

VERBATIM PROCEEDINGS

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

JULY 11, 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, held at the Legislative
4 Office Building, 300 Capitol Avenue, Hartford,
5 Connecticut, on July 11, 2012 at 9:05 a.m. . . .

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CHAIRPERSON ANNE MELISSA DOWLING: If
10 everybody is ready, we'll get started. Sorry we're
11 starting a little bit late. I'm Anne Melissa Dowling,
12 and this is Mark Espinosa, your co-Chairs for the Health
13 Plan Benefits and Qualification Advisory Committee.

14 I would like to make a couple of comments
15 as we start our meeting, and we're also going to do one
16 small change in the agenda. The public comments, we have
17 two people, who would like to speak. We're going to move
18 that up to the front of the meeting.

19 So, actually, why don't I have the two of
20 you come. Let's have Nicole first, and then we'll get to
21 the business of the meeting. This is Nicole Stacy.

22 MS. NICOLE STACY: I thank you for bearing
23 with me. I've never done this before, and I'm pretty
24 nervous. I am 26 years old. I live in Hartford. The

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1 reason I'm here is because I understand that at a public
2 hearing on June 8th it was unanimously decided that
3 abortion should be considered an essential health benefit
4 in implementing federal laws on the State level.

5 Well, apparently, nobody showed up to
6 contest this. As it turns out, by remarkable
7 coincidence, about 500 of us were down in New Haven at a
8 well-publicized rally for religious freedom. I was one
9 of them.

10 I found out about what happened by reading
11 about it in the Connecticut Mirror. What really floored
12 me was a statement, that the issue is favorably resolved
13 for all women in Connecticut, and I'm here to tell you
14 that's just not true.

15 It's not true for female taxpayers, who
16 object. It's not true for unborn girls or for the
17 desperate women, whose choice is not a choice in any
18 meaningful sense of the word.

19 I'm not here to mince words. I believe
20 it's an undisputable fact, that abortion kills a human
21 being. Now you may think that I am young and naive and
22 will come around some day, but I've spent years looking
23 for answers to questions, like what problems has abortion
24 solved? What diseases does it cure or even treat?

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1 How is the overall lot of women improved
2 by there being many fewer of us around? And I am not
3 impressed by the answers. I volunteer at St. Gerard's
4 Center for Life every week, and I know that there is a
5 better way.

6 There was a time, when most people agreed
7 abortion is tragic and should be reduced. Was that only
8 lip service?

9 When elective abortion is considered an
10 essential health benefit, we really have failed women,
11 if, in fact, we could truly fail on the current level of
12 effort that I feel that we are putting into it.

13 It offends my sense of justice, that life
14 affirming places almost always are the underdog, fighting
15 for every scrap they can get.

16 This is the moment of truth, and I really
17 cannot afford not to rise to the challenge. We need to
18 see that women deserve so much better.

19 I thank you for your time, and that's all
20 I have to say.

21 CHAIRPERSON DOWLING: Thank you very much.
22 I respect your point of view. And this is Jennifer
23 Landry.

24 MS. JENNIFER LANDRY: Hi. I'm Jennifer

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1 Landry. I'm a 27-year-old woman, a lifetime resident of
2 the State of Connecticut, and I have, you know, the same
3 point of view, in that I'm very concerned, extremely
4 concerned, and I feel just completely just at a loss of
5 words, loss for words, in terms of how women are being
6 assaulted in this country right now and now at the State
7 level, by the State putting abortion as part of, and
8 abortifacients, as part of women's health care.

9 That's an assault on who I am as a woman.
10 It's an assault on my reproductive system. My
11 reproductive system is not a disease, and I would -- I'm
12 appalled that it's being treated that way.

13 Abortions, abortifacients, all these
14 things really hurt women, and there are tons of women out
15 there, who go around with scars, because of these things.
16 Not only is it not truly a part of women's health care,
17 but it's actually an assault on women.

18 And, so, I plea, I beg that abortifacients
19 and that abortions are not considered part of women's
20 health care. Thank you.

21 CHAIRPERSON DOWLING: Thank you. Thank
22 you, both, for coming and expressing your views.

23 MS. LANDRY: Thank you for letting us
24 speak.

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1 CHAIRPERSON DOWLING: We have a third
2 person. Robert Muckel. I hope I'm pronouncing that
3 correctly.

4 MR. ROBERT MUCKEL: My name is Robert
5 Muckel from Waterbury, and I just heard about this
6 hearing yesterday afternoon, so I just wrote something
7 down, if you can bear with me, okay?

8 When talking about health these days, it
9 seems that, for some reason, abortion is included with
10 health care. I'd just like to make the comment that
11 abortion is the destruction of innocent human life that
12 has an eternal destiny, because it was human from the
13 first moment of fertilization.

14 When talking about abortion, nothing is
15 ever said about the mother of the baby that was destroyed
16 in her womb. In years to come, when she gets married and
17 has a baby, more than likely the baby will be born
18 premature. This is common for women, who have had
19 abortions. The babies are always born premature.

20 Babies that are born premature, they have
21 a great possibility of having health problems as they get
22 older, so besides the trauma of her previous abortion or
23 abortions and the future of the babies yet to be born, if
24 abortion was illegal, these problems would never come up.

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1 Do everything you can to make sure that
2 there is no abortion in health care legislation.
3 Abortion has nothing to do with health, only death, death
4 of the baby and all kinds of physical and psychological
5 problems for the mother and for society. I'd like to
6 make those comments.

7 CHAIRPERSON DOWLING: Thank you very much.
8 Thank you, all of you, for coming this morning.

9 A couple of thoughts, just to start off
10 our meeting, and Mark will chime in, as well. You
11 received a memo from Mark and I or on behalf of Mark and
12 I last night.

13 First of all, let me state what it is and
14 what it isn't for the committee. It is, as you've seen
15 us conduct ourselves the last two meetings, we have put
16 straw men out there to be considered, just to get the
17 conversation going.

18 In this case, this is something that we've
19 put a recommendation up for consideration, very
20 consistent with the way we've done it in the past. I
21 think there is some inconsistency in the work that was
22 done that may say in one place it was from the Chairs of
23 your committee and in other places said it was from the
24 staff. Let me say to you it was at our request that a

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1 straw man be put out there for consideration this
2 morning, just to move the process along. Whatever the
3 vote is is the vote, but it's a formality of a way to
4 conduct a meeting, so that we have something to talk
5 about.

6 I also want to remind you all that this
7 staff went from almost nothing to a couple of people, who
8 are staffing all of these committees now, and they all
9 meet this week, and rather than pointing out the errors
10 that they are making or contradictions in memos, I'd like
11 to take the time to thank them for the enormous amount of
12 work that they get out to us, the data to all of the
13 committees, to all of the constituencies, to all the
14 points of use, and you're only probably seeing what you
15 see on e-mail, all the work that's done, and the calls
16 that come in and all that, so I'd like to take the time
17 to thank them for everything they have done and want to
18 be very careful this morning not to spend most of our
19 time talking about errors, because of time constraints
20 and pressures.

21 I talk to these people first thing in the
22 morning, I'm talking to them again at 6:30, 7:00 at
23 night, and I would just like to take a moment to
24 appreciate all that they do get out for us.

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1 So let me be clear, that this is from us,
2 that everybody on this committee has an equal vote, has
3 an equal say, but there are Chairs of a committee, and
4 our purpose is to set agendas. Our purpose is to try to
5 conduct a meeting in an efficient way.

6 We have time constraints on us, so
7 sometimes we're going to set up meetings, so that we can
8 move towards achieving our deadlines.

9 And, this morning, we're going to conduct
10 a meeting differently. Mark and I will be facilitating
11 the meeting, which means that any comments come through
12 us, as opposed to just speaking up across the room, so
13 that we can organize it and so we make sure everybody
14 gets an opportunity to speak fairly and balanced.

15 And, so, what we will be discussing, after
16 we go through minutes and some administrative work, will
17 be this straw man, whether that's where we end up.
18 That's for the committee to decide, but it is a formal
19 structure. It's done in most meetings, where you put
20 something up for a discussion. Anything else you want to
21 add?

22 CHAIRPERSON MARK ESPINOSA: Well said.

23 CHAIRPERSON DOWLING: Okay. All right,
24 so, first, we need to just do some simple administrative

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1 work, which is to approve our minutes, and it looks like
2 we have one correction to make, and others may have some.

3 On page two of the minutes of June 19th,
4 the first sentence is just going to be removed. It's
5 incorrect. We had, in fact, eliminated the federal plan.

6 Are there any other comments to either set
7 of minutes here from the 19th or the 8th that anyone
8 would like to add before we vote to approve these minutes
9 with that one change?

10 Okay. Could I hear a motion to vote on
11 the minutes? Okay and a second? Thank you. All in
12 favor?

13 VOICES: Aye.

14 CHAIRPERSON DOWLING: Any opposed? All
15 right, thank you very much. I'm going to turn this back
16 over to staff first. I think there was going to be some
17 discussion of mental health parity that came up in our
18 discussion last time.

19 MS. JULIE LYONS: Good morning, everyone.
20 The focus of our conversation is going to primarily be on
21 essential health benefits, but this issue with regard to
22 mental health came up in our conference call on June
23 19th, and, basically, it was just there were two issues.

24 The first issue had to do with a

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1 clarification on the coverage provided through the mental
2 health parity law, and, basically, mental health must be
3 treated the same as a physical condition, so there cannot
4 be any terms or conditions, cost-sharing measures, prior
5 authorization protocol that could be more restrictive
6 than a medical service.

7 The second issue was -- oh. That's under
8 Connecticut law and federal law. The ACA extended the
9 same measures. With the passage of the ACA, it now
10 extends it to small groups, as well as large, where,
11 prior to, it was just large groups, so now federal and
12 state law kind of go hand-in-hand together.

13 The second issue is with regard to
14 cognitive behavioral therapy and whether it was a mental
15 health benefit, and our research has determined it is
16 considered a type of therapy to address mental and
17 nervous conditions.

18 Although it's a relatively new type of
19 therapy, new being since the '70s, but it is considered
20 part of the mental nervous conditions.

21 That's really it. It was just a high
22 level kind of overview. Do you have any questions?
23 Okay, good.

24 All right, so, on to the essential health

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1 benefit discussion. We have, at this point, we're going
2 to discuss the variations in the four remaining options,
3 as well as hope to make a decision on the prescription
4 drug coverage, pediatric dental, and the pediatric vision
5 services.

6 The four remaining benchmark options are
7 very similar. They provide for the same coverage
8 services throughout all the plans, and the major
9 differences amongst them have to do with the variations
10 in some visit limits.

11 The visit limits that primarily differ
12 amongst the plans, you know, are with regard to home
13 health care, physical therapy, occupational therapy,
14 speech therapy and skilled nursing facilities.

15 On this next slide, we have a chart. We
16 supplied you with numerous -- a number of charts with
17 lots of data with regard to coverage services. This grid
18 is just showing differences amongst the coverage services
19 and the benchmark plans.

20 And, as you can see, there's very few
21 differences. The coverage is, you know, 10 visits here,
22 10 visits there.

23 DR. ROBERT McLEAN: I have a question on
24 that. Could I ask a question on that? Yeah, sorry.

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1 Some of this may have been answered. I had to miss the
2 June 19th meeting, so this may have been answered then,
3 so I apologize if it's repetition, but one of the big
4 issues that we had discussed, or one of the issues that
5 came up at the last meeting in June was with physical
6 therapy type rehab services, whether these were total
7 number of visits per year or per condition.

8 And I see on this it looks like, at least
9 for the Anthem and in this chart from what I read, under
10 the Anthem, the first column, it says it's 30 days per
11 condition, and the others say just per year, so should I
12 assume that that is total for the year and not specified
13 per condition, unless it says that?

14 MS. LYONS: Yes.

15 DR. McLEAN: Okay. And the other thing
16 was, on the ones listed on this table, it doesn't
17 actually list the one that we had kind of detailed in the
18 memorandum, which is the Aetna point of service. It says
19 an HMO. Is that the same plan?

20 MS. LYONS: Oh, I'm sorry. That's a typo.
21 It should be Aetna POS.

22 DR. McLEAN: In the table?

23 MS. LYONS: Yes.

24 DR. McLEAN: Okay, thanks.

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1 MS. LYONS: Thank you. Okay. In one of
2 our meetings with the Consumer Experience Advisory
3 Committee, they had asked about the number of -- they had
4 asked for data on if the -- sorry. Okay.

5 They've asked for data with regard to if
6 the benefits that had limits were often exhausted by
7 membership, so we were able to get this information from
8 the State Controller's Office on the self-funded plan,
9 which shows that, on the left-hand margin going down,
10 that's the number of members, and across the bottom would
11 be the numbers of visits allotted.

12 According to the data, fewer than one
13 percent of all the members reflected here used or needed
14 more than 20 visits of physical therapy, you know,
15 occupational therapy, or speech therapy, so we were
16 unable to get the information from the carriers, because
17 this is a very -- it's very hard to get to that level of
18 detail, but we were able to get it for the State plan.
19 Likely, because it's a self-funded plan, and they
20 probably track things a little bit differently.

21 MS. JENNIFER JAFF: Excuse me. May I ask
22 a question? I see that there's a memo here from
23 Milamin(phonetic), that supplements the utilization data
24 that was on your last screen.

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1 MS. LYONS: Yes.

2 MS. JAFF: And it's dated July 2nd. Could
3 you just tell me when the Exchange staff received this
4 document from Milamin?

5 MS. LYONS: I believe it was last Friday.
6 I'm sorry. Thursday or Friday.

7 MS. JAFF: So is there a reason that it
8 was not shared with the Consumer Outreach and Experience
9 Committee yesterday?

10 MS. LYONS: No. It was an oversight. I'm
11 sorry.

12 MS. JAFF: Okay.

13 MS. LYONS: It was in the information.

14 MS. JAFF: Okay and, again, going back to
15 your last slide, I just want to state for the record that
16 I spoke with the Comptroller this morning, and he said
17 that I could represent to this committee that he believes
18 that the utilization data from the State Employee Plans
19 is not applicable to the market as a whole, that there
20 are strong utilization review mechanisms in place in the
21 State Employee Plans.

22 There are also things, like patient-
23 centered medical homes, all of which would affect
24 utilization rates, and, so, that would distinguish the

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1 State Employee Plans from some of the other plans that
2 we're looking at.

3 MS. LYONS: Okay. Thank you for that
4 information. Given the few differences between the
5 benchmark options that we just went through, I don't know
6 if, Anne Melissa and Mark, if you're ready to throw out
7 the straw man for a vote, or how you want to handle.

8 CHAIRPERSON DOWLING: Well, I think,
9 because it came so late, you know, and everything, we
10 should, before we get to a vote, we should have
11 discussion, but we can probably key it up simply by
12 saying, first of all, thank you for getting some
13 utilization data, because this is -- we thought we were
14 going to get none, and you got the State, and that's
15 excellent, so thank you very much for that.

16 It's one of the largest groups out there,
17 so, I mean, nothing we get from any carrier is going to
18 represent the State of Connecticut, not only today, but
19 in the future, because the composition of those utilizing
20 the Exchange will, clearly, we talked about at other
21 meetings, will be different, but we're using the best
22 data you have to make a point, and I think it's a very
23 interesting one.

24 I think Dr. McLean raised that last time,

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1 which was, you know, there was a lot of thought put into
2 a number of these limits, and that people were not seeing
3 them exceeded frequently, and they seemed to be suitable,
4 and that I will tell you, from the Department of
5 Insurance, we have zero complaints for hitting limits, in
6 terms of needing more utilization and all that, so we're
7 just not seeing it from our point of view either for the
8 other plans that represent other parts of the State of
9 Connecticut that also have very rigorous utilization
10 review processes in place at all those companies.

11 Remember that what we put out in this memo
12 there's the name Aetna, but we're not talking about
13 Aetna. We're talking about the components of its plan,
14 so please try to, when you look at this, look at the plan
15 and not think about the carrier's name, because that is
16 irrelevant, other than the fact that it's a very well-
17 respected and national company.

18 Also, remember that what we're operating
19 under here is the Affordable Care Act, and one of our
20 principles that we voted on in one of our first meetings
21 is to establish essential health benefits that allow
22 these plans to be affordable, and I would think the worse
23 thing we could do is not respect the balance between
24 affordability and comprehensiveness, because if we put

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1 something out there and then nobody can afford it, it's
2 cruel, so I want to make sure that we balance this.

3 So what you see here is, as we discussed
4 at our last meetings, very few of the plans have any
5 differences amongst them, other than these few items, and
6 we are, from what the data we could get through staff
7 only as recently as a couple of business days ago from
8 the State, is the only proxy we have for the utilization
9 materials that the committee had asked for, and, so,
10 we've gotten it when we've gotten it.

11 We've talked about how compressed our
12 schedule is, and we're trying to get a lot of work done,
13 you know, with data coming in real time, which is very
14 hard and makes everybody very uncomfortable, but it is
15 what it is, so I'd ask for a discussion what you see
16 presented to you.

17 The Aetna plan is the one that probably is
18 most restrictive on these, but we're suggesting that the
19 restricted nature of it is not harmful. It is not having
20 a series of complaints behind it, and, therefore, it
21 would address the balance of affordability, as well as
22 comprehensiveness, so that was the spirit in which we
23 threw something out there to vote about.

24 MR. STEPHEN FRAYNE: Thank you. When I

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1 looked at this material and the material from last night,
2 I, just because I think you want to initiate some
3 discussion about this, I came at it from a slightly
4 different perspective, and the perspective I came at it
5 from was, looking at the same issue of that the benefits,
6 even though it's a little bit more restrictive in the
7 Aetna form, that it doesn't create that much of a
8 problem.

9 It would seem, if that's true, which I'm
10 assuming it is, then it shouldn't be expensive either,
11 those added benefits, because, obviously, if people
12 aren't using the benefits, it's not being priced into the
13 product as an expensive add-on to the benefits.

14 So when I looked at this information, I
15 kind of took the approach of saying perhaps we don't want
16 to go with a skinniest set of benefits, even though
17 they're on the margin, in terms of the difference, and
18 perhaps we don't want to go with the most robust set of
19 benefits, which would be the State health plan, so I came
20 out on the, for different reasons, in the same place that
21 the consumer group did, which said, well, you know, if
22 you wanted to be someplace in a product, which is
23 available in the market, has a good set of benefits, you
24 know, I would go more on the ConnectiCare model, as

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1 opposed to the skinniest model that was available, so
2 that's the rationale, in terms of how I was proceeding on
3 it, but just throw it out for discussion.

4 DR. McLEAN: I think I have to agree. I
5 think, as we discussed this last month, I think there's a
6 major thing, and I come at this from the angle of being a
7 physician, that if somebody has a given medical
8 condition, what are they going to need, and I think that
9 the fact that, on average, 90 percent of people had 20
10 visits or fewer, in terms of what was in the memorandum,
11 that's kind of reassuring, that these are not necessarily
12 being over-utilized or utilized a lot by most people, but
13 I kind of have to think about the person, who has a
14 stroke, or has a particular episode, that this is going
15 to be clearly inadequate.

16 So it's great for the 90 percent, but the
17 10 percent of people, who may fall in there, you know,
18 this is going to potentially be a real problem if this is
19 the only means they have to access insurance.

20 So I still have concerns about the limits,
21 especially when it's total limits and not limits per
22 episode. And I know that we have limited choices to
23 choose from, but I think, kind of following up on what he
24 just said, I would tend to err on the ConnectiCare type

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1 plan as the Consumer Committee leaned toward, largely
2 because I think that there are a lot of people, if it's
3 10 percent of the utilizers and whatever, who this could
4 be really problematic and expensive for.

5 MS. JAFF: I have circulated two memos,
6 and I want to be very clear about the distinction between
7 the two. First, reports to you on the actions taken by
8 the Consumer Outreach and Experience Committee yesterday.

9 That is a report with no editorializing.
10 As the liaison between those two committees, part of my
11 job is to communicate to this committee what happened in
12 the Consumer Committee, but I want to distinguish that
13 memo from a memo that I submitted that comes from me that
14 is on my organization's letterhead, which I want to make
15 it very clear that these are not the views of the
16 Consumer Outreach and Experience Committee. These are my
17 views.

18 I have several concerns, and I know that
19 you'll all take a look at my memo, and if anybody doesn't
20 have it, there are extra copies at the table up front, so
21 I'm not going to go through all of it.

22 I am concerned, however, with several
23 issues. First of all, I don't think that it's -- I don't
24 think we can just assume that Aetna made an appropriate

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1 or correct judgment with respect to the balance between
2 costs and benefits, and I think that the memo from the
3 co-Chairs is wrong, when it suggests that we can rely on
4 that.

5 We know that Anthem and ConnectiCare did a
6 similar analysis, and they came to different conclusions
7 than Aetna did, and I'm sure that all three companies
8 would be, you know, would have different rationales for
9 why they came to three different benefit packages, but I
10 don't think that we can assume that Aetna is any more
11 correct than any other company.

12 Second, there is reference to an opinion
13 of an independent actuary. I've been told this morning
14 that there is no written report from the actuary,
15 however, in the memorandum, there is a representation
16 that this actuary said that Aetna represented the best
17 combination of benefits and costs.

18 The only way an actuary could have come to
19 that conclusion would have been to assess not only the
20 Aetna plan, but, also, the Anthem and ConnectiCare plans,
21 so that they, and the State employee plans, so that they
22 could all be compared, and, so, that the actuary could
23 come to a conclusion favoring the Aetna plan.

24 I would like to know what the actuarial

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1 difference is, what the cost difference is between or
2 among the Anthem, Aetna, ConnectiCare and State employee
3 plans, you know, if, in fact, the actuary did that kind
4 of analysis.

5 I also I have to take exception to the
6 language of the memorandum that refers to people with
7 higher utilization needs as unfortunate. People, who are
8 sick, who have chronic illnesses and disabilities, should
9 not be referred to as unfortunate.

10 One of the segments of the population that
11 will be added to the individual market in January 2014
12 are people with pre-existing conditions, who have been
13 unable to get insurance up until now.

14 We need a benefit package that serves the
15 needs of everybody, including people with pre-existing
16 conditions.

17 Next, if, in fact, the marginal cost of
18 expanding the visit limits is small enough, so that any
19 individual consumer would be able to pick up that cost on
20 their own, if it's such a small marginal difference, then
21 why go with the most restrictive benefit plan, rather
22 than going with something that costs a very small amount
23 more, but that provides a less-restrictive benefit
24 package?

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1 I also want to point out that the
2 rehabilitation benefit will be the model for the
3 habilitation benefit. As you know, there is no
4 habilitation benefit in any of the plans that we're
5 looking at as benchmarks, and, so, as the staff and the
6 consultants have told us repeatedly, that benefit will be
7 filled in by the plans, and it will be based on the
8 rehabilitation benefit.

9 So to the extent that we choose a
10 restrictive rehabilitation benefit, we should be very
11 conscious of the fact that we are tacitly choosing a
12 restrictive habilitation benefit, as well.

13 And, finally, I want to point out that
14 Aetna's enrollment is significantly lower than both
15 Anthem's and ConnectiCare, and I know that one of the
16 things that we've talked about several times in the
17 meetings that we've had about these essential health
18 benefits was that we wanted to find something that would
19 disrupt the market as little as possible.

20 And, so, to choose the plan with the
21 lowest enrollment seems to me to be contrary to that
22 goal. That's all I have. Thank you.

23 CHAIRPERSON DOWLING: Thank you for going
24 through this last night. I know it was very short notice

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1 in preparing those thoughts, so thank you very much.
2 What we're dealing with, I think, are the four top ones,
3 and that's what we've got to deal with, and I think, you
4 know, hopefully none of those would be disruptive.

5 MS. MARY FOX: Excuse me. Anne Melissa,
6 may I ask one question?

7 CHAIRPERSON DOWLING: Yeah.

8 MS. FOX: And maybe I should know this,
9 and it's more of a technical or process question, but, as
10 we make these decisions, I'm not completely clear on
11 whether we, as the Exchange, can put the benchmark out
12 there, but, as we submit our QFP, whatever the process
13 is, to the carriers, so that they, in return, submit
14 plans to us, can we provide additional direction with a
15 benchmark and say, well, here's something that the
16 Exchange is very interested in?

17 Maybe address some of these issues, where
18 there's one plan that looks right, but it's not as
19 comprehensive in one particular area, it doesn't seem to
20 have an actuarial impact?

21 Can we provide that kind of direction to
22 the carriers and then choose the plans that maybe are
23 competitive and are innovative, in terms of addressing
24 that?

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1 CHAIRPERSON DOWLING: I'm not sure of it
2 either. I mean the purview of the Committee is just to
3 determine the basics of the essential health benefits. I
4 think our next set of work can figure out what kind of
5 incentives we want to suggest, and we need to work with
6 the SHOP Committee and others to see how they select, but
7 I think we have to just pick the baseline that they have
8 to work from. I think that's all we can do right here.

9 Anything we want to do from the Exchange
10 I'm sure we can suggest go further, but I don't know that
11 we can penalize if they do just the minimum.

12 MR. FRAYNE: I don't know if there's any
13 more discussion, but, if there isn't, I'd be happy to
14 make a motion, at least, so we can move the debate along.

15 CHAIRPERSON DOWLING: If I can reserve
16 that for one second? Thank you. The only thing I'd ask
17 us to consider, and I really appreciate the conversation,
18 because this is all wanted to do.

19 We had hoped to get this memo out before
20 we had heard, and we didn't have any idea that we were
21 going to hear from the Consumer Committee, so, either
22 way, we've got something to talk about, which is great.

23 The only thing I am concerned about is
24 that there is going to be a much larger constituency

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1 participating in Exchange products, and we have heard
2 from the marketplace that it is going to price in an
3 assumption about the expanded pool and the expanded
4 pool's probably pent up demand and utilization and so on,
5 so we just need to keep that in mind either side of, you
6 know, the vote on this, that, so, therefore, pricing, you
7 know, is probably going to go up, no matter which one we
8 pick, because there's got to be an assumption of the risk
9 pool that you're going to be undertaking.

10 MR. ROBERT TESSIER: Thank you, Anne
11 Melissa. I guess let me start by saying I, too,
12 appreciate the work that the staff have done, that the
13 co-Chairs have done.

14 I want to thank Jennifer both for the work
15 that she did in reporting on the Consumer Outreach
16 Committee and, also, her own document that she put
17 together over night and your report this morning.

18 I think it's all useful, helpful, and I
19 agree with a lot of what your reactions are to that memo,
20 but I do think that the co-Chairs attempted, and I
21 appreciate it, have attempted to get us to a decision,
22 and I feel a little bit responsible, in previous meetings
23 and the last meeting conference call, for kind of holding
24 out for better information about why the State employee

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1 plans, which are a robust package of benefits, you know,
2 are not a realistic option.

3 I am convinced, after listening to a
4 couple of members of the Consumer Outreach Committee,
5 about how they reached their decision yesterday, and,
6 after reading the memo last night, am convinced that the
7 basic message is that the differences really are on the
8 margins.

9 And I can appreciate, if that's the case,
10 wanting to go with what may be the least costly, but I
11 just want to say I'm more sympathetic to the comments
12 that Steve Frayne made and Jennifer, that we should err
13 on the side of caution in making sure that the Essential
14 Benefits Package is adequate for people's needs. And,
15 obviously, we may make adjustments over the years as we
16 go on.

17 So I would say I'm in agreement with
18 Steve's sentiment, in terms of the ConnectiCare package.
19 I could live with the Anthem package, as well. I think
20 either or both of them are a little bit, again, at the
21 margins, a little bit better protection for people, who
22 are more in need of those services, but, in either case,
23 we'd be making, I think, a decision that balances costs
24 with services, and I'm perfectly happy to go with and be

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1 supportive of the consensus in that regard. Thank you.

2 CHAIRPERSON ESPINOSA: Bob, I'm
3 appreciative of your comments, and you made me think, and
4 I'm glad you used the words -- well, I forgot the words,
5 but the sentiment was making adjustments. I think that's
6 what you said.

7 I think that we should be erring on the
8 side of caution, yet recognizing the fact that, you know,
9 adjustments could and should be made and may have to be
10 made, and, you know, none of us have a crystal ball.

11 I mean the founding fathers wrote a
12 Declaration of Independence and didn't know anything what
13 was going to happen beyond that, and the Constitution of
14 the United States was written, and there were amendments
15 made to that.

16 I'm a historian, so I could go into all of
17 the benchmarks of how this country was formulated, but
18 none of us are perfect, and we're going to probably make
19 some mistakes in our decision making, and we'll have to
20 react to it as we can, so, in an effort to get to a
21 decision, I'm just hoping that people recognize that
22 there may be adjustments that need to be made down the
23 road.

24 None of us know what's going to happen,

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1 and I'm glad that we're getting to a point, and I thank
2 the staff, as well, for a lot of work that's gone into
3 this to get us to this.

4 I mean we are only one of, what, 15 states
5 in the Union that are as far along as we are. I think
6 that's pretty great.

7 Ex-Governor Rowland, John Rowland, on the
8 radio yesterday, talked about the possibility of creating
9 some kind of an Exchange in Connecticut. I was going to
10 call the radio yesterday and lambaste him, but, anyway,
11 that's another story, so thanks for listening.

12 CHAIRPERSON DOWLING: Thanks, Mark.
13 Before we go to a vote, I just want to make sure. There
14 are some of you that we haven't heard from on the
15 committee, and if there is just gut reactions, thoughts,
16 anything, I just want to make sure you have an
17 opportunity to speak or ask questions, because I want to
18 just make sure we have equitable participation.

19 (Off the record)

20 MS. GLORIA POWELL: Gloria Powell,
21 Department of Public Health. My questions have been or
22 are about I guess actuarial impact on whatever plan is
23 chosen, because of our concern with affordability, and my
24 understanding of how group insurance works is that, with

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1 shared risk, that there's a greater number of healthy
2 adults, who are enrolled, and that that shared risk,
3 then, allows for a lower cost. Is that impact possible
4 or anticipated for our health plan?

5 CHAIRPERSON DOWLING: Thank you. That
6 really is the crux of the question. It's so speculative,
7 in terms of whether we're going to have all those younger
8 healthy people joining in and, in fact, lowering the
9 risk.

10 We just don't know, and we can maybe take
11 a minute and talk about what we know about or what we've
12 heard from Massachusetts, but we don't know. That is the
13 design. I think that's the fundamental premise of the
14 risk plan of the Affordable Care Act, but we just don't
15 know.

16 And in the transition, we have a couple of
17 actuarial facts. I mean the lowest plan starts at about
18 a 60 percent cost sharing, and, right now, a lot of the
19 plans out there are well below that, you know, 50, 55
20 percent, so already, at the least expensive plan, there's
21 going to be a rise in cost, then we're spreading it
22 against a hoped for population of younger people
23 participating, and we're also expecting a number of
24 people to join with pent up health problems, but that may

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1 be wrong. These are all assumptions, but we think that
2 the products will be priced as a company would do
3 assuming the worst. That's the way risk management
4 generally happens, and then they'd modify years out.

5 My concern is that even if we took the
6 cheapest, most restrictive set of benefits, the price is
7 still going up for the first couple of years, just based
8 on where the metal plans begin.

9 And, then, if we add more visits, or
10 whatever it is we need to do, and then we increase the
11 risk of the population, it's still going to be highly, a
12 fairly high rate.

13 Now, over time, I think what we're hearing
14 is that incredible innovations start happening, narrower
15 network options start happening. A lot of things happen
16 that keep the pricing down. I just don't know if they're
17 going to happen in year one, and I feel the great weight
18 of responsibility, for this committee to make sure that
19 we don't do something that feels good that nobody can
20 afford.

21 It's all speculative, because pricing is
22 done, as you know, on actuarial assumptions, based on the
23 best information out there, and I'm just hoping we don't
24 give them assumptions that require higher and higher

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1 costs loading, because we just don't know, so your
2 question is the crux of this whole decision.

3 I don't know if anybody else on staff has
4 comment or perspective on that. If not, you know, we're
5 where we are.

6 DR. McLEAN: I would just add I think a
7 comment I already made, but while it's helpful to see how
8 many enrollees these various plans had, from my
9 perspective there's so many factors that go into that
10 it's almost irrelevant.

11 I mean I think we need to kind of look at
12 in a vacuum, relatively speaking, of what services do
13 people need from a health care standpoint. If Aetna,
14 ConnectiCare, Oxford, whoever, had more or less
15 enrollees, the multiple factors that weigh into that are
16 the local market, what their employer chose, how many
17 doctors were in the network.

18 I mean there's just so many factors there,
19 so the fact that Aetna was lower I don't really know how
20 to interpret that. It may be important. It may not be.
21 That doesn't really weigh in when I'm looking at the
22 plans.

23 I'm really looking at what is the benefit
24 that I think an average patient is going to need, and

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1 what is someone going to need if they have something
2 disastrous. And my earlier comments on the
3 rehabilitation PT type stuff, you have to kind of keep
4 that in mind.

5 You have someone, who has a devastating
6 condition or illness, you want to at least cover the
7 start of that, without making -- you know, we're trying
8 to avoid people going bankrupt from health care expenses,
9 so if we're going to provide an essential health benefit,
10 that's got to be part of the goal, too.

11 And since these people have said the
12 margin of difference here is pretty low, as others have
13 said, I would err on the side of trying to give the
14 people of Connecticut, you know, the most reasonable
15 essential benefit package, realizing that some of these
16 insurers are going to say, hey, you know, we can provide
17 more visits or whatever, but we need to kind of decide
18 what that minimum is.

19 DR. JOE TREADWELL: Hi. Joe Treadwell. I
20 agree with what Dr. McLean is saying. Unfortunately, I
21 do a lot of amputations in patients with diabetes, and I
22 know we're not just talking about these four options that
23 we're seeing here, as far as home health care skilled
24 nursing. There's a lot of other things, but if we just

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1 had to go off of this chart here, to me, Aetna wouldn't
2 even be in the running, because people, who have open
3 amputations, they can't leave the hospital with closed
4 incisions. They're not even healed within 20 or 30 days,
5 and, then, if you throw on top of that strokes,
6 congestive heart failure, cardiac complications,
7 rehabilitation, the numbers listed by one of these
8 excludes it completely in my mind, where you're just not
9 providing service to a patient.

10 If that's what we're trying to do, Aetna
11 is what we're seeing here is not getting it done.

12 CHAIRPERSON DOWLING: What's your
13 experience with your patients, in terms of coverage? How
14 have you experienced that?

15 DR. TREADWELL: Well I have two patient
16 clienteles, one through my private practice, and then I
17 work with the indigent clinic Medicaid clinic out of the
18 Hospital of Central Connecticut, and we're talking about
19 a population, whose chronic illness, because the medical
20 home is not established, is huge, and those costs are
21 significant in that population, and that's the group
22 we're talking about right here.

23 The cost factor actually does become an
24 issue, besides just the services we're providing, because

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1 if we price them out, it goes back into a situation we
2 have now. These patients come into the ER for
3 everything, as opposed to being able to afford a plan.

4 CHAIRPERSON DOWLING: I was asking if,
5 when you make an appeal for your patients to the company,
6 do the companies tend to add coverage or no? Your
7 experience.

8 DR. TREADWELL: This is anecdotal, and I'm
9 sure this will get me into trouble, and I'm sure Dr.
10 McLean has run into this. I just want something simple,
11 like an MRI, and the patient was actually riding a
12 motorcycle, was hit by a car, was seen in the emergency
13 room, and then referred to me appropriately, and the
14 insurance company people were sitting there, reading off
15 of the list, saying have they had four weeks of
16 conservative care? Have they had anti-inflammatories?

17 I was like the person was hit by a car on
18 a motorcycle. I need to assess other things, besides
19 just the bones, and they had other issues, and they said
20 no, so I actually called a department here within our
21 state to advocate for the patient, and what they went and
22 said to me the paperwork for the insurance company
23 supports what they did.

24 I was like, but isn't it your job to

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1 protect the patient? And I never heard a response after
2 I sent that nasty e-mail, but it's very difficult
3 sometimes to get services that you need.

4 CHAIRPERSON DOWLING: If that was my
5 department, let me know, and we'll talk about that later.
6 Thank you.

7 DR. McLEAN: I'll add a specific detail.
8 So, for example, I mean, as I mentioned earlier, if
9 someone has a stroke, you know, if someone has a
10 devastating stroke, they're going to be needing intensive
11 physical therapy to strengthen and get all their mobility
12 back, all those kinds of things, if they can, and, you
13 know, under the Aetna POS product, outpatient PT is,
14 presuming once they left the hospital, is 20 visits per
15 year.

16 So if the person is going, people are
17 going two or three times a week for physical therapy, you
18 know, an hour, whatever it is, I'm not that closely
19 related to exactly how physical therapists might be
20 appealing this, but that's a month.

21 Three times a week -- actually, I'm sorry,
22 it's like six weeks. Whatever. People need months and
23 months of physical therapy to recover from some of these
24 kinds of conditions, so that's the thing that jumped out

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1 at me. Twenty visits of outpatient PT for the year is
2 clearly inadequate, unless you have some, you know, minor
3 reversible injury. Just about everything else has a very
4 good chance it's going to require more than that.

5 MS. JAFF: And I appreciate that the
6 Insurance Department has not had complaints about visit
7 limits, but we get those kinds of complaints all the
8 time.

9 One Connecticut consumer, in particular,
10 comes to mind. She has fibromyalgia. It's pretty bad,
11 and when she is able to go to physical therapy, she's
12 able to work and manage her household and all of that,
13 but when she gets to the point of the year, where she
14 hits her annual visit limit, she ends up losing her job,
15 because she can't get to work, because she's in so much
16 pain, and she just can't move well.

17 And, so, she's constantly on this rotation
18 of, you know, going to work, and then going out on
19 disability, and then going to work, and going out on
20 disability, and it's because of the low visit limit.

21 I know Vicki Veltri is here. I don't know
22 if she has any input from the Office of the Health Care
23 Advocate on whether she sees complaints about visit
24 limits, but, certainly, dealing with the chronically ill

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1 population that we deal with, we definitely see that
2 problem.

3 MR. KEVIN GALVIN: Hi. Kevin Galvin. I
4 thank everyone for this dialogue we're having right now,
5 because I think it's timely and it's been missed up to
6 now.

7 As a consumer on the Board, on the
8 Committee, and with not a lot of technical expertise that
9 many of you have here, but as a parent of a child with a
10 chronic illness and representing small business and
11 independent insured that are looking for maximum benefit,
12 lowest price, I'm frankly more confused right now after
13 the last 10 minutes than I have been throughout, and that
14 is with no disrespect to anyone, because the conversation
15 is great. How do we navigate this?

16 CHAIRPERSON DOWLING: Have you experienced
17 this limit issue yourself with your child?

18 MR. GALVIN: Oh, absolutely. Absolutely.
19 We spend a lot of time in appeals that, frankly, that
20 because we're experienced in the process, the process is
21 daunting, but because we're experienced in the process
22 and have medical professionals, who have become friends,
23 we go well armed.

24 It is, for the docs, who have been here,

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1 people, who have dealt with challenges with chronic
2 illness with insurers that are in the appeal process,
3 daunting is the word, so the answer to that is yes.

4 But, I guess, back to my original
5 question, where do we go from here? I'm confused. And
6 thank you, everyone.

7 MS. MARCIA PETRILLO: Have Dr. McLean go
8 first, and then I'll come.

9 DR. McLEAN: I was going to say, I think,
10 as far as the affordability question, which is a very
11 good one, I think that, and that's the big question for
12 me, in terms of all these Exchanges, you know, that we're
13 kind of -- I think we should kind of set out what we
14 think is a reasonable Essential Benefit Package that
15 people need, and then it's the market to determine, you
16 know, the price and competition, quite frankly.

17 So we're going to set out a definition of
18 what the Essential Benefit Package should be, and every
19 health insurer can say, okay, we'll do our actuarial
20 analysis and figure out what it's going to cost, how much
21 do we need to make, so how are we going to price it?

22 And if they want the market, they will
23 price it competitively, and if they really don't know
24 about this new market, because there's a lot of

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1 uncertainty how many healthy coming in, how many
2 chronically ill going in, if they don't really want to
3 touch that market too much, they may price it higher,
4 because they want to be there, but they don't want to
5 necessarily get everybody, and we saw this back, you
6 know, in the '90s, where there were, I think it was in
7 the Medicaid market, it's kind of like to be an insurer
8 in the State, you kind of had to be in the Medicaid
9 market or something.

10 I don't remember this exactly, but there
11 are some insurers, who I believe tend to -- the price
12 here, because they just didn't want that population. We
13 may see that, but it's a huge unknown, and I think that
14 we worry about affordability, but until we say this is
15 what the Essential Benefit Package is, go ahead and price
16 it, I think it's a huge unknown.

17 And since no other state has really done
18 this yet, although I'm sure that there's probably some
19 experience that might help us with that -- other states
20 have? Okay, well, finish my sentence, then. That's all
21 I have to say.

22 MR. KEVIN COUNIHAN: As a former resident
23 of the Golden State, I was just going to comment that the
24 State of California defined its EHB several months ago.

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1 DR. McLEAN: -- meant to imply they
2 haven't necessarily priced it yet, or have they? It will
3 be very interesting to see, if other states have
4 established it, how is the pricing compared between the
5 payers? I don't know.

6 MS. PETRILLO: This conversation has been
7 very interesting, and I think we have a daunting
8 challenge ahead of us, because we really don't know the
9 answer, the ultimate answer of what to prescribe as the
10 basic plan, and then what is it going to cost?

11 And, then, on top of that, we have no idea
12 who our constituency, what the makeup of our constituency
13 is going to be, so I think we have to think about going
14 to a balance of trying to not go with the least, just
15 because we know that the constituency is going to be
16 different than the commercial constituency is right now,
17 because of the pre-existing conditions and for those, who
18 haven't been able to get insurance.

19 Now how many young people will join in to
20 balance that? We don't know. It doesn't mean that if we
21 choose a plan that's somewhat richer than what the Aetna
22 plan appears to be, it doesn't mean that every single
23 person, who signs onto it, is going to use all of the
24 benefits, so it's still that balancing act.

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1 And if the plans have good programs for
2 eligibility of whether you're eligible to use a benefit,
3 in other words, if you're in a skilled nursing facility,
4 but what you're looking at is custodial care versus true
5 skilled nursing facility care, then maybe that particular
6 patient isn't eligible.

7 But, at the same time, if what you get is
8 X number of visits under the Aetna plan for
9 rehabilitation services, but you need a little bit more
10 to keep you out of the inpatient setting, then that's
11 something we need to look at.

12 So I would urge us to consider something a
13 little bit above what the Aetna plan is, saying that it's
14 the best guess that we have to be able to serve the
15 population that this Committee and the Health Insurance
16 Exchange has been chartered to serve, and, again, it's a
17 big question mark.

18 MS. DEIRDRE HARDRICK: And I just wanted
19 to state that I agree with Ms. Petrillo, what you were
20 saying, as well as you, Dr. McLean. I think that, you
21 know, the challenge is going to be affordability in
22 striking the balance.

23 We have been talking a lot about those
24 with chronic conditions, who are going to be needing

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1 excessive care, but, as you just stated, there are going
2 to be several people, also, who are not going to use all
3 the benefits, so how these get priced, you know, people,
4 who do not use the benefits, are going to have to pay
5 more for services that they're not using, and then you
6 have the other end, where people may have need for more
7 extensive services, who, you know, we are trying to
8 accommodate, as well.

9 I also wanted to mention that, in terms
10 of, you know, once we pick a base plan, I mean I don't
11 know the specifics around how additional benefits get
12 authorized. I'm sure there's a process. There's case
13 management. There's disease management.

14 You'll find with all the plans have all of
15 these different services to kind of assist through this
16 process, so if you have a chronic illness or injury, you
17 know, they do have processes in place, where you can
18 appeal or request additional services.

19 I don't think it's like 20 visits, that's
20 it, you get nothing, and you're left out in the dark, but
21 I think, you know, we just need to consider all of these
22 other factors, but there does have to be -- there has to
23 be a balance. There's not an easy solution.

24 MS. JAFF: Just from my experience, doing

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1 a zillion insurance appeals, I can tell you that there
2 actually is no appeal if you're at a contractual visit
3 limit, because the contract is what it is. You get what
4 you paid for.

5 So if you had, say, 30 physical therapy
6 visits per year and your insurance company allowed you 10
7 and decided that the eleventh was not medically
8 necessary, you would definitely be able to appeal and try
9 to get that up to the 30 contractual limit, however, once
10 you hit that visit limit that's in the actual contract,
11 you cannot go over that, and appeals don't consider
12 waiving contractual limits, in my experience.

13 MS. PETRILLO: I agree with Jennifer, and
14 that's one of the reasons that I would ask us to consider
15 going a little bit above what the maximum is here,
16 because of the appeal process.

17 And it is true, the insurance companies
18 have contractual limits, and they have every right to
19 implement them, so the issue is how do we work on behalf
20 of the consumer to give the opportunity for those, who
21 need more, to be able to access them by adjusting the
22 plan upward a little bit.

23 CHAIRPERSON DOWLING: Maria, do you have
24 any comment? You don't have to, but I just want to make

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1 sure everybody gets a chance to speak.

2 MS. MARIA DIAZ: Well I think I'm, you
3 know, I think I believe that -- I guess I have a lot of
4 questions about the cost sharing aspect of things, so
5 that gives me pause.

6 We certainly want to consider the very
7 fiscally-responsible, make whatever plan modality we
8 choose to be affordable, but the thing that constantly
9 looms over my head, and this is a question that may have
10 already been answered, but are there going to be
11 deductibles that the patient has to meet, and that, to
12 me, just is a big, huge question mark.

13 So when you look at the documents that
14 were distributed at our last meeting and it tells what
15 the premiums were, when you consider what the deductible
16 is for the patient that they have to reach versus what
17 their premium is, like for the best plan with Anthem,
18 they don't have any deductibles, so the Aetna POS has a
19 deductible.

20 When you factor all that in, it still
21 comes down to the annual or the yearly expense. The
22 price differential I calculated was about \$500 at the end
23 of it. At first glance, it looks like the federal or the
24 State Blue Care Plan is very expensive and comes in more

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1 economical, but when you figure out what the out-of-
2 pocket expense is to the patient and you drive that over
3 the 12 months, there's not a big price differential
4 there, so, then, the question comes in to usability and
5 utilization again.

6 So is the patient, when you consider a 22-
7 year-old, are they going to be needing (coughing) care,
8 and are they going to have to pay into their deductible?
9 Probably not, unless something catastrophic happens, in
10 which case the Aetna plan is going to be more affordable.

11 But when you consider a patient, who is
12 chronically ill and they have to meet their deductible,
13 then the plan is going to come out almost similar to what
14 the State Blue Care Plan is.

15 So that's my big pause in the road, I
16 guess.

17 CHAIRPERSON DOWLING: I appreciate that.
18 Yes, Kevin?

19 MR. COUNIHAN: So to just say a couple of
20 things, first of all, as a representative of staff, I
21 just wanted to first thank everyone on this Committee for
22 the quality of this dialogue.

23 As being very new to the State and to the
24 Exchange, five days now, this has just been a really,

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1 really rich discussion. I just wanted to represent that
2 staff was not looking to make any specific
3 recommendations in providing this information. I want to
4 be clear on that.

5 Number two, this information was really to
6 help facilitate this dialogue. If it helped contribute
7 to that, that's great. If there's more that we can do in
8 the future to help do that, that's clearly our role on
9 what we want to do.

10 We were clearly trying to be consistent.
11 I think Dr. McLean or others made this point, about
12 trying to integrate the recommendations of the IOM, the
13 Institute of Medicine, with some of the guidance provided
14 by CMS about how to help states come to terms with these
15 issues.

16 We were also trying to be a little bit
17 aware of not letting the perfect be the enemy of the good
18 in trying to figure out what works for the majority of
19 people in the State, because, frankly, you can't please
20 everybody in this. It's degrees of losing.

21 So we were trying to figure out how best
22 to provide the Committee with information to come up with
23 this type of richness of dialogue, and, so, on behalf of
24 the staff, I just wanted to thank you for that.

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1 DR. McLEAN: If I could just clarify what
2 I think the questions that Maria said? As I understand
3 it, and clarify me if I'm wrong, we ask what the
4 essential health benefits will be.

5 Those will go out to the payers to come up
6 with their actuarial what the numbers should be, and,
7 then, within each of those options, there will be a gold,
8 silver, bronze, or platinum, which is where the
9 differentials are, in terms of deductibles, co-pays, all
10 that stuff, so there's not going to be one set of
11 deductibles and all those other numbers for a given plan.
12 Everyone will have three tiers. I think that clarifies
13 where you were going.

14 CHAIRPERSON DOWLING: Thank you. Is there
15 anybody else, who wants to comment, and then we need to
16 probably frame into what we can achieve this morning?
17 Oh, certainly. Yes.

18 DR. TREADWELL: I want to comment on the
19 discussion about the appeals process, just in case this
20 Committee comes out saying, oh, let's allow an option,
21 where a company can allow the consumer to appeal to have
22 more visits.

23 That's very dangerous, because an appeal
24 process delays and impedes the quality of care, so while

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1 it's nice for us to say, you know what, let's make it a
2 20-visit, and then say the cap is really 30 or 40 if they
3 appeal it, you have companies that have contracts that
4 say that it's a 30-day minimum wait before you can
5 appeal.

6 That's devastating, because that can
7 create permanent harm to a patient, so it has to be what
8 it is, designated on the piece of paper. It can't be
9 let's give him an option to appeal later. It has to be
10 pre-set, or it should be, at least.

11 CHAIRPERSON DOWLING: Thank you. Thank
12 you, all, for participating and all the thought that's
13 gone into this. I think we've had a really good balance
14 of all different kinds of voices, and our memo, for
15 whatever controversy it may have said, did what it was
16 intended to do, which was get the conversation going, so
17 thank you.

18 I will just ask whoever would like to put
19 forth, and it may be, Stephen, a motion for a vote, that
20 whatever we vote, we just vote with balance, you know,
21 for the affordability and the comprehensiveness.

22 And remember that our charge is to come up
23 with the minimum essential health benefits that any plan
24 has to contain. It doesn't mean that carriers can't

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1 offer more or plans with more, but it's a minimum, and,
2 unfortunately, our task is very narrow to that. It's not
3 to the pricing. That's going to be the next stage for
4 them to respond to.

5 Hopefully, the pricing is attractive
6 enough that the Exchange can exist and become financially
7 self-sustaining, because there's enough participation in
8 it to cause that, so there are a lot of ripple effects
9 that we were trying to do all at once, but, really, our
10 task is very narrow to defining the minimum essential
11 health benefits this morning, so I would open it up
12 again.

13 MR. FRAYNE: I would make a motion. I
14 mean, based on the discussion so far this morning, it
15 seems to me there's a general consensus, that we don't
16 want to go with the plan that has the most limited set of
17 benefits.

18 And while many of us may feel that we'd
19 also like to go with the plan that has unlimited
20 benefits, that's probably not practical really in today's
21 environment.

22 And I think, also, the general sense is
23 that while we don't have all the pricing information or
24 any pricing information that would help us really

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1 understand what the marginal cost of these extra benefits
2 are that would, for example, exist in a ConnectiCare
3 plan, as compared to the Aetna design or the Anthem
4 design, for the folks, who actually need those services,
5 you know, it really is, I think, a game changer for them
6 to have those benefits, and, as best we can tell, it
7 probably wouldn't have that much extra cost.

8 So, for those reasons, I would make a
9 motion that we design the essential health benefit plan
10 based upon the benefit design, as outlined in the
11 ConnectiCare plan.

12 CHAIRPERSON DOWLING: Is there a second?

13 MS. PETRILLO: I'll second.

14 CHAIRPERSON DOWLING: Any further
15 discussion before we take that to a vote? Okay, then,
16 all in favor?

17 VOICES: Aye.

18 CHAIRPERSON DOWLING: Any opposed? Okay,
19 it looks like it carries unanimously. Thank you very
20 much for the rich discussion on this.

21 So let me just make sure I understand. We
22 have, then, concluded our task on the essential health
23 benefits for that piece of it.

24 I need to look to the staff to -- we still

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1 have the bits on prescription drugs and pediatric dental
2 and vision.

3 MS. LYONS: That's correct.

4 CHAIRPERSON DOWLING: Okay. Thank you,
5 all, for that. How would you -- are we prepared to go to
6 that this morning?

7 MS. LYONS: We can.

8 CHAIRPERSON DOWLING: Okay, then, let's do
9 that.

10 MS. LYONS: Okay. Another choice we have
11 to make is on prescription drug coverage and pediatric
12 dental services and vision, so starting off with the
13 prescription drug coverage, the services cannot be
14 administered to the essential health benefits plan by a
15 rider.

16 They have to -- the riders are not
17 permitted per the federal government, so we have to look
18 to the next benchmark plan that has the benefits included
19 in them.

20 So the choices would be the Oxford PPO Rx
21 plan and the federal health benefits program. Those are
22 the two choices that we can choose from.

23 In yesterday's consumer meeting -- well,
24 let me take a step back. The benefit needs to cover at

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1 least one drug in all categories or classes, and our
2 research has determined that that is the case, that all
3 the drugs are reflected between these two prescription
4 drug plans, and, so, therefore, they're equivalent, in
5 terms of selecting for the essential health benefits.

6 In yesterday's consumer's meeting, the
7 request came through to do a little bit more analysis, in
8 terms of really creating another grid on identifying all
9 the classes or categories and really do a one-to-one
10 comparison.

11 So we still have to do that piece of
12 information, and I don't think that we can really vote on
13 the prescription drug piece, unless you see otherwise.

14 CHAIRPERSON DOWLING: What kind of timing
15 do you need to get that done, because another alternative
16 is to take a vote contingent on finding something, you
17 know, aberrant in your analysis? I like that approach.
18 I don't know. I haven't -- you know, yesterday's
19 meeting, between yesterday and today, kind of went by
20 like a flash, so I'm not even sure what it would entail.

21 DR. McLEAN: Since I prescribe drugs, I
22 really want to see that list. I mean, in all honesty,
23 there are so many factors, especially in looking at
24 various high-cost medications, kind of wearing my hat as

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1 both a primary care doctor, but, also, as a
2 rheumatologist, there are a lot of medications that are
3 newer in the last decade or so that are tremendously
4 expensive, but are tremendously helpful for people, who
5 have different rheumatologic conditions, and that goes
6 for cancer medications, too, so there are lots of nuances
7 that, you know, may be there that I kind of would like to
8 enlighten the group on before we make a decision on that.

9 I'm not certain how easy it is to put that
10 information together, but it's really pretty critical to
11 look at that, at least in some way.

12 CHAIRPERSON DOWLING: The question I think
13 we're figuring out is process, not content. When do we
14 need to make this? We've been trying all along to get to
15 I think it's the July 26th Board meeting with this
16 answer, and I'm just fearful that -- what's today, the
17 11th?

18 That with the public notice requirement,
19 we have to have another meeting. I just would like to
20 try to back into when we could have a, you know, if it
21 had to be a call or a meeting, where you could get that
22 data to us, and I know you're saying you don't know, so
23 I'm just trying to figure out how can we satisfy
24 everybody's interest in that list.

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1 MS. JAFF: Let me see if I can maybe help,
2 just because we struggled with this yesterday, as well,
3 and, you know, I think maybe we could do something that
4 would be contingent, because what the staff and the
5 consultants to the Exchange have been representing to I
6 think both committees is that both -- that, first of all,
7 what we're looking at are the classes of drugs, we're not
8 looking at the formulary, and that the Oxford plan and
9 the FEHBP are identical with respect to coverage of
10 classes of drugs.

11 And I believe we also got confirmation at
12 some point in our discussions, that both plans do cover
13 specialty drugs, so I suppose, for the sake of efficiency
14 and timing, we could vote to -- we could vote on one or
15 the other, contingent on those facts being borne out,
16 that the classes of drugs, the coverage of classes of
17 drugs are identical, right, and that that's really the
18 only thing that we're looking at for the essential health
19 benefits purpose, so I think we can do that.

20 DR. TREADWELL: On the next slide -- can
21 we pull up the next one? Maybe not. Prescription drugs.
22 There it is. The second and third points, if these are
23 accurate, in the second point, Connecticut Insurance
24 Department prohibits carriers from excluding any FDA

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1 approved drug that is deemed medically necessary to treat
2 a covered illness or injury, I guess the one question is
3 who is deeming it medically necessary, because sometimes
4 we see satisfaction guaranteed, and it's by the person
5 who is selling the product, not by the consumer, that's
6 being deemed medically necessary by the physician. I
7 don't think there's a concern about putting a vote out,
8 and the third bullet just follows it up if they need it.

9 MS. JAFF: Commissioner? I'm sorry. I'm
10 sorry. Could I just say one thing in response to that,
11 and that is that we also discussed yesterday the FEHBP is
12 an open formulary.

13 The Oxford plan is subject to this
14 Connecticut Insurance Department rule, however, what we
15 were told yesterday is that this is a rule, not a statute
16 or a regulation, so it's kind of a practice. It's not,
17 in any way, a mandate, and, so, we don't know whether --
18 we don't know what the Exchange is going to do, in terms
19 of health plan certifications through the Insurance
20 Department, and whether that rule will continue to be in
21 effect, at least that's what we were told yesterday.

22 So if I have mistaken any of that, I'm
23 sure the staff will correct me, but my understanding is
24 that, for EHB purposes, we're not even looking at whether

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1 it's an open formulary, or closed formulary, or whether
2 the Insurance Department prohibits plans from doing
3 certain things. It's just we're just looking at classes
4 of drugs, if I understand this correctly.

5 MS. LYONS: No, you're correct. I can
6 attest that the Insurance Department will not approve any
7 policy forms that state otherwise, and that's been their
8 position for the last 17 years, so, even though it's not
9 a specific regulation, that is their opinion, and all the
10 carriers need to follow that rule.

11 MS. JAFF: So, then, if we chose the
12 Oxford plan, the Oxford plan would be subject to that
13 rule, the FEHBP would not?

14 MS. LYONS: Well, the Oxford, the
15 Connecticut Commercial Plans are all subject to this
16 rule.

17 COURT REPORTER: One moment, please.

18 MS. LYONS: That is the rule that the
19 carriers need to live by. The federal plan, they also
20 have pre-certification requirements, but I'm not as well
21 versed in federal plans.

22 CHAIRPERSON DOWLING: We do want to
23 remember that whatever name is on something now it's
24 going to be a Connecticut plan, and it will go through.

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1 Nothing is going to change, in terms of what the
2 Insurance Department's process is, no matter what the
3 plan is, and, as you all know, we have a memo of
4 understanding now with the Exchange to continue all the
5 functions that are stipulated there, and this would be
6 one of those.

7 So I really am grateful that you made that
8 distinction, about the fact that we are not getting into
9 the formulary here, just simply the classes.

10 DR. McLEAN: Question or clarification.
11 Sorry. So it sounds like, so, we have these two plan
12 options that we need to choose between, the Oxford plan
13 and the generic, for lack of a better term, federal
14 employee plan, but they both are covering, you know, all
15 classes, apparently, and I guess what's the difference
16 going to be between them, that it's not a formulary?
17 Cost? We're not looking at that issue, are we?

18 So, I mean, does anyone know what the
19 difference between these two options are?

20 MS. LYONS: Well I think, you know, cost
21 sharing will come into play, generic substitutions, mail
22 order options, so the only thing that we've been focusing
23 on were if these elements were in the actual content of
24 the benchmark plans to determine what the benchmark plan

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1 was.

2 DR. McLEAN: Okay, so, those details are
3 things that we need to kind of decide we do or don't
4 want, between those two?

5 MS. LYONS: Yeah.

6 DR. McLEAN: Okay. I just wanted to know
7 what the difference is going to be.

8 MS. LYONS: Steps two and three.

9 DR. McLEAN: Okay.

10 CHAIRPERSON DOWLING: But even those
11 details are coming from the design of the plan, as
12 opposed to what we're doing here today.

13 MS. LYONS: Right.

14 CHAIRPERSON DOWLING: I mean it's almost a
15 vote without a distinction, so we can say we voted for
16 one or the other, but, in fact, we're voting for that
17 coverage of those plans, so I would go as far as to say
18 it doesn't matter, because what we're really doing is the
19 description underneath either heading is going to be the
20 same. Is that correct?

21 MS. LYONS: That's what we thought, as
22 well.

23 CHAIRPERSON DOWLING: So rather than
24 saying we voted on Oxford's plan or federal, we'll say we

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1 voted on this structure that's represented there, I mean
2 just in terms of documentation?

3 DR. TREADWELL: Maybe I misunderstood, but
4 would the Oxford -- not Oxford. What's listed as the
5 Oxford plan, I see that the CID is listed here, and I was
6 under the impression that, one, the Connecticut Insurance
7 Department may have some kind of purview over, and the
8 other they would not. Is that incorrect, or these last
9 two bullets, the CID may have some input?

10 CHAIRPERSON DOWLING: Yeah. This is an
11 important, subtle. As I understand it, we don't approve
12 the federal plan, so we don't have any jurisdiction over
13 that. That's history when it was the federal plan. All
14 we're doing is looking at the structure within the plan.
15 Do you know what I'm saying? So that that's out there,
16 so is Oxford. Whatever happened historically, you know,
17 the governance, the regulatory, is almost irrelevant.

18 DR. TREADWELL: So, then, these last two
19 points are actually quite important, because it may
20 dictate when medications can or cannot be substituted,
21 but the CID had purview.

22 I'd feel more comfortable saying, okay, if
23 this is what they've been doing for the last 17 years and
24 insurance have had to abide by it, then the federal plan

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1 comes and says, well, this is our plan, and we don't have
2 to fall under your CID thing, that's a big deal.

3 CHAIRPERSON DOWLING: That's what I'm
4 trying to reassure you of, is that whatever plan we pick
5 is going to fall under. We weren't before, but we get to
6 use their structure as an optional choice.

7 Okay, so, how would you feel? Our vote
8 caller, maybe you can clarify.

9 MR. FRAYNE: I can do that, if you'd like.
10 The one thing I think that we haven't talked about so far
11 in this discussion is that, you know, the benefit design,
12 the grand view that we're creating, we know will be good
13 for kind of two years, and, at that point, presumably
14 either the federal government will continue to kick the
15 can down the road and not come up with a more national
16 standard, or it will decide that it will come up with a
17 more national standard.

18 So I think, in the remaining things that
19 we're looking at, it might actually behoove us to begin
20 to think a little bit more long range about what that
21 national standard might be, so I was kind of looking at
22 this as, perhaps, on this one, maybe we'd be better off
23 going more in the direction of the federal design, simply
24 because, you know, it's more than likely our plan design

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1 that we just picked will be richer than what would be
2 permissible in two years.

3 So how many more logs do we want to add
4 onto that fire? Maybe we should begin thinking about at
5 least having portions of our plan somewhat more modeled
6 on what would probably be more acceptable.

7 I would find it hard to believe that in
8 two years that they're going to say that the federal
9 employee health benefit plan design for the prescription
10 drug benefit would no longer be acceptable as an
11 essential health benefit design.

12 That seems to me to be more likely
13 sustainable, so even though it might at the moment appear
14 like there's not much difference, at least I think
15 there's actually probably more difference than we know,
16 and I would encourage us to look more at the federal
17 design versus the state design.

18 CHAIRPERSON DOWLING: I'm not sure I'm
19 following. I understand them to be representatives
20 identical, as far as we know it, although I really do
21 appreciate, and I think we all do, the reminder, that
22 whatever may happen in two years may mean that we get
23 ourselves in a position of a takeaway, and because the
24 state can't afford to subsidize, but can you just assert

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1 for us one more time the basic structure is exactly the
2 same, and what we've been discussing here is the
3 regulatory side of it with the Insurance Department, but
4 are the basic structures the same? We don't get to vote
5 on the formulary here.

6 MS. LYONS: That's correct. Are the
7 classes or categories, you know, duly represented in each
8 plan, and we found that they were.

9 CHAIRPERSON DOWLING: So, Stephen, where
10 were you seeing the distinctions?

11 MR. FRAYNE: The distinction I was looking
12 at was it would seem to me that, in the future, we would
13 have to demonstrate how, assuming we went on the Oxford
14 kind of design, how our design, in fact, is consistent
15 with, equal to, no greater than what the federal design
16 is, and I would think there's a greater probability the
17 federal design would be more based upon the federal
18 employee health benefit plan model for prescription
19 drugs, as opposed to, if you just went with the federal
20 employee health benefit design, my guess would be in the
21 future that would probably be automatically accepted.

22 There wouldn't be any proving that one
23 would have to do to show that their plan isn't richer
24 than what is being established as the national standard.

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1 It may be a distinction without any
2 difference, and I think we believe that to be true at the
3 moment, but my assumption is, in the future, we're going
4 to have to prove that there's no difference if we go with
5 a more state-based product, as opposed to a more federal-
6 based product.

7 CHAIRPERSON DOWLING: How about the idea
8 that was discussed a few minutes ago, which is we vote,
9 contingent to your doing a little further research to the
10 design, and if we find a distinction, we need to come
11 back to the table to re-vote?

12 MS. LYONS: That sounds fine.

13 CHAIRPERSON DOWLING: Okay. Do we have
14 someone, who would like to make a motion to that?

15 DR. McLEAN: A motion to what you just
16 said. (Laughter) A motion, that we approve either of
17 these two plans, as long as they appear similar in their
18 general design.

19 CHAIRPERSON ESPINOSA: A second to what
20 she just said. No. What the doctor just said. Is there
21 a second? Do we have a second?

22 CHAIRPERSON DOWLING: Bob.

23 CHAIRPERSON ESPINOSA: So shall we go list
24 the first one? All in favor of? I was just going to ask

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1 for a vote on each one.

2 DR. TREADWELL: I'm not sure that's
3 possible. You're voting to accept those plans, assuming
4 they're equal?

5 CHAIRPERSON ESPINOSA: No.

6 DR. TREADWELL: We need to pick one or the
7 other and vote on that plan to choose from, either Oxford
8 plan or the federal employee plan. You can't say we're
9 going to -- I don't think we can say we're going to
10 motion to pick one of the plans, assuming they're equal.
11 We need to pick one of the plans, right?

12 CHAIRPERSON ESPINOSA: Could we modify the
13 motion, and could we specify which we -- I was going to
14 do it by process of elimination. Actually, I was just
15 going to format it that way, but if it's okay with the
16 committee, can we just modify the motion that says will
17 recommend the federal -- whichever plan. Just take a
18 vote?

19 DR. McLEAN: So you suggest that we just
20 kind of randomly pick one of those two? I mean I have no
21 problem with that.

22 MR. GALVIN: Yeah. That's essentially
23 what we need to do.

24 DR. McLEAN: I'm uncomfortable with the

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1 idea that we're actually deciding, without really knowing
2 what we're voting on, which is kind of what you're
3 getting at. We don't think that there are major
4 distinctions between them, but without seeing that, I
5 don't know.

6 And, so, either we vote on one of those
7 two, or we vote on the premise, that, you know, there's a
8 design that exists, and it has, you know, options and
9 reasonable co-pays or something. I don't know what else
10 to say.

11 CHAIRPERSON ESPINOSA: Or there's a third
12 option, we table the action until additional information
13 is supplied and the committee feels comfortable with
14 that. That's, obviously, an option. Go ahead, Kevin.

15 MR. GALVIN: Yeah, that's where I was
16 going with it. What is the downside of tabling this
17 until we get a little more information? I'm completely
18 in the dark on this, and to the doctor's point, I can see
19 exactly why he made the motion he made, because we have
20 no data, so I'm wondering is there a timeline that is
21 driving us to make a decision today, or do we have some
22 time?

23 CHAIRPERSON DOWLING: Fair enough. Let me
24 try it again. I am trying to back us up from the July

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1 26th Exchange Board meeting, and I can't remember how
2 much notice we need to give to have another meeting of
3 our committee for Freedom of Information and open meeting
4 regulations, so we'd end up calling a meeting on very
5 short notice.

6 We need to give notice, all that, so I'm
7 worried about the practicalities of getting a quorum, all
8 that type of stuff, to reconvene us, so the motion I
9 thought -- but we can do that. We can do it. I just
10 think it's going to be practically a little messy.

11 What I understood staff to tell us was
12 that both plans for the purposes of the drug categories
13 are identical, so it doesn't matter whether we vote for
14 Oxford or federal. We're voting for the structure that
15 they represent identically, with the contingency that if,
16 on further research by staff, they find distinctions, we
17 come back to vote again.

18 I thought it didn't matter which one we
19 voted for, because they've represented to us that they
20 are in those categories exactly identical.

21 MR. GALVIN: Then the next question would
22 be, then, then how do we frame a motion to do that, and
23 is there a comfort level with that process?

24 DR. McLEAN: Can I make a suggestion?

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1 Given the discussion we had about a month ago, concerning
2 that there are limits potentially, and I don't know this,
3 on federal laws maybe related to women's health, and I
4 have no idea whether, for example, contraceptive pills
5 are part of the federal plan or not, I think it's more
6 likely, based upon potential federal laws, that the
7 Oxford plan may actually be more inclusive.

8 I don't know that, but on the premise that
9 that's a possibility, given our previous discussion, I
10 would venture to make a motion that we approve the Oxford
11 plan conditionally, that we are happy with it when we see
12 the comparison.

13 MR. TESSIER: And I second and withdraw my
14 second from the previous one.

15 CHAIRPERSON DOWLING: Is there any further
16 discussion on that? Thank you. Steve?

17 MR. FRAYNE: Just for discussion purposes,
18 I'm fine with going forward with the Oxford plan, but not
19 for the rationale set forth. It seems to me, based on
20 the discussion we had earlier today by the public
21 speakers, as well as discussion we just had now, I don't
22 believe we can adopt a plan in Connecticut that would not
23 be in compliance with the federal requirements, so the
24 federal requirements say that you can't cover abortion,

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1 you can't cover abortion, it says you can't cover certain
2 medications, you can't cover certain medications, so you
3 wouldn't be permitted to use any of the subsidies or any
4 of the other things, which are prohibited under federal
5 law in the Connecticut plan, so I think we just need to
6 be very careful about how we're describing what we're
7 doing, because at least my recollection of the discussion
8 that we had several months ago was not reflective of what
9 appeared in the newspaper at all, by any stretch of the
10 imagination.

11 So, in this instance, I think I'm
12 comfortable with the Oxford plan. I think it makes
13 perfect sense, but, as far as I know, we don't have the
14 ability to change what the federal requirements are. The
15 state can't trump the federal requirements.

16 MS. JAFF: I just need to state for the
17 record that it is not at all clear that the Affordable
18 Care Act prohibits a state from including an Essential
19 Health Benefits Package, reproductive health care
20 services. It's not entirely clear.

21 I'm happy, Steve, if you want, I'm happy
22 to give you the research that we've done on this, but I
23 agree with you. I don't think that that issue, which is
24 a huge political football, I don't think that that issue

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1 needs to be addressed for purposes of making this
2 decision, and I'd be comfortable voting for the Oxford
3 plan, contingent on confirmation from the staff, that the
4 same classes of drugs are covered under both of the
5 prescription drug plans.

6 DR. TREADWELL: This is for Julie. When
7 you're going through the plans, even though the
8 formularies were similar, was there any issue with access
9 to medications, like, okay, these formularies you can
10 just go to the pharmacy and pick up versus these you need
11 to do a mail in?

12 MS. LYONS: I don't recall that level of
13 detail. For example, there's features in the federal
14 plan that one of the options didn't have a mail order
15 program, so like there's things like that, but to get to
16 the level of medication, I don't recollect.

17 They did not specify any exclusions
18 either. I really have to now go back and look.

19 MS. JAFF: But none of that is relevant
20 for the EHP purposes, right, I mean whether it's mail
21 order, or whatever?

22 MS. LYONS: Right. That's exactly right.

23 MS. JAFF: I mean we're only looking at
24 what classes of drugs are covered.

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1 MS. LYONS: Right.

2 MS. JAFF: That's all we're looking at.
3 We're not looking at cost sharing. We're not looking at
4 mail order. We're not looking at anything else, just
5 classes of drugs.

6 MS. HARDRICK: Right, and it would be up
7 to the plans to develop those, the issuers, the QHPs to
8 develop the plans to cover all of these services that
9 we're putting into the plan, what's going to be in the
10 benchmark.

11 CHAIRPERSON DOWLING: That's correct. Our
12 scope is fairly narrow. There is a motion on the table
13 and a second, so all in favor of this motion, which was
14 to approve the Oxford prescription plan, contingent upon
15 staff finding anything different from that in the federal
16 plan, is what we are voting on, so all in favor?

17 VOICES: Aye.

18 CHAIRPERSON DOWLING: Any opposed? Thank
19 you, all.

20 MS. LYONS: The next decision that needs
21 to be made would be with pediatric services, dental
22 services. The two options that we have available are the
23 Fed VIP program, which is a federal employee health
24 benefit program, and the State CHIP Program.

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1 Both of these plans cover, you know, basic
2 preventative dental services, such as cleanings and
3 fillings. They also provide coverage for more
4 complicated services, such as root canals and crowns,
5 and, in addition, orthodontia is also covered, if
6 medically necessary.

7 Again, for these elements, they're
8 essentially the same. There's no meaningful difference.
9 So the decision would be made between these two options.

10 MS. JAFF: Just to share with you the
11 rationale that the Consumer Outreach and Experience
12 Committee adopted yesterday, Bob Scalettar suggested that
13 because Connecticut providers are familiar and
14 comfortable with the CHIP Pediatric Dental Plan and
15 because there appears to be no significant difference
16 between the CHIP plan and the Fed VIP plan, that we would
17 lean towards the CHIP plan, because it's something --
18 it's a known quantity in Connecticut.

19 I personally found that to be persuasive
20 yesterday, so I would share that with the Committee.

21 MR. FRAYNE: I apologize for having the
22 diametrically opposed view. It might be 360. I don't
23 know. I think, you know, the CHIP plan, or the Medicaid
24 version of dental coverage in the State, has had a very

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1 rocky road. It was the subject of many years of
2 litigation.

3 While it's true it offers a benefit
4 design, I don't know that a lot of folks in the provider
5 community are particularly happy with that design, so
6 while it may be true that they're equal, at least the
7 general sentiment of Medicaid and its coverage of dental
8 services is not really held in very high regard, as far
9 as I know.

10 There are a lot of hospitals that offer
11 dental clinics. There's a lot of dental services being
12 done in the Emergency Department, particularly because
13 folks cannot find access through the Medicaid program for
14 dental services.

15 It is clearly better today than it was
16 four or five years ago, but that's not a very high
17 benchmark to exceed.

18 CHAIRPERSON DOWLING: Given that our
19 choices are these two, do you find the federal plan to
20 address the concerns you have in contrast?

21 MR. FRAYNE: Personally, I would think
22 that the federal design is a little better, particularly
23 in regard to at least on orthodontia. I think it was
24 almost twice the difference, in terms of what would be

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1 allowable.

2 For any of us, who have had kids, who need
3 that kind of work, even \$1,500 doesn't go that far, so
4 having a benefit design as low as \$725 for orthodontia
5 just seems to me not a very useful benefit design, so I
6 would personally prefer to go with the federal plan, just
7 because I think it offers more benefit, and, also,
8 there's the notion, that perhaps we want to be picking a
9 plan that at least hasn't had such a rocky history.

10 MR. TESSIER: If I may, a question for
11 Steve?

12 CHAIRPERSON DOWLING: Certainly.

13 MR. TESSIER: Aside from the orthodontia
14 coverage, is your concern about the CHIP plan the benefit
15 design, or is it the provider reimbursement, because,
16 presumably, this would not -- that wouldn't be the issue
17 here. It's benefit design.

18 MR. FRAYNE: I think there is a difference
19 in orthodontia, which is substantial, but I think the
20 issue regarding in the Medicaid program the funding has
21 not been there forever, in terms of being able to provide
22 an adequate network for dental services.

23 It's better today than it was, but it's
24 still got a far way to go, so I think, even though it

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1 would be true, that if we picked the CHIP design, it
2 would be priced at a commercial level, I just think we
3 would be sending the wrong signal to the dental
4 community, that we've established something, which is
5 based upon a program that they don't hold in very high
6 regard.

7 MS. HARDRICK: I have a question, and I'm
8 not sure if anyone here can answer it, but I'm wondering
9 if the dollar limits will actually apply for the
10 pediatric dental, because under the ACA, aren't we
11 removing dollar limits?

12 I'm not sure if it applies to this or not,
13 but I wanted to bring that up, if that's a factor or not
14 a factor.

15 MS. LYONS: That is a true statement, that
16 there are not allowable limits, dollar limits on
17 benefits.

18 CHAIRPERSON DOWLING: So that removes the
19 orthodontia question. I have to say I do have some
20 sympathy with the known quantity in the State, and I am
21 concerned that maybe the bad rep is the reimbursement,
22 and that's outside of this purview, and hopefully will be
23 addressed later, as we go through this, so for what
24 that's worth.

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1 DR. McLEAN: Well, along the same lines, I
2 mean we're looking at existing plans, I guess, and
3 picking them, without them having a name attached to
4 them.

5 I mean, currently, that's the CHIP plan,
6 but when it gets rolled out, it's not going to be
7 identified as the CHIP plan, despite the fact that it has
8 a bad rep, which I recognize, similar to, you know, the
9 EHB is not going to be the ConnectiCare plan. It's going
10 to be the plan.

11 Historically, I understand completely what
12 you're saying, and there's that risk, that if people
13 recognize it as, oh, I didn't like that plan, but I think
14 it's going to probably be looked at in a vacuum as this
15 is the EHB, no matter where it came from.

16 CHAIRPERSON DOWLING: If there's not
17 comment, why don't we have a vote, if someone would make
18 a motion on this, one way or the other? And I will
19 state, you know, also, I have some sympathy, also, for we
20 have another committee, who spent some time on this, that
21 we need to collaborate with or whatever, so, you know,
22 something to be said for, you know, working in
23 collaboration with their sentiment, as well, moves me a
24 bit on this.

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1 MR. TESSIER: I'll move we adopt the CHIP
2 plan as the model.

3 DR. McLEAN: Second.

4 CHAIRPERSON DOWLING: All right, all in
5 favor of the CHIP plan as the design?

6 VOICES: Aye.

7 CHAIRPERSON DOWLING: And opposition?
8 Stephen, okay. Thank you.

9 MS. LYONS: One more. One more. The last
10 option is -- well, it's not an option. It's the vision
11 coverage, and the guidance suggests that the states model
12 the coverage after the federal plan, which provides
13 coverage for routine eye exams for fraction, and some
14 coverage for corrective lenses and contact lenses, so
15 that would be the last benefit, and there's really no
16 other option.

17 CHAIRPERSON DOWLING: So I guess we can go
18 through the formality of a vote to adopt that, because
19 that is our choice, but we can affirm that. Could I hear
20 a motion for that?

21 MS. DIAZ: I'll make the motion. I make
22 the motion that we adopt the model coverage of the
23 federal vision plan for the benefits of the quality
24 health plan for vision.

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1 MS. PETRILLO: I second.

2 CHAIRPERSON DOWLING: Thank you. Any
3 further discussion on that? All right, all in favor?

4 VOICES: Aye.

5 CHAIRPERSON DOWLING: Any opposed? Two
6 more items, and I thank you. I am humbled by the fact
7 that we got here, and this is something that you are all
8 so passionate about, and, you know, as your volunteer
9 time on this Committee to get a plan for the citizens of
10 Connecticut is laudable, and I thank you all for the time
11 you spend here, the time you spend reading, the nights
12 you spend reading, because we can't always get things to
13 you with enough lead time, and we apologize for that.

14 And I just want to thank each of you for
15 your participation, for your, particularly today, the
16 richness of the conversation.

17 Just keep your eyes peeled, in case we
18 need to reconvene on this topic. We have other work in
19 front of us, but I really thank you for getting us where
20 we are. It was a little bumpy, but we got here, so thank
21 you.

22 We do have a request. Because we moved
23 this, the public portion to the beginning, and I think we
24 missed a person, who thought it was going to be at the

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1 end, we have one more person that --

2 MS. JAFF: Is that time correct, because
3 we've always met in the mornings, and I had it written
4 down as the morning, and, so, I just want to make sure
5 that that is -- is 1:00 the next one?

6 MS. LYONS: I will go back and check and
7 let you know.

8 MS. JAFF: Okay, thanks.

9 CHAIRPERSON DOWLING: Thank you for
10 correcting that. So is Nicole here? Thank you.

11 MS. NICOLE PECK: Okay, I can't see you.
12 I'll be blinded by the light here. I'm here. I don't
13 know if someone can move the projector or turn it, turn
14 the bulb off. Thank you. Now we'll blind somebody
15 behind me.

16 Thank you very much. My name is Nicole
17 Peck, and thank you, again, for allowing me to speak at
18 the end here. I'm here today, because I want to tell you
19 and the men and women here present the truth about
20 abortion and its devastating impact on women's lives --
21 of women and men are the voice that must be heard in this
22 debate, and we're often neglected and not heard.

23 I believe in and trust women. I believe
24 that every woman should be able to make decisions about

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1 her own body and her health care. I think, on that
2 point, everyone agrees on both sides, however, I want
3 women to make informed decisions.

4 Women need to understand that it is a baby
5 they're carrying, and it has a beating heart around 21
6 days. It's simply not a blob of tissue. And I want them
7 to know what can happen to them after an abortion.

8 Abortion is simply not health care, and it
9 does not help women, or families, or our future legacy as
10 a state or a country. Abortion left me unable to
11 conceive another child. It is a choice I regret to this
12 day.

13 I found out I was infertile when I married
14 in my forties, and I wanted a child then, but found I
15 could not have one.

16 I did do infertility treatments to an
17 extent. I did have some surgery, but nothing was able to
18 help me. And I did seek a doctor for in vitro
19 fertilization, which I would not have gone through with,
20 but I was told my eggs were too old. So, when you get to
21 that point, you have no other option.

22 Unfortunately, that abortion affected my
23 future husband, and I was never told the truth about
24 abortion and its devastating effects, which, for me, was

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1 infertility. We know there are breast cancer links,
2 future miscarriages that occur with women. They often
3 spiral into drug and alcohol abuse, eating disorders,
4 depression. I contemplated suicide.

5 There are relationship issues, bonding
6 with future children, and the list can go on. I'm here,
7 because I want to put a face to a post-abortive woman.

8 The effects are real and devastating and
9 life altering. It's not a simple procedure, and often
10 the medical community is not prepared today to even help
11 post-abortive men and women with the emotional and
12 psychological issues that they deal with.

13 We do struggle with these feelings, and we
14 often suffer in silence, and we feel alone, and we don't
15 talk about it, and I often think, if abortion was really
16 so good for us, why are we afraid to talk about it?
17 What's the big secret?

18 And, unfortunately, women are still dying
19 today from abortion, like Laura Smith from Hyannis,
20 Massachusetts, who hemorrhaged to death in 2007, because
21 of an abortion that had gone awry.

22 We don't talk about these things, but they
23 do happen, and that is not health care. We should be
24 protecting women from harm and giving them the truth

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1 about abortion and giving them options, and one of those
2 facts is that surgical procedures, such as abortion, can
3 lead to death, and they're not told that.

4 I was not told any of the facts that I
5 just gave to you. Often, they deal with this for five,
6 10, 15 years more after their abortion. They may not
7 deal with it right away, because they feel they're in
8 denial, they're relieved they don't have a pregnancy to
9 deal with anymore, they can move on. That's where I was.

10 Unplanned and crisis pregnancies are very
11 devastating. If you're not expecting it, you are
12 surprised, and, at 15, I was surprised, but real health
13 care helps women or this couple in the situation, and
14 abortion seems to be the easy answer, but it is not.

15 The long-term effects cannot be minimized,
16 and a woman in an unplanned pregnancy needs love,
17 support, she needs a helping hand. She doesn't need to
18 terminate her pregnancy, and there are a lot of pregnancy
19 centers in the state and around the country that do just
20 that.

21 To be honest, adoption seems to be the
22 forgotten option. We don't talk about it, but had I
23 known about adoption as an option, perhaps I could have
24 had a relationship with my child 35 years later.

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1 I just turned 50 last week, and I was 15
2 when I had my abortion. With open adoption today, I
3 could have maybe met this young man.

4 Adoption is really close to my heart,
5 because my husband and I decided to adopt, due to my
6 infertility from my abortion. I never thought I would
7 ever have children, but God had another plan, and he
8 blessed us with two sons, a five-year-old, and we just
9 got back from Texas adopting a two-week-old, so we have a
10 newborn right now.

11 But adoption really is a blessing, and we
12 don't talk about it, and it is the best choice for
13 everyone involved. We have so many couples that want to
14 adopt infants, and we just -- it's just not an option.
15 People don't talk about it or think about it.

16 So I'm just here to advocate that abortion
17 is not health care, that we should really think about
18 what we're doing to our young girls and our families, and
19 that we just should not mandate abortion or
20 abortifacients. Thank you.

21 CHAIRPERSON DOWLING: Thank you, Nicole.
22 Thank you for your courage coming forward, and good luck
23 with your sons.

24 MS. PECK: Thank you.

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1 CHAIRPERSON ESPINOSA: The next meeting is
2 9:00 a.m. to 11:00 a.m., August 8th. That was confirmed.

3 CHAIRPERSON DOWLING: Bob?

4 MR. TESSIER: Commissioner, you started
5 the meeting referencing the new staff at the Exchange,
6 and I assume you meant when you said that I assume you
7 were including our new CEO. I'm wondering if not only
8 could we introduce him, but, also, all of the Exchange
9 staff, who are here, who have provided the support to our
10 Committee, as we've worked along. I'd appreciate it.

11 CHAIRPERSON DOWLING: Yes. If anyone in
12 the audience is not aware, maybe we should, just for a
13 quick moment, you know, ask you each to introduce
14 yourselves, and start with Kevin, our new CEO.

15 MR. COUNIHAN: I'm Kevin Counihan. Thank
16 you, Anne Melissa. I'm the new CEO of the Insurance
17 Exchange, and very excited and delighted to be on the
18 team.

19 MS. LYONS: Julie Lyons, Director of
20 Policy and Plan Management.

21 MR. DAVID LYNCH: Dave Lynch, Plan
22 Administrator for the Exchange.

23 MR. GRANT PORTER: Hi, Grant Porter. I'm
24 one of the Senior Analysts with the Exchange.

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1 MR. JIM WATLEY: Hi. My name is Jim
2 Watley(phonetic). I'm the new Chief Information Officer.
3 I've been here for two days.

4 MR. JASON MADRAK: Jason Madrak. I'm the
5 Director of Marketing and Communications at the Exchange.

6 MS. KEISHA STAFFORD: Keisha
7 Stafford(phonetic), Analyst at the Exchange.

8 CHAIRPERSON DOWLING: You all know Bob
9 Carey, who has been advising us all along. Oh, and Amy.
10 Yes. That was a great idea, Bob. Thank you. So that's
11 the gang. Thank you, all.

12 And, with that, I think we will adjourn,
13 unless there's anything else. Thank you.

14 (Whereupon, the meeting adjourned at 11:03
15 a.m.)

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