

VERBATIM PROCEEDINGS

EXCHANGE ADVISORY COMMITTEE MEETING

CONSUMER EXPERIENCE AND OUTREACH

MAY 15, 2012

LEGISLATIVE OFFICE BUILDING
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RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 . . .Verbatim proceedings of a meeting
2 before the Exchange Advisory Committee, Consumer
3 Experience and Outreach, held at the Legislative Office
4 Building, 300 Capitol Avenue, Hartford, Connecticut, on
5 May 15, 2012 at 9:03 a.m. . . .

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CHAIRPERSON VICKI VELTRI: -- to start the
10 meeting. I would think those people, who said they were
11 coming, are here, so, before we start, why don't we just
12 go around the room and make introductions, so everybody
13 knows who everyone is around the table.

14

15

16

I'm Vicki Veltri. I'm the State Health
Care Advocate, and I'm also co-Chairing the Consumer
Committee.

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CHAIRPERSON TANYA BARRETT: I'm Tanya
Barrett, and I'm with United Way of Connecticut, 211, and
I'm also co-Chairing this Committee.

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21

MS. ARLENE MURPHY: Arlene Murphy,
Fairfield.

22

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MR. GERARD O'SULLIVAN: Gerard O'Sullivan,
State of Connecticut Insurance Department. I'm the
Program Manager for Consumer Affairs.

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RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 MS. CLAUDIA EPRIGHT: Claudia Epright.
2 I'm with United Action Connecticut, and I'm an advocate.

3 MS. CHERYL FORBES: Good morning. I'm
4 Cheryl Harris-Forbes with Harris-Forbes Associates, a
5 Small Business and Consumer Outreach and Small Business
6 Outreach person for Small Business for a Healthy
7 Connecticut.

8 MS. JULIE LYONS: Julie Lyons, Director of
9 Policy and Plan Management with the Connecticut Health
10 Insurance Exchange.

11 MS. TIA CINTRON: Tia Cintron, Acting CEO
12 of the Exchange.

13 MR. BOB CAREY: And I'm Bob Carey, a
14 Consultant to the Exchange.

15 MS. NELLIE O'GARA: I'm Nellie O'Gara.
16 I'll be your facilitator today.

17 MR. GRANT PORTER: Grant Porter. I'm
18 Exchange staff.

19 MR. ROGER ALBRITTON: Roger Albritton,
20 KPMG, the Technical Advisor for the Exchange.

21 MS. KATHY MORELLI: Kathy Morelli, Account
22 Executive at Mintz and Hoke Communications Group.

23 MR. CHRIS KNOPF: I'm Chris Knopf, CEO of
24 Mintz and Hoke Communications Group.

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 MS. JENNIFER JAFF: Jennifer Jaff,
2 Executive Director of Advocacy for Patients with Chronic
3 Illness.

4 MR. JOHN ERLINGHEUSER: John Erlingheuser,
5 Advocacy Director for AARP in Connecticut.

6 MS. CINTRON: Vicki, do you know if we
7 have anybody on the phone? I do not know. Is there
8 anyone on the phone?

9 CHAIRPERSON VELTRI: No. No one calling
10 in.

11 MS. CINTRON: Okay.

12 CHAIRPERSON VELTRI: Before we begin, I
13 just want to say that my co-Chair, co-Chair Barrett and I
14 and several of the Committee members have had a
15 discussion about the agenda before today, and we also had
16 a little bit of a discussion with Nellie before the
17 meeting started about time management and the breath of
18 the agenda, and we're looking at what we hope is to
19 entertain a motion to revise the agenda, and that
20 revision would be to eliminate the briefing on the final
21 rules for Navigators and Brokers today.

22 To move the KPMG discussion up to the
23 beginning and to maybe cut short some of these other
24 discussions, we'll let Nellie do the time management on

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RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 the Mintz and Hoke and the overview of the Committee
2 Task, so that we leave the bulk of the discussion today
3 for the Essential Health Benefits. Could somebody move
4 that?

5 A FEMALE VOICE: So moved.

6 CHAIRPERSON VELTRI: Okay, thank you.

7 A FEMALE VOICE: I second it.

8 CHAIRPERSON VELTRI: Okay, great. All in
9 favor?

10 VOICES: Aye.

11 CHAIRPERSON VELTRI: Okay, so, that motion
12 is passed, so we have now altered the agenda, so I guess
13 what we would like to begin with, if we can, is a
14 discussion, a very short discussion on the Guiding
15 Principles, so I guess Bob is in charge of that.

16 MS. O'GARA: Actually, Grant and I can
17 help you with that.

18 CHAIRPERSON VELTRI: Okay.

19 MS. O'GARA: So the Guiding Principles I
20 believe you were given a handout that might have changed
21 a bit, or is it the same?

22 MS. CINTRON: It's in their packet today.

23 MS. O'GARA: Okay.

24 MS. CINTRON: It should be included in

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 their packet today.

2 MS. O'GARA: So it's included in your
3 packet, and what we'd like to do is just give you a few
4 minutes to take a look at that.

5 I think that there was -- I'm going to ask
6 Vicki. There was a modification for one of them to align
7 with the Quality Health Plan Committee, and there was a
8 modification of another one to align with the Board's
9 general Guiding Principles.

10 Other than that, they stand as they were
11 at our last meeting.

12 MS. CINTRON: So it was number seven, so
13 your original packet went out a week or so ago, and, on
14 number seven, is what Nellie is alluding to, so it now
15 reads affordability is of great importance, and it's
16 essential to the ability of Connecticut residents to
17 obtain, so there was a couple of word changes.

18 CHAIRPERSON VELTRI: So discussion about
19 the principles? No?

20 MS. O'GARA: So, Vicki, we'd like to take
21 a roll call vote, and I can read the names, and if people
22 would just say yea or nay?

23 And according to -- I'll go in the order
24 on my list. It will make it easier. Arlene Murphy?

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 MS. MURPHY: Yea.
2 MS. O'GARA: Claudia Epright?
3 MS. EPRIGHT: Yea.
4 MS. O'GARA: Gerard O'Sullivan?
5 MR. O'SULLIVAN: Yea.
6 MS. O'GARA: Jennifer Jaff?
7 MS. JAFF: Yea.
8 MS. O'GARA: John Erlingheuser?
9 MR. ERLINGHEUSER: Yea.
10 MS. O'GARA: Tanya Barrett?
11 CHAIRPERSON BARRETT: Yea.
12 MS. O'GARA: Vicki Veltri?
13 CHAIRPERSON VELTRI: Yea.
14 MS. O'GARA: Cheryl Forbes?
15 MS. FORBES: Yea.
16 MS. O'GARA: And Cee Cee Woods?
17 MS. CEE CEE WOODS: Not sure. I'll have
18 to abstain. I just walked in. Thank you.
19 MS. O'GARA: Okay. Did I miss anyone?
20 All right, so, they've been substantially approved in the
21 format that we gave them to you, and I think we could
22 move on to the next agenda item.
23 This is a very brief overview of the
24 Committee Tasks and Responsibilities. We're going to ask

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 Bob just to highlight those for us.

2 MR. CAREY: Sure. I mean I guess the
3 central focus of this Committee's charge is to develop a
4 Consumer Outreach Education and Marketing Plan, in
5 concert with the contractors that the Exchange has hired,
6 so your charge really is to provide Mintz and Hoke and
7 the Exchange staff with your thoughts and recommendations
8 on how best to reach consumers and what type of
9 information you'll want to receive, or the Exchange will
10 want to receive on an ongoing basis to monitor consumer
11 outreach and the consumer experience.

12 So there's a number of tasks that we've
13 listed out. Some of these are more advisory than others.
14 I mean the Committee as a whole is an Advisory Committee,
15 but I think the central task of this Committee, as laid
16 out in the, you know, priority tasks, is to advise the
17 work that Mintz and Hoke is doing and of the Exchange
18 staff, in general.

19 That also, obviously, includes the product
20 on the shelf of the Exchange, and that's why, you know,
21 we believe that this Committee's and the Qualified Health
22 Plan Committee are the two Committees that we believe
23 should work most closely on the Essential Health Benefits
24 Package, so there are a number of tasks in here.

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RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 I want to be mindful of the focus today on
2 the Essential Health Benefits, so, if it's okay with the
3 Committee -- yes?

4 MS. JAFF: It appears that the Basic
5 Health Program has been lost on the list of our tasks.
6 Could we possibly restore that? I believe it got put off
7 until July for the Health Plan Committee, so perhaps it
8 could be added to the July agenda for this Committee.

9 MR. CAREY: Yeah, it should be on the July
10 agenda, so we think, because of the import of the
11 decisions regarding the Essential Health Benefits, that
12 that will take precedent and priority for the next
13 probably month or so.

14 We haven't forgotten about the Basic
15 Health Program, but we do think it can be deferred a
16 little later in the summer, and, so, we'll put that back
17 on. It's been inadvertently omitted. We'll put that
18 back on, and that will be for the, you know, July/August
19 time frame.

20 MS. JAFF: Thank you.

21 MR. CAREY: So I don't know if there are
22 any questions about any of the other. There are a number
23 of other issues on the priority tasks, if Board members
24 want to review, and, if they have any comments, they can

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 perhaps feed them through the co-Chairs, but, for the
2 sake of time this morning, I thought we would just move
3 on to the discussion.

4 MS. MURPHY: I just have one quick
5 question. With respect to the reviewing the report on
6 the Consumer Assistance Resources that may be leveraged,
7 does this group make recommendations with respect to
8 that, or is our job just to review the report?

9 MR. CAREY: I think it's to review and
10 comment on report, so, you know, if there are things that
11 are omitted on it, or there are other areas that you
12 would like us to focus on, I think that's the
13 opportunity.

14 MS. O'GARA: Okay, so, moving ahead, we're
15 going to invite the KPMG folks for their report.

16 MR. ALBRITTON: Thank you. I'm Roger
17 Albritton, and what we'll be doing today is discussing
18 our current analysis of the consumer experience, or what
19 we call the current state blueprint.

20 What we'll be going over today is our
21 Consumer Assistance Analysis. What we developed was what
22 we call a current state blueprint, which is a blueprint
23 of the current capabilities that several agencies within
24 the state have around consumer assistance, call centers,

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 and their web portal functionality.

2 In addition, we'll give you a highlight of
3 some of the business process flows that we developed as a
4 part of that analysis, our key observations, and,
5 obviously, answer any questions that the Committee might
6 have.

7 Next slide, please? Thank you. So, as a
8 part of this work stream, which is our Consumer
9 Assistance Analysis, we had four areas that we needed to
10 accomplish.

11 One was the current state blueprint, which
12 is the current work product that we have just completed,
13 the second piece is working on the consumer experience
14 business and technical requirements. That's basically
15 coming up with the requirements that are necessary for
16 the Exchange under the Affordable Care Act to support
17 consumer assistance and call centers and their web
18 portals.

19 The next is, once we have the
20 requirements, identifying some procurement strategies
21 that the Exchange may utilize, in order to procure either
22 the software, hardware, or services that they might need
23 around consumer assistance support.

24 And, finally, once we've decided on a

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 procurement strategy, developing the technical
2 requirements or the contractual specifications to allow
3 the Exchange to enter into an agreement with whatever
4 vendor that they may choose or vendors that they may
5 choose to provide those services or products.

6 Next slide, please? As a part of our
7 current state blueprint -- oh, yes, ma'am? I'm sorry.

8 MS. JAFF: I'm sorry. Do you want
9 questions at the end, or do you want them in the middle?
10 I'm happy to wait.

11 MR. ALBRITTON: It doesn't matter to me.

12 MS. JAFF: I was just wondering why you
13 limited your work to the state agencies, because there
14 are a lot of non-profits, there's legal services,
15 there's, you know, a lot of other organizations, who help
16 consumers navigate the health care system in Connecticut,
17 and, so, I'm just wondering why there was that focus on
18 just the state agencies.

19 MR. ALBRITTON: As you can see from the
20 next slide, ma'am, I just want to make a little
21 clarification, we started off with the major state
22 agencies, and then that led us to an example is United
23 Way.

24 They were one of the areas that we did

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 discuss, because they have a vocal point with supporting
2 the Department of Social Services around some of their
3 Medicaid and CHIP programs, so we did reach out and
4 expand.

5 So, as you can see from this slide, the
6 major agencies that we looked at, because they provided a
7 large group of support, was the Connecticut Insurance
8 Department, the Office of the State Health Care and
9 Advocate, and the Department of Social Services.

10 Now two of these agencies have direct
11 support for insurance programs. That's being the Office
12 of State Health Care Advocate and the Connecticut
13 Insurance Department.

14 We also looked at the Department of Social
15 Services. Because of their work around Medicaid and
16 CHIP, we felt that that would be relevant to the
17 activities that would be occurring within the Exchange
18 Health Care Program.

19 MS. JAFF: Sure. I absolutely understand
20 why those three agencies were included. My concern is
21 for all of the non-profit community that was excluded
22 from your consideration. I'm just wondering if there was
23 a reason for that, if you're going to go back and look at
24 that at some point, because you mentioned United Way,

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 and, of course, the United Way is important, but
2 Connecticut Legal Services is one of the most important
3 statewide organizations that helps people with Medicaid
4 and Husky.

5 I know we do a lot of health insurance
6 work. I know there are many other non-profits around the
7 state, who are part of the, for lack of a better phrase,
8 safety net, that help Connecticut consumers to navigate
9 the health care system.

10 MR. ALBRITTON: So what we'll do is, if we
11 don't mind, if we could take it off line, we'll get you
12 your agency. We did look at other agencies, besides just
13 these three.

14 What we found was that most of those
15 others just didn't have any scale to their particular
16 support. We would be more than willing to get the
17 information about your particular agency or agencies.

18 One of the questions that we did ask, as
19 we went through our interview process, so one of the
20 things that we did here is we did interview the major
21 agencies and asked them what other groups were providing
22 support.

23 We also did web searches to try to
24 identify organizations that might be providing some

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 material, consumer assistance support, to people in the
2 insurance markets, or around what we call the Medicaid or
3 CHIP programs.

4 From that, we did develop the business
5 flows. The business flows kind of outline who they
6 interacted with and how those interactions flowed, and
7 then we also filled out what we called a matrix of
8 capability.

9 We had about 36 different attributes that
10 we determined that we filled out for each of these areas.
11 From that, if we can, we did find, as you noted, ACS,
12 United Way and the Pool Administrators, Incorporated,
13 that were providing services for DSS around their
14 Consumer Assistance support.

15 The current work product that we have is
16 broken up into the current state assessment. It includes
17 an assessment, as well as the business process models
18 representing the current state as we know it, the
19 observations and recommendations, and then strategic
20 considerations for the Exchange Consumer Experience.

21 The next one? This, I can tell, you can
22 see right back from the back. You can read every bit of
23 it. What this is is to kind of give you an overview of
24 what some of the matrix were that we picked up, so we had

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 basically three groups of matrix.

2 One was on consumer assistance, the other
3 was on call center, and the other was on web
4 functionality.

5 What we were trying to determine were
6 things like did they have a call center, did they have a
7 web presence? Within that, did they have social media
8 presence, billboards?

9 When we looked at the call center, we
10 looked to see if they had a customer relationship
11 management system. Did they have triage capabilities,
12 meaning that they had the ability to identify the issue
13 and prioritize it and move it through?

14 Did they have call transfer capability?
15 And, on the website, we looked for things, like did they
16 have frequently asked questions? Did they have chat
17 capability? Did they have the ability to fill out an
18 online form or complaint? So we looked at a variety,
19 again, 36 different matrixes to identify that.

20 The other area that we looked at was the
21 volumes, because we felt volumes were very important. So
22 example is is that the Office of State Health Care
23 Advocacy received about 8,200 calls during the year,
24 whereas DSS was in the almost 600,000 types of reports

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 they handle, so we were trying to see what type of
2 volumes they could support. And if we could change the
3 slide, please?

4 MR. O'SULLIVAN: Just one update. For the
5 Insurance Department, we do have Facebook, Twitter and
6 YouTube videos, as well.

7 MR. ALBRITTON: Thank you. We were
8 informed that yesterday. Thank you. So the next slide
9 is to show the example of the end-to-end process.

10 What we find is that it was a similarity
11 in all of the major agencies in what they did, and that
12 they had someone, a consumer, initiated a complaint or an
13 inquiry, they had individuals assigned to resolve those
14 complaints, and they use some form of a Consumer
15 Satisfaction Survey to determine how well that was
16 accomplished.

17 The difference was down in the Department
18 of Social Services, where they have United Way doing the
19 initiation on the application inquiry. They also process
20 application, process re-determines, and then do change of
21 status, which would be consistent with what they're
22 trying to do, which actually is enroll people into a
23 particular program, where the other agencies were to
24 manage consumer assistance and complaint issues.

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RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 If you can go to the next slide, please?

2 This slide was really -- the purpose of this was to let
3 you guys know one of the things that we tried to track as
4 it relates to the business process flows was how well the
5 tiers were used.

6 We basically used a four-tier approach,
7 looking at tier zero being either a web, or a voice
8 recognition system, Interactive Voice Recognition system,
9 IVR, a tier one being a traditional call center, which is
10 triaging the calls, accepting the calls, trying to answer
11 the questions immediately, or repointing the person back
12 to the tier zero type support.

13 Tier two being more of a resolution area.
14 This is where someone would take a complaint, or take a
15 need and try to resolve that issue. And tier three being
16 where there is a problem that's been identified either
17 with the process or with the application that requires a
18 change, and that change being developed at the tier three
19 and then repopulated back out, so that the consumers can
20 reuse that.

21 What we found was in our analysis is that
22 a lot of the activities had very little tier zero,
23 meaning that there was very little ability to handle the
24 problem on the website or through an IVR system.

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RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 Most of the calls went directly to a tier
2 two, where if someone tried to directly resolve the
3 issue. This works very well in the volumes that were
4 going through this. It may provide more difficulty in a
5 high-volume type call center activity.

6 Obviously, the people were doing a very
7 good job of resolving the issues and tracking those
8 issues within this process. What we did is we actually
9 flowed out 10 specific flows or processes within that
10 area.

11 Next slide, please? Okay, key
12 observations. The first observation that we had is that
13 no existing consumer assistant entity currently serves
14 all of the health insurance needs of the Connecticut
15 consumer.

16 Well that's really driven by the rest of
17 the observations, and a lot of that has to do is that the
18 existing Consumer Assistant Programs are operating as
19 silos. There are few opportunities for self-help exist.

20 There's no common method of identifying
21 consumers exist, common method of identifying consumers.
22 There are numerous 1-800 numbers and websites exist for
23 consumer assistance.

24 The technology is outdated and lacks

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 automation. Staffing is constrained at the Consumer
2 Assistant Programs and call centers. The call centers
3 hours of operation are limited basically to the state
4 hours of 9:00 to 5:00.

5 Most locations have limited space to
6 expand consumer assistant staffing, and that personnel
7 responding to simple inquiries are often the same
8 individuals resolving the consumer assistant issues, and
9 that they are currently limited, in terms of a formal
10 program within to manage navigator-like entities.

11 Now the next slide. So where we're at is
12 that we've identified a current State blueprint. We're
13 currently working on gathering the business and technical
14 requirements that are required for an Exchange, for the
15 Exchange-type services, and the volumes that are expected
16 for the Exchange-like services, and then we will be
17 working with the Exchange to identify a procurement
18 strategy, and then, eventually, helping them come up with
19 the technical requirements and the contract
20 specifications, so that they can procure the services or
21 software and hardware that they need to support the
22 Exchange activities. Thank you.

23 CHAIRPERSON VELTRI: I'm not going to
24 comment directly on any agency, because I feel like that

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 would be a bit of a conflict of interest for me, but I
2 would say, from what I understand, there's going to be
3 some kind of narrative portion or more detailed report
4 that's supposed to be developed about this, so that maybe
5 it would inform the Committee or others more about the
6 extent of the detail into which KPMG got with each
7 agency, in terms of their capacity to handle appeals,
8 whatever else that they were doing.

9 I don't know if that's available now, or
10 going to be available soon.

11 MR. ALBRITTON: We did provide a narrative
12 report. It's currently in draft format. As the
13 gentleman indicated, there are some updates that people
14 keep providing us, as to new capability.

15 What we're also working on is that trying
16 to, as we parallel on, because we have some very tight
17 timelines, the Department of Social Services is currently
18 going through an up modernization of their IBR system and
19 their call center operations.

20 We're trying to work to monitor that and
21 to see if there's updates that we need to make to that
22 document at that time to see if there are things that
23 possibly could be leveraged from that particular
24 modernization project, so we're trying to keep the things

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 running in parallel to make the timelines work, but,
2 eventually, there will be a document that documents all
3 of the findings that we had in the current assessment.

4 MS. JAFF: I'm going to be a little more
5 assertive. I know you all think I'm very assertive, but
6 I'm actually going to be a little more assertive than I
7 usually am.

8 I really don't see how you can possibly
9 get an accurate picture of what's going on in the State
10 of Connecticut, in terms of helping people navigate the
11 health care system without looking in the private sector.

12 I mean I'm sitting next to somebody, who
13 works with HIV AIDS patients, and on my other side is
14 AARP, and these organizations all provide assistance to
15 consumers.

16 There's statewide legal services. Of
17 course the Department of Social Services did not point
18 out the existence of Connecticut Legal Services, because
19 they often sue the Department of Social Services, so you
20 have to ask other people where these other agencies
21 exist.

22 We have agencies that represent people
23 with mental health and substance abuse disorders. None
24 of that is here, and I just feel like you've caught the

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 tip of the iceberg here, in looking only at the state
2 agencies.

3 I mean if you think that the private
4 sector agencies are only open from 9:00 to 5:00, you're
5 completely wrong, and, so, many of us have more capacity
6 on our websites and have more of a Facebook presence, or
7 whatever, and I'm really not talking about my
8 organization, because we're tiny, compared to some of my
9 colleagues here in the state, however, I just don't see
10 how you can feel like you've gotten an accurate picture
11 of the blueprint without talking to all those other
12 agencies.

13 MR. ALBRITTON: As I said, ma'am, we're
14 more than welcome to try to get more information about
15 other agencies.

16 We did go through an extensive list of
17 other agencies. We contacted them by phone to determine
18 what their capabilities were. What we're really looking
19 at was capacity in some of these organizations.

20 We don't doubt that they are involved.
21 It's just that they were not taking in what we would call
22 large volumes of consumer assistant calls and processes.

23 If that information is inaccurate, we'll
24 be more than glad to follow-up on those that someone

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 feels has some capacity that's worth the time to look at.

2 MS. O'GARA: Can I make a suggestion? Is
3 it possible that we could filter an additional list
4 through the co-Chairs, to Tia, if it's important? Does
5 that make sense?

6 MS. FORBES: Absolutely.

7 MS. O'GARA: So, perhaps, I don't know,
8 Roger, what timing you would need that list.

9 MR. ALBRITTON: As soon as possible.
10 Obviously, we need to get all of this work completed in
11 the July time frame, so that a procurement decision can
12 be made. I know that -- so we just need it as soon as
13 possible.

14 MS. CINTRON: So, Vicki, can you -- I'm
15 sorry. Go ahead, Cheryl.

16 MS. FORBES: Yes. I know you said you
17 didn't look at some of the or any of the outside
18 agencies, but I wondered, in your consideration, the
19 models that you're recommending, is it scalable to non-
20 profits or quasi-governmental organizations, and, if not,
21 what are the recommendations for integration of those
22 coordinating systems for the non-profits, quasi-
23 governmental organizations to work with the state
24 agencies that you've analyzed?

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 MR. ALBRITTON: I want to make sure I've
2 made it clear. We did look at agencies, not-for-profit
3 organizations. There's a couple of small ones that we
4 did look at. I can get you the names of the
5 organizations we looked at. I just did not include them
6 in the report, because what we found was that they did
7 not have sufficient scale to provide any bearing on the
8 analysis that we had done.

9 They didn't change what our conclusions
10 were, but we can get those others. So, again, we're more
11 than welcome to look at other agencies. We just need
12 that information, so that we could look at them.

13 MS. FORBES: One last thing. I'm going to
14 push it just a little bit further. You're saying that
15 you're going to get the information, but I'm saying, in
16 your recommendations, was there any consideration, as to
17 how, knowing that those organizations exist, even on what
18 we're saying basically is a minimal level, were there any
19 considerations, as to how those agencies would integrate
20 with the work that you're doing with the ones that you've
21 analyzed?

22 MR. ALBRITTON: Currently, we're working
23 on what we call the to be, so what the Health Exchange
24 Consumer Assistant support would look like, so we are

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 evaluating all of those options as we go forth on looking
2 at what are the options to provide a cost beneficial
3 Consumer Assistance Call Center Support for the Exchange.

4 CHAIRPERSON VELTRI: Could it be that
5 you're just -- I mean people are confused, as to what the
6 definition of consumer assistance is under the Exchange.
7 Maybe it would be helpful if we supplied that for people.

8 MR. CAREY: You know I think that my
9 understanding is the focus of the KPMG work was on the
10 business side of intaking calls, and processing
11 enrollment, and not on consumer assistance, in terms of
12 all of the various agencies across the state that provide
13 consumers with assistance as they try to navigate the
14 system.

15 It was more in terms of the ability, for
16 example, could the Exchange leverage DSS's call center to
17 process enrollments and eligibility for Exchange
18 enrollees, and what's their capacity, and what's the
19 volume of calls, as opposed to all of the assistance,
20 hands-on, you know, assistance that's provided across the
21 state.

22 It was not an assessment of, for example,
23 which entities could serve as navigators, right, because
24 that's not typically a state entity. It's all of the

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 private non-profit entities that could serve as
2 navigators.

3 It was more on the business side of
4 handling call volume, processing enrollment, and the
5 technical aspects of setting up a business, if I'm not
6 mistaken.

7 MR. ALBRITTON: That is correct. Ours was
8 based upon the business process needs and the technical
9 needs for establishing the systems that would support
10 that.

11 To the Chairman's recommendation, we can
12 provide the requirements that are set out by ACA, the
13 Affordable Care Act, as to what the needs are for the
14 Exchange.

15 They are different than some of the things
16 that individuals have tried to communicate here. It is a
17 narrow set of needs to support the Exchange, as it
18 relates to making sure that people can get access to the
19 Exchange and get the support to work through the portal's
20 processes, but we can give you the full exact definition
21 as it comes from the Affordable Care Act.

22 CHAIRPERSON VELTRI: Go ahead, Sheldon,
23 and then I think Arlene.

24 MR. TOUBMAN: To clarify what Jennifer was

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 talking about earlier, in terms of legal services, I'm
2 with New Haven Legal Assistance, and, so, you understand
3 the structure, statewide Legal Services is an 800 number,
4 and all they do is take calls all day long, thousands,
5 tens of thousands of calls, so they're out there state-
6 wide, very prevalent.

7 They, then, refer to the three Legal
8 Services programs, service programs, or field programs.
9 Connecticut Legal Services is state-wide, except for New
10 Haven and Hartford. I'm with the New Haven group, and
11 Greater Hartford Legal Aid covers Hartford.

12 The thing about our organizations,
13 however, is we are, as most people know, focused on low-
14 income consumers, so, certainly, anybody, who is eligible
15 for Medicaid, would be within our guidelines. Some
16 folks, who are not eligible for Medicaid, also are.

17 But that focus, you should understand,
18 we're a very prevalent set of organizations out there
19 that do aggressively provide consumer assistance, so I'd
20 appreciate being included in the discussion.

21 CHAIRPERSON VELTRI: Arlene?

22 MS. MURPHY: I'll be really brief. I
23 guess the reason that, you know, I'm concerned about the
24 key observations and making sure that some areas are

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 addressed in them is because this constitutes the call
2 center, correct, the call center that people will be
3 calling to enroll? Yes?

4 MR. CAREY: Yes. It would constitute the
5 call center.

6 MS. MURPHY: So the target population that
7 we're talking about here are low-income working families,
8 you know, single working men, and, so, how well that call
9 center functions, how accessible that call center is is
10 going to determine the success of the program, because if
11 people get frustrated when they call in, then it won't be
12 as successful in reaching our objectives.

13 And, so, I hear a July procurement, so I
14 would just -- there might be some additional concerns
15 that might want to be included in the key observations
16 portion of this report.

17 MR. ALBRITTON: Can you clarify a little
18 bit more, because I'm not --

19 MS. MURPHY: Well the key observations are
20 going to play a role in the next phase of your process,
21 right? You're going to be using the key observations of
22 your report to determine the procurement for the call
23 center, so the issues that need to be address in the
24 procurement process should be identified, and it sounds

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 like there are concerns around the table that might need
2 to be included in those recommendations. Maybe not here.
3 I mean we could figure out a process of getting those
4 concerns to you in writing and seeing if those could be
5 addressed as part of your key observations.

6 MR. ALBRITTON: I just want to make sure
7 that we're clear. There are two steps to this process.
8 One is is that we are identifying the business and
9 technical requirements for what the Exchange needs, so
10 that's the to-be.

11 That, then, will look at what you have as
12 capability to do that, and, again, I'm hearing a lot of
13 things, and we're not doubting that people have the
14 ability to call 1-800 numbers for legal assistance and
15 things like that.

16 That is not in the functionality of
17 supporting a call center that supports a web application,
18 and that is the key differentiator that we're trying to
19 get here to, is that by establishing the web portal for
20 the Exchange, one of the key things to keeping the cost
21 down will be how well it's adopted by the users and how
22 well it's used, so that they can use it in the most cost-
23 effective manner.

24 For those individuals, who have ever used

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 Amazon.com, or bought a plane ticket on an airline and
2 had an issue while trying to do that transaction and
3 you've called a call center, that is the type of call
4 center that you're going to need to have supporting your
5 Exchange, and those are the type of requirements that
6 we're trying to gather at this point, and we'll match,
7 again, against the capability.

8 CHAIRPERSON VELTRI: I mean, obviously,
9 there's still some confusion about what you're doing, in
10 terms of assessment versus what will be the end product,
11 in terms of the consumer assistance function, and I think
12 we can have a very long discussion, obviously, if we kept
13 going.

14 And I think that the narrative that you
15 have referenced and that you've given a draft of is
16 actually going to flesh out a lot of detail for people
17 and kind of guide them, as to what you're really looking
18 at overall is not just the capability, but, also, what
19 will be -- what functions actually have to be provided by
20 these consumer assistance entities, whether it's appeals,
21 whether it's advice, whether it's education, so it's not
22 just the call center. It's all the other pieces to it
23 that I think you've been looking at, because we've been
24 assessed.

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 But I think what would be actually helpful
2 is for us to get the list of names of these
3 organizations, and I do think probably should be
4 examined, because of their consumer assistance
5 capabilities, together, and maybe they can come through
6 Tanya and me, and we'll farm them over to you, and then
7 get a list of concerns of the people around the table
8 about the call center issue or the capability
9 assessments, and also get those to you in one, just one
10 package, so that you can review, and then get back to the
11 Committee on. Is that acceptable to everyone?

12 MR. ALBRITTON: That's acceptable, yes.

13 MS. O'GARA: That sounds great, Vicki.

14 Okay.

15 MS. CINTRON: And I just need to add that
16 if we could get that done very soon, that would be
17 helpful, too.

18 MS. O'GARA: All right. With that, I
19 think we can move to the next item on the agenda, and
20 that would be the EHB.

21 MR. CAREY: Okay, so, the discussion today
22 on the EHB that we've set it up sort of to walk the
23 Committee through, first all, the role of the Exchange
24 Board and the role of the Advisory Committees with regard

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 to the Essential Health Benefits Package, which applies
2 to all consumers purchasing in the individual and small
3 group market, both inside and outside the Exchange, so
4 we're going to talk through sort of the process with
5 regard to the Essential Health Benefits Package, a brief
6 overview of Qualified Health Plans, and what needs to be
7 included in the Essential Health Benefits Package.

8 And just so folks understand, the
9 Essential Health Benefits are what's covered, not the
10 cost of the coverage or the cost to the member of the
11 coverage, so the Essential Health Benefits Package is
12 what are the set of services or benefits that will be
13 required to be included in a Qualified Health Plan that's
14 sold on the individual and small group markets starting
15 in 2014 for Connecticut, and there is significant
16 guidance from the federal government and a set of
17 parameters by which states will need to make a decision
18 with regard to EHB.

19 I'm going to talk a little bit about the
20 treatment of state-mandated benefits and how that's
21 evolved over the last 18 months, the Health and Human
22 Services Benchmark Plan approach to defining Essential
23 Health Benefits, Connecticut's options with regard to
24 Essential Health Benefits, and then sort of next steps

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 and additional resources that are available.

2 So, as we go along, if folks have
3 questions, let's take them as we move through.

4 So, as I mentioned, the decision with
5 regard to the Essential Health Benefits Package applies
6 not just to the Exchange. It does apply to the Exchange,
7 but it also applies to the individual and small group
8 market in Connecticut in 2014 and beyond, so there's a
9 market that exists currently today in the individual and
10 small group market. There will be a market that exists
11 in 2014 outside the Exchange in the individual and small
12 group markets.

13 And, so, the decision with regard to the
14 Essential Health Benefits Package is a market-wide
15 decision, not one specific to the Exchange.

16 The Advisory Committee's opportunity or
17 input is critical in this decision-making process, but it
18 is not a final arbiter of what will be included in the
19 Essential Health Benefits Package.

20 Your recommendation, in concert with the
21 Qualified Health Plan's Advisory Committee's
22 recommendation, will go the Exchange Board, which will
23 then recommend an Essential Health Benefits Package to
24 the administration.

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 At this time, there's not been a decision
2 made in Connecticut with regard to who decides what the
3 Essential Health Benefits Package is, so, again, it could
4 be the Department of Insurance. It could be the
5 Governor's office. If the legislature were to come back
6 into session and wanted to weigh in on this, they might
7 have a different take on who decides what the Essential
8 Health Benefits Package is.

9 I can tell you that it is extremely time-
10 sensitive, so if the State doesn't make a decision with
11 regard to what's the Essential Health Benefits Package,
12 the federal government will make that decision on your
13 behalf, and the federal government default Essential
14 Health Benefits Plan or Package is the small group
15 product with the largest enrollment in the State of
16 Connecticut.

17 And as we'll walk through the benefits
18 that are covered by the various options, you'll see that
19 there is some difference, but not what I would call a
20 meaningful difference, in terms of the benefits covered.

21 There are certainly meaningful differences
22 in cost-sharing that applies to the benefits, but there's
23 not a meaningful difference, I think you'll find, with
24 regard to what's covered in the various options that are

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 available, so that's sort of the context that we're
2 working in. I just want to make sure people are level
3 set on that.

4 Again, it needs to be decided by September
5 of 2012, not only for federal reasons, but, also, because
6 the carriers will have to develop products or modify
7 existing products, so that they are aligned with and
8 compliant with the Essential Health Benefits
9 requirements, so that takes time for carriers to develop
10 products.

11 They'll need to understand what additional
12 benefits might need to be included in the products that
13 they sell in the individual and small group market for an
14 open enrollment that will occur in October of 2013 for an
15 effective date of coverage of January 1, 2014.

16 Okay, so, the ACA requires that all
17 individual and small group products sold in 2014 and
18 beyond be Qualified Health Plans.

19 Qualified Health Plans need to cover the
20 Essential Health Benefits, and the ACA lays out 10 broad
21 categories of care or services that must be covered as
22 part of the Essential Health Benefits Package within a
23 Qualified Health Plan.

24 The EHB is a part of, but it is not a

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 determinant of the actuarial value of a product, so an
2 actuarial value is essentially how much of the Essential
3 Health Benefits are covered by my premium, and how much
4 on average would I pay in cost-sharing co-pays,
5 deductibles and the like, so you have in the ACA those
6 four tins of platinum, gold, silver and bronze,
7 catastrophic plan is available to some folks.

8 That's really a cost-sharing issue, as it
9 applies to the EHB, but the EHB, itself, is simply the
10 range of services and benefits that are covered by a
11 Qualified Health Plan.

12 The law directs the Secretary of Health
13 and Human Services to establish the specifics with regard
14 to what's covered within the 10 broad categories of care
15 outlined in the ACA.

16 In December of 2011, the Secretary
17 essentially deferred that decision or pushed that
18 decision to the states to decide for themselves what will
19 be the Essential Health Benefits Package for the State of
20 Connecticut within certain parameters.

21 First of all, the Essential Health
22 Benefits Package must cover services within the 10 broad
23 categories of care, and, furthermore, the secretary
24 identified 10 plans that states could use as a benchmark

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 plan for the purposes of the Essential Health Benefits
2 Package.

3 Those 10 plans are the small group
4 products with the -- the three small group products with
5 the largest enrollment in the state, the three State
6 Employee Plans, if there are three State Employee Plans,
7 with the largest enrollment, the three Federal Employee
8 Health Benefit Plans with the largest enrollment, or the
9 HMO, non-Medicaid HMO with the largest enrollment in the
10 state.

11 In Connecticut, one of the three largest
12 small group plans is also the largest HMO, so instead of
13 10 options, you're down to nine options. In addition,
14 the State Employee Health Plan, the coverage, in terms of
15 what's covered, is the same.

16 There are differences, in terms of cost
17 sharing, so in terms of the benefits, themselves, and
18 what's covered, you essentially have one State Employee
19 Plan to look at, and, so, now you're down to seven plans
20 that you can take a look at.

21 In addition, the Federal Employee Health
22 Benefit Plan, the two of three largest, are essentially
23 the same, in terms of the benefits covered. The
24 difference is cost-sharing again, so, when you eliminate

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 sort of any difference, based on cost-sharing, and look
2 only at the benefits covered, you get down to a --

3 (Off the record)

4 MR. CAREY: -- in a column, but you'll see
5 that a couple of them have been collapsed, because,
6 again, the largest HMO enrollment is also the largest,
7 one of the largest small group plans, and the Federal
8 Employee Plans are collapsed, and the State Pay Plan is
9 collapsed.

10 If the Essential Health Benefits Package
11 that you are examining does not include certain
12 categories of care, in particular, it's been pointed out
13 that habilitative services, as opposed to rehabilitative
14 services, tend not to be covered by most commercial
15 insurance products, you would need to supplement whatever
16 plan you chose if it does not include habilitative
17 services, for example, or pediatric dental is another
18 common benefit that is not commonly covered in a medical
19 plan. It's typically covered in a separate dental plan
20 and pediatric vision, as well.

21 And, so, when we look at the specifics
22 about what's included in the Essential Health Benefits
23 Package, we'll need to think about potentially
24 supplementing whatever plan that is for those services

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RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 that may be excluded from that plan.

2 So, for example, if a plan does not
3 include prescription drugs, prescription drugs is a
4 required element that must be covered as part of the
5 Essential Health Benefits, you would have to supplement
6 the plan with a prescription drug benefit.

7 MS. JAFF: Just to clarify, when you say
8 supplement, it's my understanding that what we would do
9 is actually take that category of services from another
10 benchmark plan and move that over to the benchmark that
11 we are selecting.

12 It's not like we would be inventing a
13 whole coverage category on our own?

14 MR. CAREY: Correct. That's right. So
15 you would look, for example, you know, actually, the
16 State Employee Plan prescription drugs is a rider. It's
17 not part of the base package, so you might look to the
18 Federal Employees Health Benefit Plan, in which
19 prescription drugs are covered within the core set of
20 services. Thank you for that clarification.

21 Okay, so, here are the 10 broad
22 categories, as listed out in the Affordable Care Act.
23 Ambulatory Patient Services, Emergency Services,
24 Hospitalization, Maternity and Newborn Care, Mental

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 Health and Substance Use Disorder Services, Prescription
2 Drugs, Rehabilitative and Habilitative Services and
3 Devices, Laboratory Services, Preventive and Wellness
4 Services and Pediatric Services, including Oral and
5 Vision Care.

6 Now the charge for the Secretary was
7 initially to establish an Essential Health Benefits
8 Package for the entire country, and I think that was the
9 assumption most people had going in beyond the passage of
10 the law in May of 2010.

11 Again, the federal government has decided
12 to allow states within some parameters to set their own
13 Essential Health Benefits Package, so you may see, you
14 will likely see that the Essential Health Benefits in New
15 York may be slightly different from the Essential Health
16 Benefits Package in Connecticut.

17 But, at its core, these are the 10 broad
18 categories of care that all Essential Health Benefits
19 Packages must cover.

20 So let's talk a minute about state-
21 mandated benefits. Under the law, the Essential Health
22 Benefits Package, which originally was assumed to be
23 developed by the Secretary of Health and Human Services
24 for the entire nation, they included in the law a

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 provision that said that if a state has a mandated
2 benefit or a requirement that exceeds the Essential
3 Health Benefits Package, the state would have to pay for
4 the cost of that benefit, the excess and premium for that
5 benefit, for any mandated benefit that exceeded the
6 Essential Health Benefits Package for all people
7 purchasing coverage through the Exchange.

8 So if there was a mandate that didn't fall
9 within the 10 categories of care, or that the Secretary
10 did not include in the specificity of what exactly is
11 included within those 10 categories of care, states would
12 be responsible for potentially the cost of those mandates
13 that exceed the Essential Health Benefits.

14 But because the federal government has now
15 turned to the states and said states can determine what
16 is considered the Essential Health Benefits Package,
17 including any state mandates, for example, that may apply
18 in a small group product, so it's something to think
19 about as we go through this, that, you know, as you look
20 at the small group products in the State Employee Plan
21 and then the Federal Employee Health Benefit Plan, if a
22 state, for example, chooses the Federal Employee Health
23 Benefit Plan and if the Federal Plan doesn't include some
24 state mandates, the state would potentially be on the

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 hook in 2014 and 2015 for the cost of those mandates that
2 exceeded the Essential Health Benefits Plan, so it's
3 something to think about as we go through this process.

4 Now for Connecticut's perspective, because
5 the State Employee Plans and the Small Group Plans all
6 include state mandates, if the state chose either a small
7 group plan or the largest HMO, the HMO with the largest
8 enrollment, or the State Employee Plan, the state would
9 not be responsible for any potential fiscal impact for a
10 mandate that might otherwise fall outside of the
11 Essential Health Benefits Package, so this applies at
12 least for 2014 and 2015.

13 The guidance that was put out in December
14 notes that HHS will revisit this at some point. They
15 pointed to 2016 as the potential year in which they would
16 revisit this, or year in which there may be changes, but
17 for at least 2014 and 2015 and I guess to be determined
18 going forward, state-mandated benefits may be included
19 within the Essential Health Benefits Package, and the
20 state will not be responsible for the cost of covering
21 those mandates for people purchasing coverage through the
22 Exchange.

23 MS. JAFF: I just want to clarify, make
24 sure everybody is clear on this. To the extent that any

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 of the state mandates fall within the 10 broad categories
2 that are listed in the ACA, those are not at risk for any
3 state, even if HHS changed the Essential Health Benefits
4 Package in 2016. That's my understanding.

5 For example, to the extent that a mandate
6 applies to prescription drugs and prescriptions drugs is
7 one of the 10 categories, then whatever the Secretary of
8 HHS did down the road the state would not be responsible
9 for paying for that mandate.

10 And one of the things that the Health Plan
11 Committee yesterday asked the Exchange staff to do for us
12 before our next meeting is to take the list of state
13 mandates and categorize them and show us which one of the
14 broad categories each mandate falls within, so that we
15 know which ones we are at risk of having to pay for down
16 the road, those that don't fit into any of the 10
17 categories, as opposed to those that are within the 10
18 categories and we don't need to worry about those. Is
19 that right, Bob?

20 MR. CAREY: Yeah. So that's a good point.
21 Our initial review of the mandated benefits suggest that
22 most probably fall within one of the 10 broad categories
23 of care. There may be some that fall outside. We'll try
24 to identify, or we will identify those.

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RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 Again, this will just be, you know, our
2 estimation of which mandates fall inside versus outside,
3 but if the state chose a small group plan or a State
4 Employee Plan, which currently includes the state
5 mandates, it would not be liable for any fiscal impact in
6 2014 and 2015.

7 MR. TOUBMAN: Just to sort of move the
8 discussion along, and maybe it's a little premature, but
9 it sounds like there is, in order to preserve the
10 mandates, and a lot of the folks around the table care
11 about that, it sounds like we're guaranteeing that, at
12 least for 2014 and 2015.

13 Beyond that, for anything within the 10
14 categories, so there's probably not very much out there
15 left, it seems like the only danger would be if we chose
16 one of the Federal Employee Plans, so is there a reason
17 not to right now just knock them off as being not for
18 consideration to limit what we're going to talk about?
19 Do you see what I'm saying?

20 MR. CAREY: So what we are going to do,
21 also, is map the state mandates against the Federal
22 Employee Health Benefit Plan, so it may be that, you
23 know, I don't think all of the mandates are covered by
24 the Federal Employee Health Benefit Plan, but I would

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 suggest probably a fair majority of them are covered, but
2 we'll go and identify those.

3 And I think you're right, that, you know,
4 my read of this is most states are looking not to the
5 Federal Employee Health Benefit Plan, but to a small
6 group product offered in the market today that
7 encompasses all of the state-mandated benefits, but
8 that's an option on the table.

9 We didn't feel we wanted to remove
10 anything from the Committee's consideration, but I think
11 it is worth pointing out that that is probably the
12 biggest distinction amongst all of your choices.

13 A couple of other points, just before we
14 get into the details of what's covered by each of these
15 benefit plans.

16 Once the state has chosen a benchmark
17 plan, all plans in the individual and small group market
18 are required to offer benefits that are substantially
19 equal to the benchmark plan, so there may be some
20 deviations in what is covered plan-by-plan.

21 Our read of this is that will be up to
22 the, because this affects all plans in the individual and
23 small group market, at the point of review and approval
24 that the Connecticut Insurance Department will need to do

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 for all products.

2 They will have to make a decision, as to
3 whether the plan is substantially equal to the benchmark
4 plan that the state selected for its Essential Health
5 Benefits Plan, so there may be minor differences, but, in
6 general, or overall, the plans are substantially equal,
7 in terms of the benefits covered.

8 The final point is that, again, HHS has
9 indicated that they will be updating this guidance at a
10 later date, but I think, as of right now, we're pretty
11 confident that this is the path that they've chosen.

12 I will say it's a bulletin. It's not a
13 regulation that HHS issued, so they'll have to figure
14 out, and I think they're trying to noodle over exactly at
15 what point they make this a final regulation, as opposed
16 to a bulletin, which is more sort of guidance-like.

17 So what we did to try to help move this
18 discussion along is working with the Connecticut
19 Insurance Department, surveyed the carriers to obtain
20 information on the benefits covered for their largest
21 small group products.

22 All nine of the benchmark plans cover
23 services in most of the 10 required categories of
24 benefits, and you'll see there is some difference, but,

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 in general, there's not sort of widespread disparity, in
2 terms of really what's covered by small group versus
3 state employees versus the Federal Employee Health
4 Benefit Plan.

5 Again, not cost-sharing. There are
6 differences in cost-sharing, but there are not
7 significant differences, in terms of the benefits that
8 are covered within each of those 10 categories of care.

9 MS. JAFF: It's me again. So we had a lot
10 of discussion about this yesterday at the Health Plan
11 Committee. As you know, I'm your liaison to that
12 Committee, so I think this may be a good point to give
13 you the list of additional information that the Exchange
14 staff is going to provide to everybody, including this
15 Committee, so that we can maybe cut through some of those
16 questions and know that those questions are going to be
17 answered.

18 The list, in addition to categorizing the
19 mandates according to the 10 benefit categories, we will
20 be given a summary of benefits for each of the benchmark
21 plans.

22 Typically, the first eight to 10 pages of
23 a Certificate of Coverage or Summary Plan Description is
24 a summary of everything that's covered in the plan, and

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 it will tell you not only whether something, like
2 physical therapy, is covered, but how many visits per
3 year, and the benefit limitations are definitely
4 something that does differ among the benchmark plans,
5 and, so, something that we need to consider in balancing
6 which of the plans we think is most beneficial for
7 consumers, so the first thing we will get is that brief
8 summary of the benefits covered by each plan.

9 We will get some information on where some
10 of the following services fall into the 10 categories, so
11 physical therapy, occupational therapy, speech therapy,
12 durable medical equipment, some of the mental health
13 services, inpatient, outpatient, prescription drug tiers
14 and especially specialty tiers.

15 We also were asked by a representative of
16 Aetna to include some information about what the cost
17 difference to consumers will be if you have a plan that
18 provides for 30 physical therapy benefits per year, and
19 you have another plan that provides for 90 physical
20 therapy benefits per year. What will be the difference
21 in cost to the consumer in the form of premiums?

22 There was some discussion of trying to
23 flesh out some of the benefit categories and look at
24 possible innovations that may be included. For example,

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 we've got this broad category of preventive and wellness
2 services and chronic disease management, which currently
3 kind of doesn't exist under most plans, except maybe some
4 preventive care, and, so, there was some discussion of
5 looking at things, like patients that are at medical
6 homes, or other kinds of practice innovations that might
7 contribute to that category of benefits.

8 And then the last item that I had on my
9 list is we would be given a list of the exclusions, the
10 items that are expressly excluded from each of the
11 benchmark plans, so that we would know that those
12 services under no circumstances will be covered if we
13 choose that benchmark plan. Did I leave anything out?

14 CHAIRPERSON VELTRI: Thank you, Jennifer.

15 That was very detailed. Thank you.

16 MR. CAREY: Yes. You're hired.

17 CHAIRPERSON VELTRI: But we needed it. I
18 have a question. On the rehab and habilitative services,
19 Jennifer brought up PT, ST and OT, and those are huge
20 issues that consumers face in lacking access to,
21 especially a lot of people, who have never had speech,
22 the traditional response from the carriers is, sorry,
23 you're not covered, because it's not restorative.

24 You didn't speak first and didn't lose it,

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RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 so you're not going to get coverage to get it back, and
2 that's going to be a critical issue, so the habilitative
3 services is going to be a really important thing for us
4 to nail down, and it's also really important from the,
5 and I will be upfront about it, from the kids on the
6 autism spectrum disorder, and we have an autism mandate
7 in Connecticut that was passed a few years ago and is a
8 pretty good mandate.

9 It has a cap on it, but it's still a
10 pretty good mandate, and it's something that some of the
11 services underneath it are habilitative that would not
12 have otherwise been covered without that mandate, so, to
13 me, it's critical that we maintain that kind of service.

14 And, in addition, our mental health,
15 generally, our mental health mandates go a little bit
16 farther than -- they definitely go farther than the
17 Federal Employee Health Benefit Plan.

18 We actually have a mental health mandate
19 that requires that the carriers cover residential
20 services if they're medically necessary, things that
21 aren't just, you know, traditional inpatient/outpatient
22 kinds of coverage, so I'll be looking to make sure that
23 we maintain those kinds of coverages, because they're
24 critical going forward for our consumers, who obviously

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 span the gap, in terms of income and in terms of level of
2 need.

3 And the other thing I guess I would just
4 add to this is probably completely a long time, and you
5 can tell me if it is, and we'll come back to it some
6 other time, but, in terms of habilitative services and
7 Medicaid and whatever Medicaid has to do with Essential
8 Health Benefits, I'd be interested to know, you know, is
9 the Medicaid requirement for Essential Health Benefits
10 does that line up with this requirement for Essential
11 Health Benefits, or is it different, because habilitative
12 services is one of those areas, where our state is
13 currently lacking in coverage for people who need those
14 kinds of services.

15 MR. CAREY: It can be different, actually.
16 The Medicaid benefit for the expansion population can be
17 different. It doesn't have to follow the Essential
18 Health Benefits Package for the individual and small
19 group market.

20 Okay, so, we tried now to sort of flesh
21 out in a bit more detail underneath each of these sort of
22 broad categories. The line item services that one might
23 presume to be included, for example, under ambulatory
24 patient services and then emergency services is also

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 included here, so the yes in all the boxes means that the
2 benefit is covered in the plan within the column for that
3 applicable plan.

4 Where there are limits, specific limits,
5 now I'll say this with a caveat, that this doesn't mean
6 that there's not prior authorization, or medical
7 management programs that are put in place by the carrier
8 as they administer and operate the plan of benefits, but
9 within the contract, itself, there is no express limit,
10 except where noted.

11 So, for example, home health services is
12 limited to 30 visits for Oxford PPO, whereas it's 100
13 visits, up to 100 visits for ConnectiCare and for Anthem
14 Blue Cross/Blue Shield.

15 Now, again, there will be a medical
16 necessity determination made with regard to how many
17 visits someone actually gets, so it's not a blank check
18 that you get 100 visits, whether or not the carrier
19 determines that you need them, but in terms of a hard
20 stop, that's what's put in place for these plans.

21 And then the same with the skilled nursing
22 facility. The plan of benefits covers up to 30 days for
23 Oxford PPO, whereas it's 90 days for ConnectiCare and
24 Anthem Blue Cross/Blue Shield.

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 There are no limits or restrictions, in
2 terms of emergency room use, or emergency transportation,
3 or ambulance, no sort of you get, you know, two visits a
4 year. There's no express limit on any of those. Again,
5 cost sharing does not factor into any of the
6 consideration here.

7 Yesterday, I thought it was helpful that
8 we went through if people have, you know, additional line
9 items that they're looking for information on underneath
10 these broad categories of care.

11 If you, either now or perhaps no later
12 than tomorrow, let, through Vicki and Tanya, let them
13 know, and we can, then, take that back and go back to the
14 evidence of coverage and fill that in if people need
15 additional information, so maybe, you know, you don't
16 have to tell us now, unless you know, but as soon as
17 possible, so we can turn that around for you.

18 The next three categories are
19 hospitalization, maternity and newborn care, and mental
20 health and substance use disorder services. Again, sort
21 of the general requirements in Connecticut are such that
22 these types of services have been addressed through
23 statutory requirements for the individual and small group
24 market, and, so, there are no express limits in any of

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 the plan designs that we reviewed.

2 The prescription drug piece is, you know,
3 for three, actually, of the six plans that we looked at.
4 The drug benefit is a rider, so it's not part of the base
5 package of coverage. You could purchase an Anthem Blue
6 Cross/Blue Shield HMO without prescription drug coverage,
7 so it's added as a rider.

8 To Jennifer's point earlier, if we were to
9 select the Blue Cross plan, we would need to supplement
10 it with the prescription drug benefit of one of the other
11 plans, in which it's not a rider.

12 That, actually, is still under discussion
13 or consideration by HHS, as to whether or not you could
14 just couple, you know, Anthem's core coverage with
15 Anthem's rider drug coverage, and, so, they're going back
16 and forth on that, as to whether a state could choose
17 Anthem's Blue Cross with also the Anthem rider for the
18 prescription drug benefit, but that's still an open
19 question from CCIIO.

20 Rehabilitative and habilitative services,
21 we did note the PT/ST/OT in the description. I think it
22 would be helpful if we flesh that out, so have more
23 details about exactly what, because, typically, those are
24 limited in duration, or in terms of the number of visits,

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RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 and, so, we'll want to flesh that out with a bit more
2 detail.

3 And then we included imaging underneath
4 laboratory services, so lab and x-ray and any high-tech
5 imaging, all of the plans cover it without any sort of
6 explicit limitation on the number of services.

7 The final two sort of -- certainly, one is
8 less well-defined. Typically, the carrier won't put into
9 its contract specificity with regard to sort of the
10 wellness programs that they operate.

11 Those are generally available. They tend
12 to change over time, so I think that the carriers are
13 more likely to have them as a service, not as expressly
14 documented in a contract between the individual and the
15 carrier, so, you know, all of the carriers have wellness
16 and chronic disease management programs. I guess I would
17 suggest that they vary, in terms of their intensity or in
18 terms of the services that are provided.

19 Finally, on the pediatric services, we did
20 note that while they're covered, there are certainly
21 limits, and the federal government has recognized that
22 pediatric dental and oral, dental and vision is not
23 typically covered in a commercial insurance product, and,
24 so, they pointed to the CHIP benefit, the CHIP dental

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 benefit, or the Federal Employee Health Benefit Plans
2 dental rider or vision rider as potentially satisfying
3 the requirement that pediatric dental and vision services
4 be included within the Essential Health Benefits Package.

5 CHAIRPERSON VELTRI: I guess I would
6 suggest, on the pediatric dental and the vision, you
7 know, oral health care is one of those things that,
8 unfortunately, you know, it sort of gets left behind a
9 lot, and, so, I would really appreciate as much
10 information as we can get about the pediatric oral health
11 packages that there are, so at least we can make a really
12 good recommendation about that. It's been too long
13 neglected.

14 I have a question about, going back to the
15 plan designs, let's say we chose, we recommended, this
16 Committee decided we recommended the largest, the
17 ConnectiCare HMO or the State Employee Plan, for that
18 matter, so what could happen is that we recommend that,
19 and let's say the other plan, the other Committee agrees
20 with us, that becomes the recommendation, the carrier can
21 then, even after the plan is selected, can the carrier,
22 then, change the benefits within -- not the benefits, but
23 like the limits within a certain benefit, as long as the
24 Insurance Department decides it's substantially equal?

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RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 So we make a recommendation, basically,
2 that we know the State Employee Plan offers 20 PT visits
3 or something, and we think that that's a good thing, for
4 whatever reason we think that's a good thing, and
5 everybody agrees with it, and then the carriers are
6 bidding, or putting in to participate, and they say, no,
7 we want to limit, okay, fine, PT is in there, but we want
8 to limit it to 10, they can do that, as long as they can
9 show the Insurance Department is a substantially equal or
10 actuarially equivalent or something?

11 MR. CAREY: Yeah, so, the term that they
12 use to substantially equal to provide some flexibility to
13 carriers. I think that maybe a better example might be
14 that sometimes a carrier will have -- one carrier will
15 say there will be 20 PT visits post-discharge, or after,
16 you know, a condition, and another carrier might say,
17 well, we'll give you, we'll provide, you know, 90 days of
18 PT from the point of the, you know, discharge or the
19 accident, and, so, you know, the actuaries or the
20 Department's review will say, you know, generally, you
21 get, you know, two visits a week for 10 weeks, or, you
22 know, 90 days, it's basically the same, it's
23 substantially equal.

24 It doesn't have to be exactly 20 PT

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 visits. It could be something they could frame it
2 differently, but, in essence, it's substantially equal,
3 so that's sort of an example.

4 I would suggest that 10 PT visits versus
5 20 PT visits might not be, but, again, this will sort of
6 -- it just provides some flexibility, so that, you know,
7 as you know, you know, products differ across the
8 marketplace, and what they're trying to do is recognize
9 that and not create substantial disruption in the
10 marketplace, particularly for those people, who are
11 currently covered in an individual or small group product
12 and having to have sort of a, you know, significant
13 change in their plan design, so long as it, again, is
14 substantially equal to and it covers all of these
15 Essential Health Benefits.

16 I can tell you that all of the products in
17 Connecticut, all of the products across the country will
18 change in 2014, in order to comply with the Essential
19 Health Benefits Plan.

20 The question is how much disruption, and
21 is it necessary, so long as the benefit is substantially
22 equal?

23 CHAIRPERSON VELTRI: I hear what you're
24 saying, and I understand. I just wanted to make sure

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 people are aware, that there's still that flexibility in
2 there, so that there's no expectation, there isn't a real
3 expectation that it's a rigid, you know, formulation once
4 we all recommended it and it gets passed or gets -- or we
5 make it policy in the State of Connecticut, that there's
6 still some flexibility in there. Jennifer?

7 MS. JAFF: I just want to really say to
8 the members of this Committee how important it is that we
9 get your feedback, especially about the populations that
10 you serve that we may not serve the same populations.

11 Sean just asked me a couple of questions
12 about HIV AIDS coverage, which I don't know the answers
13 to, and, so, you know, I've encouraged her to, you know,
14 funnel that through the co-Chairs as questions.

15 I think, you know, to the extent that
16 there are people here representing, you know, not just
17 over 65, but over 55, and, you know, and small business
18 owners, and people with mental health and substance abuse
19 issues, I think it would be really helpful, for those of
20 you, who serve specialized populations, to help us think
21 about questions we should be asking, because, otherwise,
22 I mean, you know, the Health Plan Committee is just not
23 going to think of all the right questions, so we really
24 could use your help with this.

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RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 CHAIRPERSON VELTRI: I was going to
2 recommend, since we're going to get the SPDs or the
3 Certificates of Coverage, the summaries of those, that
4 maybe, I mean I'm just throwing this out right now, but
5 maybe that our Committee, the people, who have
6 specialties on the Committee, sit down and examine their
7 areas of those SPDs, or Certificates of Coverage, to see
8 what they think is the best recommendation.

9 Hopefully, it's not one from this plan,
10 one from that plan, and one from the other plan, but it
11 might be a way for the Committees to use its expertise in
12 evaluating what the benefits are that are out there right
13 now.

14 CHAIRPERSON BARRETT: And, actually, Bob,
15 I have one question, and I'm not sure if it actually fits
16 here, but one of the issues that always comes up in
17 people selecting plans is with regard to access to
18 specialists and whether or not it's like a gatekeeper
19 model, or that type of thing.

20 And I'm wondering, because I don't really
21 see it here, whether that would be something that was
22 being included as part of kind of the decision-making
23 process, because it's great to have, you know, all of
24 this full array list of benefits, and then, you know, you

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 have to jump through 10 hoops to open the door. People
2 are not going to do that and for people to be able to
3 factor that in, so I don't know what the intent is, or
4 where it would go, but how would we know that?

5 MR. CAREY: So I think that's a good
6 question, that it would not apply to this discussion, in
7 terms of the benefits covered. It would apply to a
8 subsequent discussion we'll have, in terms of any
9 selection criteria for the Exchange.

10 Okay, so, that would be an Exchange-
11 specific issue, in terms of what are the types of plans
12 that the Exchange wishes to offer to its individual and
13 small group purchasers, and, so, we'll have a
14 conversation about, you know, the types and number of
15 plans that the carriers offer.

16 This conversation really is specific to
17 what are all of the services that must be covered within
18 all of the health plans sold in the individual and small
19 group market?

20 A subsequent discussion will be does the
21 Exchange want to require certain types of coverage or
22 access, certain guarantees of access for certain
23 services, and, so, we'll have that discussion, but I
24 think it will be down the road a little bit.

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 MS. MURPHY: It might be helpful for that
2 portion of the discussion to have this similar comparison
3 of the plans that we're comparing for the Essential
4 Health Benefit Plan noted with those types of limitations
5 noted, like, you know, you get 90 visits, but you have to
6 go through prior authorization.

7 It would be helpful to have that kind of a
8 description, so that we can see where those kind of
9 procedural limitations impact on the care to the
10 benefits.

11 MR. CAREY: Well, again, I would suggest
12 that is, you know, a relevant discussion to have, but not
13 with regard to what are the services that must be
14 covered, but, rather, what are the types of products that
15 the Exchange wishes to offer, and the Exchange might want
16 to know, specifically, as it goes out for solicitation,
17 so, as part of the Exchange's solicitation of Qualified
18 Health Plans, you know, it may be a preference that or a
19 requirement may be that the carriers must submit
20 information with regard to prior authorization rules, or
21 generics preferred, or any other type of medical
22 management programs that they have in place.

23 So if I could suggest that we sort of put
24 that in a parking lot, not forget about it, but, for

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 right now, I think --

2 CHAIRPERSON VELTRI: So, Bob, do you want
3 to, then, summarize the next steps with respect to this?

4 MR. CAREY: Sure. I don't want to cut
5 anybody off, in terms of questions or comments.

6 CHAIRPERSON VELTRI: Go ahead, Sheldon.

7 MR. TOUBMAN: I just wanted to clarify
8 this last thing, because the prior authorization rules,
9 the gatekeeper rules can be far more important than the
10 other things in realty, but, as I understand what you're
11 saying, is that, for purposes of what HHS is requiring in
12 selecting this benchmark plan, it doesn't matter what the
13 prioritization rules are, because all you're saying is
14 this is the plan, in terms of the benefit coverage, and
15 you could pick them, and they could change their prior
16 authorization rules.

17 It's not going to be relevant in the
18 selection of what the baseline is. Did I get that?

19 MR. CAREY: Correct. That's correct.

20 MR. TOUBMAN: Okay.

21 MR. CAREY: Again, you know, for the
22 purposes of the Exchange and the types of plans the
23 Exchange wishes to offer, well for the purposes of the
24 Department of Insurance oversight and monitoring of, you

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 know, does the carrier, you know, is the carrier living
2 up to the details of the contract, or is it sort of a
3 bait and switch thing, where they put in so many hurdles
4 that someone really can't get access to services, that's
5 sort of a separate, although, to your point, maybe more
6 important consideration, in terms of oversight and
7 monitoring and the selection of Qualified Health Plans,
8 but, for the purpose of HHS determination of the services
9 and benefits covered by the Essential Health Benefits
10 Package, it's not sort of part of their consideration.

11 CHAIRPERSON VELTRI: So, Bob, there are,
12 by looking at these small groups and the Federal Employee
13 Plan and the State Employee Plan, we know that the State
14 Employee Plan is identical, in terms of mandate, or the
15 coverages, as the small group, how many or can you
16 identify for us how many benefits will be brought in for
17 the individual policyholders that they don't currently
18 carry in Connecticut, because we'll be using the small
19 group, because we may be doing a mandate?

20 If we don't use the Federal Employee Plan
21 and we use the small group and the State Employee Plan,
22 we have mandates that to some degree exceed those in the
23 individual marketplace in Connecticut. Do you know which
24 ones we would be bringing in? I mean I think autism is

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RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 one, but I don't know about the others.

2 MR. CAREY: We'll list those out. It's my
3 understanding that most of the state mandates apply both
4 to the individual and small group market, but we'll
5 identify. Autism actually has been one of those
6 benefits.

7 I know, in other states, that applies to
8 the small group market, but does not apply to the
9 individual market, so we'll make sure to identify any
10 mandates that are applicable only to the small group
11 market and not to the individual market.

12 CHAIRPERSON VELTRI: Okay and then the
13 only other thing I would say is that yesterday at the
14 plan meeting, which, obviously, Jennifer is a member of
15 over there, we were talking about -- one of the items we
16 talked about at the end of the meeting was some of the
17 ideas that Arlene was bringing up and Tanya, about, once
18 we make the EHB decision, what we have to do to insure
19 that there's adequate choice, and there's affordability,
20 and all those kinds of things for people.

21 I'm assuming that we're going to get to --
22 we'll get to that discussion once we make the decision on
23 the EHB, but there's lots of stuff we still have to talk
24 about, like transparency and some other things.

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 MR. CAREY: Yeah, I mean, I recognize it's
2 sort of hard to silo these things, but I think, for our
3 purposes of trying to move forward, I think it's
4 important that we sort of limit our consideration right
5 now to just what the benefits cover.

6 So let me talk about next steps. First of
7 all, we have a to-do list, which we're working on, and
8 we'll get to the Committee hopefully next week. We'll
9 have at least some of the information, if we don't have
10 all of the information, so the Committee has it in time
11 to digest, and you may have additional questions that
12 come up.

13 I would just encourage you to try to get
14 those to us as quickly as possible, so that we can turn
15 that around.

16 We'll have a meeting to really be into
17 narrow our choices, and we'll walk through sort of key
18 differences, I think would be important to sort of
19 highlight the key differences across the options, and
20 that will be part of our June meeting.

21 And I think that, you know, we would like
22 at that time -- if we have to have another meeting, I
23 guess we could have another meeting, but we would like at
24 that time hopefully that you'll have received the

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 information in time, so that you can digest it and be
2 prepared at the next meeting to make a recommendation.

3 Again, if you don't feel that you have the
4 information needed, or you're not ready to make a
5 recommendation, I guess we could defer it another few
6 weeks, but it is relatively time sensitive, because it
7 needs to go to the Exchange Board, who then needs to
8 consider it, but, of course, all of the Exchange Board
9 members have been sort of either here or will be here to
10 digest this.

11 So the current plan is that the Exchange
12 Board would review the Committee's recommendations at the
13 July meeting. We could, I guess, put it off to the
14 August meeting, again, if the Committee doesn't feel it
15 has sufficient time, and then it says CID will make that
16 determination, but my understanding is that's still not a
17 certainty, as to who exactly will make the recommendation
18 with regard to the Essential Health Benefits Package.

19 We felt that this Committee, these
20 Committees, plural, structure provided a significant
21 amount of input from key stakeholders, and, so, we wanted
22 to use this opportunity to leverage the expertise around
23 the table, so that's the schedule.

24 MS. JAFF: And, Bob, you said we're going

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 to have a joint meeting with the other Committee?

2 MR. CAREY: Yeah, so, our plan is,
3 initially, for each Committee to review independently,
4 and then we'll have a joint meeting between the Qualified
5 Health Plan Committee and the Consumer Outreach Committee
6 to make a joint recommendation on a path going forward.

7 CHAIRPERSON VELTRI: Okay. If there's
8 nothing more on that, then we can move onto the Mintz and
9 Hoke presentation, and I think you have a good 15 minutes
10 or so for it.

11 (Off the record)

12 MR. KNOPF: Thank you very much for having
13 us here. My operator is over there. Okay, move forward.
14 Okay. Here's our agenda. We're going to talk about the
15 work streams that are underway, timeline and update on
16 progress.

17 The work streams are market exploration,
18 which we're deeply embedded in at this point, the
19 Bridging Communications Program, which is on the verge of
20 being launched across the board, and the strategic
21 development, which is really another way of saying,
22 getting into hard-core primary consumer research.

23 Here's our timeline. It's a little hard
24 to see, but it's in your handouts. In the first several

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 months of this year, we've been going through stakeholder
2 discussion groups. We've just undertaken some webinars,
3 which was a suggestion made by the Board, an excellent
4 one, where we've extended the ability for people to
5 participate in these, because, this way, you know,
6 without having it be face-to-face.

7 And we've had great turnout. We've
8 already had one, where we had about 10 people, 20, I mean
9 20 people, and we expect another 20 for the next round,
10 so it's going very well.

11 You can see there 5/21 to 7/11 is our
12 phase one primary consumer research. This is qualitative
13 research, which is being undertaken statewide, with
14 representatives of every constituency in the state, who
15 could be affected by this. That will also begin very
16 soon.

17 You'll see, up on the top there, a social
18 listening report. This is just what it says, where our
19 social media experts are monitoring the current chatter,
20 for lack of a better term, in the social media realm, in
21 order to establish some kind of a sense of what's going
22 on out there, so we can then sort of reaching out.

23 A lot of activity will happen in a couple
24 of weeks with the launch of the -- this is the bridging

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 campaign, which will involve a sitelet, which is another
2 way of saying some kind of a small-scale website that
3 would be, eventually would be superseded by a full-scale
4 site, and we'll have postcards that are going to go out
5 to all the stakeholders to alert them to the beginning of
6 this process, and then we're going to have e-mail updates
7 that will be scheduled on a regular basis.

8 The audience mapping is a sort of a first-
9 pass look at the demographics across the state. I know
10 there's a much more thorough study being done, but that
11 won't be available for a little while, so we need to have
12 a good handle on where our constituencies live and where
13 they're clustered, so that our research is focused on
14 those areas, where the richest information can be
15 derived.

16 And this follows us through into the --
17 until past July, and then, after that, we will have a
18 full-blown report, the deliverable full communications
19 report and a media plan.

20 So just kind of quickly move through the
21 various stages. The webinars, as I said, have gone out
22 to the original stakeholder groups that we addressed.
23 That list has expanded quite a bit, because, as we've
24 gone along, you all have been instrumental in adding

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RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 important constituencies we didn't have originally, and,
2 as I said, 20 participants each. I mean, if we need to
3 do more, we'll do more, just to go through the basic
4 state of affairs, and the real goal of these forums is to
5 get input, what are your interests, what are your needs,
6 what things should we be focused on?

7 So social listening is, again, as I said,
8 we're monitoring what's going on. We're also doing a
9 pretty much a thorough audit of the media. It's not that
10 different from examining the social ecosphere to identify
11 reporters and editorial people, bloggers, who are focused
12 on this issue.

13 And we had to set up a protocol for how
14 we're going to approach it once we've figured out what
15 the lay of the land is.

16 The bridging communications we've been in
17 discussions with BEST, which is the State's IT Group, on
18 how we set up the sitelet. Oh, wait a minute. I'm
19 sorry. This is yours. Go ahead. I was going to do
20 that.

21 MS. MORELLI: For anyone in the room, who
22 is not familiar with the bridging communications
23 strategy, that is an interim communications program,
24 aimed at stakeholders, who are affiliated with the

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 Exchange, providing updates on Exchange progress and
2 information as we prepare a more full-scale, or as the
3 Exchange prepares a more full-scale outreach program to
4 consumers.

5 One tactic involved in that communications
6 program is the websitelet that Chris alluded to, which we
7 are aiming to launch on May 26th, so that content can
8 begin being populated on the site.

9 We are working with the State's IT
10 Department, BEST, to use their platform for hosting and
11 supporting the sitelet, mainly because it's going to
12 allow us to maximize efficiencies on cost and on time.

13 Many of you may be familiar with the state
14 web guidelines that are used for the visuals that you see
15 on websites, like CT.gov, or on the OHA website, for
16 example.

17 We've been working with the Exchange to
18 establish a site map and wire frames, and for anybody,
19 who is not familiar with those terms, a site map is
20 essentially a taxonomy for the site, so we've performed
21 an audit of the content that the Exchange currently has
22 sitting on the health reform and innovation site, as well
23 as the OPM website.

24 We've organized that content into buckets,

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 so that it can be presented on the new sitelet in a
2 format that is very clear and really guides the visitor
3 through the story of the Exchange and frames what the
4 Exchange's -- who benefits from it and what its real
5 purpose is, for anybody who is not familiar with it.

6 Currently, we're working on writing some
7 new content for some of the primary pages on that
8 website, again, so that we can frame that story a little
9 bit easier for somebody, who is not familiar with it.

10 In addition to that, we'll be migrating
11 all the existing content from the OPM and health reform
12 websites onto that site.

13 The visual that you're looking at on
14 screen, again, is an example of those state web
15 guidelines, as applied to CT.gov.

16 We're going to maximize the flexibilities
17 within those guidelines as much as possible, and, in
18 front of that, you can see an example of a wire frame for
19 the home page of the website, which essentially is a
20 skeleton of the page, so that you can see the structure
21 of the page and the type of content that you can expect
22 to see on it.

23 MR. KNOPF: So the first stage in the
24 bridging campaign is to get a postcard out. It's kind of

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 a homey thing, but it's a these days e-mail campaigns
2 have been subject to a lot of spam issues and so forth,
3 so this allows us to alert people, that this is coming.

4 Kathy, if you'll flip to the next? So we
5 open up on the postcard with something like this. We're
6 off to a healthy start, and then you flip it over, and it
7 says starting with our Connecticut Health Insurance
8 Exchange Updates, and this postcard goes on to explain.
9 You can see the copy in your handouts there what's
10 coming, what to look forward to.

11 So, very soon after that, we will launch
12 the e-mails, and it will involve basically weekly
13 newsletters. Well the weekly newsletter to the Board
14 will evolve, so we can have a coordinated effort between
15 what we're doing here and what those of you who are on
16 the Board have been receiving on a regular basis, and
17 then we'll have informational updates and progress news.

18 There's a lot of information. I mean even
19 what we've heard today, it's ideal to fold into these
20 informational updates. It will be mobile-friendly. It
21 will be straightforward design, simple.

22 We really want to be sure that people see
23 that this is an informational and educational effort.
24 It's not meant to be any sort of Madison Avenue glitz.

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RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 It's meant to convey information.

2 And, as we go along, we'll evaluate
3 response rates, and we'll continue, you know, we'll
4 evolve and continue to improve and refine it. That's the
5 heading for the current newsletter that's been going out
6 to the Board.

7 Our market exploration is we're working on
8 an audience map. We were able to derive a lot of data
9 from conventional data sources, but these, when we first
10 looked at it, it was confusing, because they were limited
11 to county-by-county, and, when you go to places, like
12 Fairfield County, where there's the most wealthy people
13 and least advantaged people in the world, in the country
14 anyway, it didn't make any sense, so we moved to -- we
15 went to CERC, who has data, the same data on a town-by-
16 town basis, and we're going to Cross-Reference that with
17 the existing material, and, very soon, we'll be able to
18 pump out really excellent information.

19 It's not going to be as detailed as the
20 study that's going on now, but it will provide us what we
21 need to do, our phase of this, and it will inform the
22 research and the recruitment.

23 So our primary research, a significant
24 aspect of that, is that we've engaged with two partners

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 in this. We have a professional researcher, a long-time
2 guy, who has done a lot of this work all around the
3 country to help inform our protocols and so forth, and
4 we've also joined up with our multi-cultural partners,
5 Bauza and Associates, and I'd like to introduce Raul
6 Lorenzo, who is a principal with that agency, and he's
7 going to tell you a little bit about them and their
8 involvement in this primary research.

9 MR. RAUL LORENZO: Thank you, Chris. Like
10 you said, I'm Raul Lorenzo. I'm actually the V.P. of
11 Operations at Bauza and Associates and taking the lead
12 with this particular account.

13 Just to tell you a little bit about Bauza
14 and Associates, we are a fully integrated marketing
15 agency that specializes in segment markets. We have done
16 work for the State of Connecticut through DPH, the Anti-
17 Tobacco Campaign.

18 We've also done work with DOT, the Click
19 It or Ticket, so anything that you see out there that is
20 specifically targeting especially the Hispanic market and
21 Spanish, etcetera, we've touched upon.

22 We're incredibly honored and proud to be
23 partnering with Mintz and Hoke on this particular
24 project, a very important project.

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 What we specialize in is the trans-
2 creation of materials into the culture and the language
3 that the culture understands.

4 Specifically, we're looking at all the
5 research materials, translating that material, so that it
6 could be utilized, and we're actually we'll be leading
7 the research process into communities to have a high
8 portion or proportion of minorities, so, specifically,
9 Hispanic, African-American, black, etcetera.

10 We will be conducting this research
11 starting later this week and early next week, in
12 collaboration with the Mintz and Hoke folks.

13 And we're also in the process of
14 collaborating with Mintz and Hoke on just starting to
15 conceptualize and go through the creative process, so
16 that not only the language is covered, but, also, the
17 culture aspect of communication is also covered from the
18 get go, so kudos to the Mintz and Hoke team for having
19 that foresight to actually bring us in on the front end,
20 rather than giving us something to just translate. Thank
21 you so much.

22 MR. KNOPF: Thank you, Raul. So the
23 approach for the research is to -- is we will be face-to-
24 face with individual consumers. We have a certain

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 demographic designation that we've established with the
2 help of the Exchange.

3 We're going to be recruiting seven
4 different ways, so this is a very complex issue that
5 we're grappling with here, and, so, there's no one way
6 we'll bring in all the people that we need, in order to
7 really cover all these audiences.

8 So it could be everything, from mall
9 intercepts to working very closely with the Community
10 Health Centers all across the state, who have joined with
11 us eagerly, and they've been terrific.

12 And, again, I want to thank the Committee
13 and many of you on the Committee, who have guided us
14 really well in this in establishing where to go and how
15 to set up these community-based efforts.

16 So there will be focus groups, there will
17 be one-on-one interviews for sort of the first phase, and
18 then, eventually, after we've pretty well delved into the
19 depth of all this, we're going to mount a web-based
20 process, in order to, again, expand the numbers of people
21 that we're able to reach with this effort.

22 So the initial one-on-ones and the focus
23 groups, they're excellent for essentially narrowing the
24 story, you know, deleting those things, which are not

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 effective, adding on those things that we're learning out
2 there. We're going to learn a lot of stuff. I guarantee
3 you, we're going to be really intrigued by some of the
4 things we'll get back from our consumers.

5 And, so, that when we go out to something,
6 like a webinar-based interviewing process, we'll have a
7 refined discussion guide, and we'll be well-informed at
8 that stage.

9 At that point, we'll actually be using
10 things, like inexpensive advertising, web-based
11 announcements, that sort of thing, to really draw as big
12 a net as we possibly can.

13 I think we've demonstrated with the
14 webinars that we've done how potent this technology can
15 be in expanding numbers, so we look forward to that.

16 And then, obviously, we'll continue to
17 work with you guys, the Committee, as we go along, keep
18 you updated on what's going on, and continue to seek your
19 assistance, which has been invaluable.

20 So, again, there's the timeline backup,
21 and are there any questions? Hi, Jennifer.

22 MS. JAFF: Actually, I just wanted to make
23 a comment. I did participate in one of the webinars, and
24 I thought it was incredibly useful, not only -- I mean it

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 wasn't useful so much, in terms of what I needed to say,
2 but what I heard, that were, you know, things that I had
3 not thought about, and I just thought it was tremendously
4 useful, so I would encourage anybody on this Committee to
5 see if you can make the time to participate in one of
6 those sessions.

7 MR. KNOPF: Thank you.

8 CHAIRPERSON VELTRI: I wanted to add that
9 I think the sessions that we've had have been very
10 productive. Actually, some of the things I've heard are
11 even just surprising to me, things that I didn't even
12 know, you know, the barriers to care and perceptions that
13 people have about health care in Connecticut.

14 And I also want to welcome Raul to this
15 big team, because it is really important that you're
16 here. We have a significant population, as you know,
17 that speaks Spanish in Connecticut, and we need to be
18 culturally aware, linguistically aware of what the
19 barriers they're facing, as I want to thank Claudia, who
20 I think is like the champion of the month, in terms of
21 hooking up Mintz and Hoke with community groups to meet
22 with. She's been amazing, as the whole Committee has
23 been really amazing.

24 I do have one question, and that is the

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 website that you're looking at on the state's site.
2 Would that replace the current Exchange website that's,
3 you know, the combined website that's with the health
4 reform, Office of Health Reform and Innovation?

5 MS. CINTRON: Yeah. We just need a, you
6 know, a site that's dedicated, because there is so much
7 content and so much that we have to discuss and post, and
8 we need to start, you know, you guys can speak better to
9 this, in terms of starting to create an Exchange now that
10 we're an entity. Do you want to speak to that?

11 MS. MORELLI: Sure. Currently, in OPM and
12 the Office of Health Reform and Innovation have been very
13 generous in offering to host the Exchange's information
14 on their websites, but I think it's important that the
15 Exchange start to establish, like Tia said, an entity in
16 and of itself, and, also, a unified presentation of
17 information that will bridge the gap between now and the
18 larger, the more full-scale website that will be launched
19 down the road.

20 CHAIRPERSON VELTRI: Thank you. I'm very
21 glad to hear that, actually. Thank you.

22 MR. KNOPF: Okay. Thank you very much.

23 MS. EPRIGHT: I have a question, this is
24 Claudia Epright, I'm with United Action, for Raul. In

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 the discussions that I've participated in, we've talked
2 about the numbers of non-Latino-speaking communities.
3 There are a wide range of other cultures, besides the
4 Latino and the African-American populations, and, in your
5 work, are you planning to address creating materials that
6 will be matched to those cultures, as well?

7 MR. LORENZO: You know, it is part of the
8 discussion, and it is something that obviously we're
9 taking into consideration and moving forward. I think,
10 initially, for the research aspects of this particular
11 phase, we'll be looking to receive the support of the
12 communities that were outreaching to us, the
13 organizations within those communities to help us access
14 those individuals, and then, obviously, we're going to be
15 partnering with others, who may have a much easier time,
16 especially from a linguistic perspective, outreaching to
17 those communities, as well.

18 MR. KNOPF: So like the process, in
19 general, it's sort of iterative. We want to first get
20 secure that our messages have been refined, and that
21 we're learning with the bulk of the population, and then,
22 also, when we get into these communities, as Raul says,
23 we'll be able to identify and do a little mapping on
24 where all these other cultures are, and there's a lot of

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 them.

2 I mean that's a challenge, and, again,
3 we'll be working closely with you all to help guide us,
4 because, in a way, it's an insurmountable issue to get to
5 every single. There's something like 50 different
6 languages spoken in Connecticut, so we need to address
7 it. No question about it. We'll be better suited to
8 address it after we've gone through some of the initial
9 phases.

10 By the way, Bauza has all sorts of
11 demographic information relating to different cultures
12 within the state, so they've got a good, basic
13 understanding, but we just have to refine it when we get
14 out there and be face-to-face with these various groups.

15 MS. O'GARA: Okay. Thank you very much.
16 The next piece on the agenda is just to highlight the
17 agenda, potential agenda items for the next meeting, and
18 I'll ask Bob if he can do that for us.

19 MR. CAREY: Well, I mean, I think the
20 obvious big item on the Committee's plate is the
21 discussion and a recommendation on Essential Health
22 Benefits Package, so we're going to devote, I think,
23 really the majority, if not all of the next meeting, to
24 finalizing hopefully that discussion and the

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 recommendation, and then we think that it is important
2 that we hold separate meetings with the Committees, and
3 then a joint meeting of the Qualified Health Plan
4 Committee and the Consumer Outreach and Education
5 Committee, but I'll defer to the Chairs and the members
6 of the Committee, as to that.

7 CHAIRPERSON VELTRI: Go ahead, Sheldon.

8 MR. TOUBMAN: I'm very concerned about a
9 mistake that keeps happening. It's something that
10 Jennifer asked about in the beginning.

11 At the kickoff meeting, there are slides
12 that said the QHP Group would be looking at the Basic
13 Health Plan, and I asked the question about what about
14 the Consumer Advisory, and I was told that was a mistake,
15 that it shouldn't have been in there.

16 And then the minutes came out and did not
17 reflect the fact that that was changed, and that took
18 awhile to fix, and that's been fixed.

19 And then presented today is priority
20 tasks, going through to September, plus the chart, a
21 diagram, and nowhere there is a Basic Health Plan, Basic
22 Health Program option.

23 This is a critical choice that must be
24 made, is a decision that the group, the co-Chairs decide,

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 not consultants, not staff, and given the fact that the
2 Mercer report found that half of the folks between 138
3 percent of poverty and 200 percent of poverty won't
4 participate in the Exchange at all, because of
5 unaffordability, and given the fact that affordability is
6 a paramount concern, according to our Guiding Principles,
7 there's a real problem. This mistake keeps happening.

8 So I guess what I'm asking is what are we
9 going to do to fix this problem to make sure that, as a
10 critical timely issue, this group is going to completely
11 review the whole question of a BHP option and make
12 recommendations on it.

13 Again, if it were on here, I wouldn't be
14 concerned, but since it's completely missing in any of
15 the slides, which is a mistake, as was before, I want to
16 see how we're going to go forward.

17 CHAIRPERSON VELTRI: Okay, so, I think
18 what may have happened is, before you walked in, we had a
19 discussion about the BHP and about the need to still
20 discuss it, and we decided, based on the EHB discussion
21 that we had to get done, that we would put, and the fact
22 that the session is over, that we would put it in July's
23 agenda to start --

24 MR. TOUBMAN: I was here for that. I'm

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 sorry I was late, but --

2 CHAIRPERSON VELTRI: You were here for
3 that?

4 MR. TOUBMAN: I was here for that.

5 CHAIRPERSON VELTRI: All right.

6 MR. TOUBMAN: And the thing is that you
7 said July or August, but then you just said now,
8 actually, next month July is going to be dedicated
9 mostly, if not entirely, to EHB, so maybe it's August,
10 maybe it's September.

11 The point is that we don't have a lot of
12 time here to make this recommendation, so that's why I'm
13 agitating on it.

14 MS. JAFF: All right and the same issue
15 was raised yesterday in the Qualified Health Plan
16 Committee, as well.

17 CHAIRPERSON VELTRI: I think where we had
18 left off in the discussion was that we knew we were going
19 to have to have a hearty discussion next month.
20 Obviously, we're going to have to have some discussions
21 between now and I think in the next meeting to sort of
22 wrap our heads as a Committee around where we want to go
23 with this, so that by the next Committee meeting we're
24 moving a lot more quickly and more forward on the issue,

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 but that, by July, the issue is more a, I think, more
2 wrapped up into a kind of a recommendation and a vote, so
3 I believe there will be room in that discussion for us to
4 have a substantive, room in July's meeting to have the
5 substantive discussion on the BHP beginning.

6 That's my understanding. If I'm wrong,
7 somebody correct me.

8 MS. JAFF: And I was given the same answer
9 yesterday at the Qualified Health Plan Committee, that it
10 would be discussed in July.

11 MR. TOUBMAN: If that's the case, then it
12 seems to me -- I mean, frankly, I think the Mercer report
13 it's discussion of the BHP was extremely extensive, and I
14 think that would be a fine starting point for this group,
15 but if there were going to be a briefing paper on BHP,
16 then that should be produced in advance substantially of
17 that advance, as was the EHP one, so that, you know,
18 people can think about it, talk about it and prepare.

19 MR. CAREY: Yeah. I think that that's the
20 plan to go forward, is that we're going to wrap up,
21 hopefully wrap up EHB in June.

22 I did not want to presume that the
23 Committee would be ready in June. I hope, you know,
24 folks will be ready to make a decision on the EHB in

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 June, and that we, then, can move forward into the
2 discussion of a Basic Health Plan in July, and, so, there
3 are a number of issues, I would suggest that there are a
4 number of issues, in addition to the issues that were
5 identified in the Mercer report, that are critical to an
6 important policy decision that the State will make with
7 regard to a Basic Health Plan.

8 I just don't want to rush that discussion,
9 as well, but I recognize that it is time sensitive, as is
10 many issues that this Committee needs to deal with, but I
11 do think EHB is sort of in order of priorities has got to
12 be the first priority, and then we can move to the Basic
13 Health Plan.

14 CHAIRPERSON VELTRI: Yeah, and it's my
15 understanding, from sitting on the Board at the last
16 meeting, there was some information that the Board is
17 actually expecting to receive, in terms of demographics
18 and all this kind of stuff, that I think Bob is working
19 on with someone else. I can't remember who. I'm sorry.

20 That would be actually helpful to this
21 group to have in its discussion about a BHP.

22 MR. TOUBMAN: Thank you.

23 MS. O'GARA: Okay. Vicki, there's one
24 more item, which is the public comment, so we have about

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

1 five minutes left. If there's anyone in the audience
2 that would like to come forward, if you'd just state your
3 name and use the microphone?

4 So we have no visitors today, who are
5 coming forward.

6 CHAIRPERSON VELTRI: We've discussed
7 already what will be on the agenda for next month, which
8 is pretty much EHB, so I guess we are ready to adjourn,
9 if there's no other comments that anybody wants to make
10 around the table. Anyone?

11 MS. EPRIGHT: I move for adjournment.

12 CHAIRPERSON VELTRI: Who moved? Okay,
13 Claudia moved. Is there a second?

14 A FEMALE VOICE: Second.

15 CHAIRPERSON VELTRI: Okay. All in favor?

16 VOICES: Aye.

17 CHAIRPERSON VELTRI: Okay. We are now
18 adjourned.

19 (Whereupon, the meeting adjourned at 11:02
20 a.m.)

RE: EXCHANGE ADVISORY COMMITTEE MEETING
MAY 15, 2012

AGENDA

Call to Order and Introductions	2
Guiding Principles	5
Committee Tasks and Responsibilities	8
KPMG Report	10
EHB	32
Mintz and Hoke Presentation	69
Agenda Items for the Next Meeting	84
Adjournment	90