

VERBATIM PROCEEDINGS

CONNECTICUT HEALTH INSURANCE EXCHANGE  
HEALTH PLAN BENEFITS AND QUALIFICATIONS  
ADVISORY COMMITTEE MEETING

MAY 14, 2012

LEGISLATIVE OFFICE BUILDING  
300 CAPITOL AVENUE  
HARTFORD, CONNECTICUT

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RE: CONNECTICUT HEALTH INSURANCE EXCHANGE  
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1 . . .Verbatim proceedings of a meeting  
2 before the Connecticut Health Insurance Exchange, Health  
3 Plan Benefits and Qualifications Advisory Committee  
4 Meeting, held at the Legislative Office Building, 300  
5 Capitol Avenue, Hartford, Connecticut, on May 14, 2012 at  
6 9:00 a.m. . . .

7  
8  
9

10 CHAIRPERSON ANNE MELISSA DOWLING: Good  
11 morning, everybody. Thank you for joining us. I'm Anne  
12 Melissa Dowling, and I, along with Mark Espinosa, are  
13 your co-Chairs, and we didn't introduce ourselves at the  
14 last meeting and just wanted to do so, and I had a couple  
15 of things I just wanted to share with the Committee and  
16 Mark, as well.

17 And just for those of you, again, I think  
18 we did this last time, but I'm the Deputy Commissioner of  
19 Insurance. What I observed from the last meeting and,  
20 also, you know, some communications in the meantime, I  
21 just wanted to suggest that we're here for you as a  
22 Committee, so if there are agenda items you want to see  
23 in the meantime, if there are questions you have, or  
24 there are things we need to do as a Committee or content,

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1 we'd like you to funnel those to us, so we can sort of  
2 operate in that way and be your advocates as we go  
3 through.

4           The other thing I want to be really clear  
5 on, everybody is so passionate about these topics, as  
6 they should be. There are fewer things in a person's  
7 life that one is either more vulnerable or more in need  
8 of than health care and affordable health care, and I  
9 think, as a result of that, sometimes passions can run  
10 high about opinions, and I just want to ask us that while  
11 we're in our meetings, we all listen to one another  
12 fully, and, you know, don't talk over or discount another  
13 person's point of view, and let that be heard.

14           And I'd ask for the same thing between  
15 meetings, that when we communicate with each other, it's  
16 fine to throw out questions out there, but that, in fact,  
17 we do it respectfully.

18           And if there are issues, we should do it  
19 face-to-face, and, if we need to meet more frequently, we  
20 will, because there's so much to get done in a short  
21 period of time, so I just want to offer the two of us up  
22 there. You have our contact information.

23           When I started talking about more  
24 meetings, I think I'm running into Mark's point, so I'm

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1 going to turn this over to Mark.

2 CHAIRPERSON MARK ESPINOSA: Thanks. Good  
3 morning. Yes, Mark Espinosa. Thank you, co-Chair.  
4 Yeah, my question, more than a comment, would be in terms  
5 of more meetings, in terms of what is needed, interim  
6 meetings.

7 I, again, have started at the beginning of  
8 this process, you know, somewhat overwhelmed with the  
9 overall task at hand and a very ambitious agenda. I also  
10 support the sentiment regarding our passion towards this  
11 subject matter.

12 My concern is that, in speaking, and this  
13 is not a criticism, this is a critique, based on  
14 information I was given, you know, I've shared a lot of  
15 this information with my major consultant out of  
16 Washington, D.C. for the -- she is the Senior Vice-  
17 President of National Health Compliance, Practice Leader  
18 of the Segal Company out of Washington, D.C., and I'm not  
19 going to get into specifics.

20 I've shared with her a lot of the  
21 information we've been given as Committee members. Her  
22 concern, and, like I said, I don't want to get into he  
23 said, she said, or, you know, what wasn't done, her first  
24 blush at it was that she didn't believe that we, as

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1 Committee members, were given enough information yet at  
2 this juncture.

3 She thought that the information shared  
4 had been very minimal, at best. That's just one person's  
5 opinion coming out of Washington, D.C., who is a fairly  
6 known expert in this field in health care.

7 So that being said, not a criticism, just  
8 a critique, because I'm still lost. I'm supposed to be a  
9 Chairperson here and acting in some capacity of  
10 leadership, and, you know, I'm concerned when I look at  
11 this time line, you know, are we meeting enough? Are we  
12 attempting to get as much done, because there is so much  
13 passion, and sitting down, talking to everybody's  
14 opinions, and need to be heard, and what is it that the  
15 Board needs from us?

16 So, that being said, I mean I'll be more  
17 than happy to share with anyone from the non-Committee  
18 situation the comments that I have received from  
19 Washington relative to where we are, where we probably  
20 should be, but I do recommend some more meetings, if at  
21 all possible, with everyone's busy schedules. Thank you.

22 MS. TIA CINTRON: So, with that, if we can  
23 start with some introductions? Nellie, do you want to  
24 start?

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1 MS. NELLIE O'GARA: Sure. My name is  
2 Nellie O'Gara, and I met you last time. I'm going to  
3 help facilitate this meeting.

4 MR. GRANT PORTER: I'm Grant Porter. I'm  
5 the analyst of the Exchange.

6 MS. O'GARA: Deirdre?

7 MS. DEIRDRE HARDRICK: Good morning. I'm  
8 Deirdre Hardrick. Do I need to go into --

9 MS. O'GARA: No, that's fine. Margherita?

10 MS. MARGHERITA GIULIANO: Margherita  
11 Giuliano for the Connecticut Pharmacist Association.

12 MR. JOSEPH TREADWELL: Joe Treadwell, Foot  
13 and Ankle Surgeon, Connecticut Podiatry Association.

14 MR. STEPHEN FRAYNE: Steve Frayne from  
15 CHA.

16 MR. THOMAS MARCHOZZI: Tom Marchozzi,  
17 Hartford Health Care.

18 CHAIRPERSON DOWLING: Anne Melissa Dowling  
19 from the Department of Insurance.

20 CHAIRPERSON ESPINOSA: I'm Mark Espinosa,  
21 President of United Food and Commercial Workers Union,  
22 Local 919, based in Farmington, Connecticut.

23 MR. KEVIN GALVIN: Kevin Galvin, Chair of  
24 Small Businesses for Healthy Connecticut.

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1 DR. ROBERT McLEAN: Robert McLean, an  
2 Internist, Primary Care in New Haven, representing the  
3 American College of Physicians and the State Medical  
4 Society.

5 MR. ROBERT TESSIER: Bob Tessier,  
6 Connecticut Coalition of Taft-Hartley Health Funds and an  
7 Exchange Board Member.

8 MS. GLORIA POWELL: Gloria Powell,  
9 Department of Public Health Designee for Commissioner Dr.  
10 Jewel Mullen.

11 MS. JENNIFER JAFF: Jennifer Jaff,  
12 Executive Director of Advocacy for Patients with Chronic  
13 Illness.

14 MS. MARY ELLEN BREault: Mary Ellen  
15 Breault. I'm with the Insurance Department.

16 MS. JULIE LYONS: Julie Lyons, Director of  
17 Policy and Plan Management with the Exchange.

18 MS. CINTRON: Tia Cintron, Acting CEO,  
19 Connecticut Insurance Exchange.

20 MR. BOB CAREY: Bob Carey, a consultant to  
21 the Exchange.

22 MS. O'GARA: Okay, so, I'm going to direct  
23 your attention up here to this particular PowerPoint  
24 slide, and you also have a copy of the PowerPoint slides

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1 at your seat.

2 Just to point out to you a couple of  
3 things, we're going to try and run as close to the timed  
4 agenda as we can. You'll notice that there are some  
5 things that require some of our discussion, and, so, we  
6 want to make sure we have enough time for those.

7 So I'd like to direct your attention to  
8 the first item on the agenda, which is the Committee  
9 Guiding Principles.

10 You have a copy of these, as well, in a  
11 separate document. We also have them recorded on these  
12 PowerPoint slides.

13 I'd ask you to take a minute, if you have  
14 not, and read through them. You were provided, I  
15 believe, this information ahead of time, and I see some  
16 heads shaking yes.

17 In the interest of time, what I'd like to  
18 point out to you is that these six Guiding Principles  
19 were as stated at the end of our last meeting. Between  
20 then and now, we've made no changes to them, and what I'd  
21 like to do is suggest we do a vote for approval.

22 What we've talked about, in terms of  
23 voting, is that we would take a roll call vote and make  
24 it consistent for all matters that we need to approve, so

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1 if you want to just take a few minutes to take a look at  
2 these, and if there are any comments or suggestions, we  
3 have just a couple of minutes for those before we'll take  
4 a roll call vote.

5 CHAIRPERSON ESPINOSA: May I just point  
6 out, not to be antagonistic, but this is the kind of  
7 information that I think the Committee needed to be aware  
8 of.

9 I, for one, unless I'm speaking out of  
10 turn again, I didn't know -- I mean, if everyone is ready  
11 to vote, that's fine, but I was hoping that there would  
12 have been -- I'm not sure, and I apologize, because I've  
13 been traveling for the last two weeks, I didn't know.

14 Not that I'm not prepared to vote, and not  
15 that I won't vote, but that's just an example of the kind  
16 of information that I wanted to see shared more with the  
17 group, just speaking. Thank you.

18 MS. O'GARA: So, at the last meeting, we  
19 went through each of these, and I think, between then and  
20 now, have you all received a copy of this to take a look  
21 at?

22 Okay, so, what we'd like to do is take a  
23 vote, then, and I'll read through the members of the  
24 Committee that are here, and if you'd just say yes or no,

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1 in terms of approval? So we're voting to approve the  
2 Committee's --

3 MS. MARY FOX: I have a question first.  
4 I'm sorry.

5 MS. O'GARA: Sure, Mary.

6 MS. FOX: I'm trying to do the crosswalk  
7 in my mind between what the Board voted on as a Board set  
8 of Guiding Principles, based on a Vision and a Mission  
9 Statement they approved, and then each Committee seems to  
10 have a slightly different set, so how do these come  
11 together?

12 MS. O'GARA: I can ask staff to comment on  
13 that. I think, Grant, you did a crosswalk?

14 MR. PORTER: Yeah. We took the  
15 Principle's vision of the Board, the document that you  
16 all received, and just made sure that there were no  
17 inconsistencies with the determination that you  
18 collectively made with respect to the Advisory  
19 Committee's Guiding Principles last meeting, and there  
20 was no inconsistencies, so we didn't have to change  
21 anything.

22 So what's provided, the Guiding Principles  
23 for the Health Plan and Qualifications Advisory  
24 Committee, is what was determined last time, and there

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1 were no inconsistencies with the Board Principles.

2 MS. O'GARA: Okay. Can I take it to a  
3 vote, then? All right, so, all I'm asking for is a yes  
4 or no in approval of these Committee Principles, and I'd  
5 like to start, then, with Anne Melissa Dowling.

6 CHAIRPERSON DOWLING: Yes.

7 MS. O'GARA: Yes? Deirdre Hardrick?

8 MS. HARDRICK: Yes.

9 MS. O'GARA: Gloria Powell?

10 MS. POWELL: Yes.

11 MS. O'GARA: Jennifer Jaff?

12 MS. JAFF: Yes.

13 MS. O'GARA: Joseph Treadwell?

14 MR. TREADWELL: Yes.

15 MS. O'GARA: Kevin Galvin?

16 MR. GALVIN: Yes.

17 MS. O'GARA: Margherita Giuliano?

18 MS. GIULIANO: Yes.

19 MS. O'GARA: Mark Espinosa?

20 CHAIRPERSON ESPINOSA: Yes.

21 MS. O'GARA: Robert McLean?

22 DR. McLEAN: Yes.

23 MS. O'GARA: Robert Tessier?

24 MR. TESSIER: Yes.

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1 MS. O'GARA: Stephen Frayne?

2 MR. FRAYNE: Yes.

3 MS. O'GARA: Tom Marchozzi?

4 MR. MARCHOZZI: Yes.

5 MS. O'GARA: Did I miss anyone? Mary Fox?

6 MS. FOX: Yes.

7 MS. O'GARA: Marcia Petrillo? Could we  
8 have a yes or a no vote on the Committee Principles?

9 MS. MARCIA PETRILLO: Yes.

10 MS. O'GARA: Thank you very much. The  
11 Committee Principles are approved as they stand, and we  
12 can move to the next agenda item.

13 Bob Carey is going to take us through the  
14 briefing on the EHB and the Benchmark Plans, and we have  
15 40 minutes for this discussion, Bob. Thank you.

16 MR. CAREY: Good morning. You had been  
17 sent, prior to the meeting, a brief overview of the  
18 Essential Health Benefits and that issue. We thought it  
19 important for this Committee to focus the majority of  
20 this discussion on reviewing what the requirements are of  
21 the ACA, the role of the Connecticut Exchange and the  
22 Connecticut Advisory Committees to the Exchange with  
23 regard to the Essential Health Benefits requirements, the  
24 treatment of State Mandated Benefits with regard to the

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1 Essential Health Benefits, HHS's Benchmark Plan approach  
2 to Essential Health Benefits, we thought important to go  
3 through that with the Committee, then Next Steps and some  
4 additional resources, which we think would be helpful to  
5 the Committee, as it leaves here today to digest.

6 We're not going to take a vote on  
7 Essential Health Benefits today. This is meant to  
8 provide an overview of the issue and an opportunity to  
9 discuss the options that are available to the State.

10 So just with regard to the role of the  
11 Connecticut Exchange with regard to the Essential Health  
12 Benefit, the decision and the -- yes, ma'am?

13 MS. JAFF: Hi. I just have a question.  
14 We've had some -- I did send some questions, just for the  
15 record of this meeting, I did send some questions to  
16 everybody, who was copied on this e-mail, from the  
17 Exchange acting CEO and her staff.

18 My questions were sent on May 2nd, and  
19 what I've been told off line by staff of the Exchange is  
20 that these more detailed questions will be answered at  
21 some point before this Committee has to take action.

22 Where I'm confused is we were given a  
23 timeline at the last meeting for when certain decisions  
24 needed to be made, and it looked to me like that timeline

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1 was pretty well-packed with a lot of substance, this  
2 month being the EHB, next month being the BHP, you know,  
3 subsequent months deciding on the number of plans and  
4 what the Exchange's role is going to be in that, so these  
5 are all really big issues that have been slated for  
6 these, you know, monthly meetings.

7 And, so, I wanted to see if perhaps we  
8 could flesh out today when this additional information  
9 would be coming and when this Committee will be expected  
10 to act on the EHBs.

11 MR. CAREY: So the timeline that we've  
12 laid out is for discussion at this meeting and for  
13 additional information to be provided between this  
14 meeting and the June meeting and for options and  
15 recommendations to come out of the June meeting, and we  
16 hope to address all of your questions and issues as part  
17 of this discussion, and anything that we need to take  
18 back and obtain additional information we'll provide to  
19 the Committee before the Committee will be asked to take  
20 a vote on anything.

21 CHAIRPERSON DOWLING: I think, Jennifer,  
22 you're underscoring the point we made when we started the  
23 meeting, that it may mean that we need to meet more  
24 frequently, you know, in between for everybody to feel

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1 comfortable with that data, rather than just finding it  
2 on e-mail and all that, so let's kind of go through, and  
3 then see how we feel, and we'll, you know, kind of wrap  
4 up the meeting with whether we should do a couple, one or  
5 two more interims between now and June. Thanks.

6 MR. CAREY: Okay, so, just sort of back to  
7 the role of the Connecticut Exchange, the issue before  
8 each state is what the federal law calls the Essential  
9 Health Benefits, which is the services that would be  
10 covered or that would need to be covered by all qualified  
11 health plans offered in the individual and small group  
12 markets.

13 It's not just the Exchange that is  
14 affected by the decision with regard to the Essential  
15 Health Benefits. It cuts across the entire marketplace.

16 For that reason, the Exchange's role is  
17 critically important, but the Exchange is not the only  
18 entity that will be effected by the decisions with regard  
19 to what's covered as part of the Essential Health  
20 Benefits.

21 So the Exchange provides an advisory role,  
22 and it provides an opportunity for stakeholders to  
23 convene, and to discuss, and to recommend what is the  
24 Essential Health Benefits package for the State of

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1 Connecticut, but the decision, with regard to what is the  
2 Essential Health Benefits, may not be the Exchanges to  
3 make in isolation.

4 And, so, we think that this is an  
5 important area for the Exchange to weigh in on, but  
6 because it had broader market-wide implications, the  
7 suggested approach is that the Exchange consider the  
8 options and make a recommendation, but it may be that the  
9 Connecticut Insurance Department or the Administration is  
10 the ultimate arbiter of what is included, or what is the  
11 benchmark plan that will be chosen by the State of  
12 Connecticut for people purchasing coverage in the  
13 individual and small group market.

14 I don't think that decision has been made  
15 with regard to who will be the final arbiter of Essential  
16 Health Benefits for Connecticut. The guidance from the  
17 federal government is vague, in terms of who is the  
18 ultimate responsible party to make that decision, and I  
19 think we collectively will need to figure that out.

20 MS. JAFF: I want to apologize for  
21 commenting at everything that is said, and it's not my  
22 intent to be obstructionist in any way. I want this  
23 process -- nobody wants this process to work more than I  
24 do, however, what you just said is huge news to everybody

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1 in the State of Connecticut, including the General  
2 Assembly, who I believe has delegated the obligation to  
3 select an EHB and perform all other Exchange related  
4 functions to the Exchange Board, so I think what you just  
5 said is fairly important and definitely news to me.

6 If it's not in the statute or something,  
7 then somebody can correct me if I'm wrong, but it's my  
8 understanding that this is the Exchange's responsibility  
9 entirely.

10 MS. BREault: Jennifer, I don't believe  
11 that is in the statute with regard to the Exchange  
12 functions, but, you know, this is something that we do  
13 have to have a discussion with the administration, and I  
14 do believe we did discuss this at the last meeting.  
15 These points were brought out. I believe they were,  
16 actually.

17 MR. TESSIER: Thank you. I certainly  
18 agree, Bob, with everything, all of your comments, in  
19 terms of the implications far beyond the Exchange offered  
20 products, but I'm also confused. As Jennifer is, I'm  
21 confused.

22 The material, slide eight, says, I  
23 believe, that the decision will be set by the Department  
24 of Insurance.

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1 MR. CAREY: Well it's probably premature  
2 on my part to note that it is the Department of Insurance  
3 that will make the decision. That decision on who  
4 decides hasn't even been made.

5 My point on this slide, or our point is  
6 simply that we need to recognize it has broader  
7 implications for the entire market, and there's nothing  
8 in statute that directs the Exchange to make that  
9 decision.

10 In fact, the letter from the -- HHS  
11 direction is to the Governors, actually, of the 50 states  
12 to make that decision. Some states are deferring simply  
13 to the Departments of Insurance to make that decision,  
14 but it's really up to each state to decide how they set  
15 their Essential Health Benefits Package.

16 So perhaps the slide, which it says the  
17 Department of Insurance will make that decision, is  
18 premature. The administration needs to decide who will  
19 make the decision on behalf of the State of Connecticut.

20 MR. GALVIN: Hi. Kevin Galvin. I'm  
21 sorry. I think, for my benefit, if we have the time, if  
22 we could just start again and roll back 10 minutes,  
23 because I have just -- I'm completely lost, as to where  
24 we are and where the authority is going to lie in the

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1 decision making, who it's going to be, and I apologize  
2 for that.

3 MR. CAREY: So the issue we wanted to  
4 address head on is that, two things, one, market-wide  
5 implications not specific or not exclusive to the  
6 Exchange, and, two, that the decision needs to come from  
7 the Administration, and whether the Administration defers  
8 to the Exchange to make that decision or not is an open  
9 question.

10 And, so, my point on this slide is simply  
11 to ground us, so that we understand that it is not just  
12 the Exchange, and the Exchange doesn't have currently  
13 statutory authority to make that decision on behalf of  
14 all individual purchasers and all small group purchasers  
15 for the State of Connecticut.

16 CHAIRPERSON DOWLING: As I understand it,  
17 and maybe for us to move forward, because I understand  
18 this is confusing, you know, we are an Advisory Committee  
19 to the Exchange, but, fortunately, we have all the voices  
20 that Bob has mentioned, you know, the Department of  
21 Insurance. We have Exchange staff.

22 So I will perhaps ask your indulgence to  
23 say I have a feeling, and, you know, my understanding  
24 from various conversations with the Administration, that

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1 it is looking very heavily to the recommendations from  
2 this Committee. It will come down to the Governor and  
3 how he decides to delegate it, but this is the group in  
4 the state that's looking at it.

5 So I might ask, if we can proceed, we will  
6 clarify in between, so we can get into the content, but I  
7 think it's really a good question. We need to get this  
8 nailed down, and, so, we'll come back with a little more  
9 clarity on that, but I appreciate. I think it's a very  
10 fair conversation, but if you're all comfortable, can we  
11 -- we'll get into the meat, and then we'll come back with  
12 the process. Thank you.

13 MR. CAREY: Okay, so, the timeline, I just  
14 want to point out, is critical that a decision needs to  
15 be made by the State by September, because, if not, the  
16 feds will decide which plan serves as the benchmark plan  
17 for the Essential Health Benefits Package for the states  
18 that don't make that decision.

19 Current guidance, subject to change, but  
20 current guidance from HHS is the default plan for EHB is  
21 the largest small group -- the small group plan with the  
22 largest enrollment in the State of Connecticut. That's  
23 the default plan.

24 If you don't make a decision, then the

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1 decision is made for you, and that decision is the  
2 largest small group plan by enrollment in the state.

3 Qualified Health Plan, so the Affordable  
4 Care Act requires all health plans sold in the individual  
5 and small group market inside and outside of the Exchange  
6 to meet minimum requirements in order to be deemed a  
7 Qualified Health Plan.

8 Qualified Health Plans must cover the  
9 Essential Health Benefits, which includes an array of  
10 services within 10 broad categories, and the law lays out  
11 those 10 broad categories, and we'll walk through them.

12 The law, then, defers or directs the  
13 Secretary of Health and Human Services to make the  
14 decision with regard to fleshing out the specifics with  
15 regard to the Essential Health Benefits Package, but, as  
16 we know, the Secretary has now deferred to the states to  
17 make that decision within certain parameters, and we'll  
18 go through those.

19 The EHB, what's covered within the  
20 Essential Health Benefits Package, is not the cost  
21 sharing. Cost sharing is not a part necessarily of the  
22 Essential Health Benefits Package.

23 The Essential Health Benefits, in essence,  
24 lays out all the services that need to be covered by a

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1 health plan. It doesn't, then, dictate what the cost  
2 sharing is for those services. That is determined by the  
3 actuarial value levels for each of the plans that will be  
4 sold in the individual and small group market, and we've  
5 walked through those at the last meeting with regard to  
6 the tins, or the Platinum, Silver, Gold and Bronze Health  
7 Plans, so all of those health plans need to cover the  
8 Essential Health Benefits.

9 The difference between a Gold and a Silver  
10 plan will be the cost sharing associated with a member  
11 when he goes for care.

12 So, as I mentioned, the law directs the  
13 Secretary to make this decision with regard to Essential  
14 Health Benefits. The Institute of Medicine did a report,  
15 issued in the fall of 2011, which discusses at great  
16 length the options and the considerations that they  
17 suggest that the Secretary make.

18 In December of 2011, the Secretary issued  
19 a bulletin, which directs the states to make the decision  
20 with regard to the Essential Health Benefits within those  
21 broad categories of care for the individual state, and  
22 they lay out 10 options.

23 The three small group plans with the  
24 largest enrollment, the three, if there are three, State

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1 Employee Plans with the largest enrollment, the three  
2 Federal Employee Health Benefit Plans with the largest  
3 enrollment, or the largest HMO, the HMO with the largest  
4 enrollment in the state.

5 In Connecticut, the HMO with the largest  
6 enrollment in the State is also one of the three largest  
7 small group plans, so when we go through these options  
8 today, there are nine plans, actually, that we'll be  
9 talking about, not 10, but just so you know, that the  
10 largest HMO is also the small group plan with the largest  
11 enrollment.

12 Again, the default Essential Health  
13 Benefit would be the small group plan with the largest  
14 enrollment, and then the benchmark plans, the EHB, it  
15 doesn't cover certain benefits that are laid out in the  
16 law, in particular, pediatric dental coverage, pediatric  
17 vision coverage, habilitative services, are frequently  
18 excluded, or not included in the Essential Health  
19 Benefits or a Benefits Package in the small group market,  
20 and, so, the bulletin directs states to supplement the  
21 Essential Health Benefits Package, or the Benchmark Plan  
22 if it doesn't include certain key services.

23 So, just so you know, it's not simply the  
24 small group plan, or the plan that you select. It also

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1 has to be supplemented if there's any benefits that are  
2 not covered within that benefits package.

3 Okay. Here the 10 broad categories, as  
4 defined in the Affordable Care Act, ambulatory patient  
5 services, emergency services, hospitalization, maternity  
6 and newborn care, mental health and substance use  
7 disorder services, prescription drugs, rehabilitative and  
8 habilitative services and devices, laboratory services,  
9 preventive and wellness services and chronic disease  
10 management, and pediatric services, including oral and  
11 vision care.

12 So those are the broad categories of  
13 services that are laid out in the Affordable Care Act  
14 that must be included within the Essential Health  
15 Benefits Package.

16 Pursuant to the ACA for coverage purchased  
17 through the Exchange, states may be required, according  
18 to the law, states may be required, would be required to  
19 pay for any state mandated benefits that fall outside of  
20 the Essential Health Benefits Package, so if the state  
21 has certain mandates that aren't included within those 10  
22 broad categories, or the assumption going in to execution  
23 of the law, is that the Secretary would lay out  
24 specifically what those Essential Health Benefits are.

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1                   And if a State had a mandate that exceeded  
2                   what is included in the Essential Health Benefits for  
3                   people who purchase coverage through the Exchange, who  
4                   would be required to purchase a product that had that  
5                   State mandate that isn't part of the Essential Health  
6                   Benefits Package, the State would have to pay for the  
7                   premium difference associated with the State mandate.

8                   So the people follow us, so if there is a  
9                   mandate that is in excess of the Essential Health  
10                  Benefits Package for anyone purchasing coverage through  
11                  the Exchange, the State would have to pick that up. Yes,  
12                  ma'am?

13                  MS. JAFF: Hi. Are you going to talk  
14                  about the guidance that was promulgated by HHS, because  
15                  that's no longer exactly true the way you've said it?

16                  MR. CAREY: Yes, ma'am. What I was  
17                  talking about was that if you read the law, the way the  
18                  law is written --

19                  MS. JAFF: Just the ACA?

20                  MR. CAREY: Right, the ACA.

21                  MS. JAFF: Without the guidance?

22                  MR. CAREY: Correct. Right, so, the  
23                  guidance that was put out in December 2011, which, in  
24                  essence, you know, pushed the decision with regard to

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1 Essential Health Benefits to the states within certain  
2 parameters, in essence, provides a transition period that  
3 allows a state to adopt an Essential Health Benefits  
4 Package that does include state mandates and that does  
5 not require states to pay for the cost of those mandates  
6 that may exceed the Essential Health Benefits Package.

7 Yes, ma'am.

8 MS. JAFF: So I believe you said it's a  
9 transition period. We don't know that yet, right,  
10 because the guidance says maybe HHS will revisit this in  
11 2016, but maybe they won't.

12 MR. CAREY: Correct.

13 MS. JAFF: Number one. Number two, any  
14 mandates that fall within the 10 mandated categories will  
15 be paid for. As long as they fall within the 10 mandated  
16 categories, those are going to be paid for no matter  
17 what.

18 And, number three, when we're talking  
19 about the state paying for something, we're talking about  
20 the state paying for the portion of the subsidy to people  
21 who qualify for a subsidy that otherwise it's covered by  
22 your health insurance premium, Mary Ellen, no?

23 MR. CAREY: No, that's not correct.

24 That's not correct. So points one and two are correct,

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1 so the guidance, if you read the guidance, we'll give you  
2 the guidance if you don't have it, the guidance says this  
3 is a transitionary period in 2014/2015. We plan to  
4 revisit it.

5 Well, you know, who knows whether they  
6 will revisit the decision with regard to Essential Health  
7 Benefits, but it does provide at least a two-year window.  
8 It could be a 10-year window, during which time states  
9 may decide to require that the Essential Health Benefits  
10 Package include mandates that may fall outside of what is  
11 generally referred to as the core, you know, 10  
12 categories of service.

13 During that period, if a state adopts an  
14 Essential Health Benefits Package that includes state  
15 mandates that may be outside of those 10 areas, states  
16 will not have to pay for the cost, the premium cost of  
17 those mandates that are outside of the Essential Health  
18 Benefits Package.

19 The law requires, if a state does adopt --  
20 if the Essential Health Benefits Package excludes certain  
21 mandates, many mandates would be covered within the  
22 Essential Health Benefits Package. Some may not.

23 The law requires states to pay for the  
24 premium cost for everyone purchasing coverage through the

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1 Exchange for the cost of those benefits that may fall  
2 outside. It's not just people, who are getting a subsidy  
3 to purchase coverage, so any small group and any  
4 individual, whether or not they get a subsidy, according  
5 to the law, the State would be required to pay for the  
6 cost of those mandated benefits that are outside of the  
7 Essential Health Benefits Package.

8 This interim period, if the State decides,  
9 for example, to adopt a small group product, which would  
10 include all of the Essential Health Benefits, the State  
11 would not have to pay for those mandates that may fall  
12 outside of the Essential Health Benefits Package.

13 So, in addition to the decision with  
14 regard to the Essential Health Benefits Package, the  
15 guidance also talks about some carrier flexibility once a  
16 state has chosen a benchmark plan, and all plans in the  
17 individual and small group market would be required to  
18 offer benefits that are substantially equal to the  
19 benchmark plan.

20 And, so, again, that would be a decision,  
21 because the plans are licensed and reviewed and approved  
22 by the Department of Insurance, it is likely the  
23 Department of Insurance would be responsible for products  
24 sold in the individual and small group market to

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1 determine whether the benefits package is substantially  
2 equal if there's any deviation from the Essential Health  
3 Benefits Package.

4 Again, with regard to updating the  
5 benchmark plans, HHS expects that they will take another  
6 look at it over the next year or two and make a decision  
7 with regard to what would be the Essential Health  
8 Benefits Package in 2016 and beyond, but at least for  
9 2014 and 2015 the decision that Connecticut makes with  
10 regard to the Essential Health Benefits Package will  
11 apply to all individual and small group products sold in  
12 the market over the next two years. Yes, sir?

13 MR. FRAYNE: Just a clarifying question.  
14 Do you mean by this point for a plan that's selling both  
15 in and outside of the Exchange, or --

16 MR. CAREY: Correct.

17 MR. FRAYNE: -- regardless of whether  
18 they're selling inside or outside the Exchange? So, in  
19 other words, let's say a plan chooses not to participate  
20 in the Exchange. Does it still have to comply with that  
21 requirement?

22 MR. CAREY: Yes.

23 MR. FRAYNE: Okay.

24 MR. CAREY: Yeah, all products sold in the

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1 individual and small group market, whether or not they're  
2 sold in or out of the Exchange.

3 Okay, so, now let's talk specifically  
4 about Connecticut's options with regard to the benchmark  
5 plan and the Essential Health Benefits.

6 In December of 2011, the Department of  
7 Insurance surveyed the carriers with regard to plan  
8 designs and the benefits covered in the largest plans for  
9 each carrier within the small group market.

10 Our review of the information suggests  
11 that all of the plans, the three small group, the largest  
12 HMO, the three State employee plans and the Federal plan  
13 essentially covers all services within each of those 10  
14 categories.

15 There are some issues that will need to be  
16 addressed with regard to, particularly, although not  
17 exclusively, rehabilitative and, more to the point,  
18 habilitative services, which are commonly not covered by  
19 commercial insurance products.

20 Wellness programs, we'll have to flesh out  
21 exactly what is considered as part of a wellness program  
22 for the carriers, and then pediatric dental and vision,  
23 which may or may not be covered by a commercial insurance  
24 product.

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1                   So those are the three areas, in  
2 particular, that we identified. There may be, as we go  
3 through this, other areas that we'll need further  
4 clarification on with regard to the specifics about  
5 what's covered under each of those 10 categories of care.  
6 Yes?

7                   MS. JAFF: You've got stop calling me  
8 ma'am, because it makes me feel so old. One of the  
9 things that I've been struggling with as I've been going  
10 through both the guidance from HHS and the briefing paper  
11 that the Exchange staff provided to us, as well as some  
12 other material about the Essential Health Benefits Plan,  
13 is, if you look at the 10 categories, it's not clear  
14 where some of the services that I think we all kind of  
15 take for granted, like durable medical equipment, home  
16 health, you know, I think those are kind of big  
17 categories that we all expect to have some coverage of  
18 with our insurance.

19                   I guess my question for you is do you feel  
20 that those are included in the 10 categories somehow, or  
21 are we going to be looking at benefits that go beyond  
22 those 10 categories that will make up what I think is a  
23 plan that most of us are used to having?

24                   I mean, certainly, CAT scans and MRIs and,

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1 you know, kind of basic, some durable medical equipment  
2 benefit, those things are usually covered.

3 MS. BREault: To the extent that the State  
4 chooses one of the plans outside of the Federal Employees  
5 Plan, all of the State mandates will be included, and  
6 they're really not that different, so all of the  
7 coverages that are in that benchmark plan currently, so  
8 they do all include home health care, and they include,  
9 you know, the imaging and all of that, those, for at  
10 least 2014 and 2015, will become the Essential Health  
11 Benefits for the State for those two years.

12 We really don't have to go through and  
13 decide at this point where do they fit in, because they  
14 will be part of the Essential Health Benefit Package.

15 MS. JAFF: I wasn't even talking about  
16 mandates, because it's not clear to me that there are  
17 mandates for some of those broad categories.

18 DME, imaging and home health were the  
19 three categories that whether or not they're in the  
20 mandates, I think they are things that most of us are  
21 used to having included in our insurance.

22 MS. BREault: But if they are in the  
23 benchmark plan, they will be covered. They will become  
24 part of the Essential Health Benefit Package, and those

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1 are pretty standard coverages from the reviews that we do  
2 at the Department.

3 MS. JAFF: Okay. I guess my question goes  
4 to the larger picture of not just for 2014 and 2015, but,  
5 you know, my question really is are those kind of, you  
6 know, big buckets of services, are those intended to be  
7 included in the 10 categories in the ACA, or --

8 MR. CAREY: Yes. Yes, I would suggest  
9 that those types of services are anticipated to be  
10 included. Lab services would include imaging.

11 MS. JAFF: Okay.

12 MR. CAREY: Rehabilitative and  
13 habilitative would include DME, I'm assuming.

14 MS. JAFF: Okay.

15 MR. CAREY: And home health could be  
16 included in, you know, one of or two different  
17 categories, so we included them in as we went through.  
18 Trying to fit services under each category, we include  
19 those. I think you're exactly right. People expect  
20 those types of services to be provided.

21 They are currently provided in the  
22 marketplace today, and we would assume that they would be  
23 provided in the future.

24 MR. TESSIER: If I can just clarify, I

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1 think what she's getting at, which is also something I  
2 wasn't certain of at the beginning, so since there are  
3 nine benchmark plans that we're going to be looking at,  
4 we could look at all of them. As long as they have  
5 something within those 10 categories, they fit the bill.

6 If we look at them and say, well, you  
7 know, there's not enough coverage with DME, quite  
8 frankly, we don't have the ability to say we want more,  
9 because as long as the benchmark has it, that's kind of  
10 the minimum standard that we need to embrace.

11 So I don't think we can go down on each of  
12 these and say, well, we really need more. In my private  
13 insurance, I have more of that, and I want more for  
14 everyone. I don't think we have the ability to do that,  
15 whether we like it or not. That's correct?

16 MR. CAREY: Correct.

17 MS. JAFF: But we do have the ability to  
18 look at the benchmarks and see that some of them, I mean,  
19 I went through the benchmarks, I pulled them off of  
20 Health Care.gov, so, as best I could, you know. So, for  
21 example, the ConnectiCare HMO, which is one of the  
22 benchmarks, has a limited imaging benefit, not a full-  
23 blown imaging benefit, so, I mean, we can see those kinds  
24 of things, and I think those are the kinds of things that

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1 should at least be some of the information that we get  
2 about the various benchmarks before we choose a  
3 benchmark, so that we can compare them completely and  
4 see, you know, which one provides the best imaging, which  
5 one provides the best DME and all of the other  
6 categories, as well, so that we can decide on balance  
7 which plan is the one that we think will serve  
8 Connecticut's consumers the best.

9 MR. CAREY: That's right.

10 CHAIRPERSON DOWLING: Bob, may I? I think  
11 what I'm hearing from everybody is that there's a lot of  
12 assumed knowledge, a lot of technical knowledge, but I  
13 think we're responsible to communicating out to an  
14 audience that has much less closeness to the issues, so I  
15 would just ask you guys to err on the over communicating  
16 and assuming less knowledge, because what we do here, you  
17 know, each of us may know more, but I think others will  
18 get more comfort from it being explicit.

19 The other question I want to ask, and it  
20 may be further in here, is just the technical issue of  
21 prescription drugs. That's not in one of your three  
22 issues that need to be addressed.

23 Do we have any more guidance on how to  
24 deal with something that in many of these plans is a

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1 rider?

2 COURT REPORTER: One moment, please.

3 CHAIRPERSON DOWLING: If you're going to  
4 address this later, I'll hold my question.

5 MS. BREault: Basically, the guidance to  
6 date from HHS has said that if we choose a plan that only  
7 offers prescription drug by rider, they do not include  
8 any coverage in riders as part of the Essential Health  
9 Benefit Package, so then what the State would have to do  
10 is look to another benchmark plan that does have it, so  
11 that would be one place where you could choose, you know,  
12 kind of pick and choose from another plan.

13 In this case, we did find one plan, one of  
14 our small employer plans, that does seem to offer it in  
15 the base policy, but, also, the Federal Employee Plan  
16 would be the only other option that we would have to look  
17 at.

18 But, again, HHS is still developing their  
19 guidance, and that is all subject to change. You know, I  
20 try to take weekly calls with the National Association of  
21 Insurance Commissioners, who is, on behalf of all of the  
22 states, trying to get as much information, so as soon as  
23 that becomes available, we will share that with the  
24 group.

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1 CHAIRPERSON DOWLING: Thank you for that,  
2 and thank you for doing all those calls on our behalf and  
3 all, as well. I just want to make sure everybody is  
4 aware that that is a technical issue out there, in terms  
5 of prescription drugs, so thank you.

6 MR. CAREY: Okay, so, in an attempt to try  
7 to flesh out the specifics about, you know, what is  
8 included, for example, under ambulatory patient services  
9 and how the plans compare, again, this shows six, there  
10 are six columns for plans.

11 The State Employee Plan doesn't differ, in  
12 terms of the services that are covered, so we only list  
13 it once. Also, the Federal Employee Plan, Blue  
14 Cross/Blue Shield, the standard and the basic option  
15 cover the same services.

16 There's different cost sharing associated  
17 with the standard versus the basic plan, but, in terms of  
18 what is covered, there's no difference between the two,  
19 so we just combine those for just ease of comparison.

20 So, as we went through these, we did not  
21 identify a significant difference, in terms of the types  
22 of services covered. You'll see, with regard to home  
23 health care visits, for example, there are different  
24 limits, from Oxford PPO vis-à-vis the Anthem/Blue Cross

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1 HMO and the ConnectiCare HMO, but all three of those  
2 plans do cover home health care services. All three also  
3 cover skilled nursing facility services, although there  
4 are different limits associated with one plan versus the  
5 other, and where we were able to identify any difference,  
6 in terms of the scope of coverage, we captured that and  
7 provided that here. Yes, sir?

8 DR. McLEAN: A question. So there are  
9 many yeses. Are there any limits where there are yeses?  
10 I mean we see limits in certain boxes, but there's so  
11 many yeses there has to be a limit on some of those  
12 levels.

13 MR. PORTER: Most of these were based upon  
14 the results provided to the Connecticut Insurance  
15 Department Survey, and it's just whether they specify  
16 limits or not, so we'll be doing a further analysis of  
17 each of the plans, looking directly into all their plan  
18 brochures, so there may be some limitations that will be  
19 included in the comparison, but this was based upon  
20 whether any were specified initially to us.

21 CHAIRPERSON DOWLING: Is it your intent,  
22 though, to share that in our next iteration? Okay,  
23 perfect. I think that will give everybody a little more  
24 comfort. Thanks.

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1 MS. BREault: And I think, for the most  
2 part, many of these services are not limited, like for  
3 having day limits. For example, office visits,  
4 hospitalizations, etcetera.

5 I think the home health care skilled  
6 nursing are typically some of the types that would have  
7 them. That doesn't mean that there might not be  
8 utilization review on some of these things to make a  
9 medical necessity determination, but as far as coverage,  
10 which is really what we're trying to get at, you know, I  
11 think this seems to be fairly reflective.

12 MR. CAREY: Yeah, so, the point with  
13 regard to the management of the benefit is a carrier-  
14 specific decision means by which they operate, so there  
15 may be prior authorization required for certain services,  
16 and there may be medical review that goes on for certain  
17 services, but, in terms of the breath of coverage with  
18 regard to the specific contract between the individual  
19 and the carrier, there is nothing that specifically  
20 limits the duration of care, except where we called it  
21 out in those specific areas for home health care services  
22 or skilled nursing facility services.

23 MR. TESSIER: So not that I want to get  
24 completely drowned in details, but it sounds like, to

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1 kind of really decide, as I said earlier, we need to  
2 really drill down to a lot of details to compare these,  
3 including, you know, co-pays for ER visits.

4 I mean are we're going to be getting at  
5 that level to really compare these things fairly?

6 MR. CAREY: Well the cost sharing is not  
7 part of the discussion, so cost sharing is limited in the  
8 ACA at each of the metallic tiers, so the 90 percent  
9 benefit would have an, on average, 10 percent would be  
10 the member cost, and 90 percent would be the plan cost.  
11 The goal plan is 80/20, so those decisions aren't part of  
12 this conversation, but specific limits with regard to  
13 duration would be and should be part of this  
14 conversation.

15 MR. TESSIER: How soon do we think we'll  
16 have the further information that was mentioned, so that  
17 we have an answer to the question about -- I mean we  
18 started the meeting with discussion about the time frame  
19 and the September deadline for the State to make a  
20 decision and for this Board to make a decision to the  
21 full Exchange Board, and then other entities that we'll  
22 be considering.

23 I'm curious, because I think the issue of  
24 identifying in more detail where there are benefit limits

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1 beyond what carriers said in a survey, it seems to me we  
2 need more certainty.

3 MR. CAREY: Yeah, so, our plan is to go to  
4 the carriers to obtain the EOB, you know, the explanation  
5 of coverage, the specific contract, you know, the 300-  
6 odd-page documents that are associated with these  
7 specific plans.

8 What we want to do here is to obtain from  
9 the Committee any specific areas in which -- you know,  
10 those are big documents. I guess we could provide that  
11 to the Committee members. I don't know if they want to  
12 go through that, but we can, but we would like to capture  
13 any specific areas that the Committee feels you need  
14 additional information with regard to, for example,  
15 skilled nursing facilities and where there are specific  
16 limits.

17 We try to identify those areas where there  
18 aren't specific limits in the contract.

19 MS. JAFF: In my admittedly limited  
20 experience, compared to that of the Connecticut Insurance  
21 Department, typically, the first 10 or so pages are the  
22 certificate of coverage or a summary plan description,  
23 will be a summary of the benefits, and it will say you  
24 get, you know, 30 physical therapy benefits, 30 physical

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1 therapy visits, or 50 mental health benefits, or subject  
2 to prior authorization, or whatever the limitation is on  
3 the service, so, perhaps, for the benchmark plans, if we  
4 could just get those pages that would include the summary  
5 of benefits, I think that would show everybody the  
6 limitations on services that I think everybody is asking  
7 to see.

8 MR. CAREY: Sure. We can provide that.  
9 Are there any additional questions, just on these first  
10 two categories?

11 I guess the open question is are there  
12 additional categories, you know, sort of service lines  
13 within each category that Committee members would want to  
14 see, so, as we go through this, if you have other areas  
15 that you're particularly interested in and would like  
16 information, you know, raise it, we'll find out about it,  
17 and get it back to you.

18 MS. JAFF: You want a list of the other  
19 services?

20 MR. CAREY: Sure.

21 MS. JAFF: I mean I would want to know,  
22 for example, for each plan how many prescription drug  
23 tiers they have. For rehabilitative and habilitative  
24 services, it talks about the -- and I'm sorry. We don't,

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1 or at least I don't have the same document that's being -  
2 - that's on the screen. The one that we were handed out  
3 has a little more text on it, but, anyway, that text for  
4 rehabilitative and habilitative includes home health and  
5 autism spectrum disorder, and some about  
6 Sniffs(phonetic), but nothing about PT/OT/ST, so those  
7 were things that would be things that I would want to  
8 know about.

9 You're suggesting that lab services would  
10 include imaging. I would want to make sure that that's  
11 explicit. Durable medical equipment is also something  
12 that I'd want to take a look at, and I know we have a  
13 mandate in Connecticut for the first \$1,000 of ostomy  
14 supplies, for example, but there may be other DME  
15 services that people would be interested in, like, for  
16 example, wheelchairs.

17 I think there's a fair amount of fleshing  
18 out that needs to be done here.

19 MR. CAREY: Okay, so, my suggestion would  
20 be maybe that the Committee members route their specific  
21 line items through the Chairs. That way, we can make  
22 sure that staff has all of the specific areas and they  
23 will follow-up.

24 CHAIRPERSON DOWLING: If we could do it by

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1 Wednesday, that would be great. Thank you.

2 MR. GALVIN: Hi. Kevin Galvin. Just a  
3 question. I'm wondering, as we look at page eight in the  
4 bottom grouping, where you're talking about inpatient and  
5 outpatient mental behavior health, that seems to be one  
6 of the dark holes, as far as coverage for the consumer.

7 I'm wondering if in this conversation  
8 there could be more detail around that area.

9 MR. CAREY: Sure. The next three areas  
10 are hospitalization, maternity and newborn care, and  
11 mental health and substance abuse disorder services.

12 Again, we will flesh this out in  
13 additional detail. Again, there may be, there likely is,  
14 you know, medical review, prior authorization that goes  
15 on at the plan level with regard to these and other  
16 services.

17 The question is not the manner by which  
18 the carrier is administering the plan. It really is what  
19 is the benefit covered, in terms of the contract between  
20 the individual consumer and the health insurer.

21 MS. BREault: And I would just like to  
22 make one more comment. In September of 2010, there was  
23 part of the federal requirements that even though  
24 Essential Health Benefits were not yet defined, there

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1 could be no annual dollar limits on these things, so the  
2 Connecticut Department took a very somewhat harsh stand  
3 on this after discussions with HHS, so, for example, the  
4 ostomy mandate that says you only have to cover \$1,000 a  
5 year is now an unlimited coverage, so you are not going  
6 to see as many limits.

7 You may see a few day limits on a few  
8 services, but I don't really expect that we're going to  
9 see a lot of limits on many of these services, just so  
10 you, you know, keep that in mind.

11 DR. McLEAN: In follow-up to that, I guess  
12 to try to minimize the amount of digging work that will  
13 need to be done, when we look at these whatever, six  
14 plans across the columns, I mean, for example, the Oxford  
15 PPO has only 30 home health days and 30 skilled nursing  
16 days.

17 I mean if the group decides that's just  
18 too little, don't even waste time looking at that plan,  
19 as far as fleshing it out. Does that make sense?

20 I mean I realize they kind of met all the  
21 criteria, but if the group decides that that's just too  
22 minimal, just take it off the slate. Is that possible or  
23 realistic?

24 MR. CAREY: Certainly realistic to take it

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1 off the slate. It would just have to be a decision of  
2 the Committee, as to which one. If we could narrow down,  
3 that would be helpful, but we're expected to flesh out  
4 all of the options.

5 MR. TREADWELL: I have a question about,  
6 you know, what she brought up. If we like, let's say we  
7 take Oxford, and that's the only two things you don't  
8 like, do we have the option of going back to the insurer  
9 and saying, you know what, we really like your plan  
10 overall, but if you could extend X service by this  
11 amount, you know, as opposed to writing them off, there  
12 may not be a compromise anywhere, or is it whatever they  
13 provide that's their final offer?

14 MS. BREault: No. Basically, the way the  
15 federal definition is, it is a benchmark plan that was  
16 sold in the state the first quarter of this year.

17 MR. TREADWELL: Oh, okay. Okay.

18 MR. CAREY: So, then, moving along to the  
19 next page with regard to prescription drugs,  
20 rehabilitative and habilitative services and devices and  
21 laboratory services, we do capture, under prescription  
22 drugs, the fact that there are three tiers, which is  
23 standard practice really in the industry at this point.

24 We didn't capture whether or not there is

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1 a specialty tier, or any sort of different treatment of  
2 biologics, but we can follow-up with that request, as  
3 well.

4 And then, on rehabilitative and  
5 habilitative services, we should also capture physical  
6 therapy, speech therapy, occupational therapy, so we'll  
7 make sure to have that for the Committee, but we do  
8 capture DME here, and we'll need to flesh that out with  
9 regard to whether or not there are any specific limits  
10 around DME, and then lab and x-ray we do include imaging  
11 services, as well as diagnostic tests.

12 And then, finally, with regard to  
13 preventive and wellness services and chronic disease  
14 management -- yes, sir?

15 MR. MARCHOZZI: Could we include  
16 categories that are already a state requirement? Like,  
17 under drugs, you have experimental drugs that are, if  
18 it's through a certain FDA qualification, are included.

19 Could we include all those requirements  
20 that are already part of the state requirement?

21 MR. CAREY: So, in the material that was  
22 sent to the Committee, I believe we do list out all of  
23 the state mandates. All of those are included within the  
24 small group plan.

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1                   What we could do is take a look, perhaps,  
2                   if the Committee is considering the Federal Employee  
3                   Health Benefit Plan, which is a self-funded plan and does  
4                   not need to cover all of the individual state mandates in  
5                   which it's sold, any deviation between what's covered  
6                   under a state mandate and what is covered under the  
7                   Federal Employee Benefit Plan.

8                   MR. MARCHOZZI: Any of the plans exceed  
9                   the state mandate?

10                  MR. CAREY: Exceed the state mandate, in  
11                  terms of?

12                  MR. MARCHOZZI: Whatever. There's 45  
13                  categories or 45 items.

14                  MR. CAREY: I don't know offhand.

15                  MS. BREULT: Well the mandates generally  
16                  are fairly specific coverages within the bigger  
17                  categories. For example, we do not have a prescription  
18                  drug mandate in the state, so, basically, all of the  
19                  mandated coverages are here, but all of the plans are  
20                  very consistent in covering office visits and outpatient  
21                  surgery and hospitalization.

22                  MR. MARCHOZZI: Right.

23                  MS. BREULT: Those are not exactly  
24                  specifically mandates, but those are standard coverages.

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1 MR. MARCHOZZI: Some of the mandates have  
2 minimums and maximums?

3 MS. BREault: Right, but, as far as any  
4 annual dollar limits, those are gone now if they fell  
5 into one of the categories of the Essential Health  
6 Benefits.

7 MR. MARCHOZZI: Okay, thank you.

8 MR. TESSIER: Thank you. Bob, could we go  
9 back to the prescription drugs item? Anne Melissa asked  
10 earlier the significance of the rider issue, and I'm not  
11 quite sure I understood the significance of it.

12 If it's a rider, that means it's not  
13 considered under the regulations as a covered essential  
14 benefit, is that right?

15 MR. CAREY: No. Prescription drugs is a  
16 covered benefit that needs to be --

17 MR. TESSIER: I'm sorry. I meant by the  
18 plans that have it as a rider.

19 MR. CAREY: The plan is sold as a rider,  
20 so you could buy the base package, without prescription  
21 drug coverage, today in Connecticut.

22 MR. TESSIER: Right.

23 MR. CAREY: Prescription drugs is not a  
24 mandated benefit in Connecticut.

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1 MR. TESSIER: I understand that. That  
2 part, I do understand. I guess what I'm trying to ask is  
3 does the fact that they're not -- that for two of the six  
4 plans it's a rider and not a part of the basic benefit  
5 package, does that have any implications for this  
6 discussion and decision, and can you be more explicit  
7 about what that is, because I didn't feel like I followed  
8 that exactly.

9 MS. BREault: Yes. Basically, under the  
10 guidance that we've gotten from the federal government to  
11 date, and, you know, most of the states have expressed  
12 major concerns, especially with prescription drug, so  
13 this is not to say this will be the final guidance,  
14 because they've taken it back under consideration.

15 But, as of now, if prescription drugs are  
16 covered under a rider, they are not considered part of  
17 that benchmark plan, and what a state would have to do to  
18 include it, because Essential Health Benefits do include  
19 prescription drugs, is we would have to go to another  
20 benchmark plan that included it.

21 And, as I said earlier, right now, one of  
22 the plans, I believe it was the Oxford plan, does have it  
23 as part of the base policy, and, also, the Federal  
24 Employee Plan has it as part of the base policy, because

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1 even under the State Employee Plan, it's a separate  
2 rider, so we could not even use the State Employee Plan.

3 MR. TESSIER: Thank you, Mary Ellen. So  
4 does that -- I mean does that mean that the plans, where  
5 it's a rider, are disqualified?

6 MS. BREault: No, not the plans. Just you  
7 couldn't have -- you can't use that rider to determine  
8 your prescription drug Essential Health Benefit.

9 MR. TESSIER: Okay.

10 DR. McLEAN: On the prescription question,  
11 so if we pick a small group product and two of those have  
12 the rider, do we have to pick the other small group  
13 prescription plan, or can we pick it from any of the ones  
14 that are available? Do you understand my question?

15 MR. CAREY: Yeah. I don't believe that  
16 they've made a final decision on this. My suspicion is  
17 that they will allow the state to determine on its own  
18 what the supplemental benefit might be, so there are  
19 other categories, also.

20 Drugs is one, which is typically sold as a  
21 rider. I think HHS has gone back now and is rethinking  
22 the way in which they approach this question with regard  
23 to states that want to choose a small group product for  
24 other reasons and what type of prescription drug benefit

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1 they will be provided.

2 The pediatric dental is another one, where  
3 specifically in the guidance they talk about that it may  
4 not be typically covered in a typical employer plan, but  
5 if a state chooses a product or a plan that doesn't  
6 include pediatric dental and pediatric vision, the  
7 guidance has been that the state needs to supplement that  
8 with the CHIP benefit, which is typically provided to  
9 children as part of the CHIP benefit for dental and  
10 vision, or the Federal Employees Health Benefit Dental  
11 Plan and Vision plan, so they do identify specific areas  
12 that are not sort of typically covered that the states  
13 will need to go to supplement the benefit package.

14 MS. JAFF: If we're thinking about the  
15 Federal Employee Plans, it would be actually, regardless,  
16 it would be really helpful to me. I tried to do this  
17 myself, but the list of mandates that you gave us it's  
18 not clear which of the 10 categories those mandates fall  
19 within.

20 I could make arguments, for example, for  
21 some of them that might go in one category versus  
22 another, and, so, it would be really helpful to me if you  
23 could just add to this excellent chart that you did about  
24 the mandates which of the 10 categories, and that will

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1 allow us to see which ones you don't think fall within  
2 any of the 10 categories, so that we would be potentially  
3 taking a risk, starting in 2016, of having to pay for  
4 those benefits.

5 And there are, just going back, there are  
6 some of those mandates that do refer to prescription  
7 drugs, like psychotropic drugs and providing syringes and  
8 things like that, that it might be important for us to  
9 know if those are covered by any of the plans that have a  
10 prescription drug benefit as part of a plan.

11 MR. CAREY: So my understanding is that  
12 the mandates that apply to prescription drug coverage  
13 only apply if the plan includes prescription drug  
14 coverage, so they would be required to cover those  
15 mandated prescription drugs as part of the rider.

16 MS. JAFF: Right, and I didn't mean to  
17 just single out the prescription drugs. I'm just trying  
18 to figure out which of the mandates you all feel would  
19 not be covered by the 10 categories.

20 MR. CAREY: Sure. We can flag those.

21 MS. JAFF: And, for the rest of the  
22 riders, where it's unclear which of the 10 categories it  
23 falls into, it would be helpful to know what category you  
24 all think they fall into.

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1 MR. CAREY: Sure. We can do that.

2 MS. JAFF: Because, then, if there were,  
3 for example, a coverage limit on something that affected  
4 a mandate, that would be something that we should know  
5 about.

6 MR. CAREY: Okay. We'll do that.

7 MS. HARDRICK: Hi. Excuse me. This is  
8 Deirdre Hardrick, and I'm from Aetna. I didn't say that  
9 earlier.

10 One of the things I was wondering, this  
11 may be too preliminary, but I know we're talking about  
12 what's covered in the Essential Health Benefits, but one  
13 of the things that concerns me is the affordability and  
14 the downstream cost to the consumer, and I don't know if  
15 there's any additional information we could be provided  
16 with once we start comparing the plans on what the  
17 potential cost, you know, of the different plans, the  
18 downstream cost to the consumers.

19 I mean we're talking about visit limits,  
20 but we don't know is there a considerable difference. If  
21 there's 30 visits versus 100 visits, will it make a  
22 material difference in cost to the consumer? So I wanted  
23 to see if that's some type of information we might be  
24 able to consider, as well.

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1 MR. CAREY: Sure. We should definitely,  
2 in those areas, where there is a difference in the visit  
3 limit, we should be trying to provide -- we will provide  
4 the Committee with potential marginal costs of the  
5 additional visits. In your example, the 30 versus the 90  
6 days.

7 Okay, so, we went through them again. The  
8 dental and the vision benefit, we're not certain that the  
9 benefit provided by the plans would meet the standards  
10 that HHS will set, so we'll have to review exactly what's  
11 the pediatric dental and vision benefit that's provided  
12 in the benchmark plan options.

13 The no with regard to the Federal  
14 Employees Plan is because the dental and vision benefit  
15 is not part of the medical benefit that's provided to  
16 federal employees. It's a separate benefit package  
17 that's provided through a separate carrier for their  
18 dental and vision coverage.

19 Okay, so, I think the charge for the  
20 Committee is, if there are specific areas as you go back  
21 and talk to folks that you want to see additional  
22 information on, if you could route that through the co-  
23 Chairs, who will then provide it to, or, you know, you  
24 could c.c. staff, as well, or the Exchange, so that we

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1 can then provide for you in a timely fashion that  
2 additional information, which will be helpful for the  
3 June meeting, at which time we're going to put in front  
4 or we will discuss a potential recommendation on which of  
5 these plans the State or the Advisory Committee would  
6 like to see or is recommending be offered as the  
7 Essential Health Benefits Package.

8 Because we have multiple Committees  
9 looking at the same issue, we think it important for  
10 potentially a joint meeting between the Consumer  
11 Experience and Outreach Committee and the Qualified  
12 Health Plan Committee, and we're going to be vetting this  
13 with that Committee tomorrow, I think.

14 And, so, our expectation is that there be  
15 a joint meeting amongst the Committee, the Committee  
16 members to discuss the recommended approach with regard  
17 to Essential Health Benefits.

18 CHAIRPERSON DOWLING: Bob, are you  
19 suggesting that would be soon after the June meeting?

20 MR. CAREY: We think that that -- yeah.  
21 We might need an interim meeting, so there might need to  
22 be perhaps two meetings, during which we flesh this out  
23 further to your point earlier, that if the Committee felt  
24 that they needed to discuss further before they come back

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1 with a recommendation, that we could.

2 CHAIRPERSON DOWLING: Perfect, because  
3 that was going to be my second question. I wouldn't  
4 assume we're going to do this in June. I'd say it's the  
5 next couple of weeks, so thank you.

6 You just need to let us know, you know,  
7 how short of a time frame you can respond to the things  
8 we sent to you.

9 MR. CAREY: Yeah. I mean we have the  
10 information in-house, so we should be able to, you know,  
11 if you itemize areas in which you're looking for  
12 additional information and we can provide that, you know,  
13 upfront, you know, 10-page summary or so, as well as  
14 specific requests for additional information from the  
15 Committee members, so if you could provide that to us by  
16 Wednesday of this week, we should be able to turn that  
17 around by the middle of next week.

18 Again, the calendar is compressed, only  
19 out of necessity, so we think that the recommendation  
20 from the Advisory Committee needs to be brought to the  
21 Board of the Exchange at the July Exchange meeting, and  
22 that the Exchange Board will then vote on a  
23 recommendation that it believes, with regard to the  
24 Essential Health Benefits Package.

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1                   And, again, the decision, not at this time  
2                   known who will make the ultimate decision about what's  
3                   the Essential Health Benefits Package for Connecticut,  
4                   but that decision needs to be made by September of 2012  
5                   to satisfy the federal guidance, but, also, with regard  
6                   to the carriers needing to develop products that capture  
7                   and cover all of the Essential Health Benefits Package.

8                   The timing for product development is not  
9                   short, and the decisions that Connecticut makes with  
10                  regard to the Essential Health Benefits Package then need  
11                  to be internalized by the carriers offering products  
12                  across the individual and small group markets for  
13                  products that will be available for sale in 2013, but  
14                  with an effective date starting on January 1, 2014.

15                  Again, the Exchange also needs to get  
16                  products on its shelf sometime in 2013, and, so, this  
17                  timing needs to occur in the fall of 2012, so that a  
18                  solicitation by the Exchange can occur in the winter of  
19                  2012/2013, so that products can be selected and offered  
20                  for sale starting October 1 of 2013.

21                  MS. O'GARA: Are we ready to move to the  
22                  carrier concerns, then?

23                  MR. CAREY: Well just at the back of this  
24                  deck, there's also -- we tried to provide a range of

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1 resources that the Committee members may be interested in  
2 reviewing that's particular to Essential Health Benefits.  
3 This was not sort of an exclusive list. There's lots of  
4 information out there. It won't take you long to search  
5 and find information, but we thought this provided a  
6 cross-section of opinions and input with regard to the  
7 Essential Health Benefits Package.

8 If there are others that the Committee  
9 members feel would be helpful and relevant to your fellow  
10 Committee members, we would suggest that that, again, be  
11 routed through the co-Chair, so that we could make it  
12 available to people as they go back and discuss and  
13 consider the Essential Health Benefits Package.

14 MS. FOX: Can I ask a question? Is  
15 anybody thinking about, outside of or even within all the  
16 federal regulations and the guidance we've been given,  
17 how does this Committee begin to look at any innovations  
18 that may serve the basic purpose of, you know, providing  
19 Essential Health Benefits, but maybe not in a traditional  
20 insurance design that we've been looking at?

21 So, for instance, you know, how do we  
22 start thinking about and talking about and incorporating  
23 in the recommendations potentially looking at ACOs, or  
24 some of the other innovative products and designs that

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1 other states are beginning to look at, or that carriers  
2 may be designing, but they're not on the sheet yet?

3 MR. CAREY: So I think that that area is  
4 one in which this Committee will have an opportunity for  
5 discussion and potentially promotion, in terms of the  
6 products that the Exchange offers as part of its suite of  
7 health plans, so, in Massachusetts, for example, when we  
8 solicited health plans that would be offered through the  
9 Connector, there was a preference for, you know, select  
10 network products, or a preference for innovative medical  
11 management, and we sort of listed out there were five or  
12 six preferred options.

13 New cost structures, for example, was a  
14 part of that preference, and, so, this Committee will  
15 have an opportunity to discuss that with regard to the  
16 solicitation that the Exchange will need to put forward  
17 in, as I mentioned, in sort of December/January time  
18 frame 2012 and 2013.

19 MS. FOX: Okay.

20 MR. CAREY: But I don't think it's part  
21 and parcel of the Essential Health Benefits Package.

22 MS. FOX: Okay, thank you.

23 MS. JAFF: Within the 10 categories,  
24 though, I think there is one category that probably does

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1 need some fleshing out, and that's the Preventive  
2 Wellness and Chronic Disease Management, where there's a  
3 lot of innovation going on. It's not currently built  
4 into many plans.

5 I'm not suggesting that we create another,  
6 quote, unquote, "mandate," but is that an area, where  
7 this Committee, or the Exchange Board, or whoever can  
8 kind of encourage the carriers to expand and innovate?

9 MR. CAREY: Yeah. I think that that is  
10 within the purview of this Advisory Committee and the  
11 Exchange, again, when it goes to the marketplace to  
12 solicit products.

13 If it has preference for various maybe  
14 innovations, that it be part of the solicitation that the  
15 Exchange offers to the marketplace.

16 Okay, so, I think we've wrapped the  
17 discussion on Essential Health Benefits. We have a  
18 number of takeaways. I don't want to move off it if  
19 folks have comments or questions. This isn't the last  
20 time, obviously, you'll have that opportunity, but we did  
21 want to make sure that all of the Committee members had  
22 an opportunity to ask any questions specific to the  
23 discussion.

24 CHAIRPERSON DOWLING: Thank you for that,

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1 and thank you for your receptivity to all the input.

2 MR. CAREY: The next agenda item we at the  
3 last meeting discussed the fact that the Exchange is a  
4 voluntary marketplace for carriers, as well as consumers,  
5 and the notion, that the Exchange needs to consider  
6 carriers as customers along the same lines that they  
7 consider the ultimate consumer as a customer of the  
8 Exchange, and, so, we went to the Connecticut Association  
9 of Health Plans and asked them if they would put together  
10 sort of the top line areas of concern or interest or  
11 focus from the perspective of the carriers that operate  
12 currently in the Connecticut individual and small group  
13 market, and the Association provided us with their  
14 feedback, and we wanted to share that with the Committee.

15 So a couple of sort of high-level, so  
16 concept one is that the Exchange must adopt fair and  
17 objective standards for health plan participation. They  
18 are not supportive of sort of the active purchaser model,  
19 and there are different models out there.

20 If you go to the literature, there's sort  
21 of an active purchaser would be someone that acted more  
22 like a large employer, in terms of negotiating benefits  
23 with the carriers, whereas sort of a free market  
24 facilitator sort of sets minimum standards, and that,

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1 then, allows the carriers to participate if they meet  
2 those minimums. Yes, ma'am?

3 MS. JAFF: This one I'm positive of,  
4 because I checked before I got here. The statute does  
5 require the Exchange Board to limit the number of plans,  
6 so, without a statutory change, I think the Exchange  
7 Board becomes at least semi-active purchaser.

8 MR. CAREY: Yeah, I think that you're  
9 exactly right. In fact, even in those states, in which  
10 the statute directs or that the philosophy is that they  
11 will be sort of this free market facilitator, there will  
12 be a limit, in terms of the number of products that are  
13 available.

14 It will be somewhat self-limiting from the  
15 perspective of the carriers, but it will also likely be,  
16 and this is another area in which this Committee is  
17 charged with advising the Exchange Board, in terms of the  
18 number and types of health plans that will be offered  
19 through the Exchange, so there will be some limitation.

20 The question is whether the Exchange  
21 engages in sort of active negotiation with the carriers  
22 with regard to products or prices that are offered on  
23 those products through the Exchange.

24 DR. McLEAN: Since your experience was in

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1 Massachusetts, was Massachusetts more of a facilitator or  
2 a purchaser?

3 MR. CAREY: You know, they started with  
4 middle of the road, I guess. They set standards, and  
5 they limited the number of products that were offered in  
6 specific areas, and, so, they're more of a selective  
7 contractor, I would consider them.

8 They don't negotiate premiums, but the  
9 power of transparency has helped, I think, reduce premium  
10 increases in the state, and I think that that's one role  
11 of an Exchange, is to be a transparent marketplace, so  
12 people can see, you know, that there are differences in  
13 prices for comparable products.

14 MR. TESSIER: Bob, wasn't there, also, in  
15 the maybe second or third year after the Connector was up  
16 and running, was there legislation, or was it the  
17 Governor, who there was a rejection of kind of across the  
18 board rate increases, premium increases that the carriers  
19 submitted?

20 MR. CAREY: Yeah, so, that was through the  
21 Division of Insurance in Massachusetts, and they do  
22 pretty aggressive rate review and approval, and there was  
23 a wholesale rejection of 200 and some odd requests or  
24 plan increase request that the Division of Insurance, and

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1 that was market-wide. That was not the Connector or the  
2 Exchange.

3 A couple other just key points with regard  
4 to sort of the ground rules from the perspective of the  
5 carriers. No additional issuer or product requirements  
6 above and beyond the minimums, so there were certain  
7 minimums set out in federal law and federal regulation.

8 Their preference is that there not be  
9 additional issuer or product requirements, and that the  
10 rules be consistent for products purchased inside and  
11 outside the Exchange.

12 The potential for risk selection is not  
13 insignificant if you have different rules for  
14 participation inside and outside an Exchange, so we just  
15 need to be mindful of the fact that there is this broader  
16 outside marketplace that will continue to function after  
17 the Exchange is up and running.

18 The second major point is to promote  
19 competition choice and innovation in product offerings.  
20 To the point with regard to Massachusetts, the  
21 Massachusetts Connector sets the specific cost sharing  
22 features for all of the products that are offered through  
23 it.

24 They originally or initially allowed the

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1 carriers to have some variation in product design and  
2 structure, and they've gone now to a more standardized  
3 fashion.

4 If you go to the Utah Exchange, for  
5 example, that's more of a free market facilitator, and  
6 they don't specify the cost sharing features within the  
7 products offered through them.

8 So there will be some limitations, because  
9 of the fact that the carriers and the plans need to meet  
10 the actuarial value targets at 90, 80, 70 and 60 percent,  
11 and, so, that, in itself, will limit the amount of  
12 variation across carriers and across products, but there  
13 still will be an opportunity, unless the Exchange decides  
14 otherwise, to allow some innovation and variation, in  
15 terms of the products that are offered through the  
16 Exchange, but, again, this is something that this  
17 Committee will be advising the broader Exchange Board  
18 about with regard to the solicitation of the products.

19 COURT REPORTER: One moment, please.

20 MR. CAREY: The third major comment or  
21 concern from the carriers is not to duplicate or create  
22 additional regulatory requirements. They believe that  
23 the Connecticut Insurance Department should retain its  
24 regulatory authority over the products sold inside and

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1 outside the Exchange, and the Exchange should not be a  
2 regulator of products offered through it.

3 The Exchange needs to work out a memoranda  
4 of understanding with the Connecticut Insurance  
5 Department to determine which party will be responsible  
6 for certain statutory requirements that will take effect  
7 in 2014, and we're working through that right now, but  
8 the preference from the industry is that the Department  
9 of Insurance retained its authority, sole authority for  
10 sort of the regulatory review and approval of products  
11 and rates.

12 Minimize disruption to the existing  
13 marketplace and allow, for example, and they pointed out  
14 two areas, in particular, again, this Committee will be  
15 looking at.

16 One is the expansion of the small group  
17 market to groups of 100 or fewer employees in 2014, as  
18 opposed to the 2016 requirement, that the small group  
19 market be expanded.

20 So under the ACA, the current limit for  
21 group size with regard to the small group market in  
22 Connecticut is 50 employees or fewer. The ACA requires  
23 states to expand the definition of small group to 100 or  
24 fewer, but provides an option, that that be deferred

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1 until 2016, at which point it's required.

2 And, so, the preference from the carriers  
3 is that the small group market be retained to groups of  
4 50 or fewer in the 2014 and 2015 period.

5 CHAIRPERSON DOWLING: Bob, can you just  
6 remind us when we need to make that call?

7 MR. CAREY: So, you know, HHS has been  
8 relatively silent, in terms of states that don't change,  
9 so the current rule is 50 or fewer.

10 I don't think that the legislature needs  
11 to do anything to modify the current definition if it's  
12 the choice of Connecticut to stay at 50 or fewer  
13 employees.

14 If the decision is to expand the  
15 definition to 100 or fewer, that decision would need to  
16 be made I think early in 2013 to allow for the market to  
17 adjust and for those larger groups of 51 to 100 to now be  
18 included in the small group market.

19 CHAIRPERSON DOWLING: And if nothing is  
20 said, it stays as is, but we probably need to affirm  
21 formally.

22 MR. CAREY: Yes. I think, if the state  
23 does nothing, I think that HHS may request a letter from  
24 the Department of Insurance or from the administration,

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1 that it is maintaining the current definition at 50 or  
2 fewer employees.

3 CHAIRPERSON DOWLING: So we should  
4 probably just let the Committee know that we're going to  
5 put it on August's agenda or something, or whenever, just  
6 so that we can have a formal.

7 I know the Exchange Board, too, has heard  
8 presentations from you on this, but I just think we  
9 should put some date in place, where everybody knows that  
10 it's going to be a finite call.

11 MS. BREault: And, actually, I think right  
12 now the guidance that we've received from HHS is that we  
13 do not have to take any affirmative action to maintain  
14 that, so we'll be watching, in case they change that  
15 guidance.

16 MR. CAREY: But it is on this Committee's  
17 agenda to review the advantages and disadvantages and the  
18 issues associated with expanding the market definition to  
19 groups of 100 or fewer.

20 CHAIRPERSON DOWLING: Well I know you made  
21 a great presentation to the Exchange Board, so probably  
22 we should just do that again for this group and have some  
23 formal statement vote, whatever, that comes to one  
24 conclusion or another, so the carriers know.

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1 MR. CAREY: Yeah. It's on our agenda.  
2 When we went through sort of the list of issues that this  
3 Committee needs to address, the question of whether to  
4 expand the small group market is part of the Committee's  
5 charge.

6 MR. TESSIER: Just to clarify, is the  
7 current definition of 50 a statutory definition? It  
8 would require legislation to change it, is that correct?

9 MR. CAREY: Yes.

10 MR. TESSIER: Thank you.

11 MR. CAREY: The other comment from the  
12 carriers pertains to the merger of the individual and  
13 small group market, so, currently, there are two separate  
14 risk pools and two separate marketplaces, the individual  
15 and small group market.

16 The law does not require the states to  
17 merge them. It simply allows the states -- to be honest,  
18 the states always had this authority to decide whether to  
19 merge their individual and small group pools.

20 Only one state has merged its individual  
21 and small group market. That's your neighbor,  
22 Massachusetts, which at the time had a largely  
23 dysfunctional individual market that was shrinking in  
24 size, and they decided, when they passed health reform in

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1 2006, that they would merge a very small pool of people.

2 In the individual market, it was about  
3 50,000 people in the individual market. They merged that  
4 with the small group market, which had about 800,000  
5 people, so you created a much larger marketplace for  
6 individual purchasers, without materially affecting the  
7 rates of the small group market, although there was some  
8 impact to rates in the small group market that resulted  
9 from the merger, but that's the only state to date that  
10 has a truly merged individual and small group market.

11 Again, that will be on the Committee's  
12 agenda to discuss and review.

13 Just a few more comments from the  
14 carriers. Encourage participation, while also preventing  
15 adverse selection, helping individuals obtain and  
16 maintain coverage, with a consumer-focused approach to  
17 eligibility and enrollment, letting health plans know the  
18 requirements very soon, so that they can make  
19 adjustments, if necessary, so that they can participate  
20 on the Exchange, and this applies not just to decisions  
21 that the state needs to make, but, also, with regard to  
22 final decisions that HHS and the federal government needs  
23 to make with regard to participation by the carriers in  
24 Exchanges.

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1 I think that's it for the carrier  
2 concerns. Any comments?

3 MS. HARDRICK: Yes. This is Deirdre  
4 Hardrick again. I do have a comment. Maybe more of a  
5 general, broad question, in terms of the activities the  
6 Exchange is involved in at the federal level.

7 We haven't heard much. I know the  
8 federal, the HHS and CCIIO, they're starting to engage in  
9 more activity, but how operationally you're going to be  
10 working, exchanging data, operationally, the technical  
11 interfaces, you know, between all of these entities, and,  
12 you know, sharing the information, the subsidy  
13 information, premium credits, what sort of involvement or  
14 activity is the Exchange Board involved in at the federal  
15 level?

16 MR. CAREY: Daily activity with partners  
17 at the federal government. We actually will be in  
18 Washington Monday, Tuesday and Wednesday of next week for  
19 the grantee conference with HHS. We have probably daily  
20 phone calls with them with regard to some of the  
21 technical issues.

22 We have a vendor, who is pulling together  
23 all of the business requirements for the Exchange. We  
24 also need to set up and are in the process of doing so a

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1 working group with health plans, a technical working  
2 group with the carrier, so they understand what  
3 information they'll need to provide and what information  
4 will be provided to them on issues, such as the advanced  
5 premium tax credit, or cost-sharing reductions, or  
6 enrollment forms and so forth, so we are assembling that  
7 working group to work on technical issues, not policy  
8 issues.

9 And then we'll also be in D.C. Thursday  
10 and Friday for what's called a gate review with the  
11 federal government, in which we lay out our plan of  
12 operations and discuss with the federal government how  
13 we're going about sort of the business side of the  
14 Exchange.

15 MS. HARDRICK: Okay, thank you.

16 MR. CAREY: Okay, so, I think we're done  
17 with carrier concerns.

18 MS. O'GARA: Now we had another item on  
19 the agenda for the Tribe. We wanted to describe some of  
20 their concerns, as well.

21 MR. PORTER: So the ACA outlines a few  
22 requirements with respect to dealings with the Exchange  
23 and federally-qualified Tribes in Connecticut.

24 We have two, the Pequots and the Mohegans,

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1 roughly about 2,500 total individuals in those two  
2 Tribes, and, just listing, there's a whole slew of  
3 requirements pertaining to our dealings, the Exchange's  
4 dealings with tribal issues, and, so, these are just  
5 specific to the Qualified Health Plans.

6 So the provisions of the ACA most directly  
7 affecting the Native Americans in Connecticut will be  
8 they're exempt from the individual mandate, and, so, that  
9 will affect Outreach and the Navigator Program and sort  
10 of incentivizing participation.

11 We're beginning an ongoing -- I'm sorry.  
12 They have a monthly enrollment period, as opposed to the  
13 annual open enrollment, and, so, we have to factor that  
14 into the technical design of the Exchange, whether it's  
15 manual or automated through the web portal.

16 There is a requirement for a Tribal  
17 Consultation Policy. That may have some impact on the  
18 Essential Health Benefits. There's some -- there could  
19 be some variation with respect to the Indian Health  
20 Services and Essential Health Providers that we'll have  
21 to consider.

22 And then there's premium sponsorship by  
23 Tribal Governments, so this is not required. It will be  
24 to be determined by the state and Exchange, whether we

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1 allow group payment of premiums.

2 And because we just have the two to deal  
3 with and the Mashantucket Pequots are currently self-  
4 insured, they may not be interested, and, so, that's  
5 where the consultation policy will really come into play  
6 of determining the needs and requirements of that.

7 And, then, finally, there's no cost  
8 sharing of any sort for members with incomes under 300  
9 percent of the federal poverty line, and this will go,  
10 again, to Deirdre's point, about interfacing with the  
11 carriers, because the carriers will need to know who  
12 those individuals are and that those individuals should  
13 not be charged any premiums or any cost sharing, and then  
14 we could do selective contracting with the Indian Health  
15 Service Facility in Connecticut.

16 This sort of -- these are -- just going  
17 back to those comments I made, just sort of the steps of  
18 the action plans that we'll have to do, consider, the  
19 enrollment and plan design with respect to the monthly  
20 enrollment period, the cost sharing with those under 300  
21 percent of poverty line.

22 There's been no final ruling on it, but --  
23 so because the plans cannot charge any cost sharing for  
24 those under 300 percent of the poverty line, that would

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1 impact the premiums for the rest of the groups, and  
2 there's no clear regulations on who pays that, who picks  
3 up that cost.

4 And call two weeks past made it seem that  
5 the final rule will be that the federal government is  
6 going to pick up those cost sharing, any cost sharing  
7 associated with American Indians earning under 300  
8 percent of the poverty line, so it shouldn't affect  
9 premiums for others, who are in that same carrier with  
10 that same plan.

11 Again, sponsorship of the tribal members,  
12 we'll have to make a decision on that if we're going to  
13 allow the group payment, and the inclusion of Indian  
14 health providers in Exchange plans. Will we want those  
15 included? Will they have to be in everyone's network, or  
16 just specific to regional plans? And then our  
17 determination of our marketing and outreach to Native  
18 Americans.

19 MS. O'GARA: Okay, well, we've left a  
20 pretty good portion of time to talk about next meeting,  
21 and I think my observation is that there may need to be  
22 an interim meeting between now and the next regularly-  
23 scheduled June meeting, so that would be one discussion  
24 point.

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1                   The other, and maybe we should do it  
2 first, is the agenda items that need to be covered  
3 between now and then, so maybe you can reflect on that  
4 for us, Bob and Tia.

5                   MS. CINTRON: Yeah. We need to, as we  
6 discussed, do a deeper dive into the EHB and Benchmark  
7 Plan discussion, so we'll be taking the information that  
8 we gather from you by Wednesday and going further with  
9 that.

10                   We need to also talk about, you know, how  
11 we're going to frame the recommendations as we discuss  
12 them in the June meeting to the Board, and then we also  
13 wanted to start the discussion around the QHP and their  
14 requirements, both on the Federal and State and Exchange  
15 levels.

16                   So those were the topics that we wanted to  
17 cover in June. Anything else?

18                   MS. JAFF: Tia?

19                   MS. CINTRON: Yeah?

20                   MS. JAFF: I thought we had the BHP on the  
21 agenda for June, as well.

22                   MR. CAREY: I think that what we -- we may  
23 need to push that out to July, given the, you know,  
24 pretty significant discussion around the EHB, so that

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1 might be -- I think that we had talked internally about  
2 the need perhaps to defer that for --

3 MS. JAFF: I'm just making sure we don't -  
4 -

5 MR. CAREY: -- but it's not off the list.  
6 It's just on a different track.

7 CHAIRPERSON DOWLING: I think that makes  
8 sense. I would say we have an interim meeting that's  
9 nothing, but just the benefits, you know, between now and  
10 the June one, and then can discuss it.

11 We may have to have a little one that lets  
12 people digest between the June meeting and the July  
13 presentation to the Board, where we get together maybe  
14 just for an hour to talk about how we're going to  
15 present, because we want to make sure that everybody here  
16 has all the questions out, so that they don't come up at  
17 the Exchange and there's any awkwardness, or lack of  
18 unity, I think, so I think we want to have a unified  
19 voice when we finally get to the Exchange, so we may have  
20 two interims, you know? But I would suggest our first  
21 interim is nothing, but just the benefits.

22 MR. CAREY: I think that makes sense. So  
23 we'll work with Committee members to schedule a meeting,  
24 solely focused on the Essential Health Benefits and a

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1 review of the information that we provide prior to that  
2 meeting.

3 CHAIRPERSON DOWLING: Does that make sense  
4 to everybody else? I shouldn't have just assumed that.  
5 Okay.

6 MS. O'GARA: Bob and Anne Melissa, do you  
7 see that as just this Committee, or is that going to  
8 include the other Committee that's working on it?

9 MR. CAREY: I would suggest that it be  
10 this Committee, that there be a separate joint meeting,  
11 at which, once we flesh out the details of it further,  
12 and Committee members are satisfied that we've addressed  
13 all the issues, and we have a recommendation to move  
14 forward.

15 CHAIRPERSON DOWLING: Yeah. I think,  
16 until we're unified, we can't, then, meld, so, yeah.  
17 But, hopefully, that will happen.

18 MR. FRAYNE: In terms of a request, does  
19 someone need to send your request for the plan summary  
20 documents, or is that already on the list? So you don't  
21 need someone to ask for that by Wednesday?

22 MR. CAREY: Yeah, that's on the list.

23 MR. FRAYNE: Okay, thank you.

24 MR. CAREY: Thank you.

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1 CHAIRPERSON DOWLING: With that, I would  
2 ask you would you tell us what's on the list, so people  
3 don't need to re-send? That would probably be helpful,  
4 and then we'll just, on the margin, send anything else.

5 MR. CAREY: I'm looking at my colleague.  
6 Can you go back and just pull together what the Committee  
7 members noted that we're looking for, in terms of  
8 information?

9 MR. PORTER: So we have the mini-summaries  
10 of each of the plans, of each of the benchmark plans, and  
11 then, with respect to specific benefits that wanted  
12 further specific categories that you want further  
13 information about, the prescription drugs tiers, the  
14 habilitatives and rehabilitative services, including PTO,  
15 and then, also, lab services, durable medical equipment  
16 services, mental health coverage, specialty tier for  
17 prescription drugs, and that's what I have so far.

18 MR. CAREY: Yeah and then, also, the  
19 mandated benefits and the categorization of those  
20 benefits and any that may fall outside of the 10  
21 Essential Health Benefits categories.

22 MR. PORTER: Right, so, the inclusion of  
23 the state mandates and the federal plans, and then sort  
24 of a crosswalk between the state mandates and the 10

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1 categories, and what we think might fall outside of the  
2 EHB.

3 That wouldn't be a determination of the  
4 Exchange, of what falls outside, so we'll probably err on  
5 being conservative and maybe excluding things that could  
6 be ruled as falling under the EHB.

7 CHAIRPERSON DOWLING: Thank you. Were  
8 there others you wanted to send, or did they capture our  
9 input? Because we can say that's it.

10 MS. HARDRICK: The only thing I would add  
11 is information on marginal cost differences.

12 MR. PORTER: Yes. Sorry. You wanted,  
13 yes, more information on affordability and a cost  
14 analysis of the plan differences.

15 MS. FOX: I still have an open concern. I  
16 think Jennifer's example of innovation within one of the  
17 benefit categories is one thing that we should be  
18 considering from the get-go, but, also, you know, as we  
19 move down the path, how do we make sure we're taking a  
20 broader look at some innovation in plan designs, per se,  
21 where risk sharing may take a completely different, you  
22 know, definition?

23 I'm just afraid that we'll get all the way  
24 through this Committee, come up with recommendations, and

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1 eliminate the, you know, or overlook the opportunity to  
2 really make a difference, in terms of cost containment,  
3 in terms of, you know, disparities in health care, in  
4 terms of chronic disease management, things we've been  
5 talking about along the way, but there's no specificity  
6 yet.

7 MR. PORTER: We can look into the existing  
8 benchmark plans if those innovations are included as part  
9 of their benefits, but if they're not included in the  
10 benchmark plans, at this date we're sort of limited, so  
11 that will be further down the road.

12 MS. JAFF: Could I add one more thing to  
13 the list, and that is express exclusions from the  
14 benchmark plans, items that are expressly excluded?

15 MR. CAREY: Yeah, we'll provide that, as  
16 well.

17 CHAIRPERSON DOWLING: So, then, you won't  
18 hear anything more from us. It sounds like you've got  
19 our list documented. Of course, if something comes to  
20 you and you think about it in the next 24 hours, feel  
21 free.

22 MS. O'GARA: And the only other thing I  
23 had, Bob, was a note on clarifying the authority for the  
24 final decision-making. That's an ongoing discussion,

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1 right? Okay.

2 Okay, then, Anne and Mark, we've completed  
3 the staff part of the agenda.

4 CHAIRPERSON DOWLING: I think we'll just  
5 open it up to the Committee. Anything else you wanted to  
6 share and talk about? If not, we'll open it up.

7 CHAIRPERSON ESPINOSA: I just have one.  
8 It says June 12th or 13th. When are we deciding that  
9 date? I'm out on the 13th, but the meeting can certainly  
10 continue without me.

11 MS. CINTRON: I think, Mark, we'll loop  
12 back with all of you through Amy.

13 CHAIRPERSON ESPINOSA: Okay.

14 MS. CINTRON: And see what's convenient  
15 for the group.

16 CHAIRPERSON ESPINOSA: Okay.

17 MS. CINTRON: All right?

18 MS. O'GARA: Okay, then, Anne, would you  
19 like to open it up, Anne and Mark, to public comment?

20 CHAIRPERSON DOWLING: Yes, thank you.

21 MS. O'GARA: If you could state your name  
22 and then --

23 MS. VICKI VELTRI: Thank you. I'm Vicki  
24 Veltri. I'm the State Health Care Advocate. I'm also a

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1 member of the Exchange Board and the co-Chair, one of the  
2 co-Chairs of the Consumer Committee. I wanted to come  
3 today to listen to the discussion, because we're having a  
4 meeting tomorrow.

5 What this discussion is, as made clear to  
6 me, is that the discussion tomorrow is going to be of a  
7 very different ilk, and the sooner I think we can put  
8 those two very different discussions together I think it  
9 will be very helpful, because I think the approach that  
10 this Committee is taking from the plan side may be very  
11 different from what the consumers will tell you that  
12 they're saying and what's the most valuable to them, in  
13 terms of benefits, notwithstanding the fact that we are  
14 going by the plans that are offered, and pretty much  
15 everything that's in the State mandates will be offered.

16 I think it might be helpful for everybody  
17 here to hear the flip side of the discussion.

18 Also, I just had two comments. One is, on  
19 the design and sort of getting to what Jennifer and Mary  
20 were talking about, the issue of the cost and the  
21 affordability, and, actually, Deirdre was addressing, is  
22 going to be huge for these consumers, and I think one of  
23 the things that would be helpful if this Committee  
24 addressed, I think ours is going to address, too, is the

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1 transparency issue, you know, the pricing issues, the  
2 cost issues underneath the benefits, so that we're not  
3 just talking about offering a benefit with and assuming  
4 that the costs are what they are.

5 We need to get underneath those costs and  
6 find out if those costs could be lowered, if the charges  
7 are, you know, are the charges really out of whack with  
8 the costs of the benefits underneath, all those kinds of  
9 things we can do to drive down, or do what we can to make  
10 the products affordable.

11 The other thing, the other issue I would  
12 say, and there's obviously three members of the Board  
13 sitting up here on this Committee and me sitting here  
14 now, and I think we should bring the issue about the  
15 decision-making on the EHB back to the Board for a  
16 discussion on Thursday.

17 I don't think the statute -- I think the  
18 statute, at least on my read, pretty clearly addresses  
19 everything back to the Board, the General Assembly and  
20 the Governor, all three parties, and it would be, I  
21 think, surprising to the community at large to have one  
22 department, as well-intended as they are, but one  
23 Executive Branch Department decide public policy for the  
24 whole state.

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1 I think we need to really go back and have  
2 that discussion, and, as I said, four of us are here, and  
3 I'm sure we'll be willing to go back to for that, but  
4 thank you.

5 CHAIRPERSON DOWLING: Vicki, before you  
6 go, you know, your first point I think leaves me hanging  
7 a bit. Can you give us a little bit of color about how  
8 far apart we are?

9 MS. VELTRI: I don't really think it's  
10 necessarily so far apart. I just think it's view, the  
11 viewpoint of the issue, so I think there's a lot of  
12 members on the Consumer Committee they're not insurance  
13 educated, other than what they've experienced in their  
14 lives with respect to, you know, problems they've had,  
15 and whether something has been denied, or getting -- they  
16 have a child with special health care needs, so they're  
17 viewing the system or the delivery of insurance benefits  
18 from the perspective of, you know, having chronic  
19 illness, or needing to have an appropriate design to fit  
20 them, as maybe a little different from viewing it as  
21 Essential Health Benefits under the Affordable Care Act.

22 They may be looking it as Essential Health  
23 Benefits, what they think is essential, and I think we  
24 sort of need to make that connection, and we're going to

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1 do our best, obviously, and Bob and Tia have been really  
2 good with the Committee and trying to get things put  
3 together, and I think we'll try to do that tomorrow, but  
4 I just think it may be a different angle coming in.

5 I know we're all consumers, but the  
6 consumers that are on this Committee pretty much are  
7 people, who have dealt with really serious illness in  
8 their family, and chronic illness, and issues with  
9 accessing health care and affording health care, so they  
10 bring a value perspective that I think would help us all  
11 in viewing the overall issues around not just the EHB,  
12 but, you know, premium and how we're going to make the  
13 products work for them, and that's why the second point,  
14 the affordability point, is so important, that we connect  
15 the dots and not just sort of leave the EHB out here and  
16 affordability over here, that they're all sort of one  
17 piece.

18 DR. McLEAN: I have a question or a  
19 comment. Our hands are somewhat tied, because we have to  
20 pick one of these benchmark plans, and the insurers are  
21 going to decide how to price them, so I would agree with  
22 you.

23 I would love to be able to say, hey,  
24 that's too much, if it is, but, I mean, are we powerless

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1 in that? It seems like we are.

2 MS. VELTRI: Okay, I guess I would  
3 suggest, from my office's standpoint, that the pricing by  
4 the insurer comes down to factors that relate to the  
5 cost, you know, the unit cost of a particular service,  
6 what the provider is charging for it, how well the  
7 negotiations go between the insurer and the providers.

8 There's lots of things underneath the  
9 actual premium that can be addressed, maybe not by this  
10 Committee as a whole, but just in terms of, you know,  
11 making those things a little more transparent to people.

12 I think transparency alone in cost is  
13 maybe one thing that could maybe move costs down a little  
14 bit. I can't say that for sure, but we do have some  
15 control. I think we do have some control, in terms of  
16 making, you know, asking plans, you know, we'll reward  
17 the plans that are the most transparent, or the providers  
18 that are most transparent, etcetera. That's my own  
19 viewpoint.

20 MS. BREault: Just one comment with regard  
21 to the pricing. I think, at this juncture, we are not  
22 going to have really complete information with regard to  
23 the pricing of these plans, by choosing the coverage that  
24 has to be in the plan.

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1                   You know, I think, in another year, when  
2                   the carriers are gearing up to making these offerings,  
3                   they're looking at changing their networks. They may  
4                   have, you know, different negotiations with providers, so  
5                   we can get an estimate, based on current prices, but I  
6                   don't think we can really assume that that's necessarily  
7                   how things will be in a year. Just a caution there.

8                   MS. VELTRI: I agree with that. I'm just  
9                   saying, I guess I'm hoping that -- I know my Committee  
10                  will, and I'm hoping this Committee, when it addresses  
11                  innovation after the EHB discussion, gets to some of  
12                  those issues that can maybe drive the pricing equation.

13                  MR. GALVIN: Hi. This might be a question  
14                  to Bob. Vicki framed what I've been thinking about for  
15                  the last hour and a half, is are there any structures in  
16                  this process that helps prevent a potential logjam  
17                  between the thinking of the Consumer Committee and this  
18                  Committee as we roll along, or are we going to get to  
19                  August plus and not have a real succinct thinking between  
20                  the two groups?

21                  MR. CAREY: No. Our approach is to have  
22                  individual discussions initially, and then, as the  
23                  Committee begins to proceed down to coalescing around,  
24                  you know, a decision, that then we bridge those two

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1 Committees, and we'll see what the discussion -- what  
2 happens tomorrow during the Consumer Committee's meeting,  
3 and if there's anything sort of that we think that  
4 there's a significant divergence of opinion with regard  
5 to the issues and discussion, we'll make sure to bring  
6 that back to the Committee, but our hope is that, given  
7 that there is a limited -- you know, to a certain extent,  
8 the structure of the decision is limited, so there's not  
9 sort of an unlimited number of options available for the  
10 state, and, so, that, in itself, I think puts some  
11 confines around the ability for widely divergent  
12 opinions, at least with regard to the options on the  
13 table.

14 MS. JAFF: And just so everybody on the  
15 Committee is clear, I was voted by the Consumer Committee  
16 to be the liaison to this Committee, so some of the  
17 questions I've been asking and the points that I've been  
18 making have been questions and points that I think will  
19 be of concern to the Consumer Outreach Committee, and I'm  
20 certainly prepared to, you know, work with the co-Chairs  
21 of this Committee and work with the co-Chairs of that  
22 Committee, and make sure that there's good communication  
23 between the two Committees.

24 CHAIRPERSON ESPINOSA: We were just

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1 speaking on that situation, Jennifer, and I think that  
2 might be a good idea, for the co-Chairs to get together  
3 independently of the Committee, itself. We'll talk.

4 MS. O'GARA: Are there any other comments  
5 from the public? If you could come to the microphone and  
6 state your name?

7 MS. JILL ZORN: Hi. I'm Jill Zorn,  
8 Universal Health Care Foundation of Connecticut. I just  
9 would like -- I'm so glad that Vicki is here and Jennifer  
10 as the liaison.

11 I see an agenda here today that has  
12 Carrier concerns, Tribe concerns, and not consumer  
13 concerns, and I just hope that there's a way, perhaps  
14 through the Committee that Vicki co-Chairs, that we make  
15 sure that consumer concerns are brought back to this  
16 Committee, so that they are considered equally and  
17 weighed in the very difficult decision that you have to  
18 make.

19 And I also second Vicki's concern, about  
20 who makes this ultimate decision. I hope it will become  
21 more clear who is responsible for that decision, because  
22 that was certainly news to me, that it's an  
23 administrative decision only.

24 Usually, when we're talking about benefits

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1 in the state, the legislature certainly does weigh in, so  
2 I hope that will become more clear. Thank you.

3 MR. TESSIER: Jill, I'm one of the people,  
4 who, at the last meeting, when there was a brief mention  
5 of carrier concerns, I asked Bob and Tia to insure, and  
6 there may have been other people on the Committee who  
7 did, as well, but I remember asking, specifically, if we  
8 could either invite carriers in or if something could be  
9 done to kind of bring their concerns together, so that we  
10 had it explicit and out there.

11 I think it's a good thing for us to have  
12 it on the table and be aware of what they are. We want  
13 them to participate, and we ought to at least be having  
14 that dialogue.

15 MS. FOX: To the original point, I think  
16 it would make sense, at least, you know, in one of the  
17 ensuing meetings, to have a focus on the consumer  
18 concerns, as we did today on Carrier and Tribal, and I  
19 would include not just this Committee with the Consumer  
20 Experience as their charge, but, also, the work that's  
21 going on with Mintz and Hoke, which does touch a very  
22 broad range of people, and they're in the process, last  
23 week and this week, of reaching out to quite a few folks  
24 to get very detailed input on some of these very issues.

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1 MR. CAREY: So Mintz and Hoke is --

2 MS. FOX: So if we could bring it together  
3 here, I think it would make sense.

4 MR. CAREY: So given the topic and the  
5 time we had today, we didn't include Mintz and Hoke on  
6 the agenda. Mintz and Hoke is on the agenda for two of  
7 the Advisory Committees later today and tomorrow, but we  
8 can certainly bring them back, bring them to this  
9 Committee, so that they can discuss what they're doing  
10 with regard to consumer outreach and marketing approach  
11 that they'll recommend to the Exchange Board.

12 MS. CINTRON: And, to that point, if you  
13 have an interim meeting, co-Chairs and Committee, that  
14 they can possibly come to that, as well.

15 CHAIRPERSON ESPINOSA: Did the group you  
16 were mentioning, Mintz -- thank you. They're doing a  
17 webinar May 16th. I don't know if everybody has been  
18 contacted by them to participate, but, anyway, I was, so  
19 I'm planning on viewing that.

20 I think, also, I think it's good we talked  
21 earlier about, you know, the Joint Committee meeting. A  
22 lot of those issues can be addressed, so, I mean, I hope  
23 that we're going to focus on an overlap of Committees to  
24 address those kinds of issues, consumers and whatnot.

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1 MS. O'GARA: Okay, then, Anne, I think,  
2 and Mark, if you want to call the meeting to an  
3 adjournment?

4 CHAIRPERSON ESPINOSA: So moved to the  
5 motion of adjournment, and we had a second by Bob. Thank  
6 you.

7 (Whereupon, the hearing adjourned at 11:03  
8 a.m.)

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