VERBATIM PROCEEDINGS

SMALL EMPLOYER HEALTH OPTIONS

(SHOP)

EXCHANGE ADVISORY COMMITTEE MEETING

JUNE 12, 2012

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...Verbatim Proceedings of a meeting before the SHOP Exchange Advisory Committee Meeting, Brokers, Agents and Navigators, held at the Legislative Office Building, 300 Capitol Avenue, Hartford, Connecticut on June 12, 2012, at 10:00 a.m.

(Whereupon the meeting had already commenced and the testimony was started at 10:20 a.m.)

MR. CAREY. . . . So going forward, we have the employee plans and the current small group plans, which is a big point for Aetna.

So we have additional information. And really the distinctions, at this point, get down to the limits that might apply to services such as, you know, PT, OT or ST, home-health services, skilled nursing facility services. Those

types of services typically have limits; whereas, others don't. You know, you don't have to have a hard limit on the number of in-patient visits, of course, but you do have limits on some of these ancillary benefits, maybe, so it's not a core benefit package.

So the Committee wanted additional information about exactly what were those limits that we have, so we have sort of some additional information that we will provide to the group. They were also interested in Roman Numbers, that were asking if the Roman Numbers would be different with the plans across the State. The employee plan will be very different than a small group plan, but that was another point of interest for the group.

They also mentioned premiums, but the problem with the premiums is the premiums take into consideration cost sharing differences that will be very different in the small group market than the State employee plan. So we will provide them with information; but the caveat is to say it really isn't an indicator of the comprehensiveness of the package. It's more an indicator of what is the group and what the market looks like than what is the cost area. So those are two key pieces of

information and then we will have a consumer meeting tomorrow. Thanks.

MR. PUSCH: Bob, is there any significant difference that you can point out between the State plan and the marketplace in terms of those service areas that you were just describing? Is there a real difference between the two?

MR. CAREY: If I may, it's the cost, as well. So the big difference is that at first glance, it looks like the state employee plan has unlimited benefits in that regard. They don't put a fixed limit on the number of days that someone could get. For example, physical therapy. The reality of the situation is that those are managed plans. Right? So it's not like just because it says unlimited doesn't mean you get, you know, to go see your physical therapist every day, if it's not necessary.

So even though the contractual limits that would be in place in the smaller State employee plan -- you know, I'm not sort of certain that there is really a distinction in terms of if people need a certain level of care, that they are not provided for with regard to either the State

employee plan or the smaller group plan than with the State employee plan. But there are certain categories where there is no hard limit placed on the State employee plan, but there are hard limits placed on the small group plan.

As for impact, on premiums, you know, it's probably marginal because those aren't really highly utilized services. You know? It's not hospitalization or it's not a doctor's visit or it's not prescription drugs, so if you start to break down the cost of a health policy, those big ticket items really drive the cost and will have an effect. But I think it will be a marginal effect. I don't know, John, are there any other --

MR. FLEIG: No, I don't -- I had another question, John.

MS. O'GARA: John, if you could state your name for our court reporter.

MR. FLEIG: John Fleig, United Health Care. And I just want to ask, have you a sense of the benefits, the active benefits? Aren't the limits like part of the cost share? So are you taking the benefits and not limits in terms of the pictures of central benefits then the limits could actually fall in the different metal tiers as a

carrier, depending on what kind of latitude they have to the medical tiers? In theory, I don't think it would go in that bucket. But the first step is just to pick the benefits themselves, Bob. In fact --

MR. CAREY: The law in the regulations talks about limits with regard to these central health benefits package. The cost sharing will be -- we will you get to the tins, you know, the gold, silver, bronze and the different costs associated with all of the different services. But the package of services can have limits on certain benefits and that's what we are getting to right now as part of this discussion.

MR. PUSCH: Real quick, Tim Pusch, if I can?

MR. CAREY: Yes.

MR. PUSCH: The carriers have not NONL SDICHTDly WVENT plan options. They have extended to limit chiropractic visits essentially for all health plans not included in that, the differentiation we have from plan to plan. We find that typical. Am I correct on that, Chris?

MR. McKIERNAN: Say that again.

MR. PUSCH: Just essentially that the

plans in the small market have not used different numbers of visit limits for different health plan designs. They tend to keep the number of visits consistent.

MR. McKIERNAN:

MR. PUSCH: I'm just saying at this point in time, they have not used those services in that regard. They have been consistent in terms of the limits.

MR. KATZ: Matt Katz. I somewhat disagree. They use the deductible and co-payments associated with those ancillary benefits as an indicator of plan to plan, not necessarily specific benefits, but the cost components associated with that are definitely used and differentiated between the plans.

And specifically with regard to what Bob had said, whereas there were benefits as to whether or not that was a driver, something to look at, because those vary more significantly in that market than I think any other benefit. The dissatisfaction that I have seen with the small market in Connecticut, outside Federal requirements, tied to the inconsistency of certain components, but the level of those benefits and the

specificities to it vary greatly. I was wondering if that was brought up.

MR. CAREY: Mary Ellen, do you want to comment?

MS. BREAULT: I'm not -- because we do have mental health purity in the State, so as far as cost sharing levels or any kind of limits, those are, you know, purely comparable. There's no limits on inpatient hospital or office visits, not that we have seen.

MR. KATZ: The outer network benefit component not in network, I think the Shop Committee versus the network, it does not vary from a plan design perspective, but the costs run significantly higher with the outer network design tied to whether it's mental, behavioral health or regular office visit design.

MS. BREAULT: But, again, I would think that would not be part of the discussion for benefits. That would come to cost sharing after everything else is defined.

MR. KATZ: Is that part of the tier or not part of the tier?

MR. CAREY: The decision that needs to be made right away is what is the package of

services that will be part of the (inaudible). That is Step One. It's a multistep process. Another step, maybe Step Two, what does cost sharing look like in the different tins that's out of network and how the Exchange would like to offer products on its shelf again. And this discussion is a market wide discussion or decision and what its effect will be inside the Exchange, outside the Exchange, in the small market group. When we get to the cost sharing, any decision that the Committee wants to make with regard to recommendations for how packages are structured, when you were THD is purely an Exchange decision. It does not effect -- it doesn't apply necessarily outside.

MS. COLE: So in terms of preparing for the State certification, we had a group that went down a couple of weeks ago for a day and a half and the objective was to provide them with a comprehensive overview of where we are at operationally and otherwise. So we had a 100 plus slide deck that is now posted to our website that kind of walked -- we walked things through history and provided them with the background of where we are at to date and then the strategy and direction

we are going in there. So I think it was very well received and we will be receiving an evaluation of that probably in a couple of weeks and then we can share that with you. But it was a very, very well received visit. And I think this will be very helpful because, you know, questions were asked and information gathered and there was just some very good feedback for us as a State.

MR. CAREY: It was very positive.

Ms. Cole: Pam, I think we are Ready to for me to turn the discussion -- I will turn it over to Bob.

MR. CAREY: Okay. Thanks very much. I wanted to give you sort of a SHOP 101 or maybe a SHOP 201 to try to ground the discussion and hopefully move into consideration in your thoughts on a couple of issues. One, the models that might be offered through the SHOP Exchange and the second discussion will be about the potential to leverage existing resources, resources that are existing currently in the Connecticut marketplace.

And i would like to ground you in terms of expectations of enrollment in the SHOP Exchange because I think it's terribly different than the expectations in enrollment in the --

because of the current market conditions, which are so different in the individual market versus the small group market. So that is the agenda.

And just sort of as an overview, we will talk about employer eligibility, who is eligible through the SHOP Exchange and the key functions of the SHOP Exchange, meaning that the business of SHOP Exchange participation and contribution requirements that exist in the market today and whether those should be mimicked in the SHOP Exchange, the purchasing models in Connecticut's current small group market and then sort of an identification of some key issues for you to consider.

So just in terms of the SHOP Exchange being open to small groups, which currently is defined in Connecticut as groups of up to 50 employees, which will continue to be allowed to purchase coverage or will be allowed to purchase coverage through the SHOP Exchange in 2014 and 2015, the SHOP small group market in Connecticut is redefined according to the ACA in 2016 to include groups of up to 100 employees.

Connecticut has the option to move up that day of expansion to 2014 or 2015, if it so

chooses. That will be an issue for this Committee to consider as we move forward. But under the current definition, it's limited to small groups, which are 50 or fewer in the first two years and then expanding to up to 100 in the year 2016. And then beyond that, expanded to a larger market under the law. That is an option for the states to consider. I think the states right now -- I know that certain states right now are just focusing on getting this thing up and running and not really looking to 2017, but that will be something to consider down the road.

Through the Exchange, sort of an exclusive advantage that the Exchange may have in 2014 and beyond that, the employer -- that is the employee or low wage workers, that's workers with an income up to $50,000, although at $50,000, the subsidy is pretty much gone, so it's on a sliding scale, but for some employees, the low wage workers, the employer, not the employee, the employer can get a tax credit for a portion of his or her share in the premium. So the employer offers coverage through the Exchange and pays 50 percent of the premium. Let's say that the employer could get a subsidy or a premium or a tax

credit worth up to 50 percent of his share of the premium.

MR. PUSCH: Bob, will you clarify for me who would be exempt as an employer from that average wage determination, whether the owner might be and so forth, that sort of thing, or would there be exemptions from that determination of that average wage earner?

MR. CAREY: I don't know offhand who is exempt. Maybe with the law that is in effect today, I will say there is the ability today for small employees to meet the size and wage and to get a smaller share of the premium. Again, I do not know. It's not been -- it's not been overwhelmingly successful to the date to the employer.

MR. PINTO: Tony Pinto. I sat in on a presentation of that and it's not only the owners, but it's also the immediate family members. Pretty much generally the family members in a small business have a lot of exemptions. You know, it's pretty broad, the way it was written. It's not just the owners, but it's also their families and close relatives.

MR. CAREY: You're right. So the

owner and the family members are generally not eligibility for the premium subsidy. I guess the question is how the average wage is calculated.

MR. PUSCH: Yes.

MR. PINTO: It's calculated without them, so it's covered out. So it's really specifically for the non family employees.

MR. CAREY: I don't know if some of the folks do business in the small market today. Can anyone comment about the ability so far of employers to take advantage? I do think it's been pretty under whelming over in Connecticut, but I do think, you know, at least on the face of it, this is -- the potential advantage that the SHOP Exchange has to offer to small employers, it's two years of tax credits, but I don't know if two years beats one year.

MR. PUSCH: Could you clarify one more time about this issue? If you qualify for the tax credits as an employer, do you also get to deduct the premiums you're paying, as well? Because I know that was a question that employers had about whether or not they would be able to deduct the premiums and take the tax credits.

MR. CAREY: I don't know. I can't

believe you would be able to double-dip like that, that you would be able to take 50 percent and then, you know --

MR. PUSCH: That's a misunderstanding that is out there, Bob. BOK okay.

MR. PINTO: It's pretty confusing, but it is a pretty broad tax credit, really driven so if you actually can go back to 2010 and your tax credits are going in arrears, we can bring them forward, so it's a little confusing. It's a little hard to understand, but it's very, very broad. It's very limited in it goes away after 2015.

MS. PULISCIANO: I believe that there's a worksheet to calculate deductibles on the IRS website and it should list all of that information, so maybe we can look into that and bring it back to the Committee.

MR. CAREY: I do know that there have been some problems with estimated tax out of the tax credits today. But essentially that's -- that will be available only through the Exchange in 2014 and beyond. So it's not currently -- you can get -- I think there's a potential marketing administration for the SHOP Exchange to be able to offer to small employers.

MR. CAREY: The key functions of the Exchange, just so people have an understanding of, you know, what the thing is supposed to do, first of all, you know, the SHOP Exchange will solicit qualified health plans from employers. This is sort of a voluntary participation where insurers are not required to participate on the SHOP Exchange, nor are they required to participate in the individual plan. So the Exchange sent out solicitation to receive responses from the carriers of the products that they wish to offer. On the SHOP Exchange, they have to fit within one of the four tins, Platinum, Gold, Silver and Bronze. The SHOP needs to provide some way for people to come on line or call or have information about what is the benefit or what are the benefits packages.

There's got to be some way to compare plans across -- compare the different plans across the different carriers and development a monthly premium so as opposed to the individual market, where people will come in one by one or family by family and they will enter their own information on their own family and the premium will be developed in a subsidiary will potentially apply. This requires the employee senses that is loaded and

then generates premiums for the various options that are available to the employer. It's just a different way in which the premiums will need to be generated in the SHOP Exchange.

Employer contribution then needs to be pegged and set and, again, we'll sort of go with the different purchasing model options, but there are various ways in which an employer could set his premium based perhaps on a single plan tier plan. Again, we will talk further about that. That is sort of the key decision, the administrative IT infrastructure that allows them to do this and the broker to do this on line to help the employer make that decision.

There is then an open enrollment period where people can sign up for coverage. Particularly if you sign more than one plan, more than one carrier, this is different really than the current market where lots of times the employer picks out a couple of plans and then there's sort of a limited amount of choices, broad choices. There's different cells. It moves into a infrastructure post wholesale to a retail type of operation with regard to the involvement of potential employers and then the involvement

reaches out to his or her employees.

The Exchange would then need to transfer, once open enrollment is closed, the Exchange would need to transfer information that the employees have made with regard to their issuers and then the issuers would then need to enroll people in coverage. Upon premium billing and collection would need to be -- essentially if you had multiple carriers, multiple plans, the employer does not want to exceed multiple choices for those employees. And so the employer or the back office apparatus for the employer would need to handle and sort of centralize the information. That requirement is not an option under the law.

The employer needs to set that up on behalf of the employees and on behalf of the employees' fa milites. The employers -- if mid year it changes, employees leave, new employees come in, someone gets married, all of that stuff, then that needs to be handled with options to transfer to another carrier. And then, you know, decide in the beginning, again, you know twelve months later.

So I just thought it would be helpful to walk through that, the business of setting up an

employer; and understanding that, you know, it's more than just a website. There's a lot of functionality requirements and businesses that need to be handled. The other key distinction of the SHOP Exchange from the individual is that the enrollment environment will occur throughout the year. So unlike the individual market, where there is a defined open environment period that a small group market employers will renew different points of rates change during the course of the year; whereas in the individual market, you will have the limited period in the small group market. The employer is going to have to deal with new groups hopefully coming on throughout the course of the year. So it just sort of changes the business model from one in which enrollment is very limited versus spread out throughout the course of the year.

MS. MACLUBA: Marta Macluba, the other departments of small group market handles not just contributions, but participation for really the group. So out of the underwriters, is that going to be some sort of functionality of the SHOP Exchange? Especially since there is going to be multiple carriers so that all of that still has to

occur with eligibility.

MR. CAREY: Actually, a couple of slides up we will talk about participation and contribution requirements and the verification that will likely need to occur by the SHOP Exchange to determine if the group is really a group. It's not just a bunch of guys that live in the same neighborhood that participation and contribution requirement rates are satisfied. Do we also have to in our conversation also have to make a decision about maybe 1099 employees, are they really an eligible employee of the group or not an eligible employee of the group? What is an eligible employee?

MR. CAREY: Well, I think there needs to be a standard definition across the board for SHOP and all of the carriers as to exactly what a participant is. It's my understanding that carriers may have a different way of verifying that a group is a group and who is eligible to participate. So there needs to be a common definition, how it will define the group or the requirements associated with the defining that group. So, you know, part of the employer's responsibilities will be to get carriers together

to agree upon a common standard for defining what is a group and who is eligible to participate.

MS. PULISCIANO: I have a question with regard to the cost. With regard to the costs, has that been identified? Because all of these services, there are costs associated with them. These are administrative services. And with the insurance companies, normally what we do now, we have a middle person, a middle body. Have we identified what the cost of all these services are going to be now and in the future? And how are we going to pay for that?

MR. CAREY: That will lead into our discussion later in this meeting. There is the ability leverage so that you don't have to set up from scratch with the entity to do things that are currently done in the marketplace, potentially done in the marketplace. The Exchange approach currently is to think about this as potential coverage from the individual. So there is -- you know, eligibility on the individual side will be, you know, running through the federal data hub detailing whether someone is eligibility for a subsidy. And subsidies on the individual side, you don't have all of that on the SHOP side. You have

different eligibility requirements on the SHOP side, but you don't have to capture all of the information about family income, for example, or family -- you know, as to how large the family is, you don't have to determine whether they are Medicaid eligible or CHIP eligible on the SHOP side. So we think there is an opportunity to carve out SHOP as its own little business and see whether there might be some potential to leverage against resources in the marketplace to serve and to do all of the functions that perhaps that they are already doing in the marketplace today. So that will be a decision that this group makes. Has there been -- have we calculated what it's going to cost? No, we have not yet calculated that because it will depend on what approach you take.

MR. McKIERNAN: So are you saying essentially the SHOP or the Exchange will be an avenue for only subsidized employers to partake in or not?

MR. CAREY: No. No, not subsidized employers. If you want the subsidy, you know, the employer is the only place you can go in 2014 and in 2015, through the -- it's only through the availability through the SHOP Exchange, but that

won't be the only universe, hopefully.

MR. McKIERNAN: Okay.

MS. BREAULT: Just going back to, you know, the definition of an eligible employer and employee. We have the statutory definition right now and they will have to be tweaked, certainly no later than 2016, but we envision that that will still remain a statutory requirement that applies both inside and outside of any association type groups, private groups --

MS. SKINNER: Also with regard to the administrative oversight of the groups, are the plans that are participating in the Exchange every year making sure that, you know, they're looking at the rates and overall performance; correct?

MR. CAREY: Correct. Recertification of the plan, yes. There's a whole plan management component that the plan has available. And with regard to the individual versus SHOP Exchange, the law allows the State to set up really two ideas, the individual Exchange or benefit Exchange and then the SHOP Exchange. It doesn't preclude the State from having one entity oversee both exchanges. And, in fact, regulations, as they tease this out, they strongly suggest, and I have

not seen any State go down the path of setting up 2 Exchange boards to oversee, you know -- one to oversee the individual and one to oversee the SHOP Exchange. Connecticut chose one employer board to mange and one administrative overseeing both programs. And so for administrative purposes, you might be able to split them out into a SHOP small group marketplace and an individual marketplace. Even if you combine them, you don't have to combine the risk pools. That's another decision. But the current approach is tentatively that we will continue to have an individual market and a small group market and not mesh the two. But you could -- that is sort of -- that is a different issue than administrative versus individual.

MR. PUSCH: Do you have a sense of what the carriers think about that issue?

MR. CAREY: Merging the pools? Yeah. Our discussion with them is they are not overly excited about merging the pools.

MR. PUSCH: That's my assumption, Bob. Yeah. I think that's pretty common. That's pretty common across the country.

MR. CAREY: Right.

MR. FLEIG: John Fleig. In terms of

-- in terms -- what Committee is going to figure this out? I guess it's gets very technical. As you know, there's a lot different options. Can we select within those?

MR. CAREY: Yes. We weren't really thinking that that is a Committee issue, which we will develop. We are in the process of developing business requirements and there's literally hundreds of business requirements associated with that. We could brief the Committee on -- you know, if you are interested in taking a look at the business requirements, we certainly could walk you through all of them. We thought it was just a bit too technical to sort of get into it today, but we could certainly share what, you know, we are thinking. And that is that we are going to -- we are developing business specifications that will be necessary to run a SHOP Exchange and then we will have to figure out, you know, whether we issue RFP's to have vendors come in and tell us what their ability to do is and what the price is --

MR. FLEIG: Are you asking the State Board for input? Obviously the carriers have -- and I'm not speaking for all of the carriers we have and others may have their own ideas about how

they should work.

MR. CAREY: You know, we are -- we will definitely involve the carriers. We need the carriers to play. You can set up all of the fanciness you want; but if they are not CDIA, you really don't have much, particularly with the SHOP Exchange, which I think is a tougher sell to the individual.

The individual market, it has been my experience, and we will talk a little bit about the experience in Massachusetts and the experience in Utah. With regard to participation and contribution requirements this is what the current market looks like in terms of requirements for the percentage of eligible employees that must participate, so that it's a minimum level. So carriers put in place the participation requirements really to protect adverse group of ten people, they don't want just one person or two people coming in and participating in that group. They put in place minimum participation levels and employer needs to meet in order for the carrier to sell them a policy.

So the Exchange will need to think about whether it requires the same or different

participation requirements for the employers and employees that come in to participate. There is an exclusive caveat to that, if you are a group of ten, and one of the employees is covered under his spouse's or her spouse's plan, you know, they are not part of the denominator. But for those that are eligible and not included in the group, that needs to meet a certain minimum participation levels and there's also generally a minimum contribution level, where carriers require the employer to contribute to the employer's premium.

MR. PUSCH: Was that spouse that waived coverage to be the exclusion or is that just as an example?

MR. CAREY: That's just an example.

MR. PUSCH: Because they do allow a Medicare waiver and --

MR. CAREY: That's not on one -- but the employer will need this. It will be a policy decision that we would appreciate your advice on, about how the employer sets a minimum participation contribution. It's not required, but it's certainly, I think, envisioned in setting up the plan.

MR. PINTO: Tony Pinto. I see one

example here of a 75 percent eligible rate. Are there other models out there? What did Utah do or try to do in all of the alternatives to this?

MR. CAREY: Speaking a little bit about Utah, maybe more about Massachusetts, at least initially there was some consideration as to what the employer put in place where people didn't have to meet the 75 percent standard or the 50 percent standard. But there was significant push back into the market from deviating from the current practice.

And so the requirement in Massachusetts is slightly different. In groups of up to five, I think, it's 100 percent participation, again, excluding people's spouses and the waivers for Medicare and so forth. And then groups of six to fifty hit the 75 percent participation.

So that's just a little information as to how the market works in Massachusetts. In fact, Blue Cross Blue Shield of Massachusetts attempted to drop its minimum contribution requirement and it faced a firestorm from advocates who felt that it was way too much for employers not be participating.

Their view was they tried to bring more employers in and some employers may not be able to meet that 50 percent level, but maybe they could give 25 percent.

MR. CAREY: So I will suggest that the Committee decides on recommendations that should be consistently applied. You wouldn't want groups to be able to complete one contribution through one plan and then a different level for another plan to the employer. I do think what would be helpful is to have some discussion about whether the Committee feels that that's helpful. I mean, one thing you need to think about is how do you administer the plan? Is that a different rule for a different carrier? It could be confusing.

MR. RITTER: Wouldn't some of that be with respect to the contribution level? I mean, we have Gold, Silver and Bronze. Because obviously the more expensive the plan, the more cost to the employer. If you are taking 50 percent, but if you have a sliding scale, there may not be as much or may --

MR. CAREY: Right. So we will talk about that model. It's more as to how you structure the plan, how it was set up, how to set

up the minimum participation levels and as to what the plan designs on the purchasing model.

MR. CAREY: Just to follow-up on Grant's question, it's my understanding that they do have a participation requirement that is a minimum requirement outside the market, but their contribution requirements, they don't have any contribution requirements. So there are some employers who have a zero contribution, but there are other employers who are purchasing coverage through the small group plan.

I don't know how they work that out. To be quite honest, it doesn't sound like a group to me anymore. If the employer is not contributing, how are they a group? They're not. I don't know with their plan choices are, so there is no minimum contribution requirement in Utah. Okay.

So let's talk about the purchasing options that are out there. We have laid out four options for you to consider. One could envision, you know, a number of different options, but these are sort of the four basic ones that you will commonly hear and then there are maybe basic modificatoins based within these. And we can talk

a little bit that as we go through these four. And then there are also different employer, employee strategies that one could apply to each of these four models.

Plan one. Plan one on the SHOP Exchange, simply put, one employer or broker can view the options and the employer makes his or her choice and sets the premium and sets their premium contribution and then, you know, they offer that to their employees. I know I initially sort of dismissed this one because in this country, the market already does that to a degree. The only distinction or consideration which is adverse is the employer subsidy, the employer who may not want to, you know, deal with lots of choices, may, you know, just want this plan, you know, want this carrier, he's comfortable with them. "That's easier for me." Do you want to include that employer, you know? So that's just something to consider.

So initially it's like, why would you go there for all of this, just to offer one carrier, one plan, simply to have a SHOP format. But after further consideration, that might be something the Committee considers.

MR. PUSCH: I was reviewing this when it was handed out and I noted that you, I'm sorry, that if somebody referenced the possible composite rating if an employer chose one plan one level and is it -- is there really the possibility of realistic -- of having any kind of composite rating in this employer exchange?

It seems awfully impractical to me to do a composite rating as opposed to an adjusted rating, you know, the typical pricing that we pretty much face. So when an employer -- or when you show an employer his or her options, are you showing that employer so that --

MR. PUSCH: It's per plan. Per plan. Each plan has a different list of pricing, obviously.

MR. CAREY: So that I understand this, so a group of two men, right, a 20-year-old and a 60-year old, they will get from the same carrier, the same plan, they will get two different premiums?

MR. PUSCH: Correct. Almost. I don't know of any circumstances otherwise. I don't think any of the other carriers will do a composite rating, whatsoever, unless they are at 50 employees

plus. It's an individually age gender dependent strategic geographical area for the pricing.

MR. CAREY: And then that is rolled up into the bottom line?

MR. PUSCH: Yeah.

MR. CAREY: The employer sets his premium based on his bottom line number?

MR. PUSCH: Correct. Yes. Essentially they will determine what they can afford to pay on that bottom line number and then divide it among their employees.

MR. PINTO: No. He is correct. A lot of this will be addressed with the three to one ratio and then change the way the ratings are done right now. It's multiple and it is very detrimental to a small employer, if they hire an older employer because they are paying the older employee's rate. And it can be very detrimental to the hiring process, the process of hiring one person over another. Why hire a 25-year-old male who's paying $200 a month or, you know, not even, and then having like a 50-year-old paying $800 month in an individual plan. So it does have a lot of fallback.

MR. CAREY: Okay. So rates are

presented by the carrier and are then listed and billed and then there is a bottom line number. And I'm assuming then that the employer just decides what that bottom line number is by the number of employees to set his or her premium?

MR. McKIERNAN: No. Some employers could do composite ratings and set their own rates.

MR. PUSCH: I don't know that anyone does.

MR. McKIERNAN: I don't know. It's based -- it's gender based and then obviously there's single and different tiers and -- you know, so if you are paying 50 percent of the single rate and the 26-year-old pays $200 and the 60's-year-old pays $800, that 26-year-old person pays $50 a month, the 60-year-old will be paying half of whatever I said before, so that is the current marketplace.

MR. CAREY: So actually, you know, it's sort of simplifies things in a lot of ways. Okay. So let's move to the second option, which is one carrier, multiple plans. This is again an option to the employers where you have to compare these two plans together to offer to your employees, but this would allow an individual

employee to, you know, pick up a plan or a carrier and then provides a choice to his or her employees as to what plan they want to enroll in for themselves and their family.

So you could, you know, offer broad choices off of this plan that are available from the carrier. Also, you could limit it to, you know, one up or one down, depending on whatever the selection is going to be. So the employee could pick a silver plan based on his or her her silver level plan, but then allow the employee to take the employer contribution and buy up to Gold or buy down to Bronze. That's one way to think about this.

And then with regard to the structure contribution, say an employee wants to contribute 70 percent of the cost of the Silver level plan, he pegs his share at $209 a month. In this example, the employee, if they want the Silver plan, they pay $124. If they want, you know, Gold or Platinum, they pay more. If they want Bronze, they pay less.

(Inaudible.)

MR. PUSCH: That is most common approach.

MR. PINTO: That is what I was going to say. So I think just a percentage of the premium, everybody pays a percentage, but it sounds like we need to define the benefit. If we only define the contribution, it wouldn't work, if it's a composite rated group.

MR. CAREY: I believe so. I don't see anything in the lower percentage of the premium for a certain of these. I do know it occurs. I think what is happening in the market, the premiums ranges in which the employer contribution is fixed and then the employees can go shopping, if they want. That also -- I think that has some benefit to the employee, who can take that contribution within the top tier.

And then the fourth category is all the plans, all the carriers. Again, the employer's share is tax deductible, but I think that is all going to happen in 2014.

(Inaudible.)

MR. CAREY: Sure.

MR. McKIERNAN: So they limit that, as well.

MR. CAREY: Yeah, all of this has costs, you know, to make things, you know, more

options. You have to support those on the top tier and then the employee can take that contribution and go shopping within the top tier.

The fourth is, you know, the wild card. So you get all the plans, all the carriers. You come in; again, the employer gives his contribution based on the plan and then lets the employee SHOP for coverage.

MS. SKINNER: I have a question. These -- we're talking about baseline, when these initially were ruled out, so when we're doing -- essentially everybody is starting out fresh and it looks like the premiums, because everybody is looking at the same underwriting guidelines, the premiums should be relatively the same. What happens after two or three years when experience is factored into the annual renewal rates? Will these premiums start to really, you know, kind of like distancing, like having a broader range?

MR. CAREY: Well, these are just -- there are made up, so -- but they -- of course, but they -- but the experience of the small group overall, so that individual employers aren't experience rated. And so -- and there are limits -- and there's no -- there's limits on what grading

factors can be used, so really it's age rated. Primarily it will be an age rated system.

MS. SKINNER: So the employers can't put their premiums based on their specific experience with this group. It's going to be rated for the whole population within this group?

MR. CAREY: The carriers set their rates based on their experience in the small group market overall, so the carriers -- so Anthem will set its premium based on its experience based on its entire portfolio of smaller groups.

MS. SKINNER: So both within the experience of the package?

MR. CAREY: Correct.

MR. PINTO: Correct. Also, keep in mind, that there are non-medical ratios that apply, so it's going to be limited as to what the rate ratio differential will be. It's just going to depend on how you define the pool. Right now, everyone under 50 is in the pool.

Okay. And then the example, just on that, but again, it locks in the employer's share. The employers knows -- you know, that's what the employer wants to know, what his costs will be. Right? So the employer knows what his contribution

-- what his contribution will be or what her contribution will be. The employees then can, you know, go SHOP around, depending on what type of plan they want.

So those are the four purchasing models that we walked through. I don't know if we want to have more discussion about that or move into sort of a general overview of the Connecticut marketplace today. There are a number of questions and issues that we want the Committee to consider. So about 300,000 people quoted -- I'm sorry, John?

MR. FLEIG: Isn't the third option required for --

MR. CAREY: Yes. Sorry. Yeah. So there's a third option in which you have to provide a choice option for the employers. This is the one that the Feds said, "You've got to at least offer this in the SHOP Exchange." You can also offer the other ones, if you want. You could allow an employer to just pick a plan. But you've got to give the employer, again, it's the employer who chooses the option available to his other or her employees.

MR. FLEIG: Okay.

MR. CAREY: So Connecticut's current

small group market, about 300,000 participants or lives covered. There are four major insurers. There are lots of others that offer coverage, but these are sort of the four dominant carriers that cover the majority of the small group market. And we sort of referenced and mentioned a couple of times that there is even a private Exchange in Connecticut. That's not typical in most marketplaces. The CDIA's Health Connections is probably the most successful small group Exchange in the country. It's been around since the mid 90's.

MR. PUSCH: One further thought, Tim Bush, and I'm thinking in terms of the CDIA program. Even though CDIA has always allowed a Chinese Menu approach, one from Column A carrier, one from Column B, a plan decision. Most -- and I can tell you that all of my CDIA accounts, and I have a good number, all of my CDIA accounts, they all limits what their employees can choose from to some degree. They will limit the number of plan options they can choose; or, in many cases, they will limit it to one carrier, based on what they have determined is best for their group.

So even though it is available, most

employers don't go that route simple because of the administrative challenge of doing that, as opposed to limiting it to some degree. So they will pick sort of the best deal for their group and then kind of limit it in some way, either the number of plans or the number of carriers or carrier.

MR. CAREY: That's a good point.

MR. MATT: Tim, just a quick question on that, is it cost driven, is it administratively driven or is it plan design driven from your understanding and experience?

MR. PUSCH: Yes. Also provider network driven.

MR. PINTO: Yeah. I mean, a lot of it is, you go to an employer. They have enough decisions to make. They don't want to sit with their employee and then try to explain all of the differences. So they sit there and say, "Here are your choices. A or B?"

MR. CAREY: Okay. So that's very helpful. So they have a couple of -- they have Program 1 for small employers. They have one for maybe like mid-size, like it goes up to groups of 51 to 100. I do think it's heavily concentrated in the small, of the small employers, with regard to

the purchasing CDIA. Two insurers participate currently, Medicare and Oxford. I think Cigna was a participant. They have dropped out of the small group plan entirely.

MR. PUSCH: In its heyday, they had four carriers.

MR. CAREY: Okay. So there was a contraction in the marketplace, somewhat driven. They have about 70,000 enrollees, so they have a pretty good share of the overall small group market. So that's the -- so that in essence is the use. So CDIA has in place, you know, premium billing collection and employee choice model and is a, you know, it's a growing concern and it has lots of people purchasing coverage through them. I think, you know, the coverage needs to be understood and considered as the Committee moves forward with implementing this.

MR. UNKNOWN: You said last time that all plans after a certain year, I think 2014, have to be qualified health plans. Isn't that the case with these plans that are CDIA? Aren't they grandfathered in, in some sense, and then continued, at least as long as they don't change too much? And I'm thinking particularly about

situations like suppose a small employer doesn't want to cover something kind of exotic like invitro or something like that? They just say, "I'll just buy the same plan outside of the Exchange, rather than be forced to cover invitro inside the plan? What is the situation with that?

MR. CAREY: Well, I'm afraid we're going to get our -- lose -- you know, we are at a competitive disadvantage on the Exchange because of some of the requirements.

MR. CAREY: Well, all of the fully insured health plans sold inside or outside the Exchange have to cover the State mandates. So in your example, there certainly are --

MR. UNKNOWN: So like drug plans?

MR. CAREY: Yep.

MR. UNKNOWN: Fair enough.

MR. CAREY: There -- so plans can be grandfathered. Meaning, that if they don't change, and, really, it's pretty limited in the change that's allowed under the regulations. If they don't change, they can continue to serve the same people that they served. So you couldn't enroll a new into a grandfathered plan. So in 2014, if I had never purchased coverage before, I'm in a small

group or in a limited market, you don't have access to these grandfathered plans. It's only people who were enrolled in those plans as of, I think, March 23rd of 2010, which is, you know, the effective date of the ACA. So over time -- initially, yes, you will have some people covered in the marketplace. But over time, that number will dwindle.

MR. UNKNOWN: So no new employees at the same company?

MR. CAREY: New employees at the same company would be allowed under this plan, yes.

MR. UNKNOWN: Okay.

MR. CAREY: But not new employers. Even if you switched the carriers with the same plan design, you would lose your grandfathered status. So, you know, my thinking is that over time it's really going to dwindle and it's not going to be a long time before most plans that are in place, there will be no grandfathering.

MR. PUSCH: On the group side, they pretty much -- all the carriers have pretty much conformed their small group portfolio to federal regulation. You see more of the grandfathering on the individual side, where people had the option to

either remain with their individual plan that was grandfathered or they could change to the federally regulated plan. But on the group side, the carriers have pretty much conformed all of their plans as they came up for renewal under the federal legislation. Anybody here, if I'm not accurate on that, please, speak up, but that's my experience and understanding.

MR. FLEIG: This stuff gets really technical. We're talking in generalities here because you can't actually put what's required under the ACA in a plan and that plan could still be considered grandfathered. There's a lot, for rating purposes, etc., and one comment you said, for example, a qualified health plan is only on the employer. There's the central benefits on and off the employer, but technically a qualified -- to be certified as a qualified health plan is only on the Exchange, so it's just a lot of different technical points that, in talking in general, you might not get correct plans.

MR. G: Well, I have heard that most small business plans, I think 50 percent of them, were below Bronze. And, I mean, that's not a lot. And it just seems like those have not risen to

federal standards yet.

MR. FLEIG: Right. The small groups would have to raise to that, but that's off the employer because technically they are not qualified health plans.

MR. G: Right. But what you said surprises me because I thought every qualified plan has to be offered off of the Exchange.

MR. CAREY: No.

MR. G: I mean, that's the common phrasing for it. Maybe they are not qualified plans, but they are -- the same plan has to be offered, even if it's not qualified.

MR. CAREY: Right. So plans that are offered on the employer can be offered off of the Exchange, but what John, I think, is getting to is that there will be other plans that are non-grandfathered that are offered by carriers outside of the employer. They still need to meet the actuarial value, tins, you know, they have to stick within one of the four tins. They can't have deductibles of like $2,000 or $4,000. They have to cover the central benefits. So all of the requirements will apply for plans that meet the ACA requirements that are sold outside of the employer.

And the other point I will just make is that, you know, this number of 50 percent of people enrolled in plans that don't meet the 60 percent level, you know, I'm not a big believer in that number. So we need to have -- we're going to engage a small contract actuarial firm to come in and, you know, verify that. I can tell you in every market that I have looked at, with the actuaries that I have looked at, when looking at the small group market, that percentage below 60 percent is in the single digits.

MR. FLEIG: And that's mainly the individual market, but --

MR. CAREY: Correct. In the individual market, it's different. But in a small group market, and in a State like Connecticut -- you know, I will give you a for example. In Alabama, right, 3 percent of small groups they claim are 60 percent. Now how Connecticut suddenly got to 50 percent is beyond me. There may be some others issues. You know, some small groups don't offer prescription drug coverage. They will have to by 2014. There may be a couple of other ones. That's the biggest one, but there might be -- there will be small groups that offer a higher deductible

plan, maybe, that won't be allowed, unless they're grandfathered.

So there are certainly other issues with other plans that have to come up in terms of value. But to say that half of the people enrolled in plans in the small group market are below 60 percent, I think -- I disagree.

MR. MATT: This is Matt again. And I think what you and what John said is right, but it's specific to the high deductible component and the drug component. If you take those out, we're much closer to probably Alabama. But our -- and I don't really like saying that, but I think we are closer to that percentage than the 60 percent. But I think if you add in where everyone is today with all of those other factors, we may be closer to 50 percent, but I think there are a lot of other factors that people have to change before this is implemented and we may be talking about 5 percent, at the most. And my question, though, Bob, if 300,000 are presently in the small group market, what is the total attachment expected, you know? Is it 500,000 lives because 200,000 are not receiving it through their small employers presently? Do we know that because -- I feel like

we're shrinking the possibility -- the possible before we really know what the -- the totals.

MR. CAREY: We don't have the number of total lives in the potential -- in the small group market. I think you would have to figure out, first of all, you know, what -- how many employees are offered coverage but don't take it. Right? So that's part of the catch-all. How many employees work for a small employer that don't offer insurance. That's the majority. And then whether -- and then how many dependents of those employees of the employers that don't offer insurance.

So the percentage of -- so, you know, the offer rates for small employers, as all of you probably know, goes down significantly as you get down from 50 to 25 to 10, so that the offer rate for small employers is pretty low. It's generally 35 percent of the really small employees offer coverage for employees. So we could get a ballpark estimate for you in terms of the percentage of employees.

The question I have for the Committee is, is there anything that you see in the law of requirement of 2014 that would encourage more small

employers to offer coverage than we have today?

MR. MATT: Well, at least initially for those two years, the small employers, if they are able to take advantage of that tax credit, would be significant. One, it's going to be a big education initiative to educate them that they have this available to them and that they qualify. But I think for those small employers getting that amount of money back and then looking at, you know, and we're just throwing out numbers, but looking at and depending on how we set some of the things we set may encourage a lot of those small employers to jump in because I don't think it's the 50 employer that isn't going to play or hasn't played, but it is that 5 to 10 employer that we need to try to incentivize in that tax benefit. It's a huge incentive, if we design the plan right.

MR. McKIERNAN: Chris McKiernan, a couple of things here. Don't quote me on these statistics, but I believe a couple of years ago in the State of Connecticut, the uninsured population was about 10 percent.

MR. CAREY: If we are to use numbers, I believe it's about 375,000 people.

MR. McKIERNAN: Okay. And I believe

for the percentage, it was about 10 percent of the population in the State of Connecticut. So you could say that 90 percent of the population is insured. Secondly, you mentioned the State of Alabama from a richness standpoint. And, you know, the State of Connecticut, I believe, is in the top three of mandated benefits in the country, which means that, you know, the cost of our health plans are, because of the heavily mandated nature of the State, obviously drive up the cost, as well.

So those are significant factors, you know, from a benefit and cost arrangement as compared to other states. And, again, each state has the ability currently to offer different benefits or what are called mandated benefits and that is sort of a unique situation currently.

As we look at New York, and you've mentioned Massachusetts, as well, but currently the laws are set up differently. Community rating in New York, New Jersey has kind of a composite system nature to their rating system and obviously New York, New Jersey and Connecticut are the highest three mandated states.

MR. FLEIG: And Maryland, too.

MR. McKIERNAN: I'm being told

Maryland is up there, too. So from a cost and benefit perspective, the mandates have fairly significant cost factors, as well.

MR. PINTO: Tony Pinto. I just -- going on the issue, how do you get people to enroll? I think one of the most important things this Committee can do is define the eligibility of the group they're looking at to be eligible and how they're going to be eligible in the purchase with their employers.

Because if you take into consideration that employers with under 30 employees are exempt from penalties, there's really no significant reason for them to offer benefits and not have their employees buy direct, unless there is a reason that we give them through the Exchange to want to enroll. The tax credit is not going to cover what they pay in premiums. The number is just too significant and the tax credit too low.

So the way we define eligibility will define whether or not it's viable for an employer to be incentivized to have their employees purchase through them or to purchase direct. And that's probably one of the most important functions we are going to do here.

MR. FLEIG: I would also suggest, and I don't -- the scope of this Committee probably doesn't have this kind of reach, but those were issues (inaudible). So I don't know if that's something we need to talk to our good regulators friends about. The rules for eligibility should be the same or you are going to have people just p0ick and choose what is best for the group.

MS. MARY: Well, I think in terms of defining the eligible employer, employees, you know, that certainly should be in the statute and should be consistent with regard to participation, rules or, you know, those kind of rules. Right now, you know, they are not -- we don't have any authority over those, other than, you know, there were some guidance that was given from the federal government when HIPAA came into play and we do allow that. But, in general terms, those things aren't even filed with us.

MR. CAREY: So this, I think, is a decent segway into, you know, what's the value prop for SHOP? You know, how does -- you know, what can you offer that's currently not offered in the marketplace? Or, you know, how can it make it so that you either attract new employers to offer

insurance or you attract existing employers to give their employees, you know, choices of, you know, plans in the marketplace. So that's definitely something for the rest of us to consider and we will (inaudible.)

The second is there's an important consideration. You know, in a market where there's an existing private Exchange that offers employees a choice, you know, how can the SHOP Exchange attract enough people to be self-sustained?

So our two data points with regard to current and (inaudible). So despite my friends, you know, telling me that it's really a private Exchange run out of the governor's office and it's publically supported, so they have about 6,200 enrollees. It's been up for a couple of years. They will tell you they have been in pilot for much of that time.

And then Massachusetts small group Exchange, you know, people -- small groups can purchase coverage through the connector of 4,500 enrollees. So, you know, it's tough to think about setting up all the administrative apparatus that would be necessary to run this business if the market share is so small and you're in a situation

that you have an existing private Exchange operating.

MR. PUSCH: That's why I think it's so critical to identify where the current market is. Because I think one of your biggest challenges -- one of our biggest challenges is going to be to attract companies onto the Exchange when they're already at a level of benefits that are essentially below what we are going to end up offering in the employer. So that whole study that you want to get reviewed again, I think it's extremely important. You have to identify where the market is. Look, if the market is at a $5,000 deductible and the lowest plan we're offering in the Exchange is a $3,000 deductible, you're going to have a hard time competing on a price basis if the employer is already there. And keep in mind that many employers are already doing health savings accounts, the HRA programs. And under those circumstances, I think it's going to be critical to determine where the market is relative to what we build on the employer to attract employers. Because no matter how administratively feasible it is, you know, price talks more than anything in the health insurance business.

MR. McKIERNAN: I'm sorry, Chris McKiernan here, too. I really think that to mass -- to actually increase their enrollment over the last couple of years, and correct me if I'm wrong, but I believe the brokers got -- the agents and the brokers got involved a couple of years ago to increase that number significantly.

MR. PUSCH: Yes.

MR. CAREY: This is the April 2012 enrollment data that they provided.

MR. McKIERNAN: Yeah. So the --

MR. CAREY: The numbers of people -- this is not everyone purchasing through the -- Massachusetts has two problems. They have Commonwealth, which is commercial insurance with no State subsidy and then there's Commonwealth Care, which is subsidized program for individuals, not for groups. And so Commonwealth Care, there's about 200,000 people on the program who were receiving subsidies. Commonwealth Choice is 40,000, 36,000 of whom are individuals, not associated with a group. The remainder are associated with a small group.

MR. McKIERNAN: And I just may add, that, you know, a large part, I think, of this

process is understanding the benefit, understanding the choices. Again, I have to say that currently in the State of Connecticut, you know, those that are selling and administering these plans are licensed, go through continuing education. We have omissions coverage. We get calls every day, not just to place the insurance, but to also, in dealing with the employer market, you know, there are new legislative issues that are coming up, new regulations that they have to abide by, issues, additions, terminations, billing errors, claims questions, a whole host of things that I think if we don't take that into consideration, I think they need a quarterback, they need someone assisting them and their employees in dealing with the day-to-day functionality of the benefit marketplace.

MR. PINTO: Tony Pinto again. Yeah, there are a lot of unknowns here because we don't have guaranteed issue in the individual market today. So you can't really -- when you look at it, an employer, if the employer doesn't offer benefits, then the employee doesn't get guaranteed issued plans. So if they even have two or three employers with health issues, the only way to get

them coverage is to go through the small group market. Whereas, in this new environment, that's not the case. So the case becomes, how do you address that? And so the Exchange will have issues in getting business memberships, businesses to join, so will CDIA because their small employers are going to have the same issues.

Their small employers that have low income employees who are going to be able go to the Exchange and buy direct and they are going to opt out of their employer's plan. So that's why the eligibility and the definitions and how this is put together is going to be very important. And so, I mean, the CDIA does do it, but it's going to be a very different environment and, you know, there is a lot of unknowns still that need to be looked at.

MR. FLEIG: If the employer offers affordable coverage, I mean, there's a couple of things that go in there, the employee just can't jump to the individual employer and get a subsidy. They are not going to get a subsidy if the employer offers coverage within certain levels. So that mitigates some of that.

MR. CAREY: True.

MR. PINTO: True. But you're also

double-dipping.

MR. CAREY: It's far from being double-dipped. Connecticut has a pretty expansive legibility, so there will be an increase, but it wouldn't be anything compared to, you know, other places. But I think John makes a good point, that if you are offering employer sponsored insurance and it's affordable, quote, unquote, and it meets those minimum levels, then you're not eligible for a subsidy.

MS. SKINNER: Just to comment on the point about who is best suited to do the enrollment and education of this population. I think we talked about CDIA. We have talked about the broker community. There is probably a third option out there. I think overall we have to look at the costs of each one of these entities and see how much taking medical is going to add to the premiums and to the premium. I think we want to evaluate. We want to see if there are other options that we might be able to come up with that are more cost effective. Because, again, not only are we adding the costs of administering enrollment, but we're also going to have to add the costs of the health insurance through the employer in their annual

review process and whatnot. So the costs of administering the program becomes extremely important in terms of determining who should -- how we should let this roll out.

MR. CAREY: I totally agree. Okay. Just a couple more points. You know, basically is there potential for, you know, the SHOP Exchange to work with CDIA an administrator of the SHOP Exchange. This wouldn't meet -- you know, the requirement with regard to the plan and what is offered would be the same no matter who administers it. The question is, to your point, Ellen, is there a cost deficiency that is going to be achieved by utilizing the existing resources?

MS. SKINNER: It's not just the costs. It's service, too. What else are we -- you know, what's included in that cost in terms of the package.

MR. CAREY: And just a point about the brokers, you know, I wasn't suggesting to go in one route or another. It would exclude the need or eliminate the need for brokers to be involved in helping small employers figure out their options and respond to, you know, ongoing issues that they may have. I don't see that happening, at least in

the short-term. Employers don't want to deal with the issues that they engage brokers to deal with.

And even in an employee choice model, you might need more assistance for the employees. I think that most of the business that's written through the CDIA is broker business. I believe that most employers are coming in on their own.

MR. McKIERNAN: I believe that's 100 percent, Chris McKiernan.

MR. CAREY: So just, you know, for consideration, you know, what type of purchasing model. We went through four. Is there a preference? Can you we start breaking this down and get some thoughts on the type of purchasing models. So should there be a minimum on the contribution requirements? Should it be on par with the rest of the small group market? And then how does the employer encourage insurers to participate, I think is the key. Perhaps, you know, Priority No. 1 is getting some choice from the carriers to participate on the SHOP Exchange.

MR. KATZ: This is Matt Katz again. I do think that your first two questions help answer the third question and I think Tony had pointed that out before, how do we design the requirements?

What are the minimums and maximums? If we make this more enticing and conducive to the small employer than the existing market, if we make it more onerous, more time consuming and more costly, we will have very few going through it. But I think those first two issues are going to help drive that third issue about encouragement.

MS. RUSSEK: This is Pamela Russek. So I think the key here today is to kind of try and walk away with possibly eliminating a couple of the purchase models. Is there anybody here who has thought about -- obviously the third option was mandated, so that one stays on the table. So the fourth one with all carriers, all plans, that to me kind of seems to be administratively burdensome. Is there some thought about --

MR. RITTER: I'm still willing to consider it. It's burdensome for an individual employer, that's obvious, but it might not be for the employer to take over. Because, you know, they are going to be dealing with all of the carriers anyway. So I'm not sure if that's one of the ones that we should eliminate. I think Option 1 could be eliminated.

MS. RUSSEK: We can go there. I'm

just trying -- that's great, Grant. So we can say that 3 and 4 potentially stay on the table. Option 1?

MR. FLEIG: Well, actually, this is John Fleig. I think from the carriers' perspective, the last one is the one that the carriers are most worried about, is this going to cause a lot of adverse, potential adverse selection and a cost increase.

MR. RITTER: John Ritter. We guessed that. It sort of -- you know, I think it's worth discussing.

MS. RUSSEK: So then are there any plans that we can we take off the table? Or are we saying that this is a little bit like a pixie sticks kind of thing and we can't pull a piece out yet?

MR. KATZ: This is Matt Katz. I think it may be too premature. I think the first option may be too limiting to entice employers and employees to participate. And if we are trying to get some participation, that might be a problem. I'm not suggesting a type of risk or costs, but I'm looking again at the question about incentivising employers and employees and that one may not be a

big enough incentive or a strong enough incentive for participation.

MS. O'GARA: Yeah. Just a reference point for all of you. This is O'GARA. In your guiding principles that you set up way back a couple of meetings ago, you did make as a first guiding principle that you should offer employees with a choice of health plans from a number of health insurers. So just keep that in mind. You also mentioned that the purchasing model should be structured so employee choice does not result in risk selection problems for health insurers and adversely affect the costs.

MR. PUSCH: Right.

MS. O'GARA: So just keep those in mind.

MR. PUSCH: Totally contradictory.

MR. PINTO: Tony Pinto. I think legally you are required to take Option 3, so that has to be offered, that gives you multiple carriers, multiple -- same plan, multiple carriers. The only other way it's sold today is Option 2, which is one carrier, multiple choices, where people can buy up or down. That might be all we need to start with.

MR. FLEIG: The CDIA has multiple carriers. For what it's worth, I will just tell you this, in Maryland, it's a very Blue state. They selected obviously No. 3, which you have to offer. And, in addition, the second option, the one carrier, multiple plans, which is currently how it's set up right now.

MS. O'GARA: Could you say the last part again, please.

MR. FLEIG: Option 2, one carrier, allowing multiple plans, which is currently the way the market is set up anyway. So basically they are allowing the current market with what is required under the law, which I do think meets the guiding principles of what you said.

MS. RUSSEK: This is Pam again. So back to trying to consolidate around at least a couple of positions. I am kind of thinking for us to move forward, we should try to at least start with a couple. So 2 and 3 are workable solutions to begin with and that doesn't mean that we couldn't come back and say, "We want to pursue Option No. 4 later", as an example. But if we start with that as a working hypothesis and then we can begin to look at things like contribution

levels and participation levels and so on, could we begin to develop some viable solutions out of it and make some progress at some point.

MR. RITTER: Excuse me, this is Grant. Christopher, could you tell me again, does CDIA actually offer Option 4?

MR. McKIERNAN: That's what they did, Option 4, John.

MR. RITTER: Is that because they are an employer and, therefore, they don't see it as administratively burdensome? I mean, is that the way the small businesses want it or --

MR. PUSCH: Tim Pusch, I don't know if I want to speak for CDIA, per se, however, they have set up administrative structure to accommodate that. But having said that, my comment earlier about how employers sort of limit it, they sort of self-police this Chinese menu approach. That's not to say there aren't employers that do the Chinese menu and literally hand their employees a rate table with all of the different plan options and all of the different carrier, but the vast majority limited within their selection process.

MS. MACLUBA: This is Marta Macluba. Just so you know, CDIA does actually State that the

carriers can only have certain plans in their portfolio. So they actually limit it because they limit it internally. They may offer different -- numerous carriers, while they offered four and now they're down to only two and the last one had to get out very quickly. But they limit themselves and that is -- and I'm not sure anyone here -- you know, we would have to think about that kind of limit.

But from a carrier perspective, Option 4 is the riskiest. And I will say from an education perspective, you need to understand that it's very dangerous because you may have nuances in plans and you will have individuals that think they bought a plan that said this, but they actually bought a plan that said this. And then in the middle of the year, they're going to want to make changes. The claim costs are going to be wrong and the education part is very burdensome and one of the hardest parts when you offer too many plans and too many choices.

And I think that administrative burden needs to be understood, not from the beginning part, but really during the course of the plan year.

MR. PINTO: Tony Pinto again. There's different perspectives. We can look at it from our perspective and from the carriers' perspective, but if we are trying to get business owners to enroll, you have to get it from their perspective. So for a business owner, simple is better. And so far they either have just one choice or they have two choices from one carrier. That is usually driven in -- the conversations usually with the agents are, "Get to the point." You know, "I don't want to go through -- I don't want to go through the insurance agent. The insurer doesn't want to be the broker or the agent. And they want to make it easy on their employees, especially the smaller the business you get into. So keep that in mind.

MS. PULISCIANO: Pat Pulisciano. I guess that's where the expertise of the broker comes in because you make recommendations based on what we know is going on in the marketplace. I like the idea of giving, you know, options; and then within those options, putting criteria in place just as it states in the marketplace today based on the size. So you have a number of options; but then based on other requirements, you make some modifications.

MS. CINTRON: Would it be helpful, given our discussion, to see if CDIA, and I know we have time in terms of our overall schedule, to invite them to our next meeting to have an overview and possibly then alternately invite all of the health plans to discuss these issues?

MR. PUSCH: That would be great, if we could pull that off. It would be great.

MS. CINTRON: I'm not very confident, but I can try and I think it would be good, per our discussion, that we have comprehensive information and we can really have a good conversation and, again, I think with our overall time line in these decisions, we're okay there. So if that's beneficial to this group, we can try to do that.

MR. CAREY: The only thing I would add, as we have mentioned before, with the majority of the plans, we may want to ask one of the plans, more of the minority, to come speak, too, to see if there's any variability between the plans that have a larger percentage of the market than the smaller and maybe we can decide why and that may help guide our development, as well.

MR. PUSCH: Well, you said the majority. Those are the only four carriers

operating in the small market in the Connecticut right now. Cigna pulled out of it. And this is pretty much all that's left, with the exception of some unusual alternatives, like the self-insured alternatives and so forth. So those really are small business carriers.

MR. KATZ: If those are the four, then I retract my statement.

MR. CAREY: And the data that we have, which is not -- you know, the entire market suggests that, you know, well over 95 percent of the market is covered by one of those four, so those four are now marginal players.

MR. PINTO: Tony Pinto. Do we need to make a motion or make an assumption that we are moving forward with the choice and leave it contingent that we can always change it later and revisit it?

MS. RUSSEK: I think it's a good idea. Before we go there, though, I want to just close out on this thought. It seems like we have a consensus of opinion around the CDIA and the carriers. I think it might be helpful to make sure that that meeting is as effective as it can be to maybe have this group submit maybe to Amy, or

someone, what some of your questions would be. Because some of them could be on a spread sheeted and published ahead of time and we would save some of the sort of detail back and forth that we might end up engaging in here and chewing up the time that could otherwise be spent in more, I don't know, in more instructional type of dialogue where we would discuss some ideas as opposed to just collective data points. So, anyway, that's just a suggestion. I guess we can submit -- see if there's a motion to just work with Purchase Model No. 3 with that? Is there a second?

MR. PINTO: Second.

MS. RUSSEK: And voting? All in favor?

(Whereupon Aye was heard all around the room.)

MS. RUSSEK Any opposed?

(No response.)

MS. O'GARA: Thank you, Pam.

MS. RUSSEK: That was great.

MS. O'GARA: And the other question we had was there's a lot of data points that I have written and Bob has written, as well, additional items we have. They're part of that spreadsheet,

as well. And I just wanted to go over a couple of those and make sure I captured everything. There was a question about where the market is at in terms of deductibles and premiums and co-insurers and I think we can get you some information on that, that would be helpful in talking to the four carriers.

MR. CAREY: Yeah. Easier said than done. Any request to the carriers takes longer than one anticipates. We have engaged an actuarial firm that will be submitting data request to the carriers and that takes some time and hopefully they will be getting back to us, so I don't anticipate that happening prior to the next meeting, so just put people's expectation out there. But we are in the process of collecting that information. And we do think it's -- we do think it would be very informative.

MS. O'GARA: And then the second one was to look at the cost of administering such a program.

MR. CAREY: Sure. So we can pull, you know, existing information of potential costs to administer the program.

MS. O'GARA: And then there was the

question about existing exemptions, if you could clarify who might be exempt under what conditions and clarify the tax consequences, the credits and the ability to deduct the premiums, as well. And I don't think there was anything else.

MR. McKIERNAN: I'm sorry, Chris McKiernan. So, Tia, are they going to be participating at the next meeting? Are you going to try to do that,

MS. CINTRON: Yes, we're going to try to do that.

MR. McKIERNAN: Okay. Will it be off line or --

MS. CINTRON: We will see how -- see what they are willing to do. I think, as we had suggested, if you could submit questions or topics of most interest to Amy in the next few days, then we could then craft our discussion with CDIA appropriately, that would be helpful. We'll see what we can do.

MR. McKIERNAN: Okay.

MS. RUSSEK: If we could maybe put a hard date on it, if you can get them submitted by the close of business this week; and anything after, that we will have to leave behind.

MR. McKIERNAN: Yep. Can I just ask, who would we send this to?

MS. CINTRON: Why don't you send your questions to Amy Tibor.

MR. McKIERNAN: Could Amy just send a quick e-mail to us confirming that?

MS. CINTRON: Sure. I'm sorry, Amy. I'm speaking for you.

MR. KATZ: I think there are different questions with respect to CDIA versus carriers. If they are both coming, we may want to make sure we differentiate somewhat because I think some of our discussions today and questions were more about the structure and administration of what CDIA does and what others have tried to do, but the plan design is our responsibility.

MS. CINTRON: Maybe what would be helpful here, in your e-mail, we will frame some buckets of topics and then you can react to those and add to it.

MR. KATZ: That would be great, thank you.

MS. O'GARA: And then, Pam, we have just a couple of other items on the agenda. I think we pretty much have pretty much outlined --

MR. PUSCH: Wait a minute, are we going to go back to that last slide? Because I thought we needed to identify the issue of minimum participation and so on and so forth, that there were other elements here that we wanted to try to at least address to some degree.

MS. O'GARA: I don't know if we have time to do all of that today. Those have been raised as things we need to get to as part of our process.

MR. PUSCH: I see. Okay.

MS. RUSSEK: Here's what I would propose, I think either somehow between Grant and I, we might work with the rest of you over the next how much days until the next meeting. I think what I would like to do is potentially come up with a couple of draft proposals for some participation levels and, you know, contributions. I know there are some issues as to what those are and what we need to do in terms of the next steps. I think we need to also identify other options beyond CDIA as a way of easing some of the administrative burden, what else we might leverage, whether it's components of the brokerage community or wherever. So if we could maybe pursue some of that before we

come together again, it might help since we're out of time today.

MR. FLEIG: I think we would certainly want to ask the carriers the next time about what made them choose the participation rates and the contribution requirements that they did choose. I would like to hear that from them.

MS. O'GARA: I just want to be clear, when we send out the e-mail that asks for your questions from the carriers, we can include contribution levels and participation requirements, bring that back and have a discussion about that, once everybody has all the data points. Agreeed? That pates.

MS. RUSSEK: Agreed.

MS. O'GARA: Okay.

MS. RUSSEK: And I think any discussion we can anticipate, I mean the people here have been working with the marketplace for a while, which is not to suggest that we need to follow the marketplace as it stands. But I do think there is further thought that people do have already that potentially help or we could use to help frame where we go with this information, once we get it collected. So we may or may not have

some off-line discussion before meeting with the CDIA and/or carriers.

MS. O'GARA: We have one other piece on the agenda, which we can pole the audience. If there's anyone in the audience that wants to come forward and make a comment, you can certainly come forward and use a mic, give us your name, that would be great.

FEMALE VOICE: Good morning. My name is Arlene (inaudible), Consumer Advisory for the Committee. I would just like to express concern about current litigation of the plans to either one carrier with multiple levels or multiple carriers with single levels. I would say that there's probably the need to provide consumers with choices.

MALE VOICE: Does that mean you prefer Option 4?

FEMALE VOICE: Well, I don't think it has to be four and four. It could be two and two. It could be -- I'm just saying, you don't have to have all or nothing. There's usually a middle ground. I would give an example of two and two, two plans with multiple levels as opposed to one carrier.

MS. O'GARA: Okay. Thank you. Are there any other comments from the public?

(No response.)

MS. O'GARA: All right. Back to you, Pam.

MS. RUSSEK: Motion to adjourn?

MR. McKIERNAN: So moved.

MS. RUSSEK: All in favor?

(Whereupon Aye was said throughout the room.)

MS. RUSSEK: Any opposed?

(No response.)

(Whereupon the meeting was adjourned at 10:55 a.m.)

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