identified in the bulletin, one, was to
4 basically mimic the federal dental plan. Again, just for
5 pediatric dental, this is not sort of a full dental
6 benefit for adults. It's just for pediatric dental.
7 Either have a benefit requirement that is consistent or
8 aligns with the federal employee dental plan, or the
9 state's CHIP's program dental plan. So dental benefits
10 that are provided through Husky would also, could also be
11 required for the central health benefits.

12 The option with regard to pediatric vision
13 pointed to the federal employee health benefit plan's
14 vision plan, and, again, required a central health
15 benefits to cover for children the vision coverage that
16 is included in the federal employee's vision plan. So
17 those were the, sort of, follow up, I think, items that
18 we had identified as requiring additional information.
19 And we wanted to make sure that we covered those first.
20 Okay.

21 So, with regard to state mandated benefits
22 there were a number of questions about the categories of
23 care and what the state mandates were. I hope we didn't
24 inundate you with too much information, but we felt that

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 probably erring on the side of, you know, more was better
2 than less. And so we provided you with a chart that
3 tries to align the benefit under one or more of the
4 categories of care. We also provided you with
5 information about an evaluation by Mercer Consulting back
6 in the fall that tried to identify which of the state
7 mandated benefits might not fall under an essential
8 health benefits package. That analysis was done under the
9 presumption that the federal government would be defining
10 the essential -- would be clearly defining the essential
11 health benefits package and not pushing that decision to
12 the states. So it's somewhat dated in terms of the
13 guidance that came out that's subsequent to the analysis.

14 So, a couple of key points with regard to
15 state mandated benefits. The issue is that if the
16 essential health benefits package chosen by the state
17 doesn't include a state mandated benefit that state
18 mandate doesn't go away. That state mandate still is
19 required for the individual and group market. But the
20 issue is that the state would have to pick up the cost of
21 that benefit, for the marginal cost of that benefit for
22 those services that exceed the essential health benefits
23 package. And this really points to, from our perspective
24 or for the state's perspective, federal employee health

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 benefit plan versus all of the other options on the
2 table. So, there are a few state mandated benefits that
3 we identified in our analysis that are not covered or we
4 don't think they're covered by the federal employee
5 health benefit plan and we'll talk about those. So, the
6 issue is if we pick an essential health benefits package
7 that doesn't include certain state mandated benefits we'd
8 have to calculate what the cost of those, what the cost
9 of those, covering those mandated benefits would be and
10 then the state would have to pay the cost for those state
11 mandates that exceed the essential health benefits
12 package.

13 So, as I mentioned, all of the fully
14 insured commercial plans in the market are required to
15 cover the state mandates and so they do. The state
16 employee's plan, which is a self-funded plan, meaning
17 they don't really purchase insurance. They're self-
18 insured, but they -- and so they are not subject, legally
19 subject to the state mandates. That's also true for very
20 large employers who self-fund, who don't really purchase
21 insurance. They insure themselves. They are not subject
22 to state mandates. Many of them do cover many of the
23 state mandates. So the state employee's plan, even
24 though it's not statutorily required, they do cover all

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 of the state mandates by policy or by negotiation with
2 the state employee's unions. So, if the group we
3 recommend either one of the commercial products or the
4 state employee plan all of the mandates would be covered
5 underneath that and the state would not have any fiscal
6 liability for an essential health benefits package that
7 or state mandates that exceeded the essential health
8 benefits package.

9 We did identify in the federal employee
10 plan three benefits that we think probably aren't
11 covered. It's tough sometimes to sort of -- to draw a
12 clear distinction as to whether it's covered or not. It's
13 not listed in an exclusion section, but it's also not
14 listed in being included. So, those three were autism
15 spectrum disorder, which is a relatively new state
16 mandate, the extensive Lyme disease treatment mandate
17 that is part of the Connecticut mandates, and then in
18 vitro fertilization. All of the others, we think,
19 although again, you know, so we reviewed the evidence of
20 coverage for the federal plans, but all of the other
21 state mandates we think are currently covered or would be
22 covered by the federal employee health benefit plan, but
23 these three seem to fall outside of -- in vitro
24 certainly, Autism spectrum disorder, certainly. We think

POST REPORTING SERVICE
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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 to a fair extent the more generous Lyme disease treatment
2 mandate probably fell outside of the federal employee
3 package as well.

4 Okay. So, the ten benchmark options that
5 we identified -- and you may notice that two of the three
6 small group plans have changed. And that is because the
7 feds came back to us in May, after our meeting here, and
8 said, oh, never mind about the first three we told you.
9 We have a new list of the top three. The good news, I
10 guess, is that there is really not a huge difference in
11 terms of the coverage across any of these plans. And so
12 -- but I did want to point out that this list is slightly
13 different from the last list, so, Oxford PPO, the Anthem
14 HMO, and the Aetna POS plan.

15 The Aetna POS plan, or point of service
16 plan is like an HMO plan, is the largest of the three
17 small group plans. And so it's highlighted because the
18 guidance from the feds tells the states you can choose
19 from amongst these ten options. If you don't choose by,
20 you know, the third quarter of 2012 we'll choose for you
21 and the plan we'll choose will be the largest of the
22 small group options available or the largest of the small
23 group plans in terms of enrollment as of the first
24 quarter of 2012. And the Aetna POS plan, they've told us,

POST REPORTING SERVICE
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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 through their record keeping has the largest enrollment
2 amongst the small group plans.

3 The three state employee plans with the
4 largest enrollment, again, Anthem, two Anthem plans, and
5 an Oxford plan. Three of the federal employee health
6 benefit plans with the largest enrollment we combined
7 them because Blue Cross standard and Blue Cross basic are
8 two different plans. They differ on cost sharing. They
9 don't differ on benefits covered so that's why we've
10 combined them as one plan. And then the largest non-
11 Medicaid HMO or the non-Medicaid HMO with the largest
12 enrollment and that is the, from our understanding, is
13 the Connecticare HMO plan. So those are the ten options
14 available to the state.

15 These are the guiding principles that you
16 agreed to a couple of meetings ago. We just sort of
17 restate them here in terms of whether they give you some
18 guidance as to how to make a decision around or a
19 recommendation around the essential health benefits
20 package. And then we thought that a couple of others
21 that might also be useful is, one, is that it offers
22 comprehensive coverage. I think that, you know, by the
23 ACA requires that it be comprehensive so that's not sort
24 of a distinction that you'll see drawn across any of

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HAMDEN, CT (800) 262-4102

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 these plans.

2 The second is that, you know, that it
3 aligns with the current Connecticut marketplace and the
4 importance that there not be this dramatic shift from
5 what's currently covered in the Connecticut marketplace.
6 Understanding that there needs to be some supplementing
7 that goes on. And then third key criteria we thought or
8 decision criteria was that it minimizes any fiscal impact
9 to the state. And this gets to the issue of if you select
10 a federal employee plan and since it does not cover at
11 least three of the state mandates there may be a fiscal
12 impact to the state. So those were the criteria that we
13 threw out there, but, again, this is sort of just our
14 suggestions or, you know, thoughts on how you might go
15 about making a decision.

16 We tried to go through then and identify
17 sort of key differences. So you have, you know, all these
18 tables with benefits that we've sent to you. It's
19 sometimes difficult to sort of separate the wheat from
20 the chaff. So we identified sort of where there are key
21 differences. Almost all of the plans include and cover
22 all of the benefits in an unlimited fashion. Now that
23 doesn't mean that, you know, you can go see your doctor
24 every day if you wanted to and the health plan would

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 cover the cost of the office visit. So, there are
2 management techniques and there are certain restrictions
3 in terms of what type of care is provided, but there is
4 no hard edit or not hard stop in terms of you only get 20
5 days in the hospital. Or you only get to see your doctor
6 twice even though if you really need to see him, you
7 know, every other week.

8 So, what we've identified is any
9 contractual limitations that are in place in the benefits
10 packages. There are four areas, in particular, we
11 identified where there are differences in terms of
12 limitations. Home health, skilled nursing,
13 rehabilitation, and then underneath rehabilitation is
14 physical therapy, occupational therapy, and speech therapy
15 in particular, and then chiropractic care. We also
16 identified some consistency with regard to exclusions.
17 You know they all typically have a provision that says,
18 you know, non-medically necessary services are not
19 covered. Any service or benefit that's not specifically
20 mentioned. Home births was another area where they all
21 sort of consistently have an exclusion for coverage.

22 And then we tried to identify within each
23 of the plans some of the other key or some of the other
24 difference within each of these areas. So, I'm not going

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HAMDEN, CT (800) 262-4102

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 to go through all of these, but we tried to pull out for
2 you, just so you have sort of a starting point in terms
3 of how can I compare these plans and what are the
4 differences between Plan A and Plan B in terms of really
5 on limits, but also to a certain extent on any exclusions
6 that might be associated with those plans.

7 We're not certain also -- again, the feds
8 have not been clear as to whether the essential health
9 benefits package, the exclusions associated with the
10 essential health benefits package will need to be
11 consistent across all of the carriers that would be
12 offering qualified health plans in 2014 and 2015. They
13 did say with regard to limits that their assumption is
14 that limits would be consistent or similar across the
15 essential health benefits plans, but they were less
16 specific about any types of exclusions, that whether
17 there needs to be an alignment across the plans in terms
18 of the exclusions.

19 CHAIRPERSON VELTRI: Are people feeling
20 comfortable right now? Do you have questions, please, ask
21 because this is very, obviously, very complicated stuff.
22 Go ahead, Sheldon.

23 MR. TOUBMAN: Yes, I did have one
24 question. With regard to the statement, which we've heard

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 many times, that the, under the ACA if the state picks a
2 plan that doesn't cover the mandates, the state mandates,
3 then the state will be liable. But to clarify, are they
4 liable for the full cost of the benefit or the portion
5 which would be paid in subsidy by the federal government
6 for the other services that are included. Do you
7 understand the question?

8 MR. CAREY: Yes. So, the state would be
9 responsible for the full cost of coverage. So, basically,
10 there would have to be two prices to the plan. One would
11 be the full premium excluding those mandates. How much
12 does the plan cost if it didn't cover those mandates.
13 And then what's the margin cost for covering those
14 mandates. And it's that marginal cost of covering
15 mandates that don't fall within the essential health
16 benefits that the state would be responsible for paying.
17 And they would be responsible for paying for everyone
18 that purchased through the Exchange whether that person
19 came with a subsidy or not.

20 Okay. So we tried now to sort of pull out
21 for you, as you can see there is lots of yeses in this
22 column, that means that the evidence of coverage or what
23 the contract says between the insurance company and the
24 individual who purchases or the group that purchases what

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 it says with regard to any hard limits. You could see
2 most of the plans don't have hard limits on anything
3 except when it gets down to the home healthcare services
4 and skilled nursing facility. There is some comparability
5 although you can see that Connecticare, I guess, is --
6 the benefit is more generous with regard to home
7 healthcare services and skilled nursing facility
8 services. The state employee plan is even more generous
9 covering up to 200 home healthcare visits per year and
10 has an unlimited skilled nursing facility benefit.

11 MS. JAFF: Just to clarify, since as you
12 know I'm the liaison between this Committee and the
13 Qualified Health Plan Committee, you know that this is my
14 second time through this presentation. And I just want
15 to make sure that everybody is clear that when they talk
16 about visit limits they're not guaranteeing that you get
17 that many visits per year. All of those decisions are
18 subject to medical necessity determinations. So, if you
19 were under the Oxford plan and you were allowed 80 visits
20 per year Oxford could decide that for home healthcare you
21 only need 20 visits. That's all that's medically
22 necessary. So, the fact that you have that visit limit is
23 not a guarantee that you will get that many visits per
24 year. It's always going to be subject to some medical

POST REPORTING SERVICE
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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 necessity determination.

2 MR. CAREY: Yes, exactly. And the same
3 with unlimited skilled nursing facility or, you know,
4 limits on any of these other ones. It's not as if you can
5 just move into a skilled nursing facility, if you want
6 to, and the insurance company picks up the cost. It's all
7 specific to medical management and medical necessity.

8 There was no distinctions that we saw with
9 regard to these three categories of care. And these are
10 the -- we grouped them based on the federal government's
11 grouping of under the ACA, what the categories of care.
12 So the law has those ten categories and then it says,
13 you've got to flesh those out some more, what does it
14 mean, you know, emergency services and so forth. So,
15 that's how these are grouped. There were no distinctions
16 in terms of any hard limits in any of the plans with
17 regard to these types of services.

18 There was this question, again, on the
19 prescription drugs. You know, all of the state employee
20 plans come with a drug as a rider. It's not part of the
21 core benefit, the same with Connecticare and with Anthem
22 and Aetna. Oxford PPO and the federal employee plans
23 are, again, the only two plans or the federal employee
24 plan being free plans, but are the only plans that do

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 cover drugs as part of the base package of benefits. It's
2 not -- you don't have to purchase it separate as a rider.

3 Then with regard to rehabilitative and
4 habilitative, again, habilitative is not covered.
5 Rehabilitative is covered and there are just some
6 restrictions. Sometimes the limit applies to a plan year.
7 Sometimes it applies to a calendar year, sometimes it
8 applies to a specific illness, or a condition that an
9 individual has, and you can just see that there are a
10 range of limits that are put in place by each of these
11 different plans.

12 MR. SCALETT: I was just thinking a
13 little bit about these benefits that have limits on them.
14 And sort of building a little bit on Jennifer's point,
15 and also being mindful of your earlier point about the
16 medical management overlay to this is separate, and so
17 the benefit, if it says 30 visits, or 60 visits, or 80
18 visits we're trying to determine which of those we want,
19 not what any given insurance might have as a medical
20 management overlay. There are some insurers who have a
21 defined benefit and the test of medical necessity is the
22 doctor ordering it. There are others where the test of
23 medical necessity is a mother may I approach of the
24 doctor or the patient has to clear it with the insurer.

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 Or in some cases it's sort of a hybrid where up to so
2 many visits the insurer doesn't ask any questions and
3 after a certain amount -- and those issues of medical
4 management are unrelated to what we're trying to think
5 about now.

6 MR. CAREY: Correct, yes. That's right.

7 MS. MURPHY: I'd like to follow up on
8 Robert's point and Jennifer, so, given that we're looking
9 -- right now we're just looking at the benefit packages.
10 Where in the process does the Exchange question what the
11 utilization review or mother may I standards are of the
12 particular insurances that would be participating in the
13 Exchange? Because right now we're looking at the benefits
14 package, but where does that question, because obviously
15 it's an important question, when does that come into
16 play?

17 MR. CAREY: So, the Exchange will have to
18 issue, in essence, a solicitation of the qualified health
19 plans that it wants to offer or that it would like to
20 offer on the Exchange. And it's at that point in terms of
21 the document and what the document looks like in terms of
22 preferred approaches or we'd like to see plans that use a
23 tiered network or whatever the different options are, or
24 promote medical homes, or how it treats medical

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 management. I think it's at that point that that's an
2 Exchange decision as to how it wants to structure the
3 packages and the types of coverage that it makes
4 available.

5 MS. MURPHY: And that would include the
6 cost sharing criteria as well?

7 MR. CAREY: Yes. So, at that point --
8 right, so you'd put in place all of the cost sharing. So
9 at the platinum gold, silver, bronze will all have
10 different levels of cost sharing and any type of
11 standardization that the Exchange wanted to put in place,
12 or a preferred, a preference for co-pays as opposed to
13 co-insurance, or those types of things are Exchange
14 specific decisions in terms of the way in which it's
15 structures it, the product that it makes available on its
16 shelf. And I think it's at that point that you would --
17 that those types of issues would be identified and
18 promoted or not.

19 MS. JAFF: A question, on the slide you
20 have up there under -- in the Oxford column, so just
21 looking at inpatient rehab, 60 consecutive days per
22 condition, per lifetime. Does that mean the lifetime
23 limit applies to a condition or a lifetime limit applies
24 to the 60 days period?

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 MR. CAREY: I would have to take that back
2 and --

3 MS. JAFF: -- I'm sorry.

4 MR. CAREY: That's okay.

5 MS. JAFF: Um --

6 MR. CAREY: -- my experience has been it
7 typically applies to the condition, but I don't want to
8 say that without going and taking a look at the book.

9 MS. JAFF: Yes, because that's a pretty
10 big difference, it seems to me. I mean if it were 60 --
11 if you had 60 physical therapy visits per lifetime
12 regardless of conditions that would be a pretty lousy
13 benefit.

14 MR. CAREY: You'd want to switch plans
15 after 60, I guess, yes.

16 CHAIRPERSON BARRETT: Actually, I had a
17 question about that same slide and just wondering how
18 kind of the federal law around eliminating lifetime --

19 MR. CAREY: -- yes, so the law talks about
20 dollar limits.

21 CHAIRPERSON BARRETT: Yes.

22 MR. CAREY: The law talks about dollar
23 limits. It allows service limits, visit limits actually.

24

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 CHAIRPERSON BARRETT: Yes.

2 MR. CAREY: So there -- it's a tricky --
3 so there can be no annual limits and there can be no
4 lifetime limits in terms of dollars, but there can be
5 limits in terms of days or services.

6 CHAIRPERSON VELTRI: So, for instance, the
7 autism mandate right now is limited and it would have to
8 be, the limit would have to be lifted if --

9 MR. CAREY: -- yes.

10 CHAIRPERSON VELTRI: It is included in the
11 EHB, correct?

12 MR. CAREY: Correct. And so, you know, the
13 other area that's typically limited is durable medical
14 equipment, right. So there is typically like we'll pay up
15 to \$15,000 a year or some percentage up to that. We've
16 talked to the, our friends in Washington about this and
17 they're trying to figure it out. The autism one was one
18 that we brought up. We said, look, there is a dollar
19 limit associated with this benefit as part of the
20 mandate. And they've talked about, well, you can turn
21 that into some visit limit or, you know, some actuarially
22 equivalent way in which you can have a limit on the
23 benefit. But, I've not seen anybody come up with that
24 yet so we'll have to see. I think that the Department of

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 Insurance has viewed this as since 2010 is that you can't
2 have these dollar limits anymore. And so, the benefit
3 really isn't dollar limited although I don't think that
4 applies to the autism spectrum disorder mandate.

5 CHAIRPERSON VELTRI: I can't speak for the
6 Department, but when I asked that question they're not
7 treating it that way yet. If it becomes an EHB then they
8 will construe it that way, but they'll look at it again.

9 MR. CAREY: So, then just the final sort
10 of categories, the pediatric dental and pediatric vision,
11 they are, you know, sort of yeses in these categories,
12 but I'm pretty certain that the pediatric dental benefit
13 is not as comprehensive as will be required under the
14 ACA's definition of a pediatric dental benefit or a
15 pediatric vision benefit. So, we've provided you with
16 information about the federal employee's dental benefit
17 and vision benefit and we'll have to craft a supplemental
18 requirement for what the EHB will need to cover in those
19 areas.

20 CHAIRPERSON BARRETT: Just one other
21 question, does -- where does it also get into who can do
22 what types of care or who can provide what types of care
23 particularly like around dental screenings and things
24 like that? In Husky, you know, they've made some changes

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 to allow pediatricians to do the screens and for sealants
2 and that sort of thing. So, I'm just wondering where
3 would we get to see which practitioners would be allowed
4 to do certain things which kind of then would hint at
5 what the access will look like later on.

6 MR. CAREY: Yes, so that typically is a
7 state, state statute like allowing people to practice up
8 to the maximum of their license. I know in some states
9 they restrict nurse practitioners and what they can do,
10 they can't practice all the way up to the full scale of
11 their license. So I don't think that's part of the
12 essential health benefits discussion. It's probably -- I
13 think it's probably a Department of Insurance issue
14 whether or not a plan is allowed to restrict. I think in
15 general they're not, but they're -- I think that that's
16 probably where we would need to address that.

17 MS. O'GARA: Okay. So with the
18 recognition that this is a very complicated set of data
19 streams for you to look at, we'd like to see if we could
20 discuss a little bit, if we're at the point where we
21 could eliminate any plans. And, Jennifer, I think you
22 wanted to fill us in on something.

23 MS. JAFF: I would suggest that we -- or I
24 would move that we eliminate the federal employee health

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 benefit plans as options primarily for the reason that
2 Bob already explained that there would be state mandates
3 that would not be covered by the FEHBP's and so if we
4 chose one of those plans the state would be responsible
5 for paying the cost of any of the mandated benefits that
6 are not covered by the FEHBP's. And so, in line with our
7 guiding principle of affordability and minimizing the
8 fiscal burden to the state, I would suggest that -- or I
9 would move that we eliminate the federal employee plans
10 as options.

11 MS. O'GARA: Okay. So we have a move and a
12 second. Is there some discussion on that?

13 CHAIRPERSON VELTRI: Well, I completely
14 agree with the motion. It's -- I think it accounts for
15 consumers of the state who come to rely on the coverages
16 that the state has considered over time and have become
17 major public policies. So to go with an option that would
18 automatically remove a couple of those I think would be
19 devastating to actually some people, and probably a
20 little unfair. So I think that we could eliminate the
21 federal plans right away.

22 MS. WOODS: Have you done that in your
23 other subcommittee yet, Jennifer? Have you voted to do
24 that?

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 MS. JAFF: Yes, we did.

2 MS. WOODS: Okay.

3 CHAIRPERSON VELTRI: To be clear, it's a
4 motion to recommend that we do it. Obviously, we don't
5 have the authority, as a Committee, to make it happen,
6 but we would, if this motion passed it would be to
7 recommend that that be the case.

8 MS. O'GARA: Sheldon?

9 MR. TOUBMAN: Yes. I agree with that
10 motion. The only thing I want to say as a devil's
11 advocate is or ask is, as I understand it, the ACA and
12 CMS, not CMS, HHS has allowed these choices to give
13 flexibility to the states in choosing their EHB. Instead
14 of we all thought they were going to come out and say
15 what it was going to be, instead they said, no, states
16 you get to choose. But they gave these just as options
17 and it's really up to the states whatever their state
18 mandates might be as a huge factor to choose which ones
19 they think are best. Is that a fair statement?

20 MS. JAFF: If you're asking me, that's my
21 understanding, yes.

22 CHAIRPERSON VELTRI: Yes. Except that I
23 do think -- I mean as a Board member I think the Board
24 had decided that we would not completely hand over, but

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 give to the Advisory Committees the bulk of the work to
2 make the recommendations on what the state should choose
3 to do. So that the state isn't -- I mean nobody is doing
4 it in isolation. They're doing it with the
5 recommendations that come from these committees. These
6 are going to be -- the recommendations are going to be
7 weighed very seriously and hopefully followed.

8 MS. O'GARA: So let me ask a question, are
9 we at a position where you'd like to take a vote on that
10 motion? So, Vicki, do you want to ask for a vote?

11 MR. ERLINGHEUSER: Can I ask, I'd like to
12 ask a quick question maybe of Bob. I mean I'm inclined to
13 support it, but maybe not necessarily playing devil's
14 advocate, but I'd like to at least hear on the record
15 from Bob what down side he foresees in doing such a vote.
16 I mean just so I know.

17 MR. CAREY: I mean the work that I either
18 have been doing in other states or, you know, your
19 colleagues who have been working in other states sort of
20 this is the general approach that states are taking
21 particularly states with any type of mandates that may be
22 affected by or fall outside of the coverage that's
23 offered by the FEHBP. You know, if we went through sort
24 of the distinctions in terms of any hard limits there is

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 probably some plans within the FEHBP that are more
2 generous than your other options, but I think it's
3 probably a difference without a distinction. And I think
4 the key issue is that you have a few of these mandates
5 that fall outside of what's covered by the federal
6 employee plan and given the state fiscal situation I
7 don't think that, to be honest, even if we recommend it
8 that we went for some reason with the federal plan I
9 think that, you know, the legislature and the Executive
10 would be hard pressed to accept a recommendation that
11 resulted in a fiscal note that could be, you know,
12 anything above a couple of dollars. So, I do think that
13 that's probably just sort of a -- it's almost, you can
14 start to knock that off relatively easy.

15 CHAIRPERSON VELTRI: And I think it's
16 really important to note that the discussion that we're
17 having is really just about the benefits. You know, we
18 haven't talked about the flip side of this. I mean the
19 flip side of the decision, whatever we make, is --
20 impacts affordability. And we are going to have to have
21 that discussion because there is no -- a lot of people
22 would make the argument that the mandates, you know, they
23 cost money. There is a lot of things I think under the
24 mandates that hopefully this Committee and the Health

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 Benefit Plan Committee will really explore in terms of
2 the things that are driving costs to healthcare that may
3 help us address affordability of these mandates. But the
4 -- I think between that issue and the issue of what
5 happens if we don't approve a plan that does include this
6 state mandate, the decision we're making or we're
7 recommending does not affect just the Exchange. It
8 affects the entire marketplace outside the Exchange. So,
9 I consider the decision to be a decision that affects
10 everybody who buys individual and small group insurance,
11 not just the people purchasing in the Exchange. So that
12 also weighs on, at least, my view of the situation.

13 MR. SCALETT: I think a point that was
14 made at the previous meeting on Friday that Jennifer made
15 that's gone unsaid today and I think needs to be
16 reinforced is the whole issue around women's health
17 services and being reminded that the federal benefits
18 plan has rather restrictive limitations on women's right
19 to choose abortion as only provided for rape and incest.
20 So, aligning with the decision criteria, what's in the
21 current Connecticut marketplace and what the citizenry
22 here has endorsed becomes to me another compelling reason
23 not to support using the federal plan as a benchmark.

24 MS. JAFF: And if I could just clarify,

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 the reason that I did not bring that up today is because
2 there are some fairly complicated questions about whether
3 even if we choose a plan that includes coverage of
4 elective abortion whether that would become an essential
5 health benefit. That is entirely unclear because there is
6 language in the federal law that says that no plan can
7 require anybody to pay for -- to pay a premium that would
8 cover abortion services. So, we're -- I know Bob has
9 been trying to get some guidance from HHS on this issue.
10 We've been talking to the national women's organizations
11 and trying to get their thoughts on this, but because
12 it's such a complicated issue that's why I didn't raise
13 it today as one of the reasons for this motion. I think
14 it's another good reason, but I just think it gets us
15 into a whole thicket that we can kind of avoid for today
16 unless people are uncomfortable doing that.

17 MS. O'GARA: So I have a motion and a
18 second to drop the federal employee health benefit plan
19 from the further analysis because of the fiscal burden
20 that it could pose to the state and the fact that it
21 doesn't align well with the current Connecticut
22 marketplace.

23 And so if we could just see a show of
24 hands of those in favor of that motion. Anyone opposed

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 to that motion? Anyone abstaining? Okay, we'll put that
2 on the record.

3 So we raised a couple more questions for
4 you to consider. And I know this is a tough job that
5 you've got, but the one I want to pose to you and,
6 Jennifer, I'm going to call on you in a minute, is there
7 anyway for us to begin to narrow down even further. And
8 so, Jennifer?

9 MS. JAFF: Yes, I mean last week when we
10 met the Committee had several questions and one of the
11 questions was to get some clarification on the visit
12 limits. And you -- we now have that clarification here
13 except for the ambiguity about the Oxford visit limits
14 for in-patient and outpatient rehab. But based on that
15 clarification I, personally, am prepared to exclude the
16 Oxford plan because I think that for people with chronic
17 illness, which is who I represent, having a lifetime
18 visit limit on especially physical therapy is a real
19 problem. And even if it's a -- even if it's a lifetime
20 limit for a particular condition if you have a chronic
21 illness chances are you're going to keep needing the
22 physical therapy for the same condition.

23 And so, I would pose -- I mean since we
24 have several other options that don't have lifetime

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 limits and I don't see anything in the Oxford plan that
2 makes me want to hold onto it for any particular reason I
3 would feel comfortable eliminating the Oxford plan based
4 on the lifetime visit limits on rehab.

5 CHAIRPERSON VELTRI: So before we go --
6 before we go to any kind of motion on that, can you
7 clarify, Bob, the -- I think the guidelines suggest that
8 the plans, notwithstanding these limits that we have in
9 here, that the plans can make some adjustments to those
10 limits as long as the plans are actuarially equivalent.

11 MR. CAREY: Yes. So there could be an
12 instance in which, you know, for example, just because if
13 we selected Connecticare and it has 40 visits per year,
14 and I think this is a combined for all services type of
15 limitation, another plan that had, you know, 15 visits
16 per condition or per -- for PT, and 15 for OT, and 15 for
17 ST, I mean, you know, one could make the argument well
18 that's sort of basically, could be comparable to. So I
19 think they put, you know, similar in coverage so it
20 doesn't have to be identical in terms of the limits, but
21 it will be similar or no meaningful difference in terms
22 of the limitations.

23 So just -- but it's basically, you know,
24 it could have these types of limits. And these would be

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 sort of the floor again, you know, if a carrier wanted to
2 offer more they could if they found that that was
3 attractive and people, you know, it was something that
4 they wanted to offer.

5 The other issue is just for your -- for
6 clarification is the crack Exchange staff has informed me
7 that the lifetime limit is for a particular condition.
8 So it's not forever. It's not everything combined. So
9 just -- so for clarification on that.

10 MS. JAFF: But for somebody who has
11 fibromyalgia, for example, which isn't going to go away
12 if they need physical therapy in order to keep them
13 moving they -- because it would be the same condition
14 they would hit that lifetime limit and not be eligible
15 for any physical therapy benefit after that. And so
16 that's my concern.

17 MR. O'SULLIVAN: I can get more
18 information from other parts within the Department to
19 clarify that. I think before we count anything out we
20 should get clarification on those things.

21 MR. CAREY: Okay, great.

22 MR. TOUBMAN: I just wanted to make sure
23 that there isn't any downside to excluding Oxford. And
24 the thing that's confusing to me is the prescription drug

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 benefit because it's been identified earlier that because
2 the other plans all have pharmacy riders then we have to,
3 as Slide No. 14, that it has to either be the Oxford plan
4 or the federal plan. If we want to cover drugs, we have
5 to cover drugs, the Oxford PPO, or the federal plan, or
6 supplement the benchmark plan with the drug benefit
7 included in Oxford PPO or the federal plan. And I just
8 wanted to make sure that that's -- there is no downside
9 to that later option. Do we just do it that way, that's
10 fine, no issue?

11 MS. O'GARA: So I was going to ask, Bob,
12 if you could put that one slide up that has the item that
13 Sheldon is referring to. No, the one with the
14 prescription drugs, the matrix, I wanted you to do a for
15 instance, yes. Could you take us, like hypothetically if
16 we --

17 MR. CAREY: -- yes, so hypothetically if
18 you pick, you know, Anthem Blue Cross as the benchmark
19 plan you would supplement it, you would need to
20 supplement it either with the prescription drug benefit
21 offered by, offered through the Oxford PPO, or the
22 prescription drug benefit as defined by the federal
23 employee health plan. So that would be the state's
24 benchmark plan. It's -- Anthem is the benchmark medical

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 plan and then supplemented with Oxford or supplemented
2 with the federal employee health benefit plan
3 prescription drug benefit.

4 MS. JAFF: And so if we eliminated the
5 Oxford plan as a benchmark we would still be able to
6 borrow the Oxford plan's prescription drug benefit to
7 supplement a different plan, is that right?

8 MR. CAREY: Correct.

9 CHAIRPERSON VELTRI: We may as well ask
10 all the questions that we need to ask. In the -- on the
11 prescription drug benefit the -- so you said earlier the
12 tier situation is not an issue right now. We're just
13 talking about the coverage. We're not talking about
14 whether they have two or three tiers here.

15 MR. CAREY: Correct.

16 MR. SCALETT: I just want to clarify a
17 point you were making earlier about equivalency or
18 actuarial equivalency. I guess my bias would be trying
19 to urge that there be real uniformity. I mean it seems
20 like that the intent and the spirit of the Affordable
21 Care Act is to have some insurance reform. And the more
22 we allow individual variation we segment, run the risk of
23 segmenting the market, and get back into the cherry
24 picking cycle, and all those things.

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 MR. CAREY: Yes. So there is two ways that
2 -- to address that. One is, again, for the Exchange, the
3 Exchange could, you know, in terms of its solicitation
4 could say, now, you're required to cover 20 visits or 40
5 visits, or whatever the benchmark is so that there is no
6 variation. But that would be just for coverage offered
7 through the Exchange. The Department of Insurance would
8 be, which licenses and approves all products that are
9 offered in the individual and small group market, it
10 would be their determination of how much variance would
11 be allowed. But I did just want to point out that the
12 guidance, and again it's guidance it's not a regulation
13 yet, the guidance from the feds suggest, you know, there
14 can be some difference, you know. But again that might be
15 a decision for the Exchange to make with regard to the
16 range of variance with regard to the covered benefits
17 that it offers.

18 MS. WARREN: I totally agree with you and
19 where a consumer experience is concerned it not only
20 needs to be affordable, but understandable. And this is -
21 - this -- it's confusing me. And to -- we're talking
22 about doing outreach and for people to understand and to
23 be, and then to get on board with it where you're saying
24 there is issues, this is going to be another turn off.

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 To, okay, if this doesn't cover it, so you've got to do
2 this, and you've got to -- I mean if it can be clearer
3 and across the board I can see consumers more willing to
4 take part in it. I mean I wouldn't want to take part in
5 this right now if it's not clear.

6 MS. O'GARA: Okay. What about some other
7 voices? Anyone else have some perspective on this? Is
8 there any data or data point that you think might help
9 get you to a decision that we haven't provided you?

10 CHAIRPERSON VELTRI: I would say one of
11 the things that I think is kind of tough about this whole
12 process is if you don't know -- you know, we know that we
13 see from advocacy work that we do. Jennifer does, I do,
14 you know, people around the table do, but it would be
15 nice to know what is -- what's the utility of one benefit
16 versus another. So, are people really utilizing, you
17 know, PT up to a certain level, or OT to a certain level,
18 or whatever benefit it is? Or is the reality that not
19 many people ever really use that benefit. So I know the
20 state employee plan has this kind of data. It would be
21 nice if we could just see what kind of utilization
22 patterns there are for these services to -- I mean and
23 I'm not, obviously, accounting for the requests that have
24 been denied and have not -- people have not been

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 utilizing, but the actual utilization of a particular
2 service to see -- I mean it is a measure to me of the
3 value, and it's one measure. It's not the only measure,
4 but it's one measure.

5 MS. O'GARA: I'm sorry, Vicki, but just to
6 clarify you're talking about within those areas that
7 we've called out as different, right, the PT, that kind
8 of thing, okay.

9 CHAIRPERSON VELTRI: Skilled nursing, home
10 health.

11 MR. CAREY: We should be able to provide
12 some information on that. I will say that my experience
13 has been that when you look at -- if you have a dollar's
14 worth of medical expenditures, you know, those services
15 are generally pretty modest in terms of the percentage of
16 that dollar devoted to PT, OT, ST, skilled nursing
17 facilities, home health. Now, the issue is are they
18 limited -- are the few dollars spent because there are
19 limits or are there few dollars spent because there is
20 not the demand or you don't need those types of services.

21 CHAIRPERSON VELTRI: And I agree with
22 that. So I guess my question was more about the
23 individuals. How many individuals are using the service
24 or requesting the service versus what the claims costs

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 are because that's irrelevant to me in terms of the value
2 necessarily.

3 MR. CAREY: We should be able to get you,
4 you know, members per thousand that access physical
5 therapy or occupational therapy. That is a knowable
6 number. We should be able to get that for you.

7 MS. WARREN: I had a question. Okay,
8 these benchmark companies how eager, are they eager to be
9 a part of this Exchange, to be the benchmark companies?

10 MR. CAREY: So these are really the
11 benefits that are offered by these companies. So we're
12 not picking a company per say.

13 MS. WARREN: Okay.

14 MR. CAREY: We're picking the benefit.

15 MS. WARREN: We're just looking at them.

16 MR. CAREY: Right. Because the feds said
17 to us you can select the benefits offered by the three
18 largest, the three small group carriers with the largest
19 enrollment and you can pick from the state employees with
20 the largest enrollment. So we're -- you could actually
21 just put Company A, Company B, Company C. It's almost
22 irrelevant in terms of the company itself for our
23 purposes for this discussion. What we're really looking
24 at is the benefits that are offered by the package that's

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 covered by that company. So, it's not -- we're not
2 picking a company. We're picking the benefit package
3 that that company currently sells in the marketplace.
4 Does that help?

5 MS. WARREN: Um, hmm. Okay. Thank you.

6 MS. O'GARA: So other questions or data
7 points? Arlene?

8 MS. MURPHY: When you look at these tables
9 it appears that most of them are extremely similar. There
10 are very few differences as described in these tables.
11 The only one I can see here in Slide 29 is outpatient
12 rehab services when you talk about Oxford and the
13 possibility of dropping Oxford is that Oxford has more
14 outpatient rehab services. Now, we understand that those
15 are the ones that are on paper and that's not the ones
16 that are approved for you to get, but that's what the
17 benefit package looks like and that's what we're supposed
18 to describing. And that's the only one that I can see
19 that's significantly better than the other plans that are
20 described. So, are there other ways, you know?

21 MR. CAREY: You know, I mean that's --
22 when we looked at these it was like, you know, the
23 lifetime condition limit, I think, is certainly worth
24 noting. But otherwise, you know, they're competing in a

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 marketplace so they've got to be -- evidently that's, you
2 know, they shadow sort of price one another and they
3 shadow benefit one another. So, the benefits are
4 typically relatively comparable when you get to this
5 level. Now, that's not to say that there aren't mini meds
6 and really skinny plans that are out there, but that's
7 not our -- those aren't our options. What we're looking
8 at are plans that are already, I would argue, pretty
9 comprehensive in terms of what they cover.

10 MS. MURPHY: So to Danielle's point,
11 actually, if the plans are pretty similar and they are
12 described clearly then hopefully it won't be as confusing
13 if there isn't that many differences in the benefit
14 packages. It's the basic benefit package that you can
15 expect.

16 CHAIRPERSON BARRETT: I just have one more
17 thought about the pharmacy. I'm still wondering is there
18 any advantage to having the pharmacy benefit actually be
19 offered as part of the plan versus the rider?

20 MR. CAREY: It's not sort of is there one
21 better than the other. The issue is that the feds have
22 basically said you've got to pick -- you can't couple a
23 rider, a quote/unquote rider with your medical plan.
24 You've got to -- it's got to be inclusive of the whole

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 benefit package. So, you know, the drug rider sold by
2 Anthem, or Aetna, or Connecticare is probably a pretty
3 comprehensive drug benefit from what I've reviewed. But
4 because the feds have said, no, you can't, you can't use
5 that rider as part of your benchmark plan that's why
6 we're making sort of torturing this issue with regard to
7 prescription drugs. I, personally, think they're going
8 to revisit this issue and probably come back and say, oh,
9 it's okay you can couple it. But we're getting to a point
10 now where we have to make a decision and so my job is to
11 tell you what the guidance is saying.

12 MS. WARREN: I have a question. Okay, for
13 the prescriptions on these plans they're usually co-pays,
14 right? Now, what are the differences in co-pays across
15 the plan because if I have to pay, you know, \$15 for
16 Aetna and \$5 for Anthem, you know, and I'm on a lot of
17 prescription meds I'm going to want Anthem, whoever the
18 rider is or whatever you're talking about.

19 MR. CAREY: Yes. So, again, the issue
20 here is the benefits not the cost sharing. So cost
21 sharing is sort of the down the road issue that we'll
22 have to deal with.

23 MS. WARREN: But it is going to be all a
24 part of this process here because when you're on the --

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 versus someone with HIV, I mean you know, on the gamut of
2 medications it makes a big difference.

3 MR. CAREY: No, it makes all the
4 difference in the world between having access to -- you
5 know, you could have a really robust drug benefit, but if
6 it costs you \$100 every time you went to fill a script
7 the drug benefit is almost meaningless.

8 MS. WARREN: Right.

9 MR. CAREY: But that's sort not the issue
10 here. What we're trying to get our head around is what's
11 the underlying base of the benefit exclusive of any cost
12 sharing or not including the co-pays, just what's
13 covered.

14 MS. WARREN: Okay.

15 MR. CAREY: So then the next sort of
16 iteration, as we move down the road, is what does that
17 cost sharing look like for the individual consumer.

18 MS. WARREN: Okay, thank you.

19 MS. JAFF: I actually have two questions.
20 First of all, we've talked about habilitative, pediatric
21 dental, pediatric vision as things that are going to have
22 to be supplemented or tweaked. There is also the
23 category of wellness programs. That's mandatory under the
24 ACA. And we haven't really looked at that and I know one

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 of the things that we certainly care about when dealing
2 with patients with chronic illness is certainly patients
3 with HIV Aids, you know, chronic disease management
4 becomes very important. Is this -- is that also something
5 that we're going to have to kind of build from the ground
6 up or is that something that exists in these plans
7 already? And then just to tell you my second question,
8 just, and that is since affordability is one of our
9 criteria how are we, as a committee, going to make any
10 kind of judgments about affordability?

11 MR. CAREY: Well, the affordability issue,
12 I think, really gets down to some of these questions
13 about is it an unlimited or are you going -- that's sort
14 of a piece of it. But largely with regard to this
15 discussion I think affordability almost has to be sort of
16 a secondary issue. It's not so much around network
17 design, or the cost sharing, or incenting people to
18 change their behavior or anything like that. That's, I
19 think, again, that will probably have to be a discussion
20 that we have at some point, but is less so with regard to
21 this discussion although I would suggest, you know,
22 limits versus unlimited has an effect on -- can have an
23 effect on cost.

24 The first issue with regard to preventive

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 and wellness benefits all of these benefits provide sort
2 of chronic care management programs. I haven't seen any
3 -- and the preventative benefits must be covered as part
4 of the ACA and they're not subject to any cost sharing.
5 So all of those preventative benefits, anything that's, I
6 think, an A or B on the preventive committee's list of
7 services needs to be covered without any cost sharing.
8 And then they all so do have some type of chronic care
9 management program that they offer. But we didn't get
10 into the details of that. It's typically not part of the
11 certificate of coverage in terms of the contract that
12 they provide, but rather an ancillary benefit that's
13 provided as part of the medical management program.

14 MS. JAFF: So then how do we make sure
15 that it's covered as an essential health benefit?

16 MR. CAREY: Well, I think we need to think
17 about some language around what's expected in terms of a
18 chronic care management program, if that's the, you know,
19 desire of the committee. I've not seen anything on this
20 from the feds on preventative and chronic care. Maybe
21 that's a take away for us to go back to them and ask what
22 specifically are they looking for in terms of what's
23 covered as part of a chronic, you know, in this category.

24 MR. SCALETT: I think some of it might

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 fall under the qualified health plan work and sort of
2 what the solicitation is in terms of our plans, what are
3 NCQA accredited, and the different programmatic parts of
4 care and medical management, and preventative health
5 services that seem to have evolved as part of that.

6 But I had a separate thing I wanted to ask
7 about. So, on the affordability and to your point it's
8 going to be harder for this group to really hone in on
9 affordability acceptance so far as to say something
10 that's unlimited is going to cost more than something
11 that's limited, there was a discussion at the meeting on
12 Friday about sort of has the marketplace told us anything
13 more about these, which are more popular and whatever
14 that might infer. Do we have anything about what's the
15 membership in each of these different products within the
16 state?

17 MR. CAREY: So we're gathering that
18 information. We'll have that for you next week in terms
19 of what's the actual enrollment in these plans. And so
20 you'll be able -- I would suggest for the small group
21 plans it's sort of an apples to apples comparison because
22 it's all part of the small group market, but then once
23 you get outside of that, you know, the largest HMO
24 includes both large employers and small employers. So

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 it's going to be a much bigger number than just the small
2 group market. And then the state employee's plan is just
3 state employees and then the federal plan, you know, it's
4 nationwide, all federal employees. So it's sort of like
5 millions of people covered by Blue Cross basic
6 nationwide. But I do think with regard to the small group
7 products that would be, I think, an important data point
8 to look at.

9 The other caveat on that is because cost
10 sharing is not really -- it's not part of this
11 discussion, it could be that the largest small group plan
12 is more popular because it's less expensive because it's
13 got more cost sharing that the member pays out of pocket.
14 So, you know, you've got to be just a word of caution
15 when you look at the numbers you can't take them in
16 isolation.

17 MS. O'GARA: So we're getting close to
18 time on this.

19 CHAIRPERSON VELTRI: But just one point,
20 and since we know most of those plans are below the
21 bronze level, lots of the plans that have been offered, I
22 think we just have to be careful about what's popular in
23 the market might be just what an employer can afford
24 right now or what an individual can afford right now. So

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 we just have to be careful. But I think we have to give
2 Arlene her --

3 MS. MURPHY: -- just one more and that is
4 that the wellness services, are those described anywhere
5 separately? I mean things like smoking cessation or other
6 things that health insurances sometimes cover, are those
7 listed anywhere or compared? Are they all the same?

8 MR. CAREY: I don't if they're all the
9 same. We'll be able to pull those together for you and
10 explain what the, you know, they cover in terms of
11 wellness. So the take away on that is get more detail
12 around preventative chronic care management and wellness
13 programs.

14 MR. O'SULLIVAN: Yes. I think the
15 preventative and the wellness wants are evolving. It was
16 something that the federal government was going to give
17 guidance on and then pushed it back to the states. And as
18 you said too it goes into those other options as well
19 with all those other plans. So, it is something that
20 we're trying to get our hands around and there are
21 differences from plan to plan and we're trying to take a
22 look at those at this point.

23 MS. O'GARA: So maybe we could move to
24 what we need to do as a follow up. And I have a list of

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 data points I think you probably do too, Bob, but it
2 looks like the Committee would like some more information
3 on. That not to dismiss Jennifer's suggestion. I don't
4 know if we got a take up on that or not, or we want to
5 wait to get this other data.

6 CHAIRPERSON VELTRI: You know, it sounds
7 like people would like some additional information before
8 making that kind of decision.

9 CHAIRPERSON BARRETT: I'd like to wait
10 definitely.

11 MS. O'GARA: Okay, well let's do that. And
12 then I think we can compare our notes on the particular
13 items for follow up. We are getting close to time and I
14 want to make sure that we take public comment. So if
15 there is anyone in the audience that wants to come
16 forward and make a statement if you could come to a
17 microphone and give us your name.

18 MS. JAFF: Actually, before we do that,
19 Nellie, could I just -- so everybody knows, give the list
20 of take aways from the Qualified Health Plan Committee.

21 MS. O'GARA: Sure.

22 MS. JAFF: So they know what additional
23 data will be coming. And Bob can correct me if I miss
24 anything. But there was a request for enrollment numbers

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 in the available plans so that may or may not demonstrate
2 a sense of which plan is more popular than another. It
3 may mean it's less expensive than another. I don't know,
4 but we're going to get that. And then this issue of
5 affordability did come up and it may be that I had asked
6 for average premiums, but I was fairly convinced that
7 that would probably not tell us very much for a whole
8 host of reasons because each plan is priced differently,
9 it depends who is enrolled in the plan, and all of that
10 kind of stuff. So, I don't think that's really going to
11 help us any.

12 And then we had asked for this
13 clarification on the visit limits. So I guess we just
14 need to clarify just a tiny bit more on the Oxford one,
15 but I'm pretty sure that that it is per condition, per
16 lifetime. So then now we've added to that utilization
17 data on limited benefits and some information about the
18 wellness programs offered by the outstanding plans. So, I
19 think that's the full list of additional information that
20 both committees will be getting before they have to make
21 a decision.

22 And then the other thing that the
23 Qualified Health Plan Committee decided was that they
24 would need another meeting -- so the other committee

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RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 decided that they needed another meeting before they
2 needed to vote in the July meeting because we're all
3 going to be asked to vote on these proposals in the July
4 meeting. So, this Committee should decide whether we also
5 feel like we need to have another meeting before we vote
6 so that we have an opportunity to reviewed the additional
7 information and discuss it or whether you feel like you're
8 going to be prepared to vote at the next formal meeting
9 of this Committee.

10 MR. TOUBMAN: Well, one question I have is
11 I don't have in front of me what is the schedule for the
12 other committee's July meeting relative to ours?

13 MS. JAFF: Our meeting in July actually is
14 before the other committee, which I think I may have said
15 I thought was a little -- because I thought this
16 Committee should know the recommendation of the other
17 committee and kind of be saying whether we agree with it
18 or not. But the way it's scheduled now the -- this
19 Committee meets on July 10th and the Qualified Health
20 Plan Committee meets on July 11th.

21 MR. TOUBMAN: Is it possible, I know you
22 guys have put a lot of work into scheduling, but is it
23 possible to change that in light of Jennifer's concern?
24 And I would suggest maybe the same for -- I don't know

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 what August is, but maybe the same thing.

2 MS. O'GARA: So, we can look into the
3 sequencing of the meetings. I think your other question
4 was whether this group wanted an interim meeting before
5 your July meeting. And I believe that the other group is
6 thinking about a web based approach to that, a conference
7 call.

8 MS. WOODS: Maybe we could join yours at
9 the same time.

10 MS. O'GARA: Right. That might be
11 beneficial to have all the voices and the minds together.

12 MS. JAFF: I think that's a great idea if
13 it can be done.

14 MS. O'GARA: Okay, well, we can work on
15 that. So, that was a great list, Jennifer. I checked
16 mine off as well. So, if you're comfortable do we have
17 any people from the public who want to come forward? All
18 right then, Vicki, I'm going to toss it back to you if
19 there is anything else or we're ready for adjournment.

20 CHAIRPERSON VELTRI: I think is everybody
21 all set? Anybody have any more comments, questions,
22 suggestions? Okay. So, I guess we'll entertain a motion
23 to adjourn. Is there a motion to adjourn?

24 MS. JAFF: So moved.

RE: HEALTH EXCHANGE ADVISORY COMMITTEE
JUNE 13, 2012

1 CHAIRPERSON VELTRI: Second, is there a
2 second? Okay, everybody in favor?

3 ALL VOICES: Aye.

4 CHAIRPERSON VELTRI: We're adjourned.

5 Thank you.

6 (Whereupon, the meeting was adjourned at
7 3:00 p.m.)

8