



Council on Medical Assistance Program Oversight

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Sen. Toni Harp Sen. Terry Gerratana Summary for December 14, 2012 at 9:30 AM in LOB Room 1E

Attendance:

Sen. Toni Harp, Rep. Nardello, Sen. Terry Gerratana, Sen. Joe Markley, Rep. Michelle Cook, Rep. Betsy Ritter, Kate McEvoy(DSS), Robert Zavoski(DSS), Judi Jordan(DSS), Peter Van Loon(Health Insurance Exchange), Grant Porte(Health Insurance Exchange), Bill Halsey, Uma Ganesan(DSS), Sylvia Kelly, Mag Morelli, Jennifer Hutchison, Joe Markley, Rep. Amy Gagliardi, Beth Cheney, Jesse White Fresse, Katherine Yacavone, Mary Alice Lee, Ellen Andrews, Debbie Poerio, Vicki Veltri, Kevin Counihan(Health Insurance Exchange), Bonita Grubbs, Carol Trapp, Steve McKinnon, Roderick Bremby(DSS), Mag Morelli, Cheryl Wamuo

The meeting began at 9:30 AM in LOB Room 1E on December 14, 2012. There were introductions of the committee members.

Kate McEvoy began the first DSS Presentation- Impacts of the Affordable Care Act in Connecticut. Last month DSS's presentation gave a context for the current Medicaid programs. She introduced the members of the CT Health Insurance Exchange. There is significant contribution and collaboration with the CT Health Insurance Exchange.

The presentation focused on the main question of CT Medicaid and Health Care Reform: Where are we going? Slide is an updated Snapshot of the Participation in Medicaid Program. DSS is a significant payer of Medicaid.

- Overall, Medicaid currently serves **611,128** beneficiaries (**20%** of the state population)
 - **425,933** HUSKY A adults and children
 - **96,608** HUSKY C older adults, blind individuals, individuals with disabilities and refugees
 - **86,503** HUSKY D low-income adults age 19-64
 - **2,084** limited benefit individuals (includes behavioral health for children served by DCF, tuberculosis services, and family planning services)

2014 Affordable Care Act Mandatory Provisions - Mandatory Primary Care Rate Increases

- Effective January 1, 2013, ACA requires states to increase Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rate for 2013 and 2014 (financed with 100% federal funding)
- Final federal rule issued November 2, 2012
- The increase in finance of 100% of Federal Cost.
 - services must be delivered by a physician who specializes in family medicine, general internal medicine, or pediatric medicine
 - certain physician subspecialists who are board certified in those specialties or provide primary care within the overall scope of those categories also qualify for the enhanced payment
 - higher payment will be made for primary care services rendered by practitioners (e.g. Advance Practice Registered Nurses, APRNs) working under the personal supervision of any qualifying physician
 - DSS do plan to implement the rate increases of the Quarter of January 2013- Retro to January 1, 2013. Implementation perspective working in the first Quarter of January 2013. DSS is working with Mercer. Next week they will be able quantify financial impact.
 - Sen. Harp questioned if this going to happen in January 2013 or January 2014 and if it was included in their budget.
 - DSS responded with yes it is included in their budget in 2013.
 - There was some clarification with the language of APRNs and Supervisory role.

2014 ACA Mandatory Provisions: Reduction in DSH Payments

- Effective October 1, 2013, ACA reduces states' Medicaid Disproportionate Share Hospital (DSH) allotments and requires CMS to develop a methodology for distributing the DSH reductions
 - This issues is still in process.

2014 ACA Optional Provisions: Medicaid Preventative Services

- Effective January 1, 2013, ACA provides a one percentage point increase in federal matching payments for preventive services in Medicaid for states that offer Medicaid coverage with no patient cost sharing for services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations
 - Federal Government is incenting states to provide preventative services under their state plans. This includes immunizations. DSS already covers the bulk of the preventative services.
- 2013 ACA Optional Provisions: Medicaid Preventative Services
- Connecticut already the bulk of the listed preventative services and will be seeking the enhanced federal match for these

Comments and Discussion

- Don't cover pro-biotic acid and do not cover folic vitamins. They don't cover because they are over the counter.

- Where are we going, 2014?
- 2014 ACA mandatory provisions:
 - Coverage
 - Plan requirements
 - Health exchange related activities: web site, Navigator program, integrated eligibility determination.
 - 2014 ACA optional provisions:
 - Eligibility expansion
- 2014 ACA Mandatory Provisions: Coverage
- **Effective January 1, 2014, ACA:** Requires U.S. citizens and legal residents to have qualifying health coverage (there is a phased-in tax penalty for those without coverage, with certain exemptions).
- Medicaid is qualifying health coverage.
- Provides refundable and advance able tax credits and cost sharing subsidies to eligible individuals.
- Premium subsidies are available to families with incomes between 133-400% of the federal poverty level to purchase insurance through the Exchanges.
- Cost sharing subsidies are available to those with incomes up to 250% of the poverty level.
- There will be anticipated financial need to gain coverage.
- Requires guarantee issue and renewability of health insurance regardless of health status and allows rating variation based only on age (limited to a 3 to 1 ratio), geographic area, family composition, and tobacco use (limited to 1.5 to 1 ratio) in the individual and the small group market and the Exchanges
- Prohibits annual limits on the dollar value of coverage.
- Age and Tobacco Use are limited.
- Prohibits annual limits to help those with chronic and serious conditions.
- Requires states to operate an Internet website that links the Exchange, Medicaid, and Children's Health Insurance Plan (CHIP) and permits individuals to compare available health subsidy programs and apply for or renew such coverage
- DSS is in active preparation for that.
- Requires CMS to develop a single, streamlined form (paper and online application) that states can use for all those applying on the basis of income to applicable State health subsidy programs (e.g. premium tax credits and cost-sharing reductions in the Exchange, Medicaid, CHIP, and state qualified basic health plans)
- They will be available in paper and online format.
- Requires state Exchanges to establish “Navigator” and “In-Person Assistor” supports to provide fair and impartial, culturally and linguistically appropriate information concerning enrollment in qualified health plans and available subsidies through the Exchange, facilitate enrollment in qualified health plans, and provide referrals for complaints.
- Assessment and Methodology: Effective January 1, 2014, ACA requires states to remove asset tests and to use *modified adjusted gross income (MAGI)* for purposes of Medicaid/CHIP eligibility determination for parents, pregnant women and other non-elderly adults as well as children.

- MAGI- Adjusted Gross Income and Household Composition it will simplify the eligibility process.
- Kristin Dowty (DSS) explained how they will operationalize this plan.
- A “no wrong door” approach to the citizen web portal that will provide access to Health Insurance Exchange services as well as to non-MAGI Medicaid, SNAP, and Temporary Assistance to Needy Families (TANF)-related services and data.
- A single shared eligibility service that will be used by both the Exchange and DSS to determine eligibility for Medicaid, CHIP, Advance Premium Tax Credits & Cost Sharing Reductions (APTC/CSR), as well as non-health public assistance programs such as SNAP and TANF.
- Integration of these services is a part of the modernization and a first part of the EMS system.
- 4 Tier Systems. See Slide 21
- Systems October 2013-Slide 22
- Reviewed Planned System-Slide 23

Discussion and Comments

- Kevin Counihan discussed the shop and compare eligibility. People in the process are important. The term no wrong door- needs to have the people where the consumers are. Health Insurance Exchange needs to get out in the community to engage. It is a process.
- Ellen Andrews questioned behind a no wrong door. Who is the person they talk to do they work for the exchange or do they work for DSS?
- Kevin responded they need to look at would be the best people speaking to them. Depends how they go- Call Center or go into DSS Office.
- Peter Van Loon recognized how they need to establish a navigator program. There needs to be more education. The brokers in the state are eager to participate.
- Mary Alice Lee asked when EMS would be replaced and modernized.
- Kristin Dowty said they would be fully replaced by 2015. MAGI Rules will be applied. Tier 1 goes soon. There will be a streamline application should be completed by the end of 2014.
- Sen. Harp asked who the staff is going to be handling the processes.
- Peter Van Loon responded they are in the process of working that out.
- Katherine Yacavone stressed the importance of having onsite people at the qualified health centers.
- Vicki Veltri commented about the vision of the streamline approach. It is a ground game to get people enrolled, tell them their rights. The final eligibility determination should be done by DSS.
- Beth Cheney APRN commented about how the struggle is to find PCP to take on these members.
- Kate McEvoy acknowledged these concerns. The PCMH strategies are important in these efforts. Examples of looking at scopes of practices. Extending care team. Example of Rhode Island and Private Payer increase. There is a challenge with Federal eligibility and there is opportunity with comment period and working with CMS.
- Senator Harp questioned about how legal residents and how does the Affordable Care Act impact those people. She asked how long it will take to make programmable changes.

- Commissioner Bremby responds with the existing system and the new system will be faster. The new systems will have back-up copies of the software. The changes will be made a lot quicker than they are today. He explained about the rules engine about changing codes (Programmatic changes).
- Question rose about cost-sharing reductions with the exchange.
- Cost sharing reductions is not applicable to Medicaid. Cost Sharing Reduction applies to cost sharing to a product you would purchase.
- Sen. Harp asked about if there would be any change in coverage in Medicaid. She asked what the elements they are considering are and who is looking at this.
- Kate McEvoy commented how it is still be determined and they are still covering to 185% above the poverty level.
- Kevin Counihan commented about the decision making options and the financial impact of those options. Much of this discussion is being driven by Office of Policy and Management.

2014 Affordable Care Act Optional Provisions: Medicaid

- Effective January 1, 2014, ACA as enacted required states to expand Medicaid to all individuals **not eligible for Medicare under age 65** (children, pregnant women, parents, and adults without dependent children) **with incomes up to 133% FPL**
- Note that **Connecticut currently meets or exceeds this requirement** through HUSKY A and B for all of these groups with the exception of childless adults
- Childless adults age 19-64 are currently covered under HUSKY D (the Medicaid for **Low-Income Adults (MLIA) program**) **up to an income limit of 55% of FPL* 86,503 beneficiaries are currently being served by MLI** * for regions B & C; 67% of FPL for region A
- This expansion in coverage will be associated with **enhanced federal match funds**:
- Significant incentive for states to match.
- 100% match for calendar years 2014 through 2016
- 95% match for calendar year 2017
- 94% match for calendar year 2018
- 93% match for calendar year 2019
- **On June 28, 2012, the Supreme Court issued** 90% match for calendar years 2020 and ongoing a decision in a challenge to the constitutionality of the ACA: National Federation of Independent Business, et al v. Sebelius, Secretary of Health and Human Services, et al
- The Court: generally upheld the constitutionality of the law with respect to the mandate that States expand Medicaid coverage as described above held: that while Congress acted constitutionally in offering federal match funds to states to expand coverage
- the provision that requires states to either expand coverage of forego all federal match funds for their Medicaid programs exceeded Congress' scope of authority under the Spending Clause of the Constitution but, that this can be corrected by narrowly tailoring the expansion requirement to give states two options: to accept federal match funds for expansion in compliance with the conditions associated with those funds; or to refuse federal match funds for expansion and continue to operate their Medicaid programs as they do currently
- **How many individuals are likely to be eligible under the expansion?**

- **approximately 129,786 uninsured Connecticut residents have incomes of less than 139% FPL** (note that the 86,503 MLIA beneficiaries are a subset of this figure)/ [Kaiser Commission on Key Facts: How Will the Medicaid Expansion for Adults Impact Eligibility and Coverage, July 2012]
- Katherine Yacavone comments about the waiver and reinstatement.
- Kate McEvoy comments about those who have lost coverage and who will be given reinstatement after the date.
- Vicki Veltri commented about legal immigrants can get subsidies on the exchange. There are subsidies available for certain groups of legal immigrants.
- Mary Alice Lee commented about the estimated amount of uninsured coming into Medicaid.
- Sen. Harp commented about projecting higher because of prior experience with LIA.

2014 Affordable Care Act Optional Provisions: Medicaid Expansion/Exchange "Messaging"

- A recent study funded by the **Robert Wood Johnson** polled a representative sample of individuals age 19-64 to yield information on public perceptions of Medicaid and recommendations for how to “message” expansion of eligibility and the Exchange.
- best “testing” description:
 - *Medicaid provides long-term care to millions of seniors, covers important services that help Americans with disabilities live independently and enables millions of children to see a doctor.* note who is not referenced
- Medicaid is viewed as a good program. It is viewed positively. There is high interest in enrolling in Medicaid but much of the expansion-eligible **population doubts that they would ever be eligible for Medicaid** and is **unaware of new income guidelines**
- Most people want health insurance to: be able to stay healthy (resonates more with women) and protect themselves from medical bills when the unexpected happens (resonates more with men).
- The concern: There is worry that people with Medicaid are not treated well (Same by providers compared with people with private insurers).
- **“low-cost or free”** is the best way to describe health insurance through Medicaid
- The value: outreach should also mention covered services such as preventative care check-ups (especially for Children), hospital coverage and coverage for prescription drugs
- **the Exchange** is appealing to this population
- favorite aspects of the Exchange model include: low-cost or free plans, ability to search for and compare plans, and **availability of customer assistance**
- people want help using the Exchange – help is a key feature
- the most popular enrollment location is **from the convenience of home**, with the option for using **call-in customer assistance**
- **people do not like the idea of retail kiosks** – “it’s not private”
- **Privacy is main concern and bringing documents outside the home.** Data helps us decide what types of systems that should be discussed.
- **Dr. Geerstma** commented about something discussed in the quality assurance committee. The importance of Primary Care to adults.

2014 ACA Optional Provisions: Means of Serving Certain Medicaid Eligible Individuals under Exchange

- Additionally, the Exchange will provide opportunities for alternative coverage of parents who are currently enrolled in Medicaid.
- Grant Porter discussed his history with Medicaid and Exchange. Affordable Care Act provides assistance to individuals who otherwise couldn't afford health care. Landscape will be would be changing and the changing in benefits.

Advance Premium Tax Credits

- Based on cost of second lowest costing Silver plan, the maximum premium contribution for households with annual income between 138% and 185% of the federal poverty line will be held **constant** between 3.4 and 5.6% of their income.
- For an **Individual**: Assuming a \$350 plan, the value of the premium subsidy will between \$305 to \$230 per month for an individual
- For a **Couple**: Assuming a \$700 plan, the value of the premium subsidy will between \$640 and \$535 per month for a couple
- Katherine Yacavone questioned if the benefits of the tiered plan, the relationship between the Husky A and the Tax Credits and the benefits.
- Medicaid benefits are not part of the essential health benefits including dental, vision and NEMT. They are sold dental separately. It is a federal requirement to separate the other benefits to essential health benefits.
- Conversation about tax benefits for people that don't many taxes.
- Mary Alice Lee commented about levels of Medicaid coverage for pregnant women to 250%. Under the Affordable Care Act we can't cut them back to 138%.
- Premium tax credits that lower the cost of coverage
- As the Affordable Care Act is written there will be an out of pocket expense for that premium.

Cost Sharing Reductions

- In addition to Advanced Premium Tax Credits, this population would be eligible for **significant** cost sharing reductions.
- These reductions in typical out-of-pocket ("OOP") expenditures effectively increase the actuarial value of the Silver plan, thereby lowering the overall cost of coverage.
- between 138 and 150% of FPL, the AV of the Silver would increase to 94% (holding premium constant)
- between 150 and 185% of FPL, the AV of the Silver would increase to 87% (holding premium constant)
- These savings will go directly to the carriers. There are copays allowed for preventative services. There are additional cost savings allowed for these individuals.
- further, the maximum OOP limit would be reduced by 2/3rd:
- for an individual parent, from \$6,250 to \$2,250;
- for a couple, from \$12,500 to \$4,500
- These decisions have not been made yet by the legislature.
- As long as the state has the coverage group stays the same, no one will get pushed out of Medicaid.

- Dr. Geerstma commented on what is a simple description of the benefits getting back to these cost-savings.
- Can Medicaid act as a wraparound to the exchange? Answer: If the individual qualifies for Medicaid they won't be able to get the premium credits.
- Sen. Harp commented about the high cost of living. The way we measure affordability has to be different. The committee would like to see a side by side comparison of the programs.

Comprehensive Benefits

- The essential health benefits package will be equal to the scope of benefits under a typical employer-based plan.
- Medicaid benefits not part of Essential Health Benefits include: adult vision (EHB includes coverage for vision screening only), adult dental, non-Emergency Room transportation
- **Dental Benefits:** Essential Health Benefit includes comprehensive dental coverage for children under age 19
- The Exchange will be offering stand-alone dental options for adults.
- Early estimates on cost for a routine adult dental plan that provided coverage for preventive and diagnostic services, basic restorations, and extractions, but no major services, would be \$27-29 PMPM
- A more comprehensive plan comparable to CHIP in its scope of benefits would cost in the low \$40 PMPM

Network Adequacy

- **Network Standards for Exchange products:**
- Health plans sold through the Exchange must have a provider network that include 75% of all essential community providers, including 90% of all federal qualified health centers.
- In general, enrollees in Exchange products will have a higher level of access to health professionals and then they would in Medicaid.
- Supporting research:
- 2011 national survey of physicians: 31 percent of physicians were unwilling to accept any new Medicaid patients, compared to 18 percent of physicians who would not accept new privately insured patients. In Connecticut **nearly 40 percent of physicians would not accept new Medicaid patients.** ([Health Affairs, August 2012](#))
- 2012 Illinois-based study in which individuals, posing as mothers of children with common medical conditions requiring specialty care, called outpatient clinics asking for doctors' appointments: 68% of those representing themselves as Medicaid/CHIP enrollees were denied an appointment, compared to only 11 percent of those saying they had private insurance—a **ratio of 6 to 1.** ([New England Journal of Medicine, August 2012](#))
- Another study, using the same methodology, surveyed the ability of mothers to obtain urgent dentists' appointments for their kids: 63.5% of Medicaid/CHIP enrollees could not get an appointment, compared to a 4.6% rejection rate for those with private insurance—a **ratio of 14 to 1.** ([Pediatrics, June 2012](#))
- **And, planning ahead . . .**

Planning Ahead: Connecticut State Innovation Model (SIM) Application

How the State is proposing a Comprehensive plan for healthcare reform.

- Under the leadership of the Office of Health Care Reform and Innovation (OHRI), DSS joined a broad range of state agency partners and other stakeholders in mutually drafting an application seeking funding from CMS for formal health care reform planning efforts
- This application was submitted in September, 2012. Expect to have decisions of that application next week.
- The application acknowledges the many examples of state agency health care reform work that are already in evidence and seeks to map an overall agenda
- In support of enhancement of primary, preventative care:
- PCMH same measures of health outcomes and client satisfaction. Same type of performance incentive payments.
- DSS and Office of the State Comptroller PCMH
- EHR funding
- **In support of integration of care across disciplines:** Co-location of Medicaid medical Administrative Services Organization (CHN-CT) with the behavioral health ASO (Value Options)
- Substance Abuse and Mental Health Services Administration (SAMHSA)/Department of Mental Health and Addiction Services (DMHAS) funded primary care/behavioral health integration pilots
- The Duals demonstration is a collaborate effort.
- In support of efforts toward multi-payer approaches: use of shared performance metrics and payment strategies in the DSS and OSC PCMH initiatives
- In support of engagement of consumers in informed decision-making: Office of the Healthcare Advocate, CHOICES/Aging & Disability Resource Centers
 - Older adults with those with disabilities to inform them about coverage.
- Move away from fee for service and paying for outcomes.
- In support of efforts to positively influence health care consumer behavior:
 - OSC Health Enhancement Program - Requirements for Primary Care
 - DSS Rewards to Quit and ASO chronic disease self-management education- Care Coordination tool. Incentives to promote good behavior.
 - DPH Community Transformation Grant and promotion of Healthy People 2020- Application with CTG with rural areas in CT.

In conclusion . . .

- Connecticut Medicaid is already utilizing **diverse strategies to** support use of primary preventative care, integration of care, and rebalancing of long-term services and supports
- In collaboration with a broad range of state agency partners, DSS is partnering to plan for both mandatory and optional aspects of ACA implementation.
- Efforts are cross agency.
- Preparing to meaningfully implement health care reform. Most aspects are mandatory. Thanks the group.
- Sen. Harp thanked DSS for the comprehensive report.

- Mary Alice Lee comments about the other option and the creation of the basic health plan in CT.
- There is a basic health plan workgroup that meets to discuss the pros and cons. The US Health and Human Service won't give out regulation to rules. This makes it challenging for states to evaluate.
- Vicki Veltri commented on the membership of the Basic Health Plan Workgroup. The group has been charged to determine recommendations on what to do.
- Dr. Geerstma commented about the State Innovation Grant on how to address Quality Improvement and Federal Government help.
- Sen. Harp commented on how the State has many mandates and how it can impact the different health plans of the exchange. How does the impact the cost of the silver plan?
- Peter Van Loon commented on he's heard comments from business owners on how the state mandates are increasing the cost for insurance.
- Vicki Veltri commented on the difference between administrative and benefits mandates. She made comments about the fiscal implications.
- Rep. Nardello asked Health Insurance Exchange plans are going to be less expensive that what people can buy in the private market. How will the overlap work with Health Insurance Exchange Staff and the DSS Staff?
- Peter Van Loon commented on how they need to private affordable care and the Health Insurance Exchange is also responsible to the Insurance Department. The Health Insurance Exchange must also look at innovative ways to lessen the cost and provide quality health care. Peter Van Loon commented on how the integrated eligibility system and have a seamless transaction with DSS. There needs to be outreach done with the Health Insurance Exchange and Navigator Staff.
- Victoria Veltri commented on how you can add value to the market.
- Katherine Yacavone asked the status of the redetermination and eligibility issues.
- Rev. Grubbs recommended that DSS give regular updates to the council about the health care status on the exchange.
- Sen. Gerratana asked how much the state has received from the federal government for the Exchange.
- The State has received a 131 Million Dollar Grant and to the Exchange directly is 107 Million.
- Sen. Harp said she is looking forward to the implementation. It is a good idea to have people from the exchange at the meeting.
- Commissioner Bremby made a report about a review and investigation about documents. The documents were found in boxes. The documents in the box found were voter registration assistance requests. There wasn't urgency of office management. The management in the Hartford Office has been placed on Administrative Leave. There is an interim set of results- the documents at the Hartford office have been processed. The review team found partially processed and unprocessed documents in the group. The documents have all been processed to date. The documents processed have been dated back to 2009. DSS is collaborating with Secretary of State's office with the voter registration. DSS have received support from the Malloy Administration. Updating review process and technology. The situation at the Hartford Office is serious. The situation has been stabilized. Special review will result in maintenance and service. They

expect to complete their review by the end of January. DSS has sent the Quality Assurance team to all the offices. The condition has been stabilized.

- Katherine Yacavone asked about the other offices. They have noticed a decrease of members coming through the system. Is there a plan for eligibility workers could be available at new health centers?
- Bremby spoke about the eligibility process changing. The way the process has changed and can no longer do a case- base system instead a task- based system. The process we need to work towards is same-day. Most people who come to the office want to know the status of their application. The Modernization piece will help that process. He explained the phone system. The phone system will be updated through Modernization. DSS is moving quickly. DSS is in month 13 of 18 the Modernization process. DSS is on their way to transition the agency from that advantage point.
- Ellen Andrews commented about how people were denied there right to vote and how DSS is handling that.
- Bremby commented on communication piece. One of the employees notified the commissioner's office about the voter registration cards. DSS has communicated to their entire management that they process and there is no excuse for delay in that process. There is a focus on a broader look on all the offices. It a complete investigation for the Hartford office.
- Sen. Harp commented on how the Quality Assurance Group to go to the offices. There will be a system of monitoring and review that might capture these types of problems.
- Commissioner Bremby commented on how they will be able to track every piece of information that comes into the office with the new technology. DSS will be able to tell by data on how well they're doing.
- Sen. Harp asked if the allotment hold backs impeding there advancement in technology. Is our fiscal situation as a state is stopping the DSS from moving forward.
- Commissioner commented on how it is the time to get the processes on the ground. At the time they have enough resources for the time being. DSS needs time and patience towards the staff. DSS has dedicated staff. DSS needs a better system to bring that system so we can serve the residents of the state. The need the tools and time to get it done.
- Sen. Harp commented on how they do need to provide professional services to these citizens.
- Sen Harp thanked DSS for the presentation and thanked everyone for their professional commitment to their population. DSS has the same goals we share.
- Steve McKinnon will be presenting next month on the enrollment report.
- Mary Alice Lee asked to see the December enrollment report with the increase in premiums.
- Kate McEvoy commented on the impact of the premium increase after January.
- Sen. Harp ended the meeting at 12:00 PM.

Next meeting will be held on January 11, 2012 at 9:30 AM in LOB Room 1E