

VERBATIM PROCEEDINGS

CONNECTICUT HEALTH INSURANCE EXCHANGE

SMALL EMPLOYER HEALTH OPTIONS PROGRAM  
ADVISORY COMMITTEE MEETING

MAY 14, 2012

LEGISLATIVE OFFICE BUILDING  
300 CAPITOL AVENUE  
HARTFORD, CONNECTICUT

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

7  
8  
9  
10 MS. PAMELA RUSSEK: Good afternoon, folks.  
11 This is Pam Russek. I think we're going to get started,  
12 and I believe do we have folks on the phone now? Grant,  
13 are you on the phone? Not yet. Okay.

14 Could you just review who is going to be  
15 on the phone for folks here?

16 MS. NELLIE O'GARA: Amy, is there anyone?  
17 Just Grant.

18 MS. RUSSEK: Grant, okay.

19 MS. O'GARA: So I'm going to help  
20 facilitate this meeting. I was at your last meeting.  
21 Just a second. Grant, are you on the phone?

22 MR. GRANT RITTER: Yes, I am. Hi.

23 MS. O'GARA: Hi. We just started, and  
24 we're going to go around the room again for the Committee

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1 members. If they can introduce themselves, state their  
2 name and who they represent, that would be great. I'm  
3 going to start with you, Grant.

4 MR. RITTER: Grant Ritter. I'm a Health  
5 Economist from Brandeis University.

6 MS. O'GARA: Thank you.

7 MS. RUSSEK: Pam Russek. I'm the other  
8 co-Chair, and I represent PTR Consulting.

9 MS. ELLEN SKINNER: Hi. Ellen Skinner.  
10 I'm from the Yale School of Management, and I have  
11 insurance background prior to my time at Yale.

12 MR. JOHN FLEIG: Hi. John Fleig,  
13 representing United Health Care.

14 MR. ANTONIO PINTO: Tony Pinto. I'm a  
15 small business owner and used to be an agent for the last  
16 12 years working with small businesses.

17 MR. TIMOTHY PUSCH: Tim Pusch. I work for  
18 the Burns, Brooks and McNeil Insurance Agency.

19 MS. DEIRDRE HARDRICK: Deirdre Hardrick.  
20 I'm here on behalf of Marta McCubba (phonetic), and I'm  
21 representing Aetna.

22 MS. LYNN JANCZAK: Lynn Janczak from  
23 Learning Dynamics in Wallingford, Connecticut.

24 MS. JULIE LYONS: Julie Lyons, Connecticut

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1 Health Insurance Exchange.

2 MR. BOB CAREY: Bob Carey, a consultant to  
3 the Exchange.

4 MS. O'GARA: And I'm Nellie O'Gara, your  
5 facilitator.

6 MR. GRANT PORTER: I'm Grant Porter. I'm  
7 with the Exchange, Analyst for that.

8 MR. ROGER ALBRITTON: I'm Roger Albritton  
9 with KPMG, the Technical Advisor to the Exchange.

10 MS. MARY ELLEN BREault: Mary Ellen  
11 Breault with the Insurance Department.

12 MS. O'GARA: Okay. I'd like to direct  
13 your attention just to the slide up here if we have the  
14 agenda. Just a quick observation.

15 As you can see, we have a lot to cover,  
16 and we wanted to make sure that we spend most of the time  
17 on the items around the Essential Health Benefits, the  
18 Carrier concerns, and the report from KPMG, however, we  
19 have some unfinished business from the last meeting.

20 We sent out to all of you the Committee  
21 Operating Guidelines. I'm hoping that you all had a  
22 chance to read them. I see some heads nodding.

23 And what we'd like to do today is get  
24 approval of them. We're actually going to take a roll

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1 call vote, and I'll call your name and ask you to say yay  
2 or nay, but I'd like to entertain at this point, before  
3 we take the vote, if there's any comments, major concerns  
4 that anyone wants to raise.

5 MS. HARDRICK: Hi. This is Deirdre  
6 Hardrick. I'd like to raise a few of the concerns on  
7 behalf of Aetna. We took the Guiding Principles and  
8 reviewed them internally, and just a few points.

9 On the first Guiding Principle, we thought  
10 that it conflicted with a few of the other principles  
11 down below, because we're indicating at the latter part  
12 of that principle a choice of health plans from a number  
13 of health insurers, and we feel that that sort of  
14 conflicts with number three and number five, in terms of,  
15 you know, we feel that, through prior experience, I think  
16 we've seen even with Massachusetts, that it's difficult  
17 to manage employee choice, and that this, you know, sort  
18 of will increase the administrative burden of managing  
19 the SHOP Exchange, as well as it may limit attractiveness  
20 to plans for participating, and it may lead to adverse  
21 selections, so that was one point, in terms of offering a  
22 number of health insurers.

23 We thought that the first principle  
24 conflicted with some of the other principles you're

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1 trying to address below.

2 The second item we thought that, in  
3 looking at the principles, they did not really focus on  
4 the employer perspective, or the broker perspective.

5 We feel that employers and brokers are  
6 your primary customers, so that we need to focus on their  
7 needs, as well.

8 MS. O'GARA: I'm going to ask if, Bob, if  
9 you want to enlighten us on the conflict question?

10 MR. CAREY: Sure. I mean I think the  
11 whole concept of an Exchange is to alter the manner by  
12 which employees purchase coverage in most markets.

13 In Connecticut, you already have a SHOP  
14 Exchange to a large extent, so it's an interesting  
15 dynamic here in setting up a public SHOP Exchange when  
16 you have a private SHOP Exchange, but we'll sort of get  
17 to that later.

18 But the whole concept of an Exchange, in  
19 general, with regard to the small group market is to  
20 provide employees with choice, so we think that, number  
21 one, it's important that we recognize as a group that  
22 employee choice is an important concept behind the whole  
23 structure of an Exchange, and then we try to address the  
24 sort of almost competing, as you correctly note,

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1 objectives of minimizing risk selection, or adverse  
2 selection, and, also, making it administratively feasible  
3 and easy for employers and employees to purchase coverage  
4 through a SHOP Exchange.

5 I guess I would suggest that there's a  
6 balance that needs to be struck, and, as we get down the  
7 road, talking about the purchasing model, that we keep in  
8 mind, you know, is it administratively feasible and easy  
9 for employees and employers to understand?

10 Does it balance the risk selection issues  
11 that could be a concern or will be a concern for carriers  
12 that wish to participate on the SHOP Exchange, and can  
13 you do all that while also providing employees with  
14 choice?

15 So I think, when we put these together,  
16 those were sort of the -- there is a need for balance  
17 across each one of those principles.

18 If we just said we want to give employees  
19 choice and didn't really care about risk selection or  
20 administrative simplicity, I think that we'd be doing a  
21 disservice to the Exchange and how it sets up its SHOP  
22 Exchange, so that, I hope, addresses the issues that you  
23 raise.

24 MS. HARDRICK: I think it does, and we

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1 agree with the choice perspective, and we're just saying  
2 that the first principle that's listed here, the way it's  
3 worded, conflicts with the wording of some of the others,  
4 but agree.

5 MS. O'GARA: As far as the other concern  
6 you raised, about not addressing, potentially not  
7 addressing employers and brokers, I guess I would read  
8 that a little differently.

9 Employers are called out in number two,  
10 and small group health insurance marketplace would be  
11 inclusive of employers and brokers, and they're called  
12 out again in number five.

13 So it wasn't our intent to exclude anyone,  
14 but we didn't always reference each particular group in  
15 each one of these. Okay.

16 And, with those comments, I'd like to see  
17 if we could call for a vote, and what I'll do is read  
18 your name, and if you would just say yes or no, so this  
19 is for approving the Guiding Principles. I'm going to go  
20 on my list. Tony Pinto?

21 MR. PINTO: Yes.

22 MS. O'GARA: Ellen Skinner?

23 MS. SKINNER: Yes.

24 MS. O'GARA: Grant Ritter?

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1 MR. RITTER: Yes.

2 MS. O'GARA: John Fleig?

3 MR. FLEIG: Yes.

4 MS. O'GARA: Lynn Marie Janczak?

5 MS. JANCZAK: Yes.

6 MS. O'GARA: Marta McCubba? Deirdre,  
7 you're going to?

8 MS. HARDRICK: I'm going to abstain.

9 MS. O'GARA: Okay. Mary Ellen Breault?  
10 You're not, okay. Pam Russek?

11 MS. RUSSEK: Yes.

12 MS. O'GARA: And Tim Pusch?

13 MR. PUSCH: Yes.

14 MS. O'GARA: Patricia?

15 MS. PATRICIA PULISCIANO: Yes.

16 MS. O'GARA: Did I miss anyone? Okay, so,  
17 we have approved the Guiding Principles from this  
18 Committee, and, with that, Bob, I think you're going to  
19 go to the next item.

20 MR. CAREY: Okay, so, this gets into sort  
21 of the details about the Essential Health Benefits that  
22 will be provided by all qualified health plans that are  
23 offered in the individual and small group market.

24 This is primarily for information and

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1 discussion, not sort of a vote or a recommendation from  
2 this Advisory Committee. We have two other Advisory  
3 Committees, who will be taking action in the form of a  
4 recommendation to the full Exchange Board with regard to  
5 the Essential Health Benefits, but we thought it  
6 important that we bring this issue to all four of the  
7 Advisory Committees, so that you could provide staff and  
8 sort of public input with regard to the Essential Health  
9 Benefits.

10 Let me take a step back, and I'm going to  
11 walk you through the role of the Connecticut Exchange and  
12 the Advisory Committees with regard to Essential Health  
13 Benefits.

14 Essential Health Benefits are what's  
15 covered by the Qualified Health Plans offered in the  
16 individual and small group market. It's not cost  
17 sharing.

18 Cost sharing is treated as part of the  
19 actuarial value calculation that will also be required,  
20 but this really is a discussion about what must be  
21 covered as part of what the ACA calls the Essential  
22 Health Benefits Package, and I'll walk through why each  
23 state now is going to have to make that determination and  
24 how the process that the feds have set up to make that

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1 determination.

2 I'm going to just give you an overview of  
3 the Qualified Health Plans and Essential Health Benefits.  
4 What are the requirements under the law and subsequent  
5 federal guidance? How state mandates are treated under  
6 Essential Benefits, HHS's approach, what they refer to as  
7 the Benchmark Plan, and then some options for Connecticut  
8 and Next Steps.

9 So the Essential Health Benefits Package,  
10 as I mentioned, applies to Qualified Health Plans that  
11 are sold in the individual and small group market inside  
12 the Exchange and outside the Exchange, so it's broader  
13 than just the Exchange with regard to the effect that the  
14 Essential Health Benefits Package will have on the  
15 overall marketplace.

16 So, in 2014, the only health plans that  
17 can be sold in Connecticut in the individual and small  
18 group market will have to cover the Essential Health  
19 Benefits Package that's the sort of minimum baseline that  
20 will have to be covered, okay?

21 It's not just the Exchange. It's the  
22 broader market, so our current approach, and this is sort  
23 of open to, you know, it's a bit of an evolving process,  
24 is that because it has broader market-wide implications,

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1 we think the Exchange has a significant role to play in  
2 making a recommendation with regard to which of the  
3 options Connecticut should pursue with regard to the  
4 Essential Health Benefits Package, but because it has --  
5 because the people outside the Exchange will be affected  
6 by this decision, currently, the thinking is that either  
7 the Department of Insurance, or the Governor's Office,  
8 or, potentially, they could defer to the Exchange Board,  
9 will be the final arbiter of what's the Essential Health  
10 Benefits Package for Connecticut?

11 And there are limits that I'll walk  
12 through with regard to your options. It's not as if you  
13 can make it -- so we'll walk through what those options  
14 are, but, currently, the thinking is that the Advisory  
15 Committees will make the recommendation to the full  
16 Exchange Board, that the full Exchange Board will then  
17 make a recommendation to the administration with regard  
18 to the Essential Health Benefits Package for Connecticut  
19 individual and small group purchasers, so that's sort of  
20 the two-step process that we're taking.

21 This decision needs to be made, a final  
22 decision with regard to the Essential Health Benefits  
23 Package, needs to be made by September of 2012, or the  
24 federal government will decide what's the Essential

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1 Health Benefits Package for Connecticut, so that's sort  
2 of one deadline, and the other is sort of a realistic  
3 recognition, that carriers will need time to modify their  
4 current individual and small group products or offer new  
5 products that meet the Essential Health Benefits that are  
6 inclusive of all of the Essential Health Benefits that  
7 we're going to walk through. Yes, sir?

8 MR. PUSCH: How deep into the definition  
9 of Essential Health Benefits are we to go into for the  
10 Board to make their approval? I know we're not talking  
11 co-pays and deductibles, but how far do we have to define  
12 each of these Essential Health Benefits, in terms of that  
13 decision process?

14 MR. CAREY: So I'm going to walk through.  
15 There are 10 options that the federal guidance discusses,  
16 and we'll walk through those, and I think we'll answer  
17 your question.

18 MR. PUSCH: Okay.

19 MR. CAREY: So we think that the process  
20 is that the Advisory Committees will make a  
21 recommendation to the Exchange Board in the summer, this  
22 summer, that the Exchange Board will then make a  
23 recommendation, and a final decision will need to be made  
24 in September, one, to satisfy the federal requirements,

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1 and, two, to give carriers enough time to develop  
2 products that are inclusive of all of the Essential  
3 Health Benefits.

4 So just sort of on an overview of  
5 qualified health plans, the ACA requires, as I mentioned,  
6 all plans sold in the individual and small group market  
7 inside and outside the Exchange to cover what's  
8 considered the Essential Health Benefits, and there are  
9 10 broad categories, which we'll discuss, laid out in the  
10 federal law.

11 It does not deal with cost sharing, as I  
12 mentioned. That's a separate calculation and decisions  
13 that are made around the tins of platinum, gold, silver  
14 and bronze, and the actuarial value of those products,  
15 which will affect the amount of cost sharing that's  
16 allowed.

17 This is entirely a discussion about what's  
18 covered under Essential Health Benefits Package and I  
19 guess what's not covered under the Essential Health  
20 Benefits Package.

21 Originally, under the law, the Secretary  
22 of Health and Human Services was charged with determining  
23 that level of detail that you're talking about with  
24 regard to fleshing out underneath each of the 10 broad

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1 categories. What do they mean by, you know, ambulatory  
2 patient services, or inpatient hospitalization services?

3 The Secretary deferred that decision  
4 within certain parameters to each of the states and the  
5 District of Columbia to figure out what each state will  
6 consider as the Essential Health Benefits Package within  
7 some parameters, and, so, the bulletin that was issued in  
8 December of 2011 by the Secretary of Health and Human  
9 Services identifies four plan types and a total of 10  
10 plans that could be determined by each state to  
11 constitute the Essential Health Benefits Package.

12 And, so, those 10 plan types are, within  
13 the small group market, the three plans with the largest  
14 enrollment in the small group market, it could be one of  
15 the three State Employee Health Plans with the largest  
16 enrollment, it could be one of the three Federal Employee  
17 Health Plans with the largest enrollment, or it could be  
18 the HMO with the largest enrollment in the state, so  
19 there's sort of 10 options that states are provided, a  
20 total of 10 options the states are provided, with the  
21 default being that if you don't make a decision by  
22 September of 2012, that the federal government will deem  
23 the small group plan with the largest enrollment to be  
24 the Essential Health Benefits Package.

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1           The other caveat is that if a product that  
2           you select doesn't include services within one of those  
3           10 broad categories, so, for example, if the largest --  
4           the plan with the largest enrollment in the small group  
5           market didn't include prescription drug coverage, you  
6           would need to supplement that product with the  
7           prescription drug benefit, or, if the plan that was  
8           selected doesn't cover pediatric dental, which many times  
9           is not covered in a commercial health plan, you'll need  
10          to supplement that with pediatric dental, because that's  
11          one of the 10 broad categories that are covered under the  
12          law.

13                 And, so, you have sort of this base plan  
14          that may need to be supplemented with additional benefits  
15          in order to satisfy all the 10 categories of care  
16          identified under the law.

17                 So these are the 10 broad categories, so  
18          the plan that will serve as the Essential Health Benefit  
19          Plan for Connecticut will need to cover services under  
20          each one of these categories, and we'll walk through, you  
21          know, more detail about what we mean when we say  
22          ambulatory patient services, or hospitalization, or  
23          emergency services.

24                 So this, if you go to the law, Section

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1 1311, I believe, lays out the Essential Health Benefits  
2 and the 10 broad categories. It then directs the  
3 Secretary of Health and Human Services to flesh out these  
4 in more detail.

5 She has decided that the states should  
6 flesh out this in more detail, so that's why we're having  
7 this discussion today.

8 The other key issue for your consideration  
9 is that, under the law, if a state has mandated benefits  
10 that exceed or are not part of one of these 10 broad  
11 categories, the state would be responsible for paying for  
12 the cost of that additional benefit for everyone that  
13 purchases coverage through the Exchange.

14 So, under the law, it says that the  
15 Essential Health Benefits include these services to be  
16 determined by the Secretary of Health and Human Services,  
17 and, if a state has a requirement that goes above and  
18 beyond what is considered the Essential Health Benefits  
19 Package, the state would have to pay for the cost, the  
20 additional premium associated with covering a state  
21 mandate that isn't included within these 10 categories,  
22 okay? So that's what the law says.

23 The bulletin, then, that was issued in  
24 December, which allows a state to designate a small group

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1 plan, for example, as its Essential Health Benefits  
2 Package, essentially, it gives you at least a two-year  
3 breather, in terms of having to pay for any mandated  
4 benefits that might exceed the Essential Health Benefits  
5 categories.

6 So, for example, the, you know, in vitro  
7 fertilization, right, is a sort of prime candidate for  
8 perhaps not fitting in within one of these 10 broad  
9 categories of care, but it is a state mandate, so the  
10 marginal cost of providing that would have been the  
11 responsibility, could be the responsibility of the State  
12 of Connecticut to pay for that cost of the benefit if it  
13 was included within the Exchange plans and is still a  
14 requirement under State mandates.

15 But because you can select a small group  
16 plan, which does, in fact, include that benefit, as your  
17 Essential Health Benefits Plan in 2014 and 2015, it  
18 removes the fiscal, potential fiscal impact on the state  
19 if the state designates a small group plan that includes  
20 all of those state mandated benefits.

21 So it's really sort of what they view as a  
22 transitional period, at least in 2014 and 2015, to be  
23 determined at some later date whether they'll make any  
24 changes in 2016 and beyond.

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1 MR. PUSCH: I took a wild shot running  
2 through those mandates and giving some thought to what  
3 might apply and what might not apply. Very difficult.

4 At some point, would we be capable of  
5 doing that? Would we be able to identify the ones that  
6 wouldn't fit in with the Essential Health, if for no  
7 other reason to get an idea of the actuarial savings by  
8 not doing it?

9 MR. CAREY: Yeah, so, we had at our  
10 meeting this morning with the Qualified Health Plan, or  
11 the Qualified Health Plan Advisory Committee meeting,  
12 that was requested of staff.

13 We had a report written in December by  
14 Mercer that attempted to take a crack at that. I think  
15 that there's lots of interpretation, as to whether or not  
16 certain benefits would be included or not, and, so, we're  
17 going to go, and we will provide for the Committee's  
18 consideration, sort of an identification of potential,  
19 mandates that potentially could be determined to fall  
20 outside of one of these categories, so that we provided,  
21 in the information provided to the Committee, a list of  
22 all the State mandates.

23 We'll go back, look at the Mercer  
24 information, have discussions with the Department of

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1 Insurance, and try to identify those that could  
2 potentially be on the State's dime in 2016 and beyond,  
3 but at least, for a transitional period, there's the  
4 potential for the State to set the Essential Health  
5 Benefits Package to be inclusive of all the State  
6 mandates and, therefore, not a requirement that the State  
7 pick up the cost of the premium difference for those  
8 mandates.

9 MR. PUSCH: Just one real quick thought  
10 about that. The danger of including them, and, then,  
11 possibly two years from now, having to pull them out of  
12 the mix, just we should think about that.

13 MR. CAREY: Yeah, I mean, and that's why  
14 we raise it, because, you know, there is potential fiscal  
15 impact to the State, and it would be for all people  
16 purchasing coverage through the Exchange, not just people  
17 receiving a premium subsidy.

18 There's also potential for market  
19 distortion issues, as well, because if the benefit is  
20 paid for by the consumer outside of the Exchange, but  
21 paid for by the State through the Exchange, you may have  
22 an incentive for people, even who don't have subsidies,  
23 you know, aren't eligible for premium subsidies to  
24 purchase coverage through the Exchange and could distort

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1 the market, so there's lots of ramifications, and we  
2 wanted to keep that on everyone's radar.

3 MS. BREAULT: And just to add to that,  
4 basically, for the determination for 2014 and 2015, we  
5 have to choose one of these benchmark plans, so to the  
6 extent we choose one of the existing small employer plans  
7 that would already have the mandates, we don't have any  
8 options.

9 Those become part of that package for  
10 those two years, and it really is after that transitional  
11 period, once the federal government defines the Essential  
12 Health Benefit Package for future years, that's when  
13 we'll have to take a look and make some determinations as  
14 a State.

15 MR. CAREY: Okay, so, we talked a bit  
16 about State-mandated benefits. There is, also, carrier  
17 flexibility, so while the State will need to select one  
18 of those plans, potentially supplement it with additional  
19 benefits, carriers are provided some flexibility with  
20 regard to the actual benefits offered, so long as the  
21 benefits covered are substantially equal, this is a lift  
22 from the bulletin, substantially equal to the benchmark  
23 plan.

24 So, for example, if there's a PT/OT

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1 benefit of, you know, up to 20 visits per illness and  
2 there's a subsequent plan that has, you know, to 18  
3 visits per illness, or something, where it's a length of  
4 time after the specific accident occurs, it would be  
5 largely, because this affects the broader individual and  
6 small group market, it would likely fall to the  
7 Department of Insurance to determine that the plan does  
8 cover the Essential Health Benefits or are substantially  
9 equal to the Essential Health Benefits Package, so I just  
10 wanted to let people know that there is some flexibility  
11 built into a benefit's package that would be offered.

12 And then, also, that HHS will be updating  
13 the Essential Health Benefits requirements sometime in  
14 the future. They have not let us know when that will be,  
15 but just so this is not sort of a one-shot deal, that  
16 this will evolve over time, or at least HHS's intention,  
17 that this will evolve over time.

18 So with regard to Connecticut-specific  
19 options, in December of 2011, the Department of Insurance  
20 surveyed the carriers to identify the plan designs in the  
21 small group market.

22 There are actually nine options, because  
23 the ConnectiCare HMO plan is the health plan with the  
24 largest -- is the HMO with the largest enrollment. It's

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1 also one of the three largest small group products in  
2 Connecticut, so you have sort of both -- it is both the  
3 largest HMO, and it's also one of the three largest small  
4 group plans, so, instead of 10 options, we're down to  
5 nine options.

6 The other issue is that the Federal  
7 Employee Health Benefit Plan, two of the three, are  
8 essentially the same benefit package. The difference is  
9 only in the cost sharing, so the Federal Employee Health  
10 Benefits Plan includes what's called a basic option and a  
11 standard option.

12 The benefits are the same. The cost  
13 sharing is what differs, and, so, we're not looking at  
14 cost sharing. We're only looking at what the benefits  
15 are covered, so it sort of narrows down your choice a  
16 little bit further and just sort of takes, you know, what  
17 was 10 options down to eight options.

18 The other issue is that State Employee  
19 Plans cover all -- the benefits are the same, cost  
20 sharing is different, so it's really just one State  
21 Employee Health Plan that we need to consider with regard  
22 to what's covered as part of the Essential Health  
23 Benefits.

24 So, you know, you started with 10

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1 potential options, and you're down to seven potential  
2 options, and, as you'll see as we walk through this,  
3 there's not significant variation.

4 There is some variation, but there's not  
5 significant variation in the benefits that are covered  
6 across these seven plan options.

7 There are a couple issues that we  
8 identified right away that we may need to supplement  
9 coverage, so, you know, I talked about the 10 broad  
10 categories.

11 Habilitative services as opposed to  
12 rehabilitative services are generally not covered in a  
13 standard commercial product, and, so, some thought, as to  
14 what that benefit package looks like with regard to  
15 habilitative services, will need to be considered, so  
16 habilitative is you never -- it's not as if you lost the  
17 function.

18 If you were in an accident and you needed  
19 therapy, so that you could use your hands again, it would  
20 be an issue of you never were able to use, you know, your  
21 hands, and services are needed to provide that you are  
22 able to use that body part, so that's the distinction  
23 between rehabilitative and habilitative.

24 Generally, carriers don't cover

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1       habilitative services. Medicaid, in general, it's not a  
2       covered service, so we'll have to figure out, and there's  
3       some guidance from the feds, as to how they are  
4       interpreting this provision about habilitative services.

5               And then, also, pediatric oral and vision  
6       tend not to be a covered benefit in most commercial  
7       products, and, so, how we supplement that will be another  
8       decision that will need to be made.

9               MR. PUSCH: Can I ask one question? On  
10       the list of Essential Benefits, I saw sort of a glaring  
11       missing element, or are we assuming it's folded in  
12       elsewhere, and that's diagnostic imaging. You tell me  
13       where you think that might end up.

14               MR. CAREY: Yeah, so, we put that in  
15       laboratory services, so we'll go through now each of the  
16       categories and sort of just show you how we started to  
17       break this down, and then what we'd like from you is  
18       thoughts about did we miss anything? Do you need  
19       additional information about any of the details that  
20       we'll provide?

21               So ambulatory patient services is sort of,  
22       you know, your basic benefits package with regard to non-  
23       inpatient services that are provided on an outpatient  
24       basis.

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1 All of the carriers, all of the plans  
2 reviewed cover the services. There are some limitations,  
3 for example, on home health care and skilled nursing  
4 facilities, but other services provided are non-limited.

5 That doesn't mean that there isn't prior  
6 authorization, or there's not medical management that's  
7 going on by the carrier, but in terms of the contract  
8 document, itself, there's not a hard restriction or limit  
9 on the number of visits that someone, you know, can make  
10 to a specialist, for example, where there is with regard  
11 to home health care services and skilled nursing facility  
12 services.

13 So that's what we're doing here, is we're  
14 not showing you cost sharing or any type of medical  
15 management or carrier management of the benefit. What we  
16 explain for you here is is it a covered benefit, and is  
17 there a specific limitation or exclusion that's provided?

18 So this is the two sections here deal with  
19 ambulatory patient services and emergency services.  
20 Perhaps there's a takeaway from this meeting.

21 If you go back and take a look at this, or  
22 discuss it with your colleagues or others, and there's  
23 anything specific that you didn't see here that we think  
24 we should include, we invite you to let us know, and we

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1 can make sure we bring it back to the Committee.

2 MR. PUSCH: Just one thought, for example

3 --

4 MS. O'GARA: Excuse me, John. Can you use  
5 the --

6 MR. PUSCH: Sorry. One thought. I'll use  
7 the category specialist as an example. There might not  
8 be every service that's covered under a policy for a  
9 particular type of specialist, and I can't think of  
10 anything off the top of my head, but specialist is a, I'd  
11 say, a type of provider, but that doesn't mean every  
12 service necessarily is covered to that provider.

13 You could have an exclusion in a policy  
14 that doesn't cover a specific service to a specialist or  
15 any of those type of categories.

16 MR. CAREY: That's correct. So there are  
17 certain exclusions that will be incorporated within a  
18 policy that may limit what's provided by that specialist,  
19 but the fact that access to a specialist is covered was  
20 what we looked at.

21 I guess we could go through, and there's,  
22 obviously, at the back of most or all evidences of  
23 coverage, there's a list of exclusions that would be  
24 applicable to the plan design, and I think that that was

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1 one of the takeaways from this morning's meeting, as  
2 well, is to just flesh out what those lists of exclusions  
3 are for each of these various product offerings.  
4 Anything else on these two areas?

5 So the next item, inpatient hospital  
6 services, or hospitalization, I tried to flesh this out  
7 again. This is, you know, not like you have unlimited  
8 time in a hospital, but that there's no hard edit or  
9 limit to the number of days.

10 I do work in some states, where the  
11 Medicaid plan, for example, limits you to, you know, 20  
12 inpatient days a year. We don't have that in the  
13 benefits offered in Connecticut under these plan designs,  
14 but that's what this is getting at, is any sort of hard  
15 limit.

16 And you'll see, for all of the products --  
17 and I don't know if, Mary Ellen, you want to comment  
18 about the way that the Department of Insurance has  
19 interpreted the law with regard to annual or lifetime  
20 limits.

21 MS. BREULT: Basically, when the federal  
22 law said that you can no longer have annual dollar  
23 limits, we had Essential Health Benefits. This was  
24 beginning in September 2010, even though Essential Health

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1 Benefits had not yet been defined, so we had  
2 conversations with CCIIO and said we have many mandates  
3 that seem to fall into the categories, and, you know,  
4 like ostomy was covered at up to \$1,000 a year, and we  
5 said does that mean now, assuming that it looks like it's  
6 an Essential Health Benefit, we should say it now has to  
7 be unlimited, and they thought that was the appropriate  
8 way to go.

9 So since 2010, any new filings that have  
10 come in or renewals basically have no dollar limits on  
11 anything that would seem to fit under those categories,  
12 so that is a change.

13 And, as Bob was indicating, it's not to  
14 say you can't have utilization review for a medical  
15 necessity determination, so if you go into the hospital  
16 and it's determined you need a five-day stay, your  
17 contract doesn't say you only get five days in the  
18 hospital, but there could be, you know, this utilization  
19 review process on top of the coverage.

20 MR. CAREY: Okay, so, the next there  
21 categories are prescription drugs, rehabilitative and  
22 habilitative services and devices and laboratory  
23 services, and you can see we added imaging within the  
24 laboratory services category.

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1           Again, the rule is or the guidance is  
2 still under development, and, so, you'll see, for two of  
3 three small group products, that prescription drugs is a  
4 rider. It's not part of the base package of benefits,  
5 and I guess, even within the State Employee Health Plan,  
6 prescription drugs is a rider and is not part of the base  
7 benefit package.

8           That doesn't mean that if you selected  
9 Anthem Blue Cross/Blue Shield's HMO as the product, that  
10 you don't have to include prescription drug coverage,  
11 because prescription drugs is part of the 10, is one of  
12 the 10 broad categories of service.

13           There is no mandate in Connecticut with  
14 regard to prescription drug coverage, but, beginning in  
15 2014, all products sold in the individual and small group  
16 market will have to have prescription drug coverage.

17           This also doesn't get to any type of  
18 formulary that the carriers may utilize as they cover,  
19 whether it's an open or closed formulary, and there will  
20 be further guidance from the feds on what they mean by  
21 prescription drug coverage, but I just wanted to point  
22 that out with regard to the parens that talks about a  
23 rider.

24           So if the State established that Anthem

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1 Blue Cross HMO is the Essential Health Benefits Package,  
2 it would need to be supplemented with a prescription drug  
3 benefit. It couldn't just be part of that base package  
4 that excludes prescription drugs.

5 MR. PUSCH: Excuse me, Bob. Would we have  
6 a responsibility of further defining that Essential  
7 Health Benefits element of prescription drugs, like  
8 indicating whether an open, or closed formulary, or some  
9 number of drugs per category, or any of that further  
10 definition? Would that be part of our responsibility --

11 MR. CAREY: Well --

12 MR. PUSCH: -- Essential Health Benefits?

13 MR. CAREY: The guidance from HHS is that,  
14 currently, the current thinking is that there needs to be  
15 at least one drug per class included in the formulary.  
16 They haven't gone much further than that.

17 What I think, from the perspective of  
18 Connecticut and the decision with regard to prescription  
19 drug coverage, it would likely point to a carrier, a  
20 specific prescription drug benefit, so, for example, you  
21 could point to the State Employees Prescription Drug  
22 Benefit as the prescription drug benefit that has to be  
23 included in Essential Health Benefits.

24 It gets a bit of a slippery slope when you

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1 start, you know, down that path of being very specific  
2 about the formulary, but I do believe that it's within  
3 the purview of the State to determine what that  
4 prescription drug benefit looks like and to point to a  
5 product that's in the market today.

6 MS. JANCZAK: On the prescription drug  
7 benefit, what about experimental drugs that have reached  
8 a stage of, you know, usage, but haven't been, haven't  
9 formally been FDA approved yet?

10 Are we to consider that, as well, in the  
11 prescription drug category?

12 MR. CAREY: I don't think so, but I don't  
13 know if the State has a requirement on the use of  
14 experimental therapies.

15 MS. BREault: Right now, you know, for the  
16 policies that cover them, generally, they are FDA  
17 approved. With regard to experimental, you know, we  
18 could go to our external appeals process to determine  
19 whether it is still viewed as experimental, but that's  
20 really about as far as we go right now.

21 MR. CAREY: So you can see, again, there  
22 are some limits on patient rehab services. There are  
23 typically limits with physical therapy, occupational  
24 therapy and speech therapy, and we want to further define

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1 those, so that the Committee is aware of the differences  
2 across the health plans.

3 Again, a couple of the issues that we  
4 identified were the pediatric dental and vision and  
5 whether the coverage in the plans, where it says that  
6 it's covered, would the coverage for those plans meet the  
7 minimum set by the federal government, and they tend to  
8 point to the CHIP benefit as potentially the pediatric  
9 dental benefit that would need to be provided, or they  
10 point to the Federal Employee Health Plan dental benefit.

11 The dental benefit is separate and apart  
12 from the medical benefit for the Federal Employee Health  
13 Plans, but they point to the dental benefit that is  
14 provided separately as potentially one that states could  
15 point to as the minimum level of dental, pediatric dental  
16 benefits that would be provided as part of the Essential  
17 Health Benefits Package.

18 MR. PUSCH: Wouldn't we essentially have  
19 to be defining that, because nobody really virtually  
20 offers it at this point in time?

21 MR. CAREY: Yeah, so, that's why I think  
22 that what we would do is take a look at how it's defined  
23 under CHIP, or how it's defined under the Federal  
24 Employee Health Benefit Plan for their dental coverage

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1 and, also, look to federal guidance with regard to the  
2 dental benefit.

3 I mean I was at a CMS meeting last week,  
4 and the new line is that dental is the new SHOP, meaning  
5 that they had -- they're having a tough time figuring out  
6 the SHOP Exchange, and now they're turning to dental  
7 coverage, and they're having a tough time figuring out  
8 what the dental benefit is.

9 Typically, a commercial medical coverage  
10 does not include dental coverage, except for emergencies,  
11 or, you know, in case of an accident, so they're having  
12 to re-think how they go about dealing with that.

13 So next steps are really just to get  
14 feedback from the Committee, any additional information  
15 that you might be interested in receiving.

16 Again, this Committee is not going to  
17 vote, per se, on a recommendation, but we did feel if it  
18 was of such import that we wanted to bring it to the  
19 Committee and get input into the process, that there are  
20 two Committees, Advisory Committees as part of the  
21 Exchange, who will be, you know, sort of noodling over  
22 this at a deeper level, and making a recommendation to  
23 the full Advisory, full Exchange Board.

24 The Exchange Board, at the current

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1 thinking, is that they won't determine what the Essential  
2 Benefits are, but they will be advisory to the  
3 administration, which, under the current guidance from  
4 the federal government, is the entity that will need to  
5 make that decision.

6 Again, it needs to be made by September of  
7 2012, so we envision this being brought up to the  
8 Exchange Board around the July time frame. It might  
9 actually slip into August, given the feedback that we've  
10 received so far, but sometime this summer we need to  
11 make, Connecticut needs to make a decision, so that, by  
12 September of 2012, the Essential Health Benefits Package  
13 can be defined, that we can notify CMS, and that we can  
14 then let the carriers know what is their requirements for  
15 coverage sold in the individual and small group markets.

16 MR. PUSCH: One further clarification.  
17 Going back to this issue of therapies, is it the  
18 Essential Health Benefits Committee's responsibility to  
19 define it, for instance, in terms of number of sessions  
20 allowed, or would that sort of thing be left to the  
21 pricing mechanism of the different levels, platinum,  
22 gold, so forth?

23 COURT REPORTER: One moment, please.

24 MR. CAREY: If the health plan that's

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1 chosen as the benchmark plan has, you know, a 20-day  
2 limit, 20-visit limit with regard to different therapies,  
3 then that would be the standard by which all other plans  
4 would be measured.

5 Again, there is some flexibility built  
6 into the law, built into the regulations, I should say,  
7 but in terms of the coverage minimums, that would be the  
8 standard.

9 The question, about whether it's a \$10 co-  
10 pay or \$20 co-pay, again, would be a decision with regard  
11 to actuarial value, but in terms of any hard limit on  
12 visits, that would be part of the Essential Health  
13 Benefits Package.

14 MR. TESSIER: This is obvious, but one  
15 caution. There's a fine balance between how  
16 comprehensive something is and how affordable it is, so  
17 we have to be cognizant of both sides of that coin.

18 MR. CAREY: Correct. So, again, if  
19 Committee members have specific issues, or questions, or  
20 if you'd like additional information, we tried to put in  
21 sort of a whole list of resources that may be of interest  
22 to Committee members as they think about this issue, and  
23 we would welcome any input that you have on this.

24 MS. O'GARA: Bob, did you want to mention

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1 how we're going to go through the process, based on the  
2 input we got from the Qualified Health Plan Committee  
3 this morning? It might be of some interest to this  
4 group.

5 MR. CAREY: So we went through this, had a  
6 pretty robust discussion this morning with the Qualified  
7 Health Plan Advisory Committee. We're also bringing it  
8 to the Consumer Experience and Outreach Advisory  
9 Committee.

10 They requested that, the Qualified Health  
11 Plan Advisory Committee has requested additional  
12 information specific to the state-mandated benefits, or  
13 any limits, or exclusions that each of these plans has,  
14 and we'll be providing additional information to the  
15 Committee.

16 They will have an opportunity to discuss  
17 and to make a recommendation, and our thinking is we'll  
18 have a joint meeting between the Consumer Experience and  
19 Outreach Committee and the Qualified Health Plan  
20 Committee to have a common recommendation to the Exchange  
21 Board with regard to which of the options that are  
22 available to Connecticut, would be the recommendation of  
23 the Advisory Committee.

24 MS. JAFF: Okay, so, if we're ready and

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1 there's no more comments on that, we can go to the next  
2 agenda item, which is the Carrier comments and concerns.

3 MR. CAREY: Yeah, so, at our first  
4 meeting, we talked about the fact that the Exchange  
5 really has two sets of customers, or at least two sets of  
6 customers, one being the ultimate consumer of the Health  
7 Insurance, and the other being the insurers, who are  
8 offering their products on the Exchange.

9 It's a voluntary market. Carriers are not  
10 required to participate, and, so, one of the issues we  
11 discussed is that, you know, this is a new distribution  
12 mechanism for commercial health insurance, and that we  
13 felt it important to just advise this Committee, or to  
14 make this Committee aware of some of the common concerns  
15 of carriers that operate in the marketplace, so we worked  
16 with Connecticut Association of Health Plans, and they  
17 provided us with -- they represent all the carriers in  
18 the market, and they provided us with information from  
19 their members about sort of what are the top level  
20 concerns or issues of interest, among others, to the  
21 carriers.

22 And, so, this information was provided  
23 directly from the Connecticut Association of Health  
24 Plans, a few sort of key points.

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1                   One is that they want the Exchange to  
2                   adopt fair objective standards for health plan  
3                   participation and to minimize any additional issuer or  
4                   product requirements, so Exchanges have some flexibility  
5                   built into the law and the regulation about the standards  
6                   that they'll apply to the Qualified Health Plans that are  
7                   offered through the Exchange.

8                   It's the view of the industry in  
9                   Connecticut that there be no additional issue or product  
10                  requirements above and beyond the not insignificant  
11                  minimum standards that will be applied to all Qualified  
12                  Health Plans, including the Essential Health Benefits  
13                  Package, and reporting requirements, and actuarial value  
14                  tiers and so forth.

15                  MR. PUSCH: Such as what as an example of  
16                  their concern? What might we do, or an Exchange do that  
17                  would entail something they're concerned about?

18                  MR. CAREY: Well some Exchanges may put an  
19                  express limit on the number of carriers that they offer  
20                  through the market, so an Exchange could say we're only  
21                  going to select the top three, in terms of price, or an  
22                  Exchange could say we're going to require that the  
23                  benefit package look like this, and be very specific  
24                  about the particular cost sharing elements within each of

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1 the tins.

2 So if you go to the Massachusetts  
3 Connector website and look at the products that are  
4 offered through the Mass Connector, it's a subset of  
5 products that are offered in the broader individual and  
6 small group market, so it's sort of a narrow set of  
7 products, and they dictate to the plans what the cost  
8 sharing looks like at each of the tins, so all of the  
9 bronze plans look like this, all of the silver plans look  
10 like that, and the carriers don't have much flexibility,  
11 any flexibility really with regard to cost sharing  
12 elements, so that's --

13 MR. PUSCH: CBIA?

14 MR. CAREY: Where they set the benefit  
15 design, and the carriers respond with the product, so  
16 that's sort of an example, or it could be that the  
17 Exchange only wants, you know, limited network plans, or  
18 it only wants HMOs.

19 There's a whole number of decisions that  
20 the Exchange will need to make. It's the carriers'  
21 belief that they should be limited, in terms of how much  
22 additional requirements are put on carriers that  
23 participate in the Exchange, or the Exchange could say,  
24 if you want to participate in the individual market, you

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1 have to participate in the small group market, so there's  
2 lots of things that an Exchange could do that are being  
3 considered across the country.

4 In general, I would say this is from the  
5 Connecticut Association of Health Plans, but I can tell  
6 you, from having worked in lots of different states, this  
7 is sort of the common theme across the country with  
8 regard to the role of the Exchange in the marketplace.

9 The second point sort of builds off of the  
10 first, in terms of promoting competition, choice and  
11 innovation in product offering, so, again, their  
12 preference is the Exchange to be a marketplace, where  
13 carriers can offer different products within the limits,  
14 again, set by the law, so you still have the actuarial  
15 value levels that all of the products will need to meet,  
16 but there are different ways in which a bronze plan could  
17 be structured, for example.

18 You could have a product with an upfront  
19 deductible, and then no cost sharing after the fact, or  
20 you could have a product with no upfront deductible, but,  
21 you know, heavy co-insurance up to the out-of-pocket max,  
22 so there's different ways in which you can structure the  
23 benefit.

24 The carriers' request is that as much

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1 flexibility and choice as possible be provided to the  
2 carriers as they develop their products.

3 MR. PUSCH: Bob, that's sort of a bit of a  
4 contradiction for us a little bit, in the sense that  
5 we're seeking ease for the consumer, and, yet, they're  
6 asking for sort of flexibility that will make it a bit  
7 more complicated for the consumer.

8 And, so, we're going to be facing some  
9 conflicts here, in terms of what they're asking for  
10 versus what we're supposed to try to do.

11 MR. CAREY: Yeah, I mean I think that's a  
12 fair point, that, you know, on the one hand, you'll  
13 likely have lots of new consumers to insurance in  
14 general, and you want to make sure that those consumers  
15 are making an informed choice, and, so, on the one hand,  
16 that sort of lends itself to more of a standardized  
17 approach.

18 On the other hand, if you want choice,  
19 real choice and innovation and to be in step with the  
20 market, you want to be careful not to lock yourself into  
21 plan designs that may have looked good in 2013, but, by  
22 2014, they're out of fashion.

23 And, so, you know, I do some work with the  
24 Mass Connector, and, to be honest, that's my research, in

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1 which they ask me to go speak to the carriers, where the  
2 plans offered are kind of out of step with where the  
3 market is going, so the market in Massachusetts has moved  
4 on. There's lots of tiered network plans now, and  
5 limited network plans, and that's where the consumers,  
6 who aren't getting subsidies, are buying, but you can't  
7 find those on the shelf of the Connector.

8 So there's a delicate balance to be  
9 struck, in terms of how much standardization versus  
10 market creativity and flexibility, so you've got these  
11 dueling, somewhat dueling purposes.

12 The third sort of main point is for the  
13 Exchange not to duplicate or create additional regulatory  
14 requirements. The Connecticut Insurance Department is  
15 the agency charged with regulating the insurance industry  
16 in the state.

17 This, again, is sort of a common theme  
18 across all states, is that they don't, carriers don't  
19 want the Exchanges to serve as a sort of additional  
20 regulatory body, in terms of any requirements that might  
21 be imposed upon carrier.

22 For example, rate view and approval.  
23 Rates are reviewed and approved by the Connecticut  
24 Insurance Department. The view of the carriers is that's

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1 the proper place for rate review and approval, not an  
2 additional rate review and approval at the Exchange.

3 Now that somewhat -- some folks have read  
4 that as being in conflict with the law, because the law  
5 directs the Exchange to review and approve rates. The  
6 guidance and the regulations that have come out have  
7 subsequently pointed the Exchanges to Insurance  
8 Department, saying, oh, by the way, you already do rate  
9 review and approval in the state. That's a requirement  
10 of the ACA.

11 The Department of Insurance does that, so  
12 Exchanges can leverage what's being done already at the  
13 Department of Insurance with regard to rate review and  
14 approval, and I think that that's what this sort of an  
15 example of an option that the Exchange has with regard to  
16 how much review and approval of rates it will do.

17 That doesn't mean that the Exchange won't  
18 certify Qualified Health Plans, so that it's quite  
19 likely, in fact, it's almost guaranteed, that the  
20 marketplace will be bigger than just the products sold  
21 through the Exchange, so the Exchange will sell and offer  
22 a subset of products.

23 Even if the Exchange says to the carriers  
24 we'll take all the products that you want to sell,

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1 carriers will likely self-limit the number of products  
2 that they offer through the Exchange, and, so, there will  
3 be this issue of products coming through the Department  
4 of Insurance's review and approval that the Exchange may  
5 then select a subset of those products.

6 That doesn't mean the Exchange has to  
7 review and approve rates. The Exchange's role will be to  
8 certify the Qualified Health Plan, so the Health Plan's  
9 rates have been reviewed and approved.

10 The Exchange's option is simply do I offer  
11 this plan or don't I offer this plan, not do I approve  
12 the rate or not approve the rate? So it's just sort of a  
13 different way of looking at the role of the Exchange in  
14 the marketplace.

15 The Exchange could hire their own  
16 actuaries and do a detailed review and approval if they  
17 wanted to, if it wants to, but, currently, that's the  
18 purview of the Department of Insurance, and this one  
19 bullet speaks not specifically to rate review and  
20 approval, but it's sort of embedded within the common  
21 concern.

22 The fourth item is to minimize disruption  
23 to the existing marketplace. As Deirdre pointed out  
24 earlier, when we were talking about the principles of the

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1 Committee, that is one of them, is to minimize unintended  
2 disruption to the marketplace.

3 They point, specifically, to two options  
4 that are available under the law. The first is the  
5 merger of the individual and small group markets.  
6 Currently, those are two separate markets.

7 There is an option for states to merge  
8 those markets. There's only one state that has so far  
9 chosen to merge its markets.

10 That's Massachusetts, and the situation  
11 and circumstances there were such that it just seemed to  
12 make sense to merge those markets at the time, given that  
13 the individual market was so small, the small group  
14 market was much larger, and there was a common rating  
15 rules that applied in both the individual and small  
16 group, and the impact of merging those was a significant  
17 reduction in the small group and the individual rates,  
18 and a marginal impact on the small group rates.

19 And, so, Massachusetts is the only state  
20 that's chosen to merge their individual and small group  
21 markets.

22 The other issue is the expansion of the  
23 definition of small groups to employers with 100 or fewer  
24 lives. That's an option in 2014 and 2015. It's required

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1 in 2016, but the State could, if it wanted to, expand the  
2 definition of small groups to groups of 100 or fewer.  
3 The current definition is 50 or fewer. It's the  
4 recommendation of the carriers that the State maintain  
5 its current definition at 50 or fewer lives in 2014 and  
6 2015.

7 MR. PINTO: Yeah, I just wanted to bring  
8 up a frame of reference, that with the merging of the  
9 individual and small group market, in Connecticut we  
10 don't have guaranteed issue individual plans, but if you  
11 go to a group of one, which we do right in Connecticut,  
12 it is guaranteed issue, so there is significant crossover  
13 and cross-sales, and it's hard to just look at them and  
14 just say, well, there won't be any impact, because you  
15 don't really know who is a group of one or two employees,  
16 because they couldn't get individual coverage.

17 MR. CAREY: Yeah, so, that's, again, an  
18 issue that we'll be looking at further. The Qualified  
19 Health Plan Committee is due the discussion. I think,  
20 also, this Committee, as well, is, down the line, we'll  
21 want to take a look at that, but this is the  
22 recommendation from the carriers, that they be maintained  
23 separately as they are today.

24 MR. PUSCH: Bob, is this simply because it

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1 gives them more time to make the transition, because they  
2 ultimately do have to define it as 100 or less, so is it  
3 just a transitional period to their viewpoint?

4 MR. CAREY: Yeah, I would say that their  
5 preference is to delay this until 2016. I do think that  
6 there are significant issues associated with expansion,  
7 in general, of the market to groups of 100 or fewer.

8 We're seeing more and more groups of  
9 smaller and smaller numbers move to self-funded plans.  
10 There's the potential for I think not insignificant  
11 disruption to the marketplace when you expand the  
12 definition of a fully-insured marketplace to groups of  
13 100 or fewer, and I think that, I know that the  
14 Department is, you know, is concerned about that, and I  
15 think that we need to take a much closer and harder look  
16 at the potential impact to all groups when you expand  
17 that number to 100.

18 So given everything else that's happening  
19 and the changes that will take effect in 2014, the  
20 carriers' preference is that this be delayed until at  
21 least 2016.

22 MS. SKINNER: Will there be any specific  
23 recommendations about definitions around self-insured, or  
24 is that out of the --

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1 MR. CAREY: No. I think that that should  
2 be part of the consideration when we look at the issues  
3 around the expansion of the small group market to, you  
4 know, 100 or fewer.

5 In some states, they don't allow self-  
6 funding for groups of 50 or fewer, or they put other  
7 types of restrictions, in terms of the use of  
8 reinsurance, because what's happening, we could go into a  
9 pretty in-depth discussion, but what's happening in the  
10 marketplace today is that reinsurance is going down to a  
11 level that looks more like a deductible than it does true  
12 reinsurance, and it's distorting the marketplace, and I  
13 think that there is definite some concern I know amongst  
14 carriers, and there should be concern amongst consumers  
15 with regard to the potential effect, so I do think that  
16 it's important that the State take a close look at that.

17 MS. BREault: And, just to add, I think  
18 those things would require statutory changes. Right now,  
19 we don't have any prohibition on self-funding with regard  
20 to the size of the group, and, also, with regard to 50,  
21 you know, the definition of small group, that is in our  
22 current statute, and that would need to be changed.

23 MR. CAREY: Then just a couple of final  
24 comments from the carriers. One is sort of encouraging

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1 participation while preventing adverse selection, and,  
2 again, this gets to, particularly with regard to the SHOP  
3 Exchange, gets to the purchasing model that will be  
4 allowed, you know, in terms of the types of employee  
5 choice that might be available through the SHOP Exchange.

6 And then the last two points are sort of  
7 pleas for more information and final decisions from at  
8 both the state level and at the federal level with regard  
9 to all of the changes that will occur in 2014, so the  
10 carriers are, you know, essentially asking us to, you  
11 know, finalize these decisions, so that they can plan for  
12 the changes that will take place and for participating on  
13 the Exchange, so they know what will be required.

14 And, so, we hear them from a state  
15 perspective, and we also deliver this message when we  
16 meet with CMS, so we'll meet with the feds next week.  
17 Actually, there's a grantee meeting in Washington, and  
18 we're on calls all the time with them, you know, asking  
19 for final decisions about things.

20 They're working hard, but there's a lot  
21 more detail to be provided for, so we hear this message,  
22 we delivered this message to our federal partners, and we  
23 internalize it with regard to the need to work with the  
24 carriers.

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1 I will say that we have, in developing a  
2 working group, a technical working group with the  
3 carriers, not a policy working group, to try to get at  
4 some of the more technical administrative sort of back  
5 off its functionality that will need to be put in place,  
6 and KPMG is here today to talk a little bit about, you  
7 know, the work that they're doing on consumer assistance  
8 and the resource or environmental scan that they did, but  
9 they're also working on some of the technical  
10 requirements and what would be required of carriers vis-  
11 à-vis the Exchange.

12 MR. PUSCH: Bob, could you give us some  
13 perspective of what could cause an anti-selective  
14 environment that the carriers are concerned about, so we  
15 can sort of try to avoid that?

16 MR. CAREY: Sure. So network adequacy,  
17 right? Let's take network adequacy. If the Exchange or  
18 the Department has a network adequacy standard, if the  
19 Department has a network adequacy standard that is  
20 different from the Exchange's network adequacy standard,  
21 there could be some selection dynamics that occur, right,  
22 or, if the Exchange offers plans side-by-side and one is  
23 sort of a limited network plan and the other is a broad  
24 network plan, there could be some selection dynamics that

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1 occur there, or, if the purchasing model, that the SHOP  
2 Exchange allows employees to choose across the entire  
3 breath of coverage, so you can choose as low as a bronze  
4 plan, or as rich as a platinum plan, that's atypical in  
5 the marketplace.

6 You don't typically see, particularly for  
7 a small employer, the ability of those employees to buy  
8 all over the place across carriers, right?

9 So you've got multiple carriers with  
10 multiple products at different actuarial value levels,  
11 and if you allow employee choice, our concern from the  
12 carriers is if you allow employee choice that cuts across  
13 all carriers and all plan levels, you'll have, you know,  
14 younger and healthier people buying low, you know, less  
15 comprehensive, lower cost plans, and older and sicker  
16 individuals buying the most comprehensive, you know,  
17 highest cost plans, and there would be some selection  
18 dynamic that occur that don't currently occur in the  
19 market.

20 In the market today, a carrier might offer  
21 multiple products to an employer, but they're not  
22 offering multiple carriers multiple products, and when  
23 you start to compound the choice issue, there's a concern  
24 about the selection dynamics that could occur.

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1 MR. PUSCH: Well that does sound like a  
2 bit of a condemnation on the CBIA approach.

3 MR. CAREY: They're able to manage the way  
4 that they structure choice in that market, and the  
5 carriers voluntarily participate, so I think there's lots  
6 to learn from the CBIA approach, and how they manage  
7 risk, and how they work with the carriers to manage that  
8 risk, and the types of products that are available to the  
9 employees.

10 MS. O'GARA: Any other comments before we  
11 move off this particular subject?

12 MR. PORTER: Just add one comment with  
13 respect to carrier concerns and on the previous slides of  
14 the EHB resources. The Essential Health Benefits  
15 Coalition, we provided a list of potential resources, and  
16 if you Google EHB, you'll get many, many more.

17 The Essential Health Benefits Coalition is  
18 an organization of the small and large employers and  
19 health plans, so I might give particular interest just to  
20 get further information.

21 MS. O'GARA: Okay, we have Roger from KPMG  
22 with us today. Is he here? Where are you?

23 MR. ALBRITTON: Hi.

24 MS. O'GARA: Hi.

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1 MR. ALBRITTON: Hi. I'm Roger Albritton  
2 with KPMG. KPMG are the technical advisors for the  
3 Exchange. Currently, we're working on two work streams.

4 The one work stream is around the business  
5 and technical requirements for the Exchange, itself, and  
6 the other has been working around what we call the  
7 consumer assistance.

8 Consumer assistance really kind of breaks  
9 into three areas that we kind of looked at, Consumer  
10 Assistance programs, Call Centers, and Web Portal  
11 Functionality.

12 So what we're going to do today is kind of  
13 talk about what we did around the Consumer Assistance  
14 Analysis. We actually talk about some of the components  
15 of our current state blueprint.

16 Current state just means that it's what's  
17 existing today in the state, what we can look at at this  
18 particular point, and we've blueprinted it, meaning that  
19 we've gotten some dynamics about it, so that we can  
20 benchmark that against where we're going with future  
21 technical requirements as we go forward.

22 Also, we'll show you some samples of the  
23 business process flows that we put together as a part of  
24 this process. We did about 10 of the business processes

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1 there.

2 We'll also share our key observations with  
3 you, and then, of course, questions and answers that you  
4 may have. You have the questions, I'll try to have the  
5 answers, and we'll go forth with that.

6 So, basically, we have four components in  
7 this work stream. The current state blueprint, that's  
8 where we're at right today, and that's what we're talking  
9 about mostly today.

10 The consumer experience business and  
11 technical requirements, that will be the next set of work  
12 products that we'll be putting together. From that,  
13 we'll be able to kind of come back and work with the  
14 Exchange on what type of procurement strategy that they  
15 may need to utilize, whether or not they could leverage  
16 what they may already have in the state, whether they go  
17 out and procure that and bring that in-house, or  
18 potentially go and use an outsource model for that  
19 particular sets of service.

20 Once we've made a procurement strategy  
21 decision with the Exchange, then we would be finalizing  
22 that with them to come up with a technical requirements  
23 in the contract specifications to go out and buy those  
24 services, whatever those services may be. That could be

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1 hardware, software, or actually BPO services.

2 As a part of our approach, what we did is  
3 we interviewed the major agencies and some of the other  
4 minor players that were around. As you can see in this  
5 slide, we have the Connecticut Insurance Department, we  
6 have the Office of State Health Care Advocacy, and then  
7 Department of Social Services.

8 What we tried to do was get agencies that  
9 were either involved in the insurance markets as CID and  
10 OHA are, and those that would be involved with some of  
11 the users of the Exchange, and that's where DSS became  
12 involved, because they provide to the Medicaid and CHIP  
13 population, so we thought that would be a similar  
14 population there.

15 What we did is we interviewed these major  
16 agencies, we developed business flows, their key  
17 processes, which we're going to talk about in just a  
18 minute, and then we filled out a matrix of capabilities,  
19 so we had about 36 different attributes that we went  
20 through to measure the type of capabilities they have,  
21 and I've got an example of that in the presentation.

22 Again, this is just the current state  
23 blueprint consisted of the items I talked about. The  
24 current state assessment, which included the business

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1 process flows, our observations and recommendations, and  
2 some strategic considerations for the Exchange to take  
3 into consideration.

4 This is an example of the matrix. Again,  
5 what we did here, as you'll notice, this one has like  
6 statutory mandate, the population that it served. If you  
7 come down it a little bit, do they have a call center?  
8 Do they have IVR, which is a voice, Information Voice  
9 Recognition system? Languages.

10 We also had another group on the call  
11 center, and we had another set of matrix or attributes on  
12 web functionality.

13 The next slide is the end-to-end business  
14 flow, so what you have here is that the Connecticut  
15 Insurance Department they have people that initiate  
16 complaints or inquiries. Obviously, they resolve those  
17 complaints, and then they also do what they call a  
18 Consumer Satisfaction Survey to make sure they've got  
19 taken care of, similar to the Office of State Health Care  
20 Advocacy. They also do a similar set of groups.

21 Now the difference is that the Insurance  
22 Department is only focusing on the insurance companies  
23 that they regulate, where the Office of State Health Care  
24 Advocacy has a crossover of individuals that come in,

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1 those that would not be part, directly part of what CID  
2 regulates. This could include other needs there.

3 As you'll see down at the bottom, United  
4 Way of Connecticut is doing some initiating and -- yeah?  
5 It was the phone. Okay. I think we're good.

6 Okay. United Way does some initiating of  
7 applications, but they actually then send that over to  
8 the Department of Social Services and ACS, which actually  
9 does the processing for that, and then they process those  
10 applications, or re-determines, or a change of status.

11 Now the next slide is a detail of one of  
12 the flows, and I'm not really looking for you to read it  
13 from back there.

14 The purpose of that was just to try to  
15 give you an idea of what it was for. The main thing that  
16 we were trying to capture were the -- where the consumer  
17 sat in the process and how well the State was using the  
18 multi-tiers of a call center.

19 I don't know how many of you work with  
20 call centers or are familiar with call centers, but,  
21 typically, a tier zero means that it's being taken care  
22 of either with the web portal or your IVR system, meaning  
23 that I don't have to talk to anyone. It's taken care of  
24 for me by me asking questions or looking it up and

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1 getting the information I want.

2 Tier one implies that I got ahold of an  
3 operator, but that operator can handle my issue by either  
4 redirecting me back to the portal, or by sending me some  
5 information that I might need.

6 So, example, if I need a form, or I need  
7 to have a link that I couldn't find on the web portal,  
8 that tier one operator could handle that at that point.

9 Tier two implies that I need to do some  
10 research for you. I have an issue that requires a little  
11 bit of analysis, so I need someone that has some  
12 knowledge about whatever the issue is that you're calling  
13 about, they actually do some research, they research that  
14 issue, and try to find you a resolution.

15 Tier three typically means that I have to  
16 change something. Something is wrong, either wrong with  
17 your record, wrong with the process that you're trying to  
18 use, or even wrong with the application, so that it  
19 requires some type of change.

20 And what we try to do is flow out for  
21 these 10 business processes each of those interactions,  
22 so we could get an understanding of how well these  
23 applications were using the multi-tier approach for  
24 consumer support.

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1                   And, taking you to the next slide, so we  
2                   have, if I can find my copy of it, there we are, some key  
3                   observations.

4                   Now the first one really leads into all  
5                   the other ones. When we say that there's no existing  
6                   consumer assistant entity currently that serves all the  
7                   health insurance needs, it's really based upon the fact  
8                   that they're currently in silos, so there's no one that's  
9                   crossing all the way across. They are focused on the  
10                  area of their operations.

11                  There's few opportunities for self-help  
12                  exist, meaning there's not too many places that have tier  
13                  zero capabilities.

14                  An example is the Insurance Department  
15                  does have some ability to use the portal to fill out a  
16                  complaint, but most of the other areas don't have that  
17                  capability. It does require you to talk to someone, to  
18                  actually initiate some type of complaint or a request.

19                  There's no common method for identifying  
20                  consumers, meaning that you can't identify which group of  
21                  consumers or which consumers are shopping for appeals, or  
22                  shopping for different pieces of information, because  
23                  it's, again, in these silos.

24                  There's numerous 1-800 numbers and

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1 websites, so, again, you have to know which specific 1-  
2 800 number to call for your particular issue.

3 The technology has been put in several  
4 years ago, so it doesn't have a lot of the current  
5 technology capabilities, so that limits its ability in  
6 doing a lot of the self-help.

7 Staffing is constrained at the Consumer  
8 Assistance. This would impact you if you needed to scale  
9 up dramatically for peak time frames. You may not have  
10 the resources there to do that.

11 The call center hours of operations are  
12 fairly limited to the hours of the State, so, typically,  
13 we're talking 9:00 to 5:00, maybe 9:00 to 6:00, so,  
14 again, that limits your capabilities for those  
15 individuals that may work during those hours, that they  
16 may not be able to be supported by these particular  
17 operations.

18 Most of the locations have some limited  
19 space to expand, meaning that there's not a big open  
20 space that's available, again, to support a scale up in a  
21 call center operation.

22 Personnel responding to simple inquiries  
23 are often the same individuals resolving the Consumer  
24 Assistance issues. Again, this goes back to using the

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1 tiers. You would like, typically, to have a strong tier  
2 one support, where they would take care of your simple  
3 needs right away, i.e., repointing you back to the  
4 website, where to get information, sending you forms that  
5 you might need in order to continue the process, instead  
6 of having your analyst trying to deal with those  
7 particular issues. Your analysts have a limited  
8 bandwidth.

9 And then, finally, the entities are  
10 limited, in terms of formal programs, which to manage the  
11 things like navigators or other consumer assisted  
12 programs. It's not their core business. Yes, sir?

13 MR. PUSCH: From everything that you  
14 present, it strikes me that other than dealing with  
15 consumer complaints, which two entities appear to be  
16 having the priority responsibility, it seems to me like  
17 you're implying that we're going to need a whole new  
18 separate structure, essentially, to provide services for  
19 the Exchange. I mean is that a fair assessment at this  
20 early stage of the game?

21 MR. ALBRITTON: That is a fair assessment,  
22 based upon currently what the State has in production and  
23 available. The State is currently working with DSS, who  
24 is doing a modernization of their call center operations.

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1 We're monitoring that as we go forth with our rest of the  
2 steps of our work to see if that is an area where the  
3 Exchange may be able to leverage that modernization  
4 effort to provide some additional capabilities, because  
5 it would be a modernization of equipment, a modernization  
6 of the portal that would give you some additional self-  
7 services.

8 Now the problem is, obviously, that's an  
9 ongoing project, and it's not yet currently in  
10 production, so we're trying to monitor where they are and  
11 that their timelines match up to what the Exchange needs  
12 in order to accomplish that.

13 MR. PUSCH: Would that require any kind of  
14 legislative action to expand what that organization is  
15 doing now with respect to the Medicaid products?

16 The Exchange may want to piggyback those  
17 capabilities, but would the legislature have to support  
18 it?

19 MR. ALBRITTON: We're not aware of any  
20 legislation that would need to take place. There is, as  
21 with other State agencies, Memorandum of Understanding  
22 that the Exchange has entered into.

23 I would need for that Memorandum of  
24 Understanding to be expanded, and the financial details

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1 worked out of any cost allocation of that for them to  
2 provide that service.

3 Now that is one thing that would have to  
4 be worked out. Anywhere, where the Exchange is  
5 leveraging existing assets of the State, it would have  
6 some cost allocation, and that is one of the things that  
7 we're working on as a part of our work to determine what  
8 that cost allocation methodology is and how that might  
9 apply to the Exchange.

10 MS. O'GARA: Roger, could you tell us? So  
11 now that you've gotten the current situation understood  
12 and you're going to go from there, what kinds of things  
13 are you going to be looking at in these other three  
14 boxes?

15 MR. ALBRITTON: What we're trying to do  
16 now is taking the guidance from CMS, guidance that we've  
17 seen from other states. A number of states have issued a  
18 request for proposals, so we're taking that information  
19 to come up with what the business and technical  
20 requirements should look like for a robust consumer  
21 assistance and call center operation for the Exchange.

22 With that, we'll be evaluating that  
23 against the information that we identified in the current  
24 State blueprint, trying to identify gaps, so that we can

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1 identify if there's any reuse that the Exchange may get  
2 from the State, then that will lead us to the procurement  
3 strategy, so we'll try to provide the Exchange a couple  
4 of options on what they can do to procure the services  
5 and hardware and software that they need.

6 From that strategy, then we'll be able to  
7 go out and develop the actual technical specifications  
8 and requirements, so they can go into a contractual  
9 relationship for those services.

10 MS. O'GARA: And then one other question.  
11 How long will these processes take?

12 MR. ALBRITTON: Not long enough. No. The  
13 goal that we have is to get these accomplished in the  
14 July time frame, so we have a very short window of which  
15 to finish up the work. We're trying to match up all the  
16 needs, both from the Exchange standpoint, as well as from  
17 the Consumer Assistance standpoint, for a procurement  
18 decision in the July time frame.

19 MS. O'GARA: I think that that is pretty  
20 much the bulk of the agenda that we had today, in terms  
21 of our discussion points. Was there anything further,  
22 Bob, that we needed to bring up at this time?

23 Do we want to, then, talk about agenda  
24 planning for the next meeting and the kinds of things

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1 that we need to have prepared?

2 MR. CAREY: Sure. So a couple of things.  
3 One is really just sort of an open question, as to  
4 whether it would be helpful to go through sort of just an  
5 overview of the SHOP Exchange and how it may be  
6 structured.

7 We wondered whether the Committee might  
8 find that useful, to have a sort of a brief on the role  
9 of the SHOP Exchange, options that are available, and  
10 almost do a 101 with regard to the SHOP Exchange and its  
11 function within the broader Exchange environment, so I  
12 guess that's an open question for the Committee.

13 COURT REPORTER: One moment, please.

14 MS. RUSSEK: I think that that would be  
15 helpful. I think it would be even more helpful if we  
16 could get a little bit of that information in writing  
17 ahead of time, so that, you know, perhaps Grant and I can  
18 even work with the Committee members to come in and  
19 distill to a couple, a few points.

20 Here's what we really want to know a  
21 little bit more about, or here's what we're concerned  
22 about, or whatever that might be.

23 MR. CAREY: Sure. So we can do that.  
24 We'll put together an issue brief on the SHOP Exchange,

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1 and then be prepared to have a conversation, so go  
2 through a presentation and have a conversation about some  
3 of the key issues, as we scope out setting up the  
4 Exchange, and I think that that might, then, be helpful  
5 as we move forward, when we start talking about different  
6 purchasing options and the structure of the Exchange.

7 MS. RUSSEK: And, from that, I would -- I  
8 know we talked a little bit before about like an issue  
9 log or something, and we mentioned today a number of  
10 things that other Committees have asked for, so I'm  
11 wondering if there's going to be a central way to sort of  
12 track items that we know are forthcoming, that we're  
13 going to look for to come to us and, roughly, when we  
14 think they're coming.

15 And, then, secondly, back to some of the  
16 points raised about things like self-funding, just little  
17 notes to ourselves, sort of the things that we probably  
18 should be thinking about to get into some of our  
19 recommendations versus things that would require a  
20 legislative change that we probably shouldn't deal with  
21 for the time being, for example, but just to help keep us  
22 a little bit more honest about where we're spending our  
23 time.

24 MR. CAREY: Sure. The other piece that we

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1 thought would be helpful at the next meeting was a  
2 discussion, a bit more discussion about cost sharing, so  
3 we talked today about what's covered.

4 The other part of the equation is, you  
5 know, what's built into the premium versus what the  
6 member would pay at point of service, and, so, we thought  
7 it would be helpful to go through the specifics about the  
8 tins, or the metallic tiers as a Qualified Health Plan,  
9 and some options that are available that the Committee  
10 may want to consider with regard to cost sharing, to your  
11 point, Tim, earlier, with regard to member confusion or  
12 the ability of a member to navigate his way or her way  
13 through, whether that's an employer, or broker, an  
14 employee, with regard to their options.

15 MS. JANCZAK: The other thing I think  
16 might be helpful is, if there's any overlap in the  
17 Committees, you know, any subject matter, wherein there's  
18 an overlap, and we're not privy to what they're  
19 discussing, except for what you brief us on.

20 But if there is an overlap and we can be  
21 of assistance in any input, you know, in a shared  
22 dialogue, if you will, that might be helpful for us, as  
23 well, preliminarily.

24 MS. TIA CINTRON: Sure. We're going to

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1 try to stick to the matrix that we started with, too, in  
2 terms of where we're going with each of these decisions.  
3 We can continue to get more organized around these  
4 things, because we are operating in such a compressed  
5 timeline. Thank you.

6 MR. PUSCH: Speaking of timeline, do you  
7 have a sense of when the determination of Essential  
8 Health Benefits will be made?

9 MR. CAREY: Well, if it's not made by  
10 September, it will be made for us, so I think that's sort  
11 of the, you know, the hangman's noose. It brings a man  
12 to his senses pretty quickly.

13 MR. PUSCH: Is that what we can pretty  
14 much expect, then?

15 MR. CAREY: Yeah. I would think that it  
16 would probably take a good part of the summer to make a  
17 final decision and weigh the various options, but I would  
18 encourage Committee members, if they have, you know,  
19 concerns, comments, suggestions about information that  
20 might be helpful for you, or if you want to share your  
21 thoughts on the Essential Health Benefits Package, we'll  
22 be noodling over that over the next couple of months in  
23 working with the Advisory Committees on making that  
24 determination.

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1           The other issue for this Committee, as it  
2           may apply to the Qualified Health Plans, is, you know, a  
3           consideration of, you know, do the health plans that are  
4           offered through the SHOP Exchange are they different from  
5           the health plans that might be offered on the individual  
6           Exchange, and that's, again, one of these items of the  
7           Committee's charge, really, is to examine that, and  
8           whether there should be some consideration of structuring  
9           the health plans that are differently for the SHOP  
10          Exchange, vis-à-vis the individual Exchange, not related  
11          to Essential Health Benefits, because all plans will need  
12          to cover the Essential Health Benefit, but just in terms  
13          of the manner by which the Exchange goes about soliciting  
14          the Qualified Health Plans, which will need to occur in  
15          December/January time frame, so that plans can be on the  
16          shelf, and people can purchase coverage in October of  
17          2013.

18                   MR. PUSCH: Can we get some sort of a  
19                   progression as things go along about the Essential Health  
20                   Benefits, some issues that are discussed or at least  
21                   determined, possibly, so we have a sense of how it's  
22                   evolving?

23                   MS. CINTRON: Yes. I was just going  
24                   mention that, that the Health Plan Committee, as well as

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1 we anticipate the Consumer Committee, they're going to be  
2 meeting between now and their June meeting to discuss the  
3 EHB issues further, and we can, from our end, in terms of  
4 support and coordination and communication make sure that  
5 you all know when that meeting is, and, depending on your  
6 level of interest and participation, you can become  
7 involved, and we can talk to the co-Chairs, Pam, maybe,  
8 about what, you know, how we want to structure that.  
9 Does that answer your question?

10 MS. JANCZAK: You mentioned a July window.  
11 Are we talking last week of July, mid-July?

12 MR. CAREY: July. (Laughter)

13 MS. CINTRON: Well we have a meeting in  
14 July, so we'd like to kind of use that as our benchmark.

15 MS. JANCZAK: Okay.

16 MR. CAREY: So it's mid-July, actually.

17 MS. SKINNER: There was, on an earlier  
18 version of the agenda, something referencing the  
19 federally-qualified Tribe issues, and it's not on. Can  
20 you speak to that?

21 MR. CAREY: You know, we pulled it off of  
22 this agenda at the last minute, I guess, because it  
23 really did not apply to the SHOP Exchange so much as it  
24 did the Qualified Health Plans and the Consumer Outreach,

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1 so we certainly can -- we can share with you the  
2 information that we provided or pulled together, because  
3 there are specific requirements with regard to the  
4 treatment of Native Americans if they purchase coverage  
5 through the Exchange.

6 So, for example, the Qualified Health  
7 Plans, and this is on the individual side, not on the  
8 small group side, so Qualified Health Plans that are  
9 available to Native Americans for people, for Native  
10 Americans under 300 percent of federal poverty there's no  
11 cost sharing for those individuals, and that's different  
12 from the requirements for everyone else with income below  
13 300 percent of FPL.

14 Another difference is that there's no  
15 limited enrollment period, so, in the individual  
16 Exchange, there's a limited annual enrollment period by  
17 which people have to sign up for coverage, unless their  
18 circumstances change mid-year, but there's a finite  
19 limited amount of time people can sign up for coverage  
20 that really doesn't apply to Native Americans.

21 They can sign up, and they can change  
22 plans on a month-to-month basis. There's no sort of  
23 restriction, so there's just some things that apply  
24 differently, and it does not involve the SHOP Exchange,

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1 so much as it involves the individual market Exchange.

2 MR. FLEIG: There are probably, the  
3 process, there are a few important decisions or  
4 recommendations that have to happen. I guess there are  
5 four, or five, or six things.

6 Does this Committee, as a group, recommend  
7 to the Exchange Board? Is there a vote taken, these are  
8 yes, a majority vote, and those things have been  
9 recommended to the Exchange Board?

10 The second part to this question, when are  
11 those things going to happen?

12 MR. CAREY: So we had provided at the  
13 first meeting a list of the key decisions,  
14 recommendations that the Advisory Committee will need to  
15 make, this Advisory Committee, so I guess I would point  
16 you to that list of items.

17 And, yes, there will be, you know,  
18 official votes taken on recommendations from this  
19 Advisory Committee to the full Exchange Board. So, for  
20 example, the purchasing model, which we'll go and discuss  
21 in detail, will be something that we'll be looking to  
22 this Committee to vet and to make a recommendation to the  
23 full Exchange Board, so the staff will support, in  
24 walking through the various options, for example, on the

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1 purchasing model, and will help, will prepare a draft  
2 recommendation, which will then be, you know, considered  
3 by the Committee, based on the Committee feedback, with  
4 an official vote taken about recommending a preferred  
5 approach on that issue, for example, or the, you know,  
6 expansion of the small group market to, you know, 100 or  
7 fewer employees is something that we felt that the SHOP  
8 Exchange, because it's a small group issue, and the SHOP  
9 Exchange Advisory Committee should be examining and  
10 recommending a position through the full Exchange Board.

11 MS. CINTRON: And there's a, I think it's  
12 on slide three, there's a brief kind of high-level  
13 timeline of the next six months, seven months, for your  
14 reference, too.

15 MS. O'GARA: Okay. Is there anything else  
16 to come before us at this point? So we do need a few  
17 minutes for public comment, and we'd invite anyone, who  
18 would like to make a comment, to come and state their  
19 name, and turn the mike on. Anyone? Yes. Come on up.

20 MS. ARLENE MURPHY: My name is Arlene  
21 Murphy. Can you hear me okay? My name is Arlene Murphy.  
22 I'm here representing the Consumer Advisory Committee.  
23 I'd like to thank the group for allowing me to sit in. I  
24 learned a lot.

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1 I just, very briefly, just want to mention  
2 that I think the Consumer Advisory Committee shares your  
3 concerns about the Essential Health Benefits, and that  
4 will be discussed tomorrow, but, also, the effectiveness  
5 of the procurement of the outreach and the phone  
6 outreach, so that when people call in and have questions,  
7 so that's going to be key, I think, on both ends for an  
8 effective program. Thank you.

9 MS. O'GARA: Is there anyone else before  
10 we close the meeting? Pam, then, if you want to take a  
11 vote to adjourn?

12 MS. RUSSEK: Okay. Motion to adjourn?

13 A MALE VOICE: Second.

14 MS. RUSSEK: Okay. It's carried.

15 MS. O'GARA: Thank you very much.

16 (Whereupon, the meeting adjourned at 2:39  
17 p.m.)

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