VERBATIM PROCEEDINGS

CONNECTICUT HEALTH INSURANCE EXCHANGE

CONSUMER EXPERIENCE AND OUTREACH ADVISORY COMMITTEE

JULY 10, 2012

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1 . . .Verbatim Proceedings of a meeting of
2 the Connecticut Health Exchange Advisory Committee held
3 on July 10, 2012, at 9:04 a.m., at the Legislative Office
4 Building, 300 Capitol Avenue, Hartford, Connecticut. . .
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9 CHAIRPERSON VICKI VELTRI: The Health Care
10 Cabinet is also meeting, so maybe some people are over
11 there but good morning everybody. I'm Vicki Veltri and
12 I'm one of the Co-Chairs of this, the Consumer Experience
13 and Outreach Advisory Committee.
14 Before we get into the agenda why don't we
15 just go around -- since we're being recorded for CTN
16 broadcast, let's go around and everybody introduce
17 themselves. I just want to remind you to please use your
18 microphone when you're speaking and turn it off when
19 you're done and we'll just do the introductions and then
20 we'll move into the body of the meeting. Okay thanks,
21 and we'll start to my right.
22 MS. JENNIFER JAFF: Jennifer Jaff,
23 Executive Director of Advocacy for Patients with Chronic
24 Illness.

1 MS. ARLENE MURPHY: Arlene Murphy,
2 Fairfield, Connecticut.
3 MS. CLAUDIA EPRIGHT: Claudia Epright,
4 Consumer Representative with United Action Connecticut
5 and Advocacy Group.
6 MS. SARA FRANKEL: Hi, Sara Frankel with
7 the National Alliance on Mental Illness of Connecticut.
8 MR. GERARD O'SULLIVAN: Gerard O'Sullivan,
9 Program Manager, Consumer Affairs, State of Connecticut
10 Insurance Department.
11 MR. SHELDON TOUBMAN: Sheldon Toubman, New
12 Haven Legal Assistance Association.
13 MR. ROBERT SCALETTAR: Bob Scalettar,
14 Health Exchange Board member.
15 MS. CEECEE WOODS: CeeCee Woods, Health
16 Insurance Board member.
17 MS. CHERYL FORBES: Cheryl Forbes, Small
18 Business for a Healthy Connecticut.
19 MS. JULIE LYONS: Julie Lyons, Director of
20 Policy and Plan Management for the Exchange.
21 MR. JASON MADRAK: And Jason Madrak, the
22 Director of Marketing and Communications for the
23 Exchange.
24 MS. NELLIE O'GARA: And Nellie O'Gara,

1 Facilitator.
2 CHAIRPERSON TANYA BARRETT: Tanya Barrett,
3 Co-Chair.
4 CHAIRPERSON VELTRI: Nellie, we'll turn it
5 over to you I guess to begin.
6 MS. O'GARA: Okay, thank you all. And the
7 first thing we want to do is to review and receive
8 approval of the minutes of the last meeting. So are
9 there any comments on the minutes? Yes CeeCee.
10 MS. WOODS: I think there was a problem
11 with the adjournment time. I just have -- I'm a little
12 into details. It just appeared to be maybe an incorrect
13 time.
14 MS. O'GARA: So if the meeting was at
15 9:00, we probably adjourned at 11:01.
16 MS. WOODS: Okay.
17 MS. O'GARA: We'll make that correction.
18 Can I have a motion to approve to approve the minutes?
19 FEMALE VOICE: So moved.
20 MS. WOODS: Seconded.
21 MS. O'GARA: All in favor?
22 ALL VOICES: Aye.
23 MS. O'GARA: Okay, the minutes have been
24 approved. So we're going to move right into the first

1 topic on the agenda, which is mental health parody in
2 Connecticut. And I'd like to turn that over to Jason if
3 you'd like to give us direction on that who will be
4 making that.
5 MR. MADRAK: Yeah great, thank you. If we
6 go forward here on our slides we do have a pretty full
7 agenda today, so hopefully we'll make some brisk progress
8 through several topics. We will be going over several
9 different aspects of the EHB. I know a good amount of
10 material was actually sent in advance of today's call, so
11 hopefully there's some level of familiarity with some of
12 the topics we're going to go over. But we'll have a more
13 kind of in-depth discussion facilitated by Julie Lyons.
14 Once we've gone through that agenda item
15 we'll actually move into a review of the Thomson Reuters
16 data. Again, we sent out a good amount of information,
17 some summary tables, overviews of that. We look forward
18 to taking you through some of the high points of that
19 analysis and certainly field any questions or comments
20 that the group might have. Before we actually open it up
21 to public comment there's one more small agenda item
22 we'll just kind of slide in there quickly.
23 I know that this particular group had
24 gathered a series of questions related to KPMG's

1 assessment of current consumer capabilities here within
2 the state. We do have a response to those particular
3 questions in a document that we'd like to distribute to
4 the team to hopefully answer some of those questions and
5 so we'll take care of that very briefly right after the
6 Thomson Reuters data before we open it up for public
7 comment, okay.
8 In terms of -- just to give everybody a
9 sense of kind of where we've been and hopefully where
10 we're headed, you know, we are actually going over some
11 fairly in-depth topics as we head towards state
12 certification at the end of this year. In terms of the
13 July meeting, obviously we're focusing on the EHB and the
14 benchmark plan and continuing to review some of our
15 market overview data. You know, we're going to sort of
16 continue on that theme if you will through August and
17 then into September, hopefully be wrapping that up, and
18 also providing you with some more information around the
19 marketing outreach and communication strategy as well.
20 Obviously, we've been spending a lot of
21 time going over data and assessments and some of the
22 research we have but now that we've got a good handle on
23 that you'll start to see some very concrete and solid
24 recommendations coming out of that as well. So we look

1 forward to sharing those with this team as well. Yes?
2 MS. JAFF: Hi, I just had a question about
3 the timeline. And I don't know -- I'm not sure who I
4 should direct this to, but.
5 So we were trying to figure out at state
6 certification, is that the time when the whole outline
7 for the Exchange gets approved or not by the federal
8 government so that if we were -- if we wanted to have a
9 basic health program in Connecticut and we wanted it to
10 be up and running at the same time as the Exchange, so we
11 wanted it ready to go January 1, 2014, would we have to
12 include the basic health program in that state
13 certification for December, which of course is
14 complicated because I think we need legislation on that,
15 but I just wanted to get a sense of the timing?
16 MR. MADRAK: Yeah, I may not be the best
17 person to answer the specifics around the BHP. I'm not
18 sure if anybody else has a comment on that. In terms of
19 state certification here, we're referring more
20 specifically to the sort of agenda items that we're going
21 through. If someone does have a comment they're more
22 than welcome to come to the mike. If not, we can
23 certainly follow up with the group and let you know when
24 that specific aspect needs to be nailed down and the

1 things surrounding it.
2 MS. JAFF: Yeah, I mean my understanding
3 is that states can add the BHP whenever they want to.
4 But what I'm trying to figure out is when we would have
5 to -- when Connecticut would have to make that decision
6 in order for the BHP to be up and running 1/1/2014.
7 MR. MADRAK: Gotcha, okay.
8 CHAIRPERSON VELTRI: Jason, excuse me.
9 This is Vicki of CTN. In terms of the BHP, it's my
10 understanding we're going to have a combined meeting in
11 August. So maybe we can have the staff's best
12 understanding --
13 MR. MADRAK: At that point, okay.
14 CHAIRPERSON VELTRI: -- of what that is at
15 that point.
16 MR. MADRAK: Thank you Vicki.
17 MR. CAREY: This is Bob Carey. With
18 regard to the BHP, so the Exchange certification itself
19 is not affected by whether or not the state chooses to
20 offer a BHP. In fact, the use of federal funds for
21 Exchange development actually cannot be used to develop
22 and operate or establish a BHP. So the deadline with
23 regards to the December certification for the Exchange is
24 not affected by a decision or not whether to offer a BHP,

1 meaning that you could -- the state could choose to offer
2 a BHP and make that decision and authorize that
3 legislation in the 2013 session so that the BHP could be
4 up and running by January 1, 2014.
5 I would -- you know, as you know as well
6 or better than I do establishing a new program -- you
7 know, you need some ramp up time so you need to think
8 about that in timing. But with regards to state
9 certification of an Exchange, it's unaffected by a
10 decision as to whether or not the state offers a BHP.
11 CHAIRPERSON VELTRI: Sheldon.
12 MR. TAUBMAN: Yeah, to follow-up on that
13 though is that necessarily true if there's an important
14 issue, which is the funding of the Exchange and knowing
15 who's in the Exchange and therefore assessing the fees to
16 make it self-supporting after the first year?
17 And just hypothetically, if the feds were
18 presented with information that the Exchange plans to
19 fund itself, the presentation for state certification
20 says that the Exchange is going to fund itself by
21 assessing fees on X thousands of people which includes
22 the people who would otherwise be in the BHP, and also is
23 information that the state is actively considering
24 excluding those people then that would change the

1 economics of it and could that potentially affect the
2 willingness to certify? Do you understand what I'm --
3 the question?
4 MR. CAREY: Yeah, no I -- your question is
5 on point. Yes, the funding of the Exchange and the
6 financing mechanisms of the Exchange could be affected by
7 whether or not the state establishes a BHP or not
8 depending on the financing mechanism. So if the
9 financing mechanism is such that the state is
10 recommending that only people who receive coverage
11 through the Exchange or only policies that are purchased
12 through the Exchange will finance the administration of
13 the Exchange, if you then cut those numbers down that
14 changes the math.
15 And so on the one hand you're correct that
16 the funding mechanism will be potentially affected by
17 whether or not the state establishes an Exchange in terms
18 of the amount per person that would need to be charged to
19 administer an Exchange. And so as we move forward in
20 terms of developing a state certification plan and a
21 financing plan, that all will have to be sort of part of
22 the process. And so perhaps the state would think about,
23 you know, if we don't have a BHP we're going to recommend
24 financing mechanism A, and if we do run a BHP we're going

1 to recommend financing mechanism B.
2 And so long as you have a plan to finance
3 the Exchange under either alternative, all I'm saying is
4 you don't necessarily have to make a hard decision about
5 a BHP in December.
6 MR. TAUBMAN: A follow-up, does then that
7 auger for recommending to the Board that it be done in
8 exactly that way, that plan A and plan B financing, so
9 that the federal government knows that we have it squared
10 away that it's going to work either way?
11 MR. CAREY: Yeah, I mean I think that as
12 the Office of Health Reform and Innovation moves forward
13 with its assessment and analysis of whether to establish
14 a BHP, if we get to a point -- I would assume, you know,
15 by October or November we would know pretty much
16 directionally, yeah, this is a viable alternative. And
17 we're going to -- you know, we're potentially going to
18 recommend to the Legislature that they establish a BHP
19 then I think at that point it would behoove the Exchange
20 because it needs to be self-sustaining to recognize that
21 there may be this segmentation of a significant
22 population away from the Exchange and therefore, the
23 financing mechanism needs to reflect that new reality.
24 So I would agree.

1 CHAIRPERSON VELTRI: Since we're -- like
2 we said, we're having that combined meeting next month.
3 I think maybe we should -- since we have a really jam-
4 packed agenda, we can maybe move forward and if there's
5 extra time we can come back and discuss that.
6 MR. TAUBMAN: Okay.
7 MR. MADRAK: Alright, in the spirit of
8 moving on to a different acronym we'll move away from the
9 BHP to the EHB and we'll actually go ahead and turn that
10 over to Julie.
11 MS. LYONS: Good morning. This morning
12 we're going to talk about a few of the topics of benefit
13 categories that comprise the EHB. And those topics are
14 mental health and substance abuse disorder services,
15 prescription drug coverage, services for preventive and
16 wellness and chronic disease management, pediatric
17 services including oral and vision care and as well as
18 the two options that are available for selection in terms
19 of habilitative care that has to be incorporated in the
20 EHB package. And then lastly we received some
21 utilization data on those benefits which have visit
22 limits, and I know that -- I think that was Jennifer's
23 question or Vicki's question. So we have some
24 information pertaining to that.

1 In terms of mental health and substance
2 abuse coverage, we're providing this information on the
3 current benefit. It's not meant to, you know, discuss
4 any future plan changes or legislative changes that may
5 be in the offing. You know, we wanted to stress that the
6 mental health parody -- oh, in addition there was a
7 concern mentioned in a previous Advisory Committee
8 meeting with the health plan group, that they wanted more
9 information on the mental health and substance abuse. So
10 that's the reason why it's on the agenda in addition to
11 that it's part of the EHB package.
12 The benefits for mental health and
13 substance must be treated as parody with medical/surgical
14 conditions. The terms and conditions and cost sharing
15 measures and utilization review protocol cannot be more
16 restrictive than for other medical conditions. In
17 Connecticut, Connecticut defines mental health -- mental
18 and nervous conditions as all diagnoses, you know,
19 referenced in the diagnostic and statistical manual of
20 mental disorders. So if there is a diagnosis that is
21 reflected in that manual, that must be covered at parody
22 with medical conditions. Connecticut has had mental
23 health parody since 2000, and current state requirements
24 provide for mental health and substance abuse coverage

1 under the individual group, small and large group fully
2 insured policies.
3 The federal rules apply to insured and
4 self-insured groups of more than 51 and more members.
5 Under the ACA, these requirements will also apply to
6 benefits for individuals and small group. So basically
7 the whole waterfront between Connecticut and the federal
8 will be covered. Benefits, as I said, cannot be more
9 restrictive than that for medical and surgical conditions
10 and the prior authorization protocol also must be at
11 parody with medical conditions. Let's see, I think we're
12 -- cognitive behavioral therapy is a type of mental
13 health counseling focusing on negative or inaccurate
14 thinking. Depending on the diagnosis that the therapy is
15 being given for, if it's in the DSM manual coverage it
16 would be afforded as parody -- at parody. These are
17 certainly just the high points of mental health parody
18 and substance abuse.
19 CHAIRPERSON VELTRI: Excuse me, Bob?
20 MR. SCALETTAR: So could you just -- I
21 don't know if it's appropriate but could you explain a
22 little bit more about why this slide is up? What does
23 this actually mean?
24 MS. LYONS: Actually the issue came up in

1 the Health Plan and Qualifications Committee meeting, and
2 the comment was kind of generic. There seemed to be
3 confusion over cognitive behavioral therapy, mental
4 health benefits, substance abuse, and so basically we
5 just wanted to define what cognitive therapy is and how
6 it would apply in the scenario of mental health parody.
7 MR. SCALETTAR: And has that been sort of
8 sorted out? I'd just offer a couple of comments about it
9 as a physician, a few things. I mean, it's a reasonably
10 new technique in behavioral health care. It's sort of --
11 its origins are in the late 70's. It's short-term.
12 Usually when we think of treatment in behavioral health
13 and mental health we think about talk therapy, and the
14 thing that most people think about next is Freud. But
15 this has nothing to do with that.
16 And then -- so that the other end of the
17 spectrum is psychopharmacology; here are some drugs to
18 deal with the problem, and there doesn't seem to be
19 anything in between. CBT, so the service that is sort of
20 short-term interactive talk focus therapy, but I'm
21 wondering how you actually sort of apply that as both
22 benefits and make it accessible because if nothing else
23 there's a factoid, nothing new that we don't know about
24 problems and access. But New Haven, Connecticut probably

1 has the largest concentration of behavioral health
2 therapists in the country per capita and they probably
3 have more people trained in CBT than any other city of
4 that size in the country. But you can't get access to
5 that, so.
6 CHAIRPERSON VELTRI: I will add -- I'm
7 glad Bob made that point. So a couple of things, you
8 know, when we're working on -- the fact that a benefit is
9 included, I mean we all know even if a benefit is
10 included it doesn't mean necessarily that there's access
11 to the benefit. So mental health continues to be, in our
12 offices, the number one area that we see problems with.
13 Access is a major issue, and it's not just
14 to CBT it's to all types of mental health treatment and
15 services. So going forward it's obviously a problem that
16 needs to be addressed across the spectrum. It's not just
17 the Exchange it's the commercial side of the market that
18 really needs to attack this issue. But underlying this I
19 just wanted to make sure people understand that our state
20 law is very broad in its coverages. The CBT is one
21 example but, I mean, there's coverage for residential,
22 there's coverage for all different levels of care
23 provided they're medically necessary.
24 And we also cover -- unlike the federal

1 law, we also provide coverage for all different
2 practitioner -- all different kinds of practitioners. So
3 licensed professional counselors -- licensed family
4 medical therapists, I got the name wrong I think, social
5 workers, all across the spectrum we cover those services
6 if someone can access them. And the federal law overlay
7 provides an additional protection that some of us are
8 just beginning to really push on with the plans frankly
9 around limitations that the plans can put on services
10 around prior off and prescription drug benefits and
11 different levels of care that the state law actually does
12 not do.
13 So they come -- I look at the two laws as
14 complimentary. Like the state law is very protective in
15 certain ways the federal law is not, and the federal law
16 has attributes that the state law doesn't have. So the
17 laws are great, it's just a matter of -- there's a matter
18 of access and there's a matter of making sure the laws
19 are actually working as intended. So -- at least that's
20 the way I view the whole issue of mental health parody,
21 but.
22 MS. EPRIGHT: Hi, one of my concerns about
23 the coverage provided for CBT or any of the other talk
24 therapies is the number of visits that are covered. My

1 daughter has -- I think her -- she has her insurance
2 through her employer and they allowed her, I believe it
3 was four visits that would be covered under the
4 insurance. And perhaps that would be enough for a
5 particular issue but because of the -- I have some
6 familiarity with cognitive behavioral therapy.
7 And because of the nature of the way work
8 happens in those sessions, four sessions often is not
9 enough to get to the place where one could say that the
10 person has resolved whatever the issue was that brought
11 them there. So the number of visits that are covered by
12 insurance I think needs to be -- is important in this
13 particular type of coverage. And also where -- and
14 forgive me, I haven't read the DSM so I'm not familiar
15 with the specifics in there, but I am concerned that
16 perhaps coverage may not be sufficient to bring a person
17 to a place where they could reach a resolution of the
18 issue that brings them there.
19 So I think it's important to take a look
20 at how reaching resolution is determined, who's going to
21 determine that and who's going to determine that a person
22 doesn't need the therapy anymore. And then will the
23 insurance companies work with the doctors because really
24 the doctors are the ones who should be making the

1 decision about whether a person has been cured, quote,
2 unquote, or not.
3 MS. LYONS: It is a very sensitive issue
4 and thank you for your comments. I know that -- you
5 know, all the benefits are based on a medical necessity
6 review. So the companies work in conjunction with the
7 patient's physician to determine the medical necessity
8 and then develop a plan going forward. But, yeah.
9 CHAIRPERSON VELTRI: Jennifer.
10 MS. JAFF: I just wanted to echo what
11 Vicki said and to respond at least a little bit to what
12 you said Claudia. In the mental health area with respect
13 to all of the potential benchmark plans that we're
14 looking at there aren't visit limits for mental health
15 services.
16 What happens is in practice exactly what
17 happened to your daughter, and that's the way a
18 particular insurance company administers their prior
19 authorization process because for all mental health
20 services you need prior authorization. So they will
21 approve, you know, four visits and then the therapist can
22 go back and say we need another four visits and they can
23 say yes or no. And if they say no, then there's an
24 appeal process but none of that -- whether fortunately or

1 unfortunately, none of that is something that we're going
2 to get at by our selection in a central health benefits
3 package.
4 And the same is true even for other
5 benefits that are visit-limited. For example you could
6 have a plan that says your benefit is 30 physical therapy
7 visits per year but your insurance company is still going
8 to do a prior authorization and decide whether you really
9 need those 30 visits, or maybe you just need six. And
10 again, if they don't give you what you and your provider
11 think you need then you have the appeal process. You
12 know, I would love it if we could get to all of that
13 through our selection of a central health benefits
14 package. It would certainly make our life easier since
15 we do so many insurance appeals.
16 And I agree with Vicki, I mean, the mental
17 health insurance appeals continue to be the most
18 challenging, the most difficult and frankly the most
19 maddening strain to have the mental health problem be
20 something that could drive you mad. But that is, in
21 fact, unfortunately the way the insurance process works
22 for mental health services. So we have good solid parody
23 laws on the books in Connecticut and federally with
24 excellent regulations from the federal government on

1 mental health parody, however, they aren't being
2 enforced. So implementation is not what it needs to be.
3 But again, unfortunately none of that is
4 going to get reached by a selection of a central health
5 benefits package, so it is what it is.
6 MS. O'GARA: So with that I think Julie,
7 you've explained the mental health parody and that was a
8 good summation. We all are sensitive to this particular
9 issue and need to keep it in mind, but in the interest of
10 moving ahead could we move on to the next couple of areas
11 that you have?
12 MS. JAFF: Yup, thank you.
13 MS. LYONS: Thank you Jennifer.
14 MS. JAFF: The federal guidance on
15 prescription drugs state that prescription drug coverage
16 cannot be provided through a drug rider. Instead, the
17 guidance states that if a category is missing you must
18 look to the next benchmark plan to fulfill that category.
19 The benefits must be supplemented from the benchmark plan
20 to the plan that does not have the benefit.
21 As you know, we're down to four benchmark
22 options and those options all provide the prescription
23 drug coverage as a prescription rider. So we'll need to
24 fulfill the benefit and select from the other benchmark

1 options that contain the prescription drug coverage in
2 the list of benefits. In addition, the guidance states
3 that if a benchmark plan offers a drug in a certain
4 category or class all plans must offer at least one drug
5 in that same category or class. The specific drugs on
6 the formulary can vary.
7 The Insurance Department here in
8 Connecticut prohibits carriers from excluding any
9 prescription drug approved by the FDA that is deemed
10 medically necessary to treat a covered injury or illness.
11 Formularies are permitted, however, the Insurance
12 Department requires carriers to cover non-formulary drugs
13 if the insured has a medical condition that precludes
14 them from taking the formulary drug. And usually that's
15 handled, again, through the prior authorization process
16 between the company and the physician. Yes Jennifer?
17 MS. JAFF: This time I have a question.
18 MS. LYONS: Okay.
19 MS. JAFF: Alright, so I understand that
20 the guidance from the federal government basically says
21 that the only thing that we're looking at for EHB
22 purposes is what classes of drugs are covered by the
23 formulary is that --
24 MS. LYONS: That is true.

1 MS. JAFF: -- that's right, okay. So then
2 whether or not -- so having an open formulary versus a
3 closed formulary at this point, we're not even looking at
4 that is that correct?
5 MS. LYONS: That is true.
6 MS. JAFF: Okay.
7 MS. LYONS: As long as the --
8 MS. JAFF: So here's my question which is
9 a little bit more nuanced, and that is we've talked a lot
10 about state mandates in the context of choosing the EHB
11 --
12 MS. LYONS: Ahum.
13 MS. JAFF: -- and we know that if we
14 choose a benchmark plan that covers a state mandate, that
15 will become a central health benefit, the state will not
16 have to pay extra for it, all of that.
17 MS. LYONS: Correct.
18 MS. JAFF: So here we have a state mandate
19 that requires coverage of certain prescription drugs that
20 may not be on a plan's formulary. Is this a mandate that
21 would be treated the same as all the other mandates that
22 we've talked about so that if we chose the Oxford plan we
23 would get this non-formulary coverage with it or not?
24 MS. LYONS: You know, I understand this to

1 be a rule identified by the Department of Insurance. So
2 --
3 MS. JAFF: I see.
4 MS. LYONS: -- yeah.
5 MS. JAFF: So not a regulation or a
6 statute.
7 MS. LYONS: Right. In order for the
8 policy forms to get filed and then approved, you know,
9 this is how it is handled.
10 MS. JAFF: Okay so again, this also is
11 irrelevant in choosing an EHB benchmark is that what I
12 hear you saying?
13 MS. LYONS: The focus on the benchmark is
14 the categories and classes.
15 MS. JAFF: Okay, and there -- are there
16 any significant categories -- differences in the
17 categories and classes that I'm not seeing?
18 MS. LYONS: If I understand your question,
19 it is -- they're all reflected on both of the
20 prescription drug options.
21 CHAIRPERSON VELTRI: Arlene.
22 MS. MURPHY: Just a question, you know, to
23 follow up on -- you know, would it be productive since
24 there appear to be concerns that are being raised as we

1 are doing the selection of these benchmark plans, is it
2 possible to make a list of the concerns that have been
3 raised about them, because I think that during later
4 parts of the process, for example the questions about the
5 requirements, not just of the classes but specific drugs,
6 that somehow that can be addressed through the Exchange
7 process?
8 MS. LYONS: Most certainly. If you can
9 filter those through the Chairs we can certainly
10 research.
11 MS. MURPHY: Okay that's great, thank you.
12 CHAIRPERSON VELTRI: And I guess I would
13 follow-up with Jennifer's point maybe with Gerard, is
14 this in a bulletin or something or is this just a policy
15 that the Department is using, or?
16 MR. O'SULLIVAN: I think it's just a
17 policy in the forms approval process but I'd have to, you
18 know, find out from the Life and Health Division how
19 exactly that works --
20 CHAIRPERSON VELTRI: Okay, because then I
21 think --
22 MR. O'SULLIVAN: -- but I can get that for
23 you back.
24 CHAIRPERSON VELTRI: -- right, okay that's

1 good, because I think maybe we'd be interested in knowing
2 to sort of get to I think what Jennifer was saying, is
3 the Department going to use this rule going forward with
4 the Exchange plans in its approval of forms and policies.
5 If it is that's important for us to know, so.
6 MR. O'SULLIVAN: We can clarify that and
7 again, we use this in consumer affairs to assist
8 consumers to say alright, if you have an issue with this
9 there is the out of having that ability to say that you
10 can't take the specific drug, so.
11 CHAIRPERSON VELTRI: Right, then I think
12 it's very important for the consumers to know whether --
13 for us to know whether in the Exchange that the same rule
14 will be used or applied going forward. Thanks.
15 MS. MURPHY: I'd just like to add one
16 random question actually that just occurred to me. What
17 about new drugs, I mean, and new classifications? I
18 mean, how would this going forward be addressed? I mean
19 we have this, does this give room in the future for new
20 medications or classifications of drugs?
21 MR. O'SULLIVAN: A lot of that is done
22 through the external review process and it's automatic
23 that, you know, if it's an experimental drug then it is
24 opened up for that form.

1 CHAIRPERSON VELTRI: Okay, go ahead Julie.
2 MS. LYONS: Again, you know, the guidance
3 -- unless the guidance is revised we need to select from
4 the two options, which are the federal employee health
5 benefit programs, Blue Cross/Blue Shield standard or
6 basic option, or the Oxford PPO Rx option. You know,
7 each of these riders provide coverage in the classes and
8 categories so one must be chosen.
9 The qualified health plans must provide
10 coverage for evidence-based services or items that have a
11 rating of A or B in the current recommendations of the
12 United States Preventative Services Task Force. You
13 know, these services are preventive services in
14 screenings, adult annual exams and immunizations, child
15 exams and immunizations, routine mammography, routine PSA
16 tests, you know, gynecological tests. You know, a review
17 of the evidences of coverage for each of the benchmark
18 plans indicate that this waterfront is pretty
19 significantly covered and there's not any difference
20 really between any of the benchmark options afforded for,
21 you know, preventive and wellness services. In addition,
22 these services must be -- there's no member cost sharing
23 for these services so -- you know.
24 Yes Jennifer -- no, quite alright.

1 MS. JAFF: For the record, I realize
2 there's nothing we're going to be able to do about this
3 today but for the record it does not appear to me that
4 any of the plans has a serious chronic disease management
5 component and that is mandated by the Affordable Care
6 Act.
7 MS. LYONS: Ahum.
8 MS. JAFF: And so I would argue that the
9 EHB has to include a chronic disease management program,
10 and to the extent that that is missing it ought to be
11 treated the same as habilitation, which also does not
12 currently exist in any of the plans but it's something
13 that we're going to have to create.
14 So like I said, I know that we're not
15 going to deal with that today because that void is not
16 going to be filled in one two hour meeting. It's a huge
17 issue but I do want to put it on the record, you know,
18 for this meeting that I did raise that issue and that I
19 do think that it's something that at some point the
20 Exchange is going to have to look at seriously so that we
21 really do cover all of the 10 categories of benefits in
22 the ACA.
23 MS. LYONS: You know, our review of the
24 evidences of coverage reflected chronic programs, you

1 know like an asthma program or diabetes management. You
2 know, I see that that's not what you're meaning but
3 you're right, it did not go into very much detail. You
4 know, they have care management programs and utilization
5 programs where they reach out to the members on behalf of
6 their condition and try and assist them, but nothing
7 really detailed.
8 CHAIRPERSON BARRETT: And just a follow up
9 on that, I have a question about the preventative
10 services and whether or not the wellness and preventative
11 services actually do also reach out and make people aware
12 of what the up and coming screenings that they should be
13 getting and whether or not that's something that there
14 were differences in amongst the plans?
15 MS. LYONS: I know in -- you know, my
16 experience has been if I've missed a service sometimes I
17 get a reminder letter from the insurance carrier. A lot
18 of these programs are spelled out in their marketing
19 materials and their member handbook collaterals, but I
20 can't say for certainty which benchmark plan has such a
21 follow-up program for preventative services.
22 CHAIRPERSON BARRETT: Is there data on
23 which ones have better utilization for preventative
24 screenings?

1 MS. LYONS: I imagine that they do have
2 the -- we did not check -- we didn't reach out to the
3 carriers in terms of the utilization data for
4 preventative services.
5 CHAIRPERSON BARRETT: And just -- and I
6 think it's the same kind of circular discussion that we
7 have about access and whether or not people really have
8 access and really know what they should be getting for
9 services, so. And I realize that it also might not be
10 part of selecting the EHB.
11 MS. LYONS: Ahum. Okay --
12 MR. SCALETTAR: Well, I'm just going to
13 make a quick comment that at least as far as preventative
14 services go most of the insurance carriers do track that
15 stuff very carefully. Aside from utilization it's
16 published as part of accreditation scores and HEDIS
17 scores and that sort of -- although HEDIS has expanded to
18 acute and chronic diseases where the original notion was
19 on prevention. That's probably the most robust of a
20 source for the public to be able to look and see about
21 performance in any individual carrier or within any
22 individual program.
23 MS. JAFF: Just to respond quickly that
24 being the poster child for chronic illness that I am, may

1 I just say that I have been insured by Anthem of
2 Connecticut for as long as I can remember and I have
3 never once gotten a phone call from a care manager, a
4 case manager, or any reminders about preventative care in
5 my entire life.
6 CHAIRPERSON VELTRI: It seems like what
7 we're talking about is what needs to be done when the
8 plans are selected.
9 MS. JAFF: Right.
10 CHAIRPERSON VELTRI: You know once we
11 pick, once we get to this point -- you know, obviously
12 we're going to get to habilitative services. But chronic
13 disease management, preventative services monitoring --
14 you know, the best way to deliver services is all part of
15 what we do once we pick a plan design, right, to ensure
16 that it delivers what we want it to deliver.
17 I would suggest though also to the group
18 that the report card that's on the Insurance Department's
19 website that the managed care organizations have to --
20 well, they have to report to the Insurance Department and
21 the Insurance Department develops a report card. It
22 contains a lot of the -- at least on a high level, some
23 data about these measures for the HEDIS measures and
24 access to prevent -- not access but utilization of

1 preventative services and stuff. So that might be a good
2 place to look --
3 MS. LYONS: You're absolutely right.
4 CHAIRPERSON VELTRI: -- once we get to the
5 design.
6 MS. LYONS: And both of those, the
7 certification requirements and the report card, slipped
8 my mind. So yup, you're -- thank you. Okay, next slide
9 -- nope, we went through that.
10 Okay, the pediatric services for oral and
11 vision. Currently both of these services are rendered
12 generally in a separate insurance policy or rider.
13 They're not normally part of the health contract that a
14 member receives. The guidelines from the federal
15 government indicate that the sup -- that we may
16 supplement the EHB package with dental services from the
17 federal employee's FEDVIP program or the Connecticut
18 children's health insurance CHIP program. Both of these
19 plans are also very similar, they cover cleanings,
20 fillings, root canals and crowns and orthodontia as
21 medically necessary.
22 Basically there's no significant or
23 meaningful differences between these two plans as far as
24 the pediatric vision. CESIO (phonetic) or the federal

1 government suggests selecting or using the FEDVIP vision
2 program with the highest enrollment. And coverage would
3 include some coverage for hardware, contact lenses,
4 corrective lenses and routine eye exams with refractions.
5 In terms of habilitation --
6 CHAIRPERSON VELTRI: I'm sorry, yes
7 Jennifer.
8 MS. JAFF: I'm sorry --
9 MS. LYONS: That's okay.
10 MS. JAFF: -- just a very quick question.
11 Is there any -- just trying to figure out between the two
12 pediatric dental plans, I'm trying to figure out if
13 there's any reason to prefer one over the other, is there
14 any ease of administration or anything in the fact that
15 in taking both the dental and vision from the FEDVIP plan
16 so those are already linked? I mean --
17 MS. LYONS: No, we just merely looked to
18 see if the coverage was comparable in those two plans.
19 We didn't get into -- we just wanted to make sure that at
20 the first blush the plan met the requirement, so we
21 didn't look into that. You know, if you forward that
22 question to Vicki we can certainly research.
23 MR. SCALETTAR: So it seems to me if the
24 guidance from staff is that there are no significant

1 differences between plans to be responsive to your
2 comment Jennifer, what makes sense to me is the notion of
3 the CHIP plan is already in play in the State of
4 Connecticut and it's known by networks and providers in
5 terms of what it is. So for ease of administration and
6 reduction of confusion, consistency by our thinking about
7 the CHIP as the pediatric dental, it certainly makes
8 sense to me.
9 MS. EPRIGHT: Excuse me, I just want to
10 comment Bob about some personal experience with the CHIP
11 program. Access, again, is a huge issue with that and I
12 wondered if there was a -- is there any information about
13 the access to the FEDVIP versus CHIP in Connecticut? Are
14 there more providers who accept the FEDVIP versus those
15 that accept the CHIP?
16 MS. LYONS: I don't know.
17 CHAIRPERSON VELTRI: Just to clarify, I
18 don't know that that's an issue for picking the plan
19 obviously. But just to kind of go back to the issue on
20 access, I think actually access under CHIP and Medicaid
21 has greatly improved. It's much, much better than it
22 ever used to be as a result of a litigation that was
23 actually brought a few years -- awhile back that was
24 settled a couple of years ago that increased the

1 reimbursement rates to the dental providers. So it has
2 greatly improved the access and also increased the
3 utilization rates for kids in CHIP, as well as on the
4 Medicaid side, but I also think -- it always amazes me
5 when we're in this discussion that we're still -- at the
6 federal level and the state level we still think of
7 vision and dental as somehow separate.
8 They're -- you know, our eyes and our
9 mouths are not part of our body for some reason and we
10 always have to have a separate benefit package for them.
11 So I know -- it's the way it is and we have to deal with
12 that for now so it is the way it is, but I guess I have a
13 question in terms of adult oral health care and can we
14 offer -- I mean, I realize that they would have to pay
15 for it 100 percent but can we offer a rider for adults in
16 the Exchange to buy dental so that they at least have
17 access to it even if they can't get -- I mean, they're
18 not going to get it as part of a plan like the kids will,
19 but.
20 MS. LYONS: Yeah you know what, honestly
21 --
22 CHAIRPERSON VELTRI: I don't know.
23 MS. LYONS: -- I don't know, I'd have to
24 check for you.

1 MS. JAFF: I could be wrong but my
2 recollection is that one of the things the Exchange is
3 supposed to include is one standalone dental plan that's
4 going to be available. That -- I have that in the back
5 of my mind. Bob stepped out of the room, he would know.
6 MS. LYONS: Yup, that's who I was looking
7 for.
8 MS. JAFF: But that stuck in my head
9 because I don't have dental coverage and I thought it was
10 a good thing when I read it, so.
11 MS. LYONS: Right. Okay, we'll get back
12 to you on that point. Let's flip to habilitative. Okay
13 in terms of habilitative services, you know, we've
14 discussed what those services are and that they're not
15 clearly defined within any of the benchmark plan options.
16 The guidance that we've received from the federal
17 government suggests that habilitative services could be
18 offered -- there's two choices.
19 They could be offered at parody with other
20 like services like PT, OT, speech, or the option could be
21 left up to the carriers to decide how to create their
22 habilitative benefits and then each carrier would have to
23 report back to the government on their approach. So
24 those are just the two options that have to be considered

1 from the carrier's perspective in terms of the benefit
2 packages. The main differences that are addressed are
3 with regards to visit limits on home health care,
4 physical therapy, occupational therapy, speech therapy,
5 skilled nursing, but other than that the benefits are all
6 the same. I believe in your packet you have a chart just
7 showing the differences amongst the four benchmark plans
8 that do have visit limits, which you might find helpful.
9 Yup, there it is.
10 Next, and then this last slide speaks to
11 the utilization data for the state plan. On Friday we
12 received the information from the State Comptroller with
13 respect to visits and the usage. So on the left hand
14 side, those visit limits -- on the left side of the
15 margin represent the number of employees and the numbers
16 along the bottom represent the number of visits for
17 services such as home health care, chiropractic and, you
18 know, PT. We received a report from the actuarial --
19 from Milliman, who's an actuarial analyst firm, and their
20 data suggests that fewer of one percent of all the
21 members exhaust more than 20 outpatient visits for
22 physical therapy, occupational therapy and speech
23 therapy.
24 We were not able to get any data from the

1 commercial carriers. They -- it's my understanding is
2 it's a very difficult level of detail to get down to.
3 They don't store the information according to procedure
4 code level, so it was quite a large time consuming task
5 for them to extract that information and it's not likely
6 we'll get that information. So we only have the Milliman
7 report, which was not included in your packets but I have
8 the information here and I'll pass it around.
9 CHAIRPERSON VELTRI: I want to thank you
10 for getting the data from the state employee plan because
11 this is the exactly the kind of thing that I was
12 interested in seeing.
13 MS. LYONS: Ahum.
14 CHAIRPERSON VELTRI: And it kind of
15 confirms what my thinking was about the rate of
16 utilization of these services. So thank you for getting
17 it.
18 MS. LYONS: Oh, you're welcome. So that
19 really ends the EHB discussion and thank you. If you
20 have any questions please forward them to Tanya and Vicki
21 and we'll do our best to respond in a timely fashion.
22 MS. O'GARA: So I think we're at the point
23 where we want to dialogue for a few minutes about the
24 selection of an EHP. And we have a couple of ways to go

1 about doing that. We could have a general discussion
2 about the plans and then move to identifying one, or if
3 you've had enough time and though about this we could
4 take a motion to select a plan. So I leave it up to you
5 how you'd like to proceed.
6 CHAIRPERSON VELTRI: Personally, I'd
7 prefer that we talk a little before we make a motion to
8 just choose a plan because I think -- no? Okay, because
9 we have a diverse group here and I just want to make sure
10 everybody's opinions get heard, thanks.
11 MS. O'GARA: Jennifer.
12 MS. JAFF: So I've given this a huge
13 amount of thought and I continue to be somewhat
14 frustrated with the lack of all the information that we
15 would like to have. I think -- you know, if we had
16 utilization data from the other plans we might be able to
17 compare them to the state employee plans. If we had in
18 particular more information about costs, we could
19 understand the implication of choosing a plan that is a
20 somewhat richer package of benefits.
21 But at this point where -- we have all the
22 information we're going to get and so we have to make a
23 decision. I think -- and as you all know, we asked to
24 have this meeting and tomorrow's Health Plan

1 Qualification meeting flipped so that we could kind of
2 review the health plan and Qualification Committee's
3 recommendation and see if we agreed or disagreed, and
4 that turned out not to be possible. So we are in the
5 position of being the first Advisory Committee to make a
6 decision. And I think that we can see that as an
7 opportunity.
8 I think that we, as consumers and consumer
9 representatives, have the opportunity now to influence
10 the decision that is made tomorrow in the Health Plan
11 Qualification Committee. Julie, you're trying to say
12 something?
13 MS. LYONS: Right, I -- you know, we
14 recognize that you wanted to switch the meetings and we
15 really couldn't at that late stage.
16 MS. JAFF: No, I understand and I'm not
17 criticizing.
18 MS. LYONS: So the plan really -- we
19 wanted to just supply you with this overview, and really
20 tomorrow the Health Plan Benefits and Qualifications
21 Committee is the one that would make the recommendation
22 and then we were going to have a follow up meeting with
23 this Committee to hash out all the details.
24 So if -- you know, that's really the

1 approach that the Exchange would like to take in terms of
2 making a recommendation.
3 MS. JAFF: Well and that's -- you know, so
4 I have no problem revisiting things after the -- you
5 know, at the August meeting after the Health Plan
6 Qualification Committee meeting. But what I was getting
7 at was -- you know, for my colleagues on the Committee
8 is, I think we have an opportunity to perhaps in some
9 small way influence what the Health Plan Qualification
10 Committee does tomorrow because as your liaison to that
11 Committee, I will certainly make sure they know what our
12 leaning is, what our recommendation is.
13 MS. LYONS: Right.
14 MS. JAFF: And so -- and I think that we
15 have an opportunity here to make a difference. That
16 said, I think if we want to be taken seriously one of the
17 issues that we have to care about is cost and
18 affordability. This is going to be the benchmark plan
19 not only for everybody inside the Exchange but for
20 everybody in the State of Connecticut. And affordability
21 is going to matter, not only to people in the Exchange
22 over 400 percent of federal parody, but also to people
23 outside the Exchange who are purchasing insurance in the
24 State of Connecticut.

1 And so as much as the consumer in me wants
2 to go to the wall for choosing a state employee plan, I'm
3 fairly certain that the Health Care Qualification
4 Committee would -- will not do that. There have been two
5 votes already to exclude the state employee plans from
6 consideration and those votes have been close. I suspect
7 that tomorrow those plans will be excluded from
8 consideration no matter what this Committee does. So I
9 think if we choose a state employee plan we, in a way,
10 make ourselves a little less relevant. And so like I
11 said, there's part of me that really wants to go to the
12 wall for a state employee plan. I'm not sure that it
13 would have any significance; I think we would make
14 ourselves irrelevant if we did that.
15 So my thinking is that we look at the
16 remaining plans and see which one does have the best
17 package of benefits. And based on the limited
18 information we have, as best I can tell the ConnectiCare
19 HMO has the highest visit limits to the extent that there
20 are any differences among the plans with respect to visit
21 limits and there aren't a lot of differences. But for
22 physical therapy, which as you just saw from the
23 utilization data from the Comptroller's office, is one of
24 the services that does get utilized a fair amount. I

1 think that really makes a difference. I think skilled
2 nursing facility days makes a difference and ConnectiCare
3 is just a little bit -- a little bit richer than the
4 Aetna and Anthem plans.
5 So based on all of those considerations
6 taken together, I've kind of -- and I'm not saying I
7 can't be convinced to change my mind, but I have -- I
8 would be comfortable right now voting for the
9 ConnectiCare plan.
10 CHAIRPERSON VELTRI: Okay, so I think we
11 should try to have like a robust discussion about this.
12 And so with that, I'm going to throw out the
13 consideration around affordability as an issue. It would
14 be interesting to know -- you know, I don't know what
15 data we have. I know we have the UConn study, which is
16 the -- you know, tells us what the cost is, PM/PM on each
17 one of the mandates.
18 But it would be kind of interesting to
19 know, and we're not going to have it obviously but maybe
20 for the other Committee, you know, what the difference in
21 cost is of these plans, what are the different visit
22 limits, and know the cost may change depending on the
23 risk profile of the population and all that kind of
24 stuff. But as just a general idea, I mean, how much does

1 it contribute to the premium to have an extra 20 days for
2 the visit limit for PT, OT and ST. I don't imagine it's
3 that much but again, my concern with every one of these
4 decisions -- even though I am the health care advocate
5 and I'm very concerned about people getting comprehensive
6 benefits, I'm also concerned that people be able to
7 enroll and afford a plan in the Exchange.
8 MS. JAFF: Exactly.
9 CHAIRPERSON VELTRI: So I think there is a
10 balance here that has to be struck and I'm not exactly
11 sure how to strike it because as we know, every one of
12 the plans includes mandates, it's just differences on the
13 limits. So I'm just throwing that out there as a
14 consideration for the Committee. So John?
15 MR. ERLINGHAUSER: Yeah, maybe a question
16 for Jennifer as the liaison from the other Committee.
17 Before I would consider excluding the state employees I
18 would like to at least have in my head what the thinking
19 is in terms of the other Committee as to why they would
20 reject the state employee plans at least.
21 I mean, I have a suspicion, but I'm
22 curious as to what the tone of the discussion was.
23 MS. JAFF: It's purely about affordability
24 so -- you know, we did get a little bit of information

1 which as Bob has pointed out to us several times the base
2 premium numbers that we got really compares, I think it
3 was apples to watermelons. But if you do look there you
4 can see that for the most part the state employee plans
5 have a higher base premium, the ConnectiCare plan is kind
6 of right in the middle.
7 I think in the absence of the kind of
8 information that Vicki just asked for, the actuarial
9 value of having unlimited physical therapy visits versus
10 60 physical therapy visits -- I mean you know, that's the
11 information we would need to know to really make a
12 calculated decision based on affordability. But the
13 general consensus I think is that the richer the benefits
14 the more it's going to cost. And the state employee
15 plans having unlimited benefits for several of the
16 categories we're looking at, it's fair to kind of assume
17 -- although we wish we weren't assuming but it's fair to
18 assume that those plans are going to cost more.
19 If you have unlimited benefits it's going
20 to cost more than if you have limited benefits, simple as
21 that.
22 MR. TAUBMAN: Yeah, just since it's an
23 open discussion and I'm not necessarily saying my view on
24 this one thing to think about is that for people below

1 400 percent of poverty, they get it thorough subsidies.
2 And the way it's designed is that there will be no more
3 than certain -- there's a cap on how much your
4 responsibility would be and the federal government will
5 subsidize the rest, so the affordability issue is really
6 less, far less of a concern for those below 400 percent
7 who are in the Exchange.
8 What Jennifer is pointing out though is
9 that these rules will affect the standards generally
10 where the person could be responsible for covering some
11 of those expenses and therefore, it's an issue. I mean,
12 the reason I say this though is that a legitimate view
13 would be that people who are lower on the income scale,
14 we should be most concerned with them because they
15 obviously have fewer resources. And people higher on the
16 income scale, we're concerned with them but perhaps not
17 as greatly and therefore one could say well, it's really
18 important to have as robust a package as possible. The
19 state employee plan is a real plan that's operating for
20 many, many people in Connecticut right now and it's for
21 people lower on the scale. It makes sense that they
22 should have that plan even though adopting that does
23 create affordability -- potential affordability problems.
24 As Jennifer pointed out we don't really

1 have the actuarial data, but potential affordable
2 problems for other folks.
3 CHAIRPERSON VELTRI: So just to try to
4 generate some discussion, I was hoping to hear from some
5 people who haven't really talked much about what their
6 views are. But just to play devil's advocate a little
7 bit, you know, obviously I care very deeply about people
8 who need benefits and comprehensive benefits, especially
9 people of lower income who have fewer resources.
10 I guess one of my concerns is yes, people
11 get subsidies but only if they enroll. And my concern is
12 not turning off people because of the price of the
13 products before they even enroll to get the subsidies.
14 So -- you know, because you're going to be looking at
15 this on a web portal and you're going to see -- you're
16 going get information maybe about the subsidies, but you
17 may see the product prices and that could be a potential
18 turnoff. So that's just another thing to kind of throw
19 in the hopper in terms of the consideration of the issue.
20 But anyway, Bob.
21 MR. SCALETTAR: And I think building on
22 your point Vicki is, remember this essential health
23 benefit sets the floor for the market inside the Exchange
24 and outside the Exchange. So there are people who won't

1 have subsidized coverage that will see higher numbers as
2 well.
3 CHAIRPERSON BARRETT: I'll just say that,
4 you know, like Jennifer I'm very torn too because I
5 really want to say state -- I want to say it, but I also
6 agree with the recommendation for ConnectiCare. And you
7 know, I think there's just a slightly richer package to
8 the extent that we could get something that is more
9 affordable but still rich. That's probably the way to
10 go, so that's just my two cents.
11 MS. MURPHY: Just to get a sense, I mean
12 when you -- just to get a sense about the fiscal impact
13 that -- and we understand that it seems pretty clear that
14 the state plan would be significantly some amount more
15 expensive as a premium than the other plans, it sounds
16 like it.
17 Just to get a sense, is there any way
18 anybody could kind of give a kind of -- any kind of a
19 comparison about the differences in premium between the
20 other three? Is there anything about how much is it, is
21 it a factor of 10, is it a factor of .10?
22 MS. O'GARA: Jennifer, do you have that
23 data that we shared? You do.
24 MS. JAFF: At our -- I don't know if this

1 was -- was this given to this Committee too, because I
2 have it from the Health Plan Quality but it doesn't
3 matter. So the Anthem -- the base premium for the Anthem
4 plan is $525, the base premium for the Aetna plan is
5 $371, and the base premium for the ConnectiCare is $430,
6 so right in the middle.
7 And then we can talk about all the reasons
8 why you can't really make those comparisons, but --
9 MS. O'GARA: And then you want to add the
10 base premium for the state?
11 MS. JAFF: -- so I'm sorry, base premium
12 for the state employee plans, the Anthem Blue Care Point
13 of Enrollment is $604, the Anthem Blue Care Point of
14 Service is $624. The Oxford HMO is $482, which is still
15 a little bit higher than the ConnectiCare plan but more
16 in line with the small group plans.
17 MS. LYONS: You know, in that meeting that
18 we distributed that information we also discussed that
19 those premiums really weren't meaningful because so many
20 different factors go into the plan design that the
21 premium is being charged for network, benefits -- yeah,
22 so it really isn't a clear indication. So our main focus
23 has been on making sure that the guidance that we've been
24 given and the benefits that are outlined in each one of

1 those benchmark options were indeed reflected.
2 So I understand your concern about premium
3 and costs and your comments are valid, but that was not
4 the part of the exercise.
5 MS. O'GARA: Are there any other comments?
6 Sheldon.
7 MR. TAUBMAN: Yeah, I'm going to offer
8 sort of a -- I guess a compromised position on this one,
9 which is I'm very concerned about the people below 400
10 percent and I'm really concerned about the people below
11 200 percent. The Medicaid program is like the state
12 employee plan in terms of there's no limits for most
13 things, numerical limits.
14 There was a couple of exceptions, but
15 basically there's no numerical limits and that's the way
16 it should be because these are folks, in the Medicaid
17 program I'm talking about, who -- there's just no way
18 they can pay out of pocket. They can't, and our program
19 reflects that so I guess what I'm thinking is perhaps,
20 over great reluctance, I might agree with Jennifer. But
21 for people below 200 percent of poverty, if we're --
22 again, if we're going to the BHP if that's the
23 recommendation then there's more to a recommendation of
24 whether we go to a BHP. There's also a recommendation

1 of, well what is the BHP?
2 And one of the recommendations could be
3 they should have as robust a program as possible and that
4 would be something like the Medicaid program, which
5 doesn't have any limits like the state employee plan.
6 Well, there are a few limits actually in the state
7 employee plan but there are no limits in Medicaid. So
8 that's what I'm suggesting is we might want to -- I would
9 maybe relucently go along with Jennifer's suggestion of
10 the ConnectiCare plan, the most robust of the non-state
11 employee plans, but preserving the concern that that's
12 not going to be good enough for people below 200 percent
13 poverty.
14 MS. JAFF: Bob do you -- my recollection
15 is that the EHB is what has to be covered by the BHP.
16 MR. TAUBMAN: It's just a floor.
17 MS. JAFF: It's just a floor, so we can go
18 above that? Okay, and that's a great --
19 CHAIRPERSON VELTRI: But maybe before we
20 go farther into this discussion it makes sense to --
21 maybe I'm jumping the gun a little, but it seems that the
22 Thompson Reuters data is relevant to this discussion. At
23 least it is to me in terms of the profile of the people
24 at these different income limits whether or not they may

1 have reported a disability or not, whether they have
2 access to care issues.
3 I mean, that might make a difference to
4 what a group -- tomorrow I'm sure it may make a
5 difference for them and I think it might make a
6 difference to us, as to whether we thought we should
7 recommend one plan or another plan depending on what the
8 profile is of the population. You know, I think the data
9 is showing that there's a lot a lot of people over 400
10 percent of FPL over there, but there's also a lot of
11 people under 200 percent. And the in between, you know,
12 may be okay and it just butts Sheldon's remarks, but.
13 MR. MADRAK: Yeah, we can certainly
14 transition and go into the data to the extent that that
15 helps to color the recommendation or provide some
16 additional perspective. We can certainly take that
17 route. I don't want to derail the conversation here if
18 people are having some good dialogue, but if we do
19 transition we can run through that fairly quickly and
20 then continue to see how that might impact this
21 particular discussion. Okay?
22 CHAIRPERSON VELTRI: Go ahead.
23 CHAIRPERSON BARRETT: Yeah, just before --
24 and I don't know where this goes but where do we fit in,

1 you know, the whole conversation around access and plan
2 design in terms of how people are going to be able to get
3 benefits whether there's gatekeepers, that sort of thing?
4 Because I think that also figures in to -- you know, you
5 could have a plan with less benefits but more access and
6 maybe you choose that over one that has no limits, but
7 you can't get in to see a doctor.
8 And so I know that it's not part of the
9 EHB but where do we learn that or how do we set those?
10 MS. LYONS: A lot of those come into play
11 with the QHP certification process. So that's like steps
12 two through a bazillion to figure out.
13 CHAIRPERSON VELTRI: Does that come before
14 we go to the feds with our design? I mean, we as -- the
15 Exchange Board decides, I think it's the Board, decides
16 what a QHP should look like on top of the EHB issue.
17 Then there's the QHP issue, so now we've decided the
18 benefits but in addition to the benefits we want you to
19 have a network that does XYZ or we want you to have
20 access standards that are -- meet this and that criteria.
21 We do all that before that goes to the
22 feds or do we not, I can't --
23 MS. LYONS: Well, I know that the
24 declaration and the blueprint needs to be submitted by

1 November 16th. So that's all a part of that.
2 MR. TAUBMAN: So this is important because
3 if what you're saying is that we will be specifying those
4 things before November, things like -- I mean, because
5 this is all the issues we've been talking about earlier
6 and saying, but we're not talking about them like prior
7 authorization, like limiting to four at a time can be
8 approved, which is really unreasonable which insurers do.
9 And wanting to say we don't want to allow
10 that, we're going to -- for behavioral health or perhaps
11 generally we're going to say we're not going to allow
12 that. Are you saying that those things would all have to
13 have to be put in there by November?
14 MS. LYONS: It's part of the
15 certification. Some of those things are part of the
16 certification process.
17 MR. TAUBMAN: Because -- I mean I think
18 kind of, this Committee really doesn't know the answers
19 to these questions, that is what has to be decided by
20 then. Because if in fact they do have to be decided by
21 then, I think from the conversation earlier today there's
22 a lot of things people feel strongly about that should be
23 recommended.
24 MR. CAREY: Bob Carey. So I don't believe

1 that the issues with regards to network adequacy
2 standards or preferred plan design options need to be
3 part of the certification, but they certainly need to be
4 part of the solicitation that is made to the health plan.
5 So you spell out to the health plans, we expect for the
6 plans being submitted to the Exchange that you meet these
7 certain standards, that -- you know, not have four free
8 visits before you're authorized for additional ones.
9 Whatever the issues are that the Advisory
10 Committee and the Exchange Board should be part of a
11 qualified health plan. So each Exchange across the
12 country will establish its own standards with regards to
13 the qualified health plans that are offered through the
14 Exchange. Some Exchanges are sort of taking, you know,
15 any willing provider, meaning any plan that meets minimal
16 standards. Other Exchanges are establishing more
17 detailed standards about what they expect from the
18 qualified health plans. So while that does not need to
19 be part of the state certification per se, I think the
20 timing is pretty close in terms of the solicitation to
21 the health plans.
22 You need to let the health plans know
23 what's the road map or what are the rules that you're
24 going to establish in receiving their proposals or their

1 plan designs and then certifying them as qualified health
2 plans or not. So while it's probably not November 16th,
3 it's probably not too far after that.
4 MS. O'GARA: So, I would just like to make
5 a suggestion. Before we go and transition to the data
6 there has been a suggestion, and I want you to keep in
7 mind Sheldon made the suggestion of a lean towards CCI's
8 current benefit plan as the benchmark plan, but reserving
9 the -- I don't know how you want to say it, the option
10 that a robust as possible be available for those under
11 200 percent. Did I get that right?
12 MR. TAUBMAN: That's roughly accurate.
13 MS. O'GARA: Okay. And we can rephrase
14 that and get it the right way, but I want you to be
15 thinking about that as you go looking at the data okay?
16 MR. MADRAK: Alright, with that said I
17 think as Monty Python used to say, now for something
18 completely different. I think as many of you know, we
19 commissioned Thomson Reuters to conduct a series of data
20 analysis for us about three or four months ago. It took
21 them roughly about six weeks to go ahead and crunch all
22 the numbers and then they provided us with this
23 information back roughly around the time of our last
24 meeting.

1 So over the past 30 days during the time
2 that we last met, we've gone through the information and
3 prepared a series of summary tables on the information
4 which we sent to you as part of the pre-read packet.
5 There's also a cover memo to that information, which
6 provides some analysis and analytic points around overall
7 findings and some specific findings. There's quite a bit
8 of information there. For the sake of our presentation
9 today, we'll cover things at a somewhat high level but we
10 can always circle back and answer more detailed questions
11 as we all continue to pour through some very, again,
12 detailed information.
13 The information that Thomson Reuters used
14 comes from several different sources. The major ones,
15 obviously the U.S. Census provides a boatload of
16 information. The ACS survey, which delves into very
17 specific insurance-oriented data points is also mine,
18 that's conducted on a level of frequency which is usually
19 every three or five years and then aggregated up every 10
20 years at various levels of detail, whether it's statewide
21 or even down to the block level. So there's a real
22 treasure trove of information there from different time
23 points. And then lastly, they utilize several different
24 proprietary analytic and forecasting tools, which use

1 statistical methods to take that type of information and
2 then make projections for how those populations may
3 change in the years ahead.
4 The final deliverable that we got was
5 actually two very large excel tables with a series of
6 pivot tables, functionality layered on top, that allowed
7 you to manipulate the data and analyze that. I spared
8 you all getting those in your inboxes so it didn't crash
9 your computers, but certainly if anybody is interested in
10 spending a weekend pouring through that, please let me
11 know and we can set you up with access. So in terms of
12 the order, the first excel table that we actually got
13 contained estimates of the number of Connecticut
14 residents in seven major insurance categories. So, you
15 know, certainly we're very interested in finding out how
16 many uninsured residents that live in the state. But
17 it's also very important that we know the overall sort of
18 insurance coverage landscape across the state.
19 And so those seven categories you'll see
20 listed here in the pink box, those with Medicaid
21 coverage, Medicare coverage, and then likely those
22 individuals who have dual coverage, we looked at the
23 number of people who have employee-sponsored insurance,
24 and then those individuals purchasing non-group insurance

1 through a private exchange, purchasing non-group
2 insurance through a non-exchange or just the open market,
3 and then those individuals who are currently uninsured.
4 We're then able to take each of those seven groups and
5 further split them out across four major sublevels, which
6 would be County then down to the zip code level and then
7 age and gender as well. So as you can see as you start
8 to cut across these and look at the different
9 permutations, it gets quite detailed quite quickly.
10 So in other words, you could take a look
11 at an uninsured individual in a particular County then
12 break that population down into the zip codes they
13 resided and then look at the male and female splits and
14 then conversely even among the male and female groups
15 look at age. So it is a boatload of information which
16 becomes, you know, very unwieldy without the proper tools
17 to analyze. Lucky for you we took the time to put
18 together some summary information so we don't have to go
19 ahead and do that all by ourselves and low and behold,
20 you know, just on a summary level if you see the table
21 below there's a couple of kind of key takeaways that we
22 wanted to at least make sure that this group is very
23 aware of.
24 You know, the first group that we took a

1 look at was the uninsured population. And with the
2 Thomson Reuters data, they're putting that in the current
3 year at around 344,000 individuals statewide that
4 represent really roughly one in ten Connecticut residents
5 falling into that population, which is obviously quite a
6 high number. For the purpose of our initial
7 investigation and certainly for the summary information
8 which we provided you, we chose to focus here first.
9 This is obviously a group of great importance and so it
10 sort of beckoned our attention. As a tertiary set of
11 analysis we also took a look at the Medicaid population
12 since that program is expanding. We also thought it
13 would be germane to walk away with a very concrete
14 knowledge of what that group currently looks like as well
15 given that other people are going to fall into that
16 particular program.
17 That group, again according to this
18 particular data, also represents about 15 percent of
19 residents thus far. So putting those groups together, I
20 think it's actually quite a staggering number, 15 and 10
21 is 25, one in four Connecticut residents either in the
22 Medicaid population or uninsured, certainly one of the
23 reasons we're all here today. We then took a look and
24 tried to drill down just a bit more specifically from a

1 geographic standpoint. Certainly statewide data is
2 insightful, but from the standpoint of trying to actually
3 start to put together meaningful programs and selfishly
4 from a marketing and communications standpoint, we very
5 quickly need to move towards a place where we know where
6 these people are residing on a very specific level.
7 I think as you saw if you went through
8 some of the analytic points, there is a heavy, heavy
9 concentration of the uninsured in a very small set of
10 geographies. And so as you look at the table here, you
11 can sort of see where those concentrations start to
12 emerge. So just by way of kind of familiarizing you with
13 the data, if you looked at New Haven County for example
14 there are about 110 individuals projected in New Haven
15 County who are uninsured. That represents about a third
16 of the overall state uninsured population. But then as
17 we start to drill down within the County you can see that
18 just the top 20 zip codes within New Haven, which contain
19 the uninsured population, represent over 80 percent of
20 those individuals.
21 And if you delve down more specifically in
22 any of these particular Counties, you find that it's
23 actually concentrated even in a smaller group within
24 those 20 zip codes. Some you know, by way of the callout

1 here if you looked at Hartford County for example just
2 five zip codes within the city limits of Hartford itself
3 comprise one and a third of all uninsured individuals
4 within Hartford County. So -- oh, question Bob?
5 MR. SCALETTAR: So I don't know too much
6 about zip codes. Are they done in population
7 concentrations or geography or some other thing, because
8 I guess the question that occurs to me is so how many zip
9 codes are there in each of the Counties?
10 MR. MADRAK: Yeah, that's a great
11 question. These are postal zip codes, so there's other
12 ways to analyze population data. You can look at things
13 like block group or other types of configurations. For
14 the sake of this analysis these are postal zip codes. We
15 can get definitions for each of these to give you the
16 specific range and in many ways if you looked at a map,
17 it carves out really a specific block or group of blocks
18 if you will.
19 For example in Hartford, if you looked at
20 a particular zip code you'd get a nice map and it would
21 show you, you know, specifically for example the Frog
22 Hollow area and it would be concentrated, this analysis,
23 within there. In terms of the total number of zip codes
24 contained in any one city, that's also publicly

1 available. It's not particularly in this analysis but we
2 can certainly include that as a follow-up point as well.
3 From the standpoint of a marketing and communication
4 program or really any of the types of outreaches that
5 we're looking to do, this information and this particular
6 finding is actually, I believe, quite good. It shows
7 that really we can really focus our efforts and come up
8 with some very meaningful programs but not have to deal
9 with the challenges of a widely disbursed population if
10 you will.
11 Now, I caveat that by saying we are in no
12 way, shape and form suggesting that we're excluding
13 people or only focusing on these areas. But from an
14 efficiency standpoint and from an outreach standpoint
15 having concentrated groups of individuals in certain
16 areas is definitely helpful to make sure you have a very
17 efficient program. Question Arlene?
18 MS. MURPHY: Well, I think that these data
19 are very helpful in kind of seeing where you can make the
20 biggest bites out of the problem. But then, you know,
21 there is the other side of that which is percentage of
22 population and the concentration of uninsured. And so I
23 agree and I understand the rationale for doing that, but
24 the only thing else you have to be careful about is

1 community impact and looking at those communities outside
2 of your focus areas because those communities might be by
3 population disproportionately affected by being uninsured
4 and lack of access to health care.
5 MR. MADRAK: Absolutely.
6 MS. MURPHY: But I hear what you're saying
7 too, so.
8 MR. MADRAK: Yeah, absolutely. And
9 really, when you have a situation like this with, again,
10 a high concentration and then maybe some more disbursed
11 populations it will help to shape the ultimate strategy
12 which we'll come back to this group with, with how we
13 actually go ahead and approach those sort of, you know,
14 bifurcated situations.
15 The second set of analysis as we alluded
16 to was to take a look then at the Medicaid population.
17 And what I found to be quite interesting was that the
18 dispersion of the Medicaid population or conversely the
19 concentration was actually nearly identical to what we
20 saw on the uninsured side. That might be surprising; it
21 might also be wildly unsurprising to some people. But
22 these two groups tend to reside basically in the same
23 exact spots in the same exact zip codes. Again, I think
24 from a communication standpoint having that sort of

1 concentration of now both these groups within a very
2 similar set of geographies could again be helpful from
3 the standpoint of launching a very efficient marketing
4 and communications program on the back end.
5 Within the document that we'd sent out,
6 you can take a look at each County. You can take a look
7 at the distribution of these populations across the top
8 20 zip codes. They're also rolled up by city. And then
9 if individuals do have a desire, you know, that larger
10 data set with the several hundred zip codes in
11 Connecticut can be provided. But again, since the top 20
12 typically represent 80 percent of the population it's a
13 pretty good read of sort of the overall dynamics and
14 layout of any particular County or city. Moving on to
15 the second data set that we had commissioned Thomson
16 Reuters to put together, this one profiles demographic
17 characteristics which is more germane probably to the
18 conversation that we were just having of the current
19 uninsured population who are going to be eligible for
20 either the Medicaid enrollment through the expansion of
21 that particular program or enrollment via the Exchange as
22 a result of the eligibility requirements.
23 There were four major groups that were
24 profiled sort of at this level. The first was with these

1 new changes to the marketplace, children in the state who
2 would be eligible for Medicaid or S-CHIP. The second
3 group was adults 18 plus in the state who would now be
4 eligible for Medicaid, again, given the expansion of that
5 particular program. And then the last two groups are
6 more in line with the Exchange overall, children in the
7 state that would be eligible for the subsidized purchase
8 via the Exchange. And obviously we're referring to
9 children in homes here not children who are, you know,
10 making $30,000 a year. And then adults age 18 plus, same
11 thing, who would now be eligible for the subsidy and
12 purchase by going through the Exchange.
13 In the packet, again the pre-read packet,
14 there's analysis of each of the tables just, again, to
15 acclimate this group to what the data was sort of
16 alluding to. I chose to focus really just on the adult
17 population. Again, there's information on the under 18
18 population within the packet and some analytic points
19 there as well but the overall table really just profiles
20 the data points that we had access to. So for each group
21 we looked at citizenship, both those who are current U.S.
22 citizens and then those who are actually U.S. born.
23 Obviously the number of citizens exceeds those who are
24 actually born here because people can apply for

1 citizenship.
2 We took a look at the number of people who
3 are disabled overall and then within two disability
4 categories below that, ambulatory difficulty and self-
5 care difficulty. And then lastly we took a look at some
6 race and ethnicity figures as well, which you can see
7 listed there. And then lastly, this is a self-reported
8 metric but those individuals who said that they had
9 difficulty speaking English, and that's defined as
10 speaking English. Again, this is a self-reported measure
11 as less than well, so in terms of what you're seeing here
12 and some of the kind of key takeaways for the Exchange
13 and those individuals who are going to be eligible for
14 purchase on the Exchange, you know, roughly 6.4 percent
15 of those individuals are reporting that they have some
16 level of disability.
17 In terms of the Medicaid population, that
18 number is actually twice as large. It's actually 13
19 percent, so some really major differences there. This
20 particular slide is calling attention to some of the more
21 meaningful disparities not necessarily all the
22 similarities. Likewise if we look at the two populations
23 and look at a race and ethnicity, those individuals
24 likely to purchase insurance through the Exchange, 66

1 percent or about two out of three are being reported as
2 white. And that number is actually fairly or much more
3 significantly larger than the individuals who would be in
4 the Medicaid population where that number is actually
5 only about half. And then likewise, this is also very
6 germane to the conversation that we were just having
7 earlier. Actually in both categories 17 percent,
8 actually almost approaching one in five individuals in
9 both categories, whether Medicaid eligible or Exchange
10 eligible, indicated that they did have some level of
11 language difficulty speaking English, which I think is
12 going to be obviously keenly important as we look to put
13 together a really impactful, linguistically appropriate
14 communication program, reaching out to these particular
15 populations.
16 Outside of that you do see, you know, some
17 consistency across these particular groups. But
18 hopefully as we start to think about, again, the programs
19 that we were recently discussing and how they're going to
20 impact those individuals who are going to be purchasing
21 them, this is just a nice quick overview of what these
22 populations actually look like. Now with that said --
23 Vicki, did you have a question?
24 CHAIRPERSON VELTRI: Well, I just -- when

1 I was looking at these numbers what I thought that was
2 also really interesting was the age distribution of the
3 uninsured. So 43 percent --
4 MR. MADRAK: Ahum.
5 CHAIRPERSON VELTRI: -- of the uninsured
6 are between 18 years old and 34 years old.
7 MR. MADRAK: Correct.
8 CHAIRPERSON VELTRI: That's -- I mean,
9 that's a completely different demographic than the -- you
10 know, than the 19 percent between 45 and 54. I mean,
11 they're all -- everybody is obviously -- most people are
12 concentrated between 18 and 54.
13 MR. MADRAK: Correct.
14 CHAIRPERSON VELTRI: But with the
15 predominant number between 18 and 34, so I think that
16 makes a big difference in what we're looking at in terms
17 of the --
18 MS. O'GARA: And Vicki -- this is Nellie.
19 Is that 18 to 34 is also male?
20 CHAIRPERSON VELTRI: Not total, 18 to 34
21 --
22 MS. O'GARA: Yeah, and then if you look at
23 the dominance among that group --
24 CHAIRPERSON VELTRI: -- then it's

1 predominantly male.
2 MS. O'GARA: -- yeah, so when you're
3 thinking about your benefit points --
4 CHAIRPERSON VELTRI: Right, exactly. So
5 there's -- so that plays into it. And also, the other
6 thing that surprised me was the distribution of uninsured
7 by income.
8 MR. MADRAK: Ahum.
9 CHAIRPERSON VELTRI: Which I think is
10 obviously relevant or would be relevant to most of us, I
11 think, around the table in terms of plan design and stuff
12 because there were -- it was a more significant
13 population of people over 400 percent of FPL that did not
14 -- that were uninsured than I thought there ever was.
15 MR. MADRAK: Ahum.
16 CHAIRPERSON VELTRI: But then there is a
17 very big population obviously in the up to 200 percent
18 FPL bracket.
19 MR. MADRAK: Correct.
20 CHAIRPERSON VELTRI: So that's why I
21 thought it was important for us to see this because of
22 the age distribution, the income distribution, the
23 disability in terms of what we thought might be the best
24 option for a plan design.

1 MR. MADRAK: Yeah, I think in some ways
2 you'll see this data actually reinforcing some things
3 that maybe we already knew in terms of, you know, the
4 young invincibles maybe skewing heavily male. This
5 actually is a really nice solid confirmation that that
6 isn't, you know, a reality, a true phenomenon, and then
7 as it relates to some of the income levels. And those
8 charts all contain FPL breakdowns. It does actually call
9 some attention to maybe some more surprising takeaways to
10 show that there is more of a distribution and sometimes
11 it's not as concentrated as you may or may not think.
12 So, you know, in the essence of time I
13 chose not to profile each and every figure because as you
14 can see there's a robust amount of data. Hopefully the
15 analysis and the pre-read in those summary tables will be
16 helpful, but I would definitely encourage you if you have
17 any additional questions or comments as you go through
18 that information, do not hesitate in the least to reach
19 out and let me know and we can certainly provide some
20 additional perspective or additional cuts.
21 John, did you have a question?
22 MR. ERLINGHAUSER: Yeah, I was going to --
23 because in the preamble it says adult population will be
24 impacted and be in the Medicaid expansion, and then in

1 the actual data it says uninsured adults in Connecticut
2 currently Medicaid eligible. Does that mean under the
3 expansion --
4 MR. MADRAK: Correct.
5 MR. ERLINGHAUSER: -- or under the current
6 benefit?
7 MR. MADRAK: No, this is under the
8 expansion. It's a great question.
9 MR. ERLINGHAUSER: So do we have any idea
10 of the number of those people that are currently eligible
11 for Medicaid who are not accessed to the program?
12 MR. MADRAK: I think we could derive that,
13 but that wasn't part of the analysis. So you're saying
14 under current rules --
15 MR. ERLINGHAUSER: Current Medicaid rules
16 how many -- what number of people that are uninsured
17 would currently be eligible for Medicaid but haven't
18 gotten access to a program?
19 MR. MADRAK: We could follow up with that,
20 yup.
21 MR. ERLINGHAUSER: Okay.
22 MR. TAUBMAN: So to -- if this could be
23 explained to me I think it would be helpful in terms of
24 the -- what we were discussing earlier and about the

1 people below 200 percent. Does one of these charts tell
2 us what percentage of the uninsured population is between
3 138 and 200? I know there's a group there, 139 to 190,
4 which is roughly the same.
5 MR. MADRAK: Ahum.
6 MR. TAUBMAN: What percentage is in that
7 group versus over 200 percent?
8 MR. MADRAK: Yup.
9 MR. TAUBMAN: Do we have that from --
10 MR. MADRAK: It should be in the tables,
11 so there should be a breakdown for all groups of
12 uninsured across each of the FPL breaks. And you can add
13 those together or break them apart.
14 MR. TAUBMAN: Yup, okay so -- that's
15 uninsured children though.
16 MR. MADRAK: There should be four tables,
17 one for --
18 MS. O'GARA: There's an uninsured children
19 and uninsured adult Sheldon.
20 MR. MADRAK: Correct, thanks.
21 MR. TAUBMAN: So yeah, I'm trying to
22 figure out which -- there's one that's entitled uninsured
23 adults in Connecticut currently Medicaid eligible, but
24 that's strange because at the higher income levels

1 there's no way they'd be Medicaid eligible.
2 MR. MADRAK: Is there an income break on
3 the chart that's in excess of what you would expect to
4 see? There should be two adult tables; one is adults who
5 would be Medicaid and one --
6 MR. TAUBMAN: Ah, I think it's on the
7 back, okay.
8 MR. MADRAK: -- okay.
9 MR. TAUBMAN: Okay I'm sorry, it was on
10 the back. So in other words if I have -- now I'm looking
11 at uninsured Exchange eligible adults in Connecticut.
12 MR. MADRAK: Yup.
13 MR. TAUBMAN: And the four brackets are
14 139 to 190, 191 to 300, 301 to 400 and above 401. So if
15 we use 139 to 190 as a rough proxy for 200 percent, it
16 says 21.4 percent. So that means 21.4 percent of
17 uninsured adults are in the group that I expressed
18 particular concern about?
19 MR. MADRAK: That's exactly right, you're
20 correct.
21 MR. TAUBMAN: Okay, thank you.
22 MR. MADRAK: Okay.
23 CHAIRPERSON VELTRI: What I'm trying to
24 figure out is why is the grand total on the last page or

1 on the page that Sheldon's just talking about, the last
2 page --
3 MR. MADRAK: Yeah.
4 CHAIRPERSON VELTRI: -- it's not really
5 helpful to just say the last page. The grand total says
6 205,401. How does that relate to the 344, because I
7 thought the total of uninsured was --
8 MR. MADRAK: 344.
9 CHAIRPERSON VELTRI: -- no, right, but I
10 thought the total uninsured -- oh okay, it's just --
11 these are just the adults.
12 MR. MADRAK: That's correct.
13 CHAIRPERSON VELTRI: And the rest are the
14 children, okay. Medicaid adults, these adults plus the
15 kids all add up to 344.
16 MR. MADRAK: You got it, yup. It can be a
17 challenge to navigate between about 16 different tables,
18 that's right.
19 CHAIRPERSON VELTRI: I think this is, you
20 know, some of the most helpful information we've seen so
21 far because it really gives us a picture of what
22 Connecticut looks like.
23 MR. MADRAK: And wait, there's even more
24 coming so in terms of the next steps. Okay, Arlene.

1 MS. MURPHY: Before we move on I have a
2 question for Bob.
3 MR. MADRAK: Sure.
4 MS. MURPHY: Is this picture somewhat
5 similar to what you saw in Massachusetts? Is this very
6 different, is the picture really very different or is
7 this kind of consistent?
8 MR. CAREY: No, it's completely
9 consistent. Young males between 19 and 34 make up a
10 disproportionate share of the uninsured population, vis-
11 à-vis their share of the overall population. It's also
12 quite comparable in terms of your CHIP program being
13 quite expansive here just as it was in Massachusetts, so
14 a very small percentage of kids are uninsured currently.
15 So there won't be a huge increase in the number of
16 insured children, it's really adults that is the primary
17 driver of the uninsured.
18 MS. O'GARA: Vicki and Connie, if I could
19 point out we have about 20 minutes left and we have the
20 EHB decision and then we have the Rx option. So are we
21 ready to go back to our selection discussion?
22 CHAIRPERSON VELTRI: Yeah, I mean I think
23 we obviously have to go back to the selection discussion
24 but I'm just -- it's an interesting thing to look at this

1 and think that only 72 percent of the uninsured adults
2 are in the subsidy range. The other 28 percent are
3 unsubsidized if they even choose to enroll because
4 they're over 400 percent of the federal poverty level.
5 So to the extent that has any bearing on our discussion,
6 I'm just throwing it out there.
7 MS. MURPHY: And I think it absolutely
8 does because it impacts on the cost of their plan. It's
9 not just the -- you know, so I think it's going to have a
10 broad impact on that population, so.
11 CHAIRPERSON VELTRI: Good point.
12 MR. MADRAK: Actually -- and if I could
13 just lastly -- you know, we have two data sets here. One
14 which provides a very detailed geographic view, the other
15 provides sort of the high level overview of some race and
16 ethnicity figures, FPL level, but they're separate
17 analyses. And so we are working on one final set, which
18 would really provide almost a combined view if you will.
19 So as we do get down to the very specific zip code level
20 we would actually be able to take a look at a more
21 detailed demographic profile if you will.
22 So these two separately provide a huge
23 amount of benefit, but if we can actually combine them so
24 we can actually go into a particular geography and know

1 even more about the individuals and constituents we're
2 going to be dealing with that would be wildly helpful.
3 So that analysis is actually going to be forthcoming and
4 we'll make sure we share that with you once that's ready
5 as well. So I just wanted to allude that there is still
6 just a little bit more, just to provide that sort of
7 complete picture if we don't have enough already.
8 MS. O'GARA: Okay, so we have a couple of
9 -- do we have someone who wants to formulate a
10 recommendation?
11 MS. JAFF: So I think my recommendation
12 was Sheldon's amendment is kind of where we're at, which
13 is that we would select the Connecticut -- ConnectiCare
14 plan as the EHB benchmark plan with a strong
15 recommendation for consideration of a BHP for people
16 between 133 and 200 percent of federal poverty which
17 would have a more robust benefit package that is more
18 along the lines of the Medicaid benefit package, right
19 Sheldon?
20 MR. TAUBMAN: Yes, I think that was clear.
21 MS. JAFF: Okay.
22 CHAIRPERSON VELTRI: Is that a motion?
23 MS. JAFF: Yes. So yes, that's a motion.
24 CHAIRPERSON VELTRI: Is there a second to

1 that motion? Somebody said -- okay. Okay, we have a
2 second and any discussion?
3 MR. TAUBMAN: Yes, just to clarify. I
4 mean, I'm fine with it as stated but the problem is that
5 you can't do different benefits for the people under 200
6 percent unless you have BHP because that's what there is.
7 That’s the model and I think that's -- there are other
8 reasons for the BHP as well, but this is certainly an
9 important one.
10 MS. JAFF: Right, and that's why when I
11 stated your amendment I put it in the context of a BHP
12 because I realize that that's the only way to get where
13 you're trying to get, which I actually completely and
14 totally agree with, so.
15 MS. O'GARA: Any more discussion before we
16 move to a vote?
17 CHAIRPERSON VELTRI: Don't be shy.
18 MS. O'GARA: Then I'd like to do a roll
19 call vote. If we could do a roll call vote please? Just
20 signify your agreement as yeay, and not in agreement as
21 no. Arlene Murphy.
22 MS. MURPHY: Yeay.
23 MS. O'GARA: CeeCee Woods.
24 MS. WOODS: I'll pass right now.

1 MS. O'GARA: Cheryl Forbes.
2 MS. FORBES: Yeay.
3 MS. O'GARA: Claudia Epright.
4 MS. EPRIGHT: Yeay.
5 MS. O'GARA: Gerard O'Sullivan.
6 MR. O'SULLIVAN: I abstain.
7 MS. O'GARA: Jennifer Jaff.
8 MS. JAFF: Yeay.
9 MS. O'GARA: John Erlinghauser.
10 MR. ERLINGHAUSER: Yeay.
11 MS. O'GARA: Robert Scalettar.
12 MR. SCALETTAR: Yeah.
13 MS. O'GARA: Sheldon Taubman.
14 MR. TAUBMAN: Yeay.
15 MS. O'GARA: Tanya Barrett.
16 CHAIRPERSON BARRETT: Yeay.
17 MS. O'GARA: Vicki Veltri.
18 CHAIRPERSON VELTRI: With some hesitation
19 I'm going to have to pass for a minute. I need to think
20 a second, I'm not sure I can make this vote.
21 MS. O'GARA: I'll come back to you.
22 CHAIRPERSON VELTRI: Okay.
23 MS. O'GARA: Sara Frankel.
24 MS. FRANKEL: Yeay.

1 MS. O'GARA: And Vicki.
2 CHAIRPERSON VELTRI: Was the language of
3 the motion a recommendation of consideration of the BHP
4 or recommendation that we do the BHP?
5 MS. JAFF: The language of the motion was
6 that it would be -- that our recommendation is that there
7 be a strong BHP, which would include a richer benefit
8 package more akin to the Medicaid program.
9 CHAIRPERSON VELTRI: Okay, so while I
10 completely support the concept and I'm on the workgroup
11 that's exploring the BHP, I just don't feel I can vote
12 for a strong BHP at this particular time. It doesn't
13 mean I won't, but I just feel like I need to consider as
14 a member of the workgroup and keeping faith with that
15 workgroup, that I'm going to abstain right now.
16 MS. JAFF: Well, should we amend the
17 language of the motion Sheldon?
18 MR. TAUBMAN: I was going to suggest
19 amendment of the language to -- I think the word
20 consideration has to be in there, strong consideration of
21 a BHP which would do these things.
22 MR. SCALETTAR: So just to clarify, this
23 is not a personal endorsement of the BHP or the
24 Committee's endorsement of the BHP, it's saying should

1 there be a BHP and whatever bodies will discuss and
2 decide that our view is that should there be a BHP it
3 ought to have a very -- consideration for a more robust
4 benefit package would be desirable?
5 MS. JAFF: I think we'd want to go just a
6 touch further than that and say that our recommendation
7 is for strong consideration, right, strong consideration
8 of a BHP that would have a richer benefits package. So
9 we're not voting in favor of the BHP, we are voting in
10 favor of recommending very serious consideration of the
11 BHP.
12 MR. TAUBMAN: And that's because that's
13 the only -- as I said earlier, that's the only way we
14 could get richer benefits for those under 200 percent of
15 people if we are selecting the ConnectiCare option for
16 the EHB.
17 MS. O'GARA: So do we need to take the
18 vote again or is everybody on line?
19 CHAIRPERSON VELTRI: Let's -- before we
20 take the vote -- I'm sorry to be so technical but I think
21 we need to just -- let's lay out the motion again very
22 carefully all at once so that --
23 MS. O'GARA: So what I have is to select
24 the CCI benefit plan as the EHB benchmark option with a

1 strong -- with strong consideration for a BHP for those
2 133 to 200 percent of federal poverty level including a
3 more robust plan along the lines of the current Medicaid.
4 MR. SCALETTAR: And Sheldon, I have a
5 quick question. So does that mean to the points I think
6 I've been understanding you to say, that if it didn't
7 include that language that you would still be trying to
8 argue for this Committee voting on the adoption of the
9 state health benefit plan?
10 MR. TAUBMAN: Right, in the sense that it
11 was a compromise because I am very concerned about the
12 lack of a robust package. But as I said, particularly
13 for the lower income folks, and that's why I was
14 suggesting it as a compromise.
15 MS. MURPHY: Okay, what I thought I was
16 voting for -- do you want to go?
17 CHAIRPERSON VELTRI: No, that's okay.
18 MS. MURPHY: Okay, this is Arlene. What I
19 thought we were talking about was that we had selected
20 for the essential health benefit package, we had
21 recommended -- I don't know the letters, Connecticut --
22 MS. O'GARA: Connecticut plan design.
23 MS. MURPHY: -- right, plan design, but
24 that for the population of 138 to 190, right -- to 200,

1 excuse me to 200 percent poverty, that we strongly
2 recommended the -- an expanded benefit package that was
3 reflected in the basic health plan. Are we endorsing the
4 basic health plan or are we endorsing a more expanded
5 benefit package, which is what I thought we were talking
6 -- voting for?
7 CHAIRPERSON VELTRI: So I -- I kind of
8 think it might make sense, let's -- can we split this?
9 Okay one decision is, we're making a recommendation about
10 an EHB, which actually the other Committee has to do but
11 we're giving an endorsement from our Committee on one
12 particular plan. That's one thing.
13 The other issue is the issue around BHP,
14 or not. You know, my feeling about that -- I'll just say
15 my feeling about that, is there's a workgroup that's
16 working on this very issue right now that's made up of
17 probably half advocates and half folks from the
18 administration and experts. And that is going to meet
19 with this Committee next month to talk about this very
20 issue in which I think, and I don't -- you know, as a
21 person who really feels strongly about the option of a
22 BHP, and I want that to be clear to everyone on the
23 Committee, I still think it might be more appropriate to
24 tackle that issue next month because it is a separate

1 issue from the EHB.
2 So the recommendation of this Committee
3 for a BHP could come next month independently of this
4 discussion. If it affects your decision on which plan to
5 choose, then I think that's a separate issue about which
6 we have to make a decision on, whether you vote yeay or
7 nay on the ConnectiCare option. And if everybody votes
8 nay we go with a different option.
9 MS. MURPHY: Well, I think that we had
10 gotten to a gray point where the essential health
11 benefits package, that first part for the population over
12 200 percent poverty, the reason that we felt comfortable
13 recommending that was that the concern that was expressed
14 for the population below 200 percent, that they would
15 have a more enriched benefit package that would be
16 reflected in the basic health plan.
17 I think that the thing is that we're
18 talking about is recommending the essential health
19 benefits plan for those over 200 percent of poverty but
20 then expressing the need for a more enriched benefit
21 package for those below 200 percent poverty. So it's not
22 that -- so I think maybe we could maybe use some language
23 that's more neutral?
24 MS. O'GARA: Well, you could have two

1 different --
2 MS. MURPHY: Right, exactly.
3 MS. O'GARA: -- recommendations. The
4 first recommendation -- I mean wait, Vicki, your first
5 recommendation could be to recommend selection of the CCI
6 benefit plan as the BHP for those 200 -- for those over
7 200 percent of federal poverty level. Then you could
8 have a second recommendation that says strong
9 consideration for a basic health plan for those under 200
10 percent of federal poverty level along the lines of the
11 current Medicaid program.
12 Is that acceptable? Let me ask staff, is
13 that acceptable to you in terms of what you need from
14 this Committee?
15 MR. MADRAK: Yes.
16 MS. O'GARA: So without tying -- I don't
17 know how to tie them together Sheldon, but what I'm
18 saying is you could put forth two motions.
19 MR. TAUBMAN: All I'm saying is they
20 should be done today together because -- I mean, they can
21 be separate motions, that's fine. But I feel, and it's
22 clear from Arlene's comments and others, that it's really
23 the quid pro quo for some of us that we're very nervous
24 about not going for the more robust package. But in

1 particular for the lower income folks, we need that
2 protection.
3 And of course the recommendation is only
4 as for our recommendation because Vicki's pointing out
5 that we're going to have another co-meeting with those
6 folks too.
7 MS. O'GARA: Alright, then why don't we
8 take it in two. So I need a motion on the first.
9 MS. JAFF: I move that we select the
10 ConnectiCare plan as the benchmark for the EHB for those
11 over 200 percent of poverty.
12 MR. SCALETTAR: I don't see how we can
13 segregate that. I mean, it's either this is the
14 recommendation for the essential health benefits or it's
15 not the recommendation.
16 MS. JAFF: Yeah, I agree with Bob. I
17 mean, we can't -- you know, we're trying to -- we really
18 can't. So we have to pick an EHB benchmark and then we
19 can have a second vote that says we strongly -- this
20 Committee strongly recommends that there be a more robust
21 benefits package for people under 200 percent right?
22 So the first motion -- do you want to do
23 the -- maybe you want to do them the other way around.
24 Okay, so the first motion then is that ConnectiCare --

1 the ConnectiCare plan be chosen as the benchmark for the
2 essential health benefits package.
3 MS. O'GARA: I need a second. We have a
4 second, and we need a vote. So are we ready to vote on
5 that motion? Okay, Arlene Murphy.
6 MS. MURPHY: Yeah.
7 MS. O'GARA: CeeCee Woods.
8 MS. WOODS: I will vote yes, but I cast
9 this as a preliminary vote given that I still have more
10 information to review. So I will vote yes.
11 MS. O'GARA: Thank you. Cheryl Forbes.
12 MS. FORBES: Yeay.
13 MS. O'GARA: Claudia Epright.
14 MS. EPRIGHT: Yeay.
15 MS. O'GARA: Gerard O'Sullivan.
16 MR. O'SULLIVAN: I abstain.
17 MS. O'GARA: Jennifer Jaff.
18 MS. JAFF: Yeay.
19 MS. O'GARA: John Erlinghauser.
20 MR. ERLINGHAUSER: Yeay.
21 MS. O'GARA: Robert Scalettar.
22 MR. SCALETTAR: Yeay.
23 MS. O'GARA: Sheldon Taubman.
24 MR. TAUBMAN: Yeay.

1 MS. O'GARA: Tanya Barrett.
2 CHAIRPERSON BARRETT: Yeah.
3 MS. O'GARA: Vickie Veltri.
4 CHAIRPERSON VELTRI: Yeay.
5 MS. O'GARA: Sara Frankel.
6 MS. FRANKEL: Yeay.
7 MS. O'GARA: Okay, motion is passed. Now,
8 if we could have the second motion.
9 MR. SCALETTAR: Is there such a thing as
10 something other than a formal motion of a sense of the
11 Committee?
12 FEMALE VOICE: You can make a motion as a
13 sense of the Committee. You can --
14 MS. O'GARA: Okay.
15 MR. TAUBMAN: Well, I guess my feeling is
16 it's one or the other. Either a -- not a sense but a
17 vote for a strong recommendation for the BHP or a sense
18 of the Committee that there shall be a BHP.
19 MS. JAFF: I thought we --
20 MR. TAUBMAN: Not a sense but there should
21 be consideration.
22 MS. JAFF: -- I thought what we decided
23 was that we were not going to say the BHP, that what we
24 were going to say is that our recommendation is that

1 there be a more robust benefit package for people under
2 200 percent poverty?
3 MS. O'GARA: So that would be a -- the
4 Committee recommends --
5 CHAIRPERSON VELTRI: I think it's, we
6 recommend that we consider a more robust package. That's
7 my feeling because, I mean, there is this working group.
8 I mean, there are people working on the issue. I think
9 we're kind of -- I don't want to say we're getting ahead
10 because a lot of us have been working on this issue for
11 months, but they are -- we are having this combined
12 meeting next month to discuss this very issue at which
13 we, in my opinion -- this is my own feeling about this,
14 is at that meeting we may have the information necessary
15 to make a more defined or clearer statement from the
16 Committee than just a consideration of a broader benefits
17 package.
18 But at this time, I don't feel comfortable
19 voting saying I'm recommending or I'm voting for the BHP
20 until the workgroup has a chance to meet with the
21 Committee and discuss all the details, so.
22 MR. ERLINGHAUSER: Vicki, what's the
23 timeframe of the workgroup and where does that fit into
24 the --

1 CHAIRPERSON VELTRI: That's a good
2 question. So the workgroup is -- well, I do know that
3 the next meeting is August. There's a smaller group of
4 the workgroup that has been formed to answer some very
5 detailed questions around risk profile, provider access,
6 potential costs of setting up a BHP, whether it would be
7 covered or not, you know -- or whether DSS could bear the
8 cost or not depending on how it's structured.
9 So there's a lot of detail that that
10 workgroup is going to be working on for several months I
11 think, but that said I think -- you know, my feeling and
12 I've been actually -- it's no secret that I've been a
13 strong supporter of the option of a BHP. But I also
14 think it's -- since we know now that that group is
15 working on the detail, I feel like it's giving them sort
16 of the discretion or the time to work on it before next
17 month's meeting with the joint -- the joint meeting
18 between that work and this Committee is something that we
19 should probably give them so that we could have that
20 robust discussion at the next meeting and then make a
21 recommendation about a BHP.
22 I think it's fine to make a recommendation
23 to consider a stronger benefit package, that I don't have
24 a problem with. But to recommend it today without having

1 done the combined meeting next month, I think is
2 premature in my opinion.
3 MR. ERLINGHAUSER: Well, and I tend to
4 agree with that, I mean, in having supported the BHP in
5 testimony in the past and probably in all likelihood will
6 in the future. But I don't see any reason to go on the
7 record saying that we should have a BHP at a time when we
8 probably will have at least a couple of more bites at the
9 apple when we'll have more information and more data.
10 And I'd feel more comfortable, you know,
11 either coming out in favor of it in all likelihood, but
12 at least reserve my right to be opposed to it without
13 having gone on record without the full wealth of the work
14 that the subgroup is doing. So that would be my -- I
15 wouldn't oppose necessarily saying the consensus is that
16 we recommend a stronger benefits package for those under
17 200 percent of poverty without formally making an
18 endorsement of a product that we don't know exactly what
19 it is. I mean, that's where I am.
20 MS. O'GARA: So rather than making a --
21 CHAIRPERSON VELTRI: I have a question --
22 Nellie.
23 MS. O'GARA: I was going to suggest that
24 rather than making it a formal motion, that instead we

1 say that there is a majority opinion of the Committee
2 that strongly suggests a more robust benefits structure
3 for those under 200 percent of the federal poverty level.
4 CHAIRPERSON VELTRI: Sheldon.
5 MR. TAUBMAN: Several things. First of
6 all, there's a Committee that's working on this but you
7 know what, I'm not a part of that Committee. I think
8 Vicki is the only one who's on that group. Some of us
9 have been working on this for several months and studied
10 extensively and are prepared now to strongly recommend
11 the BHP. And this group could do that and vote that way
12 right now and Vicki can abstain, there's nothing wrong
13 with that.
14 MS. O'GARA: Well, I wonder if we could
15 get a sense of hands if that's correct?
16 MR. TAUBMAN: But if I could -- but I do
17 have -- I do recognize what Vicki is saying about the
18 benefits of a joint meeting and agree a lot with what
19 John just said. I would -- I think one of -- we've
20 talked about it so many times in different languages, but
21 I think if we could just -- I do want it to be a formal
22 motion because I just voted on the other thing which is
23 conditioned upon this. And I'm going to withdraw that
24 vote if it's not going to be a motion, a formal motion

1 that says this group strongly recommends consideration of
2 a more robust package of benefits for below 200 percent,
3 period. That's my motion.
4 MS. O'GARA: Is there a second?
5 MR. ERLINGHAUSER: Before we vote on the
6 motion could we get a consensus of -- I'd be interested
7 to know, I mean at least hear from the Exchange members
8 as to their feeling on this, you know. I mean, I think
9 there's a value to having that discussion.
10 MS. O'GARA: I need a second before we can
11 have a discussion. And then as to timing, we're past
12 time. We have one more vote to do on the --
13 MR. ERLINGHAUSER: I mean Vicki, are you
14 comfortable with that particularly as somebody who's a
15 member of the Exchange?
16 CHAIRPERSON VELTRI: Well, so here's the
17 thing. Am I -- I sit on the Exchange as the Health Care
18 Advocate, so I do have major concerns about what will
19 happen to people who are below 200 percent of the federal
20 poverty level in terms of affordability and access. So I
21 don't have a problem with recommending consideration of
22 it, my concern was recommending that we do it without
23 having the additional information that the workgroup is
24 actually exploring.

1 So the short answer is I don't have a -- I
2 would vote in favor of this motion.
3 MS. O'GARA: Alright, so we have a motion
4 on the floor that this Committee strongly recommends
5 consideration of a more robust health plan option for
6 those under 200 percent of the federal poverty level.
7 MS. JAFF: Sheldon, did you mean to say
8 health plan option or benefits package?
9 MR. ERLINGHAUSER: Relating to benefits
10 package, a more robust benefits package.
11 MS. O'GARA: So this Committee strongly
12 recommends consideration of more robust benefits package
13 option for those under 200 percent of the federal poverty
14 level.
15 MS. JAFF: Why do you need the word
16 option?
17 MS. O'GARA: That was in the first one.
18 MS. JAFF: Sheldon, do you need the word
19 option?
20 MR. TAUBMAN: I can strike the word
21 option.
22 MS. JAFF: Okay.
23 MS. O'GARA: Alright, and we had a second
24 to that motion and if we could take a vote?

1 FEMALE VOICE: A roll call or just --
2 MS. O'GARA: Yeah, I'll just do a roll
3 call. Arlene Murphy.
4 MS. MURPHY: Yeay.
5 MS. O'GARA: CeeCee Woods.
6 MS. WOODS: I'll pass right now.
7 MS. O'GARA: Cheryl Forbes.
8 MS. FORBES: Yeay.
9 MS. O'GARA: Claudia Epright.
10 MS. EPRIGHT: Yeay.
11 MS. O'GARA: Gerard O'Sullivan.
12 MR. O'SULLIVAN: Abstain.
13 MS. O'GARA: Jennifer Jaff.
14 MS. JAFF: Yeay.
15 MS. O'GARA: Robert Scalettar.
16 MR. SCALETTAR: Yeay.
17 MS. O'GARA: Sheldon Taubman.
18 MR. TAUBMAN: Yeay.
19 MS. O'GARA: Tanya Barrett.
20 CHAIRPERSON BARRETT: Yeay.
21 MS. O'GARA: And Vicki Veltri.
22 CHAIRPERSON VELTRI: Yeay.
23 MS. O'GARA: Okay, so the last item on --
24 CHAIRPERSON BARRETT: She didn't get my

1 vote.
2 MS. O'GARA: And I had a pass with CeeCee
3 CHAIRPERSON BARRETT: Yeah, I vote yes
4 with the same caveat that I will reserve the right to
5 review additional information.
6 MS. O'GARA: Very good.
7 MS. FRANKEL: I vote yes as well.
8 MS. O'GARA: Did I miss you Sara, I'm
9 sorry.
10 MS. FRANKEL: Yes.
11 MS. O'GARA: I apologize. Okay, we did
12 want to get to the Rx option. Do I have a motion on the
13 Rx option?
14 FEMALE VOICE: So moved.
15 MS. O'GARA: You had a presentation and
16 the Oxford and the federal employee health benefits plan
17 were the two remaining options for consideration.
18 MS. JAFF: I'm going to move that we
19 choose the Oxford prescription drug plan.
20 MS. O'GARA: Is there a second?
21 MR. TAUBMAN: Second.
22 MS. O'GARA: Any discussion? We'll go to
23 a vote then. Arlene Murphy.
24 CHAIRPERSON VELTRI: So I think people are

1 feeling like they don't feel comfortable voting on the
2 option. So maybe can we just -- since our vote is
3 advisory only, I think we could probably pass on that
4 option today if people don't feel comfortable voting, or
5 table it for the next time we meet although it may be
6 after the Health Care Benefit Committee votes. But I
7 think it's better to vote with information rather than to
8 just vote for the sake of voting.
9 MS. JAFF: I think we can vote on the
10 pediatric vision because there's only one option, so we
11 could definitely vote for that. And we might be able to
12 vote for pediatric dental. I think Bob raised some -- I
13 was convinced by Bob's remarks on that one.
14 MS. O'GARA: Alright, so I'm sensing --
15 we'll table the Rx option for today.
16 MR. SCALETTAR: I just wonder if we
17 couldn't get people to be comfortable on the Rx because
18 we have talked about it and maybe what it needs is just a
19 -- since it wasn't formally on the agenda today, a quick
20 refresher of the story that was presented because I think
21 Jennifer started to sort of make mention of getting ready
22 for the vote. But the options that we have, there's
23 really no difference in the benefit package. So it's
24 like, I'd put my hand to vote for either one of them --

1 MS. O'GARA: So Julie, do you want to
2 address that --
3 MR. SCALETTAR: -- a motion was made just
4 to bring closure to the issue.
5 MS. O'GARA: The question was, if there
6 was a little bit more background on the vote so both
7 benchmark options meet the requirement correct?
8 MS. LYONS: That's correct.
9 MS. O'GARA: One is an open formulary --
10 it doesn't make a difference?
11 MS. LYONS: It doesn't make a difference.
12 MS. MURPHY: Could we start just by voting
13 for vision and dental and get those set aside since we
14 are in agreement with vision and dental, and then deal
15 with prescription drugs separately please?
16 MS. O'GARA: That would be fine. I need a
17 motion on the vision.
18 CHAIRPERSON VELTRI: Do we need to vote on
19 -- there's only one option right?
20 MS. JAFF: Okay, I'm going to make a
21 motion that we choose the CHIP dental and the FEDVIP
22 vision.
23 MR. SCALETTAR: Second.
24 MS. O'GARA: Okay, no discussion? Arlene

1 Murphy.
2 MS. MURPHY: Yeay.
3 MS. O'GARA: CeeCee Woods.
4 MS. WOODS: Yes.
5 MS. O'GARA: Cheryl Forbes.
6 MS. FORBES: Yeay.
7 MS. O'GARA: Claudia Epright.
8 MS. EPRIGHT: Yeay.
9 MS. O'GARA: Gerard O'Sullivan.
10 MR. O'SULLIVAN: Abstain.
11 MS. O'GARA: Jennifer Jaff.
12 MS. JAFF: Yeay.
13 MS. O'GARA: John Erlinghauser.
14 MR. ERLINGHAUSER: Yeay.
15 MS. O'GARA: Robert Scalettar.
16 MR. SCALETTAR: Yeay.
17 MS. O'GARA: Sheldon Taubman.
18 MR. TAUBMAN: Yeay.
19 MS. O'GARA: Tanya Barrett.
20 CHAIRPERSON BARRETT: Yeay.
21 MS. O'GARA: Vicki Veltri.
22 CHAIRPERSON VELTRI: Yeay.
23 MS. O'GARA: Sara Frankel.
24 MS. FRANKEL: Yeay.

1 MS. O'GARA: Okay, so we have those. Is
2 there anymore discussion on the drug option? What do we
3 need to know? Sheldon?
4 MR. TAUBMAN: Yes, I have a question which
5 is if the -- if they really are the same, if the two
6 choices in the drug benefit are the same then to me the
7 tiebreaker, even though I realize technically it's
8 irrelevant to the EHB selection, is if one has an open
9 formulary versus one that doesn't I would rather pick a
10 plan that has an open formulary.
11 MS. LYONS: I believe the federal plan had
12 the open formulary but the Oxford plan, it might have the
13 formulary but there's an opt-out through prior auth and
14 medical necessity. So it's sort of the same.
15 MR. TAUBMAN: Well actually, in reality
16 those are hugely different. I have extensive experience,
17 those are hugely different and that's why even though I
18 realize technically it makes no difference under the EHB
19 analysis, I like that model better. And we are after all
20 the Consumer Advisory and I would select it for that
21 reason.
22 MS. JAFF: So Sheldon, are you making a
23 motion?
24 MR. TAUBMAN: I make a motion that we

1 select the federal employee drug benefit as the -- I
2 don't know what the language is, as the --
3 MS. O'GARA: As the benefit option,
4 prescription benefit option.
5 MR. TAUBMAN: -- as the prescription
6 benefit option for the EHB.
7 MS. O'GARA: Is there a second?
8 MS. WOODS: I second.
9 MS. O'GARA: Are we ready for a vote on
10 that?
11 MS. O'GARA: Arlene Murphy. I can come
12 back to you if you want.
13 MS. MURPHY: Come back to me because I
14 have reservations, thank you.
15 MS. O'GARA: CeeCee Woods.
16 MS. WOODS: I abstain on this one.
17 MS. O'GARA: Cheryl Forbes.
18 MS. FORBES: Abstain.
19 MS. O'GARA: Claudia Epright.
20 MS. EPRIGHT: I vote yeay.
21 MS. O'GARA: Gerard O'Sullivan.
22 MR. O'SULLIVAN: Abstain.
23 MS. O'GARA: Jennifer Jaff.
24 MS. JAFF: With some reluctance I'm

1 actually going to abstain. I'm -- I just -- I need to
2 know that there's really no difference between the two
3 plans and I just don't feel like I can conclude that at
4 this time.
5 MS. O'GARA: John Erlinghauser.
6 MR. ERLINGHAUSER: Abstain.
7 MS. O'GARA: Robert Scalettar.
8 MR. SCALETTAR: I find myself in the same
9 position as Jennifer. I was under the impression that
10 they're the same but they're obviously not, so I'm sort
11 of back where Vicki was in saying maybe we're not ready
12 for this.
13 MS. O'GARA: Sheldon Taubman.
14 MR. TAUBMAN: I agree with Bob in spite of
15 it was my motion.
16 MS. O'GARA: Tanya Barrett.
17 CHAIRPERSON BARRETT: Abstain.
18 CHAIRPERSON VELTRI: Can we withdraw the
19 -- somebody might want to withdraw the motion, or?
20 MR. TAUBMAN: Yeah, I will withdraw the
21 motion in light of that consideration.
22 MS. O'GARA: Alright, so we'll withdraw
23 the motion and table it for next meeting.
24 MS. JAFF: Can I make a suggestion to

1 staff for next meeting that maybe what -- I mean, what
2 you're telling us is that the drug classes are exactly
3 the same in the two plans. Maybe if you do a side-by-
4 side of the drug classes that would allow us to actually
5 see that, that might give us that additional level of
6 comfort so that we could feel like we were making a
7 responsible decision.
8 MS. O'GARA: Okay, staff will take that
9 back. We had one other agenda item, which is public
10 comment if we could stay for another few minutes. Is
11 there anyone in the public that wants to come forward and
12 make a comment?
13 We don't have anyone Vicki and Tanya, so I
14 think that concludes our business for today.
15 MR. MADRAK: Actually Nellie, just one
16 last thing.
17 MS. O'GARA: I'm sorry.
18 MR. MADRAK: As I alluded to earlier with
19 the KPMG follow-up, I won't focus on it any longer but I
20 will give you a very large document to take home with
21 you. So for all the questions that you had related to
22 the scope of the engagement, some issues around
23 additional clarity for some of the metrics profiled,
24 hopefully this full report, which has much more detail

1 than the information presented prior, will answer those
2 questions.
3 We will actually make sure that we reserve
4 time on the agenda up front next time so as you do go
5 through that after our additional follow-up questions, we
6 can take those at that time.
7 CHAIRPERSON VELTRI: Okay, and I want to
8 thank the staff for responding to the concerns that the
9 Committee had. We really appreciate it and I guess with
10 that, we're adjourned.
11 (Whereupon, the meeting was adjourned at
12 11:20 a.m.)