Agenda

Tobacco & Health Trust Fund Board

Friday, October 15, 2010
10:00 a.m. to 12:00 Noon.

Room 410, State Capitol
Hartford, Connecticut

I. Welcome and Introductions

II. Approval of September 2010 Minutes

III. Presentation of Evaluation Findings on FY 08 Cessation Programs
Amy Griffin, The Consultant Center

IV. Preliminary Discussion of FY 11 Funding Recommendations

V. Adjournment into Executive Session

VI. Next Meetings
November 19 and December 17

D R A F T Meeting Summary

Tobacco and Health Trust Fund Board

Friday, September 17, 2010

10:00 a.m. - 10:30 a.m.

Room 1A

Legislative Office Building

Hartford, Connecticut

Members Present: Anne Foley (Chair), Ken Ferrucci, Norma Gyle, Elaine O'Keefe, Ellen Dornelas, Andy Salner, Cindy Adams, Larry Deutsch, Cheryl Resha, Diane Becker, Geralyn Laut, and Dianne Harnad.

Members Absent: Nancy Bafundo, Doug Fishman, Pat Checko, and Steve Papadakos.

Item	**Discussion/Action**
Welcome and Introduction	The meeting was convened at 10:05 a.m. The chair reminded members that this would be a brief meeting and the public hearing would begin at 10:30 a.m.
Approval of January 2010 Minutes	Elaine O'Keefe moved approval of the July minutes and the motion was seconded by Cindy Adams. The minutes were approved on a voice vote with one abstention by Diane Becker.
Update on FY09 and FY10 Disbursements	Board members reviewed the status of the trust fund disbursements for FY 2009 and FY 2010.
Next Meeting	The evaluator of the FY08 cessation program funding for women at community health centers will attend the board's October 15 meeting to discuss the results of the evaluation. The report will be distributed to board members prior to the meeting.

	At the October meeting the board will also discuss recommendations for FY 11 disbursements. Following this discussion, the board will adjourn into executive session to discuss the proposals received for Innovative Programs and the process for review and selection. The Chair reminded board members of upcoming meetings on October 15, November 19, and December 17.

Statutory Mandates

The board of trustees may recommend disbursement from the trust fund to:

1. Reduce tobacco abuse through prevention, education and cessation programs,
2. Reduce substance abuse, and
3. Meet the unmet physical and mental health needs in the state.

The board's recommendations must give:

1. Priority to programs that address tobacco and substance abuse and serve minors, pregnant women and parents of young children, and
2. Consideration to the availability of private matching funds.

Tobacco & Health Trust Fund Board of Trustees
Guiding Principles for Funding Decisions

Originally Adopted at the September 2001 Meeting and Amended Periodically

The following principles, which guide Board funding decisions, are not in priority order. Despite the focus on anti-tobacco efforts, other areas within the broad charge of the Board will not be dismissed without consideration.

1. **Sustainable programming**. Funding decisions should focus on programs that can be maintained without significant increases in use of trust fund dollars. Based on reasonable projections, budget forecasts will be used to help the Board identify future programming needs. In addition, resource development opportunities and other potential funding sources will be investigated.

2. **Consistent with existing public research and plan documents**. The Board will assess to what extent the proposed programming is consistent with existing research and plans, including, but not limited to:
   - Best Practices for Comprehensive Tobacco Control Programs by the U.S. Department of Health and Human Services Centers for Disease Control and Prevention, October 2007;
   - Local Tobacco Control Action Plans by the Connecticut Prevention Network, September 2001; and

- Connecticut Tobacco Use Prevention and Control Plan by the Connecticut Department of Public Health and the Department of Mental Health and Addiction Services, 2002.

3. **Complement and enhance existing programming and expenditures**. The State of Connecticut, as well as agencies external to state government, have made a commitment to programming in this area. To the greatest extent possible, funding decisions should build on existing programming to ensure the most efficient use of the Trust Funds resources.

4. **Focus on societal/environmental change**. The Board will support efforts that are designed to seek a cultural shift in the use of tobacco. The Board will not focus exclusively on efforts that treat individuals, but also on efforts that change the way society views tobacco and the way systems work to control the use of tobacco. For example, population-based messages will be used, not just messages that are targeted to smokers.

5. **Cultural Sensitivity**. Recognizing that tobacco companies target their audience, the Board will ensure that marketing messages and other programming take into consideration differing cultural perspectives and languages.

6. **Effective and outcome-based efforts**. To the greatest extent possible, the Board will fund endeavors that are measurable, science-based, and proven to be effective.

Tobacco and Health Trust Fund

Board Disbursements FY 03 – FY 10

	FY03	FY04	FY07	FY08	FY09	SubTotal FY03-09	FY10 Recs.	Total
Counter Marketing	$350,000		$100,000		$2,000,000	$2,450,000	$1,650,000	$4,100,000
Website Development	$50,000					$50,000		$50,000
Cessation Programs	$400,000	$300,000		$800,000	$1,612,456	$3,112,456	$1,550,000	$4,662,456
QuitLine		$287,100			$2,000,000	$2,287,100	$1,650,000	$3,937,100
School Based Prevention					$500,000	$500,000	$500,000	$1,000,000
Lung Cancer Pilot					$250,000	$250,000	$250,000	$500,000
Evaluation					$500,000	$500,000	$300,000	$800,000
Innovative Programs						$0	$477,745	$477,745
Total	$800,000	$587,100	$100,000	$800,000	$6,862,456	$9,149,556	$6,377,745	$15,527,301

Connecticut Prevention Network

Local partnerships promoting wellness by addressing substance abuse statewide.

Tobacco and Health Trust Fund Public Hearing

My name is Marlene F. McGann. I am the Executive Director of the Meriden and Wallingford Substance Abuse Council, a CT Regional Action Council. I am here on behalf of the CT Prevention Network of Regional Councils. We are on the front-line of prevention in every community in this State for problems of substance abuse, smoking prevention, gambling and other addictions. As such we work with a wide variety of community members and see the devastation that addiction to tobacco can bring to an individual, a family and a community.

In 2000 the RACs were empowered by the Legislature to conduct a Tobacco Needs Assessment in each of the 169 towns to determine the then current tobacco-related services, programs and policies in each town. Each town also developed an action plan to address what they determined were critical needs locally related to tobacco. This work was completed in a brief six weeks, an unheard of mobilization of communities in such a short period. The RACs were able to deliver statewide community level data and mobilize local communities through our extensive grassroots network.

Prevention should not be neglected when funding cessation and tobacco research programs. It has been shown that it is much less expensive to stop someone (especially children and adolescents) from starting smoking than to spend the funds on getting them to quit. According to local and national surveys, children begin experimenting with smoking at age 12. Focusing prevention efforts on elementary and middle school age youth is a good investment

The RAC structure has been addressing prevention at the local level for many years with diminishing funds. Currently RACs provide services in their communities including:

- Afterschool alternative to school suspension classes for students ages 12-18 who are found smoking at school
- Media literacy on the effect of tobacco advertising to 6th and 7th grade students
- Secondhand smoking education to parents of 5th graders
- Interactive presentations on smoking to 2nd grade students
- Merchant education and collaboration on compliance checks of retailers
- Smoking cessation classes and assistance in implementation for disabled populations
- Graphic design projects with youth ages 12-21
- Technical assistance to communities and businesses to develop smoking polices
- Print materials and educational sessions for parents and educators on smoking and health

It would be beneficial for Connecticut to have some of the available funding directed to prevention efforts for pre-teens and adolescents. We urge you to consider funding prevention efforts on a statewide or regional basis and partnering with the Regional Action Council network in these efforts. Thank you.

Marlene F. McGann, MSCJ
CT Prevention Network

September 17, 2010

Community-Based Cessation Programs

- Programs enrolled 240 people into tobacco cessation programs between September 2009 and March 2010.

- Close to 24% of the enrollees smoked less than 10 cigarettes per day, 43% smoked 11-20 cigarettes per day and 13% smoked more than 21 cigarettes per day. Data was missing for 18% of the enrollees.

- The largest proportion of referrals came from health care or mental health providers.

- Program enrollees represent: 53% White, 20% African American/Black, 13% "other" race and 11% Hispanic.

- Close to 57% had a high school education or less and of those reported their income, 52% made $10,000 a year or less.

- About 10% had no insurance and another 75% had some form of government sponsored insurance.

- About 25% of enrollees had 1-2 counseling sessions, 25% had 3-5 counseling session and 12% had 6 or more sessions.

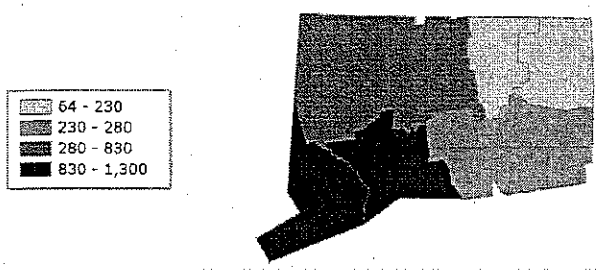
- About 28% of the enrollees that completed or dropped out of the program did not continue to smoke, 65% continued to smoke everyday and 6% smoked occasionally. 96% of enrollees quit for less than one month (data is derived from the program completion forms –out of the 92 cases only 32 responded.)

Source: Tobacco Cessation Program Aggregate Quarterly Report – March 2010

Performance Dashboard
Connecticut QuitLine

Contract dates from 7/1/2009 through 6/30/2010

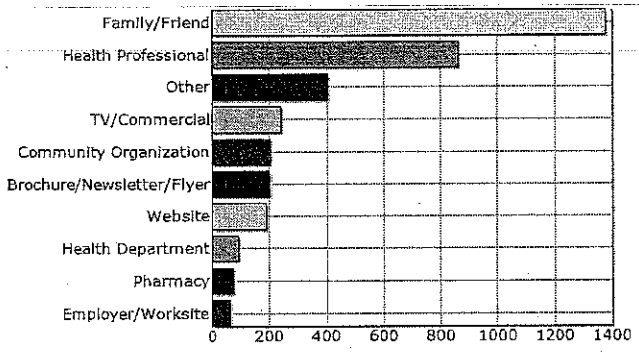
Tobacco Users Served YTD (Adults)



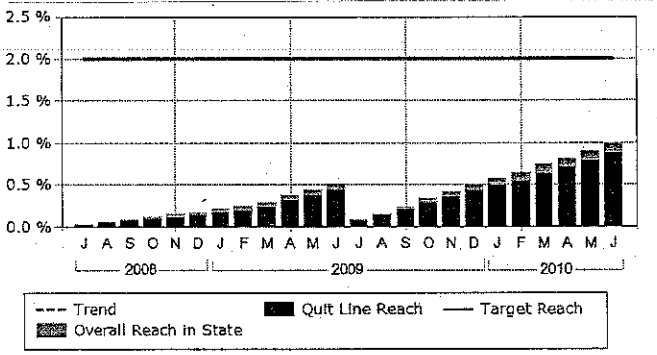
	Population	Prevalence	Tobacco Users
Adult	3,034,060	15.4 %	467,245

		Quitline	State
Tobacco Users YTD		4,066	4,677
Target Reach		2.0 %	2.0 %
Reach YTD	1	0.87 %	1.00 %
Reach - NAQC	2	0.73 %	0.73 %
Annualized Reach	1	0.87 %	1.00 %
Annualized Reach - NAQC	2	0.73 %	0.73 %

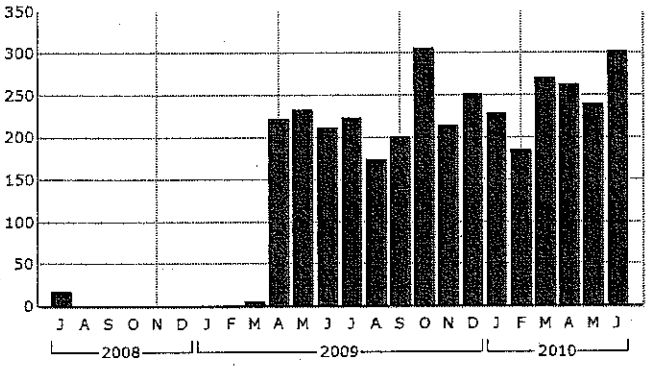
Top 10 How Heard About (Contract YTD)



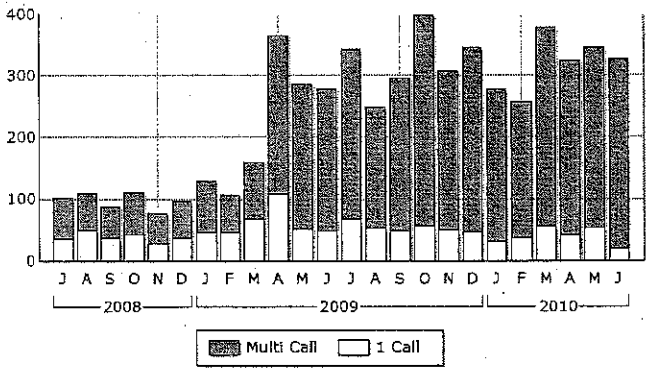
Cumulative Reach Rate



Tobacco Users Receiving NRT



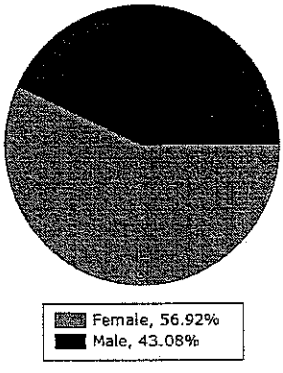
Tobacco User Enrollments By Program Type



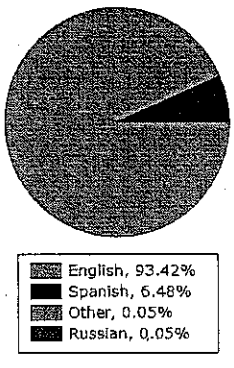
NOTE: Includes Tobacco Users only, does not include Proxy or Provider.

Demographics (Past 6 Months)

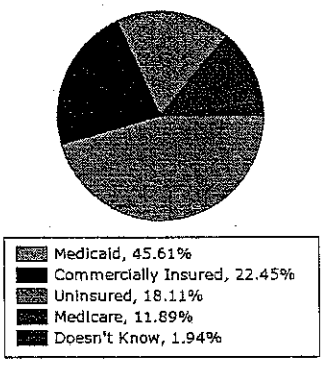
Tobacco Users By Gender



Tobacco Users By Language



Tobacco Users By Health Plan

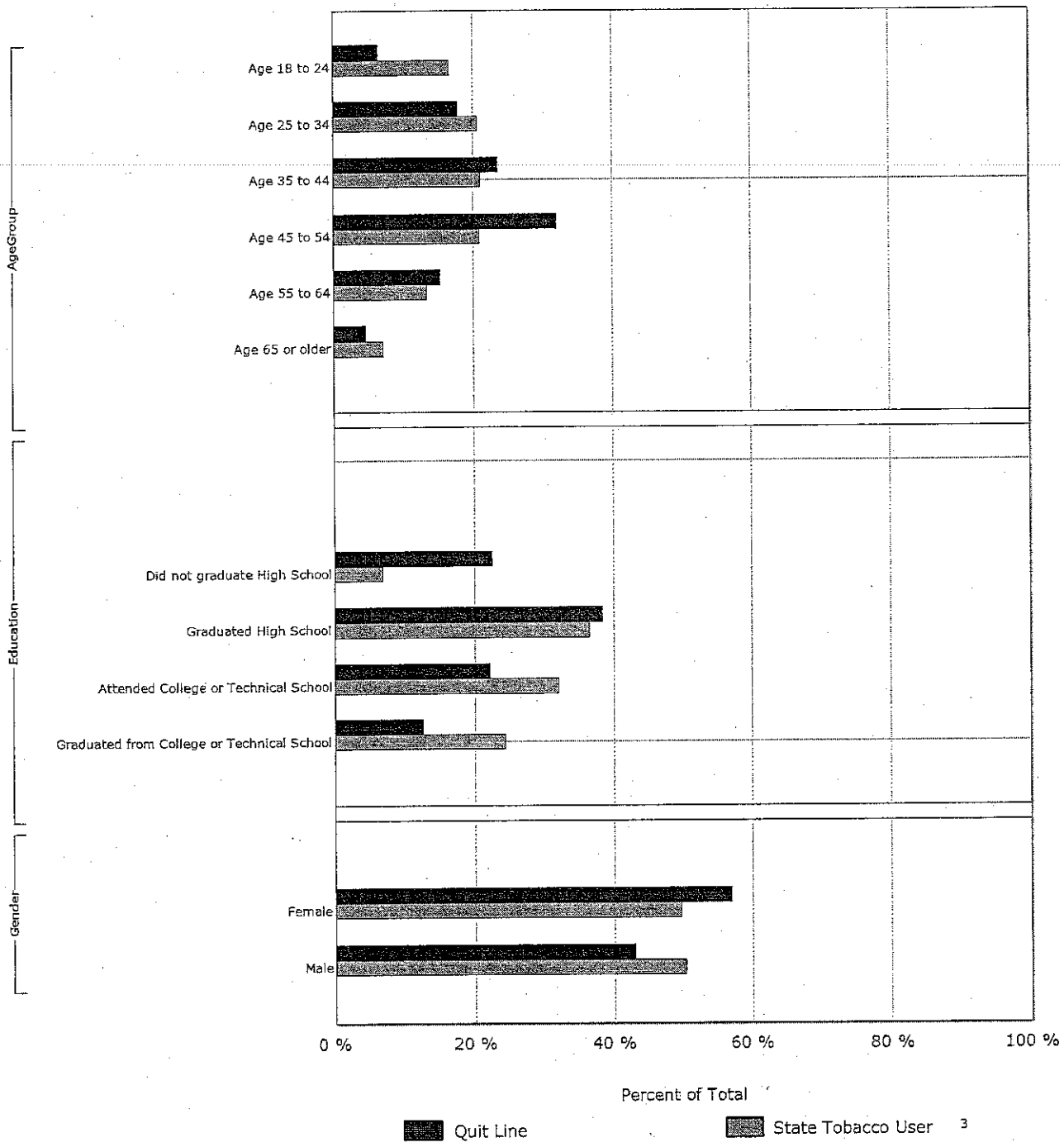


1. Reach - includes all tobacco users, regardless of service requested.
2. NAQC Reach - includes tobacco users provided minimal, low-intensity, or higher intensity counseling OR medications OR both counseling and medications.

Performance Dashboard
Connecticut QuitLine

Contract dates from 7/1/2009 through 6/30/2010

Demographic Comparison



3. Data Source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2009.

PRELIMINARY RESULTS: 7- AND 13-MONTH FOLLOW-UPS

Table 1: Survey Call Disposition

	7-month follow-up		13-month follow-up	
	N	%	N	%
Completed surveys	309	38.1	194	35.1
Long surveys completed	*256*	*31.6*	*170*	*30.8*
Short surveys completed	*53*	*6.5*	*24*	*4.3*
Located; unable to survey after 11 attempt days	286	35.3	196	35.5
Unable to locate caller (i.e., wrong or disconnected #)	179	22.1	111	20.1
Refused to participate in survey	31	3.8	48	8.7
Other (ill, deceased, incomplete survey)	5	0.6	3	0.6
Total	810	100.0	552	100.0

Table 2: Overall Satisfaction with the CTQL (Source: Follow-up Survey)

	7-month follow-up		13-month follow-up	
	N	%	N	%
Satisfied	285	96.9	171	93.4
Very satisfied	*188*	*63.9*	*84*	*45.9*
Mostly satisfied	*50*	*17.0*	*45*	*24.6*
Somewhat satisfied	*47*	*16.0*	*42*	*23.0*
Not at all satisfied	9	3.1	12	6.6

Table 3: Respondent Quit Rates (Source: Follow-up Survey)

	7-month follow-up		13-month follow-up	
	N	%	N	%
7- and 30- day point prevalence tobacco abstinence rates	305		192	
Respondent 7-day quit rate	104	34.1	57	29.7
Respondent 30-day quit rate	85	27.9	49	25.5

Table 4: Tobacco Reduction Rate among Current Tobacco Users (Source: Follow-up Survey)

Results are reported only for those still using tobacco or who were quit less than 30 days at the time of the follow-up survey.	7-month follow-up		13-month follow-up	
	N	%	N	%
Tobacco use reduction (cigarette users only)	195		131	
Less than baseline	112	57.4	73	55.7
As many or more than baseline	83	42.6	58	44.3

PENNSTATE

Potential Costs and Benefits of Smoking Cessation for Connecticut

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April 30, 2010

Acknowledgements
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Executive Summary

Background. Cigarette smoking is the single leading cause of preventable disease and preventable death in the United States (US), leading to more than 400,000 deaths annually. The CDC and the U.S. Department of Health and Human Services have both issued guidelines on smoking cessation to help people to quit smoking that include: access to counseling, access to all FDA-approved over-the-counter and prescription medications; multiple quit attempts; and reduced or eliminated co-pays. However, access to these aids is limited since many payers do not cover these treatments. The objective of this study was to determine whether the cost of making such smoking cessation programs available at the state level could be justified by the benefits.

Methods. We performed a cost-benefit analysis of access to smoking cessation programs using a societal perspective using state specific data. Smoking cessation programs based on three treatment alternatives were studied: nicotine replacement therapy (NRT), bupropion, and varenicline. Each approach was evaluated with and without individual counseling. Benefits were estimated as reductions in medical expenditures, premature deaths and increased workplace productivity. Costs were estimated as direct cost of the smoking cessation programs, the lost tax revenue to the public sector and the lost revenue to retailers and distributors, since smokers who quit will no longer purchase cigarettes. Other model parameters included how many smokers take advantage of the programs and the programs' effectiveness in helping smokers to quit. The cost-benefit model was parameterized using data from CDC, and various national surveys, including the Behavioral Risk Factors Surveillance Survey and the Current Population Survey.

Results. Results from our model suggested that in Connecticut the annual direct costs to the economy attributable to smoking were in excess of $3.5 billion, including workplace productivity losses of $654 million, premature death losses of $1.1 billion, and direct medical expenditures of $1.7 billion. While the retail price of a pack of cigarettes in Connecticut is on average $7.45, the combined medical costs and productivity losses attributable to each pack of cigarettes sold are approximately $22.94 per pack of cigarettes. The ratio of benefits to cost varies from $0.97 to $2.48 saved per dollar spent on smoking cessation programs, depending upon the type of intervention. Nicotine replacement therapies, generic bupropion and varenicline showed substantial benefits to costs from the societal perspective across the range of values used for treatment effectiveness. Only brand name bupropion was marginally a positive benefits to cost ratio at the low end of the range. Detailed results can be found in Tables 1-8, which are attached.

Conclusions. For most smoking cessation treatments, the benefits of smoking cessation programs statewide greatly outweigh the cost to implement them.

Tables

Table 1: Baseline data on smokers and smoking in Connecticut.

Variable	Total
Resident Smokers in CT[1]	442,035
Visiting Smokers in CT[2]	28,768
Total Smokers	470,803
Total Packs Sold to Residents	155,856,741
Total Packs Sold to Visitors	10,143,259
Total Packs Sold[3]	166,000,000
Average Packs Per Resident Smoker Per Year	353

[1] Data from the Behavioral Risk factor Surveillance System, Connecticut Calculated Variable Data Report, 2005. Retrieved on September 7, 2009 from: http://apps.nccd.cdc.gov/s_broker/htmsql.exe/weat/freq_analysis.hsql?survey_year=2005

[2] Data from http://www.cultureandtourism.org/cct/lib/cct/CCT_Impact_Report_Web_.pdf, The Economic Impact of the Arts, Film, History and Tourism Industries in Connecticut

[3] Data from http://www.tobaccofreekids.org/research/factsheets/pdf/0099.pdf, Campaign for Tobacco Free Kids.

Table 2: Total productivity losses attributable to smoking. Includes productivity losses due to premature death, and workplace productivity losses due to absenteeism and the net loss of productive work time.

Component	Total	Per Pack	Per Smoker
Premature Death[1]			
Men	$760,084,489	$9.95	$3,508.66
Women	$418,318,757	$5.26	$1,855.86
Combined	$1,178,403,246	$7.56	$2,665.86
Workplace Productivity[2]			
Current Smokers[3]	$444,972,014	$2.86	$1,006.64
Former Smokers[4]	$209,371,615	$1.34	$473.65
Combined	$654,343,628	$4.20	$1,480.30
Total Productivity Losses	$1,832,746,874	$11.76	$4,146.16

Adjusted for inflation to 2009

1. SAMMEC. Adult Smoking-Attributable Mortality, Morbidity, and Economic Costs Calculator. Atlanta, GA: CDC; 2008.
2. Data from Bunn WB, 3rd, Stave GM, Downs KE, Alvir JM, Dirani R. Effect of smoking status on productivity loss. J Occup Environ Med 2006 Oct;48(10):1099-108.
3. Per Bunn et al. total cost per current smoker in the labor force is $4430, with a net effect of lost productivity of $1807.
4. Per Bunn et al. total cost per former smoker in the labor force is $2623, with a net effect of $623.

Table 3: Direct expenditures on medical care attributable to smoking and smoking-related events in Connecticut. Total expenditures per pack for both medical care and productivity losses are $22.94 per pack.

Cost Component[1]	Total	Per Pack	Per Smoker
Adult Expenditures			
Ambulatory Care	$264,055,576	$1.69	$597.36
Hospital Care	$775,209,029	$4.97	$1,753.73
Rx	$296,759,707	$1.90	$671.35
Nursing Home	$259,210,519	$1.66	$586.40
Other Care[2]	$146,562,957	$0.94	$331.56
Total	$1,741,797,788	$11.18	$3,940.41
Neonatal Expenditures	$1,139,173	$0.01	$2.58
Total Expenditures	$1,742,936,961	$11.18	$3,942.98

Adjusted for inflation to 2009

1. SAMMEC. Adult Smoking-Attributable Mortality, Morbidity, and Economic Costs Calculator. Atlanta, GA: CDC; 2008.
2. Other Care includes home health, nonperscription drugs, and nondurable medical products.

Table 4: Components of cigarette prices, including taxes, distributor markups, and retailer markups.

Component	Price
Factory Price[1]	$2.36
Total Taxes	$4.43
Federal Tax[2]	$1.01
State Tax[2]	$3.00
State Sales Tax[3]	$0.42
Distributor & Retailer Mark-ups[1]	$0.66
Final Retail Price	$7.45

Adjusted for inflation to 2009

[1] Economic Research Service, U.S. Department of Agriculture, Tobacco Briefing Room, "Most Frequently Used Tables," Number 9, http://www.ers.usda.gov/ Briefing/tobacco, downloaded January 23, 2007 (adjusted to reflect Philip Morris price cuts to four of its major brands).
[2] Data from http://www.tobaccofreekids.org/research/factsheets/pdf/0099.pdf, Campaign for Tobacco Free Kids.
[3] Data from http://www.rjrt.com/StateMsaPayments.aspx, State MSA Payments.

Table 5: Costs for smoking cessation treatments. Costs are for a full course of treatment, which varies by treatments.

Treatment	Alone	With Counseling
NRT	$231	$371
Bupropion (Brand)	$354	$494
Generic Bupropion	$203	$343
Varenicline	$300	$440

Source: Treatment costs are at national retail pricing from Drugstore.com (2009). Prices were adjusted to 2009 dollars.

Table 6: Marginal treatment effectiveness, including baseline values and ranges used in sensitivity analysis.

Treatment Option	Marginal Treatment Effectiveness		
	Baseline	*Low*	*High*
NRT[1]	5.8%	5.0%	6.6%
Bupropion (Brand)[2]	7.0%	5.4%	8.6%
Generic Bupropion[2]	7.0%	5.4%	8.6%
Varenicline[3]	14.9%	10.2%	20.4%
NRT Plus Counseling	8.0%	7.1%	8.9%
Bupropion (Brand) Plus Counseling	9.3%	7.6%	11.3%
Generic Bupropion Plus Counseling	9.3%	7.6%	11.3%
Varenicline Plus Counseling	18.5%	13.0%	24.8%

1. Silagy C, Lancaster T, Stead L, Mant D, Fowler G. Nicotine replacement therapy for smoking cessation. Cochrane Database Syst Rev 2004(3):CD000146.
2. Hughes JR, Stead LF, Lancaster T. Antidepressants for smoking cessation. Cochrane Database Syst Rev 2007(1):CD000031.
3. Cahill K, Stead LF, Lancaster T. Nicotine receptor partial agonists for smoking cessation. Cochrane Database Syst Rev 2007(1):CD006103.

Table 7: Results of cost-benefit analysis at baseline marginal effectiveness

	No Counseling			
Costs/Benefits	*NRT*	*Bupropion (Brand)*	*Generic Bupropion*	*Varenicline*
Medical Expenditures Avoided Plus Productivity Gains	$20,694,441	$24,914,279	$24,914,279	$53,295,541
Costs of Cessation Program	$10,211,009	$15,661,742	$8,956,071	$13,240,716
Lost Tax Revenue	$3,997,681	$4,812,855	$4,812,855	$10,295,450
Lost Business Revenue	$597,331	$719,134	$719,134	$1,538,340
Benefit/Cost Ratio	**1.40**	**1.18**	**1.72**	**2.13**

	Counseling			
Costs/Benefits	*NRT*	*Bupropion (Brand)*	*Generic Bupropion*	*Varenicline*
Medical Expenditures Avoided Plus Productivity Gains	$28,518,510	$33,371,323	$33,371,323	$66,009,775
Costs of Cessation Program	$16,399,499	$21,850,232	$15,144,561	$19,429,206
Lost Tax Revenue	$5,509,108	$6,446,558	$6,446,558	$12,751,542
Lost Business Revenue	$823,167	$963,241	$963,241	$1,905,327
Benefit/Cost Ratio	**1.25**	**1.14**	**1.48**	**1.94**

Adjusted for inflation to 2009

Table 8: Sensitivity analysis of cost-benefit analysis at low values of marginal effectiveness

	No Counseling			
Costs/Benefits	*NRT*	*Bupropion (Brand)*	*Generic Bupropion*	*Varenicline*
Medical Expenditures Avoided Plus Productivity Gains	$17,900,372	$19,430,716	$19,430,716	$36,449,870
Costs of Cessation Program	$10,211,009	$15,661,742	$8,956,071	$13,240,716
Lost Tax Revenue	$3,457,932	$3,753,559	$3,753,559	$7,041,261
Lost Business Revenue	$516,682	$560,854	$560,854	$1,052,101
Benefit/Cost Ratio	**1.26**	**0.97**	**1.46**	**1.71**

	Counseling			
Costs/Benefits	*NRT*	*Bupropion (Brand)*	*Generic Bupropion*	*Varenicline*
Medical Expenditures Avoided Plus Productivity Gains	$25,305,330	$27,065,226	$27,065,226	$46,637,253
Costs of Cessation Program	$16,399,499	$21,850,232	$15,144,561	$19,429,206
Lost Tax Revenue	$4,888,397	$5,228,367	$5,228,367	$9,009,224
Lost Business Revenue	$730,421	$781,219	$781,219	$1,346,153
Benefit/Cost Ratio	**1.15**	**0.97**	**1.28**	**1.57**

Adjusted for inflation to 2009

Table 9: Sensitivity analysis of cost-benefit analysis at high values of marginal effectiveness

	No Counseling			
Costs/Benefits	*NRT*	*Bupropion (Brand)*	*Generic Bupropion*	*Varenicline*
Medical Expenditures Avoided Plus Productivity Gains	$23,438,305	$30,912,303	$30,912,303	$72,870,113
Costs of Cessation Program	$10,211,009	$15,661,742	$8,956,071	$13,240,716
Lost Tax Revenue	$4,527,731	$5,971,533	$5,971,533	$14,076,798
Lost Business Revenue	$676,531	$892,263	$892,263	$2,103,346
Benefit/Cost Ratio	**1.52**	**1.37**	**1.95**	**2.48**

	Counseling			
Costs/Benefits	*NRT*	*Bupropion (Brand)*	*Generic Bupropion*	*Varenicline*
Medical Expenditures Avoided Plus Productivity Gains	$31,673,953	$40,269,052	$40,269,052	$88,520,533
Costs of Cessation Program	$16,399,499	$21,850,232	$15,144,561	$19,429,206
Lost Tax Revenue	$6,118,665	$7,779,037	$7,779,037	$17,100,092
Lost Business Revenue	$914,247	$1,162,339	$1,162,339	$2,555,085
Benefit/Cost Ratio	**1.35**	**1.31**	**1.67**	**2.26**

Adjusted for inflation to 2009

Connecticut Statute Regarding Executive Session

Sec. 1-231. (Formerly Sec. 1-21g). Executive sessions. (a) At an executive session of a public agency, **attendance shall be limited to members of said body and persons invited by said body to present testimony** or opinion pertinent to matters before said body provided that such **persons' attendance shall be limited to the period for which their presence is necessary to present such testimony or opinion** and, provided further, that the minutes of such executive session shall disclose all persons who are in attendance except job applicants who attend for the purpose of being interviewed by such agency.

(b) An executive session may not be convened to receive or discuss oral communications that would otherwise be privileged by the attorney-client relationship if the agency were a nongovernmental entity, unless the executive session is for a purpose explicitly permitted pursuant to subdivision (6) of section 1-200.

(P.A. 75-342, S. 11; P.A. 81-431, S. 5; P.A. 86-226; P.A. 97-47, S. 9.)

History: P.A. 81-431 exempted names of job applicants interviewed during executive session from disclosure; P.A. 86-226 added Subsec. (b) prohibiting convening of executive session to receive or discuss oral communications that would otherwise be privileged by the attorney-client privilege unless session is for a purpose explicitly permitted under Sec. 1-18a(e); P.A. 97-47 made a technical change in Subsec. (b); Sec. 1-21g transferred to Sec. 1-231 in 1999.