

VERBATIM PROCEEDINGS

STATE OF CONNECTICUT

PUBLIC FORUM

RE: HEALTH INSURANCE EXCHANGE

STRATEGY COMMITTEE MEETING

JANUARY 24, 2013

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1 . . . Verbatim proceedings of a Public
2 Forum on Health Insurance Exchange held on January 24,
3 2013 at 12:49 p.m., at the 1 Elizabeth Street, Hartford,
4 Connecticut . . .

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6
7 CHAIRPERSON MARY FOX: Okay. We're going
8 to call the meeting to order a few minutes early because
9 we've got everybody on the Committee here and our guest
10 speaker. We'll do some quick introductions just for a
11 couple of people -- well, for Tom and a couple of people
12 in the room. Vicki, do you want to start?

13 MS. VICKI VETRI: Sure. I'm Vicki Veltri,
14 I'm the State healthcare advocate and I am a member of
15 this Committee, co-chair of the Consumer Experience and
16 Outreach Committee and a member of the Board.

17 MR. KEVIN COUNIHAN: Kevin Counihan, CEO of
18 the Exchange.

19 DR. ROBERT SCALETTAR: Bob Scalettar, Board
20 member.

21 CHAIRPERSON FOX: And I'm Mary Fox, Board
22 member and Chair of the Strategy Committee.

23 MR. BOB TESSIER: Bob Tessier, Board
24 member.

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1 MR. GRANT PORTER: Grant Porter with the
2 Exchange staff support to this Committee.

3 MS. ANNE MELISSA DOWLING: I'm Anne Melissa
4 Dowling, and I'm Deputy Commissioner of Insurance and on
5 the Board.

6 CHAIRPERSON FOX: Okay. We're going to
7 probably rearrange the agenda a bit to accommodate Tom who
8 was so kind to come to speak to us and we don't want to
9 make him wait through all of these administrative pieces.
10 So we will just put everything from number two forward
11 after Tom speaks. Is that good? Is that okay with you
12 Tom?

13 DR. TOM RASKAUSKAS: That's fine.

14 CHAIRPERSON FOX: Okay. So Kevin, do you
15 want to introduce this?

16 MR. COUNIHAN: Absolutely. I first met Tom
17 I think about in the summer, is that right, in August or
18 so? And I think he called me up saying that he was a
19 fellow Michigan transplant and had some very interesting
20 experiences from his work in Michigan that might be
21 relevant to what we were trying to do. So he came to the
22 office and I have to admit, I get a fair number of these
23 calls and I have a lot of these kinds of meetings and I'm
24 always -- I've learned to become -- to cushion myself that

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1 most of them are kind of -- that people are selling
2 something. And so Tom walks in and starts talking and
3 things started clicking and I just felt that he
4 represented the type of innovation and type of new
5 thinking that was very refreshing and would be aligned
6 with what I believed was the spirit of the Board in terms
7 of promoting new thinking.

8 And so we've kept in touch since. I told
9 Tom about the Strategy Committee and its mission and it
10 felt like a great opportunity to bring Tom in and talk
11 about some of his ideas and some of the efforts he's made
12 so far.

13 DR. RASKAUSKAS: Well, first of all, thank
14 you for that kind introduction and I want to thank the
15 Committee for inviting me here. And a couple of members
16 I've actually met through different meetings here and some
17 of them formal, some of them informal. And I'm enjoying
18 the discussions at town hall meetings, I attended the one
19 in Bridgeport.

20 And in terms of innovation I actually last
21 night was at the University of Bridgeport, they had a
22 innovation event and I was one of the speakers in that
23 event. So a very quick background on who am I and how did
24 I get here to my position in Connecticut. I'm a Board

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1 Certified obstetrician/gynecologist and I actually started
2 my career on the north shore of Boston. I held a teaching
3 appointment at Harvard and teaching became more and more
4 part of what my career was, so I took a full-time position
5 at Brown University and then headed out to the Midwest and
6 spent several years in the Michigan State University
7 system where I was at one of their community programs as
8 head of the department and program director in charge of
9 teaching residents.

10 Then I got into population management and
11 went back and got my Masters in medical management at
12 Carnegie Mellon and then was a chief medical officer of a
13 Medicaid health plan called Meridian Health Plan. At the
14 time it was Health Plan of Michigan, and they went
15 multistate. They're now currently in Illinois, Iowa, New
16 Hampshire, Ohio, so they're multi-state and multi-
17 regional, knocking on the borders here in New England in
18 New Hampshire. And came back to the east coast for both
19 personal and professional reasons. My wife's family is
20 from the area and I have family up and down the east
21 coast.

22 But most importantly what opportunities I
23 had in Michigan and having grown up in the Massachusetts
24 system I was a big believer in health reform. And when I

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1 saw what was going on with the Health Insurance Exchange
2 there was a perfect opportunity to what I felt I could
3 impact healthcare as I did in Michigan and the roles that
4 I played there in the Medicaid health plan and also
5 representing the largest Medicaid plan at various state
6 level agencies. Michigan is one of the seven states in
7 the country that receive the All Payer CMS Demonstration
8 Project for healthcare reform.

9 So, in coming out here what I initially did
10 as CEO and President of St. Vincent's Health Partners was
11 quickly establish some relationships to -- because the
12 timeline is here and I knew it, it was very short. As far
13 as I'm concerned we've already passed one of the first big
14 timelines of January 1st of this year and then the one
15 that's really knocking on the door, January 1 of 2014, but
16 really we're looking at October 1 because that's when the
17 Exchange opens.

18 So in my presentation that landed me my
19 position I based my entire timeline of our organization on
20 January 1, 2014. We were either going to be ready and a
21 player, or not be ready for when the Exchange comes. So I
22 felt the Exchange is the turning point of healthcare
23 delivery in the state of Connecticut. I'm very excited to
24 see Kevin come aboard with his background and how our

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1 paths have crossed over the last 12 or 15 years in our
2 career.

3 So when I first got here one of the things
4 that I did is you'll see the Connecticut Department of
5 Public Health, the Strategic Plan 2011 to 2014, what I did
6 is looked at that in terms of how are my own visions and
7 experience similar to what the vision of what the state of
8 Connecticut is? And one of the key items in this is in C,
9 Building Strategic Partnerships to Improve the Public
10 Health System. That really was the key to driving putting
11 together St. Vincent's Health Partners. And as you all
12 are setting up the Exchange I'd like to walk you through
13 what I saw as the environment coming through, what I see
14 as the environment as where it stands, and where it is
15 that I think groups such as ours can help the Exchange to
16 be a very, very successful effort and leaders in the
17 country as we are all reading about. As a matter of fact,
18 this morning there was a nice press release on the
19 Exchange as a leader in the country that hit a number of
20 the less serves. And I'm sure you all have seen a really
21 wonderful press release, Connecticut is a leader in the
22 Insurance Exchange in the country.

23 So when I got here there was no surprise in
24 terms of the health information system. The other HIE,

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1 the Health Information Exchange, unfortunately isn't under
2 the national acclaim that the Health Insurance Exchange
3 is. We live in a very siloed world in healthcare. And
4 unlike where I had just spent the seven years in Michigan,
5 and coming here what I noted is there is only 37 percent
6 penetration of electronic medical records. Some of those
7 really were expensive coat hangers, they were installed,
8 but not used. And e-prescribing was only about 30
9 percent.

10 Going on the Connecticut state website
11 we're at 16.7 percent as of January/March in terms of
12 where the state is in health reform. So that's good and
13 bad. The bad is, it's at 16.7 percent. The good is, it's
14 a clean slate and I think that the work that you all are
15 doing, the leadership that you have, plus the proximity
16 and experience from Massachusetts, as well as looking to
17 other states, we can leapfrog over what the growing pains
18 have been and I know that I personally experienced when I
19 was in Michigan. So in our siloed system you see
20 everything is separate here, literally even within an
21 office.

22 I know as a practicing OB/GYN initially
23 when I started private practice on a paper chart system
24 there were three doctors, we had a nurse practitioner and

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1 a nurse midwife. We could have a woman that came in for a
2 prenatal visit in the morning, come back 30 minutes later
3 because she thought she was in labor, and it may take an
4 hour to find her chart. It could've been on my desk, my
5 nurse's desk, the billing desk, it could've been in the
6 area of the box to file, it could have been misfiled. So
7 literally, just within my own office we had our own silos,
8 let alone looking across the health care system.

9 Now, very coincidentally, on the way up
10 here on NPR it was the hour -- the lunch hour was on
11 meaningful use, and so it was a very entertaining
12 discussion on where we are with meaningful use. The good
13 news is, we're rapidly changing where we're headed.

14 And I'll let you know what our PHO is doing
15 in terms of electronics. Well, in terms of how we're
16 paying for it, because as I understand the Exchange
17 there's a two-year mandate, within two years it's got to
18 be sustainable. If it's not sustainable we're going to go
19 the way of Vermont, a single pair system.

20 MR. COUNIHAN: Tom, it's one year.

21 DR. RASKAUSKAS: One year.

22 MR. COUNIHAN: But who's counting?

23 DR. RASKAUSKAS: Oh, that's -- that even
24 steps up the timeline even more. But if you look at the

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1 data presented from Kaiser, we know that about 95 percent
2 of healthcare is provided in the doctor's office. Only
3 five percent is in either a hospital or skilled nursing
4 facility. Yet, when you look at this, the cost of care
5 about 20 percent is in a physician's office. And if you
6 add up hospital, home health, nursing home care,
7 residential and skilled nursing facilities, that's about
8 42 to 45 percent to the care. We do know that physicians
9 admit and discharge patients from hospitals. The hospital
10 doesn't admit, the hospital doesn't discharge, doctors do.

11 So we have to work with our provider network and work
12 with our hospitals, and as I call them, the fixed
13 facilities, skilled nursing facilities, home health care,
14 we have to coordinate care. We have to have the
15 appropriate utilization of the appropriate resources and
16 the appropriate setting.

17 So as we admit patients I asked the doctors
18 the first thing is, if they're in the hospital do they
19 really need to be in the intensive care unit? If they
20 don't, let's put them on the ward. If they don't need to
21 be admitted can they just be an observation patient? If
22 they don't, could they be in a subacute facility, a
23 skilled nursing facility? Or, could we provide home
24 health care? Even better, could this have been prevented?

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1 Educate our patients and have better access to a primary
2 care provider.

3 Now, in Connecticut, the way insurance
4 currently is it's really unmanaged care. You can go to
5 any doctor any time for most insurances, you don't have to
6 select a primary care. In our network, we are strongly
7 encouraging selection of a primary care. So we feel that
8 really is where healthcare starts and healthcare should be
9 coordinated.

10 Now, in terms of payment, how are the these
11 dollars going to come about? The Institute of Medicine
12 published this and gained a lot of press and employers
13 really have taken this on and are marching to the insurers
14 and marching to the docs and marching to the hospitals and
15 saying, almost a third of healthcare is waste. In the
16 three areas that I concentrate on this are the three
17 largest quadrants here of unnecessary services, up there
18 it's in purple at 27 and a half percent; inefficient care
19 delivery, at 17 percent; and excessive administrative
20 costs at 24 percent. Adding those together that's about
21 two thirds of that 31 cents. So 20 cents on the
22 healthcare dollar we can impact. We can improve costs and
23 make the Exchange sustainable.

24 Let's talk about unnecessary services.

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1 What are we talking about there? Well, as we talk about
2 in our committee structure it's cold and flu season. So
3 the first thing that we know is that first of all flu is
4 preventable, ideally by getting a flu shot. So are we
5 giving everybody flu shots that come into our office no
6 matter what the reason is? Somebody comes in with a
7 sprained knee, offer them a flu shot. At any point during
8 pregnancy, they're in the office, offer them flu shots.
9 No matter what the visit is for we should have flu shots
10 available.

11 I can go to a pharmacy, CVS and Walgreen's,
12 and be buying any sort of good at the CVS or Walgreen's
13 and I can get my flu shot. We want to change the way
14 healthcare is provided and offer flu shots during the flu
15 season regardless of the reason for the visit.

16 Now, the converse to that is somebody that
17 comes down with the flu doesn't need an antibiotic. They
18 may need Tamiflu, which is one of the treatments for the
19 flu, but they don't need an antibiotic. So if we give
20 them an antibiotic and then subsequently find out they
21 were allergic to an antibiotic and now they have to go to
22 the emergency room and be admitted because of unnecessary
23 care that caused an adverse outcome we are increasing the
24 cost. So what we're looking at is standardization of

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1 healthcare protocols across our health system.

2 In terms of inefficient care delivery --
3 yes?

4 MS. VELTRI: Can I ask a question?

5 DR. RASKAUSKAS: Yes.

6 MS. VELTRI: You said -- you said that you
7 --

8 COURT REPORTER: Is your microphone on?

9 MS. VELTRI: -- I'm sorry. I turned it off
10 because I was crunching on potato chips. You said that we
11 could impact the 20 cents of the 31 cents. Why not the
12 inflated prices -- or you just want to attack the bigger
13 items first?

14 DR. RASKAUSKAS: This is the easy, low
15 hanging fruit.

16 MS. VELTRI: Okay. Okay, that's what I
17 thought.

18 DR. RASKAUSKAS: The easiest low hanging
19 fruit.

20 MS. VELTRI: I just didn't want to --

21 DR. RASKAUSKAS: No, I don't want to ignore
22 the others.

23 MS. VELTRI: -- yeah.

24 DR. RASKAUSKAS: I mean, fraud certainly is

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1 an issue. And believe me, coming from Detroit, we're one
2 of the fraud capitals -- Detroit and Miami are the big
3 fraud capitals of healthcare in the country, mainly for
4 Medicare and Medicaid. But these are the three biggest
5 pieces of the pie and these are actually very easy to get
6 at. And it's standardization of care.

7 In terms of inefficient care delivery one
8 of the things is access is an issue, so we're talking to
9 our providers about improved access. The other area with
10 inefficient care delivery is duplication of services. And
11 that goes to that combination of inefficient care and
12 unnecessary services. Many of us have been to the
13 emergency room and received x-rays. And so the next day
14 do you go to your physician for follow-up they have no
15 access and so what do they do, repeat the x-ray. That
16 happens time after time after time. All of these added up
17 is a significant costs to the healthcare system.

18 And then excessive administrative costs.
19 Well, in our organization the way we're dealing with that
20 is we are leveraging the capabilities of our partners,
21 namely our hospital members and our physician practices.
22 So we don't duplicate positions. Why do I need somebody
23 in my office to provide oversight to somebody that's
24 extremely well-trained in a large medical center? What we

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1 do is to first services to our partners. I don't need to
2 hire and inflate the cost of healthcare and the charges to
3 the healthcare system. And we see this up and down the
4 market.

5 Well, what are the opportunities for
6 healthcare that we can do, look at in the physician
7 practices? Well, on the left there you'll see the primary
8 care practices. First of all, improve prevention and
9 early diagnosis and that includes, as we talked about
10 examples of the flu shot, improved access. So we're going
11 to talk in a minute about the patient's in our medical
12 home concept. Improve practice efficiencies. Our
13 providers have to be on electronic medical record that
14 meets meaningful use. There has to meet inner
15 operability. This results in unnecessary testing,
16 unnecessary emergency room visits because access is a huge
17 issue. Unnecessary admissions and unnecessary referrals
18 just because there's no time to be seen.

19 We work with our hospitals and specialists
20 to improve the efficiencies internally, within the
21 hospital system, not duplicating. An example is our
22 radiology department has made a metric of any x-ray that
23 they have across the inpatient and outpatient. So they
24 know if they CAT scan was done at one of their outpatient

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1 facilities. If you're admitted the doctor in the
2 emergency room orders a CAT scan a prompt comes up and
3 says, there was a CAT scan within the last three weeks, do
4 you really need this repeated? You can't order it until
5 you say yes or no and if you say yes you can't just order
6 it, it says, what is the clinical indication needed to
7 repeat? Is it deterioration of health? And there's a
8 series of questions. So we're putting in checks and
9 balances across our metric -- our network to ensure we're
10 controlling costs.

11 We're looking at reductions of adverse
12 events. I'm very proud to say that our hospital partner
13 was awarded one of the safety awards, a grade A level, one
14 of four hospitals in the state of Connecticut as one of
15 the safest places. We've all heard from the Institute of
16 Medicine that hospitals kill from the wrong patient
17 getting the wrong drug or getting the wrong treatment, the
18 wrong operation. Well, our hospital partner was rated one
19 of the safest.

20 Additionally, it was rated by the National
21 Association of Nurses a magnet designation on the quality
22 of nursing care. Nursing care is one of our first lines
23 of care in patient management. To get those ratings is
24 very critical because what we want to set up in the

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1 network that I think will make the Exchange successful is
2 appropriate utilization of resources in the appropriate
3 setting without detracting from the quality. The first
4 thing we want to look at his quality.

5 So this results with all providers. We
6 have improved management of our complex patients. Lower-
7 cost settings resulting in lower cost to the health care
8 system.

9 DR. SCALETTAR: Doctor?

10 DR. RASKAUSKAS: Yes?

11 DR. SCALETTAR: Just help me understand.
12 What you're describing here is a theoretical model? Or
13 this is in fact --

14 DR. RASKAUSKAS: This is our model. This
15 is our model.

16 DR. SCALETTAR: -- and how much of the
17 model is in play operationalized or how far along are you
18 on operationalizing the model?

19 DR. RASKAUSKAS: I can jump ahead about
20 four slides and show you right where we are and are set
21 up. The importance is to let you all on the Exchange know
22 setting up networks to make this successful is not going
23 to happen overnight and it is a process. I tell
24 everybody, it's not a marathon, it's an ultra marathon.

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1 This is a large turning of the titanic event that's going
2 on right now. So I'll quickly get to that to give you the
3 timeline.

4 So when we look at cost containment, which
5 is going to be the key to driving the Exchange to be self-
6 sufficient, the number one thing is appropriate
7 utilization of services in the appropriate setting without
8 sacrificing quality. Population management has to be
9 there. We have to know as a network, who in our network
10 has diabetes? Are they getting all the appropriate
11 diabetic care? Who has heart disease? Are they all
12 getting management of their high cholesterol? And if
13 their cholesterol is high are they on appropriate
14 medications? It's no longer sufficient to wait for
15 somebody to call the office for problem visits. We have
16 to have planned chronic care disease management.

17 It all is around the quality-based care and
18 this is done by alignment of physician and facility
19 incentive with the reimbursement models. The crux to a
20 lot of the success is going to be around care of
21 coordination. Each step of the way there has to be
22 coordination of care so there's a continuation across the
23 continuum of what the plan of care is. And this is done
24 through medical management.

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1 Well, to answer your question, how did we
2 get where we are? We are in existence. I'm proud to say,
3 we are the only network in the state that actually has a
4 network contract going on with a major insurer right now.
5 Without naming them, they are the largest private insurer
6 in the state. This is a new, innovative way that we are
7 going to reimburse our hospital and providers not just for
8 doing this service, but was it the correct service in the
9 correct setting. And so there are quality and utilization
10 components within the contract.

11 Well, in January 19th, 2011, two years ago,
12 the medical staff and the hospital got together and said,
13 there's this whole new thing called Obamacare out there
14 and health reform. What should we do? We need to respond
15 and improve care and respond to it and not wait for
16 insurance companies or employers to tell us what to do.
17 We provide the care, we're the care providers, we're the
18 doctors, we're the hospital, we have to be responsive to
19 the market and control costs. So the president of the
20 medical staff presided over the advisory board, there were
21 hospital representatives, and we had the physicians, those
22 that provide the care. They met over the next four months
23 and looked at what were the various components of
24 alignment strategies to respond to health care reform and

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1 what was felt to be one of the biggest successes. There
2 was a lot of education I had to go on, a lot of new
3 terminology, and the initial plan was developed to bring
4 the medical staff together, give them a very, very
5 intensive retreat based educational series of lectures,
6 and then develop the model.

7 Well, over the last part of a year and a
8 half ago, from June through December, the plan was
9 developed and it was decided to do a physician hospital
10 organization leading to a clinically integrated network.
11 I was recruited and came aboard last June. The entire
12 model of healthcare reform where we feel it's going to go,
13 and it's been looked at across the country, is the patient
14 center medical home concept.

15 Now, most of us just call and get an
16 appointment when we are sick. Some of us, as an OB/GYN I
17 have to admit, I'm used to a lot of the well woman exams.
18 As a man I probably get one every five years. I'm
19 terrible in my own healthcare. But the point is, we have
20 to manage it better. We can't just wait. We have to
21 reach out and remind, not unlike my car. Every time I get
22 my oil changed there's a new sticker on my car and I get a
23 call or a letter from the mechanic, you're due for an oil
24 change. The same thing with the dentist. Healthcare

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1 needs to go in that direction and that's where we're
2 headed.

3 We also have to do trackings. So if a test
4 is ordered you have to make sure, was that test obtained?
5 Was it normal or was it abnormal? The person that had the
6 test done on them, the patient, did they realize it was
7 normal or abnormal? Did they get the information? If it
8 was normal, what's the follow-up? If it's abnormal,
9 what's the follow-up? That was not occurring. Yes?

10 MS. DOWLING: How -- it makes so much sense
11 from this side of it. How do you make that leap with the
12 physicians and the hospital for learning to take on shared
13 risk? You know, just as a cultural thing saying, suddenly
14 it's not just fever service, but how did you get your crew
15 to agree to that? And second, how do you work with the
16 hospital, which as I understand it, if your model is
17 successful you would have one of your goals to have -- I
18 think, but this could be a misconception, fewer hospital
19 admits. So do they share in the overall savings? I'm
20 just trying to get to the business model because at the
21 end of the day it comes down to the money.

22 DR. RASKAUSKAS: Oh, absolutely.
23 Absolutely.

24 MS. DOWLING: How do you, you know, get

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1 people, the physicians to take risks and how do you get
2 the hospital to buy in? Because of that question I asked.

3 DR. RASKAUSKAS: Well, this goes back to
4 the advisory board. The hospital and the physicians
5 created this looking at models across the country and in
6 looking at this the realization the hospital is not a
7 hotel. A hotel is in business by filling beds. And so,
8 the whole mentality is transaction. There is no incentive
9 to discharge somebody from the hospital when you think
10 about it. There is -- and from the doctor's office, why
11 let somebody get better? They don't come to your office.
12 It's transactional. You want -- it's the ink in your
13 printer, you want to keep that ink flowing because that's
14 the charge -- that's disease.

15 And in the realization that there's
16 responsibility in looking at what the Connecticut
17 Department of Public Health strategic goal is, improving
18 the health of every citizen in the state, and the
19 realization of the fiscal responsibility as we as
20 providers of care have to be part of that solution. This
21 was a whole new paradigm that the first time in my career
22 in almost 30 years in healthcare employers, doctors,
23 hospitals, insurers are in the room talking together, not
24 pointing fingers and saying, well, I want more of the

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1 hospital's money and the hospital saying, I want more of
2 the doctor's money, it's creating these solutions
3 together.

4 The hospital understands there are going to
5 be decreased admissions and so the hospital, part of their
6 business plan is to look where other revenue stream is
7 going to come from. But that we have to get people in and
8 out of the hospital for appropriate utilization in the
9 appropriate setting. One of the big reasons is
10 infections. There's infections that you get while you're
11 in the hospital are antibiotic resistant. And adverse
12 events happen in hospitals, so let's get people fixed when
13 they need to be in a hospital and get them out of the
14 hospital when they need to get there.

15 MS. DOWLING: So how do they benefit from
16 the lost revenue of keeping people sick or, to use a
17 pejorative term, is it that they share in the group's
18 savings?

19 DR. RASKAUSKAS: Right. One of the two
20 areas of reimbursement, the models -- fever service is
21 still part of the model, but then you have quality
22 metrics. So for example, we're here at the lunch hour and
23 the analogy I give, if every hamburger in the country or
24 in the state of Connecticut cost \$20 whether you went to

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1 McDonald's or to the Ritz-Carlton, because it's a
2 hamburger is \$20, that's where healthcare is. You go see
3 a physician for this complaint, no matter which doctor you
4 go to, here's the fee for your insurance. Whether they
5 gave you the right treatment, the wrong treatment, even if
6 you even saw the doctor, you may have just seen a PA or a
7 nurse practitioner, not to denigrate nurse practitioners
8 and PAs, but you thought you were seeing a physician, the
9 charge is the same and the payment is the same.

10 Well, now we're looking at outcomes. If
11 you have the flu, did I write for an antibiotic? That was
12 the wrong treatment. If you're admitted to the hospital
13 and discharged and you're readmitted within 30 days, why
14 were you readmitted within 30 days if it's the same
15 diagnosis? Were you discharged too early? Were you given
16 the wrong medicines at discharge? And that's care
17 coordination. So it's a complex formula of looking at
18 quality metrics and then after that the shared savings,
19 the expected expense based historically on a cohort that
20 was budgeted by the insurer, and the actual expense for
21 saving money.

22 MS. DOWLING: And is there a critical mass?
23 Because you could have one error that could wipe out your
24 sort of net income, you know, in this model. Is there --

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1 DR. RASKAUSKAS: There is and, you know,
2 that certainly -- there's a lot of debate about that.
3 Medicare, it's accountable care organizations that they've
4 set up, have 5,000 covered lives to award the accountable
5 care. I can tell you from my experience as a CMO in a
6 multistate product, 5,000 is a little short, 10,000 is
7 probably a better number. And a healthier population
8 under 65, 5,000 is not unreasonable, particularly when you
9 look at more healthy women and children because you don't
10 have as much sickness, it's really the childbearing and
11 the kids and other than immunization it's all those
12 regular physicals the children are always running to the
13 pediatrician and the shots they get. So that's less
14 expensive and the number, 5,000, you can take that
15 catastrophic couple of events that happens for like
16 childhood leukemias and things like that, but in an older
17 population you really need a little bit more to spread the
18 risk.

19 MS. DOWLING: Thank you.

20 CHAIRPERSON FOX: I have just a follow-up
21 to that. So you spoke to a couple of the reimbursement
22 models that maybe are motivating hospitals and providers
23 to this model. Are there also cost savings from the prior
24 slide that you talked about in terms of efficiencies that

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1 can drop to the bottom line for hospitals and potentially
2 --

3 DR. RASKAUSKAS: You mean this cost here?

4 CHAIRPERSON FOX: -- right. Well, we were
5 just talking about the motivation for, for instance, to
6 admit fewer patients to a hospital if that's the
7 appropriate thing to do. And the reimbursement models are
8 kind of supporting that more and more.

9 DR. RASKAUSKAS: That's with the shared
10 savings. So if you expected X number of admissions based
11 historically on how we provided care, and as long -- the
12 baseline is, and I want to make sure everybody
13 understands, you have to have the quality first. Because
14 we could just stop taking care of people to save money and
15 delay admissions for a year and make it up on the shared
16 savings. That's not the intent. The first thing is, it's
17 all about the quality. And with the quality metrics being
18 met at the benchmarks, both in the state and national
19 benchmarks, if there's shared savings from more
20 appropriate care in the appropriate setting, so for
21 example, a very, very simple thing is there are certain
22 surgeries that basically, for those of you in the room
23 with kids and get their tonsils out, they go, they have
24 their tonsils out and they go home the same day. Yet,

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1 there are some places, some doctors just aren't
2 comfortable saying, you know, that should be an overnight
3 admission just in case. Well, we're not paying for just
4 in case. That extra day of hospitalization is
5 unnecessary. And so it should be in and out surgery.

6 So looking at those kinds of things, what
7 are those surgeries that should go home the same day and
8 what percent are, we look at those kinds of metrics. So
9 there's a lot of ways that we look to ensure how are
10 majority of providers doing this as long as it's safe and
11 quality. We don't want these cutting edge type things. I
12 don't want a hip replacement done in your kitchen. On the
13 other hand, there are many things that can be done in a
14 physician's office that as recently as a couple of years
15 ago could have only been done in a hospital.

16 So again, that's the appropriate
17 utilization of resources and the appropriate setting and
18 making sure that the quality of care is there. After
19 those are met, expected costs over actual cost you split
20 with the insurer in terms of the reimbursement model and
21 certainly the goal is to go back to the employer and say,
22 we can provide lower-cost care to you when you have a
23 network where everybody is looking and linked together
24 because they're in this network and all have the same

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1 philosophy. Does that answer your question?

2 CHAIRPERSON FOX: Yes.

3 DR. RASKAUSKAS: So in going through this
4 we looked at, what are the levels of integrated care?
5 Well, the first one, the level one ACO is in the doctor's
6 office, the primary care provider. When you add the
7 specialists, that really becomes the level two, that's all
8 outpatient. And you certainly conform in network that
9 way. The only thing is, if you recall even though I said
10 95 percent of care is in a doctor's office, only 20
11 percent of the cost is there. So you really need to look
12 at that level three when we look at how do you make the
13 Exchange -- excuse me, sustainable? Doctors, when they
14 have high-cost care admit to acute care facilities or
15 subacute. So there needs to be some kind of cooperation
16 and network such that care provided in the hospital is
17 coordinated with care that's provided in the outpatient
18 setting.

19 And then certainly, the ultimate is when
20 you add the public health and safety net clinics. So what
21 our network is, is we are looking to be by the end of the
22 year completed as a level three network.

23 Well, let's quickly talk, what is a
24 physician hospital organization? Very simply, it's a

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1 legal entity that by law, and the FTC guidelines can
2 contract in behalf of the physicians and hospitals that
3 are members. Now, when we talk about a clinically
4 integrated network that starts taking on a little bit
5 more. And the Federal Trade Commission has three very
6 strict guidelines that need to be met for clinically
7 integrated network. The first one is establishing
8 mechanisms to monitor and control utilization of
9 healthcare services that are designed to control costs and
10 assure quality of care. The second one is, selectively
11 choosing your physicians who are likely to further these
12 efficiency objectives. And then third, is the significant
13 investment of capital, both monetary and human, to meet
14 these. All three of these have to be met.

15 So the hospital, so St. Vincent's Health
16 Partners, our organization, we charge doctors and
17 hospitals to belong to our organization. We are setting
18 up quality metrics and utilization metrics for appropriate
19 care and we're monitoring this. And for all of our
20 committees, the time is donated, we're not paying our docs
21 to be on the committees. They've donated actually a huge
22 amount of time as well as all of our hospital members as
23 well. Yes sir?

24 DR. SCALETTAR: So some of us, like

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1 yourself, who have been in healthcare for too long, or a
2 long time, sort of think about some of these things and
3 say, well, actually this sounds like the staff model HMOs
4 that existed in the 80s in the mid-90s. So with the
5 demise of those and the advent of PHOs in the middle 90s
6 and now we're back again. What's different today that
7 these kinds of ideas are now ready for prime time and
8 leading edge and no longer bleeding edge?

9 DR. RATHAUSKAS: That's a very good
10 question. And the answer is not as easy. The first
11 thing, as I said, this is the first time in my career -- I
12 was there in the 80s when those came about and even though
13 we had PHOs then the way it was described, they were
14 either little P's, bit H, where the hospital really
15 controlled it, or big P, little H, the physicians
16 controlled it, and there was really no working together.
17 And there was a PHO in Connecticut that was shut down
18 because it was a sham and Connecticut's a little bit
19 reticent to relook and reembrace to ensure that it's not
20 violating the antitrust, which is why I have -- this is up
21 here to make sure that we're not violating the competition
22 and that we are aligned with quality and utilization.

23 One of the biggest things that's there is
24 the IT is now catching up with what we wanted to do.

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1 There was no IT. Computers, there was no such thing as a
2 desktop in the 80s. Right now, I mean, I've got more
3 power on my iPhone then was on the computer that put the
4 man on the moon. And so, with the evolution of IT we
5 actually have shared data. I gave you how my office was,
6 I'm sure your office was a lot more efficient than mine,
7 we couldn't find records in the same office if somebody
8 came back the same day. Well, now, as long as you have
9 Internet access you have access -- of course it's
10 encrypted and protecting patient privacy, I don't want to
11 make it as simple as it is, but we have access to IT.

12 But more importantly, we now have mandates
13 it's called federal law, the Accountable Care Act. We
14 also have forums such as this with the Health Insurance
15 Exchange. Now, a lovely presentation by your Deputy
16 Director of Insurance that I attended talking about the
17 insurance market and the Insurance Exchange with doctors
18 in the room that weren't throwing the bottles of water at
19 her, whereas, 10 years ago --

20 A FEMALE VOICE: (Indiscernible, too far
21 from mic.).

22 (Laughter)

23 DR. RASKAUSKAS: -- right? 10 years ago
24 you present all that you're booted out of the room. We're

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1 all sitting down because we have to solve this problem.
2 We are all consumers of healthcare, we have to solve it.
3 It's unsustainable to our current market environment. And
4 who provides the care? Doctors. So doctors are waking up
5 and saying, you know what? We've got to be part of the
6 solution.

7 MS. VELTRI: Can you -- can you -- I'm
8 sorry. Can you explain to people a little bit about the
9 antitrust issue? I mean, as a state some of us have been
10 sort of on the advocates side of things, have been pushing
11 for convener status trying to make people come to the
12 table and some have argued that we don't really want to
13 force people to the table, we want them to come
14 voluntarily. And using the convener status does get us
15 around some of these concerns on antitrust. I just wonder
16 if, I mean, you're obviously doing it yourselves in the
17 PHO arrangement, but are you -- I mean, is that something
18 that you think is something that should be looked at more
19 broadly? Or I mean, is it you think it should be like PHO
20 by PHO, by PHO?

21 DR. RASKAUSKAS: Well, no. The FTC is a
22 very powerful organization and particularly here in
23 Connecticut where a PHO was shut down, anybody in my
24 similar position across the country that's leading

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1 organizations like that has this slide and the next slide
2 memorized.

3 MS. VELTRI: Yeah, right.

4 DR. RASKAUSKAS: It's one, two and three,
5 not one, or two, or three. We cannot have what's called
6 vertical or horizontal price-fixing. Horizontal is
7 nonaffiliated doctors. So if you have, say, five
8 internists in office is right next to each other, they're
9 all in private practice, they can't go collectively to an
10 insurer and say, you know what? We're all buddies, we
11 play cards together in the same building, but we're in
12 separate practices, there's no what's called financial
13 entanglement, but you contract with all five of us or none
14 of us. That's horizontal.

15 Vertical is when you have doctors in a
16 hospital come, and say, you know what? If you want to
17 contract you've got to contract with all of the doctors
18 and all of the hospital and pay us what's called the most
19 favored nation. And in Michigan, where I came from, I was
20 unfortunate -- well, I was not involved in it, let me say
21 it that way. Unfortunately, it existed in Michigan.
22 There was an insurer that had most favored nation clauses
23 with some physicians and hospitals. That's illegal.
24 That's anti-competitive.

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1 So this is one of my biggest concerns and I
2 have to ensure, which is why on these my doctors have to
3 have electronic medical record that's certified to meet
4 meaningful use. All of our primary care doctors have 24
5 months to become patients at a medical home certified or
6 they're kicked out. That's it. It's in the contract that
7 they sign. I'm not paying that board members, it's free.
8 I buy them lunch, but it's, you know, sandwiches like we
9 had outside. They're very good, but it's not a gourmet
10 meal. And there's a lot -- and there's a charge to get
11 in.

12 And when we look at it we really have to
13 make sure the program is real, a real entity. We've got
14 them -- and I have an EIN, Employer Identification Number,
15 I've got my own employees, I am separate, I have my own
16 board that I'm responsible and I'll quickly show you that
17 in a minute. And we are very cognizant when we talk to
18 insurers about how and what we are able to talk to. And
19 part of, again, my training is health law. I'm not an
20 attorney, but I can tell you our attorney fees are one of
21 our highest because we want to make sure we're not
22 violating the antitrust.

23 And that goes into a good segue to the
24 accreditation options. There's two accreditation options

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1 right now. That's the hoop jumping. You know, are you
2 meeting the minimal standards? Well, in NCQA is probably
3 more known and then the other is URAC (phonetic). I've
4 been on the advisory boards to both and have had some
5 input. NCQA accredits accountable care organizations,
6 which really is set up for Medicare, which is really a
7 more tightly defined clinically -- it's a specific program
8 that Medicare has and Connecticut's been very blessed to
9 have a number of groups named as accountable care
10 organizations by the federal government. The only problem
11 is, they're just setting them up. They put in their
12 applications and said, here's what we're going to do, and
13 specific to Medicare.

14 We are actually going after URAC
15 accreditation, and I'm very proud to state, and there was
16 a press release about a month ago, my organization and an
17 organization here in town, St. Francis, we are going to be
18 the first sites as beta tests to look at this as, are we
19 meeting the metrics? And if not, we have one year to come
20 back and be re-examined to get our accreditation status
21 that shows we comply with all of the requirements fully
22 both clinically integrated network. And the Federal Trade
23 Commission was involved and had input into the way of how
24 these were written

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1 And I can't speak for the FTC, so don't --
2 I don't want to be misquoted, but in general what the FTC
3 is stating is that we would not be in violation and they
4 feel that we could be deemed a clinically integrated
5 network as URAC has deemed it through its accreditation.
6 So that to me is a quality component and where we would
7 bring a network where we would say to a contracting
8 entity, you only have to contract with one entity, that's
9 our organization. One of the hard things as setting up a
10 network and going to all the doctors and all the hospitals
11 and all the skilled nursing facilities, all of the durable
12 medical equipment, you have to have an army of salespeople
13 in an insurance company. Well, imagine controlling costs?
14 All I need is one salesperson to call me. Right now I
15 have 300 providers, I have a hospital, I have three
16 skilled nursing facilities that we are hoping will join us
17 within the next three months, home healthcare, palliative
18 care, you have all of that access with one phone call.

19 Additionally, we're looking at extending
20 our organization up and down the corridor between Hartford
21 and Bridgeport. That's our goal. We're looking at other
22 institutions that have similar goals and say, you know
23 what? Let's have economies of scale. Imagine an insurer
24 to call one number and you have an environment in a larger

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1 geographic area that's based upon quality and appropriate
2 utilization of resources.

3 So to answer your question, how do you
4 build this? Well, the first phase is the assessment and
5 the strategy and that's what our organization did. It was
6 over four to six months here on this from this reference
7 here to the advisors clinical integration, it's two to
8 four months, and then the design is two to four months,
9 setting up the business plan, the management organization,
10 the agreements, all that legal stuff, the structure of the
11 governance.

12 And then the phase three is the
13 implementation, that's about a year. Well, the
14 implementation started for us when I arrived June 11th and
15 is still going. But we truly went operational January 1.
16 January 1 of this year is when we went live moving towards
17 a clinically integrated network contracting with a major
18 insurer to provide care in behalf of our network. We have
19 and IT platform that is going to integrate all of these
20 different systems in the different doctors offices, the
21 hospital. So for our providers that are in our network,
22 you, as a provider would have access to the information
23 that all of the other providers did so you don't
24 duplicate.

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1 MR. COUNIHAN: So Tom, is it like having a
2 mini HIE?

3 DR. RASKAUSKAS: That's exactly what it is.
4 So the example I gave last night is, our radiology group
5 has asked me, how can we help as radiologist? They were
6 talking about when you sign in can we have something that
7 weighs you? And can we take blood pressures and alert the
8 primary care that your blood pressure is high while you're
9 getting an x-ray? Imagine coming out of your x-ray and
10 they say, well, thank goodness your x-ray is normal, but
11 we were concerned about your blood pressure and we called
12 your primary care He has an appointment at 2:00 o'clock
13 or 3:00 o'clock, can our office make you that appointment?
14 That's where we're heading. That's improved coordination
15 of care. That's what we want to set up.

16 So the development we talked about 95
17 percent is in the physician's offices. We have to create
18 these solutions.

19 MR. TESSIER: What does that mean? Tell me
20 what that means, 95 percent of healthcare, what are you
21 measuring? Number of events, visits?

22 DR. RASKAUSKAS: Number of events. When
23 you go to seek healthcare --

24 MR. TESSIER: To me that's not -- that's

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1 not --

2 COURT REPORTER: I'm sorry. Can you move
3 the microphone closer? Thank you.

4 MR. TESSIER: -- sorry. I'm sorry to
5 quibble, but I -- to equate one office visit with one,
6 let's say, surgical procedure, five office visits then
7 five times the care, that doesn't equate to me.

8 DR. SCALETTAR: So maybe it's healthcare
9 services? It's the equivalent of claims, not claim lines.
10 Claims of service.

11 DR. RASKAUSKAS: Well, the point is, 95
12 percent of the care is in your doctor's office. All
13 healthcare is local. So doctors have to be part of the
14 solution. Only five percent of the care is in the
15 hospital, it's the highest cost. But doctors provide the
16 care, not the bricks and mortar, that's what the point is.
17 So who's going to help solve this problem? Ideally the
18 physicians have to be part of the solution. We say that
19 31 percent is waste. Looking at developing a local health
20 information exchange, that's the other HIE, so what we're
21 doing is at the hub, our PHO has this platform and we're
22 going to be getting information from hospitals, payers,
23 from the community, there's patient portals. If you have
24 your blood pressure done at home you can enter your blood

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1 pressure online. Employers, a lot of employers have
2 wellness, you know, you can get a flu shot or a blood
3 pressure check or your blood sugar checked at your
4 employer's office, that can attach and be part of the
5 information. Certainly from the different doctors'
6 offices.

7 Our membership is hospital members, which
8 includes hospitals, skilled nursing facilities, rehab,
9 home healthcare, palliative care and that our physician
10 members, primary care and specialists. We have a formal
11 board. The board is made up of the medical center
12 representatives and doctors. And the doctors are split
13 between primary care and specialist. Why is this? Well,
14 the question I was asked, this was set up in the 80s and
15 it didn't work, what's different now? I'm ex officio,
16 that means I'm there, but I don't vote. St. Vincent's
17 Medical Center gets one vote and the doctors get one vote.
18 So to move the organization forward a vote has to be two
19 to nothing, one to one means we don't move forward.

20 The reason it didn't work in the 80s is
21 there was filibustering by the hospital or the primary
22 care or the specialist. We have to get everybody to work
23 together. The good news is, it's worked in other states.
24 We think we can bring and develop this here in this market

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1 with the Health Exchange. We think that this is the way
2 of these kinds of networks throughout the state to make it
3 successful. We have various committees like any other
4 committees -- organizations do, our daily operations, the
5 hiring, the firing, the contracting, our information
6 technology, which is a huge component because of the
7 platform, and the connectivity that we have to have. It's
8 a huge undertaking, but I don't have a huge department
9 because I'm tapping into resources.

10 We talked about decreasing that redundancy
11 of care. Our quality and utilization, again, we go to our
12 members. The hospitals have certain committees that they
13 look on this inpatient and we're teaching them how to do
14 it as outpatient. We have a lot of doctors that are very
15 interested. I'm very proud to say that in our
16 organization we have the first practice in the
17 Fairfield/Bridgeport community that was designated as a
18 patient center medical home.

19 Patient center medical homes don't have a
20 large penetration in Connecticut. Other states have
21 larger penetration. Part of it is, as you recall, only 37
22 percent have electronic medical records. Electronic
23 medical record is a big component. But other things are,
24 you know, the doctor is not just open 9:00 to 5:00,

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1 they're open at 7:00 in the morning or 7:00 at night, some
2 are even open on Saturday mornings.

3 Then the finance and population management.
4 So our role is to help doctors to get through this, to get
5 through the patient center medical home. As a chief
6 medical officer and as a former medical director of a
7 large clinic I've taken a clinic through this
8 certification, as a chief medical officer I've helped
9 hundreds of practices through it. We're partnering here
10 with Connecticut State Medical Society to work with our
11 physician offices. We're working on the advisory board at
12 the state level for Medicaid with based on my experience
13 in other states through the patients center medical home
14 concept here in Connecticut.

15 He Medicaid department has a big effort to
16 bring its offices even more so of a needed for those in
17 the under served where access is a huge issue. The State
18 program has a huge program to encourage physicians to
19 become patient center medical home. We are the only PHO
20 in the country recognized by NCQA that sponsors providers.
21 Only insurance companies and state medical societies can
22 do it. I made a formal presentation because of my
23 familiarity with their organization, they've known me,
24 they've seen what I've done in my prior career and they

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1 said, we know -- we like what you do. Your PHO will be
2 the first in the country that can sponsor physicians to be
3 patient center medical homes. It's a big deal. That
4 gives legitimacy.

5 So the journey is a transformation phase,
6 that's a good six to 12 months. That doesn't happen
7 overnight. Then there's a certification phase, which is
8 three to six months, and then the post-certification phase
9 is dealing with the contractors, namely employer-based
10 self-insured groups or the insurers.

11 The reimbursement models, how does it work?
12 Well, it's not just fee-for-service, we look at bundle
13 payments. For a good example, as an OB I've been dealing
14 with bundle payments for years. We're the only ones that
15 have. As soon as you become pregnant you go to your OB,
16 you get what's called a global payment, it covers you all
17 prenatal, delivery and postpartum. Well, imagine that for
18 bypass surgery or hip surgery? Where there are really
19 standardized discrete bundles of care that are very, very
20 similar across that continuously. Say it's money, you can
21 do that rather than variance in charge. Why should a hip
22 cost \$10,000 at one organization and 3,000 at another?
23 That's ridiculous. It should be based on quality outcomes
24 and there should be some risk. If one hospital keeps you

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1 in there for seven days and another for three and a half
2 and there's no change in the outcome and you're back to
3 work and functional, which one do you want to pay for?
4 The seven-day stay or the three-and-a-half-day stay?
5 Those are the kinds of things that we're working on.

6 Shared savings we talked about. Capitation
7 didn't work in the 80s and 90s, the reason is we didn't
8 have cooperation and we didn't have the capability to
9 manage it with the IT systems. And then paper performance
10 is all based on quality. The quality metrics on inpatient
11 we looked at readmission rates, the right medication --

12 MR. COUNIHAN: Tom?

13 DR. RASKAUSKAS: -- yes sir?

14 MR. COUNIHAN: If you just go back to the
15 prior slide? When you look at those different
16 reimbursement models and you think about your vision as to
17 where you see your organization going, where would you see
18 in general the percentage of overall reimbursement going?
19 So if we take FFS for example, what percentage of total
20 reimbursement do you see that being?

21 DR. RASKAUSKAS: Well, I can tell you my
22 personal experience. When I left the Michigan market a
23 year ago about 82 to 85 percent of a doctor's income was
24 fee for service. 15 to 18 percent were based on quality

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1 and utilization metrics. So you made less money if you
2 didn't have as good a quality.

3 Now, in the mid-Atlantic region, and my
4 suspicion is a group in New York that I'm familiar with,
5 that I was at a presentation -- excuse me, last week where
6 this organization went to an insurer and said, you know
7 what? We want to be leaders in the market. 40 percent of
8 our income is going to be on fee for service 60 percent is
9 on appropriate utilization and quality. That's shared
10 risk.

11 I don't know what the right number is.
12 I've heard in really looking at it about 70/30 is probably
13 what I've seen in my reading of the literature. Is fee
14 for service at 70 percent and 30 percent on these other
15 forms of reimbursement because then you've got skin in the
16 game. You're going to reduce readmissions. You're going
17 to reduce inappropriate admissions. You're going to
18 decrease length of stays. You're going to provide more
19 appropriate care. So if you come in with a sprained knee
20 imagine the orthopedic doctor saying, have you had a flu
21 shot? If not, I'll give it to you. An M.D. -- a
22 pharmacist can give it, why can't an orthopedic surgeon
23 give it? Why do you need to make another visit with
24 another co-pay to go to another doctor when that doctor

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1 that's seeing you for a sprained knee can give you a flu
2 shot? That's what we're looking at. Really redoing how
3 care is being delivered.

4 An example I was discussing when talks with
5 durable medical equipment, I find out for Medicare they
6 have to do a home risk assessment for falls. I said, do
7 you have to do that for other insurers? No, not a
8 requirement. I said, how about if you come into our
9 network that will be a requirement, you got to do it no
10 matter what the insurance is? We don't want a disparity,
11 it's better care. Why give less better care just because
12 it's not a requirement? And then even better, if you see
13 a risk you go on a record shoot a note to the VNA, VNA
14 comes out the same day, does a home risk assessment and
15 fixes it. You fill out a form, you don't have to do
16 anything except to fill out the form. Let's change it.
17 That's improved care. That's having the teams of care
18 providers work and do this.

19 So we talked about the different quality
20 metrics and the utilization metrics. The point of this
21 is, I am a huge believer in what this group is doing and
22 what can be done through the Health Insurance Exchange. I
23 think there needs to be a good understanding where
24 healthcare is, how long these systems take to develop, and

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1 how to bring partners into the system to get people that
2 are leaders in the state. I feel that our organization
3 can provide some good advice, some good counsel.

4 One of the reasons that I talked to Kevin
5 when he first came aboard, we actually connected within
6 the first week of his joining, because I felt that as a
7 citizen of this state I have a responsibility. And that
8 as a licensed physician I even have a more responsibility
9 and as President and CEO of this company I have an
10 obligation to help be part of the solution. Our doctors
11 that join the organization have to get electronic medical
12 record if they're in primary care they have to be patient
13 center medical home care certified. My organization will
14 get accredited. Those are the quality metrics that we are
15 putting our doctors at risk and on the line. If you don't
16 get it you can't be in. This is all based on quality.

17 Our skilled nursing facilities, they have
18 to be top-rated. There's five stars. So you know what?
19 I want five-star organizations. Then I hear, well, you
20 know, those are hard and there's three stars. I said, you
21 know what? You can gripe all you want, five stars. The
22 government has said that. You cannot get a Medicare
23 contract unless you're a four or five star. So why should
24 I settle for a three star? There's got to be some kind of

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1 standardization. So these skilled nursing facilities were
2 part of that discussion you helped set up the metrics.
3 Just like in my organization you are going to help set up
4 the metrics, but I'm going to hold you 100 percent
5 accountable. And we have to meet those metrics.

6 So in conclusion, I want to again thank the
7 Board for your time. I would like to let the Board know
8 that this is not an event, it is an ultramarathon. We
9 need to bring in networks like this to make the Exchange
10 successful. To go out and contract with provider by
11 provider is an extremely onerous and expensive
12 undertaking. Look to organizations, the free market. The
13 free market is understanding where this is going. And
14 with that I'd like to open it up for questions. Yes sir?

15 DR. SCALETTAR: Sir, you just mentioned
16 this is a very expensive proposition to build a network,
17 much less build a network that has all of this support.
18 Is it appropriate to ask you, because I know the funding
19 to do all of this stuff that you've talked about in here
20 can't possibly come from the dues the doctors will provide
21 to join. We've watched that fail decade after decade, or
22 not fail, but the doctors don't ante up like that.

23 DR. RASKAUSKAS: I've already signed up 300
24 people and we're going to continue to sign people. If

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1 it's been successful in other --

2 DR. SCALETTAR: I'm not suggesting that you
3 won't successfully sign people, but all of this is being
4 done strictly on the membership fee?

5 DR. RASKAUSKAS: -- no, it's not. And
6 you're doomed to fail that way.

7 DR. SCALETTAR: Right. That was my point.
8 So if it's not inappropriate, where does the funding come
9 from?

10 DR. RASKAUSKAS: From the insurers. The
11 insurers are helping to pay for this transformation.
12 That's part of the quality and the utilization. With our
13 oversight that we're providing and the IT that we're
14 purchasing, IT is not cheap, the insurers understand that
15 they have to also invest because it's helping their
16 product to go to employers and say, we can provide a
17 higher quality at a lower cost.

18 DR. SCALETTAR: I see. So then --

19 DR. RASKAUSKAS: The model I'll give you is
20 Advocate Healthcare is probably one of the most esteemed
21 organizations in the country. They're out of Chicago,
22 Illinois, that's who we're modeling after. They are
23 unbelievably successful. And about 35 to 40 percent of
24 their funds come from their membership and the remainder

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1 comes from the contracts with insurers. It's not
2 duplications of services. They are providing services
3 that nobody else is providing and they have improved
4 quality, more appropriate utilization, and they're saving
5 millions. The best model that I can give you that I
6 personally was involved with is out of Michigan. It's
7 called the Physician Group Incentive Program with Blue
8 Cross/Blue Shield. They have over \$400,000,000 of
9 savings. I mean, we're talking significant --

10 DR. SCALETTAR: -- the funding, is there
11 funding or the funding is the stream from the savings?

12 DR. RASKAUSKAS: -- there's multiple
13 sources. There is some front end loading that can be
14 done. There's ongoing what's called care coordination
15 fees that's done as a per member per month. Because care
16 coordination, this year is the first year that Medicare
17 has actually come out with a care coordination fee. Up to
18 2013 there was no fee for care coordination. So in other
19 words, that hour and a half that a doctor's secretary was
20 on making all of these phone calls to other doctors,
21 arranging the wheelchair delivery, oxygen, was unpaid for.
22 And so insurers realize they've been getting away, and
23 this is where I said, this is the first time in my career
24 I'm sitting down with insurers because I was on that side

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1 of the table saying, you know what? You're right. We
2 made you pay for it and you guys paid for it. Now we
3 realize we can't keep doing that it has to be funded. And
4 that's funded by if there are patients that are medical
5 home recognized, which is a lot of hoop jumping, and a lot
6 more things to do, a lot more care coordination, they are
7 rewarded for it and we provide that care coordination.

8 And then we look at the end of the year
9 shared savings that money comes in at that time as well.
10 So it comes in at different kinds -- again, making sure
11 we're not just shifting dollars from the left pocket to
12 the right pocket though, we really want to look at the
13 total cost of the care.

14 MS. VELTRI: So, can I ask a question?

15 DR. RASKAUSKAS: Sure.

16 MS. VELTRI: A follow-up on that, I mean, I
17 have other questions, because there's a lot of good stuff
18 up here that I just want to follow-up on. But on the
19 funding issue, one of the things that our office sees is
20 people who come in who have had care at one of the
21 hospitals that has, you know, PHO arrangements, and there
22 are facility fees. And what happens is in the old
23 arrangements you went to the doctor's office, you paid the
24 doctor's fee. Now you're getting a doctor's fee and a

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1 hospital fee on top of -- you're paying twice essentially,
2 you're paying not twice, but you're paying two different
3 kinds of fee now in these arrangements and insurers are
4 subsequently paying that on behalf of the consumers in
5 most cases.

6 So I guess what I'm trying to figure out is
7 how does that work with this? I mean, so when Bob was
8 asking, you know, how do you fund this kind of program,
9 does some of it come from these, you know, the fees that
10 are being charged on patients to go to a practice that's
11 owned by a hospital? So that people know where those
12 dollars are going is what I'm saying, because people do
13 come and complain to us all the time that, why am I
14 getting two bills when I went to see the doctor's office?
15 And if it's going to something good, that's great, but
16 nobody knows that. That's important.

17 DR. RASKAUSKAS: Well, again, that's a
18 straightforward question that does not have an easy
19 answer.

20 MS. VELTRI: Okay.

21 DR. RASKAUSKAS: And the simple answer to
22 start with is number one, it's federal, as well as insurer
23 driven, not providers. Now, the reason it comes federal
24 is the facility fees are with hospitals that teach

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1 residents. It's not free to teach residents and medical
2 students.

3 MS. VELTRI: No.

4 DR. RASKAUSKAS: So that goes to what's
5 called DME, Direct Medical Education, and IME, Indirect
6 Medical Education. Federal government has set up that
7 hospitals train doctors and there's a cost to that and
8 that cost is built in in the facility fee. And so, there
9 is very complex reimbursement models that actually
10 hospital to hospital it's not the same.

11 MS. VELTRI: Right.

12 DR. RASKAUSKAS: And even type of residency
13 training, I mean, it's cheaper to train an internist than
14 it is a cardiac or brain surgeon and you can understand,
15 you know, one is a three-year residency and one is a
16 seven-year or even a longer residency. So that you're
17 going to have to change from a different direction. That
18 has to do with medical education.

19 MS. VELTRI: Okay.

20 DR. RASKAUSKAS: That's not directly
21 involved in these kinds of arrangements. And however,
22 with that what we do know is that that needs to be fixed
23 as well.

24 MS. VELTRI: Well, because there's, I mean,

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1 there's a part of me as an advocate that feels like -- I
2 worry sometimes about the level of purchasing, or the
3 level of hospitals buying out practices and the bargaining
4 power that that creates for hospitals and the potential
5 for that to drive up cost. I mean, I'm just throwing it
6 out there. I don't mean -- I'm not picking on your
7 program, which sounds like you're actually trying to do
8 something good to promote quality care.

9 DR. RASKAUSKAS: Well, the two that you
10 would look at most costly is what's called the Kaiser
11 model and the other is the Geisinger (phonetic) model out
12 of Pennsylvania.

13 MS. VELTRI: Yeah.

14 DR. RASKAUSKAS: That is totally owned.
15 Their costs are driven up. So you have to look at first
16 of all what's the mission of the organization --

17 MS. VELTRI: Right.

18 DR. RASKAUSKAS: -- and what's their record
19 and how are they set up and what's the responsibility to
20 the board?

21 MS. VELTRI: Right.

22 DR. RASKAUSKAS: So it really gets into
23 doing a little bit deeper because it is easy to
24 generalize, but there's a lot of extremely well-run

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1 organizations. There are examples across the country.
2 You know, we are blessed that there's 50 different
3 experiments and people are looking to Connecticut. How is
4 Connecticut going to do it's Exchange and will it be
5 successful?

6 MS. VELTRI: Right. And that's why it's
7 important that you're here because I mean, that -- this is
8 the general view. I mean, I think a lot of people who
9 would sit in my seat and who are not privileged enough to
10 be sitting here and hearing this presentation, that's the
11 conclusion that most people will draw is that -- is a
12 worry about the increase in health costs, you know,
13 healthcare costs by too much consolidation of the
14 marketplace in terms of where you can get healthcare. So
15 again, it's not directed at you, you know, it's just --

16 DR. RATHAUSKAS: No, but what I point
17 people to though is other industries.

18 MS. VELTRI: -- yeah.

19 DR. RATHAUSKAS: Other industries have been
20 very successful, look at the consolidation of the airline
21 industry. If the airline industry -- actually today's
22 dollar cost of living --

23 MS. VELTRI: Yeah.

24 DR. RATHAUSKAS: -- just for fun I went to

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1 Europe, it was 1981, I paid \$500 round trip. I paid
2 actually less than that two years ago to travel to Europe.
3 So other industries have solved it. We like to pretend
4 that healthcare is different. And last night at the
5 innovation talk at the University of Bridgeport what I
6 said, all of us in our wallet carry an ATM card. I have
7 two dollars and a wife. I have a daughter in Orono, Maine
8 at college. I have a daughter at Georgia Tech in Atlanta.
9 And my wife works in New Haven. I'm up here in Hartford.
10 I can go into an ATM and get all of the charges for the
11 last month if I want on my credit card that all three of
12 them have done in a bank that I don't even belong to. Why
13 is that different from healthcare? It's an electronic
14 transaction.

15 We have a different service, we provide
16 healthcare, but it's a different transaction. That's what
17 the Health Exchange wants to do and make it successful.
18 Your starting by doing exactly what the airline industry
19 did. You want to be Expedia, you want to be Exchange.com,
20 the little -- what is it, the gnome for Travelocity?

21 MS. VELTRI: Yeah. Yeah.

22 DR. RASKAUSKAS: I don't know, Kevin, what
23 you're going to have there for that.

24 MR. COUNIHAN: We're working on it.

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1 DR. RASKAUSKAS: And there's no reason it
2 can't be done. And there's artificial expenses. The
3 exact same programs, just because it says M.D. on it for a
4 doctor's office, you actually can buy almost off-the-shelf
5 in, you know, you name it, Best Buy, Target, that do very,
6 very similar types of things that are unbelievably
7 cheaper.

8 MS. VELTRI: I mean, that's a big issue. I
9 mean, I do think it's important to commend everybody on
10 the HIT issues, because frankly, the State, we've kind of
11 fallen down on the effort on the information exchange
12 here. I mean, we're having a lot of issues here in the
13 State with the hype situation, which was meant to do this
14 --

15 DR. RASKAUSKAS: Right.

16 MS. VELTRI: -- it was meant to integrate
17 technology across the State so that you wouldn't
18 necessarily have to build your own networks, but it's --

19 DR. RASKAUSKAS: The private sector is
20 picking it up.

21 MS. VELTRI: -- I think it's great that
22 you're making up for it, but I hope at some point we can
23 integrate it, because what see in our office a lot,
24 especially on the mental health side, is people are going

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1 -- they don't stay in the same system, so the kid's having
2 an issue they go to Hartford Hospital, they go to St.
3 Francis, then they go to Manchester. I mean, they're just
4 in and out, in and out because of the emergency situation.
5 So in a situation like yours, which is obviously really
6 well run and integrated, you still may not see the kid
7 going to outside your system.

8 DR. RASKAUSKAS: Right. Well, mental
9 health has a whole bunch of issues in itself --

10 MS. VELTRI: Yes.

11 DR. RASKAUSKAS: -- insofar as regulations,
12 which you can and can't disclose --

13 MS. VELTRI: Right.

14 DR. RASKAUSKAS: -- particularly when it
15 comes to children --

16 MS. VELTRI: Yep, State law.

17 DR. RASKAUSKAS: -- which are very
18 difficult. Now, with that being said, we actually have
19 mental health providers in our network.

20 MS. VELTRI: Yeah. Right. Good.

21 DR. RASKAUSKAS: And so what is allowed to
22 be shared, the other thing is just that one owner
23 relationship is it's important to share this with your
24 other providers on the team so they know.

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1 MS. VELTRI: Exactly.

2 MS. DOWLING: May I follow up on that? As
3 you were talking about working with St. Francis, are you
4 working with them, or are you just mentioning them as an
5 organization going down the same path? Because you
6 mentioned building through the corridor.

7 DR. RASKAUSKAS: I want to make sure -- I
8 didn't say we're working with St. Francis.

9 MS. DOWLING: Yeah, that's what I want to
10 clarify.

11 DR. RASKAUSKAS: I said that St. Francis
12 has a PHO similar to ours that's been longer in the state.
13 Now, with that being said, it is public that St. Vincent's
14 is in the Ascension Network, based out of the Midwest, and
15 St. Francis just signed a letter of intent to look at the
16 for-profit arm of Ascension. And so, what we're looking
17 at is are there areas of synergy and opportunity that
18 would be certainly one of the first places that we would
19 look at for a network.

20 MS. DOWLING: So, and it's very interesting
21 because then -- I'm asking Vicki's question in a different
22 way. For a state our size would a business model goal be
23 for you to cover all of the counties? You know, to have
24 your organization grow so that it might cover all counties

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1 in the state? Is that a good result? Or, you know, is a
2 nonessential result? You know, what -- if you play this
3 out to its most efficient what does that look like?

4 DR. RASKAUSKAS: My Board asked me and I
5 keep telling them my goals would be national.

6 (Laughter)

7 DR. RASKAUSKAS: But staying within the
8 confines of Connecticut you have to do -- you have to be
9 cognizant of what are current alignments in referral
10 patterns and what's real and what's doable. And the other
11 thing is, I believe in competition. I think that you have
12 to have at least three networks that would do this in a
13 statewide system, otherwise it would become a monopoly and
14 you've got five insurers that at least put letters of
15 intent in for the Exchange. And I'm talking, not the
16 dental or the mental health, I don't want to, you know,
17 denigrate all of the efforts that they are doing, I'm
18 talking about the health insurance as we traditionally
19 look at it, the five insurers that want to come to market.
20 I think that's a good thing because I think that's going
21 to provide some competition.

22 I would love an exclusive contract,
23 however, we have a President and three different bodies,
24 the executive, legislative, and judicial for a reason,

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1 there's got to be checks and balances and we have to have
2 that within the state. But that being said, using the
3 Walmart philosophy, I want, you know, 80 percent of the
4 population is up and down that corridor and so that is
5 kind of an easy thing to look at and put into a business
6 plan that in looking where physically hospitals are and
7 what services can be provided.

8 MS. DOWLING: Thank you. That's very
9 helpful.

10 DR. SCALETTAR: Two separate questions.
11 One on the Ascension issue. Does the development of a
12 clinically integrated network come out of sort of St.
13 Louis, from the Ascension corporate offices?

14 DR. RASKAUSKAS: No, not at all.

15 DR. SCALETTAR: Are these all locally developed strategic
16 initiatives?

17 DR. RASKAUSKAS: No, as I stated, I am an
18 independent organization with my own Board of Directors.
19 My hospital partner, which is St. Vincent's, is part of
20 the Ascension Network. Ascension Network does not direct
21 what we do. My Board of Directors does. And my Board of
22 Directors is made up of members of St. Vincent's Hospital
23 and our local doctor membership.

24 DR. SCALETTAR: One of the reasons I was

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1 asking that is, I know -- and you pointed it out in the
2 presentation the recognition that St. Vincent's has
3 received for it's work in patient safety.

4 DR. RASKAUSKAS: Right. That's because
5 they're my hospital member.

6 DR. SCALETTAR: Yeah. No, no, and I am
7 familiar with it and I think they've done a fabulous job.
8 And Susan Davis is -- all hospitals should have leaders
9 like Susan Davis.

10 DR. RASKAUSKAS: Thank you.

11 DR. SCALETTAR: But I also know a lot of
12 that came both from Susan and other senior colleagues, but
13 a lot of it also came out of Ascension. And I was just
14 trying to understand the relationship, you clarified that
15 for me.

16 The other thing that I wanted to get to
17 was, so this is a wonderful presentation. I understand
18 most of what you've said. I embrace it and support it and
19 have tried to live some of it in my life as a physician, a
20 physician executive. But getting from here to there is
21 always the challenge and I wish you well on that side. I
22 don't mean to say, yes but kinds of things, but to what's
23 the message to us here? Is it to contract directly with
24 an ACO, is it to be open and receptive to ACO as a model

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1 to embrace that should a carrier come with a product that
2 provides enough coverage in the state that's just ACO-
3 based, is that something we should be receptive to? I'm
4 still not sure what the real take-home message is.

5 DR. RASKAUSKAS: Okay. The real take-home
6 message is to give you an understanding where healthcare
7 is. The Health Exchange is only going to be successful
8 insofar as the provider network is successful. And what
9 are the capabilities? First of all, what are the current
10 networks? Are there any current networks? And my feeling
11 is that networks such as this, and my misunderstanding,
12 which I was corrected, is it's a one-year timeline. To go
13 out and contract with individual providers that have no
14 connectivity, no skin in the game to control costs and
15 quality, I'm not sure quite honestly that that's going to
16 build a successful model for the Exchange. I think that
17 the Exchange insurers develop networks and I think the
18 encouragement would be to encourage the insurers to look
19 at networks, to help control costs like this, to help this
20 Exchange become successful.

21 What is the basis for that network? Are
22 they real? So, for example, in setting -- as I stated,
23 CMS has awarded ACO contracts, yet some of these networks
24 are only on paper and not even really a formal structure.

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1 So you have to be careful in what is the terminology, what
2 is the formalization of those? Are there cooperation
3 across the continuum of care as I outlined? That's why I
4 gave that two slides and, you know, I hope I drove home
5 the cost of 95 percent of contacts are in a doctor's
6 office. That's not where all the cost is. Yet, if we're
7 not part of the solution and working directly with our
8 other colleagues at hospitals, home health care, skilled
9 nursing facilities, then how can you be successful in the
10 Exchange? I would encourage this, even working with the
11 medical societies in the state, because that's our formal
12 structure as physicians, so you know what? These
13 networks, foster them. Encourage patient center medical
14 home. Tell the insurers, you know what? Pay for quality.
15 Why aren't you making all of your PCPs, PCMH like they are
16 in other states?

17 MR. COUNIHAN: So Tom, just to interrupt
18 you to get to Bob's point. I guess, Bob, one thing that
19 I'm inferring from this is that perhaps part of the QHP
20 criteria at some point could be the inclusion in these
21 types of efforts.

22 MS. VELTRI: Am I wrong in saying, like a
23 bottom-line argument is adopting a program such as this?
24 And controlling the cost brings the price down. And for

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1 this Exchange to succeed ultimately people have to be able
2 to afford to buy it and so we have to control healthcare
3 costs and this is --

4 DR. RASKAUSKAS: This could be a mechanism.
5 Right.

6 MS. VELTRI: But I do think, I mean,
7 piggybacking on what you just said, with the chronic
8 disease management model, I mean, I'd be interested to
9 know, you know, how it's rolled out, what you're doing as
10 part of it and stuff. I know the state employee plan, I'm
11 looking over here at Janice, but Connecticare is helping
12 the state employee plan, it allowed a pretty robust
13 chronic disease management model. So I'd kind of like to
14 know what the components are, you know, how you're
15 tracking its, what you're doing to manage people's
16 conditions? And the one thing I actually did bring up in
17 the state employee meeting and probably here too is that,
18 there's a different reason it can't be done at least right
19 now at the state employee level and that involves
20 contracts with employees and all that kind of stuff.

21 But mental health, again, I keep going back
22 to it, but it seems to me to be one of those things that
23 would be -- unless there's not a model for yet, but ripe
24 for, you know, a disease management program. Because it

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1 itself is an issue, but it's always got something else --
2 almost always has another medical condition attached or
3 something else going on. And if we could manage it for
4 people who are experiencing a behavioral health condition,
5 whether it's mental health or substance abuse, it seems to
6 me that would be another way to improve outcomes and
7 reduce healthcare costs.

8 DR. RASKAUSKAS: I agree 100 percent. The
9 only problem is, an employer-based insurance model --

10 MS. VELTRI: Yeah.

11 DR. RASKAUSKAS: -- the employer determines
12 what your benefits are.

13 MS. VELTRI: Right. And that -- that's the
14 issue.

15 DR. RASKAUSKAS: And mental health is the
16 issue. And in terms of Connecticare, I've talked with Mr.
17 Wise and Dr. Bluestein and we've had these conversations.
18 And having been a chief medical officer -- unfortunately,
19 disease management is a misnomer, is disease information.
20 And the insurers are not providers, its care by telephone
21 and that's it. These doctors in this organization have
22 skin in the game, they pay a membership. I always joke,
23 the hardest thing for a doctor to do is put his hand in
24 his right back pocket and pull out his wallet or her

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1 wallet. They have skin in the game. They are attending
2 these meetings and designing programs because they want to
3 provide quality of care. The docs firmly believe we need
4 to change this system and with chronic disease management
5 what you're looking at is first of all, identifying who
6 has the disease --

7 MS. VELTRI: Right.

8 DR. RASKAUSKAS: -- working with employers
9 at the different types of work well or worker's comp.
10 programs that they have and then ensuring, what are the
11 standards for whatever that chronic disease be. So for
12 example, for diabetes, are they getting their eye exams at
13 least every other year? Do they have somebody looking at
14 their feet at least once a year that's a medical
15 professional? Do they have certain blood tests on a
16 regular basis to control their diabetes? If not, have
17 them come in for planned chronic care visits. Don't wait
18 for the broken body, don't wait for that bent fender for
19 the phone call. React proactively and keep them out of
20 the hospital and in the home. That's successful chronic
21 disease management.

22 Insurers know they're not doing a good job
23 because they don't provide the care, they just pay for it.
24 And as a provider I may contract with -- I may have 25 or

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1 30 insurer plans. In this PHO I have 100 percent provider
2 and they're accountable for their quality regardless of
3 the insurer to this organization.

4 MS. VELTRI: So the program is your
5 program, it's not as a result --

6 DR. RASKAUSKAS: It's not Connecticare's or
7 it's not United's or it's not Aetna's. We choose the best
8 of all of these and say, you know what? Connecticare, if
9 they come out with a program and we say, you know what?
10 Boy, this is really good quality, but you only get it if
11 you're Connecticare, so you know what? Put it across the
12 board. That's where I gave you the example of durable
13 medical equipment, they have to do something for Medicare,
14 that's a good idea, do it for everybody. Why have
15 disparate care based on insurance? Put the same process,
16 because then we get into well, what's your insurance? I'm
17 not going to give you as good a benefit. Doctors don't
18 look at insurance, they provide care.

19 MS. VELTRI: But that goes to, I mean,
20 again, to the criteria piece to me that's a way to say,
21 you know what? If your plan is committed to making
22 providers be PCMH's or whatever else, you know, maybe we
23 reward you for that.

24 DR. RASKAUSKAS: Or electronic medical

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1 records.

2 MR. COUNIHAN: That's -- well, another is
3 (indiscernible) plan designs. So for example, the co-pays
4 could be different. The reimbursement could be higher.

5 MS. VELTRI: Right, the value base.

6 MR. COUNIHAN: Right. Tom, thank you. Are
7 there any other --

8 CHAIRPERSON FOX: I just have one -- it's a
9 little bit of a drill down, but just so I really
10 understand the network. I think you said four or five
11 star is the quality you're looking for in the providers
12 that belong in the network.

13 DR. RASKAUSKAS: That's for skilled nursing
14 facilities.

15 CHAIRPERSON FOX: Oh, skilled -- okay.

16 DR. RASKAUSKAS: One star is the lowest
17 rating, five is the highest rating, that's the
18 government's --

19 CHAIRPERSON FOX: That's the category of
20 providers.

21 DR. RASKAUSKAS: -- right. Five is the
22 highest and one is the lowest.

23 CHAIRPERSON FOX: And then how do you look
24 at the docs in terms of -- is it your organization that

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1 credentials, or is it the insurer? How do you decide what
2 level of quality doc gets into the network? And then the
3 follow-up to that is, you know, are there people that want
4 in that you decide are not -- don't meet the criteria?

5 DR. RASKAUSKAS: Well, we're a relatively
6 new organization, so we're telling doctors if your primary
7 care you have to be a patient center medical home within
8 two years and you have to be on electronic medical record
9 within two years of joining. If not, you're out. Once
10 you're in, here's our quality metrics. And there's
11 national standards called HEDIS, the Health Effectiveness
12 Data Information Set, so what we look at is what are those
13 provider scores regardless of insurance? Because what I
14 don't want is, well, for this contract pays me more, I'm
15 going to come you know, and this one I'm not -- it's
16 across the board. And we're setting this up and then a
17 remediation program if they don't meet it. And after
18 remediation, if not, they have to present the Board and
19 then they will not be members if they are not meeting the
20 quality standards.

21 CHAIRPERSON FOX: Okay. Thank you. Are
22 there any other questions? Comments?

23 DR. SCALETTAR: The scores are now done at
24 the level of an individual provider?

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1 DR. RASKAUSKAS: Oh, absolutely. They've
2 always been done at the level of the individual provider.
3 They are reported by insurers, so for example, I can go on
4 the State's website and for a PPO or for commercial
5 insurance I can get the scores of any of the insurance.
6 They come out about October every year.

7 DR. SCALETTAR: No, I'm familiar with that
8 part. But of the individual doctor?

9 DR. RASKAUSKAS: Every single insurer has
10 HEDIS scores on their own doctors, absolutely.

11 DR. SCALETTAR: Well, given that some of
12 the measures are --

13 DR. RASKAUSKAS: I'm not a pediatrician, so
14 I have no immunization scores for kids. It's those that
15 are relevant based on what your specialty is. Every
16 insurer can tell you the HEDIS scores provider specific,
17 absolutely.

18 DR. SCALETTAR: Thank you.

19 DR. RASKAUSKAS: Well, thank you very much.

20 CHAIRPERSON FOX: Thank you so much Tom.
21 So Doctor, you're welcome to stay for the administrative
22 piece of this if you'd like to, but we're going to go back
23 to our original agenda.

24 MR. COUNIHAN: Mary, it looks like he's not

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1 taking us up on that option.

2 (Laughter)

3 DR. RASKAUSKAS: Unfortunately I have --

4 MR. COUNIHAN: That's right.

5 DR. RASKAUSKAS: -- I have a meeting to get
6 back to.

7 CHAIRPERSON FOX: All right. Thank you so
8 much. Okay. So we'll go back to the second item on the
9 agenda, the review and approval of minutes from the
10 November meeting, which I think was passed out by Amy,
11 right? So is there any -- any comment before we ask for a
12 motion to approve them? I have one change that I talked
13 to you about, it was on page three -- so on page three it
14 has a comment that I may -- these words may have actually
15 come out of my mouth, but what I meant to say was, it
16 says, Chairperson Fox suggested focusing issues on cost
17 versus quality. And my intent there was to focus on
18 issues of cost and quality, and I may have made some
19 comments about not assuming that higher cost -- that
20 higher quality drove higher cost. That there were
21 opportunities and some of this was very timely in terms of
22 what the Doctor just spoke to us about, that you can
23 actually make improvements in the system that lower costs
24 and increase quality for healthcare. So if we just change

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1 that sentence to, suggested focusing on issues of cost and
2 quality, I think that gets at it more accurately. Got
3 that? Thank you.

4 DR. SCALETTAR: I have a small one on page
5 four Amy, that if you could change Mr. Scalettar to Dr.
6 Scalettar? Thank you. I still pay Jewel that fee.

7 CHAIRPERSON FOX: Okay. So could I have a
8 motion to approve the minutes?

9 DR. SCALETTAR: So moved.

10 A FEMALE VOICE: So moved.

11 A FEMALE VOICE: Second.

12 CHAIRPERSON FOX: All in favor?

13 VOICES: Aye.

14 CHAIRPERSON FOX: Any opposed? Okay.

15 Thank you. All right. So the next thing is I would like
16 to nominate Dr. Robert Scalettar to co-chair this
17 Committee with me. It is up to this Committee to approve
18 that and I guess we have the authority to do that and then
19 just to report back to the Board. I am nominating Bob for
20 obvious reasons to all of us who have worked with him,
21 he's got an incredibly good understanding not only of the
22 clinical aspects of healthcare and healthcare delivery,
23 but also has the big picture in view. He's operated in
24 many different facets of healthcare, so I thought he would

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1 be a perfect person to help drive the Strategy Committee
2 and look to you all for approval of that.

3 MS. VELTRI: Well, if you made a motion, I
4 don't know, you might have to twist my arm to second it,
5 but -- actually no, I would second that if you made that
6 is a motion. Bob should be doing that.

7 CHAIRPERSON FOX: Okay. So moved. Do you
8 second?

9 MS. VELTRI: I second.

10 CHAIRPERSON FOX: You seconded first. All
11 right. Very good. Congratulations Bob. Will you accept
12 it?

13 DR. SCALETTAR: Do you want to be sure that
14 the rest of them agree?

15 CHAIRPERSON FOX: Oh, no. No votes. Okay.
16 Just one carries it. All right. Everybody good? Okay.
17 So thanks Bob for saying yes.

18 All right. So the next thing is we had
19 quite a discussion last time about the vision mission and
20 key success factors and I think the handouts today reflect
21 those comments. So we just want approval of the final
22 draft of those. And you maybe need a minute to look at
23 them? Any questions? I was going to move it.

24 MR. TESSIER: As someone who wasn't here at

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1 the last meeting I'll just say, they look good to me. The
2 third key success factor, just in terms of external
3 experts advise on ways to promote delivery system change,
4 my guess is we probably all know what we mean by that, but
5 that's an incredibly ambiguous phrase. And so whether
6 this is the appropriate place for it to be further
7 defined, or that it should be a priority going forward to
8 put something more behind that, it needs clarification.

9 MR. COUNIHAN: Bob, I think that's a really
10 good point and I think -- I guess one question for the
11 Committee would be, if we think about the first factor,
12 which is to create a strategic plan and then the tactics
13 to support that plan, would that be an appropriate place
14 that we could get more specific about what we want to do
15 for that period of time?

16 MR. TESSIER: I agree. That's fine with
17 me.

18 MR. COUNIHAN: Okay.

19 MR. TESSIER: And by the way, the
20 presentation that we just had is a perfect example.

21 MR. COUNIHAN: Yeah. Okay.

22 CHAIRPERSON FOX: Okay. So with that
23 clarification could we move to have these finally
24 approved?

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1 DR. SCALETTAR: So moved.

2 A FEMALE VOICE: Second.

3 CHAIRPERSON FOX: All in favor?

4 VOICES: Aye.

5 CHAIRPERSON FOX: Any oppose? It's

6 wonderful working with a little tiny group.

7 (Laughter)

8 CHAIRPERSON FOX: Okay. Thank you. Okay.

9 Do you want to take this --

10 MR. COUNIHAN: Sure. So I think, and I
11 would appreciate if Vicki would, or anyone others would
12 supplement this, I think as most of the Committee knows
13 that the state applied for one of two types of state
14 innovation model grants. And we actually submitted a
15 couple of times, we submitted once and then we revised it,
16 right?

17 MS. VELTRI: Yep.

18 MR. COUNIHAN: And we tried to make it a
19 little bit better, right? Yep. And there are actually --
20 there are actually two types of awards that CMS was giving
21 in this. One is called a model design award which
22 basically is a planning grant. And there's \$50,000,000
23 that CMS was devoting up to 25 states for this. And the
24 idea for this is that the state would have to produce a

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1 proposal to transform the delivery system and provide a
2 broad vision for how to make care more accessible and
3 affordable.

4 The second type is called a model testing
5 award, and that's an award, up to \$225,000,000 over three
6 to four years, for up to five states, to evaluate
7 basically the transformation of their delivery system
8 within the state. Now, we did not apply for that, we
9 applied for the first one, which is the design award. And
10 the status of that is that we were supposedly supposed to
11 be notified in December, along with any other states that
12 applied, as to our -- awarded that or not. As of a couple
13 of weeks ago CMS is still evaluating our application. And
14 I went on the website last night to see if there was
15 anything new and there's nothing new.

16 So Vicki, I don't know, do you have
17 anymore? Because I don't.

18 MS. VELTRI: No, we don't know.

19 MR. COUNIHAN: Okay.

20 MS. VELTRI: And you and I -- Kevin and I
21 were discussing whether we weren't even sure at one point
22 whether it was going to survive the fiscal cliff
23 negotiations.

24 MR. COUNIHAN: Correct.

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1 MS. VELTRI: So I think they may have held
2 back all of their evaluations of the grants, but yeah, we
3 just submitted for the design a very small thing, which
4 would have brought together the same kind of -- a similar
5 kind of structure convened through the L.G.'s office, the
6 Lieutenant Governor's office.

7 MR. COUNIHAN: Right. I mean, you know it
8 struck me, and I appreciate the Committee's reaction on
9 this, I mean, in some respects it seemed to me that it
10 would be an ideal sequence is if this Committee were to
11 nail down some options that we could then use as part of
12 that -- if we were awarded that grant and then really use
13 that to start planning for implementation. So in a way,
14 we've kind of got this a little bit backwards. We kind of
15 -- and to be very frank, our application was good, it was
16 a little broad and general I would say, but what I've
17 heard is a lot of other states are too so we might be in
18 good company.

19 I have heard, and this may just be a rumor,
20 that one state was awarded money, which is Virginia. And
21 that may just be a rumor. But anyway, I'm unaware that
22 they're not doing anything more, but still evaluating.

23 MS. VELTRI: That's right. And I know that
24 NASP actually has offered the state some technical

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1 assistance if we want to take them up on it, which is
2 something I think we still have to follow up with because
3 I think -- frankly, I think we could have used that kind
4 of assistance.

5 MR. COUNIHAN: Yeah.

6 MS. VELTRI: But also, I think it's
7 important to note that this is a much broader -- this is a
8 very broad health reform issue. They're really seeking
9 for transformation in healthcare to get to a point of
10 focusing on prevention and health as opposed to sickness
11 and treatment for illnesses. And so it will involve all
12 of the major state agency players as well as all the
13 stakeholders, whether it's carriers, hospitals, individual
14 providers, consumers, everybody is supposed to be at the
15 table. That's the idea behind this process.

16 If anyone does want to see -- I don't know
17 if the most recent application is actually up --

18 MR. COUNIHAN: I think it is.

19 MS. VELTRI: -- it is?

20 MR. COUNIHAN: Yeah.

21 MS. VELTRI: If you want to see what was
22 given -- what was submitted to the federal government it
23 is on the healthreformct -- healthreformct.gov, is that
24 right?

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1 MR. COUNIHAN: Yeah. Our website or the --

2 MS. VELTRI: It's on the --

3 MR. COUNIHAN: OHRI?

4 MS. VELTRI: -- yet, the OHRI website,
5 under SIM. Yeah.

6 MR. PORTER: (Indiscernible, too far from
7 mic.).

8 MR. COUNIHAN: Yeah, that would be good
9 Grant. Thank you.

10 MS. VELTRI: But we're kind of in a holding
11 pattern.

12 MR. COUNIHAN: So Mary, I think that's
13 really -- as big as that is, that's the latest that I
14 think we have.

15 MS. VELTRI: That's all we got.

16 CHAIRPERSON FOX: So when we do get to the
17 next step, is that the time that you would come back and
18 then you would talk about with the Strategy Committee
19 could do in terms of integrating that into the overall of
20 supporting what needs to happen?

21 MR. COUNIHAN: Yeah, it would be. I have
22 to admit --

23 CHAIRPERSON FOX: There's nothing to do
24 now, nothing we can --

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1 MR. COUNIHAN: -- correct. I'm actually a
2 little embarrassed to say that I don't even know where it
3 rests anymore.

4 MS. VELTRI: Yeah. We don't -- so my
5 understanding is, I mean, it will still be driven out of
6 the L.G.'s office, we just don't know --

7 MR. COUNIHAN: But it was in OHRI, am I
8 right?

9 MS. VELTRI: -- yeah, it was in OHRI. So
10 we're not sure exactly how it will -- how will rollout,
11 but it was still come through the Lieutenant Governor's
12 office. And I know there have been broad discussions
13 already, you know, the state agency people have been
14 talking and we've also talked to the Exchange about the
15 HIT issues that came up today, much broader HIT issues
16 that need to be tackled across all state agencies and
17 across the Exchange, vault purchasing possibilities or
18 joint purchasing possibilities. What else? Medicaid
19 expansion and the issues with that.

20 MR. PORTER: The focus of the SIM grant was
21 all the federal program, so they're most interested in how
22 can they reduce costs in Medicare, Medicaid, and through
23 the Exchange because there, you know, the premium subsidy,
24 as well as (indiscernible). And the point I note that

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1 even though whether or not the state gets the planning
2 grant it doesn't preclude us from applying for that second
3 stage of implementing grants, the much more significant
4 grants. So the Strategy Committee could still consider
5 ways in which those 20 plus million dollar grants that
6 would be awarded later in the year and into next year
7 could be utilized to implement and encourage the doctors
8 from participating in a patient center medical home and
9 doing delivery reform in that manner.

10 MS. VELTRI: And I think our application
11 was focused a lot on payment reform and delivery for
12 reform mechanisms. Piggybacking off of some of the ones
13 that are already taking place in the state, so as Tom
14 touched on, DSS is doing a very robust PCMH rollout in
15 Medicaid, you know, piggybacking on that, piggybacking on
16 the chronic disease management model that the state
17 employee plan is using. And so trying -- trying to use
18 models that exists in the state and maybe, you know,
19 develop them further or explore other options. But I
20 think CMS was really trying to tell us, you know, you've
21 really got to get to some of these payment reform issues
22 and how you pay for healthcare.

23 And I think the most important message is
24 that the administration is behind it. That's the -- the

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1 SIM initiative is a Governor's initiative, it's an
2 application from the administration to the federal
3 government.

4 MR. COUNIHAN: In the Governor did meet we
5 Secretary Sebelius in December to actually lobby for our
6 being awarded a design grant. But it wasn't clear -- so
7 we're not sure.

8 MS. VELTRI: We just don't know. Like a
9 lot of things that have kind of come into play while the
10 Affordable Care Act is rolling out things are kind of
11 getting, you know, the more urgent things are being
12 handled right away instead of kind is sitting. So we just
13 don't know.

14 CHAIRPERSON FOX: So it sounds like from
15 the description that we have to wait and see, but the
16 dollars must be earmarked for --

17 MR. COUNIHAN: So far.

18 CHAIRPERSON FOX: -- right?

19 MR. COUNIHAN: Yeah. Yeah. I just --

20 CHAIRPERSON FOX: So then our work would be
21 to figure out is there a way to connect where those
22 dollars are going to support patients on the medical homes
23 or whatever, a way for the Exchange to support that --

24 MR. COUNIHAN: That's right.

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1 CHAIRPERSON FOX: -- without the dollars.
2 I mean, so do we really have to wait for that to find out
3 what the status of the grant is? Or do we want to look at
4 the aspects of it that we think the Exchange should be
5 working through?

6 MR. COUNIHAN: Well, it seems to me that
7 the Strategy Committee for example, could still come up
8 with initiatives that we think are appropriate for the
9 state and whether we get the SIM grant or not, we could
10 still try to recommend those. And to Grant's point, still
11 try to get money to implement them.

12 CHAIRPERSON FOX: Right. Okay.

13 MR. COUNIHAN: The issue I think is if we
14 win, we're not sure where it goes.

15 MS. VELTRI: Right.

16 MR. PORTER: It was 3,000,000 -- the
17 \$3,000,000 grant, the planning grant.

18 MS. VELTRI: Yeah, and again, it's targeted
19 to very broad health reform. So it's much broader than, I
20 mean, it goes beyond the Exchange to state --

21 CHAIRPERSON FOX: One of our priorities,
22 and we articulate a good case for leveraging some of the
23 work on the dollars, we should do that.

24 MR. PORTER: I think we should, yeah.

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1 MR. COUNIHAN: Yeah.

2 CHAIRPERSON FOX: All right. So who can
3 help like distill, you know, the items in that SIM grant
4 that we ought to -- are they already on kind of our
5 developing list of initiatives that we have been talking
6 about the last --

7 MR. COUNIHAN: Yeah. The reason I'm being
8 kind of vague is to be honest with you, the application is
9 pretty big and so it's so general that yes, the answer
10 would be yes in most every case.

11 MS. VELTRI: I think if --

12 MS. DOWLING: Okay. We just do our thing
13 and then find --

14 MR. COUNIHAN: Yeah.

15 MS. DOWLING: -- we would welcome the
16 Exchange (indiscernible, talking over each other) --

17 MR. COUNIHAN: Yeah, I think so.

18 MS. DOWLING: -- is the way I interpreted
19 that. Okay.

20 MR. COUNIHAN: I think that's well said.
21 So there's plenty of opportunity to distill it into more
22 actionable items I think.

23 MS. VELTRI: That's correct.

24 CHAIRPERSON FOX: Okay. So we just had our

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1 ACO network development presentation, but I had some
2 follow-up, so I thought maybe we could talk about -- so
3 Anne Melissa, in particular, when you were listening to
4 the presentation, can you visualize or imagine how this
5 actually comes through the system for approval of a plan
6 design? Because that's, I mean, it's new territory.

7 MS. DOWLING: We have to be careful because
8 we do not, at least from our agency, get in any way
9 involved with how a carrier negotiates with its networks
10 and all of that. On the other --

11 CHAIRPERSON FOX: What would come to you
12 for -- or your agency for rate approvals? I mean, how
13 does that look? How does a get from what he's describing,
14 you know, through the whole process?

15 MS. DOWLING: -- it comes later.

16 CHAIRPERSON FOX: You'd have to prove it as
17 the Exchange --

18 MS. DOWLING: You know, as I understand the
19 math of this, you know, the upfront investment in all of
20 this could actually be substantial, so you may not -- you
21 know, your -- this is a really tricky thing. You're not
22 going to see it in lower premiums, you're going to see it
23 and lower claim costs and lower experience ultimately. So
24 it's the other side of the equation.

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1 MR. TESSIER: (Indiscernible, too far from
2 mic.).

3 MS. DOWLING: It will, yes, but I'm saying,
4 you know, it's like anything, it's like a venture capital
5 deal. All of the money is out front and then you get paid
6 --

7 COURT REPORTER: Do you have the microphone
8 on?

9 MS. DOWLING: -- yes. It's like any kind
10 of investment, you know, you put it up front and then you
11 hope to be paid back multifold later. So cash flow wise
12 we wouldn't see it in our rates for the first couple of
13 years of a carrier being involved with this. But having
14 said that, you know, without disclosing anything
15 inappropriate, all of the carriers are taking this very,
16 very seriously and it's, you know, it's an excellent
17 business model. So, you know, we see it all across the
18 board from them. They're taking it seriously. Whether we
19 could say, you know, a plan design is going to get more or
20 less play because this is the model, we're not going to
21 see that for a couple of years because you won't see
22 better rates, you won't see anything like that yet. And
23 you know, some of these conversations are subsets of
24 networks.

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1 So if we're looking at an overall plan, you
2 know, so I would say the good news is that we're aware
3 they're all very serious, but it's not going to be an
4 upfront thing. You know, we would see this from not only
5 rate review, but overall as we look at financial solvency,
6 we look at the way the organization is structuring itself
7 to be successful in the long term. But that doesn't
8 answer the immediate question of, are we going to see it
9 in product innovation for QHP certification? We're not
10 going to see that immediately, nor would we tell them how
11 to do this. But it will show up in their ultimate
12 experience later.

13 And the one question I didn't think -- I
14 think we should get more plan, you know, for all the
15 carriers we talked to is a huge spectrum of taking
16 providers along the continuum of getting involved with
17 these types of structures because they really need to --
18 providers aren't willing to just go right to a risk model,
19 you know, I mean, they're not venture capitalists. So
20 many of them have wonderful structures of a spectrum of
21 bringing people along and that's, you know, the co-
22 investment, all of that, and then little by little sharing
23 more and all that.

24 So all I can share is that every one of the

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1 carriers is very actively pursuing this. I would say that
2 Connecticut as a state isn't in the forefront yet, just
3 because of, you know, culture, you know, maybe the
4 village-like mentality of our old New England, you know,
5 mentality, all of that type of thing. There are other
6 places, other states that are further along, you know, and
7 I think there are some challenges to being in the
8 forefront in our state. But I think as we learn more and
9 more from them that's something we can have an impact on.
10 So I'm being fairly careful because we've had all these
11 presentations in confidence and I, you know, am not quite
12 sure how much more we can present other than I was really
13 pleased to see that they're also far along nationally and,
14 you know, we'll see where we go with Connecticut.

15 So I don't think it's a satisfactory answer
16 to what you want to hear, you know?

17 CHAIRPERSON FOX: Well, I just -- I'm
18 looking for what we can do strategically to support the
19 right initiatives. This sounds like innovation. It
20 sounds like a lot of things we've been talking about. And
21 even if it isn't a day one, you know, leap in quality or
22 cut in cost we should recognize the opportunity to support
23 it now and it will over time build towards sustainability
24 of the Exchange if we do this right. So I just want to

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1 make sure we're thinking about what, you know, as a
2 Committee, and what as a Board, and then certainly through
3 the agencies that we need to support the work, what we
4 need to be alert to, and maybe we need to do some things
5 differently. Maybe we need to, you know, be specific
6 about the criteria that we're using to make these
7 decisions and push ourselves so that maybe we can catch
8 up. Look what we did in six months with Kevin on the
9 Exchange. We went from the bottom of the heap to best
10 practice, right?

11 MR. COUNIHAN: Yeah. You know, I --

12 CHAIRPERSON FOX: Is that how you would
13 describe it?

14 MR. COUNIHAN: -- yeah, I would. You know,
15 it strikes me that -- and I want to throw this out to the
16 group, that even looking into, you know, next year or the
17 year beyond it, we ought to try to work with the health
18 plans in encouraging plan designs that really incent the
19 kinds of things that Tom was talking about, and use value-
20 based types of concepts as potentially a QHP certification
21 requirement. I think there's a lot we can do to help
22 guide our enrollment and our participating health plans to
23 provide those kinds of plan designs and work with them
24 collaboratively to do so.

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1 MS. DOWLING: You know, I think what's
2 interesting is that we always say it's all or nothing in
3 this state, you know, very few -- well, there's a couple
4 that may come in that are going to carve out a couple, you
5 know, parts of the state and not the whole state, but you
6 know, since these are so early along the development
7 spectrum we may work with a carrier who's got something
8 great going on in Bridgeport and Fairfield County, but
9 isn't anywhere close in Tolland County or even in Hartford
10 County. And so how do you -- do you incent if they have
11 one going but the rest of their network is not there yet
12 because maybe they haven't brought the hospital long yet.
13 So that's why I'm saying, I think we need to think a
14 little further. If they've even got one, maybe that's
15 great news, and we do something with that.

16 MR. COUNIHAN: Right. That's right.

17 DR. SCALETTAR: What I was trying to
18 understand was -- or I thought your question was, what's
19 the role CID plays in overseeing a clinically integrated
20 network and its contract with a carrier? I mean, to the
21 point you were making about so you're concerned about
22 carrier solvency, and as long as that's okay how they
23 build a network and what levels of reimbursement and risk
24 they put into the network is outside the purview of CID?

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1 MS. DOWLING: We do not tell them how to
2 structure their networks. We look to see if whatever they
3 have done maintains solvency. Yeah.

4 DR. SCALETTAR: So as long as they can
5 maintain solvency, because I think some of us have had the
6 experience of working places where risk was transferred to
7 organizations before they really were capable of dealing
8 with risk. And so, the carrier, the deep pocket, had to
9 deal with all of that and so the Insurance Division goes,
10 well, you know, that your business problem. And then it
11 became the insurers --

12 MS. DOWLING: Well, I think the Insurance
13 Department is much more sophisticated now just because of
14 the level of conversation and, you know, frankly the
15 federal act and all of that that now all of our reviews go
16 down into this much more -- but remember, many of these
17 that we're looking at we're not only looking at
18 Connecticut, we're looking at the overall company
19 nationally and internationally. So we see a very broadly.
20 But we always ask now, so tell us about what it's like to
21 do business in Connecticut and what are your hurdles? And
22 that is something I will reflect back on and see whether
23 we can consolidate that input because there's a lot to
24 work with there, you know, I think. So that I think --

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1 and some of it is just our overall cost, you know? You
2 know, make some of the competition different than the same
3 model being put in another state elsewhere in the country.
4 So I think that's part of our challenge.

5 And I can circle back and see -- we've
6 invited each of the carriers each time to see if you'd
7 like to come or come as an organization to speak on very
8 broad terms. That's a tricky invitation I think, you
9 know, it's easy for us, but I think I'd like to keep
10 pursuing that.

11 MR. COUNIHAN: One of the things, as you
12 folks may remember, that we are asking for as part of the
13 QHP applications from the plans is a narrative on what
14 they're doing to promote innovation, cost containment, and
15 saving money, and improving quality. So we're hoping that
16 that will be part of the evaluation criteria.

17 CHAIRPERSON FOX: And how are we doing on
18 establishing specific criteria? Because I imagine as we
19 make the decisions and it goes through the process we will
20 have to be ready to describe that at least and, you know,
21 we need to be able to be clear ourselves on what we're --

22 MR. COUNIHAN: You're exactly right. To be
23 frank with you, that's the next thing that we're working
24 on. The standardized plan design was a big project and

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1 with the vote today our next step is actually work on the
2 criteria. And Mary, I'm glad you brought that up, because
3 I'd like the rest of the Committee to know that part of
4 our plan is to put together a Selection Committee that is
5 cross stakeholder, like we've done with the standardized
6 plan design so we get people from the Board and from CACs
7 to participate in both developing their criteria and then
8 evaluating and scoring the submissions.

9 MS. DOWLING: Grant -- I don't want to
10 speak for him, but if I make invite him to the
11 conversation, had a really interesting idea. And it plays
12 to me wanting to consider permitting more than one
13 application from a carrier. But why don't you just --

14 MR. PORTER: Once we have the criteria
15 established and to ensure that the shopping experience
16 remains simple and take full utilization of the Web
17 portal's ability to sort, there could be an advantage to
18 allowing an additional nonstandard plan that's really
19 posed as a pilot. So it wouldn't be statewide, it would
20 be County specific, that could take advantage of a network
21 that really only involves a patient centered medical home,
22 but it wouldn't be statewide and there are sort of a lot
23 of qualifications for the enrollee, but it way for
24 carriers to -- to incent carriers to -- it would be a risk

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1 in ways without having to dilute their plan offerings for
2 the rest of the general population for the Exchange. So
3 thinking about it as sort of a nonstandard pilot program.

4 CHAIRPERSON FOX: Right. So that was
5 behind some of my questioning this morning was, you know,
6 will there be a way for us to describe in the initial
7 process, you know, this kind of an opportunity?

8 Coordination of care as a concept would be I think, you
9 know, readily embraced. I don't know -- I'm imagining
10 that maybe people would care more about that than a lot of
11 the other things that we're worrying about, you know, the
12 trade-off between the co-pay and the premium, I mean,
13 that's going to be important, but it really is about, you
14 know, getting a healthy population and having the right
15 outcomes. And so if coordination of care is appealing to
16 people, if there's a neighborhood network that, you know,
17 they trust, that may be the draw to that particular
18 product.

19 So I am totally with you on, you know, the
20 experimental nature of that, but what can we do to, you
21 know, to just sort of think that's through from the
22 beginning to the end, it starts with maybe the navigators
23 and, you know, the on the ground folks who are going to
24 describe the insurance opportunity. And when I think

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1 about people who have had no insurance ever and don't, you
2 know, don't really know the first thing, can't determine
3 the difference between a co-pay, coinsurance, deductible,
4 I mean, it's going to make people's heads spin.

5 A MALE VOICE: It's exhausting.

6 CHAIRPERSON FOX: Right. Exactly. I mean,
7 you know, even people that have worked with it forever,
8 which is part of the problem is we're so inbred and we
9 can't get out of our own way to kind of think about a
10 design that actually is simple. So as much as we try to,
11 you know, make sense of what the world is right now and
12 make it, you know, assessable and affordable and
13 communicate it. I'm just thinking that if we really did
14 talk first about, you know, the medical healthcare
15 experience versus the experience of buying new insurance
16 we might do a little better.

17 MS. VELTRI: Mary, I was just going to say
18 this may not, I mean, this may not help immediately for
19 the first year, but one of the things we're doing as part
20 of the assister process, we're doing a needs assessment
21 now. And that is, again, it's an on the ground
22 assessment, somebody is going literally to every one of
23 the zip codes and areas where the uninsured and Medicaid
24 eligible, uninsured Exchange eligible, and some currently

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1 insured people are right now to not just find out who they
2 are and who they talk to and who they trust, who might be
3 good independent assisters, but also to gauge their level
4 of knowledge and what they value and stuff. So that
5 feedback will be brought back for purposes of, you know,
6 it can't necessarily be done this year, but for next year
7 in our decision-making.

8 You know, what do consumers really want,
9 what do they value? Not what we think they value, but
10 what do they value? So I think that's really important
11 for us to --

12 MS. DOWLING: So our challenge is, what if
13 it comes back with just price, that's the answer you get
14 from your needs assessment? It's still our responsibility
15 to do what we can in the long term --

16 MS. VELTRI: That's right. That's right.

17 MS. DOWLING: -- to get the price down.

18 MS. VELTRI: I agree with that.

19 MS. DOWLING: But it's very possible that's
20 going to be your outcome.

21 MS. VELTRI: Yeah, some of it will be that.

22 MR. COUNIHAN: You know, it may be helpful,
23 I don't know if this group would be interested or not, but
24 you know, going back to the connector days, we did 18 in-

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1 depth research studies with consumers and small businesses
2 about what they do value in selection and I'd be happy to
3 share that.

4 MS. VELTRI: Yeah, we should share that.
5 That would be --

6 MR. COUNIHAN: Yeah.

7 MS. VELTRI: -- because we have a small
8 business person involved in it as well.

9 MR. COUNIHAN: But I would tell you Anne
10 Melissa, that you're right, I mean, one of the three key
11 drivers we found was price. And it varied depending on
12 the individual, but that was always one of the three. The
13 other, quite frankly, is just simplicity, you know, they
14 just get overwhelmed very quickly with too much choice.
15 And that gets to that whole concept of the paradox of
16 choice, which is people -- when you asked people how much
17 choice do you want, it's always very, very broad. But
18 when you really drill down to it they actually don't want
19 too much choice because it gets confusing.

20 MS. VELTRI: You know that HEDIS thing,
21 that was interesting. I did not know that the carriers
22 have -- you would know that probably better than us, but
23 the carriers have access to the HEDIS scores for each
24 individual -- they don't? Oh okay. But I mean, data like

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1 that, I think data is for some consumers that is valuable.

2 MR. COUNIHAN: But even if they did it's
3 not published, right? It's always aggregated anyway.

4 MS. VELTRI: Oh, all right. Never mind
5 then. I withdraw my question.

6 DR. SCALETTAR: (Indiscernible, too far
7 from mic.) to the level of reading individual documents
8 and NCQA for the last five years has been pushing that
9 notion. I think they're a lot closer to be able to do
10 that on a variety of ways, but again, remember, each --
11 some of these measures are sampling techniques and things
12 like that, so this would just be --

13 MR. COUNIHAN: You've got a risk adjustment
14 to the patient mix.

15 DR. SCALETTAR: -- and then each office has
16 multiple, multiple carriers that they're dealing with. So
17 I don't think they're at the individual level yet.

18 CHAIRPERSON FOX: Thank you for that.

19 MR. TESSIER: Kevin, I'd be interested if
20 you would share the Massachusetts research. But I'd be
21 willing to bet the two items you mentioned, simplicity and
22 cost, if anything, I bet they're every bit as much, if not
23 more important today than they were when the connector did
24 their work.

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1 MR. COUNIHAN: I'm sure you're right. I'm
2 sure you're right.

3 CHAIRPERSON FOX: Okay. We're pretty much
4 out of time. We have one more agenda item about the
5 overview of Colorado's APCD Project.

6 MR. COUNIHAN: Yeah, and I can summarize
7 that in an e-mail to the group. Do you want me to just
8 give a quick update? Okay. Well, just quickly to the
9 group, the APCD Project has been moved to the Exchange and
10 so we're in the process of developing some of the same
11 phases that Tom talked about with respect to planning and
12 staffing and developing a business plan and a
13 sustainability plan because the grant that we received in
14 our level two grant, which is \$6.6 million out of 107, is
15 basically probably going to be good for about two years
16 from what we can estimate. Last week I was with the APCD
17 staff in Colorado that's been up and running for about 18
18 months and at least has a reputation for being one of the
19 more sophisticated newer states with APCD. And they
20 shared a lot of good advice with respect to what to look
21 for in respect to staffing and planning and developing a
22 data warehouse vendor and the type of reporting to expect.
23 So, if it's helpful Mary, and to the rest
24 of the group, I'm happy to get into more detail next

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1 month.

2 CHAIRPERSON FOX: Okay. Yeah, that's great.

3 MS. DOWLING: Would you address how they
4 dealt with the emotional side, you know, the
5 confidentiality?

6 MR. COUNIHAN: The security piece? Yes.

7 MS. DOWLING: Yeah. That would be great.

8 MR. COUNIHAN: Absolutely.

9 MR. TESSIER: As a member of the APCD
10 advisory group, working group, and there haven't been any
11 meetings in recent months so I didn't miss anything while
12 I was out, but --

13 A FEMALE VOICE: They were waiting for you.

14 MR. TESSIER: -- do you know -- they're in
15 trouble. Do you know -- there was -- you just made
16 mention of talking with people in Colorado about hiring a
17 data warehouse vendor --

18 MR. COUNIHAN: Right.

19 MR. TESSIER: -- when last we left the
20 process there was an RFP that I think had gone out to hire
21 a data warehouse vendor and analytics and the whole thing.
22 I'm wondering if -- where the process was left and if you
23 are not aware, it's a good thing for you to follow up
24 with.

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1 MR. COUNIHAN: Yeah, I appreciate that Bob.
2 I have to say, I did meet with Jeanette, prior to this,
3 and with Bobby, and I was not -- that part wasn't made too
4 clear to me. So I need to revisit that with John Friedman
5 and Linda Green and find out where we are with that.

6 MS. VELTRI: And there's also the -- there
7 were draft -- there was a regulation --

8 MR. COUNIHAN: Yes.

9 MS. VELTRI: -- and there was a meeting and
10 there was a hearing on the reg --

11 MR. COUNIHAN: Yes. That's right. And
12 there were comments made about that as well.

13 MS. VELTRI: -- yeah. So I don't know
14 where that -- but a regulation has to go to the
15 legislature and the committee so I don't know where that
16 stands.

17 MR. COUNIHAN: Right. And I don't either
18 and so that's another follow-up item from the group.

19 CHAIRPERSON FOX: Okay. Any other
20 comments? Because I think we're ready to wrap. The next
21 meeting is scheduled for February 21st from 2:00 to 4:00,
22 venue to be determined, Amy will be working for the next
23 month to try to find a venue.

24 A FEMALE VOICE: You can always use our

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1 agency if we're stuck.

2 MR. COUNIHAN: Okay. That's good. Would
3 you like to have a -- should we have a working lunch next
4 time? Would that be helpful?

5 A FEMALE VOICE: That would be awesome.

6 MR. COUNIHAN: Yeah.

7 A FEMALE VOICE: If this is the attendance
8 we can certainly --

9 MR. TESSIER: You're saying working lunch
10 instead of 2:00 to 4:00?

11 MR. COUNIHAN: Well, I was just wondering,
12 since the Board -- I think we were going to coordinate it
13 with the Board meeting, right? Were we not?

14 CHAIRPERSON FOX: Yeah. But I have got --
15 I have one in between.

16 MR. COUNIHAN: Oh, you've got a conflict,
17 okay. All right. We're doing it 2:00 to 4:00 then.

18 CHAIRPERSON FOX: My calendar says we are
19 at the Lysan (phonetic) Building on the 21st for this
20 meeting of the capital --

21 MR. COUNIHAN: I think we were at 310,
22 aren't we? Do you know Amy?

23 CHAIRPERSON FOX: -- in the morning, but
24 the strategy says Lysan tentative.

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1 MR. COUNIHAN: Okay. That's easy to book.

2 (Discussion off the record)

3 MR. COUNIHAN: Okay. We'll do it at 2:00
4 and we'll clarify a location. Was this good? I mean, was
5 it helpful to have Tom here?

6 CHAIRPERSON FOX: Oh, absolutely.

7 MR. COUNIHAN: Okay.

8 CHAIRPERSON FOX: I think, you know, we
9 didn't talk about the format, but I think that's where we
10 intended with both looking at ad hoc committees and
11 getting external experts, you know, people who are
12 knowledgeable about a certain aspect of the system or who
13 may have some innovative work going on that we want to
14 really understand better and invite them in. You know, we
15 also didn't do public comment. Anybody in the audience
16 want to make any comments? Thank you for being here. All
17 right. So do we have anything we need to -- are we ready
18 to adjourn?

19 A MALE VOICE: So moved.

20 A MALE VOICE: Second.

21 CHAIRPERSON FOX: Moved and seconded. All
22 right. Thank you. We're adjourned.

23 (Whereupon, the meeting adjourned at 3:03
24 p.m.)