

VERBATIM PROCEEDINGS

CONNECTICUT HEALTH INSURANCE EXCHANGE

SMALL EMPLOYER HEALTH OPTIONS PROGRAM
ADVISORY COMMITTEE MEETING

JULY 11, 2012

LEGISLATIVE OFFICE BUILDING
300 CAPITOL AVENUE
HARTFORD, CONNECTICUT

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RE: CONNECTICUT HEALTH INSURANCE EXCHANGE
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1 . . .Verbatim proceedings of a meeting
2 before the Connecticut Health Insurance Exchange, Small
3 Employer Health Options Program, Advisory Committee
4 Meeting, held at the Legislative Office Building, 300
5 Capitol Avenue, Hartford, Connecticut, on July 11, 2012
6 at 1:00 p.m. . . .

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8
9
10 CHAIRPERSON GRANT RITTER: Hi. I'd like
11 to introduce a new member to the Committee, Kevin Galvin.
12 When this Committee was formed a couple of months ago, I
13 noted it was, you know, full of experts, but I thought it
14 was a little bit short on small business representation,
15 and I mentioned this at one of the Exchange Board
16 meetings.

17 I've sort of been looking around, and
18 Kevin is a small business owner, himself, plus he is the
19 founding Chair of the Small Businesses for a Healthy
20 Connecticut organization, and I think he'd be a wonderful
21 addition to the Committee and invited him to join, so
22 welcome.

23 CHAIRPERSON PAMELA RUSSEK: Okay. I think
24 our first order of business is to acknowledge that we

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1 have some guests here in the room today that we are very
2 interested to hear from and extend a warm welcome to all
3 of you.

4 Before we proceed, if we could just have
5 maybe we start with introductions on this side of the
6 room and go around, just so that we all get to know who
7 you are.

8 MR. BILL DONAHUE: Good afternoon. My
9 name is Bill Donahue. I am the Interim Chief Executive
10 Officer of Healthy CT, a co-op that was just recently
11 funded by the federal government, and we're seeking
12 licensure here in the state as a health insurer.

13 I was able to step in. I was able to free
14 up some time to step in for Ken Lalime, who was supposed
15 to be sitting here, so I hope I won't disappoint.

16 MR. JIM AUGUR: Good afternoon. Jim Augur
17 from Anthem/Blue Cross, Blue Shield. Vice President
18 there.

19 MS. KAREN O'CONNELL: Hello. Karen
20 O'Connell, ConnectiCare, Director Account Management,
21 Mid-Market, Small Group and Solo.

22 MS. MARTA MACIUBA: Marta Maciuba, Aetna,
23 Small Group, Sales and Service for New England.

24 MR. CRAIG BAUER: Hi. I'm Craig Bauer

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1 from Aetna, as well. I'm the Senior Actuary for health
2 care reform, Project Management Office.

3 MR. KEVIN GALVIN: Hi. Kevin Galvin,
4 Chair of Small Businesses for Healthy Connecticut.

5 MR. MATTHEW KATZ: Matthew Katz, the
6 Connecticut State Medical Society, and just out of so
7 everyone knows, from a conflict perspective, I do sit on
8 the Board of Healthy Connecticut.

9 CHAIRPERSON RUSSEK: Thank you, all, and,
10 again, welcome. Our next order of business is to -- oh,
11 I'm sorry. That's right. John.

12 MR. JOHN FLEIG: And I'm not part of the
13 panel. I'm just somehow sitting in front of the panel.
14 Hi, there. John Fleig from United Health Care. I can't
15 wait to ask myself questions. (Laughter)

16 CHAIRPERSON RUSSEK: We can't either,
17 John. Okay. Why don't we go around the room and just
18 introduce the rest of us, so that you know who we are?

19 MR. CHRISTOPHER MCKIERNAN: Chris
20 McKiernan, Abercrombie, Burns and McKiernan. We're an
21 agency in Darien, Connecticut. I also serve on the
22 Connecticut Benefit Brokers Board.

23 MR. ANTONIO PINTO: Tony Pinto,
24 Independent Consultant.

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1 MS. LYNN JANCZAK: Lynn Janczak, Vice
2 President of Marketing and Communications for Learning
3 Dynamics.

4 MS. MARJORIE COLE: Marjorie Cole,
5 Hartford Health Corporation.

6 MR. KEVIN COUNIHAN: Kevin Counihan, CEO,
7 Connecticut Insurance Exchange.

8 CHAIRPERSON RITTER: Grant Ritter,
9 Brandeis University, and I sit on the Health Insurance
10 Exchange Board.

11 CHAIRPERSON RUSSEK: Grant is also our co-
12 Chair. Pam Russek, Independent Consultant and co-Chair
13 of this Committee.

14 MS. ELLEN SKINNER: Ellen Skinner, Yale
15 School of Management, and, full disclosure, I also sit on
16 the Board of Healthy Connecticut.

17 MR. TIM PUSCH: Tim Pusch, Burns, Brooks
18 and McNeil Insurance Agency in Torrington.

19 MS. JULIE LYONS: Julie Lyons, Director of
20 Policy and Plan Management at the Exchange.

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

23 MS. NELLIE O'GARA: And, hello, I'm Nellie
24 O'Gara. I'm going to help facilitate our discussion

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1 today.

2 MR. GALVIN: Excuse me. As a matter of
3 order, I'm also on the Board of Healthy CT.

4 CHAIRPERSON RUSSEK: Okay. Thank you,
5 Kevin. Okay. Again, welcome to our guests today, and I
6 think our next order of business is approval of our
7 minutes from the last meeting, so I motion that the
8 minutes be accepted. Any? Yes, Tony?

9 MR. PINTO: Just when I looked through the
10 transcript, there's some typos. One main typo I saw is,
11 in the transcript, itself, CBIA is actually typed as CDIA
12 consistently.

13 CHAIRPERSON RUSSEK: Okay, thank you. So
14 noted. Any other amendments to the minutes?

15 MR. FLEIG: Motion to approve.

16 A MALE VOICE: Second.

17 CHAIRPERSON RUSSEK: Okay, passed. Okay,
18 I'm going to turn this over now to Julie.

19 MS. LYONS: Good afternoon, everyone. At
20 our last Advisory Committee meeting, you know, the
21 conversation was lively around things like the
22 participation requirements, and transference of data,
23 enrollment processes, etcetera and so forth, so we wanted
24 to reach out to the health plans to invite them, invite

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1 you all to come and share with us your expertise, so
2 thank you for coming.

3 MS. O'GARA: I know this is being
4 recorded, so I'll try to get back to the mike, but we got
5 a number of questions from the Committee members, and we
6 tried to put them into a couple of buckets.

7 As you can see up here, we've got some
8 questions about your preference on the purchasing model,
9 what your perspective is on different participation
10 requirements, contribution requirements and plan designs,
11 and I have a number of questions that we've put together.

12 I'm going to kind of lead off with one of
13 them and invite you to make comments. These are not the
14 only questions that are likely to come up. We're having
15 a conversation, and the conversation will probably spur
16 additional questions, so I will try to facilitate the
17 discussion a little bit.

18 We also have some public members here, and
19 we're going to wait for public comment towards the end,
20 but I think Bob Carey may want to join in some of the
21 question and answer, as well, and you're all familiar
22 with Bob.

23 So, that being said, thank you, all, for
24 sharing your time with us. I think it's going to be very

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1 beneficial to this Committee to have this opportunity.

2 The first question has to do with Health
3 Insurance Exchanges, and let me just state it for you.
4 What experience have you had in working with the Health
5 Insurance Exchange either here or in other states, and if
6 you can share with us what you learned from that
7 experience, both the positive and the negative, and I
8 just open that up for anyone, who wants to make a
9 comment.

10 MR. DONAHUE: I guess I'm the one who gets
11 to start it off. I am a consultant by trade, and I have
12 started a, or I've helped start a couple of co-ops across
13 the country, and I have multiple other co-ops that we are
14 waiting to hear on funding.

15 I've had to talk to multiple Exchanges
16 across the country, and I should change that. It's not
17 multiple Exchanges. It's multiple states that they may
18 have Exchanges. You just don't know at this point.

19 There's a lot of them, where you have
20 effectively a Sub Rosa Committee, as opposed to what you
21 guys have here. You are light years ahead of most of the
22 states that I've been to.

23 Even one of my clients is in Arizona, and,
24 as of yesterday, Governor Brewer came out and was still

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1 waffling, as to whether or not they were going to open up
2 one or not.

3 Illinois was waiting for one, but they
4 really wanted to wait until after the Supreme Court
5 decision, and yet still nothing has been done.

6 I have spoken to the folks, who are
7 working on the Exchanges there already, in case they
8 decide to flip the switch. They have had a running
9 start, but it's interesting. You're going to find a lot
10 of different approaches, and there's not going to be one
11 that's going to be the same, and, so, if you see one
12 Exchange, you're going to see one Exchange.

13 And that is one thing that is going to be
14 kind of difficult if you're looking, particularly from a
15 carrier's perspective, if you're going across the
16 country, you're going to find that you're going to have a
17 lot of different rules and regulations you're going to
18 have to adhere to that could be substantially different
19 across the country.

20 MR. AUGUR: Hi, Jim Augur, again, from
21 Anthem. Let's first say that CBIA is a type of Exchange.
22 We do not do business with CBIA here in Connecticut, and
23 they do a great job and provide a wonderful service to
24 many small employers throughout Connecticut.

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1 We do do business with an organization,
2 called Cal Choice out in California, one of our Anthem
3 markets, which is similar to CBIA, so I share with you
4 the two different business decisions.

5 In the Cal Choice situation, it is an
6 employer select model, different than kind of the CBIA
7 model here in Connecticut, and I would suggest that one
8 of the concerns in managing risk pools in the small group
9 market would be at that employer choice point, as long as
10 there's enough flexibility in plan designs and options
11 for, you know, an array of employees within an employer
12 group, that that would be a more successful model in the
13 totality of risk management and something that, clearly,
14 from a participant standpoint, is something that would
15 need to be evaluated.

16 Again, I think CBIA has done a great job
17 here in Connecticut, but we have chosen for most of our
18 broad products not to participate. We do participate
19 with our group Medicare.

20 MR. PUSCH: Jim, can I ask for
21 clarification of that a bit? Tim Pusch, by the way. I'm
22 sorry. Are you saying, in essence, that you think the
23 better approach is that old Chinese menu approach, of
24 pick any plan and pick any carrier, as opposed to

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1 limiting choice that employees have?

2 MR. AUGUR: Yeah. What I'm saying is that
3 I think that a model for better risk management and
4 understanding of that would be that the employer chooses
5 the carrier, for example, and, then, within that
6 carrier's family of products, there would be that choice
7 at the employee level.

8 MR. COUNIHAN: Just to enhance Jim's
9 comments, just for people to know, Cal Choice is actually
10 a product name. The name of the firm is Choice
11 Administrators, and, in full transparency, that's my
12 former company.

13 MS. O'CONNELL: Hi. Karen O'Connell,
14 ConnectiCare. We do participate with CBIA, however, we
15 primarily are the insurer, so we provide the benefits.
16 CBIA does all the administration of who the members are,
17 the requirements, so we truly are just the insurer in
18 that case.

19 They do work off of an employee choice.
20 Right now, there's two vendors in that, so that's where
21 we are with that.

22 MR. FLEIG: John Fleig, United Health
23 Care. I echo Jim's comments on employer choice. I think
24 that helps preserve a better risk pool. In terms of

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1 CBIA, we do work with them. They're easy to work with,
2 so I think any Exchange has to look at as a partnership
3 between the Exchange and the carrier for the ease of
4 administration, both for the consumer, the employer, and
5 the carrier, so the easier the Exchange is to work with,
6 as CBIA is very easy to work with us, they ask our
7 opinions on things, etcetera, and they do allow brokers
8 in the process, which may be important.

9 MR. MCKIERNAN: Chris McKiernan here. I
10 am an agent. In full disclosure, I serve on CBIA's
11 Agent's Advisory Committee.

12 Just to echo those comments, part of the
13 allure of a CBIA system and Exchange system is choice.
14 Part of what we've been talking about is, in addition to
15 on the group side, in addition to choice, there's a lot
16 of other things that become part of a group health plan,
17 and the administration of the plan.

18 You get into COBRA, you get into so many
19 more things, other than just the selling of the product
20 to the individual, so, from a group perspective, if we're
21 talking about group, as opposed to individual, there's
22 many pieces to that program, and a good administrator, in
23 addition to the platform of selling the insurance, can
24 also have the platform and the technology available to

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1 administer these programs, which I think is very
2 important, as well.

3 CHAIRPERSON RITTER: Could I just ask a
4 clarification? Isn't it the case that under the
5 Accountable Care Act, Affordable Care Act, I'm sorry,
6 that you have to at least use option three, which it
7 would seem to be, you know, not allowed, the employer
8 choice plans that you're talking about, because you have
9 to at least offer the employer the option of the same
10 level across different health plans?

11 I'm curious. I thought that was sort of
12 like written into the law.

13 MS. O'GARA: Bob, do you want to comment
14 on that?

15 MR. BAUER: Yeah, so, Craig Bauer from
16 Aetna. My understanding, as well, is that the way the
17 ACA was written was that the SHOP Exchange has to make I
18 guess it's option three, one, you know, sort of one metal
19 level across multiple carriers that has to be made
20 available to employers.

21 I would echo a lot of the comments that
22 have been made here, that, you know, certainly, giving a
23 lot of the choice and preserving a lot of what exists in
24 a group market, you know, is very important for the

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1 stability of the risk pools, and, you know, certainly
2 something that we encourage and give careful
3 consideration to.

4 MS. SKINNER: I have a question, just
5 thinking about, forward thinking about the risk and the
6 complexity of managing in a Health Insurance Exchange.
7 Most of the people that are going to be eligible for the
8 products are going to be at the lower end of the income
9 scale, and, so, the eligibility and the subsidy may
10 change frequently, so have you thought about reducing the
11 risk and insuring more continuance, you know, constancy
12 from plan-to-plan, you know, as these people their
13 eligibility levels differ? Is that something you thought
14 about?

15 MS. MACIUBA: This is Marta. So I think
16 it's really important to know that this conversation
17 needs to be on the SHOP and not on the individual
18 Exchange, so if we're really talking about SHOP, the
19 lower end will not really be impacted by what decisions
20 we make from a SHOP perspective. It's really the group
21 perspective that we need to focus on.

22 I think that's a great question to ask
23 maybe on Essential Health Benefits Committee, or one of
24 the other committees, where there's going to be a subsidy

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1 on the individual Exchange component and not on the SHOP
2 Exchange component.

3 The only advantage to the SHOP, if I'm
4 correct, Bob, is that there is a tax credit in the SHOP
5 Committee, and there's really no other -- we probably
6 need to, as a Committee, decide what other positive
7 features they would be to a SHOP program that's going to
8 be offered through the Connecticut Exchange.

9 MR. PUSCH: We are, also, in the SHOP
10 Committee, responsible for the individual market, as
11 well, coming out with the plan options for individual, as
12 well as small employer.

13 MR. FLEIG: Is that true? I thought this
14 was a SHOP Committee, not an individual market committee.

15 MS. MACIUBA: So Bob keeps shaking his
16 head yes.

17 MR. FLEIG: So we're not responsible for
18 individual?

19 MR. CAREY: Correct. Right. This is a
20 small group market.

21 CHAIRPERSON RITTER: We are responsible
22 for COBRA and other issues like that that were brought up
23 earlier, so it's important to know this in and outness
24 that takes place. You can't ignore it, that people will

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1 be employees one month and not employees the next month.

2 MS. MACIUBA: But that would make a
3 distinction. This is Marta Maciuba again. I guess that
4 makes a really distinction, because I don't think, you
5 know, I don't think we've gone as far, at least I think
6 from our organizational perspective, what the plans will
7 look like from an individual Exchange versus a SHOP
8 Exchange and if those plans need to be the same or not
9 the same plans.

10 I don't think our conversations have gone
11 that far. I think, right now, our main concern in
12 regards to a SHOP is the risk components and making sure
13 that, when a SHOP Exchange is put into place, that risk
14 is an important component of the conversation, and we
15 currently, outside of Exchanges, are in the current
16 environment.

17 All of us work really hard to make sure a
18 group is really a group, a group is not going to be
19 affecting the risk of the block of business, and that the
20 contribution levels are set, so you get the right
21 participation and the right employees participating in
22 the plans.

23 So, right now, it's all been about risk up
24 to this point in time for us and that depth of trying to

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1 manage those two areas.

2 MS. SKINNER: I just want to interject
3 that I think it's something that we all have to consider,
4 at least this group has to consider, because there is
5 that possibility of the on again, off again employed,
6 non-employed that we have to interface with the State, in
7 terms of their Medicaid population, so I think these are
8 considerations, and I was just inquiring if the insurers
9 of the health plans have, you know, entertained those
10 concepts at all.

11 MR. KATZ: To follow-up on Ellen's point,
12 this is Matt Katz, I think it is going to be incumbent
13 upon this group to determine when people are coming in
14 and out of the various small business versus the
15 individual, because they still need to maintain coverage,
16 and then there's going to be the aspect of them, then,
17 selecting, again, whether they went from small, you know,
18 the SHOP, small business, to an individual or vice versa.

19 They're going to have to make a
20 determination, and I don't think it's clear, at least
21 it's not clear to me, if you were an individual, then you
22 become employed, and, as an individual, you had insurance
23 through the Exchange, what happens when you become
24 employed, and do you get another choice selection, or do

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1 you carry that plan with you?

2 And I think that's why it's so important
3 and what I think Ellen was getting at, was that link that
4 we have to start looking at.

5 MR. DONAHUE: I think you're right, Matt.
6 You're going to get a lot of flips. You're going to get
7 flips from the individual Exchange, from Medicaid to the
8 having individual insurance. You're going to get folks
9 from Medicaid to actually being employed and getting
10 small group insurance at that point in time, sometimes
11 large group.

12 That is something that everyone has to
13 take into consideration, as to what your benefit plan
14 designs are, and whether or not you're going to have them
15 consistent between the individual Exchange and small
16 group, because, as you say, if you have a certain -- if
17 you have a silver that's in the individual and it's
18 silver that's different in the SHOP Exchange, they come
19 back on, they may wind up having silver and have
20 different benefit plan design, so it is something we all
21 have to take into consideration.

22 CHAIRPERSON RUSSEK: This is Pam, Pam
23 Russek. Is it appropriate for us to make sure that we
24 pass this issue as an ongoing issue on to the Benefit's

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1 Committee to make sure that there's sufficient action
2 relative to that and that they keep us apprised of what
3 their progress is?

4 MR. DONAHUE: I think, most definitely,
5 you should do that.

6 CHAIRPERSON RUSSEK: Okay.

7 MS. O'GARA: So we've kind of touched on a
8 second question that I had, and I want to make sure
9 everybody gets a chance to share their point of view, and
10 the next one has to do with which purchasing model would
11 be most successful in your point of view, and that's on
12 the SHOP Exchange.

13 We have four purchasing models. You've
14 alluded to model three, but just to refresh everyone, we
15 have the one carrier, one plan, we have one carrier,
16 multiple plans, we have multiple carriers, one plan, and
17 we have all carriers, all plans, so if you can kind of
18 think about, from your perspective, what do you think
19 would be most successful in attracting small businesses
20 to the Exchange?

21 CHAIRPERSON RITTER: Or insurance carriers
22 to the Exchange.

23 MR. AUGUR: Well I was going to ask that
24 question, is what is the -- and I don't want to get crazy

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1 here, but what is the definition of success?

2 MS. O'GARA: Well let's push it on to your
3 perspective, so what would be success in your
4 perspective?

5 MR. AUGUR: I think that, clearly, you
6 want the program to be successful, you want to have an
7 attractive program, but you don't want to have a program
8 that's going to go into any kind of a death spiral and
9 ultimately not be successful.

10 Success I'll define as, you know, a
11 program that's sustainable over a long period of time,
12 okay, and that ultimately gets at the issues that we all
13 collectively struggle with, and that's affordable quality
14 health care, right?

15 So I do come back to I think that the
16 insurance companies understand risk management, and, for
17 a program to be sustainable, then we cannot take our eye
18 off of that, and I think risk management does delve into
19 the issues that were just expressed before, because,
20 invariably, you're going to have, folks, shop like crazy,
21 and if they're eligible for an individual and eligible
22 for a group and going back and forth, they're always
23 going to be searching for what is perceived to be the
24 best value.

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1 So I come back to, again, some of my
2 earlier comments, that, you know, the one carrier of
3 multiple plans in my opinion is a model for, you know,
4 greater sustainability and risk management.

5 MR. FLEIG: John Fleig. I would agree,
6 but, Grant, I agree with your point. The way the law is
7 written is that there is some level of employee choice,
8 and what we would advocate there is -- employer choice.
9 I'm sorry.

10 Employer choice to limit that to one tier,
11 where employees then can select any carrier within that
12 one tier. If we start expanding the tiers out, then you
13 get into what Jim is talking about, is a lot of adverse
14 selection and risk.

15 You can do it a couple of different ways.
16 You can select that, because that's the law requires
17 that, and limit it to one tier, but, also, give the
18 employer the option to select one carrier with choice
19 within that one carrier.

20 Insurers are used to that, rating for that
21 type of risk, so that's what we would advocate.

22 MS. O'GARA: And, John, to do that, again,
23 successfully, the one that you just described, are there
24 certain participation requirements that you would

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1 anticipate to make that successful?

2 MR. FLEIG: Yeah. We think the
3 participation requirements should be there. Whether
4 that's the state to come up with it, we would advocate
5 something like a 75 percent participation requirement
6 that could include waive in or waives out of people with
7 other coverage, not just necessarily not taking coverage,
8 but that's all part of how to control risk within the
9 plans.

10 MR. PUSCH: Tim Pusch. John and any of
11 the other carriers, would you essentially want the same
12 underwriting guidelines for submitting a group in the
13 market, regular marketplace now to be in place within the
14 Exchange, generally?

15 MR. FLEIG: Generally, yes. I think they
16 should be the same.

17 VOICES: Yes.

18 CHAIRPERSON RITTER: Hi. Grant Ritter.
19 It seems like what I'm hearing is that you basically
20 think of this as the same model as you have now, where
21 you're accepting employers one at a time, and you're
22 looking at each one of them, do I want this employer as a
23 business or not?

24 MR. PUSCH: Let me correct that. As long

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1 as they pass their underwriting guidelines, there is no
2 choice of taking a group or not taking a group.

3 CHAIRPERSON RITTER: That's right.

4 MR. PUSCH: But as long as they pass
5 underwriting guidelines.

6 CHAIRPERSON RITTER: I have to say that a
7 lot of things I read into the Affordable Care Act seems
8 to be looking for a new model, where you're actually
9 pooling businesses, you know, and thinking of them as a
10 total group, as a large, single, you know, business, and
11 asking, you know, what rates do you have to set for that?
12 What risk are you taking on by that approach?

13 It's a different mindset, and I agree. I
14 mean you're still -- you think of these as individual
15 companies that you either are going to, you know,
16 contract with or not, then everything you said is right,
17 but if you think of it as saying like, oh, boy, we're
18 suddenly going to have either, you know, this whole big
19 mass of people, you know, coming through the Exchange,
20 what's our risk profile for that, it's a different idea.

21 I mean maybe it's a higher risk, maybe
22 it's a lower risk, because you've got much larger
23 numbers. I don't know, but it seems like that's what the
24 Act is actually trying to do, is trying to change the

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1 model for risk to something broader than it was before.

2 Am I the only one that sees it that way, I
3 mean, or is there other understanding of that?

4 MR. AUGUR: Jim Augur, again, from Anthem.
5 I understand your perspective. I would suggest that, in
6 today's small group underwriting, it is a level of
7 pooling, so, today, we set our rates, based on, in our
8 case, 90,000 people that are in our small group pool, and
9 then the variability comes in with the plan designs and
10 the associated actuarial value, some level of risk
11 profile, but it's not based on the specifics of a group.

12 It is based on demographics, areas of the
13 state, so those variabilities come in, but the starting
14 point, the foundation in which the rates are set are
15 based on the entire pool. In our case, about 80,000 or
16 so members. As a result of reform, some of those
17 qualifiers will be changing, and there will be fewer of
18 those variables that go into the ultimate rate setting.

19 So I think that I agree with the
20 direction, but I just wanted to share that, at least from
21 a total pooling concept, that exists today.

22 MR. KATZ: And I was just going to follow-
23 up. This is Matt Katz again. I think, conceptually,
24 you're thinking of it as the multiple small groups

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1 becoming one large group, and how, then, I guess the
2 question is, how, then, do you look at that large group
3 any differently than you do looking at those individual
4 groups today, or, Jim, as you had said, the total group
5 today is what Grant is looking at is how does it differ?

6 With the multiple small groups, the
7 community banding that you have now, how does that differ
8 from what you see conceptually that's going to have to
9 happen in the Exchange to make it beneficial for small
10 employers, but, also, for you as an insurer to be part of
11 that process?

12 MR. AUGUR: At this point, based on
13 everything that I see and know, I don't think it's going
14 to change much, because the starting point has to be some
15 level of population management, and understanding the
16 associated risk of this population, what I see is the
17 variables change.

18 MR. BAUER: Craig Bauer. I would agree
19 with that, with what you're saying, Jim. The concepts
20 still apply. You've got a large pool that determines
21 sort of your overall premiums and how you go about
22 evaluating risk, but that's something we do today, it's
23 something we'll continue to do, and, just as you said,
24 Jim, some of the factors that you take into account get

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1 shifted a little bit.

2 Some go away, some get squeezed, and some
3 of those things, and I think what we're in general
4 talking about here are, you know, needing to preserve a
5 stable population, and if you start taking this to one
6 extreme, where, like as Jim mentioned earlier, you have a
7 lot of choices being made, and you create more and more
8 options for people to select against a plan, or, you
9 know, specific benefit, or whatever it happens to be,
10 then that can create some of the, you know, some of the
11 spiraling that we can see occur, and then that results in
12 an inefficient market and one that can just force prices
13 up higher.

14 So, again, I think a lot of the same
15 principles apply, and you just try to protect a lot of
16 that stability that exists in the marketplace within the
17 framework that we'll have going forward.

18 MR. PUSCH: Tim Pusch. Let me ask a
19 question that's sort of building on what we're
20 discussing, I think. Is there any way in your minds,
21 therefore, that product can be created for the Exchange,
22 which could be fundamentally better priced than the
23 market today outside of the Exchange?

24 Is there anything that you can envision

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1 that could be done in creating what we offer that could
2 provide better pricing from a relative plan-to-plan
3 standpoint?

4 MR. BAUER: And just to clarify, are you
5 saying, is your question about a better pricing on
6 Exchange versus off Exchange in 2014?

7 MR. PUSCH: Yes.

8 MR. BAUER: I think that would be -- it's
9 something I haven't given a lot of thought to. I think
10 that would be -- there could be a challenge, just
11 recognizing that, you know, the way the market will work,
12 is that you will have equivalency between the two, and
13 you have to treat the pool as one, so you work within
14 some very fixed parameters, in terms of designing
15 products and so on, but you're essentially playing with
16 the same rules, you know, whether you're on Exchange or
17 off Exchange, and, so, I think that goes back to Marta's
18 point earlier, about trying to decide what are the things
19 that make the SHOP unique and valuable to small
20 employers.

21 MR. MCKIERNAN: Chris McKiernan here. I
22 would assume that both the current marketplace and the
23 Exchange for small businesses would have to adhere to the
24 same set of guidelines, and I think that's what we're

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1 talking about, but we have state-mandated benefits, so
2 we're dealing with a whole host of things, I think, that
3 we would think would be part of the same process or
4 program, so, as we get deeper into why this SHOP plan
5 will be a better program, I guess that's what we're
6 getting to here, but we have state-mandated benefits from
7 an underwriting perspective.

8 I think that the carriers would want some
9 uniformity in that. That, obviously, has risk
10 implications, and then, thirdly, you know, we have an
11 Insurance Department here, which would probably want to
12 oversee both programs, and, again, uniformity, I think,
13 would be part of the process.

14 MR. DONAHUE: This is Bill Donahue from
15 Healthy Connecticut. Grant, you had asked a question
16 that was just at the tail end, where you said how do you
17 envision the risk? Whether it's on the Exchange or off
18 the Exchange in a small group perspective, it's going to
19 be higher.

20 You're going to wind up having folks, who
21 are going to be insured now, who have not previously been
22 insured. Whether it's on an individual basis, or whether
23 it's on a small group basis, you will have small group
24 employers, who previously haven't been offering insurance

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1 to their folks. They may not have been able to have
2 coverage, so you're going to get folks, who are going to
3 have pent-up demand, so, to start with, you will wind up
4 having higher risk that's going to come in originally,
5 and, frankly, after awhile, that should settle out a
6 little bit.

7 So, Tim, to answer your question, I don't
8 see that you're going to have a considerable difference
9 on Exchange as opposed to off Exchange, at least at the
10 beginning of this whole process, probably the first two
11 to three years, because you're going to get hammered, and
12 that's why the federal government has put in there the
13 three Rs.

14 And, now, if we can only figure out what
15 exactly the three Rs are, that will certainly help the
16 carriers figure out how we're going to manage risk.

17 MS. SKINNER: Well that was the question I
18 was going to ask. Jim had said, currently, they evaluate
19 all small business in a pool. Going forward, is that the
20 same thought, that all small business, whether in the
21 Health Insurance Exchange or out, will be evaluated on
22 the same --

23 MR. FLEIG: John Fleig. The law requires
24 both in and out is one pool for rating purposes, so that

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1 will happen. I would suggest that, in terms of cost,
2 that this should not be a commodity market, meaning every
3 carrier should not have to offer the exact same thing at
4 whatever price.

5 There should be flexibility in the market
6 for carriers, whether we wanted to look at networks and
7 maybe do something with a smaller network, perhaps, or
8 within the different tiers, benefits allowed, that as
9 long as you're within your goal tier, there's flexibility
10 for carriers to have different types of benefits.

11 Things like that could help potentially,
12 both with the demand that people want and with cost, so,
13 in all the different categories, there should be some
14 flexibility for carriers and not just be a commodity
15 market.

16 MR. KATZ: This is Matt Katz. So, John, I
17 feel odd having a microphone in front of us, since we're
18 sitting right next to each other, but -- so you're
19 suggesting that really that the competition or the
20 differential should be on the product and the services
21 associated with it or the benefits, not so much the cost.

22 Are you just suggesting that it's one
23 additional thing to look at when it comes to how these
24 plans are going to compete on the Exchange?

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1 MR. FLEIG: I think it's one big thing,
2 because the cost is going to -- all those components are
3 going to determine what the cost of the product is going
4 to be.

5 MR. AUGUR: I'm going to offer two cents
6 here. I agree with John, about the commodity. We all
7 struggle with how much health care has become a commodity
8 in the small group market over the years, but it is what
9 it is.

10 On the distinction on product, I think the
11 Committees have to think long and hard about this issue.
12 I think categorizing carriers having the same product and
13 potentially a different network or some other underlying
14 difference that may not be on the surface, i.e., \$1,000
15 deductible, or a \$10 co-pay, or how is the drug managed,
16 I think could be problematic over the long run, based on
17 adverse selection and risk management.

18 For example, if the carriers participating
19 were allowed to differentiate their product, based on a
20 network, and I'll give you an example, and still have the
21 same label as being the same product, but Carrier A, for
22 example, had a very limited network and maybe did not
23 have any specialty services available through specialty
24 facilities, then where would that risk, that needy risk

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1 probably migrate to?

2 And I just suggest that, as you consider
3 the decisions you have to make, and what is a product,
4 and what is a similar or same product, I would give
5 careful consideration to that, as it relates to risk
6 management, so I'm not sure if I agree with John.

7 There's been a lot of agreement on this
8 side of the room, but I'm not sure if I agree on that
9 one.

10 MS. O'GARA: Go ahead, Kevin, and then I
11 want to follow-up.

12 MR. GALVIN: Hi. Kevin Galvin. Just
13 coming from a consumer perspective, I think we can all
14 pretty much agree, as we get to where we are now with
15 health care reform, one of the things that's universal is
16 the messaging to the public has been positively terrible,
17 and one of the things we're burdened with, trying to
18 create what we're trying to do here, is what's out there
19 is that there's going to be innovation, there's going to
20 be low cost, and it's going to be easy, of which probably
21 none of those are accurate, okay? So I think we can all
22 agree on that.

23 The other thing that I think has to be put
24 into the mix here is that we want small businesses to

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1 engage. We don't want me, as an employer, to say the
2 laptop is over there. Go pick your own insurance.

3 When we get to this in my personal
4 business, I'm going to go to my broker that I've had for
5 30 years and say what do I do next, and I'm going to do
6 what my broker tells me. (Laughter) He bought me this
7 at lunch.

8 But there are many that are going to go
9 and use the Exchange and try to do the best they can for
10 employees, so we do have to have some ease to process,
11 and the only thing I'll say to that is that more choices
12 aren't better, so if we could come up with good choices,
13 good products.

14 And I think, with all due respect to the
15 experts here, we have to find a way to bring some
16 innovation to this, or it's going to just be the same
17 old, same old, and small businesses won't engage. Thank
18 you.

19 MR. PINTO: Tony Pinto. I wanted to go
20 back to an earlier point made, about what is success. I
21 mean, as a SHOP Committee, what is our role? Is it to
22 make sure that we have a SHOP Exchange that has 100,000
23 members, or is our role to make sure that once health
24 care reform is implemented, that the small group market

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1 has 98 percent penetration, as far as companies offering
2 benefits, whether on or off the Exchange?

3 That's a very important thing to consider,
4 because having a small enrollment in the Exchange doesn't
5 mean that we haven't accomplished the goal with health
6 care reform, so what is our goal?

7 Is it to make it, so that the market is
8 more robust and small employers actually offer more
9 benefits, or are we more focused on just trying to get
10 everybody into the Exchange, when that may not be the
11 ideal solution?

12 MR. PUSCH: Tim Pusch. Tony, the only
13 problem is, though, it's supposed to be self-sustaining
14 by whatever year it's supposed to be, and hard to imagine
15 a self-sustaining Exchange with less than 10,000
16 enrollees, as we hear going on in Massachusetts and Utah,
17 so it's hard to imagine that, if that's the case, it
18 could become self-sustaining.

19 MR. PINTO: I'll follow-up on that and say
20 one of the things to consider is merging the small group
21 market Exchange with the individual Exchange, because the
22 individual Exchange should have significant membership,
23 like it does in Massachusetts, so if the SHOP Exchange is
24 just a minor portion of the overall market, then maybe

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1 that's something to consider as an alternative to keep
2 the administrative cost down.

3 MR. MCKIERNAN: Then I would say why don't
4 we do that on the current marketplace that we have? We
5 have a marketplace currently, and, again, there's risk
6 issues associated with the individual marketplace and the
7 group marketplace.

8 I guess those are going to be changing
9 somewhat with the reform that is upcoming, guarantee
10 issue, a lot of these other things, but why wouldn't we
11 do that, then, in the current marketplace?

12 MR. FLEIG: John Fleig. I just need to
13 point out we are strongly against merging the individual
14 and the small group market. Again, it's risk.

15 Who is going to buy in the individual
16 market the first couple of years, and are those folks
17 that are sick and couldn't get insurance, so those are
18 two different types of pools, and we don't want to drive
19 costs up to the small employer, at least the first couple
20 of years, until these pools stabilize, and then you
21 really have something to base on in future years, but,
22 initially, we would be against that.

23 COURT REPORTER: One moment, please.

24 MR. AUGUR: Jim Augur, again. I'm back to

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1 agreeing with John.

2 MR. PINTO: Tony Pinto. I am a proponent
3 of merging the markets, but I do understand the risk
4 side. All I was really saying is, at some point, the
5 Exchange has to be paid for. How the allocation is done,
6 that's a different discussion, as to how the
7 administrative costs of the overall Exchange are going to
8 be handled.

9 It could be one administrative staff, but
10 it could still be run as two separate Exchanges. That's
11 kind of the point I was making, is you need to look at
12 the big picture and getting back to what is success.

13 Is having membership success, or is having
14 small employers insured and have their employees insured
15 success?

16 MS. O'GARA: This is Nellie. I want to
17 take that up in another question, if that's all right.
18 Going back to success, and you raised something, Jim, how
19 you describe success, if success for the Exchange is
20 having a sustainable business and improving the number of
21 small employers, who offer insurance, let's say we can
22 have it all, right, what is it that is going, in your
23 experience, what are the features, the characteristics of
24 products that have to be offered to make that happen?

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1 MS. SKINNER: Nellie, can I camp onto
2 this?

3 MS. O'GARA: Sure.

4 MS. SKINNER: Ellen Skinner. Because
5 you're going the same path I was going. I was thinking
6 about how do we insure affordability and appropriate
7 utilization in structuring the benefit designs for the
8 products that are being offered through the Health
9 Insurance Exchange, because, ultimately, that's what
10 we're looking to accomplish?

11 MR. AUGUR: Ellen, so, that is the right
12 question. I think you qualified it a little bit better.
13 No offense. We're mandated. It's 80 percent, right?
14 The 80 percent of going to claims, so we have to focus on
15 that. That's got to be the number one focus.

16 Now whether you believe in a carrot or
17 stick approach, to incentives to get people to do the
18 right things on prevention and other things, to the
19 extent that you get into managing the cost, based on
20 providers, facilities and different things like that, but
21 we're not going to solve that right here today.

22 We, as carriers, in partnering with
23 providers, spend most of our time trying to think about
24 ways to do that, but I think that that's where the time

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1 needs to be spent.

2 MS. SKINNER: And just to follow-up, Jim,
3 where do those discussions happen, because it's relevant
4 to what the Exchange develops and how we interact with
5 the State, you know, the Medicaid population and so on,
6 so how do those discussions get started, and where do you
7 think at the appropriate level?

8 MR. AUGUR: Well, it's at every level. I
9 think that product design does come in to play. I think
10 that -- again, we could spend the whole afternoon talking
11 about this, but just some basic concepts.

12 I think we all believe that prevention is
13 important, that there should be no barriers to prevention
14 at every step of the way. Whatever age group or
15 demographic group you're in, those barriers shouldn't
16 exist.

17 There should be the appropriate
18 communication and messaging to insure people are doing
19 that. Do we need to provide more incentives for folks?
20 Do we need to understand those barriers better?

21 I think those with chronic diseases need
22 to be managed well. What are the incentives for them?
23 How are they being managed? Are they being managed in
24 the appropriate environment? How do we really focus on

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1 quality, and what does quality mean at every level of the
2 delivery system?

3 I think that that's a big part of it.
4 Again, we could spend a lot of time. I think that, to
5 your question, though, Ellen, I think that there is a
6 place for product design and managing care or keeping
7 people compliant and having the right behaviors does have
8 a place.

9 MR. FLEIG: John Fleig. I'm going to
10 agree with Jim, too. He looks bigger than me, so I
11 better agree with him. (Laughter)

12 But allow carriers to have innovation,
13 long-term solutions, quality, appropriate care
14 management, don't limit those kind of things, health
15 promotion tools. Every carrier should be able to
16 innovate those kind of things, as they've tried in the
17 past, but continue in the future, so, again, I'm back
18 just it's not one size fits all for all carriers.

19 Carriers should be able to innovate on
20 that side of the coin.

21 MR. PUSCH: Tim Pusch. Why would we not
22 do anything that you're currently doing? I mean you seem
23 to imply in a way that we might not continue to do within
24 the Exchange what carriers do on the open market, in

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1 terms of that kind of innovation, or what further are you
2 thinking that we might do above and beyond that?

3 I mean you all do managed care now. You
4 all try to control diseases and so forth and incentivize
5 and what you were discussing a few moments ago. Help us
6 figure out what we could do differently, more
7 effectively, generate less cost in the future that you're
8 not doing now on the open market.

9 MR. DONAHUE: Tim, this is Bill Donahue
10 from Healthy Connecticut. I get the advantage of sitting
11 on the sideline at the moment, simply because we are not
12 yet a licensed carrier, but we will be.

13 The world changed for insurance carriers.
14 I have run insurance companies in multiple states, and I
15 will tell you the world changed when they started coming
16 in with the MLRs and the things like that.

17 All the decisions that were made were made
18 in our Board rooms and so forth, trying to identify ways
19 that we can maximize the profits that we could make.
20 We're a business. That's what it's all about.

21 Now the world has changed, where we're
22 limited in that, so now what we have to do, and now, when
23 we're getting all this influx of members that are going
24 to come in, members that previously weren't insured or

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1 underinsured, and we're going to wind up having to do
2 this now on a survival basis.

3 You're going to have to try to find a way
4 to not get what you do have left eaten away, so you're
5 going to do everything in your power to make certain that
6 you do the management of care, you do the wellness, you
7 do all the things that you have been doing thus far and
8 amp them up, because you have to, because you're going to
9 have to sit there and preserve what you've got.

10 MR. FLEIG: Tim, you had a fair question,
11 and I agree with your points. I'm looking at it the
12 other way. Don't start limiting things.

13 MR. MCKIERNAN: But from a cost
14 perspective, though, I mean Connecticut is the third most
15 mandated state, I believe, and every year there are more
16 and more mandates that are put on, not by the carriers,
17 but by our government here, by our State government, so I
18 would ask, if we want an affordable plan, tell me what
19 you're taking away, not what you're getting, but what
20 you're taking away, because in order I think to have a
21 substantially affordable plan, according to the rules,
22 tell me what you're taking away. How are we going to
23 limit the benefit?

24 An affordable plan, in my opinion, we must

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1 think about what we're going to limit, not what we're
2 going to give, because, under the current rules, again,
3 there's 74 State-mandated benefits in the State of
4 Connecticut, and they're increasing each and every year.
5 There's a premium associated with that, so the cost with
6 that is going up. Just a thought.

7 MR. KATZ: This is Matt Katz. But I don't
8 see it. You know, if we're comparing ourselves to
9 ourselves here in Connecticut and we all have those
10 benefits, I don't see it as a problem, but if we're
11 comparing ourselves to, say, Wyoming, then it's an issue,
12 because, obviously, they don't have the same cost
13 structure, cost of living.

14 There isn't the same kind of, as you
15 mentioned, mandated benefits, however, we're looking at a
16 system that already has those benefits, and we're looking
17 at where we can potentially improve it, improve the
18 system, improve quality and decrease cost.

19 I don't think necessarily it's an
20 additive, but I also don't think it's taking something
21 away from the system. I think it's how we do it better
22 and how we improve it, and, so, I guess my question to
23 the panel would be, if we're looking at developing an
24 Exchange structure, what associated with the Exchange

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1 does decrease cost, improve productivity of the process,
2 and, therefore, improve the quality?

3 If we're creating a structure, what
4 actually works for you that will then work for the small
5 employer and the employee from a perspective of how we're
6 structuring this, so that we get some of those
7 inefficiencies out of the system and still maintain all
8 of the benefits that, at least in Connecticut, everyone
9 has fought to either maintain or increase.

10 MS. O'GARA: Matt, do you want to answer
11 your question?

12 MR. KATZ: I mean, again, I think the --
13 we had the plans here today to talk about was really to
14 look at, as we move forward with the Exchange, what we
15 can do that makes it beneficial to the insurers,
16 beneficial to the small employers, and beneficial to the
17 employees of the small employers, and, so, in looking at
18 this, the same old, same old isn't going to work, and if
19 we're simply talking about reducing mandated benefits,
20 that doesn't seem to work either.

21 The question is how do you structure an
22 Exchange that makes it advantageous for everyone to be
23 part of the Exchange, from an insurer perspective, an
24 employer perspective, an employee perspective?

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1 It can't just be a listing of benefits, or
2 a listing of plans, and you pick with a dart, throwing at
3 a dart board. There's got to be other things that would
4 actually make it easier and more efficient for an insurer
5 to operate in the market space here in Connecticut.

6 I guess what we're asking is what are
7 those things you want to see? What is that wish list
8 that would make it worthwhile for the insurers to engage
9 in the Exchange?

10 CHAIRPERSON RUSSEK: And maybe that's a
11 good segue. This is Pam Russek. I don't want to short-
12 circuit any discussion on the risk side here, but very
13 early on, there was a point made about working with
14 Exchanges, where the administrative end was handled by
15 the Exchange, and I'm wondering at some point if we could
16 get some dialogue from you folks on sort of what you see
17 as the most advantageous way to deal with some of the
18 administration from a cost, as well as ease of burden for
19 the employer and the employee and the carrier.

20 MR. PINTO: Tony Pinto here. I had a
21 general question for the carriers. Considering with all
22 the changes with the guaranteed issue and the new way the
23 rating structure is going to be, is there any analysis
24 been done, as to how the small group market might be

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1 impacted for transition from small group, like one to
2 two, three to nine, to individual, or, on the other side,
3 what the thought is, as far as transition to whether to
4 buy a small business, to buy through the SHOP, or buy
5 direct, since only one in three under 10 actually offer
6 insurance, so I think there's a lot of unknowns going
7 forward, and I know there's a lot of risk on that side,
8 but do any of you have any comments or any preliminary
9 analysis on how the small group market might be impacted?

10 MR. AUGUR: Not with any detail. Maybe
11 some broad theories and assumptions, and that would be
12 that the small employer group will shrink, the consumer
13 market will expand, that based on some of the changes in
14 rating, there are going to be, and based on the plan
15 designs that are currently offered in the small group
16 market, there are folks that are going to be buying up,
17 so I think that, broadly, those are probably the three
18 observations -- level of detail.

19 We're starting to, but I think a lot of
20 decisions need to come from this group before we
21 understand more about the potential impact, so, right
22 now, we're all playing in that space of guessing.

23 MR. BAUER: And I would concur with that.
24 Also, not at a great level of detail yet, but, you know,

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1 sort of some general thoughts about expansion of the
2 individual market, perhaps some contraction within the
3 small group market, and, you know, some real concerns
4 about affordability, and some of the changes with the
5 rating, additional assessments and so on that come into
6 the market, some of the benefit requirements, you know,
7 could very well start to, you know, could start to push
8 up costs in the individual and small group markets,
9 something we're very concerned about, because, as we've
10 all talked about here, if the products become
11 unaffordable, then you don't really have a market.

12 MS. SKINNER: If we shift from the cost
13 structure, the 80 percent, because we all know a lot of
14 decisions will come from here, and, ultimately, there
15 will be a design that will come out and you people rate
16 it, what about on the administrative side?

17 How do we work, how does the Insurance
18 Exchange work effectively with the plans, who are
19 participating, and the employer groups to ease
20 administrative burden on all fronts?

21 MR. AUGUR: I'll simply say let's not add
22 cost. Let's evaluate and eliminate costs, where
23 appropriate. I'm fortunate that I work on behalf of a
24 company that has 35 million members across the country

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1 and 1.2 million members here in Connecticut, so I can
2 spread some of my administrative costs.

3 If I've got to work an environment that is
4 I'm doing all the same things, and then I've got to do a
5 bunch of others, well, that's not an efficient
6 marketplace, so I think the evaluation needs to be about
7 what can I eliminate? What am I not duplicating?

8 If I'm creating a bunch of bills, or
9 sending, you know, files, without getting into detail,
10 let's just stick with we've got to be careful what we're
11 not duplicating.

12 MR. COUNIHAN: Jim, just to play off a
13 point that you made earlier, one potential idea for our
14 group to consider and for us to help support the health
15 plans and their analysis is to look at some of the work
16 that is done in the private Exchange world throughout the
17 country.

18 California, I think, is a pretty good
19 example of where some very prominent health plans,
20 including several represented here, are participants.
21 They do delegate much administrative work to the private
22 Exchanges, and actually have found that they cut their
23 costs to some degree, because of that delegated
24 administrative work.

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1 And, so, detailed examples of that by line
2 of function and impact on cost is available, and we could
3 supply that to the Committee, if that's helpful.

4 MS. SKINNER: A question I have. I know a
5 lot of the individual insurance is done electronically
6 now. Is that an effective means? Does that work better
7 for the insurers, the health plans than, you know, some
8 of the other administrative interactions you have,
9 administrative interactions, and could you provide a list
10 of some of the things that you do that are very efficient
11 or in areas, where you've seen states implementing some
12 efficient guidelines, where it's easier to work with?

13 MS. MACIUBA: So, from an on-line
14 perspective, there are definitely savings from doing a
15 lot of the work electronically, even from a member's
16 perspective in filling out their enrollment applications
17 and enrollment forms, to the fact that when the
18 identification cards go out, they actually go out with
19 the correct name, because that is a re-work issue that
20 occurs when you -- most people don't like very well, or
21 if you can't read very well what they write.

22 So there are efficiencies on on-line
23 processes, but, again, you know, and I know this is the
24 SHOP Exchange, but we need to also remember that part of

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1 the group, which are underinsured, are also under -- do
2 not have electronic capabilities on an individual front,
3 so there are costs in the fact that they may not have the
4 tools that are needed for that particular product at this
5 point in time.

6 So you need to consider both aspects, as,
7 yes, I think electronic would be a God sent to most of
8 us, because then it saves them a lot of re-work, but,
9 also, can everyone actually have that kind of right
10 access point?

11 MR. PUSCH: Tim Pusch. Correct me if I'm
12 wrong, the two of the carriers that work with CBIA, but
13 it sounds to me and it seems to me from my experience
14 with them their system of Exchange administration is
15 pretty efficient.

16 A lot of it is communicated
17 electronically. They do a lot of the -- not all the
18 administration, and just feed the carrier with the
19 enrollment, and then you manage the claims and everything
20 thereafter.

21 MS. O'CONNELL: Yup, that's exactly right.
22 They handle all the membership. They feed us an
23 electronic feed, and we get it into our system, so they
24 are responsible for getting the information upfront on

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1 all the members' demographic information, as well as what
2 plan they're going into, so they do handle all of that
3 for us.

4 MS. SKINNER: Is there a fair amount of
5 interoperability between the plans, so that you're
6 dealing with a single format, or is it you're developing
7 systems for each of the carriers you work with?

8 MS. O'CONNELL: Typically, it's a standard
9 electronic format, a HIPAA format that's used for the
10 eligibility feed.

11 MS. SKINNER: What about the other
12 administrative part, the billing processes?

13 MS. O'CONNELL: They also do the billing,
14 CBIA, so they take us out of that, as well. They have a
15 whole system that they use. I'm not familiar really with
16 the name of it, or how it's done, but they handle all
17 that on their end.

18 MR. PUSCH: Well let me ask you the golden
19 question, then, to that. Is the pricing for their
20 product, then, any better, because they're saving you
21 something, some administrative cost, and, therefore, you
22 can charge a little less for your product?

23 MS. O'CONNELL: I'm not sure that that's
24 accurate, because they have to pay for the administrative

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1 cost. Somebody has got to pay for it, whether it's the
2 carrier or the Exchange.

3 MR. PUSCH: Well, except that they're
4 getting dues. I see. They're getting it through the
5 dues structure.

6 MS. O'CONNELL: Yeah.

7 MR. PUSCH: Right.

8 MR. COUNIHAN: I guess, Karen, maybe to
9 rephrase, is do you find that your firm reduces your cost
10 to this private Exchange by the value to some degree of
11 the administrative work that the Exchange does?

12 MS. O'CONNELL: I am not familiar exactly
13 with the rates, themselves. They are different going out
14 the door. I don't know what CBIA charges.

15 MR. COUNIHAN: Okay. I would just tell
16 the group that, at least in California, the health plans
17 gave a credit for the value performed by the private
18 Exchange.

19 MS. MACIUBA: It's Marta Maciuba. I think
20 it's really important to know Aetna is not in the CBIA,
21 but, by law in Connecticut, you cannot have a rate in the
22 private Exchange that is different than out in the
23 public, so the rate has to be exactly the same.

24 MR. COUNIHAN: Yeah, I think I was

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1 actually speaking to a different point. It wasn't the
2 premium rate. It was more the -- what could be an offset
3 to the administrative charge provided by the PE, because
4 I thought what I had heard maybe you or someone say is
5 actually they could be additive.

6 MS. SKINNER: And, to follow-up on your
7 earlier offer, I think the information that you offered
8 would be of interest to us.

9 MR. FLEIG: I have a question, which I
10 don't know. In Connecticut, are there bands for in small
11 group?

12 MS. MACIUBA: So, currently in
13 Connecticut, we have I think seven bands, or seven age
14 groupings, technically.

15 MR. FLEIG: But what is it, five to one,
16 six to one?

17 MR. MCKIERNAN: Five-year bands.

18 MS. MACIUBA: It's seven to one.

19 MR. FLEIG: Seven to one?

20 MS. MACIUBA: So the bands are seven to
21 one, and we would be going to three to one.

22 MR. FLEIG: So that's just a point I want
23 to discuss, because that's a big swing. Going to seven
24 to one, three to one, you're going to have some big

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1 winners and some big losers. The carrier is not going to
2 be able to do anything about it, so you're probably going
3 to see the younger groups are going to see -- could be
4 substantial increases.

5 We've seen, across the country, and I
6 don't know here exactly, but 70, 80 percent increases up
7 and 70, 80 percent increases down, so you've got a big
8 risk here, in terms of who may stay and who may go,
9 because of those swings in that band.

10 The other point I'd like to make, we're
11 talking about costs. There are a couple of things that
12 carriers try to control, but they're really outside of
13 our control.

14 Where is the cost? You have unit cost,
15 which is what's charged out in the market and what
16 providers, drug companies charge, and you have
17 utilization. That's where your cost comes from.

18 So we never really talk about how to
19 control that. We try, but a lot of that's outside of the
20 control, so it's a hard topic to talk about how to
21 control cost.

22 MS. SKINNER: I think you're right. I
23 think, on the provider side, the unit cost side, there's
24 a lot of movement with the ACOs and the medical homes,

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1 whatnot, to look at different payment structures. We
2 haven't had a system that's been particularly conducive
3 to doing that.

4 There weren't incentives, but, on the
5 utilization side, certainly management it's all about
6 trying to educate the consumer to be more proactive than
7 reactive, and that's what we were talking about before,
8 in terms of where the health plans, I think that's what
9 you represented, have their infrastructure to help in
10 that area, and then, if we can carve off a few points
11 there, we can carve off a few points on the
12 administrative side, we may be coming in to a situation,
13 where we can provide coverage and cover the additional
14 administrative costs of having a Health Insurance
15 Exchange.

16 We're not looking for huge, you know,
17 cataclysmic changes, but we're looking for incremental
18 changes there.

19 MR. FLEIG: Yeah, I agree with what you
20 say.

21 MS. O'GARA: So one area we haven't
22 touched on yet, and we have a couple of interested folks
23 at the table, is your perspective on the role of the
24 broker in the Exchange. Do the carriers have a

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1 perspective on that?

2 MR. AUGUR: I do. Jim Augur from Anthem
3 again. I think that the broker has served the small
4 employer extremely well, been a trusted advisor. Many
5 small employers do not have an H.R. organization, and
6 they rely on this advisor for much more than simply
7 shopping health benefits on an annual basis.

8 So I think that it should be an important
9 consideration in the development or the distribution and
10 communication, so I think that's where that falls in.

11 And the question was asked earlier, about
12 efficiencies and on-line and things like that. I think
13 that, you know, the marketplace is evolving, and there
14 are different choices out there, and consideration needs
15 to be given, but the role of that trusted advisor is
16 important in distribution of this product.

17 CHAIRPERSON RITTER: Grant Ritter. Jim,
18 could you talk a little bit about how the broker gets
19 reimbursed?

20 MR. AUGUR: Sure. It's typical that the
21 broker gets paid a commission, based on the percentage of
22 premium, or the number of employees that are associated
23 with the group.

24 CHAIRPERSON RITTER: And that comes from

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1 you?

2 MR. AUGUR: Correct, yeah. From all the
3 insurance companies.

4 CHAIRPERSON RITTER: I was just kind of
5 curious, when we were talking about CBIA. Did they take
6 the place of a broker, or were there both brokers and
7 CBIAs involved in the action?

8 MS. O'CONNELL: There's actually both in
9 some cases. I also would want to concur with Jim, that
10 the role of the broker is essential to these small
11 groups, and, many times, they play the part of the
12 benefit administrator, so they walk them through what
13 benefits best suit their employees, how to use them.

14 They do open enrollments and explain what
15 the benefits are, so their role is very, very important
16 and essential to these groups.

17 MS. MACIUBA: This is Marta Maciuba from
18 Aetna. We would have to concur with our panel here, that
19 really, in the small group market, most small groups
20 would be very lost without their trusted advisor.

21 They count on them to submit their
22 applications, to how to get a claim filed if there's
23 issues, if there's an appeal that has to be made, so the
24 broker does an important service to a lot of the small

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1 employer groups currently, and I think a lot of them
2 would be lost without that individual going forward, and
3 they might make a decision not to purchase on the SHOP if
4 they didn't have that ability to have that person that
5 they can trust to purchase from the SHOP with.

6 MR. PINTO: This is Tony Pinto here,
7 former broker. The role of the broker is important, but
8 it has changed drastically from what it was just a few
9 years ago.

10 A few years ago, the brokers just pretty
11 much focused on the health plan choices, but now a lot of
12 them provide ancillary services well beyond just picking
13 a plan, like was mentioned earlier, you know, helping
14 with COBRA, and guidance, and some H.R. services, so the
15 role of the broker has actually gone -- it's expanded
16 quickly over the last few years.

17 But I did have one question on, as far as
18 to the carriers, how do you see the role of the broker
19 and the role of the navigators come into play?

20 MR. AUGUR: I'll take a shot. So I think
21 that the system that exists today is a good one, meaning
22 that every broker needs to be licensed, they need to be
23 certified, they need to continue to take CE credits, and
24 they need to go through this process every two years, so

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1 I think having some level of certification, a process in
2 which someone is accountable for understanding what
3 they're doing out in the marketplace, and who they're
4 representing, and how they're, I think that's important,
5 and I would suggest that, you know, as I understand the
6 navigator role, that there should be some level of
7 certification, there should be some opportunity to make
8 sure that folks that are representing products and
9 services in this space get the proper education,
10 knowledge, so forth.

11 Having said that, we are opening up to new
12 markets, if you will, and new folks will have access to
13 health insurance products they didn't have before.

14 When we think about targeting different
15 audience, or providing access, communication, education,
16 accessibility, all of those things, then we have to think
17 about distribution maybe a little bit differently.

18 I see that a role for a navigator, or
19 someone that's going to be a proxy to help someone gain
20 access to this information and these products could be a
21 valuable role.

22 I'd be concerned if it was watered down to
23 a level that there was no requirement, there was no
24 certification process.

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1 MR. KATZ: So, Jim, you're basically --
2 this is Matt Katz. You're basically saying that the
3 navigator should be like a broker? So it's not just
4 providing information, but it's providing added service,
5 or are you saying that there needs to be some
6 certification and requirement for the navigators that
7 they have to adhere to?

8 Because I think one of the issues is, as
9 you go through this, who is going to be or act like a
10 navigator? Should it be the plan's responsibility to
11 provide that education? Should it be the Exchange's
12 responsibility to provide that education and information?

13 So I just want to throw it back and ask
14 you more directly if the navigator is, in fact, the
15 broker or broker-like.

16 MR. AUGUR: Yeah. I would answer the
17 question as the navigator will be broker-like, but let me
18 qualify it a little bit further, and this maybe is more
19 appropriate for the individual market, as that expansion
20 occurs and folks in different segments, who don't have
21 access to a traditional broker, and don't have access to
22 on-line services.

23 Well how are we going to reach, we
24 collectively, going to reach those populations, educate,

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1 inform, and help them along? That might be a unique,
2 different distribution model, and, so, I'm recognizing
3 the fact that that's different, but, yet, I don't want or
4 I'm suggesting that we still have the accountability that
5 there's education and certification component of some
6 sort.

7 Maybe it's different than the traditional
8 broker model that we have today, but it's not watered
9 down.

10 MS. JANCZAK: This is Lynn Janczak, and I
11 have a question for some of the carriers. Several years
12 ago, I worked for a major carrier, and we had an Agent's
13 Advisory Council that was invaluable to us that would
14 meet periodically and give us their feedback on what the
15 market was really looking for, and this was several years
16 ago, and the market has changed dramatically, but do any
17 of you utilize an Agent's Advisory Council, and, if so,
18 do you consider it to be a valuable part of your
19 outreach?

20 MR. AUGUR: Anthem does use a Broker
21 Advisory, a Producer Advisory Group. We lean on them
22 often to understand what's going on in the marketplace,
23 and what are their respective customers saying and
24 needing, and we do it in all aspects of our business,

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1 customer service, risk management, health care
2 management, network services, innovation. It really runs
3 the whole gambit.

4 We view them as, you know, the sounding
5 board to what is going on in the marketplace. I am
6 confident that most of the carriers do things similarly
7 in that respect.

8 MS. O'CONNELL: We do at ConnectiCare, and
9 we split it up by market segment, so we have one for
10 individual, small group and large group.

11 We, also, sometimes run things by them
12 that we're thinking of putting out in the market to get
13 their feedback, so they're very useful to us, and we get
14 a lot of information back and forth, so we do utilize
15 them frequently.

16 MR. DONAHUE: Again, this is Bill Donahue.
17 Broker Advisory Councils have been invaluable to
18 insurance carriers for years. It gives us the on-the-
19 street view of what folks want, what they don't want, how
20 we can make things easier, and, quite frankly, it
21 ingratiates ourselves to the brokers, and we get to make
22 better relationships with them, so we can get them to
23 send us more business.

24 Fortunately for us at Healthy Connecticut,

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1 we're going to be consumer-driven. We're going to be
2 consumer-run by -- our Board is going to be consumers, so
3 we have an advantage there, but I will tell you we will
4 continue, we will push to make certain that we have an
5 Advisory Committee of brokers, because they do know.

6 They are the ones. At the risk of
7 sounding like Sy Syms, the educated consumer is our best
8 customer, and that truly is the fact here, when you're
9 talking health care.

10 You want everyone to know exactly what
11 they're getting into and the steps that they have to take
12 to approach this, so I think the brokers are just
13 invaluable.

14 MR. GALVIN: Kevin Galvin. Along the same
15 line, do any carriers presently have or do you envision
16 having any kind of Consumer Advisory Councils as you move
17 into this next step?

18 MR. AUGUR: I would say absolutely. I
19 think that we are getting into a space that, as I
20 suggested earlier, that the consumer market, the
21 individual market will expand, and if anyone is going to
22 be successful, then we need to understand that as well as
23 we can, and if we subscribe to the value of any kind of
24 advisory group, then a Consumer Advisory Group would be

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1 helpful.

2 MS. MACIUBA: And this is Marta Maciuba.

3 I mean, right now, I think most of us probably have
4 consumer plan sponsor, so employer-based items that we
5 currently do. We do surveys with our plan sponsors.

6 We have some advisory groups with our
7 larger plan sponsors. A lot of times, a lot of the
8 innovation comes from those particular plan sponsors, and
9 we can bring them downstream to each of our states, so I
10 would imagine that, as we move to 2014, we'll want to do
11 more and more of those type of interactions.

12 MR. GALVIN: If I could follow-up? Not
13 represented here today, so it's no one at this table.
14 Three years ago, we approached a major insurer to see if
15 they wanted a -- if we could help with as a consumer
16 advisor at any level, and we were told they really didn't
17 need it. They were consumers, also.

18 So we, as consumers, would really like to
19 have some level of interaction with you folks as this
20 thing evolves. It will help with the buy-in. I mean we
21 have to sell this thing. We really have to get out there
22 and show our folks that something has changed, and some
23 things aren't going to change.

24 Your real costs aren't going to change

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1 when the rubber meets the road. The need is going to
2 change, but we have to have something here that we can
3 sell. Thank you.

4 MR. PUSCH: I'm glad you didn't name
5 names. I'm not going to make any comment about brokers.
6 I think you probably all know where I stand on the issue.

7 I want to ask about something, though,
8 which is really troubling me, in terms of how we're going
9 to make the SHOP Exchange successful, and that's the
10 issue of where the market is today, in terms of the
11 product that the small employer offers to its employees
12 relative to the level of product that we are required to
13 offer on the Exchange under the levels of platinum, gold,
14 silver, bronze, and defining, roughly, in the silver-ish,
15 gold-ish area that Bob more or less explained to me last
16 meeting, which is a 2,000 individual, 4,000 family out-
17 of-pocket maximum plan, and looking at where the market
18 is today from, let's say, the Mercer study, or looking at
19 it further, as I believe we're doing, to get a better
20 sense of it, that over 60 percent of the current small
21 market is below the bronze level now, and I suspect it
22 could even be worse from my anecdotal experience with my
23 accounts.

24 How do we go about making the Exchange

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1 work under those circumstances, where it's going to
2 attract enough business? And I, again, look at the
3 Massachusetts and Utah circumstances, where they've
4 attracted very little, in terms of numbers of enrollees
5 in the small market area.

6 To me, it's a pretty practical problem
7 that I'm not sure how to overcome that, and I'd like to
8 hear your thoughts on the matter in any way, shape, or
9 form.

10 MR. BAUER: This is Craig Bauer from
11 Aetna. I would agree with your concerns. It is a very
12 difficult question. I don't know that there are easy
13 answers to this.

14 I think that some of the things we've done
15 and that we tried to evaluate in both individual and
16 small group markets, you know, and this isn't necessarily
17 unique to Connecticut, you know, we've looked at a lot of
18 things across the country, and based on our own
19 estimates, and there have been some published reports
20 that I think suggest similar things, that there are large
21 proportions of the population today that are below the
22 bronze.

23 We touched on this before, about, you
24 know, what might happen with premiums and affordability,

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1 and, you know, that's a direct hit. If you have to go
2 from what might be equivalent to a 50 percent, or 55, or
3 whatever, up to a 60 percent bronze, you know, that's
4 going to drive up costs, and it's something that concerns
5 us a lot.

6 One thing, in particular, I think you were
7 touching on this, is the, you know, in the group side,
8 the ACA limits deductibles to \$2,000, and that, you know,
9 certainly has the potential to, you know, be one other
10 lever that is constrained, will keep benefits at a rich
11 level, which, you know, is a good thing, but people today
12 are making those tradeoff choices with, you know, I'll
13 take a lower premium versus, you know, the risk of
14 potentially having to pay more out-of-pocket.

15 And, so, that's certainly, you know, that
16 item, in particular, is something that concerns us, that,
17 you know, it limits the innovation in the marketplace.
18 It's something that the small group markets we've seen in
19 many instances demand today, and it actually, from our
20 estimation, makes it actually very hard to achieve the 60
21 percent bronze level, which creates a real challenge.

22 And I will just offer, I'll offer we've
23 actually, you know, raised this a couple of times with,
24 you know, with members of the administration within HHS,

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1 that this, you know, based on our analysis, might be a
2 problem, so, you know, we certainly, you know, I
3 personally support the idea of allowing, you know,
4 products that might go below the 60 percent.

5 I know the way the ACA is written,
6 obviously, you know, you can't do that as it's written,
7 but, again, seeing where the market is today raises a
8 critical question.

9 Unfortunately, I don't have the silver
10 bullet for you on this one, but I think a very big
11 concern.

12 COURT REPORTER: One moment, please.

13 MR. FLEIG: That thing runs out every time
14 I'm going to talk here. (Laughter) I just want to point
15 out, I know you're aware of this, this affects off the
16 Exchange, too. It's not just in the Exchange, but it's
17 off the Exchange in the small group market.

18 MR. KATZ: I was actually going to bring
19 that up, too, because I think, because it's actually
20 happening off Exchange, it actually may benefit the
21 Exchange.

22 We're not going to be seeing -- we're not
23 the only area seeing the negative. In fact, we may see
24 the benefit of that, because if we're offering added

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1 benefit from a perspective of ease of access, ease of
2 decision making, and potentially some reductions in cost
3 if we design it right, we may see actually the small
4 employer that people are fearful we're going to see
5 dropping off.

6 They may be coming to the Exchange from
7 the existing small group, small business market if we
8 design it right. If we design it wrong, they won't be
9 coming our way.

10 But I just see that there's an
11 opportunity, because there is a leveling playing field.
12 We're both going to be having to deal with that issue,
13 and if we provide them with something additive, not from
14 a perspective of another benefit, but a benefit of the
15 actual design of the Exchange, we may see some of those
16 employers coming our way.

17 MS. O'GARA: So we had another question on
18 a different matter, but related to some prior comments,
19 about your thinking on how important it will be for the
20 Exchange to encourage the use of some of the new delivery
21 models, the ACOs, the medical homes, limited gatekeepers.
22 Do you have any perspective on that?

23 MR. DONAHUE: I'll jump in. Well, let's
24 start with reduced networks. Reduced networks are

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1 something that you're going to have to keep a very close
2 eye on, because we evil insurance people can reduce a
3 network in order to make a profit. By the same token,
4 you can reduce a network that actually makes sense in
5 certain areas of the state, so you have to keep an eye on
6 that one.

7 ACOs, patient-centered medical homes, what
8 you're starting to look at is think back to the '70s and
9 '80s, when you had the startup of HMOs, the start of
10 HMOs, where the whole idea behind health maintenance, and
11 taking care of your patients, and taking care of your
12 members is going to be a great thing, because then
13 they'll be using less health care, and costs will go
14 down, and it was all a wonderful thing, so much so it
15 just frightens me to think that even the Nixon
16 administration was the one who pushed it.

17 But what wound up happening is that it
18 never came about. Now what's happening is you're seeing
19 a -- it's a different type of HMO mentality that I see,
20 and I see that you're going to get the providers now.
21 It's a different breed. It's an entirely different
22 generation of providers, and I think these folks are
23 starting to understand what has to happen, and you're
24 going to start seeing a push to reduce care, to reduce --

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1 I shouldn't say care. Reduce costs, increase the care,
2 increase the touching of the members, and focusing on
3 chronic illnesses, focusing on those folks that need it
4 the most. That's the way we're going to keep the costs
5 down across the board.

6 MR. AUGUR: I think that, when it comes to
7 product design and payment innovation, or network
8 management, I think sensitivity needs to take place, and
9 what do I mean?

10 Anthem entered into a medical home pilot,
11 a comprehensive medical home pilot with the State of
12 Connecticut, and in the development of that program, we
13 took a hard look at is that a program designed
14 exclusively for State employees, the population that
15 chooses Anthem, or is it really available, or are what we
16 talking about is we need to let providers, hospitals,
17 doctors practice medicine, and it shouldn't be that they
18 treat an Anthem member differently, because you have one
19 ID card versus another?

20 So what I'm suggesting, potentially, I
21 guess, is just sensitivity and thought, as to do patient-
22 centered medical home, accountable care organization,
23 narrow networks, what is that role in the relation to a
24 product design versus making sure you've got the right

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1 relationship incentives, so that physicians can practice
2 medicine and do good population management?

3 So I'm just offering a suggestion, not
4 necessarily a full conclusion, but just something to
5 think about.

6 MR. DONAHUE: John, if I can, I don't
7 disagree, but if you really do think about it, if you
8 have the proper incentives in place, let's say somebody
9 has got 80,000 members, who has the right incentives in
10 place, and they have the providers going out there, doing
11 the care, having more hands-on, seeking out the folks,
12 who have chronic illnesses, finding ways of keeping them
13 out of the hospital, well that becomes a practice
14 pattern, and I don't know any physician, and I've got
15 plenty of them that are friends and relatives, and I
16 don't know any one of them that say, well, you know, I'm
17 going to treat this person differently. It becomes a
18 matter of rote. This is how I treat my patients.

19 And what will wind up happening is, if you
20 guys did that, then everybody else would get the benefit
21 of it, because they'd start changing the way they
22 practice for everyone.

23 CHAIRPERSON RITTER: I agree. Maybe I
24 understood the question/comment incorrectly. It's just

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1 is that linkage to an exclusive product, was just my
2 point, so I agree.

3 MR. FLEIG: We believe these are all tools
4 that carriers should be able to use. I'll just make it
5 that simple. Carriers are going to look at this, again,
6 both on the Exchange and off the Exchange. We want to
7 make it work in both places.

8 MR. PUSCH: Could you envision different
9 networks within the Exchange versus in the open market,
10 so that there is a different network you purchase from
11 Anthem within the Exchange than you do outside of the
12 Exchange?

13 MR. AUGUR: I think network development is
14 going to be an important part of the future. I do
15 believe in that, at every level, not just at the hospital
16 level, where, typically or traditionally, people think.
17 I do believe that it's at every level.

18 Having said that, I come back to maybe the
19 comment I made earlier, where I had a little bit of a
20 disagreement with John, just a little, and that is just
21 the sensitivity when it comes to product design, that if
22 Carrier A and Carrier B, same product, but different
23 network, but still defined as a different network, you
24 could potentially have the adverse selection, so that

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1 gets into that risk management thing, so, again, what I'm
2 saying is I believe that network accessibility will
3 evolve, will change. It will be different, but I'd be
4 concerned in a risk pool and managing a risk pool that
5 we're all playing by the same rules.

6 MR. KATZ: I guess, Jim, my question,
7 then, tied to that is how, then, do you differentiate
8 yourself as Anthem, compared to United, if it isn't based
9 upon the plan design or the network?

10 So you're different insurers. What are
11 you offering differently that would cause an employer
12 today or tomorrow on or off the Exchange to choose Anthem
13 versus United or anyone else?

14 MR. AUGUR: I think there are a lot of
15 answers to that, and it starts with customer service, it
16 starts with, you know, network. Today, our networks
17 differ. Are they wholesale different? No, but if you're
18 talking about going from 30 hospitals to 15 hospitals,
19 that's a significant material difference, and if the
20 product was categorized as the same, then I'd have some
21 concerns.

22 That's where I'm focusing, Matt, you know,
23 material differences. When you look at all of our
24 networks today, they are slightly different, and when you

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1 look at all aspects of the network, again, it's hospital,
2 specialist, primary care physicians, behavioral health.
3 It's labs. It's so many different things beyond just the
4 big things.

5 And beyond customer service and some of
6 the things that I've just been mentioning, I think that,
7 you know, what are, and this is where John and I do
8 agree, again, is that I think that points of
9 differentiation around your disease management programs,
10 around your wellness programs, your wellness incentives,
11 the additional things you get from being part of any one
12 of these insurance companies here are additional points
13 of differentiation.

14 MR. BAUER: And I think I just, you know,
15 would add, you know, our view from Aetna I think is very
16 similar in a lot of these regards, and we feel that the
17 accountable care organizations and, you know, a lot of
18 these, you know, areas of innovation are very important
19 to, you know, to the success going forward.

20 And when we think about, you know, the
21 affordability concerns that, you know, that we talked
22 about here, you know, those are potential tools to help,
23 you know, mitigate some of those, you know, actions, you
24 know, price forcing actions, but, you know, they're not

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1 necessarily going to solve all of it, but it becomes very
2 important to, you know, really putting, you know, what we
3 think would be a product on the market that would be, you
4 know, attractive and affordable and of high quality.

5 MS. O'GARA: So we have enough time for
6 maybe one more question, and then we'll wrap up with
7 final comments.

8 MS. SKINNER: This might be a bombshell,
9 but I'm thinking about one of the, in order to get people
10 engaged in the Health Insurance Exchange customer service
11 and satisfaction is eminent among that, would it be a
12 non-starter for the health plans if there was a
13 scorecard, if the Health Insurance Exchange did
14 scorecards and published it on the side, along with the
15 plan offerings?

16 How would the health plans feel about
17 that? And participate of what those criteria are, but
18 being able to ask for the consumers' input, in terms of
19 satisfaction.

20 MS. MACIUBA: This is Marta Maciuba. But
21 I believe already we do have scorecards in the State of
22 Connecticut currently, so that's actually available, I
23 think by the Department of Insurance, because we see them
24 on the website, but scorecards would be something that we

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1 currently do, and something that I think is an important
2 step, but, again, it comes down to more than just one
3 aspect. Small group is still about price.

4 MS. SKINNER: I mean there are multiple
5 factors, but that's one, in terms of satisfaction.

6 MS. O'CONNELL: This is Karen from
7 ConnectiCare. I think we would welcome that. Any input
8 from the public is only helpful, so we would have no
9 problem with that.

10 MR. AUGUR: I agree.

11 MS. O'GARA: Okay, we have one question --
12 oh, I'm sorry, John.

13 MR. FLEIG: I was going to say part of the
14 ACA requires for Exchanges satisfaction surveys and
15 ratings, so it's already part of it.

16 MS. SKINNER: I just asked if it would
17 preclude you from -- health plans from participating,
18 because the idea is we want as many participating as
19 possible, and is that, you know, necessarily a
20 preemption?

21 MR. FLEIG: I don't think necessarily.
22 Can I make just one comment, again, on the narrow
23 network? I think there's a, in folks' mind, if you
24 narrow a network down, you're reducing quality, and I

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1 don't think that's the case.

2 When we, for example, designate physicians
3 for quality and efficiency, you can have higher cost
4 physicians that are designated there, but their overall
5 outcomes are better, so I don't think it should be taken,
6 because a network is narrow, or you're necessarily
7 getting a cheaper or a worse place to go.

8 CHAIRPERSON RITTER: Grant Ritter. John,
9 I'd like to ask you. How do you narrow your network? Is
10 it really based on quality, or is it more or less based
11 on somebody taking, you know, the reimbursement rate that
12 you offer them?

13 MR. FLEIG: I think the first thing we
14 always look at is quality. When we designate -- we have
15 star ratings for quality and efficiency. You have to be
16 a quality provider, designated a quality provider before
17 you're designated an efficient provider, so that quality
18 aspect is always the first thing looked at.

19 MS. MACIUBA: Marta Maciuba. That's
20 exactly the same way we base ours. It's first quality,
21 and then efficiencies, and price is actually the third
22 component.

23 MS. O'GARA: Okay. I wanted to ask Bob.
24 You had one question we didn't get a chance to hear.

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1 MR. CAREY: So this is more of a market-
2 wide question with regard to the growth in self-funding
3 in the small group market and concerns that the carriers
4 may have, particularly as you raise up the actuarial
5 value, or you impose additional requirements in the fully
6 insured market, and whether you're seeing in Connecticut
7 a migration of more small groups moving from fully
8 insured to self-funding, so that's A of a two-part
9 question.

10 And, B, as you expand that small group
11 from up to 50 to up to 100, does that compound the
12 problem or the potential problem that may occur with
13 groups moving out of a fully-insured relationship into a
14 self-funding relationship?

15 MR. FLEIG: Don't have numbers for you,
16 but I think you hit the nail on the head. We're very
17 concerned about that.

18 We're very concerned that, particularly
19 from the group size 50 to 100 we have seen across the
20 country, they're already moving to self-insurance, so it
21 is a big concern, that if we combine that in the pool,
22 we're going to get those unhealthy larger groups in the
23 pool and just raise the prices more to compound the
24 effects I said of the band shrinking.

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1 It's just one thing added on to another to
2 make that pool more expensive, and it is a concern of
3 ours.

4 MR. COUNIHAN: John, I know you said you
5 didn't have numbers, but do you have any sense of
6 something more specific in that concern? Is there a
7 percent of small groups that you've seen convert to ASO
8 or anything of that sort?

9 MR. FLEIG: I couldn't tell you off the
10 top of my head right here.

11 MS. MACIUBA: So this is Marta Maciuba. I
12 mean we don't have numbers, but even let's say that it's,
13 you know, one percent of the small group block of
14 business that decides to go self-funded currently, and,
15 right now, under 50, there are a couple of carriers that
16 offer self-funding down to five, it is not surprising for
17 those groups to go through their first renewal and come
18 back to the guaranteed issue market that renewal, because
19 of one large claimant not being able to sustain it, so we
20 do risk currently with that issue about the risk pool
21 being maybe sicker individuals.

22 I will say that most small employers
23 currently under 50 and basically under 25 are probably
24 more uncomfortable with self-funding. It is more

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1 complex. Even if it's designed to make it easy, it's
2 still very complex, and that over 50 to 100, not really
3 here in Connecticut, but across the country, self-funding
4 is very popular in certain states in New England
5 currently in the 50 to 100 market, and definitely in the
6 mid-America region, or the mid-coast region is very, very
7 popular, 50 to 100.

8 So I think that is a concern that we do
9 have to worry about the block long-term.

10 MR. PUSCH: Real quick, I know of three
11 carriers that are currently active in the Connecticut
12 market that do a form of self-insurance. It's not
13 exactly ASO, but it is a form of self-insurance, and, as
14 you said, down to under 10 lives.

15 They make no bones about it. I've asked
16 explicitly and directly. They are cherry picking. They
17 are looking for those better groups, and the way they do
18 it is they send out an enticing rate, and then, when they
19 get the medical information, it determines the final
20 rate.

21 I've had a couple of experiences with that
22 process. It was very disappointing, but they are writing
23 business. That is for sure.

24 MR. COUNIHAN: Is it like MPP? Is it

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1 minimum premium?

2 MR. PUSCH: No. I'll explain it to you
3 afterwards. I'm not sure I want to take up the
4 Committee's time going through the details of it, but it
5 is definitely a form of self-insurance, and, if your
6 results are better than predicted, you will get money
7 back at the end of the year.

8 MS. MACIUBA: Well, and I think it's
9 important to note that in Connecticut versus other
10 guaranteed issue states currently, we collect family
11 health statements on all small groups, so someone can
12 decide to try to receive a quote from a self-funded
13 carrier and use one of our family health statements,
14 because they all are exactly the same by state law, and
15 if they don't, then they already have the material filled
16 out for us, and they just submit it to us, so that is not
17 a surprise to see in the market currently.

18 MS. O'GARA: So we want to thank you for
19 spending this time with us. We have a few pieces of
20 business to do, but is there anybody, who wants to make a
21 last comment before we close off?

22 And, Grant, I'll give it back to you,
23 then, in terms of thanking our guests, and we have to go
24 --

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1 CHAIRPERSON RITTER: Yes. I would really
2 like to tell you how pleased we are that you did come to
3 talk to us about this. I want to emphasize that the
4 Exchange is extremely interested in your participation
5 and will really be interested in the suggestions you
6 make, in order that you will participate.

7 If we have an Exchange that no carriers
8 want to join, it's kind of a, you know, a futile effort,
9 so we really do appreciate your coming to talk to us, and
10 we will continue to be asking you, you know, to pick your
11 brains about how best to move forward. Again, thank you
12 very much.

13 MS. O'GARA: Okay. That closes off the
14 meeting with the carriers, and I guess we have one
15 comment from the public. If the individual wants to
16 come, state your name, and provide your comments, that
17 would be great.

18 MS. CLAUDIA EPRIGHT: Good afternoon. My
19 name is Claudia Epright. I'm here as a consumer. I'm
20 also a member of the Consumer Experience and Outreach
21 Subcommittee for the Exchange.

22 I'm also married to a small business
23 person, and I have some questions and comments. There
24 was a discussion earlier about success and what would

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1 success be, and I had a sense that nobody really could
2 figure out how to define that, so I would like to offer
3 the possibility that success might mean 25 percent of the
4 pool eligible to participate in the Exchange, be enrolled
5 after six months of the opening of the Exchange, and
6 perhaps 50 percent of that pool enrolled by 12 months in
7 the Exchange.

8 That may be ambitious. It may not. I
9 don't know. In one of my past lives, I was an
10 eligibility technician for the Husky program at the
11 upstart of that program, and it took us a long time to
12 reach 25 percent of that population, but I'm expecting,
13 based on what I'm hearing and what I'm seeing, that the
14 effort to promote the Exchange is going to be much better
15 than the effort was to promote Husky, so I anticipate
16 there are so many more people, who know about it, that I
17 think that those might be reasonable targets to look for,
18 in terms of quality of participation. That's still lots
19 of discussion going on about that.

20 I think another comment about preventive
21 care. When we're talking about expenses, you're talking
22 about your expenses going up. We know that 30 percent of
23 our premiums are being currently used to pay for the care
24 provided through emergency rooms, because those people,

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1 who are uninsured, are using emergency rooms for primary
2 care, and it has already been established that since --
3 it's about July of 2010, right after the Affordable Care
4 Act was signed, the 26 year olds, up to 26, who are
5 allowed to stay on their parents' health care plans, and
6 children with preexisting conditions were now required to
7 receive coverage, that overall in those groups, each
8 quarter the cost of medical care for those groups went
9 down, because people were now getting the coverage and
10 the care that they needed.

11 So I would anticipate that once the
12 Exchange comes on board and these potential participants
13 come on board, the overall cost of care will go down,
14 because people will be getting the care that they need
15 going through their primary care physicians or medical
16 homes, as opposed to the emergency rooms.

17 And as far as talk about reducing expenses
18 of medical practices, I understand that the National
19 Physicians Alliance is in the process now of putting
20 together a list of unnecessary testing, and that list can
21 be -- I don't think it's been completed yet, but I
22 believe it's still in the process of being developed.

23 We have a Chapter of the National
24 Physicians Alliance here in Connecticut that is also

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1 active and some of the advocacy work that's going on in
2 the state, so I'm sure anyone could get that list from
3 them if they were interested in how that might impact on
4 some of the decisions of coverage that the carriers are
5 going to be making.

6 One of my questions is who should
7 determine medical necessity? Is it the insurance
8 company, or should it be the doctor? When a claim is
9 denied by a carrier, who makes the decision about that
10 denial, and is it made on a financial basis?

11 In other words, the company cannot afford
12 to cover that particularly and fulfill that claim right
13 now, or is there a doctor that has decided that maybe it
14 wasn't medically necessary to continue with that care?

15 I don't have the answer to that question,
16 and I have struggled with claims being denied and with
17 applications being denied.

18 Recently, I was denied, and one of the
19 reasons I was denied coverage was for menopause. That
20 would eliminate half the people in the population. I'm
21 not quite sure what the carrier was trying to communicate
22 to me about that.

23 Eventually, everybody is going to have to,
24 at least half the population, will have to face that

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1 condition, so I'd really like to know more about how
2 carriers make the decisions about to grant or deny
3 coverage.

4 I think that the Affordable Care Act is
5 going to tighten some of the ways that those decisions
6 are being made, but I think it's going to be an important
7 consideration as more people get involved with the
8 Exchange, particularly in the population you're dealing
9 with.

10 And I suspect that many of these people
11 will be healthier than you're expecting, that many of the
12 reasons that small businesses have dropped health care is
13 not because they're sick. It's because they can't afford
14 the premiums, and that they may have found alternate ways
15 to keep themselves healthier and will be happy to have
16 that peace of mind once it's affordable to them again.

17 Thank you for allowing me to make
18 comments.

19 MS. O'GARA: Okay. I think that completes
20 our agenda for today.

21 CHAIRPERSON RITTER: Motion to adjourn?
22 Is that seconded? Okay. We're adjourned.

23 (Whereupon, the meeting adjourned at 2:53
24 p.m.)

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