HEALTHCARE COST
CONTAINMENT COMMITTEE

165 Capitol Ave
HARTORD, CONNECTICUT
06106-1775
Telephone (860) 702-3480
Facsimile (860) 702-3556

STATE OF CONNECTICUT
HEALTHCARE POLICY & BENEFIT SERVICES DIVISION
OFFICE OF THE STATE COMPTROLLER

HEALTHCARE COST CONTAINMENT COMMITTEE MEETING MINUTES
November 10, 2025

Meeting Called to Order by **Josh Wojcik.**

Attendance:

Labor	State Comptroller Administrative Staff
Carl Chisem – CEUI	
Logan Place – SEBAC	Thomas Woodruff
	Josh Wojcik
	Presenters
	Bernie Slowik – OSC
	Rae-Ellen Roy - OSC
Management	Betsy Nosal -OSC
Gregory Messner	
Karen Nolen	
	Consultants
Dept. of Insurance	Terry DeMattie, Segal
Paul Lombardo	

Public Comment:

No public comment.

Financials:

Our projected appropriation balance for the active appropriation shows a deficit of approximately $46 million, which is slightly better than the deficit reported in last month's review. This improvement is primarily due to changes in the enrolled population over the past month.

Currently, we have a deficit of approximately $46 million regarding healthcare FAD accounts, which act as our checking accounts for making claims and premium payments. We are holding a surplus of about $28 million within the medical health FAD. The claim payments are stabilizing, indicating some improvement in this area.

However, on the other hand, the prescription FAD account for active employees shows a deficit of about $42.5 million. We are experiencing a significant increase in both the number of claims and the costs associated with those claims, resulting in an overall FAD balance showing a deficit of approximately $14.5 million. These values will need to be factored into next year's rates to recoup funds and build a reserve.

Regarding the retiree health appropriations, we are reporting a deficit of about $35 million, which aligns with our expectations at the beginning of the fiscal year. In the healthcare OPEB FAD accounts, the retiree health medical account, which covers premium and claim payments, shows a surplus of approximately $113.7 million, while the pharmacy account has a deficit of approximately $1.2 million. We are also seeing significantly higher claims on the prescription side for retirees.

You may recall that we previously had a large surplus in the retiree health OPEB FAD account; however, we are now spending that down. This spend-down is reflected in the appropriation deficit mentioned earlier, so the deficit could be significantly worse without it. Overall, the combined FAD balances for retirees indicate an overall surplus of approximately $112.4 million.

Partnership:

As of November 1st, we have enrolled 187 groups in Partnership 2.0, totaling approximately 29,000 employees and just over 67,000 members.

We have one confirmed group joining on November 1st, and we have also scheduled quarterly partnership update meetings for existing groups. These meetings are set for November 19th at 2:00 PM and November 21st at 9:00 AM.

During these meetings, we plan to provide the projected rate renewal range. While we don’t have that information yet, we will supply this projection to the committee before the meetings, most likely at the beginning of next week.

In Partnership 1.0, we still have four groups remaining, totaling approximately 2,300 employees and 3,000 members.

High-Level Utilization:

There are a few key points to highlight regarding the current trends. We are now at a trend rate of 9.4%, which has fallen into single digits, indicating a somewhat positive change.

The most significant shift is observed in inpatient facilities, which had been well into double digits for most of last year. Currently, the trend for inpatient facilities is around 5%.

On the other hand, outpatient services have consistently maintained high trends over the past several years. Additionally, we are seeing a significant increase in professional services. Some of this increase can be attributed to the medical pharmacy component that is being included within professional services.

In terms of pharmacy trends, we continue to experience double-digit increases at 13.7%. This surge is primarily driven by specialty drugs, particularly anti-inflammatories, which we discussed as major contributors last month. We are optimistic that there may be potential solutions and relief on the pharmacy side.

It is also important to note that we have a PMPM cost guarantee with CVS. We have received our first projection from them regarding this guarantee after the first quarter, and, as expected, the numbers are slightly above the PMPM guarantee. This indicates that CVS will need to reimburse the state dollar for dollar, up to a maximum amount. As of now, we do not anticipate reaching the maximum amount, but we will continue to monitor the situation as we progress through the year. Fortunately, any incremental increases will fall under that guarantee and will not result in additional costs to the state.

Communications Update:

In October, we conducted the well-being condition seminars with a strong focus on the Supplemental Benefits Open Enrollment. We sent out two reminders via email during the month, which resulted in higher open rates, particularly for personal emails. This trend is common during medical open enrollment.

Additionally, we targeted emails to our Flyte participants. This year, we collaborated with our administrator for the Flexible Spending Accounts to offer a program fee option that allows the Med Flex program to be used for payment. This initiative also had a notable impact.

Regarding the firefighter screenings I mentioned last month, they targeted a small group but had significant engagement, reflected in the open rates. I'm not concerned about the click rates since the screening administrator is actively following up with the lieutenants at the fire stations to coordinate the setup of the mobile unit.

Overall, our efforts aimed to raise awareness and provide education, successfully reaching a large portion of our target audience.

Flexible Spending Accounts:

At the end of 2025, we had just over 8,000 employees enrolled in the four flexible spending account programs. While transportation and parking are often grouped, they are considered separate programs based on individual needs.

The great news is that during the post-open enrollment period, enrollment has increased to nearly 9,000 employees. We are currently processing incoming applications internally, with some coming

in every day, typically one or two at a time. We expect to complete this process by the end of this week, while monitoring any special situations or needs that may arise.

This year, we successfully introduced a paper application option, encouraging more people to utilize online enrollment. Last year, we received over 500 applications that needed to be processed manually, whereas this year, the number is significantly lower. We had a very small number of individuals who required paper applications, but most were able to complete their enrollment online.

The accounts continue to be heavily used, with the Med Flex account being the most popular, followed by dependent care, and then transportation and parking. We saw nearly 300 employees add a new plan this year, many of whom were already enrolled in other accounts. This indicates that more employees are learning about and taking advantage of these plans.

We also improved our communications this year. For each account a person enrolls in, they receive a separate confirmation email to ensure they are enrolling in the correct amounts and accounts. Additionally, we send a monthly email regarding account deposits or changes in claims, as well as a quarterly statement.

New this year, we have implemented a mailed statement for those who may not regularly check their emails or whose emails may end up in junk folders. This statement serves as an annual reminder that everyone needs to re-enroll for the new year, even if they are already in a current program. It also informs them about changes and what they can carry over.

We've noticed some confusion regarding parking and transportation, with some individuals enrolling in both accounts. To address this, we plan to send out a communication to those enrolled in both accounts, ensuring they truly want both. This should reduce administrative confusion and minimize incorrect enrollments.

DEVA Audit Update:

So far, a total of 149 active dependents and 58 retiree dependents have been confirmed for removal. Most of these removals involve children who are double-covered under their spouse's insurance, as well as cases involving divorces and a few notified deaths.

Removing these dependents has resulted in a recovery of nearly $230,000 in general fund appropriations, which translates to approximately $1,000,000 in annual savings for the General Fund, based on the limited number of dependents removed to date.

We are currently communicating with our members to confirm and verify the eligibility of their dependents. As a reminder, we have split this process into four waves based on last names, with Wave 1 covering last names that begin with letters A through D. All employees and retirees in Wave 1 have received three communications informing them of their ongoing non-compliance and explaining how to respond and provide verification.

Wave 1 has reached the end of its grace period, so we have the most information about this group. Our office has received two files to date from PDA, the group conducting the audit. For Wave 1 participants, we reviewed the list of children marked as unverified and shared that information with the active agencies. For retirees, our team reviewed all available files to gather the necessary documentation to ensure continued coverage for those children.

To date, there were 2,020 active children needing verification from Wave 1, and we successfully verified 621 of them. On the retiree side, we had 403 children needing verification and were able to confirm 114 of them, significantly reducing the number still in need of documentation. PDA continues to receive verification documentation from this group daily, which is gradually reducing the numbers.

We have also received the file for Wave 2 and shared it with the relevant agencies, although we have not yet received all the required documents back. In Wave 2, there are 2,100 children and 417 retiree children who require verification.

Additionally, there are still about 1,200 households with approximately 600 spouses who need to be verified. We were unable to confirm the spouses' status through agency documentation, as we requested that they provide current information, such as tax documents or utility bills, to verify that they are still married and eligible for coverage.

We have compiled a list from PDA of individuals who are still non-compliant as of the end of this weekend. Our goal is to associate Union coding with these individuals and provide you with lists organized by Union of those who have not yet responded.

Upon reviewing the data for Waves 1 and 2, it appears that individuals who tend not to have regular computer access are those who have not responded during the initial review. Still, I must commend their agencies for returning with documentation.

Specifically, we saw a high non-compliance rate for child verifications. However, on Friday, DOC managed to provide close to 400 child verifications. One party currently lacking in response is UConn. We would greatly appreciate assistance in reaching out to those members through their bargaining representatives, reminding them of the importance of completing this verification.

Our next step will be to present to you next month the list of individuals who have not submitted any documentation across all waves. Additionally, we will show the results of our verification process, based on the documents currently available. This is to inform those members that, unless we receive the required documentation by February 1st, their dependents will not continue to receive coverage as of that date.

As of early Friday, the compliance for Group 1 (A through D) was at 87%. This figure does not include approximately 600 documents that we recently sent over, so the compliance rate should reach close to 90% by the end of today.

Group 2 (E through K), which we have just sent information to the agencies about, is currently at around 85% compliance. Groups 3 and 4 are still submitting their information to PDA as they near their due dates. Group 3 is at approximately 84% compliance, while Group 4 stands at about 80%. We are continuing to see these numbers rise.

***Question**: I have a question regarding next month. Are we going to separate the people who are still unverified into two groups: those who have not submitted anything, and those who submitted something that we deemed inadequate?*

***Answer:** The reports we're receiving from PDA are very detailed, which is extremely helpful for us. These reports indicate whether individuals have created a portal, showing that they have at least started to engage with the system, or if they have done nothing at all.*

Additionally, the reports provide information on all the communications and outreach efforts PDA has made with these individuals. Also, PDA has conducted outbound phone calls to every person for whom we have a phone number on file. While their connection rate isn't very high, they are making the effort to reach out and leave voicemails as reminders.

In summary, the report details every call that was made, every email sent, and the level of effort put forth for each individual.

Lyra Health:

Lyra Health has launched. This is our newest point solution, designed to enhance access to mental and behavioral health services for all our members.

What is Lyra? It provides a variety of support services, including coaching, wellness coaching, therapy appointments, group discussions, workshops, and medication management. We are excited to share that Lyra covers 100% of costs, with zero copay for members. This information is being communicated through both in-person and virtual appointments, allowing individuals to schedule their appointments within the first three days, if not sooner, by accessing their portal.

Additionally, members have access to 24/7 care navigators, which is a significant asset. They are also able to tap into a digital self-care library that offers meditations and other helpful tools. Lyra services are available to all family members, including spouses and children, and complement the existing Anthem Mental Health Network.

In the initial days following the launch of Lyra, we saw impressive engagement. A comptroller email was shared with the representatives on this call, and we have been distributing information to mailboxes this week. An all-user email, containing more details about the care, treatment options, and workshops via Care Compass, will also be sent out soon.

In just the first few days, 534 individuals registered for Lyra, with 294 actively searching for care, and 8 new appointments scheduled. We anticipate these numbers will continue to grow. The service is available to our non-Medicare retirees across various states, including Florida, California, Colorado, and the Northeast.

Overall, we are successfully delivering care within three days, and we expect significant growth moving forward. The expansive network of providers and the quick availability of care are key benefits of this initiative.

Lastly, the comptroller letter will be distributed, and emails about workshops have already been sent out in addition to our other wellness and chronic condition resources. We have now incorporated Lyra workshops, providing even more opportunities for well-being and connecting the Lyra Health brand to mental health care so that members will recognize and reach out for support.

Vendor Survey:

We periodically survey our members to gauge their satisfaction with their benefits and to gather feedback on specific vendors involved in our programs. We recently completed this process, which took place throughout September and early October. We received approximately 4,000 completed responses, in addition to around 800 partial responses, resulting in a total of about 5,000 members participating in the survey. To give you some context, this survey was distributed to both active members and pre-65 retirees, as well as to our partners. We offered multiple emails and opportunities for members to access and participate in the survey.

Moving on to the global question: How do you feel about the benefits available through the state's health plan? The good news is that most respondents reported being either very satisfied or satisfied with their benefits, totaling around 88%. There were very few who expressed being very dissatisfied, with only a small number reporting dissatisfaction overall.

We asked a Net Promoter Score question regarding all of our vendors. The Net Promoter Score is a standardized metric used across various industries to understand how members feel about different vendors. The question asks, "Would you recommend this vendor or service to a friend or colleague?" Responses are scored on a scale of 1 to 10, with 10 signifying a strong recommendation and 1 indicating a strong disapproval. Those who score 9 or 10 are categorized as promoters, 7 or 8 as passive, and 0 to 6 as detractors.

According to our findings, Flyte received the highest number of promoters. Other programs, such as Provider of Distinction, also received positive scores. Generally, niche programs tend to score better than larger benefit administration scenarios, which received lower ratings. Quantum Health performed the best among our global administrators.

It is also worth noting that Virta Health stands out because it offers two distinct programs. We need to break this down for clarity in future assessments. One program is a diabetes reversal program that received overwhelmingly positive feedback, whereas their diabetes management program, which focuses more on monitoring, scored less favorably. Therefore, it is important to recognize that these are two different offerings, with one performing significantly better than the other.

We inquired about response times: specifically, how long it took to receive a reply. Most respondents indicated that they received a response within two business days for nearly all inquiries. However, there are notable differences in immediate responses, particularly among those measured for Cigna and Quantum performance.

Immediate responses were given more frequently, while some of our virtual providers tended to respond the next day. Hinge and Virta, for instance, demonstrated a lower immediate response rate but performed better after one business day.

Overall, it appears that there is typically a one-day delay in response time for these providers.

We have a variety of questions focused on Quantum's services. The first question is: Why have you logged into the benefits portal in the MyQ Health app? As expected, the primary reason for logging in is to check HEP status. Other common reasons include checking benefit information, searching for healthcare providers, and contacting a Quantum care coordinator. Notably, checking HEP status drives the majority of traffic through the portal.

We included write-in responses throughout the process. While these responses provide some insight, they represent a very small percentage of the total feedback. Out of 5,000 participants, only 148 provided write-in responses. We are summarizing types of statements here, but it's important not to read too much into these individual comments. The overall customer experience and Net Promoter Score are more significant metrics.

With that in mind, here are some common write-in responses: Users mentioned needing help to resolve issues related to claims, explanations of benefits, billing, and verifying correct information. Others reported seeking assistance with finding providers and confirming network status, as well as help with technical issues.

We asked how easy it is to find network providers using the provider lookup tool in the benefits portal. The good news is that most users find it easy or very easy to do so. However, we would like to encourage more users to categorize their experience as "very easy." While the overall feedback is positive, a reasonable number of respondents still find the tool hard or very hard to use.

We included comments from those who rated their experience as easy or very easy. A larger percentage, 72%, responded positively here. Those with a good experience noted that the tool is intuitive, straightforward, and easy to navigate. They appreciated the ability to search using multiple criteria, and they found the provider search to be fast, with extensive and clearly marked lists.
A total of 28% of respondents who found the process hard or very hard reported issues such as incorrect contact details and network status. We recognize that this is a problem and acknowledge it as an ongoing challenge to keep those lists up to date. We continuously work on this in collaboration with Anthem.

Users have expressed that the search interface is confusing, as they perceive it to have limited filter options and poor sorting capabilities. Many would like to narrow results more easily by

specialty. Additionally, they found the interface to be user-unfriendly, with cumbersome navigation, frequent glitches, and confusing layouts. Many users specifically noted a lack of local providers, particularly dentists and specialists, who are in-network and accepting new patients.

We received requests for improved dental and vision coverage, which is a consistent theme across multiple surveys. While we understand our health benefits are generally more comprehensive than those of many other entities, our dental and vision benefits are not as robust as those of certain comparative entities, and we regularly receive this feedback.

Concerns about rising costs and affordability have also been expressed. There is frustration regarding increasing premiums, co-pays, and out-of-pocket expenses, which is understandable given that our last plan year saw a higher-than-average premium increase and the addition of cost-sharing on some items.

Furthermore, there is a desire for more provider choices and network expansion. Despite this, there is appreciation for the comprehensive medical coverage we provide.

Lastly, there are calls for simpler communication and program navigation. This remains a challenge; we strive to offer all appropriate benefits that meet our members' needs while communicating them in a clear and understandable manner. To address this, we have centralized resources under Care Compass to make access easier. Nonetheless, we recognize that this continues to be an ongoing challenge.

We asked participants about their customer service experience with Quantum's care coordinators, specifically if there was anything else they'd like to share.

Many reported experiencing long wait times and poor follow-up, leading to frustration with extended hold times when calling. In August, we experienced higher wait times than we had historically, and the survey was conducted shortly after that. As a result, we expect to hear about these issues in the feedback.

We have pushed Quantum to address these concerns, and they have significantly expanded their resources to support our account during high-demand periods better. There is hope for improvement in this area.

However, some participants mentioned receiving inconsistent or inaccurate information, as well as conflicting answers from different coordinators. Despite these frustrations, staff were described as friendly, helpful, polite, knowledgeable, and empathetic. Yet, there were concerns about the limited empowerment and effectiveness of coordinators, who are often unable to resolve complex issues and tend to act as intermediaries rather than decision-makers. This point is crucial for our current procurement of these services, and there are opportunities for improvement that we should explore.

Several respondents also noted challenges with systems and processes, including issues with the portal and glitches that made it difficult to access information about benefits or compliance. An

updated portal is scheduled for release in January, and we hope it will address many of these underlying issues.

We inquired about the resources that help participants and their dependents stay informed about the annual HEP requirements. The survey revealed that the most commonly used resources, which were not surprising, included letters, emails, and the annually mailed chart. Notably, the benefits portal scored the highest in terms of usefulness, suggesting that members actively utilize it to access their health information.

In the write-in responses, members mentioned using physical letters, calling Quantum directly, emails, and the online portal, as well as being informed by their doctors, care coordinators, or primary care providers about necessary screenings and requirements.

Participants also shared their thoughts on accessing and tracking compliance for family members, noting that this can be challenging with the current portal. Specifically for spouses, permissions must be granted, and we hope to simplify this process moving forward. Issues around system accuracy and updates were also mentioned, highlighting the delay between claims being filed and when bills are paid, processed, and updated in the portal.

Concerns were raised about the mandatory requirements of the HEP, which some participants feel are too rigid and don't always align with individual health needs. Scheduling appointments and meeting deadlines were also challenges reported by respondents.

Views on the program's value and incentives were mixed: some participants appreciated the reminders and focus on preventive care, while others questioned the program's effectiveness and fairness. Suggestions for improvement included offering more incentives for compliance, providing clear communication, and allowing greater flexibility for those with chronic conditions or special circumstances.

We also inquired about the Provider of Distinction program. Are you aware that this program offers incentives to plan members, such as gift cards and checks, for using designated providers for specific procedures? Unfortunately, the results were not favorable; 47% of respondents said yes, while 53% said no. This has been an ongoing challenge since the program's launch; we are struggling to help members understand its existence. With a better baseline knowledge, we hope they will engage more and choose providers based on their designation.
Currently, less than 50% of members are aware that the program exists.

We looked at how individuals heard about the program. The majority learned of it through Care Compass marketing, which includes our emails and letters. The second-largest group discovered it when they received an incentive check. Others mentioned they heard about it from friends or colleagues, which is a significant point.

18% of respondents said they were aware that they had used a provider of distinction, while 40% said no or didn't think they had. Interestingly, 42% were unsure, which suggests that a significant portion of the population is unaware of the program.

Would you consider using a provider of distinction in the future if you needed a procedure that could earn an incentive? The results showed that 52% said yes, 40% said they were not sure, and 8% said no.

Did you choose a provider because they were a provider of distinction? Among those who responded affirmatively, 209 people said yes. Out of these, 125 indicated that they knew their provider was a provider of distinction but were unaware that they would receive a monetary incentive. The majority, however, were not aware that they were choosing a provider of distinction or that they would receive a monetary incentive.

Do you like the idea of earning a monetary incentive for seeing a provider that meets the highest patient care standards for specific procedures and conditions? Of those surveyed, 64% said yes, they liked that idea. Additionally, 24% were unsure, and 12% responded 'no'. This indicates that the majority are in favor of the concept of the program.

Is there anything else you would like to share about the providers of distinction program? Respondents expressed confusion and a lack of information regarding how the program works, including eligibility requirements and how providers are selected.

There is a desire for clear communication, with respondents requesting more detailed explanations and easier access to information about the program and its benefits. Many people prefer to choose their healthcare providers based on trust, reputation, and personal relationships, rather than switching solely based on monetary incentives.

Some skepticism about the incentives and the motives behind the program was noted. A few respondents raised ethical concerns, questioning whether offering financial incentives could be perceived as a bribe or a kickback.

Additionally, challenges such as limited availability of providers of distinction in certain areas, difficulty in finding providers who are accepting new patients, and challenges in receiving promised incentives or payments after using the program were also mentioned.

There is a strong request for transparency and expansion, with respondents seeking more information on how providers are chosen, the criteria used, and how ratings are determined. They also suggested expanding the program to include more providers, specialties, and geographic areas, as well as improving the process for claiming incentives.

Next, we have Cigna. Is there anything else you'd like to share about the limited provider network and the frequent changes that have frustrated you, particularly regarding the shrinking network of providers?

Many have expressed dissatisfaction due to frequent changes in provider status, which often require individuals to switch dentists after years of loyalty. Others are concerned about poor coverage and high out-of-pocket costs, leading to overall dissatisfaction with the benefit design.

Additionally, there are issues related to a lack of transparency and poor communication regarding planned changes to coverage details and provider status. At least two of these points have emerged as significant concerns this plan year, as changes were not adequately communicated until several months after they were implemented. This has contributed to the frustration reflected in the survey.

We offer a variety of healthy living programs. Have you participated in any online healthy living sessions, such as the webinars titled "Mindfulness," "Stress Management," or "Food as Medicine"? 15% of respondents said they have participated, 80% indicated they have not.

Among those who participated, many found the programs useful, helpful, or informative. However, a significant number felt that the information provided was too basic, generic, or common sense. Some participants mentioned that it served as a good reminder of important concepts.

Several individuals reported improvements in their health and stress levels, particularly enjoying specific sessions such as "Mindfulness" and "Diabetes Prevention." However, scheduling conflicts were a noted challenge, as these sessions are offered at specific times, which may not align with participants' work schedules.

If you were to join a weight management program, which type would you prefer? Please choose only one option. This question was a follow-up to a survey conducted a couple of months ago, aimed at understanding the feedback from some members interested in weight management programs who prefer not to be on medication for extended periods.
The options presented were: A clinical weight management program that includes injectable anti-obesity medication (such as Metformin and Ozempic), which could result in weight loss of up to 14%. Respondents were likely to continue using these medications to maintain weight loss.
A hybrid clinical weight management program that incorporates injectable anti-obesity medication but focuses on reducing or eliminating the need for these medications over time, or A weight management program that emphasizes exercise, nutrition, lifestyle changes, and ongoing support without relying on anti-obesity medications.

The majority of respondents expressed a preference for the third option, focusing solely on lifestyle changes and support.

How have you searched for a mental health care provider or substance use treatment? Have you used treatment for yourself or a covered family member? Please select all that apply.

This survey aims to gauge the membership's feelings about the process of finding a mental health provider. As we bring on Lyra, we want to see if this sentiment changes over time. It was helpful to establish a baseline before moving forward.

The results indicate that 65% have never searched for a mental health care provider or substance treatment. The responses break down as follows: 12% used the find provider tool through the benefits portal in the MyQ Health app, 4% contacted Quantum, 5% were referred by their treating physician, another 4% found their provider through Care Compass or the Behavioral

Health webpage, additional methods included Googling, referrals from providers, utilizing EAP services, and contacting providers directly by phone or email.

Is there anything else you would like to share about your experience in accessing mental health care or substance use treatment?

The first notable issue is the difficulty in finding in-network providers, along with long wait times and challenges in locating mental health and substance use providers who accept insurance. Other frustrations include outdated provider lists, long waiting lists, providers not accepting new patients, complications with insurance coverage and reimbursement, a preference for in-person care, and challenges with virtual programs. There is a clear need for better communication, support, and awareness of available programs, as well as easier navigation of resources and more proactive support.

What additional healthy living programs would you recommend adding to the health plan?

Consistently, members have expressed interest in gym memberships and fitness incentives. There is also a strong interest in nutrition and healthy eating programs, which aligns with our findings on weight management. Additionally, mental health, stress reduction, and mindfulness programs are popular among members. Our offerings from Lyra include many of these options, particularly in mindfulness and stress management, which feature self-directed programs that don't require meetings with providers. Other suggested areas include massage therapy, alternative and holistic therapies, as well as expanded vision, dental, and preventive care.

Joshua Wojcik – Invited other questions or comments from committee members and the public. There were no additional questions or comments; call for a motion to adjourn.

Motion to Adjourn was made by Dan Livingston and seconded by Greg Messner.

The meeting was adjourned.