CHAIRPERSON: Senator Matt Lesser,
Representative Sean Scanlon

SENATORS: Cassano, Hartley, Kelly,

REPRESENTATIVES: Dathan, de la Cruz,
Delnicki, Floren, Hughes,
O’Neill, Pavlock-D’Amato,
Polletta, Riley, Rosario,
Turco, Vail

SENATOR LESSER (9TH): Good morning. I’d like to call to order the public hearing of the Insurance and Real Estate Committee. In the interest of safety, I would ask you to note the location of and access to the exits in this hearing room. The two doors through which you entered the room are the two emergency exits and are marked with exit signs. In an emergency, the two doors behind the legislators can also be used. In the event of an emergency, please walk quickly to the nearest exit. After exiting the room, go to your right and proceed to the main stairs or follow the exit signs to one of the fire stairs. Please quickly exit the building and follow any instructions from the Capitol police. Do not delay, and do not return unless and until you are advised that it is safe to do so. In the event of a lockdown announcement, please remain in the hearing room and stay away from the exit doors until an all clear announcement is heard.

With that, we are going -- we are going to begin the public hearing portion. The first hour is reserved
for legislators, agencies, and municipal officials, and first up on Senate Bill 317 we’re going to be hearing from Senator Eric Berthel. Good morning, Senator.

SENATOR BERTHEL (32ND): Good morning, Mr. Chairman, Chairman Scanlon, Ranking Member Kelly, Ranking Member Pavalock-D’Amato, and distinguished members of the Insurance and Real Estate Committee. I am state Senator Eric Berthel. It’s good to see friendly faces around the desk. I am testifying today in support of Senate Bill 317, AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR BARIATRIC AND METABOLIC SURGERY. The purpose of this legislation is to essentially require health insurance coverage for bariatric and metabolic surgery. Many of you know I am a bariatric surgery patient. I can attest that this surgery is an effective and lifesaving procedure. Today, 40 months after my surgery, I have maintained a 130-pound weight loss and have taken back a healthy lifestyle. Obesity is a health crisis that is facing our nation and state, and this surgery has a proven track record of improving many conditions that are associated with an individual being overweight. These health-related conditions, also called comorbidities, include type 2 diabetes, heart disease, orthopedic issues, high blood pressure, and stroke.

Currently, most insurance plans in the state do not provide coverage for bariatric and metabolic surgery. However, the coverage is currently provided to Connecticut residents who are covered by our state’s HUSKY plans, and bariatric and metabolic surgery procedures are covered in full by the state of Connecticut employee’s insurance plans.
Bariatric and metabolic surgery should be considered an essential health benefit in our state as it helps individuals live longer and healthier lives. Many individuals will not be required to take as many prescription medications once they receive surgery and lose weight, and the cost of the comorbidities, diabetes, heart disease, stroke far surpass the cost of bariatric surgery, and more importantly, this surgery returns individuals to a health lifestyle, and again, I am living proof of that.

Today, you will hear testimony from doctors, nurses, and patients who have all been involved with or affected by bariatric surgery, and I hope that you will give very serious consideration. Connecticut is one of the last states that does not require this as part of a comprehensive coverage for insurance services, so I’m happy -- thank you for the opportunity to speak with you. I’m happy to answer any questions at this time.

SENATOR LESSER (9TH): Thank you so much, Senator, for your testimony, and I’m glad to see that the -- that it’s worked well for you, and I’m -- I’m happy to hear about your advocacy for this important issue. How many -- how many other states -- you said other states have done this?

SENATOR BERTHEL (32ND): You know, Senator, I do not have the actual numbers, but I know some of the people that are here testifying before the committee today can provide those statistics. We are the only state in the Northeast that does not -- does not require coverage for bariatric and metabolic surgery.

SENATOR LESSER (9TH): And, the other I think that will be helpful for us is I think you know under the
Affordable Care Act any new health insurance mandates do require an expenditure by the General Assembly, so if it’s something you have data about what this would cost and if any associated savings on a per member per month that would be helpful for us -- with the committee.

SENATOR BERTHEL (32ND): Okay. Sure. We can get that data for you.

SENATOR LESSER (9TH): Terrific. Are there questions from members of the committee? Oh, yes, Representative Dathan.

REP. DATHAN (142ND): Thank you very much, Senator Berthel. I really appreciate your story.

SENATOR BERTHEL (32ND): Thank you.

REP. DATHAN (142ND): And, it was really inspiring to hear. One question I had is I see how beneficial the surgery has been for you, but do you think there needs to be any sort of program associated with it so that patients who receive the surgery can have followup successful lives, learn how to eat healthily, learn how to have their body adjust to it --


REP. DATHAN (142ND): Make sure it lasts in the long-term?

SENATOR BERTHEL (32ND): I’m sorry to interrupt you.

REP. DATHAN (142ND): That’s all right. Thank you.

SENATOR BERTHEL (32ND): Thank you for the question, and that’s really, Representative, a great -- great question. That is an integral part of the care that is given post-surgery, and there are -- you know,
you might hear some arguments that would say that -- that you would have people that return to a -- a pre-surgery state because -- because they -- they failed in staying compliant. I think what you’ll hear from -- in testimony today from patients that are here -- the medical community will tell you that -- that they are doing what they can within -- within the scope of their practice, within the scope of the -- the coverage that is already provided by some insurance policies. I think you’ll hear from patients that they’re working with their care teams and you know, I -- I had surgery at one hospital here in Connecticut -- there are representatives here from hospitals all over who will speak to the importance of that and the success in doing that. There is an old saying though, you know, you can lead a horse to water but you can’t necessarily make it drink, but there are more success stories than failures in -- in this particular -- this particular type of surgery with respect to permanent weight loss.

REP. DATHAN (142ND): Great. Thank you very much.

SENATOR BERTHEL (32ND): Thank you.

REP. DATHAN (142ND): Good luck to you in the future.

SENATOR BERTHEL (32ND): Thank you.

SENATOR LESSER (9TH): Thank you, Representative. Other questions or comments from members of the committee? If not, thank you very much, Senator.

SENATOR BERTHEL (32ND): Thank you, Chairman.

SENATOR LESSER (9TH): Sorry, I didn’t have the list. Next -- next up commenting on Senate Bill
318, we have James Michel from Access Health Connecticut. And, we will ask if -- if you are here to speak on multiple bills, if it is possible you could combine your testimony that would be helpful for us as well. Good morning.

JAMES MICHEL: Good morning, Chairman Lesser, Scanlon, Ranking Member Kelly -- ranking members Kelly, Pavlock-D’Amato, and members of the Insurance and Real Estate Committee. My name is James Michel. I’m the C -- CEO of Access Health Connecticut. I’m here today to testify in opposition to three bills, Senate Bill 318, AN ACT REQUIRING PRIOR APPROVAL OF ASSESSMENT AND USER FEES CHARGED TO HEALTH CARRIERES BY THE CONNECTICUT HEALTH INSURANCE EXCHANGE, and also Senate Bill 321, AN ACT REQUIRING DISCLOSURE AND PRIOR LEGISLATIVE APPROVAL OF SEVERENCE AND NONDISCLOSURE AGREEMENTS WITH THE CONNECTICUT HEALTH INSURANCE EXCHANGE, and Senate Bill 322, AN ACT REQUIRING -- AN ACT CONCERNING THE BOARD OF DIRECTORS OF THE CONNECTICUT HEALTH INSURANCE EXCHANGE.

Senate Bill 318, Access Health Connecticut is required by legislation and the ACA, the Affordable Care Act, to be financial self-sustaining. Statutes 38a-1083(c)(7) authorizes and empowers the Exchange to charge an assessment or user fees to help carriers that are capable of offering a qualified health plan through the Exchange or otherwise generate funding necessary to support the operations of the Exchange and imposes interest and penalties on such health carriers for delinquent payments of such assessment of fees. Access Health Connecticut receives no appropriation from the state budget to support these operations or activities. Access Health Connecticut assessment rate is set annually
at a series of public hearings through Finance Committee and Board of Directors, and has one of the lowest assessment rates at 1.65 basis points in the nation including the fair rate of Exchange. We have only raised our system once since we began operations in 2013. We have not increased the assessment since 2015, and do not intend to increase this year or in the near future. Requiring legislative approval of the -- of the Access Health assessment rate would be overly burdensome, and Access Health sets the rate through an open and public meeting process.

Senate Bill 321, during the 2018 session, the legislature passed Public Act 18-137, which included various recommendations by the Auditors of Public Accounts. Section 26 of this act provides that effective October 1, 2018, no quasi-public agency, as defined in section 1-120 of the general statutes, shall make a payment in excess of $50,000 dollars to an employee resigning or retiring from employment with such quasi-public agency for the purpose of avoiding costs associated with the pension litigation or pursuant to a non-disparagement agreement. Accordingly, restrictions have already been put into statutes impacting Access Health Connecticut and the other quasi-public agencies of the state.

It is Access Health’s belief this legislation -- this legislation is not needed. Access Health is opposed to this -- to the section of this bill that seeks to further limit Access Health’s ability to offer severance pay to its employees. This -- this is -- this restriction would inhibit Access Health’s ability to attract qualified employees and to manage its staff and operating budget. Access Health
employees are not employees of the state of Connecticut. They are not eligible to receive the benefit package offered to state employees. However, Access Health employees also object to the state code of ethics and to additional legislative restrictions on future employment pursuant to statutes 38a-1081; therefore, if an employee is terminated through no fault of their own when a position is eliminated or staffing is -- is restructured, Access Health would be restricted in its ability to offer a fair severance package to these employees.

State Senate Bill 322, Access Health Connecticut is opposed to this bill as it seeks to apply term limits to appointed members of the Access Health Connecticut Board of Directors. This -- this restriction has not been imposed on other quasi-agencies of the state of Connecticut. Putting restrictions on the Access Health Board of Directors could be extremely challenging in our organization and its future. Access Health Connecticut has experienced challenges in the past with open appointments not being made on its board. It is important for Access Health to have continuity with its board of directors to support its operations and have the subject matter knowledge regarding the Exchange operations.

Senate Bill 322, also looks to require that all members of such board have insurance experience. Currently, legislation statute 38a-1081, subsection b and a, already specify the particular subject matter required for each appointment of the Executive and Legislative branch of government. Access Health has -- has 14 board members, 6 commissioners, all designees, and 8 who are
executive and legislative appointments. All but one of these require some industry expertise. Only one appointment is more consumer advocate-focused rather than insurance industry knowledge.

Access Health Connecticut respectfully requests that the members of the Insurance and Real Estate Committee oppose Senate Bill 318, 321, and 322. I am happy to answer any questions.

SENATOR LESSER (9TH): Thank you, Mr. Michel for your testimony. Are there questions or comments from members of the committee? Representative Delnicki.

REP. DELNICKI (14TH): Thank you, Mr. Chair. Good morning, Mr. Michel. How are you?

JAMES MICHEL: I’m doing well. Thank you.

REP. DELNICKI (14TH): Senate Bill 322. How many board members did you say are -- there are?

JAMES MICHEL: 14.

REP. DELNICKI (14TH): Okay. Can you tell us what their average term has been in serving and the amount of time the longest serving member has been serving?

JAMES MICHEL: I can’t give you an answer for every one of them, but a number of them have been on the board since we started, and --

REP. DELNICKI (14TH): Which would be how many years?

JAMES MICHEL: The board started out, I believe, in 2012 -- late 2012 or early 2013.

REP. DELNICKI (14TH): Okay.
JAMES MICHEL: And, the others -- we’ve had some new ones that have come on recently, but I can give you a full detail terms of service by each one of them in the near future.

REP. DELNICKI (14TH): Getting -- getting back to the concept of term limits, if there were to be term limits on the board members, what would you say would be a reasonable number?

JAMES MICHEL: Oh, I’m not -- I’m not sure that I could answer that question.

REP. DELNICKI (14TH): Well, currently, how long is their term?

JAMES MICHEL: Right now --

REP. DELNICKI (14TH): When you get appointed, before you get reappointed.

JAMES MICHEL: It varies. It varies. Some are 3, some are 2, and they get reappointed based on the governor or the legislature’s desire, and also, commissioners they serve by default based on their commissioner. There are 6 agencies that are appointed to the board, and based on the commissioner’s terms and service, so that changes -- that could change over time.

REP. DELNICKI (14TH): Okay. Well, thank you for your testimony and the answers to the questions. Thank you, Mr. Chair.

SENATOR LESSER (9TH): Thank you, Representative. Other questions from members of the committee? Mr. Michel, I guess, I -- I -- I personally just speaking about the -- the term limit portion, I’m not a big fan of term limits in general, but what I would hope to see from the -- from the Exchange and
from -- from your board is a real sense, at this point, at time of enormous turmoil in the industry nationally I think stemming from actions by this administration in Washington that have attempted to destabilize Exchanges, I think we need to see more proactive work from -- on the state level to make sure that we are stabilizing what we have, and my hope is working together between this committee and the Exchange we -- we can find ways to do that. So, if you could pass that message on to your board, I think that would be very helpful going forward.

JAMES MICHEL: Will do. Let me just make one closing comment.

SENATOR LESSER (9TH): Okay.

JAMES MICHEL: In that you know Connecticut has enjoyed the -- the reputation as been the best Exchange in the country, and in part -- in part because we’ve had a board that is fairly engaged. We’ve had a board that is knowledgeable about the industry that we are in, and also, they have served, and we have had continuity in our board since we’ve started, so I think that has been a big contributor to our success thus far, and I hope that that will continue to be the case for us. But, Chairman, I will -- I will get you the information that you requested.

SENATOR LESSER (9TH): Okay. Yes, Representative Floren.

REP. FLOREN (149TH): Thank you, and thank you for being here. I just had a question. Are your board members compensated for service?

JAMES MICHEL: No. They’re not.
REP. FLOREN (149TH): They’re not. Thank you.

SENATOR LESSER (9TH): Thank you, Representative. Any other questions from members of the committee? If not, thank you so much for your testimony today. It’s good to see you.

JAMES MICHEL: Thank you.

SENATOR LESSER (9TH): Next up, we have Senator Rob Sampson. Senator Sampson, are you in the room? I don’t think Senator Sampson is in the room, so we will proceed. Is Senator Looney in the room? Senator Looney is not in the room. Is Ted Doolittle? Mr. Doolittle, are you in the room? Good morning.

TED DOOLITTLE: Mr. Chairman and all the members of the committee, thank you so much for having me this morning.

SENATOR LESSER (9TH): Can you move your microphone a little bit closer to you?

TED DOOLITTLE: Thank you so much for having me this morning. I am the head of the Office of the Healthcare Advocate and for those in the room who might not know, we engage in policy matters, but we also provide essentially constituent services for folks who are having troubles with their health insurance. We are the staff of nurses, attorneys, paralegals, and other professionals that can help you if you are having a struggle with your health insurance company, so keep that in mind. My comments are going to be very brief today, and --

SENATOR LESSER (9TH): I’m sorry. Mr. Doolittle, can you please identify yourself just for the
record? I know who you are but I’m not sure that everybody else here today.

TED DOOLITTLE: Oh, I am sorry. My name is Ted Doolittle. I am the head of the State Office of the Healthcare Advocate. I’m here today on Senate Bills 330 and 331. I will keep my comments brief because I know you have an ambitious schedule. Senate Bill 330 is AN ACT ESTABLISHING A HUMAN RIGHTS EQUAL ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF HEALTH. This language did exist with no problems that I am aware of for a number of years in the statute books, and it was eliminated in my view probably inadvertently when the statute involving the commission on health equity was dissolved, and so I think it was an important statement of the values of Connecticut to have -- to have that statement reinserted into the statute books. I have filed some written testimony. I know there’s others from the public who are going to comment on this, and I will associate myself with their comments as well.

With respect to Senate Bill 331, that’s AN ACT REQUIRING THE INSURANCE COMMISSIONER TO CONSIDER AFFORDABILITY IN REVIEWING HEALTH INSURANCE PREMIUM RATE FILINGS. This is a reference to the fact that health insurance rates are set on an annual basis. The companies are required to propose their rates, and then the insurance company reviews them, and during that review, there is already, in my opinion, authority for the insurance commissioner to delve into matters of affordability and cost. Why is the medical trend 9 percent -- I’m making that up -- but why is the increase in medical cost 9 percent per year? What providers in your network are driving that cost? This type of inquiry. I believe there
is already authority to do it. I think past insurance commissioners have either reviewed that as discretionary or viewed it as -- my interpretation-- as not the right interpretation, but it is an opportunity as I say to -- that exists nowhere else in state government to have actual review and accountability on what the underlying costs are. Health insurance is expensive for one reason only. It’s expensive because healthcare costs are expensive. This is an opportunity to have accountability and transparency in that regard.

So, again, I want to keep my comments brief. Those are my comments. I am happy to answer any questions.

SENATOR LESSER (9TH): Thank you -- thank you, Mr. Doolittle, and thank you for your testimony. Are there questions for members of this committee? Yes. Representative Delnicki.

REP. DELNICKI (14TH): This is more a comment than a question. I want to thank you for what your organization is doing. I’ve got a number of constituents that have benefitted from your office, and I’ve got one who has had some arduous feelings with the insurance industry, and your folks have helped out quite a bit, so my only comment is keep up the good work.

TED DOOLITTLE: Yeah. Thank you. It -- it really is unfair that folks have to battle on the financial side right at the time when they’re struggling with their health issues, so Connecticut is wise, and one of the only states in the union to have this type of free service for the -- for the citizens and residents of the state.
REP. DELNICKI (14TH): I just think you need to officially know that there’s people that really appreciate what you’re doing there. Thank you, Mr. Chair. Thank you, sir.

SENATOR LESSER (9TH): Thank you, Representative. I think we all -- all -- all the legislators in this building either rely or should rely on the office for assistance in constituent matters. Just specifically with regard to Senate Bill 330, which would restore the language about healthcare as a human right; what’s the substance of the fact of that? Is there one or is that more of a statement of principle?

TED DOOLITTLE: I believe it’s a statement of principle, Mr. Chairman. It existed for a number of years, perhaps less than 10 years but more than 5, I’m not sure exactly on the statute books when the Health Equity Commission was in play, and I don’t believe there was a substance effect, so it is much more, in my view, a declaration of principle of the state.

SENATOR LESSER (9TH): And, then specifically, we received a lot of pushback -- understandably I guess -- from -- with regard to Senate Bill 331, requiring the commissioner to consider affordability and rate reviews. What -- how would that work? Do other states do this? Is that something that the department is able to do? I don’t -- I don’t know if you’ve seen some of the written testimony we received in response from -- from the industry, but I just wanted to see if you could sort of comment how that -- how you sort of envision that working? I guess there’s already permissive authority in -- in existence today? Is that -- is that something
that actually happens in the real world and is this department capable of doing that?

TED DOOLITTLE: So, in terms of other states that have it, next door in Rhode Island where they have a slightly different configuration, they have a separate office of health insurance commissioner as opposed to health insurance -- an insurance commissioner like we have that contains all the forms of insurance. They do have affordability standards and rate reviews here. I -- I believe that both in terms of the authority, again, my belief is that the authority is -- is already there as I say that may be a point of dispute. I certainly grant you that. I will note that Governor Lamont on October 22, in front of the CONECT group, the Congregations Organized for a New Connecticut, did commit that he would instruct his insurance commissioner to take this step and consider affordability under the rate review process. It -- have I answered your question, Mr. Chairman?

SENATOR LESSER (9TH): I think -- very well. I look forward to working with you.

TED DOOLITTLE: Thank you.

SENATOR LESSER (9TH): Next up, we have Senator George Logan. Is Senator George Logan here? Okay. Senator Mae Flexer? It’s like we’re going down the roster of members of the General Assembly. [Laughter]. Representative Holly Cheeseman. Representative Cheeseman, would you like to testify? If you’d like to be? We could also give you a minute to prepare yourself. Good morning, Representative Cheeseman. Please press here.
REP. HOLLY CHEESEMAN (37TH): Press my button. I should know that by now. Good morning, Senator Lesser. I didn’t think I’d be here first. I will get the appropriate public hearing testimony.

SENATOR LESSER (9TH): Take your time.

REP. HOLLY CHEESEMAN (37TH): I see Representative Scanlon isn’t here, but I will address my comments to -- to you and the rest of the distinguished members of the committee. Thank you so much for allowing me to come and testify today on proposed bill redefining third party administrators to include pharmacy benefit managers. I know this committee has worked very hard to address some of the more egregious practices of pharmacy benefit managers. In the past few years, we’ve passed some very important legislation that would ban claw backs; whereby, a patient is unwillingly charged a higher copay at the pharmacy if they use insurance as opposed to paying cash. We also banned gag orders, but there is still more work to be done, and I think this would be a good first step. Indeed, I would be very happy, although increasing the transparency, increasing the accountability by including pharmacy benefit managers under the heading of third-party administrators is as I say a good first step. I would be delighted to see this bill used as a vehicle to advance some of the things the comptroller has proposed for the state pharmacy benefit system. His new agreement would have to include the fact that PBMs pass on all rebates to the state, only charge the state the actual cost of the drug. Pricing models must be based on incentivizing the use of highest value drugs from a therapeutic point of view, and it includes an expanded audit authority. Of course, this only
applies to the state system. I would love to see this enhanced so it would include private insurance plans that cover the majority of people in the state, and I think the time is right. There has been legislation passed at the federal level that we continue to do all we can to make sure our patients, our residents, our state are not overpaying for prescription drugs. I think when you go to pay for your prescriptions, it is like the kind of cost awareness you have when you write your check for your local property tax. I dare say nobody here can say how much they pay in local, state or federal tax, but when you actually have to write the check to your municipality, when you go to the pharmacy and discover that that generic for which you are being billed $5 dollars a year or two years ago is now $20, $30, or $40 dollars, you feel that pain. You feel it on a monthly basis and everything that we can do to ensure that companies like pharmacy benefit managers are operating in the best interest, not only of their bottom line, but of the people who are availing themselves of their services, so I would welcome the chance to have the committee’s support this proposed legislation, but I would also welcome the chance to enhance it, to make our citizens lives better, to hold down cost for the state, and in effect to make everybody healthier because you can’t improve your health by taking your prescription medication if you can’t afford it.

So, I want to thank you again for taking the time to hear me today. I think this is an incredibly important issue, and I would look forward to answering any questions from the committee. Thank you.
SENATOR LESSER (9TH): Thank you, Representative Cheeseman. I’m sure we all share your concern about the rising cost of prescription drug and the impact on our constituents. I know that that’s been a major focus of this committee and will remain so this year. There’s other legislation that we’ll be hearing at future public hearing also on a similar topic, specifically with regard to the proposal that you have, I’m trying to understand what it would mean to classify PBMs as third party administrators. Are you specifically concerned about PBMs operating within the context of a health plan or outside of the context of the health plan.

REP. HOLLY CHEESEMAN (37TH): I think inside the context of health plans. As you know, this is how insurers typically contract to handle their prescription drug needs. As I say, this is a first step of a certain regulation with regard to third party administrators in terms of having to be audited, making certain figures available, so I think with a view toward increasing that transparency. Again, it’s an important first step to make that information available.

SENATOR LESSER (9TH): And -- and are there specific proposals -- are there specific activities that you’re looking to curtail or are there specific things that you would be able to achieve by classifying a PBM as a TPA?

REP. HOLLY CHEESEMAN (37TH): I think it’s -- the purpose is to reveal -- give insurers and other people administering the plans, the ability to more readily access that data so they can see whether or not PBMs are operating in the best interest.
SENATOR LESSEER (9TH): Okay. Thank you. Are there other questions -- yes, Representative Floren.

REP. FLOREN (149TH): Thank you so much for being here, Representative Cheeseman. I was just wondering how are the mergers, you know, with the sale of Express Scripts, etc.? Are -- is it going to affect your proposal?

REP. HOLLY CHEESEMAN (37TH): I think they’re going to make bigger -- obviously, perhaps bigger PBMs, and I think that is something we have to be aware of where an insurer and a company or Aetna and CVS that administer pharmacy benefit managers, and I think that was probably one of the reasons why there were antitrust concerns, so I cannot specifically say how it would be affected. I think the proof of the pudding is in the eating, and I think that’s something that which we should be vigilant and possibly concerned.

SENATOR LESSEER (9TH): Thank you, Representative Florent. Other questions from members of the committee? If not, thank you very much for your testimony, Representative.

REP. HOLLY CHEESEMAN (37TH): Thank you very much for your time today, and thank you for --

SENATOR LESSEER (9TH): Thank you. Is Representative Kim Rose here? Hello, Representative Rose. Good morning.

REP. ROSE (118TH): Good morning. I’m Kim Rose. I represent the 118th district of Milford. Senator Lesser, Representative Scanlon, Senator Hartley, and Representative Dathan, and members of the committee, thank you for allowing me to testify. I’m testifying today in support of House Bill 5425, that
would require home improvement contractors to maintain a $250,000-dollars minimum of liability insurance testimony. I’ve also submitted pictures of my own home. I would appreciate it if you would take a look. I had buckets literally in my house yesterday from the rain. Let me start by saying I worked for a building department in the city of Bridgeport for about 17 years. Seen repeated incidences with folks, our constituents having issues with contractors. Knowing what I know, I ended up applying CBD grant through the city of Milford, so my job was bid -- went through a bid process.

I know better than to take the lowest bid. In this instance, I didn’t have a choice. I was literally up here in session. My son called me at 12:00 at night. I was out in front of the Capitol telling me that there was a flood in my house. The contractor that was hired to replace my roof and my skylights did not tarp my roof. It rained. My entire dining room was ruined. Contractor finished the job -- long story short 8 years later my roof is still leaking. I have -- you’ll see pictures. My kitchen, my living room ceiling is half down, my bathroom ceiling fell down yesterday.

During the course of trying to get some remediation, the state of Connecticut has what they call a guarantee fund and what that is is it is paid for out of the registration fees that contractors pay to the state of Connecticut. Our contractors are not licensed. They are just merely registered. What happens with the guarantee fund is it’s capped at $15,000 dollars. So if a consumer has an issue with the contractor, they first have to go to court, sue the contractor, win their case, and then have the
contractor default on his payment. They then can go to the state of Connecticut and get some remediation from the guarantee fund. In many, many cases, the $15,000 dollars doesn’t even come close to bringing a homeowner whole in this situation.

In my situation, I privately sued the contractor. He was underinsured. His insurance agents were on, on the roof of my house with my attorneys and their attorneys and my insurance. They came down laughing saying there’s no flashing. We don’t know how they gave a CO to this job. The city did. Long story short, I was able to settle the case for about $17,000 dollars. Paid a new roofer to come out to try to repair the roof. That didn’t work. Not only do I now need a $25,000 roof, because I currently have a lien on my property for $25,000 from the original grant, I have about $25,000 in additional damage to the interior of my home. Called my home owners. They don’t cover shoddy workmanship. Since I called them, I was placed in high-risk pool with my insurance. My home owners policy now is much higher. My roof is still leaking. I got an estimate on the sale of my house last summer and my house is grossly underwater because of the damage.

So my biggest asset that I worked for for 30 years is basically ruined because of a shoddy contractor. I hope that you will see fit to bring this through and actually write a bill so that we can get it up and passed this year. I’ve been attempting to do this for several years and I would also recommend that maybe 250 isn’t enough, because I’ve spoken with a lot of contractors who do numerous jobs, you know, especially in Fairfield County, a kitchen is $80,000. We have the support of the Building Officials Association, NARI, which is the
Remodeler’s, Contractor’s Association in Connecticut as well as the Home Builder’s Association. Thank you, and I’m happy to answer any questions.

SENATOR LESSER (9TH): Thank you, Representative, and I am so sorry that you went through what you went through. That sounds awful, and as a homeowner myself. I was in par because I’m looking at a kitchen renovation myself coming up, so I -- so that’s -- that’s a -- that’s a word of warning. I do -- I do appreciate your testimony here today and it is good to see that you’ve done the work to build support among contractors as well. I see that they’ve also submitted testimony in support of this legislation, so I want to thank you for coming before us and for sharing your story and hopefully, there aren’t too many other folks out there in Connecticut who have horror stories like the one that you went through. Are there questions from members of this committee? Yes, Representative Turco.

REP. TURCO (27TH): Representative Rose, good to see you. Thank you for bringing this bill to our attention, and when you spoke to me about this about a week or two ago, I had work being started on my bathroom for a bathroom remodel and I actually have a local contractor from Newington doing the work, so said this is perfect. I’m going to ask them how they would feel about this bill. Is it going to be a burden on the industry or is this something they think is appropriate. And they responded to me when I told them about this proposal, please, please be part of passing this. This will make sure that there’s only responsible contractors doing the home improvement work. They thought the $250,000 dollars was actually low, that a good contractor should have
higher limit than that and that it would help root out the irresponsible contractors from the industry and protect consumers and homeowners like us. So I think this is great.

I’m just curious, in your conversations with other contractors in the industry, have they been acceptable to this and supportive? Thank you.

REP. ROSE (118TH): Thank you for your question and good luck with your bathroom remodel. You know, most contractors will -- in response to your question, every contractor that I’ve spoken to is in support of the bill. They’re conducting business in the state of Connecticut. This is a consumer protection piece right here. I’m not the only one that this has happened to. You’re absolutely right $250,000 dollars is not enough.

Look, we all make mistakes. You know, I go do something, I’m cooking, and I burn my finger. That’s hurting myself. So these contractors are vulnerable. Things happen. But when you’re irresponsible and you’re not conducting business the way you should be in the state of Connecticut, mistakes happen. Responsible contractors that have enough insurance they can go to their insurance to make a claim. I have a friend whose husband is a contractor. Long story short they had a roof problem. One of his guys literally fell through the roof into a lady’s bedroom. The first thing he said is I’m insured. Let’s call my insurance company. They paid, you know, like a $300,000 dollar claim because there were a lot of issues. So, yes. Thank you for asking.

SENATOR LESSER (9TH): Yes, Representative Hughes.
REP. HUGHES (135TH): Thank you Senator Lesser. Kim, I also heard this very same story on the campaign trail from several of my constituents whose contractors left and stiffed them, and they now have liens on their house and can’t sell their house underwater because they can’t get the seal, you know, that whole loop completed and they’ve tried to go after the contractor and it’s disappeared. So I’m hoping -- I don’t know that this would totally cover that, but I’m hoping that they -- they begged for some kind of legislation to, you know, create a standard, and I’m hoping this also closes that loop for contractors that take off.

REP. ROSE (118TH): Thank you Representative Hughes. Unfortunately, it does not. This covers liability. For years I’ve been trying to get the state of Connecticut to actually test contractors. Sitting in Bridgeport in the building department, they would come in with stick figures not even knowing the basic building codes, so it’s really an unregulated business, and unfortunately, those contractors can go in, start a project, run out of money, steal the money, don’t pay their subs, they walk off the job. They close their business, file bankruptcy and then they reopen under a relative’s name, so that’s a whole other issue, and then bonding is also something that I’d love to see someday.

REP. HUGHES (135TH): So this does not cover that, but it covers the liability up to $250,000 dollars, right? This particular legislation.

REP. ROSE (118TH): It would cover if they do additional damage to your House. I mean, you know, if a good contractor is laying down a roof and
they’re using blow torch and they set your roof on fire, you know, it would cover things like that.

REP. HUGHES (135TH): Great. Okay, thank you for clarifying. Thank you for your testimony.

REP. ROSE (118TH): Thank you for your question.

SENATOR LESSER (9TH): Thank you Representative Hughes. Other questions from members of the committee.

I do have one question. There was an individual submitted testimony who asked that, I guess in some cases, you can -- there are people who get a home improvement contractor license solely for the purpose of taking out permits to work on their own home. He asked that they be exempt from the provisions of this. I’m not sure I understand why you would do that, but that’s what his testimony said. Do you have any objection to limiting this to solely to people who work on other people’s homes??

REP. ROSE (118TH): In my 17 years of experience with building permits in the city of Bridgeport, homeowners are allowed to just take out a permit to work on their homes. If you’re hiring a contractor, then you need to hire a registered contractor.

To build a new home, the homeowner would have to -- if they wanted to build their own home, I believe that they would have to have a new home builders registration, but not a home improvement. If you want to work -- if you decide you want to do your kitchen, there’s no requirement saying that you can’t take the permits out and do your own kitchen.

SENATOR LESSER (9TH): Okay. Thank you. Thank you very much Representative. Next up, I see
Representative Cook is in the room to testify on House Bill 6096. Good Morning Representative Cook.

REP. COOK (65TH): Good Morning Senator. Actually it’s 6069.

SENATOR LESSER (9TH): I apologize.

REP. COOK (65TH): No worries. Thank you for being here and thank you for hearing me. Chairman Lesser and ranking members and members of the Insurance Committee, I am testifying in support of the underlying intent of House Bill 6069, AN ACT RESTRAINING CHANGES TO HEALTH INSURERS’ PRESCRIPTION DRUG FORMULARIES. The original intent of this legislation was to prohibit insurer’s from altering formulary coverage with limited exceptions during a formulary contract year. The only reason for this change is so that insurers can derive greater revenues through savings. The impact of mid-year formulary changes have adverse patient outcomes, which include changes of dosage, decline in adherence, increased hospital readmission, ER visits, outpatient visits, and other medical and pharmacy costs. This practice shifts healthcare costs at the expense of the consumer and the patient and the healthcare system. I am not aware of any other industry which allows for a contractor’s rules or a contract rule of coverage to be changed midyear, so why is this practice allowed?

Several other states have already enacted similar protections for patients and consumers, California, Nevada, Texas, and more recently Illinois. And, presently, there are many other states considering similar legislation. Presently, Connecticut insurers are not required to honor the terms of the prescription coverage contract they advise and sell
to consumers. Taking advantage of this loophole, insurers often reduce coverage for medications forcing patients who are stable on their treatment onto insurers’ preferred medication. Patients are then locked into the coverage and have no way to change the plan. Insurers are free to change or adjust their formularies during open enrollment when consumers have a fair chance to review and compare their options. This is not a freezing of the formulary but rather protecting consumers from bait and switch tactics. Generic substitutions would still be allowed with the patient’s healthcare providers consent and drugs could be removed for safety reasons.

Currently, the insurers have the ability to control drug prices under the contracts. In fact, most insurers have already negotiated contracts with suppliers to restrict price increases and know the maximum of -- a medication will cost for that plan year. Sometimes, they even know pricing for a few years to come; therefore, any claim that health plans should need to adjust their formularies throughout the year due to the price increase is false. Not only do contracts with pharmaceutical manufacturer’s mean insurers likely pay less than the public price of medications but most have cost caps and even cover multiple years making it even more unfair that a consumer’s pharmacy benefits can currently be reduced within the plan year.

I would ask that the members review OLR report 2017-R-202, which is attached in your online testimony that we have sent over, an insurance coverage for certain prescription drugs removed from a formulary. As you will see, the existing state statutes do not adequately protect patients and consumers from
having their medication coverage changed during a policy year or require consultation with the medical provider. I, therefore, would respectfully ask the committee to amend HB 6069 to strengthen the patient protections. I have attached the recommended language for the committee’s consideration. Thank you all for your time and consideration on this extremely important consumer proposal.

SENATOR LESKER (9TH): Thank you, Representative, and I -- I will note that this is similar to a concept we heard last week that, I believe, Senate Bill 39, introduced by Senator Martin Looney, also concerned about this similar practice that you’re describing, so thank you so much for your testimony. It’s certainly a concern that I think a lot of people in this building are -- are expressing. Are there questions from members of this committee? Well, thank you -- thank you very much. It’s something I think the committee will be looking at very closely, and I really appreciate you bringing this to our attention, Representative.

REP. COOK (65TH): Thank you, Senator, and thank you for entertaining the addendum this year.

SENATOR LESKER (9TH): Always a pleasure.

REP. COOK (65TH): Happy Valentine’s Day. Have a wonderful day.

SENATOR LESKER (9TH): Thank you. Speaking of Senator Looney, I think I see him in the -- in the room, so Senator Looney, would you like to testify on -- on several bills before us? I think you have a few. And, then following Senator Looney, that’ll end the public official portion of this morning’s public hearing, and we will then alternate between
Members of the public and elected officials for the balance of the hearing. With that, Senator Looney, good to see you. Please press the button. Thank you.

SENATOR LOONEY (11TH): Thank you very much, Mr. Chairman. It’s wonderful to be here once again and before this -- this committee, and Chairman Lesser and members of the Insurance and Real Estate Committee, I am Martin Looney, senator from the 11th district, representing parts of New Haven, Hamden, and North Haven, and I’m here to testify in support of several bills; Senate Bill 327, Senate Bill 330, Senate Bill 331, and House Bill 6096 of which Representative Cook just testified before me, and it is indeed quite similar to Senate Bill 39 that was on the agenda last week that I -- that I had introduced, and would certainly endorse Senate Bill -- or House Bill 6096 also.

Public Act 15-110, require that ambulance services make a good faith effort to determine whether a patient has health insurance prior to billing that patient, and this Act was passed in response to numerous complaints by residents who were billed sometimes with aggressive collection techniques immediately after requiring a ride by ambulance to the emergency room. It appears that some ambulance companies were making no attempt to discover whether a patient had insurance that would cover these expenses, so Senate Bill 327 would require health insurance coverage of ambulance services, and would require that these services be provided at an in-network cost-sharing level. The legislation would also prohibit balance billing for these services. The ambulance rides to the emergency department are not shoppable services, and a patient who requires
immediate emergency medical attention should not be left with a large bill for an unavoidable service.

Also, in 2016, the commission on health equity was abolished. The statute section that created the commission had included the following language “Equal enjoyment of the highest attainable standard of health is a human right and a priority of the state.” While the commission no longer exists, health remains a human right and the Connecticut general statutes should include this language, and Senate Bill 330 provides for restoration of this language. Senate Bill 331 would add the term affordability to the criteria that the Department of Insurance should consider when approving or denying health insurance rates. Clearly, the affordability of the plan for policy holders is of extraordinary importance when analyzing these rates. Prior to this, the position of the department is -- has been without explicit inclusion of the word affordability that cannot be one of the standards that the department applies in evaluating rates, and this would make it explicit that it -- it is and should be, and as I said, House Bill 6096 is similar with Senate Bill 39, AN ACT OF LIMITING CHANGES TO PRESCRIPTION DRUG FORMULARIES DURING THE TERM OF CERTAIN HEALTH INSURANCE POLICIES. Both are designed to protect patients from formulary changes during their policy terms. It’s simply unfair that if a patient buys a health insurance policy that includes prescription drug coverage for a specific drug that the health insurer then can change the formulary during the policy term and exclude that drug. In fact, if it is a fairly rare drug, it may be that inclusion that attracted the -- the person to select that policy in the first place. I have a
concern that -- that -- that House Bill 6096 is currently drafted might allow the insurers to deny coverage prior to the FDA expressing safety concerns if the insurer claims that there were concerns expressed in peer review medical literature generally recognized by the relevant medical community, and there are times when a physician and a patient knowingly choose a drug that has some documented dangerous side effects because despite these dangers, it appears to be the best course of treatment for that patient, and of course, an insurer could contact the physician to share any safety concerns it had rather than denying coverage as the first step, so I look forward to working with this committee and with Representative Cook and others on drafting legislation to address this vital patient protection issue, which is certainly an important consumer protection issue in terms of defeating the reliance that people have in choosing policies in the first place. Thank you, Mr. Chairman.

SENATOR LESSER (9TH): Thank you, Senator Looney, and it’s good to see you back before this committee. It sounds like you’ve got a few ideas on health insurance, and it’s great to hear you and see you before this committee. Just with regard to Senate Bill 327 --

SENATOR LOONEY (11TH): Yes.

SENATOR LESSER (9TH): I’m -- I think I share your frustration. I’m sort of confused as to why this bill is even necessary given that we already regulate ambulance rates through the Department of Public Health. Why -- do you have any idea why -- why they’re not already covering ambulance
services and why that -- why that process isn’t currently happening? Why -- how -- are there barriers to these ambulance companies determining why there cannot be filed health insurance coverage?

SENATOR LOONEY (11TH): Well, we continue to hear reports that there are and also, of course, [coughing] Public Act 15-110 dealt with the problem of the -- the patient being directly billed before they received an inquiry to find out if -- if insurance was -- was in place, and so I believe that was remedied in that bill, but Senate Bill 327 would require those companies -- would require insurance coverage of ambulance services and would require [clearing throat] that these services be provide at an in-network cost-sharing level, and I think that’s the issue in Senate Bill 327 in terms of in some cases out-of-network costs may be imposed that makes the ambulance trip much more expensive than it might be if it were designated as an in-network covered item, and this would -- because of the emergency nature and you don’t -- when you’re seeking an ambulance for emergency transportation to the hospital, you don’t have time to negotiate with perhaps different ambulance companies who is or is not within your insurance plan, so I think the -- it’s a -- it’s a dangerous thing to have someone possibly slapped with an out-of-network charge when he was not in a position because of the critical and time-sensitive nature of the -- of the call for the ambulance to negotiate or to -- to make any inquiries about who is in or out of network at the time of the emergency.

SENATOR LESSER (9TH): And, I guess since -- since ambulance rates are regulated when we think that
they would all be in network, but I -- I guess we’ll -- we’ll --

SENATOR LOONEY (11TH): Well, I think the rates are regulated but the coverage is different, you know. I think that’s the problem. The -- what is charged out-of-network can be greater than what is charged in-network, and I think that’s where the difference lies.

SENATOR LESSER (9TH): Thank you, and -- and definitely appreciate that. With Senate -- Senate Bill 330, the establishing a human right to equal enjoyment of the highest attainable standard of health, your understanding is that simply restores the statue quo ante of what we had in legislation before we deleted that section of the statutes?

SENATOR LOONEY (11TH): Yes. That’s -- as I said, in 2016, the previously existing commission on health equity was abolished, and the statute section that created that commission included that language explicitly, so with the -- with the negation of that section, that language was also canceled, so this is just a restoration of what had been a pre-existing statement of principle in our statutes that equal enjoyment of the highest attainable standard of health is a human right and a priority of the state as, again, this was in our statutes prior to -- or until the -- the Act of 2016 canceled it out.

SENATOR LESSER (9TH): And -- and then with regard to Senate Bill 331, I asked a question earlier. I don’t think you were in the room, but Ted Doolittle, our State Healthcare Advocate, testified in support of that, and I asked him a question. Right now, I understand the department has permissive authority to consider affordability and -- and rate reviews,
but I don’t think they’re currently doing that. do you identify any barriers to that? Are there things that we can do to empower the departments to consider that and are there any other -- other policy considerations we should take into consideration?

SENATOR LOONEY (11TH): Well, I think that what this would do, obviously, is mandate the consideration of affordability, that if for any reason the department is using its discretion not to consider it, that would -- would end that discretionary refusal to consider affordability. Obviously, I think that was an issue previously where -- where the department said it did not -- at one point, said it didn’t have the -- didn’t have the right to include affordability because it was not a statutory criteria. Like you just said, more recently, it is a matter of discretion, but you can’t rely on discretions to necessarily always be applied in the right way, so this would just make sure that it is one of the criteria to be considered.

SENATOR LESSER (9TH): Thank you very much, Senator. Are there questions for the senator from the committee? Yes, Representative Dathan.

REP. DATHAN (142ND): Thank you very much, Mr. Chairman. Senator Looney, thank you for these thoughtful bills. I am very much supportive of 327. I -- I’ve had a constituent who was really stung in this, and I see it’s a big issue. My question actually is regarding Senate Bill 331, which I think is -- is a good bill as well. My question to you is are you aware of any other --

SENATOR LOONEY (11TH): [Sneezing].
REP. DATHAN (142ND): Bless you.

SENATOR LOONEY (11TH): Thank you.

REP. DATHAN (142ND): Are you aware of any other states that have such bills and you know, is there -- how do -- how is it working in other parts of the country?

SENATOR LOONEY (11TH): [Sneezing] Excuse me. I believe there are some. I can get that to you. I don’t -- I don’t know offhand how many, but obviously, we can find out if there are statutes that already mandate it because from the consumer point of view that’s really an essential criteria.

REP. DATHAN (142ND): It’s a consumer protection bill --

SENATOR LOONEY (11TH): Yes.

REP. DATHAN (142ND): Which is like my new favorite thing, but I do see this is as a protection for consumers.

SENATOR LOONEY (11TH): Right.

REP. DATHAN (142ND): Thank you.

SENATOR LOONEY (11TH): Thank you.

SENATOR LESSER (9TH): Thank you, Senator. Other questions from members of this committee? If not, thank you for your testimony. I’m sure you’ll be back, but it’s good to see you here today.

SENATOR LOONEY (11TH): Oh, I sure will. Thank you, Senator, and -- and Representative Scanlon, again, I do applaud you in all your excellent consumer advocative work and protection of patients and
consumers in the state. Thank you. Thanks to the committee.

REP. SCANLON (98TH): All right. Good morning everybody. We are going to now begin alternating between some elected officials who are here and our guests from the public, and we’re gonna start with Dr. Craig Floch, and I apologize if I mispronounced that, but we’re on Senate Bill 135. Just please state your name for the record since I probably butchered it.

DR. CRAIG FLOCH: Hi. I’m -- I’m speaking about -- I’m Dr. Craig Floch. I am a general bariatric surgeon practicing in the state of Connecticut since 1994. I grew up in this state. I’m passionate about what I do. I happen to be the director of Metabolic and Bariatric Surgery at St. Vincent’s Medical Center in Bridgeport, and I also run a big private practice surgical group, and we operate out of Danbury hospital, Norwalk hospital, St. Vincent’ Griffin Hospital.

I thank the committee for hearing me. I’m passionate about taking care of my patients. I have several patients who you’ll hear from later. We’re speaking in regards to health insurance coverage for metabolic and bariatric surgery. We have an epidemic in the United States. It involves obesity, which is a disease like heart disease, diabetes, sleep apnea, hypertension. Obesity linked with these other disease we also know has a big association with all types of cancers including breast, colon, lung. I can name all of them. We have a problem in the fact that coverage is limited in our state, and we have to empower my colleagues, who are also going to speak to you later, and the
people in this room to be able to help constituents of Connecticut so that they can get the surgery they need, which is life-saving. There’s a lot of stigma and a lot of prejudice against people who have obesity, and we talk about obesity as a disease, not that people are obese. It is a disease like everything else.

We need to have a mandate so that insurance has to cover obesity surgery because obesity surgery works in people with sustained weight loss can be insured or improve their medical illnesses such as diabetes, hypertension. Overall, when you look at the cost savings and you’ll look at the statistics -- and I know there’s been a lot of written testimony -- you’ll see that in about the 24 to 36-month mark there is a cost savings, so it is short-sided and short-term not for there to be coverage for this surgery and in the long run, it’s life-saving. It will afford people the ability to get back to work. We know that there’s less doctor’s visits, less hospitalizations, less use of medications, and improve lifestyle of patients and the ability to return back to work; therefore, the workforce is stronger, and overall, we save Connecticut tax payers money.

I -- I can’t urge you enough, and I have to thank mostly the public and the patients who are going to speak to you because those are the people who really let us do what we have to do, and I know the other surgeons sitting in this room, we’re all on the same side and we’re compassionate about what we do and we do what we do to help people. It’s not a financial motivation for us. It’s to help save the public and improve their health style and lives, and I think that point we’ll get across. I’m not sure if I used
up my 2 or 3 minutes I’m allowed or I’m told I’m allowed, but I can keep speaking all day if you want, so I thank you again.

REP. SCANLON (98TH): You’re welcome, Doctor. Thank you very much. So, I think you had inadvertently signed up to testify on a different bill, 135, so we’re going to hear from other folks on your bill in a moment, but do -- do any members of the committee have questions for him? Representative Dathan.

REP. DATHAN (142ND): Thank you, Doctor, for coming in today. This is really helpful. Just as a general question, approximately how much is the cost of the -- the full treatment, the surgery as well as any post care followup that may be born by insurance companies?

DR. CRAIG FLOCH: So, I don’t -- I can’t tell you exactly what the hospitals are reimbursed, but we know that the charges for somebody’s who’s insured undergoing, for example, sleeve gastrectomy or gastric bypass in the state of Connecticut roughly about $20,000 to $30,000 dollars, which includes -- which includes a hospital, the surgeons, anesthesia. That -- that’s about the going rate. I must mention too we see people leaving -- leaving and going to other countries to have this surgery and coming back who are not insured, who we treat in our emergency rooms throughout the state daily who have no -- no benefits.

REP. DATHAN (142ND): Okay. Great. Thank you very much.

DR. CRAIG FLOCH: You’re welcome.

REP. SCANLON (98TH): Any further questions? Again, we will probably have a larger discussion about this
bill in a few minutes, but for now, Doctor, thank you very much --

REP. SCANLON (98TH): Thank you, sir, for testifying today.

DR. CRAIG FLOCH: Sorry, I signed the wrong page.

REP. SCANLON (98TH): No. It’s all right. Next up is Jill Chmielecki. I -- I apologize. Actually, I see my colleague, Representative Petit, over here, so we’ll ask him to come up, and then we’ll return to Jill Chmielecki on Senate Bill 135.

REP. PETIT (22ND): Thank you, Mr. Chair and members of the committee. I am here with my colleagues from the Connecticut State Dental Association. This is Dr. William Nash, former president of the Dental Association and co-chair of the committee on legislation, and he is here to speak on Bill 6088, so I will see the rest of my time to Dr. Nash.

DR. NASH: Thank you, Dr. Petit. This bill basically is -- I don’t -- I don’t know what to call it -- housekeeping thing -- but it’s a -- we want to be included in something that was long establishing of the original statute. It’s a matter of transparency. It’s a matter of communication between the providers and the -- their insurance company. And, basically, what we want to do -- which had just come up last year -- we want to be sure that if an insurance company has decided to change their fees or change the contract, providers need to be notified. They need to be notified well ahead of time because when they -- when an insurance company changes their terms of the contract, some of us may decide not to participate anymore. In this instance, that came up it was a substantial change
in fees for which we were -- nobody of the participants were informed before the fact, and even after the fact, we were not informed. We had to wait until we submitted for payment for -- for procedures that we had did and get the -- what they call -- the explanation of benefits to see our fees had been changes, and we had to figure it out piece-by-piece. That’s pretty unfair, and again, it’s a -- it’s a practice that is not allowed in any other health provider situation, just that dentists got left out. Are there any questions?

REP. SCANLON (98TH): Thank you, Doctor. I appreciate you being here today and joining us. Any questions from the committee? Representative Pavalock-D’Amato.

REP. PAVALOCK-D’AMATO (77TH): How much do you think this cost you a year or does it cost you anything? Are you able to recover the difference from the patient or how exactly -- how is it impacting you as a business?

DR. NASH: If you participate with the insurance company, you -- you accept their fees, and the problem is they were not telling our -- their participants the fees, so again, it gives you a chance to -- to withdraw from the contract so that’s -- that’s basically -- did that answer the question?

REP. PAVALOCK-D’AMATO (77TH): But, after -- as you said after you’ve already performed the services, that’s when you realized that -- [Crosstalk].

DR. NASH: That’s when we found out how much it was. Yes, exactly.

REP. PAVALOCK-D’AMATO (77TH): And, so they don’t send any notice when the fees do change?
DR. NASH: No. Some insurance companies do, but apparently, by -- by statute, they’re not required to do it, and like I said, this has never come up before, so it’s something that we felt strongly that we should be included on.

REP. PAVALOCK-D’AMATO (77TH): And -- and under the terms of your contract with them, it says that you can only charge up to a certain amount, and it doesn’t give language. I guess I would want to see that language to see exactly how it’s written, if it covers for just at that time as far as the contract that you can -- that you can recover or get from the insurance company, but I would definitely take a look at that language.

DR. NASH: They’re very strict about not balance billing.

REP. PAVALOCK-D’AMATO (77TH): Yes, which I -- which I understand, but again, you contracted at the time -- at the certain time under certain fee guidelines, so -- and I’m sure they have something that says fees are subject to change, however.

DR. NASH: Yes.

REP. PAVALOCK-D’AMATO (77TH): Still looking at the whole contract. If you have a sample or anything that you could send us, that would be great.

DR. NASH: Okay. I think we can manage that, yeah.

REP. PAVALOCK-D’AMATO (77TH): Thank you.

REP. SCANLON (98TH): Thank you, Representative. I just have one question. In the testimony that we have received from the Association of Health Plans, and I’m not -- I’m not asking you -- you probably haven’t seen this, but -- and I’m sure they’ll
discuss this later, but they say that they oppose this bill because they feel like the disclosure of fees must be done with caution given that they don’t want to create a race among providers to the top rate at the expense of consumer. Can you talk a little bit about why you don’t think that that would be the case if you were given the same transparency as the regular physicians?

DR. NASH: Well, I would ask the question; does it happen in other fields? If it doesn’t happen in other fields, then why would it happen in dentistry? That’s --

REP. SCANLON (98TH): So, your answer is no? You don’t think that would be an issue?

DR. NASH: No.

REP. SCANLON (98TH): Okay.

DR. NASH: Short answer, yes. Sorry.


DR. NASH: Thank you.

REP. SCANLON (98TH): So, back to Senate Bill 135. Jill Chmielecki. And, Jill, I just want to confirm, are you here for 135? You’re here for 317. Okay. Yeah, is Heather Schlott here? Just hang -- hang with us Jill. I made a little paperwork error here, but we’ll have Heather testify on this bill, and then we can move on to 317 as it seems like there’s a lot of folks here for that. Just state your name for the record, please. Please continue.
HEATHER SCHLOTT: [no mic] is formulas and foods are and how difficult it is to get insurance to cover them, so PKU is a condition in which you can’t metabolize phenylalanine, which is one of the basic components of protein, and so it’s very hard to get appropriate nutrition. If you ingest protein, your phenylalanine levels build up, and it causes brain damage, and so we screen for this condition in our newborn screen, and we identify patients with this condition, but then we fail to go on to support many of them by providing the special formulas and foods that they need to avoid suffering brain injury, mental health conditions, seizures, retardation, and things like that. And, so we often cover drugs, but we don’t cover the formulas and foods. There are misconceptions about -- about what we are asking for, so these low-protein foods are things that can’t necessarily -- can’t be bought in a grocery store. They come from special medical food suppliers, and so for example, you can buy low-protein pasta for $11.49 from one of these suppliers. You can buy a box of crackers that, you know, would replace what your child might eat in the form of Cheez-Its and those crackers will cost like $6.49. You can buy -- you need to substitute pretty much all of the food they eat with something that contains low-protein. They can eat some fruits and some vegetables, but they can’t go to a child’s birthday party and eat pizza that contains cheese. The flour contains gluten, which is the protein. They can’t eat birthday cake. They can’t eat school lunch.

The really are entirely dependent on the formula that has the phenylalanine removed and will provide them the protein they need to grow, and they need
specially modified low-protein foods, and unfortunately, health insurance often doesn’t cover those or covers them only up to a certain age even though this is a life-long condition, and so we are interested in seeing some legislation that would support health insurance coverage for these kinds of things.

REP. SCANLON (98TH): Thank you very much, Heather. Are there any -- to your knowledge, are there any other conditions that insurance currently does cover something similar -- food or something similar to that?

HEATHER SCHLOTT: So, unfortunately, the legislation is spotty, so you know, there is language around specialized formulas for -- so inborn errors of metabolism are the group that this falls under. There are also some -- some conditions that fall in terms of in sort of Gastroenterology bucket that where people can’t tolerate certain types of things, and so they have to have diet modification rather than the drug as a therapy for that, and so there are a variety of conditions beyond PKU that are reliant on diet as the gold-standard therapy as something that’s extremely effective as it is in PKU.

REP. SCANLON (98TH): But, are any of them currently -- are there any laws on the books to your knowledge that require insurance carriers to -- to cover the food for those conditions.

HEATHER SCHLOTT: So, in Connecticut, we have Section 38a-492c, which does cover some inherited metabolic diseases, low-protein foods, amino acid modified formulas, and specialized formula, but I think that our dieticians have seen that health
insurers don’t -- don’t always grasp what that means -- what that statute means or how to apply it, and often families are not getting the coverage they deserve, so.

REP. SCANLON (98TH): It looks like in your testimony you say that only -- that statute only covers up to the age of 12 for formula, not for food, right?

HEATHER SCHLOTT: Yes.


REP. FLOREN (149TH): Thank you so much for being here. This is a very rare condition isn’t it?

HEATHER SCHLOTT: It is.

REP. FLOREN (149TH): Twelve thousand people, maybe?


REP. FLOREN (149TH): Now, are the foods -- the special foods and formulas -- are they prescribed by a doctor or who monitors what you can do and what you can’t?

HEATHER SCHLOTT: That’s an excellent question and you are correct. They are prescribed by a physician.

REP. FLOREN (149TH): They are. So, it is prescription-driven?

HEATHER SCHLOTT: Yes. It is.

REP. FLOREN (149TH): So, it should be considered medicine basically? Not groceries?
HEATHER SCHLOTT: We would like to see that happen, yes.

REP. FLOREN (149TH): Okay. Thank you.

REP. SCANLON (98TH): Thank you very much. Any further questions from the committee? I’m seeing none. Heather, thank you very much. Next, Representative Perillo.

REP. PERILLO (113TH): Good afternoon, Representative Scanlon, Representative Pavalock-D’Amato, and members of the committee. I appreciate the opportunity to be here in support of House Bill 6095. I’m going to hand most of my time over to Mr. Schwab here, but this is actually something that’s pretty significant, especially in this age of the opioid epidemic being what it is. Many individuals who are suffering through a substance use disorder and really seeking recovery have a very difficult time with their insurer either not providing the level of coverage needed for both in-patient and outpatient care and also, throwing up barriers in the form of medical necessity. I -- I certainly know that representatives in the insurance industry might disagree with me on that and as always, I’m very happy to work with all stakeholders coming up with a language that makes sense for everyone, but I’ve been working in the industry for a while, and it’s one of those things you don’t really know until you actually see it, and I see how difficult it’s become, but Mr. Schwab is really the expert here, so I’ll pass this off to him so he can share his thoughts.

JERRY SCHWAB: Thank you. Senator and Representatives, my name is Jerry Schwab. I’m the president and CEO of High Watch Recovery Center.
High Watch Recovery Center is the world's oldest and first 12-step-based treatment center. We were founded in 1939 by Bill Wilson and Marty Mann, some of the founders of Alcoholics Anonymous, so we've got a rich history in recovery. I'd like to thank you for the time and to be able to talk on this bill. I'm not going to read the testimony yet. We have a lot of people here, so I'll just kind of make my points, and if you have any questions for me. A couple of things that are important to us; see I'm the person that, you know, when somebody is in the depths of it -- I'll also mention I am a person of long-term recovery. I've been through this process myself. I'm the person that, you know, people call when they need help, so then we get stuck in the position of trying to figure out, you know, getting that person help and then what are their abilities to pay for it and what are their coverages, so you know, when you hear people often -- in many of these committees over time, you've heard people talk about, you know, difficulty finding a bed at places, you know, so we're the person who tries to get these people in and get these people help. We are a nonprofit. We've been a nonprofit since 1939. We also give away to a lot of charity, but at any given time, however, our beds are 100 percent free, so I just want to mention that also.

But, this -- this legislation would provide guaranteed coverages for different levels of care for patients, so a patient who is suffering from some sort of substance use disorder, whether it be drugs or alcohol, you know, the medical industry, you know, everybody pretty much understands that, you know, there's -- there's a whole continuum of care that you go through with this, and depending on
a patient’s policy, you know, some of those continuums of care just might not be a covered service, so you might not have detox coverage but you’ll have residential, and you might have residential coverage, but you might not have detox, so this is a very loose attempt to begin a conversation of putting in some of those kind of minimum standards, you know. I mean the standards are kind of low in the proposal that it is now, but at least, it’s kind of somewhere to start the conversation and then guarantees kind of all levels of care for somebody as opposed to -- because you really can’t skip them, so we’ve got patients who don’t have levels of care that are covered, so they’ll be in our facility, we’ll go to step them down to the next level of care, and -- and we’re not able to do that because of, you know, their insurance situation, so we have to get creative.

The next thing that’s not addressed in the bill that we’d like to see addressed in the bill is medical necessity. You know, who deems medical necessity. You know, High Watch is very aggressive with working with the insurance companies, working with the care managers on making sure that, you know, we can articulate all the details of a patient’s case as specifically as we can. We advocate very, very much for our patients with regards to exhausting all levels of appeal, but I can tell you from personal experience there’s some insurance providers in the state that are very good and are kind of partners with us, and there’s other insurance providers that -- that really aren’t. We track the amount of days that are approved for somebody, so we work with maybe six major providers. If you look at the top provider, who provides the best level of care with
regards to the amount of approved days and forget the reimbursement rates -- but we’re just talking about days covered based upon medical necessity -- is 50 percent higher than the worst provider that we work with, and if it’s the same population and they’re looking at the same ASAM criteria, you would think that those should all be similar and they’re not, so there’s a grave discrepancy for patients that are out there suffering from substance use disorder on the level of care they get based upon what insurance company that they have, and while the providers will tell you we all follow the same criteria, how they apply that criteria is drastically different. One might say you need to meet, you know, two of the three dimensions. Another might say you need to meet all the dimensions, and I don’t need to get in the specifics of it, but you know, I’d be happy to share with the committee, you know, some of our data over time, if you’re interested, that shows kind of the blatant discrepancies on some of these -- some of the insurance providers because they’re significant. I mean 50 percent is a -- is a substantial difference, and you know, in some of these cases, we’ve gone back to these insurance companies and said, you know, there’s a problem here with what you’re approving, and you know, High Watch got smacked with the -- with the largest audit we’ve ever seen from that insurance company, so you know, if you point out too many problems, you know they’re gonna -- they’re gonna address you in a way that will probably not want you to ask a question again. So, with that, I thank you for your time.

REP. PERILLO (113TH): And, if you don’t mind, I’d like to point out Jerry shared some of those
statistics with me in the data, and it’s worth noting that the most generous insurer when it comes to actually approving days and -- and trying to help their members is actually Anthem.

JERRY SCHWAB: Which, you know, it’s a -- you know, Connecticut based Anthem, you know, they’re a -- they’re a great partner of ours. You know, I don’t want to throw everybody -- you know, I think that they need to get some credit with regards to their excellent to work with, they provide what we think is what everybody should be providing, and I don’t have any Anthem stocks, so sure [laughing], but not all the other providers are as good as Anthem.

REP. SCANLON (98TH): Well, Jerry, first of all, I want to thank you for coming in today. Representative Perillo can probably tell you this issue is very personal and important to me personally. I have many members of my immediate family in long-term recovery, and recovery is different for everybody. You know that, and so I’m wondering if you can talk a little bit about -- so you have 78 beds at High Watch -- talk a little bit about what the average length of stay for a typical detox program would be for somebody?

JERRY SCHWAB: So, there’s different levels of care. Obviously, we have 78 residential beds, then we have about 20 -- so we’re increasing our program to have like longer-term care beds. We have a long-term care program. There’s data and statistics that show the longer somebody is in, you know, treatment the better off they are. Back in the 1930s-40s, they said 90 meetings in 90 days cause they knew that amount of time allowed your brain time to heal and you know, those levels to come back up and be able
to be addressed, but the average detox you’re really looking at -- medically necessary detoxes are opiates. I mean -- excuse me -- are alcohol and benzos. Those are -- you know, the withdrawals from those can be -- can be fatal. Those are usually 3-5 days, 5 days being more common. It can be up to 10 depending on the use, and then the level of where they need to detox is different, so detox you’re looking at 5-10 days.

REP. SCANLON (98TH): But, Representative Perillo’s bill is 7 days, but you obviously feel like that’s adequate because it covers probably what would be the longest stretch somebody might need for detox, right?

JERRY SCHWAB: We’ve clocked some of this. Pennsylvania had some good stuff, so we pulled some of this stuff out of Pennsylvania just to kind of get a conversation going, but yeah, I would -- I would think that 10 days would be a better number.

REP. SCANLON (98TH): Okay. And, then typically -- again, every path to recovery is different -- but somebody would go through detox and then more often than not try to go to a residential treatment facility for in-patient care, right?

JERRY SCHWAB: Correct. I think usually most people want that. I mean I can speak for myself as a person in recovery. Unless I was taken out of the environment that I was in and in an environment that was safe and I didn’t have access to the substances, I don’t think I would have been able to be successful.

REP. SCANLON (98TH): So, Representative Perillo’s bill, again, says that no fewer than 30 days of
residential treatment services during any year. Do you feel like that would be adequate for most individuals to try to attain that sobriety through an in-patient residential facility treatment?

JERRY SCHWAB: No. It -- it would be -- it would be a bit low.

REP. PERILLO (113TH): You know, I’m right here. [Laughter].

JERRY SCHWAB: It would be -- it would be on the low side. I’d say that’s about the average stay, and again, everybody’s path to recovery is different. You know, people do, unfortunately, have relapses along the way, and you know, that would eliminate somebody from coming back in, but again, this was just an attempt to get a minimum in there. There’s -- I mean there’s some great policies that -- that, you know, we work well with that are fine, but there’s some that won’t even cover the 30 --

REP. SCANLON (98TH): Yeah.

JERRY SCHWAB: So, this is like how -- you know, what could we get?

REP. SCANLON (98TH): And, then last question from me would be that, in your opinion given your own personal experiences and then what you do professionally, somebody who goes through detox, goes through residential in-patient treatment, if they are not working in some sort of outpatient program, whether it’s 12-steps combined with MAT or if it’s you know whatever; do you feel like the chances of that person sustaining that long-term recovery are less than they would be if they just got discharged from an in-patient facility and they
were left to their own devices because they didn’t have coverage for that outpatient treatment?

JERRY SCHWAB: It would beyond extremely unlikely.

REP. SCANLON (98TH): Yeah.

JERRY SCHWAB: Even with an MAT program -- you know, MAT is kind of the -- the maintenance part of it. A lot of these people depending on their, you know, what they’ve -- what they’ve experienced in their life with regards to trauma, a co-occurring disorder, unless those issues are adequately addressed the odds of somebody maintaining long-term sobriety without, you know -- people don’t talk about social workers enough, the therapy side of things, or the 12-step -- for me, the 12-step side of things -- you know, without having that kind of human contact with another person to kind of work through your issues, you know, the odds of them being successful are going to be slim, specifically on the outpatient services because a lot of these people need to -- you know, trauma is a big thing for a lot of people with substance use disorder, and unless you’re treating their underlying trauma or their underlying co-occurring disorder, the odds of them maintaining long-term sobriety are slim.


JERRY SCHWAB: Thank you, Senator.

REP. SCANLON (98TH): Any questions from my committee?

JERRY SCHWAB: Representative.
REP. SCANLON (98TH): That’s all right. I go by Sean too. Any questions? If not, thank you both very much.

REP. PERILLO (113TH): If I could ask just one thing? Jerry mentioned the -- the bill does not address medical necessity. I know there’s a representative from Haven Health here who has submitted language on that. I read it, and it seems reasonable, so I would just suggest to the chairs as you’re screening and working through issues and talking with LCO you may want to look at that language.

REP. SCANLON (98TH): Thank you very much.

REP. PERILLO (113TH): Thank you very much.

REP. SCANLON (98TH): Thank you both again.

JERRY SCHWAB: Thank you.

REP. SCANLON (98TH): All right. Senator Lesser I think stole my list. All right. On 135, Susan Halpin [phonetic]. Pass. Okay. We will go onto 317, which I know a lot of folks are here for, and then we’ll begin to re-alternate to some legislators that are in the room, but we’ll start with Dr. Aziz Benbrahim.

AZIZ BENBRAHIM: Dear Chair Lesser, Chair Mr. Scanlon, Ranking Member Kelly, Ranking Member Pavalock-D’Amato, and distinguished members of the Insurance and the Real Estate Committee, I am here to support the Bill 317 from Senator Berthel, who is also my patient. Morbid obesity is a disease. It is chronic. It’s complex. A patient with morbid obesity does not equate through lack of health advise and exercise. Prior to 1921, diabetes were
so because they always found their way to sugar. However, in 1921, insulin was discovered and the patient stopped being guilty by suspicion. Similarly, the disease of obesity or morbid obesity is real, is common, and needs to be treated as such. A disease segregation has to end.

My friend’s father has metastatic cancer with his outlook, which is grim. He is receiving now a $40,000 dollars monthly chemotherapy. This amount would cover for bariatric surgery for two patients who would later rejoin society healthier because of the resolution or the improvement of their medical issues. The health expense savings would replace the cost of surgery in three years approximately. I have been a general surgeon for Hartford Healthcare and with Meriden. I have been exposed to the treatment of disease of morbid obesity for about 25 years. The success of surgery I can tell you is beyond any medical, diet, or exercise program. Our patients are handicapped socially, physically, and psychologically. Please use our skills, our results, and our commitment to help them, and stop the medical segregation against them. Thank you for your understanding, support, and hard work to make our state in the forefront of healthcare as it can be and as it deserved. Thank you. Do you have any questions?

REP. SCANLON (98TH): Thank you very much, Doctor. Do you know of any states in the country that do currently cover bariatric surgery?

AZIZ BENBRAHIM: I can tell you, sir, that the only state in the Northeast who doesn’t cover it is Connecticut.
REP. SCANLON (98TH): That was a better way of answering it, I guess. [Laughter]. Thank you very much. Any further questions from the committee members? Senator Lesser.

SENATOR LESSER (9TH): Thank you, and obviously, I -- I -- Doctor, I appreciate your testimony, and it sounds like you did a -- did a good job on -- on Senator Berthel or else he wouldn’t be here introducing -- introducing this legislation, and I’m gonna ask you a question, but I’ll also open it up to other people because I know there are a lot of other people here who are testifying on this, and I’m trying to review some of the literature because one of the things that the Affordable Care Act does it said at any time we pass new laws requiring health insurance coverage the state has to pick up the cost of that. I understand one of the arguments in support of this proposal is that the savings achieved by providing patients with bariatric surgery exceed the cost of the particular surgery. I’ve been reviewing some -- trying to review some of the medical literature about that and whether or not that actually -- the savings are real or not, and that’s -- that’s one of the questions that I would like the committee to sort of answer to is -- because some of the literature seems to indicate that -- that know that those savings don’t outweigh the -- I saw a 2013 journal article that seems to indicate that the cost of surgery exceeds the savings, but I don’t know that that’s the case, so to the extent that there’s evidence out there and literature out there that helps -- can help elucidate that, I think that would be helpful for Connecticut.
AZIZ BENBRAHIM: Yes. I will be able to -- my partners who might be presenting, I believe there is a lot of data to show -- to show otherwise. I have actually said for 25 years I have seen about 75 percent of the patients doing extremely well.

SENATOR LESSER (9TH): Thank you very much, and I very much appreciate you coming -- you coming out here, and it’s clear you’ve got a very grateful patient there.

REP. SCANLON (98TH): Senator, since you’re here with your physician, I figured it might be a good time for you to say a few words.

SENATOR BERTHEL (32ND): Thank you. I spoke earlier. I testified. I was first in the room today. A long time ago it seems like, right?
[Laughing]. But -- but thank you, Mr. Chairman. I appreciate that. Thank you, Representative.

REP. SCANLON (98TH): This is what happens when you show up late to your own hearing. [Laughing]. [Background talking]. You’re welcome. Any further questions? I’m seeing none. Thank you both very much. Representative McCarthy Vahey.

REP. MCCARTHY VAHEY (133RD): Good afternoon, Mr. Chair, Senator Lesser, distinguished members of the committee. I’d like to introduce to you today my constituent, Tom Griffen, and Sterling Griffen, who is hiding under the table here, and he is going to speak to us today in support of House Bill 5850. Tom.

TOM GRIFFEN: Thank you, Representative McCarthy Vahey, and good afternoon, members of the committee. Happy Valentine’s Day to everyone here. My name is tom Griffen. I’m a resident of Fairfield,
Connecticut, and I am strongly in support of HB 5850 in which it’s purpose talks about the purpose -- the purchase of a medically necessary assistance gauze for person’s with disabilities that have been diagnosed. To reveal -- and I did submit my testimony to you -- I am a type 1 juvenile diabetic. I am wearing an insulin pump. I also have multiple sclerosis, which has created balance and gait issues. I’m also a heart attack survivor, and I am pleased to say that I am a lung cancer survivor, so from diagnostic purposes, I am a medical mess.

With that said and done, Sterling is classified as a medically alert service dog or assistance dog. He has been specifically trained for over 2 years before I got him to respond to the alarms on my insulin pump. When my sugars get too high, an alarm goes off and he responds or vice versa if it gets too low. He can help me with my gait and my balance. If you will see when you look at Sterling he wears it’s a cane-like vest, so I can use that to get myself up and down if I’m having difficulties or when I fall I can -- he can lock his back and I can use him to almost become my step stool to push up.

With all that said and done, what I’d like to give you is a very specific example. In June 2018, Sterline and I were camping in Northwest Connecticut. Around 2 o’clock in the morning, I am sound asleep and all of a sudden Sterling jumps on the bed and brings me this b-a-g -- it’s a command -- which has my blood glucose meter kept and tablets and all the stuff that a diabetic needs. He jumps on my bed. He’s 65 pounds. He’s on my chest. He’s licking me, and he drops this, and I’m really not paying attention. I -- long story short, I was going into high blood sugar, and when that usually
happens, you become unfamiliar with your environment. Then, all of a sudden, I hear him go into the refrigerator and he pulls out the j-u-i-c-e, jumps on the bed, and now drops this on me, which is his way of saying, Tom, something’s wrong, do something. I now begin to kind of come out of unconsciousness and I pull out my insulin pump, and I’m looking at it, and I’m saying there’s no alarms going off, what is Sterling doing, and I realized that this piece of durable medical equipment, which was paid for by my insurance company had stopped working. It had malfunctioned. While what Sterling did, I believe, is that through his sense of smell he was sensing a change in my chemistry through their sense of taste and smell. What did he do? He knows that when he smells things, while it would usually be in connection with an alarm; what did he do? He brought me a b-a-g and he brought me j-u-i-c-e. If he did not do that, I am convinced by the morning I would have gone into a diabetic coma, an ambulance would have had to come, would have had to have come, would have brought me to a hospital. I would have had to go through treatment, potentially even a DKA episode, which is when you go very high with your sugar levels.

So, now, let me go to where I’m going with this little story. A service dog or a working dog or an assistance dog cost X amount of dollars. If Sterling didn’t do his job, then my insurance company would have had to have paid for an ambulance, would have had to have paid for treatment in an emergency room, would have then had to have paid for probably 1-2 nights of a hospital stay to stabilize my condition, which would have been between $100,000 to $200,000 dollars, so I’m looking
at this from pennywise pound foolish. If -- if an assistance dog is not being covered as a piece of medical durable equipment, then my insurance would have had to have paid for the treatment rather than for the prevention.

Last -- the last point I’d like to make is the federal government and the ADA and the IRS tax codes do recognize durable medical equipment as things that are medically necessary to assist with a medical diagnosis, so I’m just making this connection if an insurance company in Connecticut provides for durable medical equipment, then why is an assistance dog not covered? Durable medical equipment is identified as primarily and customarily needed for a medical purpose. They are not useful to persons that in the absence of a disability or a medical diagnosis are ordered and prescribed by a physician. Sterling was prescribed by a physician, Dr. Joseph A. Rosa, who is an endocrinologist working out of the Northeast Medical Group that they can stand repeated use and that they are appropriate for use in the home, so when I look at that definition everything is well Sterling is that, Sterling does that.

So, in closing, I would also like to say that if my insurance company covers the cost of an assistance dog, I still have the option and the right if I choose to submit a claim that’s fine. I can also choose not to submit a claim. There are some people who would say they don’t want insurance companies to get involved because they feel that it might regular their use of an assistance dog. If that’s your concern, then don’t submit the claim. Pay for it out of pocket. There are people we all know that there are -- and I’ll use the example I used to work
in the healthcare environment, that in the days of past if people were diagnosed with aids they did not submit claims cause they didn’t want their employer to know, while the same thing could work with here, but I would strongly advocate that by requiring health insurance coverage for the purchase of medically necessary assistance service dogs for persons with recognized disabilities, you will help promote prevention and save lives in the same way that Sterling saved mine. Thank you very much.

REP. SCANLON (98TH): Thank you. Thank you, Tom. And, I can tell it’s Valentine’s Day because nevertheless we’d never have a Boston College graduate and a Notre Dame graduate sitting together wearing red. That would never happen.

TOM GRIFFEN: And, we’ll save the remarks that BC certainly is better than Notre Dame for another day.

REP. SCANLON (98TH): Please remind her of that because she reminds me the other way, going the other way all the time. But, in all seriousness Tom, it’s great to be here. You and I have met before. I have had the chance to meet Sterling and hear your story. It’s very, very powerful and speaks to why we’re hearing this bill today, so thank you very much for coming. Do any of my colleagues have any questions? Representative Floren and then Representative Dathan.

REP. FLOREN (149TH): [Speaking off mic].

TOM GRIFFEN: So am I. [Laughing]. Yeah, I can give you the range -- the -- the organization where Sterling comes from, which is ECAB, which is located in Winchester, Connecticut. They roughly charge the client about $25,000 dollars, but they cost
approximately $40,000 dollars, but then they do some fundraising that reduces the price down, so I would say in general whether it’s, you know, a dog that’s the guide dogs or the canine dogs or service dogs, which by state law in Connecticut is referred to assistance dogs, $25,000 to $35,000 dollars tends to be the cost, and as I said like with Sterling, he went through just shy of 2 years of training.

REP. FLOREN (149TH): Yeah.

TOM GRIFFEN: You know, so these are not just dogs that learn how to sit and stand and poop outside as opposed to inside, so that’s the expense of the dogs.

REP. FLOREN (149TH): Thank you. Could I ask you one more question? [Crosstalk]. Why did you spell j-u-i-c-e?

TOM GRIFFEN: Do what?


TOM GRIFFEN: No. I didn’t say it because it’s a command. I -- if I were sensing my sugars going low, this is the fastest way to get sugars up without eating like chocolate bars, so I would say I could be in my bedroom and I’m sensing, you know, that I’m getting a little, I can say, “Sterling get my ___” and then he will find it by going into a refrigerator, and it’s the scent on this -- this thing, and then he opens up the refrigerator, pulls it out, and will bring it to me, you know, so.

REP. FLOREN (149TH): Thank you.

TOM GRIFFEN: Yeah, you’re welcome.
REP. SCANLON (98TH): Representative Dathan.

REP. DATHAN (142ND): Thank you very much, and thank you Representative Floren cause you asked one of the questions I wanted to ask. Thank you very much, Mr. Griffen for coming today. How many -- are you aware of how many dogs there are in Connecticut that would help individuals like yourself? I mean I see it as a cost benefit instead of having around-the-clock nursing care, and I wonder how many people are utilizing them?

TOM GRIFFEN: Well, I can maybe respond this way, and I’ll try to answer your question. I know that there is a demand for assistance dogs that people who could benefit from them cannot afford them, so that creates one problem, and then there is the issue of the organizations to be able to provide enough dogs to meet the demand, if you will. It’s this, you know, balancing act. I know like at ECAD and I’m not representing them, potentially where he comes from, not every dog who is born makes it through all of the training. Their personality characteristics like barking and stuff like that, which they become known as release dogs, so it’s a long-winded way of saying that I do know people who would benefit from these dogs that there’s no way that they have the financial means and -- and the challenge of organizations to train enough of the dogs to meet, so am I answering your question or not?

REP. DATHAN (142ND): Yeah. I mean -- I -- I see the need there. It sounds like it would be good. I also see a use in the Alzheimer’s community.

TOM GRIFFEN: Sure.
REP. DATHAN (142ND): My mom suffers from Alzheimer’s, and I can imagine that in a stage before someone would go into advanced care that, you know, medically assistance dogs like you have would really be beneficial.

TOM GRIFFEN: Yeah, and that’s why I wanted to emphasize in terms of the purpose of the bill that Christine had, you know, written it. It talks about medically necessary. You know, we’re not talking about emotional support dogs and therapy dogs, which I’m not, you know, downplaying the validity, but there is a difference. By law, an assistance dog has to be a dog that can mitigate diagnosed disabilities, you know, per various either state laws or federal laws, so you know, as I said, I know for -- for -- well, the organization that he comes from they train dogs in three realms. People on the autistic cycle or the autistic spectrum, people with neurological issues, which is where I come under with my multipole sclerosis, and -- and people with posttraumatic stress disorder, largely, you know, the vets. And, when I approached ECAB, that -- that’s why he’s classified as a medical alert service dog because they said, well you had this MS so you have to have a dog that when you fall and you’re by yourself how are you going to get off the ground. He can also get my phone. Again, it’s a command c-e-l-l, and he can find that phone. They smell the battery, and he brings me the phone so I can then use it to 9-1-1 or something like that, but I’m also diabetic, so in essence, he’s multi-skilled to handle two things, and that’s why I said like with my insulin pump he hears the alarm, and that’s where he knows. He hears the alarm and this is what
he’s supposed to do, but e didn’t hear the alarm because the pump --

REP. DATHAN (142ND): Was malfunctioning.

TOM GRIFFEN: Malfunctioned. So, through the rest of the night, just to finish that -- you know -- every 2 hours I set my alarm to go off so I could do it the old-fashioned way, you know, get the syringe and do that. you know, in the morning, I called the company, and I said this pump ain’t workin, we have a problem. I’m camping in Northwest. Well, you know, by that night, they had delivered a brand new insulin pump, so that -- so the rest of that day I’m doing it the old-fashioned way until the night, you know. Well, if it weren’t for him -- so -- and I do feel that -- that there are so many chronic diseases that could benefit -- you know, the patients could benefit, which again as I say, do you work on the prevention? My hope is that Sterling, his training, he’d never have to use it. Like schools and fire drills; why do we do that? So, in the event the school goes on fire, the kids know how to get out. You don’t wait until the fire to teach them how to do that, so that’s my long-winded way of --

REP. DATHAN (142ND): Thank you.

TOM GRIFFEN: Being very passionate about this.

REP. DATHAN (142ND): Thank you very much for coming.

TOM GRIFFEN: Thank you for having me.

REP. DATHAN (142ND): Thank you, Representative Scanlon.
REP. SCANLON (98TH): You’re welcome. Any further questions? If not, good to see you. Thank you for coming.

TOM GRIFFEN: Thank you very much.

REP. SCANLON (98TH): Representative.

TOM GRIFFEN: Thank you very much.

REP. SCANLON (98TH): All right. We are going to go back to 317, and we’ll be on this for a while, so Linda Hegedus is next up, followed by Dr. Makram Gedeon.

LINDA HEGEDUS: Good afternoon. My name is Linda Hegedus, and I am here I support of SB 317. After having been morbidly obese for well over 14 years, I’ve encountered many medical issues such as high blood pressure, sleep apnea, osteoarthritis, psoriasis, insulin resistance, and high cholesterol. At that point, I was barely walking with the assistance of a cane, and I was told by my orthopedic surgeon to begin to look at the reality of being in a wheelchair for the rest of my life. This was when I decided to finally get bariatric surgery.

As an employee of the state of Connecticut, I was fortunate enough that my insurance company would cover my procedure. On April 4, 2011, Dr. Neil Floch performed my life-changing, if not life-saving, Roux-en-Y gastric bypass surgery. Excuse me, gastric [clearing throat] bypass surgery. Today, I no longer require a cane, a CPAP machine, or cholesterol medication. This tool gave me the necessary cues I needed to become healthy and fit once again. I also returned back to an active lifestyle, which entails Yoga classes,
training, cycling, and gardening. I have reignited a spark within me that I thought was gone forever. By having bariatric surgery performed, it eliminated the cravings for foods I used to eat, eventually having me tipping the scale to 330 pounds to my 5 feet 4 body frame. The challenges I face will always be with food, and having an addiction to food is different than drugs or alcohol. We all need to eat in order to survive. This is the longest period of time I’ve maintained a healthy weight, and I attribute it to the surgery. I finally feel whole, energetic, and most importantly healthy. I am living a pain-free and productive life, and I’m very grateful that these weight loss procedures are available for people like myself where the finally make it possible to conquer this battle once and for all. I am here today in support of SB 317, that insurance companies provide coverage to people who require bariatric surgery in order to eliminate their long-term health issues that accompany obesity. It would reduce costly medical bills insurance providers currently pay out for individuals who are denied this benefit. Thank you for your consideration.

REP. SCANLON (98TH): Linda, thank you for coming here today and sharing your story. We certainly appreciate it.

LINDA HEGEDUS: Thank you.

REP. SCANLON (98TH): Any questions from the committee? All right. Thank you very much.

LINDA HEGEDUS: Thank you.

REP. SCANLON (98TH): Representative Gilchrest.
REP. GILCHREST (18TH): Good afternoon, Representative Scanlon and members of the committee. Thank you for the opportunity to provide testimony in support of House Bill 5860, AN ACT REQUIRING HEALTH INSURERS TO ACCEPT PAYMENTS FROM CERTAIN NONPROFIT CORPORATIONS.

In 2016, the Centers for Medicare and Medicaid services issues federal guidance on third-party insurance payments for the new Exchange plans offered under the Affordable Care Act. CMS failed to include nonprofits on the list of acceptable arrangements for patients covered by qualified health plans, a direct contradiction to the standard currently used by Medicare for nonprofit charity third-party payers. I introduced House Bill 5860 after meeting Colleen Brunetti, a West Hartford resident. She explained that the ACA loophole, as it is commonly referred to, prevents charitable organizations from helping to pay for a patient’s health insurance premiums and copayments. She could do a much better job of explaining the issue and its impact, so I’m going to turn this over to her, but before I do, I will leave you with the question I am still left with. If they’re receiving their payment, why would a health plan reject premium and cost-sharing assistance from a nonprofit third party? Why does it matter where the payment comes from so long as they’re getting the payment?

COLLEEN BRUNETTI: Thank you Jillian. So first, let me say I am really grateful to be in a proactive state like Connecticut with representatives like Jillian who are working so hard to protect our healthcare system for rare disease patients like me. It’s been very enlightening sitting in here this morning, and thank you for the committee for
allowing me to give testimony today. So, I come to you today to speak on behalf of all rare disease patients.

I am diagnosed with a rare incurable and usually fatal lung disease called pulmonary arterial hypertension. Average survival rate runs at about 50/50 at 7 years. I just reached the 11-year anniversary of my diagnosis. A diagnosis like pulmonary hypertension is emotionally devastating enough. Following the news that you are likely dying, comes news that the options you have to fight your disease come in the form of pharmaceuticals with mind-blowing price tags. For me, this means roughly $250,000 dollars a year in medication. While I do have insurance, it is a high deductible plan with out-of-pocket cost that each year have become more and more difficult to meet. More so than ever this year, as my plan is switched to a copay accumulator model and refuses to apply my $6000-dollar copay card for a single medication to my high deductible, instead holding me responsible for that cost despite the fact that I able to secure help from the manufacturer.

One option patients have had in the past is to get copay or premium assistance through charities set up to help patients with out-of-pocket costs. In the pulmonary hypertension world, this used to be a relatively easy thing as we had one go-to charity that helped countless people. That charity is now closed. Today, patients like me have to keep an eye on a number of other charities who funds open and close at random and may only be available to apply for a few hours for a few days, and now, over the last couple of years, advocates in the rare-disease community have watched the practice spread where
insurance companies are refusing to take these charitable funds at all.

I echo Jillian’s original question. Why would such a policy even exist? They’re getting their money. I would say the answer is fairly simple. I am expensive and refusing to allow me to get financial help be it through charities or copay cards applying to my high deductible, it makes it possible to discriminate against my pre-existing condition while still following the letter of the law. If I can’t get help paying for my medications, the time may come where I can’t pay for them, and then in theory neither would the insurance company have to since I can’t kick in my part. I say this about pulmonary hypertension all the time. Being sick is hard enough, and yet, we patients find ourselves constantly fighting an ever tightening set of insurance policies and ever rising drug prices. We don’t just fight to stay alive with our health. We have to fight hours and hours to get to the policies that block us from accessing our life-saving medications. As we look at HB 5860, AN ACT REQUIRING HEALTH INSURERS TO ACCEPT PAYMENTS FROM CERTAIN NONPROFIT CORPORATIONS, I encourage support for any legislation that requires insurers to count cost-sharing payments made by or on behalf of an individual, towards that individual’s cost-sharing amount no matter where it comes from. The insurance companies will get paid. It shouldn’t matter from where the patient is able to piece together the assistance. Thank you.

REP. SCANLON (98TH): Thank you very much for coming in here today, and I know it’s not an easy thing to do, so I really appreciate you being here and sharing your story with us. The insurance companies
did not submit testimony. At least, it hasn’t come up yet on our system, so I haven’t seen what they’re going to say, but when you interact with your insurance and you try to do this -- what seems like a pretty simple thing -- do they just tell you that they can’t figure out a way to make it work or they are telling you that they cannot accept the payment?

COLLEEN BRUNETTI: So, I haven’t run into the ACA loophole issue personally. I wanted to address it as volunteer advocate. As far as copay accumulators go, they say that it more actively reflects my out-of-pocket cost and that -- that it’s impossible to get any sort of answer as to -- as to why that doesn’t hurt my family’s financials.


COLLEEN BRUNETTI: Thank you.

REP. SCANLON (98TH): Any questions from the committee? Representative Dathan.

REP. DATHAN (142ND): Just a quick question. The not-for-profit that you get assistance from, presumably they have employees?

COLLEEN BRUNETTI: The one did, yes.

REP. DATHAN (142ND): Yeah. Do they help their employees pay for their insurance premiums?

COLLEEN BRUNETTI: I’m not sure I understand the question.

REP. DATHAN (142ND): So, does the not-for-profit pay anything alongside the employer portion of a health insurance premium?

COLLEEN BRUNETTI: Oh, for their own employees. I -- I’m not sure.
REP. DATHAN (142ND): So, my question is more of if the health insurance provider or the health insurance company is taking premium dollars for -- on behalf of an employee, why would it not take from someone else?

COLLEEN BRUNETTI: I would love to hear the answer to that.

REP. DATHAN (142ND): Just a question. Thank you very much.

REP. SCANLON (98TH): I see no further question. Thank you for coming in today. Representative, thank you.

REP. GILCHREST (18TH): Thank you.

REP. SCANLON (98TH): All right. Dr. Makram Gedeon, followed by Amanda Christie.

MAKRAM GEDEON: Good afternoon. My name is Makram Gedeon. I’m a bariatric surgeon with Bristol Hospital and Healthcare Group. I also serve as a board member at large at the Connecticut -- with the Connecticut chapter of the American Society of Metabolic Bariatric Surgery. Before I begin, I’d like to thank committee co-chairs, Senator Matt Lesser and Representative Sean Scanlon as well as vice-chair Senator Joan Hartley and Representative Lucy Dathan. Those I’d like to recognize ranking committee members, Senator Kevin Kelly and especially Representative Cara Pavalock-D’Amato who has been a generous and long-time supporter of Bristol Hospital for many years now.

I was recruited to Bristol Hospital 10 years ago to help structure and grow the Bariatric Surgery Center. I’m proud of all the work that we have done
together building our center, which has touched the lives of more than 1000 patients. I am honored but mostly I’m humbled by the trust that my patients have given me. In the past few years, I’ve unfortunately witnessed the discrimination against patients who qualify for weight loss surgery and who are denied the medical care they need because of lack of insurance coverage. This is the reason I’m sitting in front of you today asking for support in passing Senate Bill 317. Being overweight and obese greatly increases the risks of health problems including type 2 diabetes, sleep apnea, high blood pressure, heart disease, and even cancer. As a matter of fact, the American Medical Association now considers obesity to be a disease on its own rather than a predisposing condition leading to other health problems.

As you all know, the obesity epidemic is increasing at an alarming rate. Currently, one-third of the U.S. population is overweight and obese; yet, sadly only 1 percent of people who qualify for surgery actually get the care they need. I’m certain that almost everyone sitting on this committee knows of someone or has a loved one affected by this disease. After a certain weight -- after a certain weight-to-height ratio, otherwise known as BMI, is reached, diet, medication, and exercise are not sufficient anymore and surgery becomes the only effective and doable treatment option. For this reason, the medical community today agrees that weight loss surgery is not a luxury, and is not an esthetic solution to a problem, but is a safe, necessary, and life-saving prescribed treatment.

After bariatric surgery, patients show dramatic improvement and even resolution of course of the
conditions as after treated with [inaudible - 02:04:46] including diabetes, high blood pressure, and sleep apnea. The difference that weight loss surgery makes in the lives of our patients is undeniable. I would like to commend and thank Senator Berthel for introducing Senate Bill 317. Being a weight loss patient himself, Senator Berthel can speak firsthand about how weight loss surgery has positively affected his own life. Senator Berthel’s continued support, advocacy, and courage in putting the issue forward is much appreciated.

Honorable Representatives, on this Valentine’s Day, I am asking for your help in supporting in passing Senate Bill 317. I am hoping that together we can help our neighbors, friends, and family members in Connecticut get the treatment they need and deserve. Thank you for the opportunity to speak today, and I’ll be happy to answer any questions you may have.

REP. SCANLON (98TH): Thank you Doctor. Representative Pavalock-D’Amato.

REP. PAVALOCK-D’AMATO (77TH): Thank you. Thank you, Doctor, for coming today. I really appreciate you and -- and the other people from Bristol Hospital for coming to testify, and I -- I am glad that Senator Berthel put this bill in. My question -- my first question is how many different types -- and somebody may have asked this before -- how many different types of the surgery are there an then how many different types are performed at Bristol Hospital?

MAKRAM GEDEON: Thank you for the question. So, the most common operations that we perform are the sleeve gastrectomy. That’s the most common operation in the United States today, and this is
what we call restrictive operation, and then there’s the Roux-en-Y gastric bypass, and that is -- that has two components, which is one is a restrictive component allows patient to eat less and there is a malabsorptive component. At Bristol Hospital, we perform both operations. Like I said, in the United States, the most common operation is sleeve restricting.

REP. PAVALOCK-D'AMATO (77TH): And, do you think -- cause I -- I’m -- always in my visits to Bristol Hospital for various things, they always are great at keeping data, and I was wondering do you think it’s possible or do you have data regarding people who have received it and people who haven’t and the costs, you know, after denial due to the different complications and diabetes that, you know, have cost them and probably cost insurance companies in the state subsequent to that denial; do you think that’s possible?

MAKRAM GEDEON: Thank you for the question. I don’t have this particular data, but I can send you that. On the long-term when you treat diabetes, when you treat hypertension, when you treat sleep apnea, besides a direct cost, there is indirect benefits, okay, so some of my colleagues are going to be presenting a little bit later and showing the actual dollar numbers, but there is definite long-term benefits of pursuing weight loss surgery. The other argument to this is the fact that obesity is a disease, and it’s not a luxury, so mindset is to only treat it because we’re saving that’s one thing but the mindset is to treat it because it’s a disease that’s another way of looking at it.
REP. PAVALOCK-D'AMATO (77TH): Right. And, so how many people do you think in your experience have had their insurance cover this surgery, if any?

MAKRAM GEDEON: I’m sorry. I don’t --

REP. PAVALOCK-D'AMATO (77TH): How many -- how many patients have actually had the -- been approved for insurance coverage in this? Are there any insurance companies that cover this right now?

MAKRAM GEDEON: Well, I can tell you, yes.

REP. PAVALOCK-D'AMATO (77TH): Or some?

MAKRAM GEDEON: Most of the -- yes, most of the private insurances and the state covers. There is the (inaudible - 02:00:39) of Access Healthcare doesn’t cover.

REP. PAVALOCK-D'AMATO (77TH): Okay.

MAKRAM GEDEON: The -- I can tell you the United States 1 percent of patients who need the care get it, so 99 of 100 patients will qualify but not get the care they need.

REP. PAVALOCK-D'AMATO (77TH): And, I think somebody else said before that -- that people are going overseas to get the -- get the surgery. Do you find that as well?

MAKRAM GEDEON: Yeah, we do -- we do get patients who get their care done outside of the United States, which is sad in a way because there’s no way -- with all respect to any other countries -- but there’s no way to really monitor, and programs in United States follow a very rigorous dietician program to help to follow certain -- they have to respond to certain quality standards, and so when
patients get out of the country to get the care outside, you know, the care is not usually or always on the same standards in this country.

REP. PAVALOCK-D'AMATO (77TH): Right. Thank you. I appreciate it.

MAKRAM GEDEON: Thank you.

REP. SCANLON (98TH): Thank you, Doctor, for being here today.

MAKRAM GEDEON: Thank you.

REP. SCANLON (98TH): Appreciate your testimony. Next up is Amanda Christie, followed by Julie Sjoblom.

AMANDA CHRISTIE: Good afternoon. I am here in support of SB 317. My name is Amanda Christie, and I’m a physician assistant who has been working in the field of bariatric surgery in Fairfield County for almost 4 years. I’m here today to share with you of my experience of just how valuable bariatric surgery is as a tool to help people fight obesity and regain control of their lives. During my years of working in bariatrics, I’ve taken care of patients who have had a gastric bypass, a sleeve gastrectomy, adjustable gastric LapBand, and patients with gastric balloons. These are all tools available to patient to help them lose weight and become healthier. These surgeries are not an easy way out and they require an extraordinary amount of discipline, hard work, and attention to detail by the patient on a daily basis. I am proud to say that I’ve seen many patients use this tool to help them eat smaller portions, eat healthier foods resulting in weight loss. I am also proud to say that I’ve watched my patients collectively lose
hundreds of pounds each year. There are a few clinical experiences that I’d like to share with you. I have seen patients who were previously dependent on insulin to treat diabetes, able to essentially correct this diabetic state and no longer require the use of insulin to regulate their blood sugar after bariatric surgery. I’ve also seen patients who relied on daily medications to control their hypertension or high cholesterol become completely free of medication through weight loss and healthier lifestyle.

One of the most rewarding parts of my job is telling patients that they no longer need these medications that they’ve been taking daily for years or celebrating with a patient as they lose enough weight to reduce their body mass index from morbidly obese to obese to overweight to normal weight. The long-term benefit of bariatric surgery is not just weight loss. It’s really the freedom to -- from being dependent on the daily medication. It’s being able to breath better, being able to move around with less pain, to have more confidence, and of course, to be able to teach the skills of healthy eating and portion control to our younger generations.

Bariatric surgery saves lives, and in my opinion, it’s the best tool we have despite chronic diseases such as diabetes, sleep apnea, high cholesterol, and hypertension. I would encourage you to seriously think about how beneficial this surgery is to such a great number of patients. Thank you.

JULIE SJOBLOM: Good afternoon. My name is Julie Sjoblom, and I have struggled with weight since I was a child. It has always been with me no matter what I did, diets, exercise, I’ve tried and failed. I was prediabetic, high cholesterol, high blood pressure, infertility, and depression. I was placed on many medications to manage these conditions. I was lucky enough to become pregnant despite the challenges of infertility. It took a carnival ride for me to push myself into action. I was with my son who was 2 at the time. He wanted to go on some silly ride. We sat down and the attendant couldn’t close the bar. I was too big. We were asked to get off the ride. As you could imagine, this was my moment, my ah ha I need to do something moment not only for myself but for my son and my family as I was so embarrassed and humiliated. I had thought about bariatric surgery and researched it. I tried every diet, every program, and yes, the torture of going to the gym but feeling too embarrassed to go regularly for fear of failure and judgement. When I attended a seminar at Norwalk Hospital, I knew that this was the right decision for me. I met Dr. Craig Floch, and I made the decision to have bariatric surgery. I had a sleeve gastrectomy on September 23, 2013 and have lost over 75 pounds and have maintained my weight loss. My health is great and I am off all medications.

So much so, I have a special connection to the issue. I went to work for Dr. Craig Floch. I personally know and feel firsthand the significance and great health benefits bariatric surgery can deliver and bring to patients struggling with morbid obesity epidemic and other health problems. Every day I talk to patients. Some days are harder than
others. It’s still difficult to meet someone at a seminar, know that their health and quality of their life could be greatly improved by bariatric surgery only to have to tell them that it is an exclusion on their insurance policy. There is no harder part of my job than to be the one to deliver such disappointing news. Imaging having to tell someone with a BMI of 45, diabetes, high blood pressure that there is a treatment that could absolutely help them improve their health, but they have no access to this treatment.

Obesity is not treated like the disease that it is, and this has to change. I am here because I believe in the surgery and know its value. I believe that everyone should have access to this life-saving treatment. Every resident of the state of Connecticut should have access. In working with patients and their insurance plans on a daily basis, I see the struggle. Our state Medicaid plan covers bariatric surgery, federally sponsored Medicare plans cover bariatric surgery; unfortunately, there is no mandate for coverage of bariatric services and there should be. Some people don’t understand. They tell me but my doctor said it’s medically necessary, and they’re right, but it’s still not covered. This needs to change and the change needs to start today. I’m fortunate to have good health insurance coverage. I’m grateful to have had coverage for bariatric surgery. I made the decision to take control of my life and my health. I’m happy to share with you that I live a normal active, healthy, and completely hectic life. My son is now 15 and I have a daughter who is 12. I can ride the rides. I can get on an airplane. I can go to Disneyworld, and I have. My wish is for everyone
who wants this life-changing surgery to have access to it. Thank you, and I appreciate your time.

REP. SCANLON (98TH): I was going to ask you if you’ve been back to that ride, but I’m glad to hear you’ve done it.

JULIE SJOBLOM: Absolutely! [Laughing].

REP. SCANLON (98TH): Thank you for being here today. Any questions? Thank you, Julie.

JULIE SJOBLOM: Thanks.

REP. SCANLON (98TH): Dr. Jonathan Aranow, followed by Dr. Melissa Santos.

JONATHAN ARANOW: Thank you, Committee. I appreciate the opportunity to present today. I am — my name is Jonathan Aranow. I’m a former president and acting board member of the Connecticut Chapter of the American Society of Metabolic and Bariatric Surgery. I’m an active member of the Connecticut chapter of the American College of Surgeons, and I’ve been practicing bariatric surgery at Middlesex Hospital in Middletown, Connecticut for almost 20 years. The testimony that I’m presenting today is on behalf of the Connecticut Chapter of the American College of Surgeons and also the Connecticut State Medical Society, and also the Connecticut Surgical Collaborative. I would appreciate your indulgence at the end of this statement as I would like to address the questions that were raised earlier.

Our respect to society strongly supports Senate Bill 317. The American College of Surgeons is a long partner with the Connecticut chapter of the Society of Metabolic and Bariatric Surgery, and its
predecessor organization. We’ve been collaborating well for over 15 years to provide access to bariatric and metabolic surgeries to all Connecticut patients by all insurers. Over the years, we have entered into discussions with the third-party payers and have presented compelling scientific and socioeconomic data encouraging them to make this access available; however, these efforts have been unsuccessful. The failure to provide patients suffering with the disease of obesity access to coverage by all insurers in Connecticut is discriminatory as medical evidence has demonstrated obesity is caused by genetic, environmental, developmental, as well as behavioral factors. The states of Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, New York, New Jersey, Maryland, and Delaware all have recognized the disease of obesity and have enacted an essential health benefit that includes access to care for bariatric surgery for all residents. Connecticut lacks the same basic right to help for those suffering from the disease of obesity. The lack of bariatric surgical care is a burden to the taxpayers of Connecticut as many patients suffer from chronic health conditions and comorbidities for which obesity is responsible.

With obesity untreated, chronic illnesses progress; thereby, requiring more medications, doctor visits, emergency room visits, and longer hospital stays. It hurts our economy as well. Obesity suffers are often unable to work with higher incidents of 6 days and their disease can be an obstacle for them being fully productive. Bariatric surgery and treatment to morbidly obese patients has proven to reduce and cure comorbidities including diabetes, hypertension,
sleep apnea, heart disease, and liver disease to name a few. The elimination or reduction of these comorbidities creates enormous cost savings over the lifetime of the patient. Patients who have surgery and lose weight cost less to insure. They’re often able to stop medications, enjoy better health, and over the long term, there will be less lifetime spending per patient. Medical evidence shows that coverage of bariatric surgery by insurance companies does result in cost -- long-term savings. We believe that Connecticut insurers continue to take short-term perspectives assuming that by the time complications occur their patient will be under the care of another carrier or Medicare. Bariatric surgery is a life-saving procedure; yet, currently bariatric surgery is not a covered benefit on all health insurance plans offered in Connecticut, but it isn’t covered -- but it is covered by state Medicaid plan and it is covered by federal Medicaid program. It has been backed by the Centers for Medicare and Medicaid services since 2006. The American College of Surgeons and Connecticut State Medical Society believe it is in the best interest of our patients to have this life-saving treatment available to all residents of the state of Connecticut. Being the regional anomaly, how long will it be before Connecticut best trained bariatric and metabolic surgery surgeons leave the state to further -- further reducing patient access to care. Every state bordering Connecticut provides access to all patients for this treatment. Historically, Connecticut insurers have not treated obesity as a serious medical illness -- as a serious medical condition. Diseases like diabetes, hypertension, and high cholesterol all can be addressed by bariatric surgery in a patient with obesity. All
these diseases are covered; yet, we fail to address the root cause to the dealings of obesity.

We continue to ask why are the only states -- why are we the only state in New England and the Northeast that does not cover it? According -- adding this coverage is and has been the right thing to do for your constituents and our patients. It is compassionate, proven to be effective using evidence-based medicine, it saves money over the long-term, it improves our economy, and most importantly, it will save Connecticut lives. I ask that you support SB 317 and require health insurance coverage for metabolic and bariatric surgery.

REP. SCANLON (98TH): Thank you, Doctor.

JONATHAN ARANOW: As for the questions --

REP. SCANLON (98TH): Okay.

JONATHAN ARANOW: The questions regarding the cost. Senator Lesser actually eluded to a study done in 2013. I know the one he’s referring to. That was in fact conducted by the insurance agencies looking at cost effectiveness, and that did find that there was questionable cost effectiveness to -- in that particular paper, but there are at least three to four other papers that show cost effectiveness and a breakeven point at two to three years. In general, obesity accounts for 21 percent of the National Health Spending. Obese patients carry 42 percent higher angle healthcare costs, 77 percent higher prescription costs, 37 percent higher primary care costs, and annual medical cost for an individual are increased by $200,741 dollars, and that is somewhat older data. There’s a 50 -- 50 percent increase to lifetime medical costs in a patient with morbid
obesity, a 1.3 times increase -- increase rate in absenteeism, and 194 percent increase likelihood that that patient will use all of their paid time off.

In 2008 there was a study published by a surgeon named Kramu [phonetic] who elected total cost savings over three to four years following surgery and found that the breakeven point occurred in 25 months. In 2018, a study by Dr. Pally [phonetic] looked -- created a computerized model of a theoretical payer. This was a study performed by physicians in Connecticut -- in Kentucky, New York, and New Jersey. In this payer model, there were 100,000 computer-generated clients. They presumed in this study that the health of those individuals 50 percent would be severely or morbidly obese, which is their general population. They added to that an incident of diabetes that also is comparable to our current prevalent of diabetes. Using this calculated model, they came out with the per payer per month incremental cost at the various years following the presumed surgical procedure using average data for what hospitals and healthcare costs were for the surgery. In year one, the year of the surgical procedure, healthcare cost per payer -- per member per month was increased by 30 cents to $3.6 dollars per payer member per month. At 5 years, there was a breakeven point and at the 10 years, the savings ranged from $1.2 dollars per member per month to $31 dollars per member per month.

We’re not reinventing the wheel here. This has been covered by the Center for Medicare and Medicaid since 2006. The data is known about the cost. It is cost saving. I’m happy to provide the literature to you.
SENATOR LESSER (9TH): Thank you, Doctor, for your testimony, and I appreciate -- although I was out of the room at the very beginning part of it, I do appreciate you answering my question from before. That is exactly the kind of data and evidence-based evaluation of particular that I think we’re hope -- I’m hoping to do in this committee, and so that’s actually super helpful, so I really want to thank you for providing that -- that specific information that I think will probably help us inform our decision-making process. With that, are there questions from members of the committee? Well, thank you very much. I really appreciate it. Next up, we have Dr. Melissa Santos, followed by Dr. Jeffrey Nicastro. Good afternoon, Doctor.

MELISSA SANTOS: Good afternoon. I’m Dr. Melissa Santos. I’m the assistant professor of pediatrics at the University of Connecticut School of Medicine and a senior pediatric psychologist and clinical director of the obesity and bariatric surgery programs at Connecticut Children’s Medical Center. I’m here today in support of this proposed legislation because everyday at the Children’s Hospital we see the devastating impact of obesity in the lives of children and adolescents. From 2-year-old weighing almost 100 pounds and showing signs of prediabetes to 500-pound adolescents who no longer attend school, we need every treatment option available to help and give Connecticut’s youth a chance to be their healthy.

There is a testimony that you have received here today. You’ll hear much about the high prevalence rates of obesity, the devastating medical comorbidities that come with obesity, which are occurring in kids younger and younger. The impact
of obesity was perhaps summed up best by our former U.S. Surgeon General who stated because of the increasing rates of obesity we may see the first generation that will be less healthy and have a shorter life expectancy than their parents. This will be the first time in 200 years that children won’t outlive their parents. You will also hear much about bariatric surgeon being the only proven effective treatment for this population and its cost effectiveness, although I can’t drop as many numbers as he did, but 5 years in adolescence and I can get you that research as well, but I want to tell you a little bit about the kids who benefit from this proposed bill. I wonder how many of you or how many of you sitting in this room would willingly go back and relive your high school years, and I wonder how many of you would want to do that as a teenager experiencing obesity in the age of social media. As a psychologist, I’m privileged to learn a side of teens that not many get to know. I’m also privy to stories and experiences that are hard to shake. From our teens who drop out of school because they can’t pass gym class or don’t have enough stamina to walk in-between their classes, or who do not fit in their chairs in their classrooms, to the kids who experience relentless teasing and bullying on a daily basis who start to believe that they are the tings their tormentors say, to the kids who can’t imagine a future and go home each day wondering if they put scissors and cut off a stomach roll if that would make their tomorrow easier, and to the kids that wonder if sticking around to tomorrow is worth it.

Bariatric surgery is the only chance some of our youth have at having a future. By providing access
to bariatric surgery, you give Connecticut’s youth a chance to dream and imagine a life they never dared to dream. We see amazing things every day at Connecticut Children’s. We’ve seen kids who never thought they would accomplish much accomplish big things after bariatric surgery. For the teens who never thought they’d go to prom, who never thought they’d join a sport, who thought they’d never go on a date, who never thought they’d graduate high school or go to college. For the teens we’ve seen become adults, get married, and have children. For the teens who never thought they’d be able to stop taking all their medications and who have now joined the medical force to provide care to others. For the teens who now have hope and imagine a future, for them and others who are seeking help. We thank you for your time and consideration, and implore you to consider Senate Bill 317. Thank you.

SENATOR LESSER (9TH): Thank you so much, Doctor, for your testimony. Are there questions from members of the committee? If not, thank you so much for coming here today.

MELISSA SANTOS: Thank you.

SENATOR LESSER (9TH): Next up, we have Dr. Jeffrey Nicastro, followed by Andrew Turenne. Good afternoon, Dr. Nicastro.

DR. JEFFREY NICASTRO: Good afternoon. Thank you, Senator, and thank you to the committee for allowing me to speak for full transparency. My name is Jeff Nicastro. I’m a general and critical care surgeon at Western Connecticut Health Network, and I’ve been practicing in the state of Connecticut for a total of 30 days. I came from a sister state to the slightly Southwest that does cover bariatric
surgery, and the reason I asked to speak today is to give some perspective outside and to support this bill. At Western Connecticut Health Network, we are the home of two ASMBS verified bariatric centers, one at Danbury, one at Norwalk, and you heard Dr. Floch, who is one of our directors, speak today eloquently on this topic.

What I’d like to focus on is less about dollars and the testimony in terms of the cost and offset with riveting actually. I didn’t have all that information, and glad I do now, but rather the fact that we’re in the era of evidenced-based medicine, and outcomes-based practice, and the American Society of Metabolic and Bariatric Surgery combined with the American College of Surgeons verifies bariatric surgery centers and ensures that they meet the standards necessary to provide quality outcomes-based, evidence-based care, and to that end, morbid obesity is not only -- or obesity itself is not only now considered a separate disease process but it has been demonstrated by clear evidence to be an independent risk factor for early death for patients suffering from it. Bariatric surgery has been shown to improve that disease and result in or return to near expected life expectancy for patients who undergo this surgery. So, without even looking at the dollars and cents, this is an effective and unfortunately, one of the only effective treatments for a life-threatening disease process that is currently a national epidemic. The fact that the remainder of the New England states, New York and New Jersey also require this for insurance companies is evidence of that. I appreciate the opportunity to speak. Thank you.
SENATOR LESSER (9TH): Thank you, Doctor, and you may not have been in Connecticut for more than 30 days, but I know that you’ve spent a fair amount of time in this building so far, so it’s good to see you again. Are there questions from members of the committee? If not, thank you very much for your testimony here today. Next up, we have Andrew Turenne, followed by Barbara Radin, I think, but I may be -- or Raclin [phonetic]. I may be misreading your name. Good afternoon.

ANDREW TURENNE: Good afternoon. My name is Andrew Turenne from the town of Plainfield, and I thank you for the opportunity to speak today. At 315 pounds, I left a career of 9 years in the fire service because my health and my weight had detrimental impacts and caused me to become a risk and liability to those I worked alongside every shift as well as to those that I was being paid to provide a service to. My health and my weight had that impact on my financial means on how I supported my family, which in turn was a direct reflection on the actual relationship that I had with my wife and the type of father that I should have been to my children. I was living my life day-to-day more of a -- a fixed figure on the couch rather than the father-figure that I should have been, living vicariously through photos and the sideline where I should have been more active as a role model. As a successful candidate from weight loss surgery, I have used that as a tool in conjunction with weight training, proper nutrition, and cardiovascular exercise where I’ve managed to lose 140 pounds, where I’ve since has coached my son’s football team, have spent countless hours at the beach with my daughter, and have completed a few family 5K road races. I’m no
longer considered prediabetic. I’m no longer hypertensive. I no longer suffer from depression, experience pain in my back or my knees, nor do I require the use of a sleep apnea machine. I am asking to push forward the bill proposed, number 317, to give others the opportunity to help control their lives, take control of their lives before they lose their lives prematurely due to a pre-existing condition. Thank you.

SENATOR LESSER (9TH): Thank you, Andrew, and I’m glad to see that you’re doing well and happy to hear that the surgery was successful and that you’re in good health now. Thank you for your testimony.

ANDREW TURENNE: I appreciate it. Thank you.

SENATOR LESSER (9TH): Are there questions from members of the committee? Representative Pavalock-D’Amato.

REP. PAVALOCK-D'AMATO (77TH): I just actually a comment. I just want to thank you. I think you brought the perspective of the emotional and physical benefits of this surgery, and just the impact made me realize the impact that it has on other people and the difference, you know, like you said from being on the couch to actively being involved in your children’s live, so I appreciate you --

ANDREW TURENNE: Thank you.

REP. PAVALOCK-D'AMATO (77TH): For coming to testify.

ANDREW TURENNE: It was more -- more than saving my life. It actually saved my marriage, and because of that, I’m very grateful, so.
REP. PAVALOCK-D'AMATO (77TH): And, I’m a divorce attorney, so that’s exactly what I was thinking of [laughter], so thank you.

ANDREW TURENNE: Thank you.

SENATOR LESSER (9TH): Hope you have a happy Valentine’s Day.

ANDREW TURENNE: You as well.

SENATOR LESSER (9TH): Thank you and have a -- have a wonderful day. Other questions from members of the committee? Yes, Representative Hughes.

REP. HUGHES (135TH): I was just -- thank you for your testimony. Wondering what the arc of timeline that you described just now from the time when you decided to get the surgery to sort of a restorative arc? What or how many years, or?

ANDREW TURENNE: I just approached my 9-year mark with the department and I was on the verge of almost 40, and I started to see where I was going nowhere. It was starting to hinder my abilities to perform my job successfully, which I started to realize it wasn’t fair to all those around me, and with the support of my wife and doing proper research, I was directed to an office in Glastonbury where I met the surgical team that provided the weight loss surgery that I had in November of 2017.

REP. HUGHES (135TH): Wow.

ANDREW TURENNE: So, I started my journey May 17, 2017, when I punched out for my last shift at 3:15, and I had surgery that November, and since then, I’ve managed to continuously lose weight and have held off 140 pounds since.
REP. HUGHES (135TH): So, less than 2 years?

ANDREW TURENNE: Correct.

REP. HUGHES (135TH): Wow!

ANDREW TURENNE: Yes. It’ll be 2 years this November.

REP. HUGHES (135TH): Thank you so much.

ANDREW TURENNE: Thank you.

SENATOR LESHER (9TH): Thank you, Representative. Thank you for your testimony today. All right. Barbara Raflin [phonetic], followed -- Radin -- Radin. I’m sorry. I was right the first time. Followed by Carol Franklin.

BARBARA RADIN: Please bear with me. I am very nervous. I’ve never ever done this before, and thank you for giving me the opportunity.

SENATOR LESHER (9TH): Take your time. We don’t bite --

BARBARA RADIN: Oh, good to know.

SENATOR LESHER (9TH): But, please --

BARBARA RADIN: Okay. My journey started with the -

SENATOR LESHER (9TH): I’m sorry. Could you -- could you please just identify yourself?

BARBARA RADIN: Sure.

SENATOR LESHER (9TH): Thank you.

BARBARA RADIN: My name is Barbara Radin, and I’m here to support SB 317 with my whole heart because it’s a life changer. My journey started with the
confirmation of my insurance company telling me that they would pay for my surgery. I went through all the prerequisites pre-surgery that I was supposed to. Shortly, before the date of my surgery, the insurance company said, no, we will not pay for this. You can imagine the disappointment because this is going to change my life. My surgeon, Dr. Neil Floch, who is so passionate about what he does and about the healthcare of his patients said, I will perform the surgery for $1 dollar, and we were all talking about the cost and what the renumeration these surgeons were gonna get. He didn’t care. I’d paid for the hospital fees and the anesthesiologist and everything else that went with the hospitalization, but I never paid my surgeon, and as a result of his kindness and his caring, I am 10 years post-surgery this year as of January 8. I have kept off all of the weight. I was 224 pounds, and now I weigh 118. It took me close to a year to lose the weight, not even, but I kept it off, I am an active mother, an active wife, active in my community. I no longer take all the medications that I had taken prior to the surgery. I was hypertensive. I was definitely down the road to diabetes. It was something in my family and I got it. I could barely keep up with my family when we went on vacation, and I had an incident in Italy where I was asked to get out of the rowboat as we were going through the Blue Grotto because I was going to tip it over. [Crying] I was beside myself. I got out of that boat, was hysterical crying. I never forgot that incident, and I never told anybody other than my surgeon about that. I wanted to share that with you right now. Thank you for listening, and please support this bill with me. Thank you.
SENATOR LESSER (9TH): Hey, don’t go anywhere just yet.

BARBARA RADIN: Oh, okay.

SENATOR LESSER (9TH): Thank you -- thank you for your testimony, for sharing your story. I hope you have another opportunity to go back to the -- to the Blue Grotto, but really, that’s an incredible story, and I’m sure you’re grateful for Dr. Floch’s kindness and things like that.

BARBARA RADIN: Very much so.

SENATOR LESSER (9TH): A powerful thing, and I’m glad you’re doing well. Are there questions from members of the committee? If not, thank you so much for coming up. You did great.

BARBARA RADIN: Thank you. Thank you for listening.

SENATOR LESSER (9TH): Next up, Carol Franklin, followed by Paul Spada.

CAROL FRANKLIN: Hello.

SENATOR LESSER (9TH): Good afternoon.

CAROL FRANKLIN: Thank you for allowing me to speak. My name is Carol Franklin. I live in (inaudible - 02:30:35) area. I am a registered nurse, but I am also a bariatric patient. The Carol Franklin you see here, 6 years -- would not be the Carol Franklin you see now. Six years ago plus, I was 352 pounds, morbidly -- super morbidly obese is the term you would find for it. A lot of it is the stories you’ve heard. I could not walk from my car up and to where I work. I work just down the road at Woodland Street, and I would have to sit two to three times to even good into the building to get to
my desk to do my job there. I would sleep with CPAP machine. I was on Victoza because of pre-diabetes, metformin, all of the things like that. You would see me using crutches probably 75 percent of the time just to be able to get around with some of the pain and the weight that I was carrying on at that point. Gout attacks common, high blood pressure like many shared, good hygiene was difficult when you’re that large no matter what I would try to do. It wasn’t always the easiest for me, and I would socially isolate for a lot of reasons and have bouts of depression, and my body was going to give out soon, and by that, I think you’ve got the picture of what six plus years ago was for me, and I was morbidly obese for several years. I did not come to this decision very easily at all. I am a widow. I became a widow at 49 after near a 30-year marriage. My husband died of a rare disease, and that was a lot of where the emotional components can come in with it because food was the natural thing there.

When I made the decision finally because I had always said, nope, not gonna do it. That’s just some, you know, an easy way out. People are just doing it. I’m not going to. When I finally made the decision, I called my daughter up in the Midwest, and I said, Shavonne [phonetic], I know you won’t believe it but mommy’s thinking of having surgery done for it, what would you think, and my daughter says, Mommy, I love you and we’re right there with you because she’s all I have right now, you know, in life. Since the surgery, crutches are very rarely seen. It’s a very rare bout that sometimes I get swelling in my lower legs that I have to do it. No more CPAP. No more diabetes. That’s all out the window and has been since the
week of the surgery. I can walk to my car and to my job without taking a break. There is nothing, you know, that I can’t do. In fact, my daughter says, mommy, I gotta walk faster to keep up with ya now when we go out together because I didn’t share and a lot of people didn’t know she would push me in a wheelchair because time together was more important to us than what her mommy or -- mommy couldn’t do it at that time. My weight loss is well over 100 pounds. It’s given me a new look at life -- look at life as far as things like that, and one of the things I do is I recognize I’m one of the lucky ones in Connecticut. I’m one of the 1 in 3. I am a state of Connecticut employee, and my insurance covered it, and they gave me this chance at life that I have here. I didn’t do the surgery for cosmetic reasons cause I have met with one of the senators a few years back. I was asked to meet and share my story with one of the senators, and I was asked that question about the cosmetics, and no, it wasn’t that. The reason I did it was because I wanted to have life where I could work, earn an income. I was close to where you would have been supporting me through, you know, nursing home or things like that. Those are other costs to consider as you’re doing this, that those wouldn’t -- wouldn’t be a part of it. In fact, I don’t know if any of you are familiar with bat wings. Have you ever heard that term? My bat wings I write stories -- I write every month for the website on that, but my bat wings are the excess skin. I will live with that because every time I look at it, it reminds me that I am alive and not dead at this point, and that I can give back to others with society as far as that.
Was it a quick-fix solution or an easy one? No. We still have to do our part as patients who have had bariatric surgery. We still have to take accountability for the decisions we make and the actions we make, but the support that’s out there for us, it’s strong. Support groups that are out there, nutritionists, things that we can do when we start to maybe have times where we might slip a little bit are there, but it’s the one thing I would ask this legislature is to give the residents of Connecticut this gift if you can. I’ve heard the good numbers on statistical data, and I know that’s how -- another one I would ask you to bring in and consider when you do look at it, and I know your insurance pay can help, but look at the facts. You’re not paying for me as a disabled person in this state, and that does add up. I am a -- I’m a hard-working Connecticut citizen -- I apologize. I am very nervous -- Connecticut citizen that’s earning an income and paying taxes in this state. If I’d continued where I was, I don’t think I would be paying taxes, that you would have been taking care of me as far as that part goes there -- there as far as that. I’m an open book. You’re welcome to ask any questions, but thank you for giving me the opportunity to share today. I really firmly it’s changed my life in a way you can’t believe, and my coworkers, they didn’t notice the weight loss first. They noticed that I smiled and laughed more. That was one of the things that really stood out over six years ago, and nobody kind of said anything, but when you look at the time it took, I had my -- and Craig close your ears, I know -- I had my surgery done on a Tuesday. I was already back to work on Saturday and Sunday because of the way it’s a noninvasive. It’s done mostly
laparoscopically now, and that’s the nurse coming out. I did surgery for years, but I -- even though it was there, it’s not like it was 6 weeks or 10 weeks for that. I was back and almost instantly becoming a good working member of society, and I -- and I don’t miss work as some of them brought up. I didn’t before either, but at least now, I’m more productive I think because my activity level. Thank you.

SENATOR LESSER (9TH): Thank you. Thank you for your testimony, and I’m glad to hear that your -- your insurance covered it and that you’re -- you’re doing well, and now advocating for others. Other questions from members of the committee? If not, thank you so much, Carol, for your testimony. It was good to see you today. Next up, we have Paul Spada, followed by Jane Sweeney.

PAUL SPADA: Hello. I’m gonna try and tell my story, and I’m gonna try to do it and not be emotional. I’d like you to know that yesterday I was told I’m dying. I’d like you to know --

SENATOR LESSER (9TH): Can you -- we want to hear your story, but can you please just start -- identify yourself for our record?

PAUL SPADA: My name is Paul Spada. I’m a recipient of gastric bypass. I’d like you to know that I was in Hartford Hospital yesterday again. I left my band on to show you. I was walked down the hall by one of the best heart failure doctors and told I’m gonna die or I’m dying. I’d like you to know that I had gastric bypass surgery, and it bought me time, but it’s too late for me. Okay? I’d like to tell you what I suffered in my life because I was obese. I had a fatal heart attack. I died -- I went to the
tunnel with the white light. I can prove all of this in a court of law. Okay? I survived that. I have sleep apnea. I have chronic congestive heart failure. I have stents all over my body. I was on the heart transplant list. I spent 8 months in intensive care at Hartford Hospital in the Cardiac Ward. I now have kidney failure. I had an ablation. I was at A-fib. I want you to know they can’t still believe I’m alive.

Now, the surgery that I had -- I had an aortic aneurysm also. All this is fatal. Okay? I’m not supposed to be here. Okay? I want you to know that what gastric bypass did for me -- it bought me time. My time is coming to an end because I had the surgery too late, because I was obese all my life, because I had diabetes. I stepped on a screw. It was in my foot for 4 hours, and I didn’t know it. I ended up at St. Francis Hospital. They were gonna take my foot off on top of everything else. I can’t do my buttons anymore. I can’t do my zipper. I can’t feel. I have no feeling in my feet at all. All of these issues are because I was obese, which caused me heart issues and that caused me with type 2 diabetes.

I want you to know that since I’ve had that surgery my cholesterol is normal, my A1c is down to 6.2. It was 11 before. I don’t know if you know what those numbers mean, okay? My sugar is normal, and everything is somewhat normal. Hartford Hospital is doing their best to keep me alive. My days are coming to an end, okay? But, I want you to know that because of gastric bypass it bought me time. I have time with my grandchild now. I have -- I had to give up a job I love. I’m now on disability. I was a nuclear submarine instructor. I drove from
Enfield to Groton everyday one way and all the way back. I couldn’t do it. I crashed my car on the way to work, okay, due to medications. I passed out near the pool and almost drowned, and I fell off a ladder and cracked my head open. All this due to low blood pressure, okay? So, my life is in limbo right now, so I want you folks to know this. Gastric bypass or all these surgeries -- it’s a good thing. I didn’t come here to waste your time, okay? I have done it too late. I’m done, so I want you to save other people. Everything I just said to you I can prove in a court of law. When I went in to file for Social Security Disability, I cried. I cried, I cried because I had to give up a job I love because of my disability. I went in there with a box of medical records that was this tall, and I said to the Social Security guy, “Don’t bother lookin’, that’s my life in that box.” Okay?

So, there is a point I want to make and for that -- that gentleman that has brought this bill in front of you folks, it works. All right? Now, one last thing. It took me 3 years to fight my insurance company -- 3 years I was deteriorating. Finally, the way I beat them, I went in there with all the receipts for 1 year. It cost $180,000 dollars to maintain me. It cost about $30,000 dollars for the surgery. Now, if I would have had that surgery a long time ago, I wouldn’t have been walked down a hall to the transplant area yesterday and told, “You better start doing things in your bucket list. Your heart’s enlarged. You got renal kidney failure, and it’s starting to catch up with you now, and there’s nothing more we can do for you.” So, anyways, I’m gonna close now. I want you to know that if you pass this bill for all these people that are not
gonna get that surgery too late as I have, you’re doing them a favor. You’re saving their life. That’s what I got to say to you folks.

SENATOR LESSER (9TH): Thank you -- Thank you, Mr. Spada, and you -- you know you said you weren’t supposed to be here today, but I think -- I think you are because your advocacy means so much to a whole lot of people who are watching around the state. I think it’s important for them to hear your story, and I think you’ll know that --

PAUL SPADA: I can prove everything I just said to you, sir, in a court of law, and I’m not supposed to be here, and it’s because I had the surgery too late.

SENATOR LESSER (9TH): Well, thank you --

PAUL SPADA: Again, time -- I have time now. Not much, but I have time.

SENATOR LESSER (9TH): Well, we -- we -- we so appreciate your story and hearing -- hearing about you, and we will -- we will keep you in our thoughts as you move forward. Are there questions from members of this committee? If not, thank you very much --

PAUL SPADA: Thank you very much.

SENATOR LESSER (9TH): For your testimony, and thank you for being here. Next, we have Jane Sweeney, followed by Scott Gruder.

JANE SWEENEY: Good afternoon, and thank you for giving me the opportunity to speak. My name is Jane Sweeney. I am a resident of Connecticut. I’ve been here over 20 years, and I’m a nurse. You know, I have something prepared to say, but I think a lot of
it has already been said, and I may speak to you about what I have seen as a nurse over the last 10 years, taking care of patients here in the state of Connecticut, and then just to add to that I am now -- just in the last 7 months -- I’ve worked for a bariatric surgery program at Hartford Healthcare, but before that, I was a med surg nurse on the frontlines for 10 years, and that is, you know, a part of my story and my journey that I want to share.

I have -- we have over a quarter of our residents in the state of Connecticut suffer from obesity. On a daily basis, more than half of my patients suffer from obesity and all the comorbidities and the emotional and the stigma, everything that goes along with that. So, on a daily basis, I was still frustrated by what I saw, and really wanted to be a part of the change and -- and to help them on their journey. That’s why I’m so happy to be doing now what I do in the bariatric surgery program, but bariatric surgery for these patients is like saving. I get to now see on a daily basis, which is so great, the full circle is I get to -- I run our support group, and I work with patients who have been lucky enough to have the surgery, and I help them through the process now, and I also get to hear their stories. On a monthly basis, we do have patient speakers and share these amazing stories how their lives have changed forever. I am also -- one of the things that touched me the most or actually really surprised me was the fact -- and I think everyone has addressed this, but the fact that Connecticut is the only state in New England including New York and New Jersey that does not require that bariatric surgery be covered. That was
shocking to me, and I think should be to all of us. It’s absolutely a life-saving procedure. You’ve heard some people now already and you can imagine I hear these stories all the time, how important I think it is that this amendment be passed.

SENATOR LESSER (9TH): Thank you very much for your testimony. Are there questions from members of the committee? If not, thank you so much --

JANE SWEENEY: Yeah.

SENATOR LESSER (9TH): For your testimony. Next up, we have Scott Gruder, I think, followed by Kerry Roy.

SCOTT GRUDER: Good afternoon. Thank you for having me. My name is Scott Gruder. I am here in support of SB 317. I am the practice manager for a corporate healthcare medical group, Surgical Weight Loss. I am also on the board of directors for the Connecticut State Medical Management Association. Thank you for having us today, and thank you, Senator Berthel for bringing this bill forward. We really appreciate it and Senator Lesser, as a constituent of yours, I’m very happy to present this testimony to you. Thank you every other committee member for having us here today. I think this is a very important and serious issue.

What I want to speak to today is the process of bariatric surgery. We have plenty of doctors here today who can speak to the statistics and patients who can speak to the emotions. Some of the things that I hear a lot from the outside are about the process. We hear patients struggling with obesity just want the surgery because it’s the easy out.
They want this because it’s the easy way. They want this because it’s the only way, and they’re not gonna have to work, it’s the silver bullet. I can tell you it is just not true. Our patients have to go through anywhere from 5 to 16 doctor’s appointments prior to the surgery. The process can last anywhere from 3 months to 12 months based on insurance. They need to see psychologists. They need to see cardiologists, endocrinologists, pulmonologists. All of that. Doctors they would have to see continuously for their comorbidities if they weren’t getting treated for the disease of obesity with us. Further, in previous experiences as practice managers of other -- or as operations managers in other practices, I have seen employees choose not to take health insurance and to opt into the HUSKY insurance specifically because it does cover bariatric surgery, okay? And, that’s an expense onto the state as well. And, also to bring to the committee’s attention the indirect cost of obesity. We heard just previously about the loss of wages or the increase with money on disability. The increased burden to the state through that. Lost wages to the employer. Loss of business through that as well as -- as well as all of the stigma around the disease itself. I think it’s really important that you take all of those factors into consideration when advancing this bill. It really is important to our -- our citizens that they can get their treatment earlier than when they currently are having it, and that they do have access to it through every venue possible and to really make Connecticut proud, to not just be the only state in the Northeast that does not have this access.
SENATOR LESSER (9TH): Thank you, Scott, for your testimony. Appreciate it. Are there other questions from members of the committee? Yes, Representative de la Cruz.

REP. DE LA CRUZ (41ST): Thank you, Mr. Chairman. What are the -- what are the numbers of folks that you think that are turned away? I don’t know if you have a percentage or out of 100 people that walk in how many folks actually have insurance or you know, and I don’t know if you have those metrics? It sounds like you as a case manager you may or may not, but.

SCOTT GRUDER: I’m a practice manager and not the case manager --

REP. DE LA CRUZ (41ST): Okay.

SCOTT GRUDER: So, it’s a little -- it’s a little different.


SCOTT GRUDER: I’m sure we could try and figure some of those numbers out for you. Certainly, on a weekly basis, we are turning people away because they do not have access to the surgery or they are paying out of pocket. Those costs as we heard previously can cost the patient out of pocket upward of $10,000 dollars depending on the surgery, and that’s just so they can live a healthy, normal lifestyle. When you talk about treating the comorbidities that are associated with obesity, like diabetes, like hypertension, none of this ever comes into play. No one is going to question giving a patient medication for -- for their diabetes. They’re never going to question the metformin. Why
are we questioning trying to give patients the treatment they need for the disease of obesity?

REP. DE LA CRUZ (41ST): Yeah. No. Those numbers that you were given just people that showed up at your door and said -- and you told them they couldn’t afford it. It’s how many people behind them that have no -- that you have no idea who will never come because they don’t have anything, so.

SCOTT GRUDER: That’s exactly right, sir.

REP. DE LA CRUZ (41ST): Yeah, so.

SCOTT GRUDER: Thank you.

REP. DE LA CRUZ (41ST): Thank you.

SCOTT GRUDER: Thank you for the question.

SENATOR LESSER (9TH): Thank you for your testimony. Always good to see constituents here, and thank you.

SCOTT GRUDER: Thank you, Senator Lesser.

SENATOR LESSER (9TH): Next up, we have Kerry Roy, followed by Jen Chmielecki, and I want to apologize to everyone whose names I’m butchering here today.

KERRY ROY: My name is Kerry Roy, and I’m a registered nurse and the Bariatric Program Coordinator for the Weight Loss Surgery Program at Bristol Hospital. I’m also representing the Connecticut Chapter of the American Society of Metabolic and Bariatric Surgery as an integrated health member, and a bariatric surgery patient. I would like to thank Senator Matt Lesser, Representative Sean Scanlon, Senator Joan Hartley, Representative Lucy Dathan for the opportunity to speak today. I also want to recognize ranking committee member, Senator Kevin Kelly and especially
thankful to Representative Cara Pavalock-D’Amato for her longtime support of Bristol Hospital and all the residents of Bristol, which include myself and my family.

Upward of 78.6 million people in the United States suffer from obesity, and the rate is growing each year. By the year 2030, the CDC projects 42 percent of the U.S. population will suffer from obesity. Currently, bariatric surgery has been proven to be the most effective long-term treatment option. How many of us have looked away if someone asks for an extension seatbelt on an airplane or have seen someone turned away from a ride at the park because of their weight. Why do we, in the state of Connecticut, continue to turn our heads and allow insurance companies the right to continue to deny medical treatment to patients suffering from the disease of obesity. In our program at Bristol Hospital, we are witness to the resolution and improvement of health-related conditions through bariatric surgery, but we also witness and celebrate non-scale victories with our patients, improved quality of life. We hear their personal stories of how they do not need the extension seatbelt. They were finally able to go on the ride at the amusement park. We listen as they tell us how they no longer need to take their blood pressure medicine. They don’t have to stick their finger four times a day to check their blood sugar. There CPAP machine is no longer a medical necessity. We celebrate jointly these successes with our patients and watch the quality of life improve. Bariatric surgery is a proven successful treatment modality for obesity; yet, sadly, patient’s access to this treatment is frequently denied by insurance for noncoverage in
their policy plan; yet, studies show bariatric surgery reduces a person’s risk of premature death by 30 to 40 percent.

By supporting SB 317, everyone here has the opportunity to improve and change the lives of many people by providing patients access to an essential health benefit that could save lives and decrease costs. I have been witness to the life-changing success that bariatric surgery provides and have experienced it myself.

REP. PAVALOCK-D'AMATO (77TH): Ms. Roy, if you could just wrap up your testimony?

KERRY ROY: Yes. Supporting Senate Bill 317 would provide all the residents of Connecticut who suffer from obesity the opportunity to share their own non-scale victories and increase their quality of life. I would be happy to answer any questions.

REP. PAVALOCK-D'AMATO (77TH): Are there any questions? Sure.

REP. DE LA CRUZ (41ST): I’m not sure if you heard the question earlier. Do you have a -- do you guys keep any count of how many folks are turned away because of insurance?

KERRY ROY: We don’t keep that count on an official metric tracking datapoint, but I can -- for instance, this week alone, we have turned down or not turned down, but we had 3 out of probably 7 patients who called to inquire about enrolling in the program that did not have insurance coverage for bariatric surgery.

REP. DE LA CRUZ (41ST): It would probably kind of - - it would be more an expense to you for nothing I
guess, but it would be nice to have those metrics
over the course of a year because I think that those
numbers mean a lot when we’re trying to make
decisions and stuff, and I think that knowing that
three-quarters of the folks are getting turned away,
then we can start multiplying out what that would
mean for everyone, but thank you. Thank you for the
work you do.

KERRY ROY: Thank you.

REP. PAVALOCK-D'AMATO (77TH): And, I just have one
question. Would any of the subsequent surgeries
when it comes to skin removal or anything else,
would that also be included or is that something
that --

KERRY ROY: That falls under plastic and cosmetic,
and they have their own set of criteria and
coverage.

REP. PAVALOCK-D'AMATO (77TH): Okay. I appreciate
it. Thank you very much.

KERRY ROY: You’re welcome.

REP. PAVALOCK-D'AMATO (77TH): Nice seeing you.
Next is Jill Chmielecki. Is she in the room? Okay.
Good afternoon. Just state your name for the
record.

JILL CHMIELECKI: My name is Jillian Chmielecki, and
I am the Bariatric Patient Support Specialist for
the Weight Loss Surgery Program at Bristol Hospital.
Today, I also am supporting the Connecticut Chapter
of the American Society for the Metabolic and
Bariatric Surgery. I would like to thank Senator
Lesser, Representative Scanlon, Senator Hartley,
Representative Dathan, Senator Kelly, and
Representative Pavalock-D’Amato for allowing me to speak today.

I am asking your support for Senate Bill 317, which was introduced by Senator Eric Berthel and would require health insurance coverage for bariatric and metabolic surgery. In my role, I am on the frontline serving as a liaison between our patients and the insurance companies. Weight loss surgery is a last resort after all other nonsurgical options have failed. Weight loss surgery is not a luxury. It is a necessity. Although weight loss surgery may be the most beneficial treatment to patients suffering from severe obesity, insurance coverage for the procedure is limited, and the cost of the surgery makes it an unaffordable procedure. It distresses me to have to tell the -- tell a patient who is committed to enhancing their health and well being that their surgery is not covered by their insurance. They often will have tears in their eyes when I tell them that I have exhausted every option in my advocacy for them, leaving them feeling defeated and hopeless once again.

Obesity is a disease throughout (inaudible - 02:57:00), and about one-third of the United States’ population is severely obese. Being overweight or obese slightly raises one’s risk for numerous health problems including heart disease, high blood pressure, stroke, diabetes, cancer, back pain, and sleep apnea. It is common to find health insurance companies that will not pay for weight loss surgery; yet, the same insurers are paying for years of treating the conditions associated with obesity. Mountain evidence shows that surgery for morbid obesity can be more cost-effective than treating the conditions resulting from obesity. One surgeon
described conditions such as diabetes and heart disease as rooms in the house of obesity. Health insurers treat each room in the house, but the roof is falling in. Under Title 19, patients who meet the requirements have their weight loss surgery covered by insurance. Employees of the state of Connecticut have weight loss surgery covered under their healthcare plans. Additionally, Medicare plans also cover bariatric procedures. If the federal and state-funded programs feel this disease should be surgically treated and covered, why can’t all of the residents of Connecticut have their cost covered for this life-changing procedure?

Access Health plans do not cover bariatric procedure, which is unfortunate for more than the 100,000 residents enrolled in these plans. Additionally, Connecticut is the only state in New England that does not provide bariatric coverage under the Access Plan. These are the handful of reasons why I’m asking for your support of Senate Bill 317, and give all the residents of Connecticut the opportunity to enhance their own health. Thank you again for this opportunity, and I would be happy to answer any questions that you may have.

REP. PAVALOCK-D'AMATO (77TH): Thank you.

JILL CHMIELESKI: Thank you.

REP. PAVALOCK-D'AMATO (77TH): Any questions? And, I want to again thank you and everyone who came from Bristol Hospital for coming up. I know -- I am aware of the program there, and we’ll -- I think all the support of this bill today definitely goes a long way, so thank you again.

JILL CHMIELESKI: Thank you.
REP. PAVALOCK-D'AMATO (77TH): Next is Catherine Furlong and if Amy Dumont could be ready after that?

CATHERINE FURLONG: Good afternoon.

REP. PAVALOCK-D'AMATO (77TH): Welcome.

CATHERINE FURLONG: Hi, my name is Catherine Furlong, and I am a bariatric patient. I had my surgery on December 19, 2017, and I’m still in the weight loss journey, but I’ve lost 120 pounds, and my journey started when I had a heart attack at the age of 53, and had to go through all the hoops for the insurance. At that point, I had cardiac disease, sleep apnea, high blood pressure, high cholesterol, borderline high blood sugar, and weight induced joint pain and the inability that comes with that.

I had been at the movie theater one day, and this is not something that I’ve ever discussed publicly, and the woman behind me talking to her husband described me as America’s problem, and I guess technically sitting here today I am America’s problem, and I’ve changed that, and the only way that I’ve been able to change that is by having life-saving surgery for a disease called obesity, and it is a stigma in our country, and it’s the last bastion of, I believe, people can cast aspersions on you and make assumptions about who you are and what your values are as a person based on your size, and I am here to tell you that it is not easy to walk around in the world in a large body where everyone sees you as America’s problem.

And, this surgery I was lucky enough to have insurance that covered it, but there are so many, as we heard here today, that only 1 percent, and that
number should be alarming to everyone who has spoken here, everyone who has listened here, that 1 percent of people who need the surgery are denied, are the only ones that are afforded the ability to have the insurance in a country that should have the best medical care in the country where obesity in young people is an epidemic and in an adult population is an epidemic. I come here just to plead that this be an opportunity for those struggling, not with a social issue, with a medical issue, an issue that affects people dramatically. It affects their family lives. One of my clinicians says you have to have a why that makes you cry, why you choose to do the surgery. It’s not an easy journey. My why is my family. I’m the mother of 5, a single mom. That’s allowed me to -- the surgery has allowed me to be more active with them, healthy, present, and fulfilled life, and so I plead with everyone who’s here still holding onto the end that they consider this as an option for people who deserve to have a good quality of life. In American, in the health system that we have, we should have that. We shouldn’t hear stories about people who are going to die because they didn’t so thank you. I appreciate it.

REP. PAVALOCK-D’AMATO (77TH): Thank you. Any questions? Representative -- hold on one second. We have a question for you.

REP. DE LA CRUZ (41ST): Thank you. Just -- just quickly. So, when you made the choice, you were covered under your insurance policy, and?

CATHERINE FURLONG: I was covered. I was one of the fortunate ones, and I consider that a true blessing, but even though I was one of the covered, I -- I
come here today to plead for those are aren’t as fortunate.

REP. DE LA CRUZ (41ST): Well, thank you for doing that.

CATHERINE FURLONG: Okay. Thank you.

REP. DE LA CRUZ (41ST): Thank you. Next, is Amy Dumont, and if Barbara Whelan could please get ready? Thank you. She’s gone? Okay. After her, would be Burt Zaretsky.

BARBARA WHELAN: Good afternoon. Thank you all --

REP. PAVALOCK-D'AMATO (77TH): Good afternoon.

AMY DUMONT: For allowing me to speak today. My name is Amy Dumont. I’m from Plymouth, Connecticut. I’m here today before you as a licensed clinical social worker who works with patients prior to having bariatric surgery and also supporting them postoperatively. I also run a bariatric support group. However, I’m also a patient, and I’ll speak from that point of view today. A lot of what I’m going to say will echo what many have said already, and I’ll try to keep it brief. I understand.

So, I had gastric bypass surgery 12 years ago, and I sustained a weight loss of 175 pounds over the past 12 years. Before surgery, I suffered from noninsulin-dependent diabetes. I had hypertension. I had sleep apnea for which I needed to wear a device called a CPAP to help me breath while I was sleeping. I had multiple other ailments, which included extreme fatigue, social phobia, anxiety as well as significant back pain and leg pain, and I was on numerous medications. So today, all of my
chronic illnesses are in remission as a result of this life-changing surgery.

We all have a turning point that brings us to surgery, and I had an unsafe event occur back then with my 2-year-old son. We were in a local mall, and he was pretty quick, and he ran off from me, and I couldn’t catch him, so I was fortunate that there was a kind stranger who caught him for me, but I -- I put him in harms way. That was not the type of mom that I wanted to be, and I had to make a significant lifestyle change for not only myself but for him and for my family. I wanted to be the best mom, the best wife the best daughter, the best friend, and the best employee that I could be, and at the age of 32 when I was going through all of that my quality of life was poor. That has all since changed.

I’m now on this side of the table advocating for those who need the surgery to change their lives and the state of their health as I did mine. I was very fortunate at that time to have insurance coverage that covered bariatric and metabolic surgery. It is imperative that everyone is given the opportunity to live their best life and not have insurance coverage be a barrier, so thank you very much, and I’d be happy to answer any questions.

REP. SCANLON (98TH): Thank you very much. I’m sorry I missed the beginning of your testimony, but thank you for being here today.

AMY DUMONT: Thank you.

REP. SCANLON (98TH): Any questions from the committee? I’m seeing none. Thank you very much. Next up is Burt Zaretsky, followed by Violet Wolf.
BURT ZARETSKY: Good afternoon. My name is Burt Zaretsky. I am the marketing director for Fairfield County Bariatrics and Surgical Specialists, that’s Dr. Craig Floch’s practice. I am also a marketing consultant to the American Society for Metabolic and Bariatric Surgery. Study after study, research product project after research project all over the world year after year continues without reservation to prove that bariatric surgery can cure or resolve life-threatening diseases like diabetes, hypertension, sleep apnea, and some cancers. New current data also indicates that obesity does affect dementia. As legislators, you have the power to help save lives. I urge you. In fact, after being witness to so many things that I’ve seen, I beg you -- I beg you to create a mandate that insurance companies must cover bariatric surgery in Connecticut. On a daily basis, I come in contact with people who have had bariatric surgery and as a result have regained their health and recaptured their lives. Some of them are off all of their meds, while others have substantially reduced the dosage of their meds, but I also meet people who discover that insurance companies do not cover bariatric surgery, and they can’t afford to pay for it out of their pocket. They are left without hope and have the possibility of eventually losing their lives to obesity-causing diseases. You and your fellow legislators can help save their lives and save the lives of others in the same position. Please, I urge you please mandate that the insurance companies in Connecticut cover bariatric surgery. Bariatric surgery does save lives. Thank you.

REP. SCANLON (98TH): Thank you for being here today, Burt. We appreciate your testimony. Any
questions? Thank you. Representative Rutigliano. Violet, I’m sorry. We’ll be with you next. Very quickly.

REP. RUTIGLIANO (123RD): Thank you, Representative Scanlon, de la Cruz, Christine, Cara -- excuse me. I’m sorry. I’m running around. So, my bill is 6087, and let me tell you what it’s all about. You can read it. You have submitted testimony, but I just wanted to talk to you about it. As we all know, Narcan is a life-saving drug, but what Narcan isn’t is a drug that you can use on yourself. It’s been reported to us, not only in Connecticut but in other states, that insurance companies specifically for life insurance, some health insurance, and disability insurance are rating people who are getting prescriptions for Narcan, which we’re supposed to be encouraging people to take out prescriptions in Narcan to save other people’s lives. It’s not for themselves, so Massachusetts just recently did a directive where they instructed insurance companies not to put that against the -- the person picking up prescriptions. I think it’s important. I think it’s important that people have it and they don’t have any consequences for having it, so there’s one thing that you can’t do with Narcan is give it to yourself. As you know, it’s for use for people who are in the midst of a drug overdose, so there’s lots of nurses, doctors, medical professionals, and family members who get the prescription so that they can save a family member’s life, so we’re trying to encourage that. If they find out that they can’t get disability insurance or their life insurance cost more or their health insurance isn’t available to them because they’ve done that, it will discourage people from
carrying this very important life-saving drug. I’d be happy to answer any questions.

REP. SCANLON (98TH): Thank you, Representative. I believe I mentioned to you on the floor the other day I thought this was a great bill. I read that article too with -- with great concern as did many of my constituents who I’ve worked with on opioid-related stuff, so I thank you for bringing this bill to us. The industry testified that they are currently prohibited from doing this, but it seems like based on what was happening in Massachusetts I believe that article with that woman it still somehow did happen.

REP. RUTIGLIANO (123RD): It does seem so.

REP. SCANLON (98TH): And, so you just look at this as a -- basically a way to codify the fact that they cannot explicitly do this, right?

REP. RUTIGLIANO (123RD): Right. They shouldn’t, plus that they can’t exquisitely do this, but why should they? If you know for a fact that somebody has a prescription and they can’t use the drug, so how they’re making the leap that they’re a drug addict or on another substance is a little odd to me.

REP. SCANLON (98TH): Thank you. Any further -- Representative de la Cruz.

REP. DE LA CRUZ (41ST): Thank you. Thank you for submitting the bill. I actually someone who has actually filled that prescription multiple times and didn’t realize it was something that was happening to myself, so I’m sure to look into it, and I -- I wouldn’t get why you’d even -- even if you were getting it for yourself --
REP. RUTIGLIANO (123RD): Right.

REP. DE LA CRUZ (41ST): And keeping it in your house, I don’t even know why that would raise your rates or have you get kicked off, so.

REP. RUTIGLIANO (123RD): Yeah, you would think that we’re encouraging people to -- to get Narcan. I mean the awareness over the opioid crisis and the use of Narcan has gone through the roof. We’re encouraging everybody to carry it. In fact, we’re mandating certain first responders to carry it. Why we would hold that against people is a little shocking to me.

REP. DE LA CRUZ (41ST): Thank you.

REP. SCANLON (98TH): Representative Pavalock-D’Amato.

REP. PAVALOCK-D’AMATO (77TH): How much -- do you know how much the -- the device costs?

REP. RUTIGLIANO (123RD): I’m not exactly sure what the device cost.

REP. PAVALOCK-D'AMATO (77TH): Can you -- can you also can you send that article? I haven’t seen --

REP. RUTIGLIANO (123RD): I can.

REP. PAVALOCK-D'AMATO (77TH): That article.

REP. RUTIGLIANO (123RD): I almost provide the ling in the testimony. I guess I should have. My -- my fault.

REP. PAVALOCK-D'AMATO (77TH): And, well I guess the person could buy it for themselves even though they can’t administer it to themselves?
REP. RUTIGLIANO (123RD): Yes. I guess you’re right. They could buy it for themselves, leave it in the house so that somebody else could direct it. It seems a bit of a stretch to be honest, but I guess it’s possible.

REP. PAVALOCK-D’AMATO (77TH): And, didn’t we -- didn’t we just pass the legislation last year that had to do with -- I -- I -- buying over the -- not over-the-counter, but -- or somebody else had to buy it, right?

REP. RUTIGLIANO (123RD): We’ve made it easier. Pharmacists could actually fill the prescription.

REP. PAVALOCK-D’AMATO (77TH): Okay.

REP. RUTIGLIANO (123RD): We’ve made a conscious effort as a state led by the Insurance Committee and the legislation to make it easier for people to get their hands on this drug in the midst of this massive opioid crisis. We’re hoping that the thread of making our insurance premium higher or nonexistent will curtail that activity.

REP. PAVALOCK-D’AMATO (77TH): Thank you.

REP. RUTIGLIANO (123RD): Thank you.

REP. SCANLON (98TH): Thank you, Representative.

REP. RUTIGLIANO (123RD): Thank you, sir.

REP. SCANLON (98TH): Violet. Thank you.

VIOLET WOLF: My name is Violet Wolf, and I’m in support of the SB 317. It’s kind of a love/hate story. I’ve had a rough life ever since I was a little kid. I’ve been picked on, bullied all through school. Pushed off the school bus cause I wasn’t like the regular kids. [Crying]. [Sigh]
Lost family members due to diabetes, cancer, heart disease, and in 2013, I lost my father. I went to his funeral in Pennsylvania, and I saw his sister. She didn’t recognize me. She goes, “Sorry, sweetie. I don’t know who you are.” My journey started with weight loss surgery in 2008. I’m 11 -- almost 11 years out in April. I had the LapBand done, but then we started having arguments with it. It didn’t like me [laughing], and I never gave up on it. 2012, I went back into surgery and had the gastric bypass done. I can honestly say now that I am a happy and outgoing person. Before, I never wanted to go out in the community. Still I work in school district in Stamford. I had my surgery at Norwalk Hospital. [Clearing throat] I’ve been married for almost 13 years in May. I married a wonderful guy who didn’t look on the outside at the 300-pound bride. He looked what was in the inside. He’s been with me every single day. He pushes me cause he knows I won’t quit, and this is the wedding gown I wore. Actually, it’s tied in the back, so it didn’t fall off. I’m 153 pounds lighter since I last wore this when I got married. I weighed 300 [talking off mic, poor audio]. And, if I didn’t have the surgery, I wouldn’t be able to walk the stairs in the public school. [Talking off mic, poor audio]. And, that’s why I get up each and every day [talking off mic, poor audio]. So, please fight for those who [talking off mic, poor audio] cause everybody has their right, and I’ve been lucky [talking off mic, poor audio]. Thank you.

REP. SCANLON (98TH): Well, I want to thank you for coming here today and sharing your story with us, and I am really happy to see you here today and -- and talking to us about your history with this and
why it was so important to you and for showing us your dress, which is a lovely dress by the way, if I do say so myself.

VIOLET WOLF: Well, my hairdresser told me yesterday, she said, “You’re the only one I knew that kept their gown. Everybody else throws them out.” [Laughing].

REP. SCANLON (98TH): [Laughing] My wife still as hers. I’m hoping we maybe sell it sometime and help pay our mortgage, but we’ll see what happens with that. Thank you, Violet. Any questions from the committee? Thank you very much, Violet. Dr. Floch, you’ve already testified. Would you like to testify again? Are you good?


REP. SCANLON (98TH): Okay.

DR. CRAIG FLOCH: So, again, Dr. Craig Floch, Fairfield County Bariatrics. I’m also the director of Bariatric Surgery and Metabolic Surgery at St. Vincent’s Medical Center in Bridgeport. I began practice in Norwalk in 1994 as bariatric surgery got safer and safer and general surgeons kind of -- general surgery got super specialized going off to breast surgery and other types of specialties. A lot of us felt that we were good laparoscopic surgeons. We kind of morphed into bariatric surgeons, and at that time in our practice, we decided we -- we were going to do things safely, and we started to track our data. I can tell you it -- in tracking our data -- and let me back up one minute. The way all of our programs work in this state is patients come to a pre-informational
At those seminars, we take down their names and their insurance. We then go to see if they have insurance coverage for bariatric surgery. In our state, Medicaid, Medicare, and Oxford cover the procedures, but none of the Obama Care plans cover. In New York, New Jersey, Massachusetts, Rhode Island, New Hampshire, Maine, and Vermont everyone’s covered. There is no coverage. So, to answer your question quickly, the commercial insurances, we in our practice have studied it from day 1 2001 until 2019, and I can tell you roughly, and I can pull the data. It’d be a little bit to do, but I can pull it. About 70 percent of commercial insurance companies in the state of Connecticut do not offer the benefit to their employers, so the employers don’t have the benefit. They can pay extra for it, but not in every case, and I hate to say this. I’m gonna admit it, but I work close with my staff, and we have the ability to change our Blue Cross plan to Oxford or to Aetna, but everyone in the practice is pretty happy with it, including our employers, but we cannot get Blue Cross -- the plan that we have now -- to offer our practice bariatric benefits. It’s an exclusion, so if they tell you that you can buy it you just have to pay extra, it’s extra, that’s not true. So, I hope that answers your question.

REP. SCANLON (98TH): Representative de la Cruz.

DR. CRAIG FLOCH: Some people cannot fit the surgery. Have you seen -- this is a life-saving thing, and we need to make a change. We should be leaders in Connecticut and New England, and we’re a follower, unfortunately, but I think we need to jump on.
REP. DE LA CRUZ (41ST): Thank you, Mr. Chairman. Thanks for answering the question. I know -- I know it’s hard to find out numbers like that cause we don’t know how many people actually never show up to any of those groups that you’re talking about, so we can’t count those folks. But, what -- what is the cost of the surgery? Cause, to me, it may be good to have insight, but if you know -- if I was going to offer someone a surgery that I know potentially would save me money for their care and I’m responsible for both, is the surgery that expensive that it’s prohibitive? Or why -- is that what it is? The initial cost --

DR. CRAIG FLOCH: So, somebody’s paying out of their pocket for -- for example, a sleeve gastrectomy, which is the most common procedure now in the United States. Depending on what our differences in our program probably ranges between $15,000 and $22,000 dollars I would say. Total cost. Hospital -- but that -- that’s not what -- don’t say -- that’s not what the insurance company reimburses the provider and the hospital. That’s what the out-of-pocket cost would be if somebody had no insurance and had to pay for -- [Crosstalk].

REP. DE LA CRUZ (41ST): But -- but for somebody who’s obese, is already costing the insurance company.

DR. CRAIG FLOCH: Correct, and -- [Crosstalk].

REP. DE LA CRUZ (41ST): Starting -- [Crosstalk].

DR. CRAIG FLOCH: And, like you heard from Dr. Aranow, Dr. Makram, and heard it about a 24 to 36-month rate point where it’s cost-effective, so in
the long run, this is a cost-effective beneficial procedure from an economical standpoint.

REP. DE LA CRUZ (41ST): Well, thank you for the answer to my question.

REP. SCANLON (98TH): Thank you, Doctor.

DR. CRAIG FLOCH: Thank you.

REP. SCANLON (98TH): Darren Tishler, followed by Jessie Moore. [Background conversation]. It’s a good place to be for him. [Laughing].

JESSIE MOORE: Hi, my name is Jessie Moore, and I’m representing the Yale New Haven System, and my -- I’m the program manager for both the Yale, New Haven, and Bridgeport Hospital Bariatric Programs. I’ve been an APRN for about 16 years. I’ve submitted some written testimony. I’m not gonna read that. You have that. The numbers that you’ve been talking about. I do keep those numbers, and I think it’s a complicated question. I’d like to address that if I could, but it’s a kind of a complicated -- depending on your population. Dr. Floch’s population down on the Southern part of the state with the companies that he works for may be slightly different and may have some differences in coverage as with Dr. Aranow’s population. We’ve been talking about this amongst ourselves ever since you asked the question, and -- but we can universally say it’s at least 40 percent, 50 percent of the patients don’t have coverage and that’s through commercial insurance. We don’t even keep track of the Connecticut Exchange because we know they don’t cover, and many of those patients are coming back to us and saying, you know, listen I’m gonna go on Medicaid so that I can get coverage
because Medicaid does cover it. We have about 40 percent population of Medicaid at Yale New Haven, and so our population of uncovered maybe slightly less because we got a lot of them covered, however, minimally so. But, nonetheless, we do -- we do that. We do about 600 surgeries. My numbers for people who we verified who have commercial insurance. We verified insurance for it, that had exclusions on those policies from commercial payers. In 2017, I had 94 patients and in 2018, I had 117, so if we do 600 surgeries, we can do the math. It’s about 20 percent of the commercial ones. That does, again, not count those Connecticut Exchange patients that may be out there, so you know, it’s all -- it’s all relative.

So, I want to put a little bit of a different face on this too. I -- I, you know, as I can tell you we all work together in the state. You don’t see us, you know, arguing with, competing or whatever. We’re very cooperative on this. We want to make -- help everybody that we can, and it’s wonderful to hear all the patient’s stories we’re hearing today. We do this every day. That’s why we do this. That’s why I’ve done this for 16 years, but the people I am concerned about are those people that are exclusion, and when I call patients to see if I can get any of my excluded patients, which I do keep a list of, to talk about what they -- you know, why they needed the surgery, one who wanted to be here is in Indiana, and with her husband who had to come with her. He weighs 400 pounds. He suffers from lymphedema, which is swelling of the legs. He has to undergo treatment that she has to do with compression, so he had to go with her. She traveled for work to Indiana -- and God bless her in the cold
weather -- and so he’s with her and they had to take their children out of school to go, so that’s a concern, and you know, those -- that’s just one of many stories. My patients who have a new disease called fatty liver, and I know I just rang, but I hope you bear with me just a moment -- but my other clinic has fatty liver disease. Fatty liver is something many of us have been told we have when your liver processes all this extra fat in the body. It tends to get bogged down and eventually can turn to cirrhosis, so out of 10 patients that we see, one patient will have cirrhosis and need a liver transplant, and we’re just starting to service at Yale and Hartford has the same thing. We’re seeing these patients, and they are being referred to bariatric surgery and they have exclusions. They can’t have a life-saving treatment, and without losing the weight, they are going to wind up on a transplant list. So, to me, that’s just appalling. I mean, we’ll pay for their transplant, but my gosh, we out to pay for their bariatric surgery because that’s what they need right now. That’s all I have to say.

REP. SCANLON (98TH): Thank you, Jessie. In your opinion as an APRN and also as the head of this program for one of the largest health systems in the state; would it be your opinion that the insurers would actually save money in the long run by covering this surgery than they would to continue paying for the cost of that individual to live out the rest of their natural life?

JESSIE MOORE: Yes. Yes. Absolutely. There’s been variable literature, and I think Dr. Aranow eluded to that. There have been variable studies. When they study younger people, they unquestionably see
improvement and reduction of costs. When they study diabetics, they see deduction of costs. When they study older people and particularly, they did a VA study, older men. They did not see the reduction as much in cost, and that’s what some of that data comes from, but yeah, if you wait too long, it’s not gonna improve. That’s one of the -- one of the witnesses said that, you know, “It’s too late for me. You need to do it sooner.” And, the sooner we start paying for it, you know?


VICTORIA DINARDO: Hi, my name is Vicki Dinardo, and I’m a registered nurse at St. Vincent’s Medical Center in Bridgeport, Connecticut, and I am supporting Bill 317. For the past 14 years, I have been working with patients who suffer with morbid obesity. I am the bariatric coordinator at the hospital, and it was actually my mother who got me involved in this. At the age of 53, she decided to have bariatric surgery, and she struggled with obesity my entire life. I watched her try liquid diets, deprive herself from food, try Weight Watchers, fad diets, and more as a child. She tried staying physically fit by becoming a volunteer on my various athletic youth team, purchased stationary bikes, and would take me on day and weekend trips to increase her activity and mine as well. I don’t recall gyms back in those days. Despite all her attempts, her weight loss always -- her weight always yo-yoed, and she was made to feel like a failure. So, in 2002, when she came to me and told me she was contemplating weight loss surgery, I completely supported her. Thankfully, at that time,
she did have great insurance, and she had the bariatric benefit, and her surgery was a success, and it was shortly after that that I took the job being coordinator. But, not all individuals are as lucky as my mom. Many patients don’t have the bariatric coverage, so they don’t get to receive the same type of treatment or care. We have lots of patients contemplating weight loss surgery for many years. As Jessie may have stated too, that you know we see these patients come to the seminars and they register through me, and I can tell you that less than 50 percent of the people who register for a seminar actually get to the seminar itself, and then I see less than 50 percent of those patients that actually attended the seminar actually have the surgery. I don’t know what it is. I think it is that they get scared and there is a stigma, and they talk to their families and friends a lot of times, and their families and friends tell them that it’s not a safe procedure and that they should just try to diet and exercise, but 3, 5, 10 years later I open up the database and I put those names back in that came to another seminar, so they’re coming 10 years later with more weight on them. They feel like the time is right, but then they find out that they don’t have the bariatric benefit after all. So, it’s back to eating right and trying to exercise more, and what’s so shocking is that this is advice has always been given, and it’s just not helping as it continues to be a problem with obesity.

So, as a daughter and as a nurse, I am here to support this bill. It’s really simple. Treat the obese patient, get them healthier, cut the cost associated with obesity. The cost of weight loss
surgery is far less than treating the obese person lifelong. Thank you for your time.

REP. SCANLON (98TH): Thank you so much for being here today and for sharing your story.

VICTORIA DINARDO: Thank you.

REP. SCANLON (98TH): Any questions? Thank you. Moving on to Senate Bill 318, Michelle from CBIA.

MICHELLE RACKEBRAND: Good afternoon. My name is Michelle Rackebrand. I’m assistant counsel at the Connecticut Business and Industry Association, and we’re here in support of Senate Bill 318 and Senate Bill 322, both of these assessment bills on the agenda for today. Any increase in an assessment returned by Access Health’s Board of Directors raises employer’s premiums in order to subsidize the state’s healthcare Exchange program. Senate Bill 318 would establish a new procedure requiring the legislature to approve any increase in Access Health assessment fees and user fees rather than just by a majority vote by the Board of Directors. Each time the assessment is raised, those costs are passed along to employers in the form of increased premiums. Access Health charges health insurance companies an assessment based on their participation in the fully insured market as well as the dental market.

Currently, there is a 1.65 assessment applied to all individual and small group markets to cover the Access Health’s operational cost, and that last year amount was $32-million dollars. The assessment is applied across the board to all insurance plans and not just those that live on the Exchange. Access Health should operate as a self-sustaining entity,
but since it does not, there must be a checks and balances system in place to ensure that the assessments levied are reasonable, justified, and do not place an undue burden on those -- on the impacted fully insured market.

As for Senate Bill 322, it imposes term limits on the members of the Board of Directors and also requires them to have insurance experience. The Board of Directors is chaired by the Lieutenant governor and is an unelected body that has power to unilaterally and arbitrarily levy fees. Limiting its member’s terms and requiring previous insurance experience, will revitalize expertise and accountability to the board. The assessment was last raised in 2015, and the majority voted to increase the assessment to approximately $277 dollars annually for a family of four. While this cost may seem marginal, it’s only one of numerous mandates, assessments, and fees that contribute to the ever increasing cost of healthcare on both the large and small employers. Thank you, and I’ll take any questions.

REP. SCANLON (98TH): Thank you, Michelle. Any questions from the committee? Representative Delnicki.

REP. DELNICKI (14TH): Thank you, Mr. Chair, and thank you for submitting the testimony on Access. Do you see any other areas that they need improvement in to get them moving in the right direction?

MICHELLE RACKEBRAND: Well, in terms of the assessment, we’re more familiar with the shop plans at CBIA just because of the small business market that they offer. At -- these assessments are
necessary in this case because not enough businesses are participating in the plan to low enrollment, requires the assessment that is levied across the state, so if they had more enrollment, we wouldn’t have to subsidize the plan, so they should try and increase the enrollment I guess would be the best answer to that.

REP. DELNICKI (14TH): So, it is safe to say that if they improve their business model they could work away from the extra assessment and then be able to cultivate more business?

MICHELLE RACKEBRAND: Yeah. If they had more participants in the pool, I think they could move away from applying the assessment to everyone insured in the state, yes.

REP. DELNICKI (14TH): Thank you for your testimony. Thank you, Mr. Chair.

REP. SCANLON (98TH): Thank you, Representative, and thank you.

MICHELLE RACKEBRAND: Thank you.


SUSAN HALPIN: Good afternoon, Chairman Scanlon, members of the committee. My name is Susan Halpin, and I’m here on behalf of the Connecticut Association of Health Plans. It’s with the committee’s indulgence I would like to speak on a couple of different bills that are before you to avoid getting up time and time again. The first bill is Senate Bill 327, regarding medically necessary ambulance services. There’s been a lot of high-profile articles in the national news about surprise bills around ambulance services. That has
not been our experience here in Connecticut. In fact, ambulance rates are one of the few regulated entities in the state of Connecticut. The Department of Public Health assess their rates, and before getting up to testify, I didn’t have the benefit of reading it yesterday, but I looked at the testimony that was submitted by one of the ambulance carriers, and a lot of the issues that we spoke to relate back to a taskforce that I’ve been privileged to be a part of in the past year, which is the mobile integrated health taskforce and all of the ambulance carriers, the EMT, ourselves, the hospitals, and others have been meeting for the last 9 months on this issue, and if I could just say I learned more about a system that’s pretty complex out there than I ever knew. They have a bill in public health, and I think whatever issues are -- are -- are intended for this bill probably would be best addressed in that context because of the complexity of the issue. With respect to Senate Bill 331, Christine Cappiello from Anthem is going to be testifying after me, and I swore I wouldn’t steal her thunder, so I’ll just say that you know rates are highly regulated here in Connecticut and at the federal level. The department looks at rates very carefully and improves them, and they have to be determined on the basis of excessive, adequate, or unfairly discriminatory. That’s what they look at when they do it. I guess if I could just add one other thing I would say that solvency of your insurer is perhaps the greatest consumer protection because when you need your claims paid, you need to make sure that your insurer has charged the right premium and has the money to pay those claims, so I would just be very careful as you look to change the rate regulation process to look at affordability.
equations that you’re pricing the product correctly to cover consumers when they need the care.

With respect to 332, compensation paid for by pharmacy benefit managers, this is a new concept to us this year. We’re still looking back to better understand what’s intended by this bill. Reading some of the testimony that was submitted, it’s my sense that it’s kind of round 2 of some negotiations that we had in the years past with the pharmacies and their association. They have a joint purchasing cooperative that -- that negotiates on behalf of all the independent pharmacies, and we actually worked together very well to develop a compromised bill on something called MAC pricing, M-A-C, which is pretty complicated stuff. That bill died a couple years in a row, probably because of the fiscal note, I believe, and I think this is an attempt to get at it from a different direction. The unfortunate part is that I don’t think that we feel that this is a place that we can negotiate, but I am still getting more information, but we -- from my early interactions, will oppose this going forward.

HB 5343, third party administrator -- redefining third party administrators to include PBMs. PBMs are already required to be registered with the Department of Insurance if they’re standalone PBMs. If they’re part of a health insurer, which some of them are, the health insurer has to notify the department of their, you know, of their existence and has to report accordingly. You’ll see in a lot of my testimony a shout out to your OLR researcher, Janet Kaminski over there, who does a fabulous job of -- of explaining complex issues, and I’ve took the liberty of lifting a few things from her summaries that talk about the fact that the current
law permits the commissioner to suspend, revoke, or deny registration to PBMs, and that they also are subject to investigation by the insurance commissioner, so I would say there’s already laws on the books in this area, and we would encourage opposition to this bill.

HB 5723, really quickly. Not quite sure what this bill is aimed at. Looked online for testimony and that did not shed any additional light on this, but if we read it as it’s written, we believe it sets a dangerous precedence because it direct health insurance reimbursements to lawyers of certain Medicare beneficiaries, so I’m not aware of -- of any arrangements where you can direct payment to someone other than the beneficiary or the power of attorney.

Very quickly, I’ll wrap up. The Chairman already referred to our testimony on 6087, and the use of a prescription for naloxone to be used in medical underwriting. We do not medically underwrite under the ACA, so I guess I’d be looking for more additional information, and I look forward to the article, but it sounds like it might be aimed at disability and life, which is not my area of expertise.

6095 -- I’m trying to move very quickly -- specifies certain lengths of stay in various detox services. Just to repeat my testimony from last week. When you mandate a specific length of stay, it -- it really creates a problem in the system because it creates a backlog or has the potential to create a backlog. If you have somebody in a bed that doesn’t need to be there, and there are differences of opinion out there in terms of how best to treat
folks with substance use disorders, there is a big component to being back in the community and working with outpatient and community providers. There are some that think that inpatient is the best. These are -- these are things that need to be determined on a case-by-case basis, but if you have a mandate, the mandate will be used, and you will have folks taking up beds, and they won’t be available to other people that need them, so I would just tell a cautionary tale. We’ve seen that happen in other states. Massachusetts in particularly got into a bad situation with that.

Last but not least, is 6096, which is restricting the year formulary changes. This is an ongoing battle that we have every year, and unfortunately, I will tell you that we still maintain a very strong position in opposition to this bill. There are numerous protections that are already on the books. Health plans, you know, one of the bills I spoke about earlier was affordability in health care rates, right? We can’t have affordability if we don’t have the tools that we can use to manage the prices and the healthcare costs that are incumbent to care, and pharmaceutical prices as you read in the headlines every day are among the top tier cost drivers in the state, and when you have a top tier, you know, brand name drug on -- on the formulary and a cheaper alternative comes online with the proper notification as required by the Department of Insurance Regs, which is 60 days -- 60 days I believe -- we can move that drug to a higher tier and encourage folks to use that new generic that may be cheaper. If we can only do that once a year, that cost is going to be born out directly to
consumers through increased premiums, and that won’t be affordable.

And, with that, I will sum up, and I thank you for your time and indulgence.


REP. DATHAN (142ND): Thank you, Ms. Halpin and thank you, Chairman. I just wanted to address Senate Bill 327, regarding in-network versus out-of-network ambulance care. I actually had a constituent that I talked to had this problem, got a surprise bill for an out-of-network ambulance, and in your testimony, you say that the -- this is unlikely to happen, so if it’s unlikely to happen, why are you opposed to such a bill? Wouldn’t we want to protect consumers?

SUSAN HALPIN: Well, I guess it’s always tough when you’re dealing with proposed bills, right, because you’re kind of getting a concept, and you’re -- you’re in some ways guessing at what the real intent is, so you know, I wasn’t exactly sure what folks were getting at. What I guess I would say is there is always unintended consequences when we -- when we deal with insurance statutes, and I would be very reticent to do -- you know, to make any changes without a more in depth review of the data and the problem that we’re trying to solve, and I think that’s what I say in my last sentence, which is you know if there is an issue out there we ought to look at it and we ought to figure out what’s going on and see what the right mechanism is to resolve the issue.

REP. DATHAN (142ND): Okay. Thank you.
REP. SCANLON (98TH): Thank you.

SUSAN HALPIN: Thank you.


SARAH CROUCHER: Good afternoon, Senator Scanlon -- Representative Scanlon -- sorry, I wanted to change your status.

REP. SCANLON (98TH): [Laughing].

SARAH CROUCHER: So, I’m here to testify in support of Senate Bill 330, and I also want to testify in support of House Bill 6093, and I think both of these bills address some of the fundamental inequities that exist in our current healthcare systems including those visible and reproductive healthcare, which is obviously what we NARAL are pro-choice, cannot primary concern with.

So, Senate Bill 330, will bring our state policy in line with the goals of international healthcare policy, and I -- I want to stress that we should talk about the fact that healthcare is a human right. It’s recognized widely by pretty much every country in the world. It’s in UNESCOs Universal Declaration of Human Rights, and so this is not something where I think we have a debate about whether healthcare is a human right. It’s a factual statement, and it used to be in our state statutes, and I think it needs to return there so that we can frame our policy in that way. So, as the world health organization, as recently stated, no one should get sick and die just because they are poor or because they cannot access the health services they need, and they also state that the right to health also means that everyone should be entitled
to control their own health and body, including having access to sexual and reproductive information and services free from violence and intimidation, and I think we’re all aware of the kind of climate in our country around reproductive healthcare in particular, and the fact that by putting this language in we help frame ourselves as to what we mean by making sure that people have access to healthcare.

As an advocacy organization for reproductive freedom, we particularly urge you to pay attention to the disparities that continue to exist, particularly on racial lines due to structural racism in our society and along broader social economic lines related to maternal health and mortality and access for reproductive rights. With a tax on access to basic reproductive healthcare coming the moment from the federal government, which are clearly set up to have the greatest impact on those who already face some of the sharpest healthcare disparities such as the domestic gag rule, which will remove Title X funding from abortion providers and disallow referrals for abortion care for Title X patients and new rules that are trying to limit abortion coverage on our state health insurance Exchange. It’s imperative that Connecticut takes action as a state to promote health equity at every level. Establishing healthcare as a human right within our state statutes will provide the framework to ensure that was we develop policy in all areas relating to health including access to all forms of reproductive healthcare that we’re guided by core principles of equity.
And, on HB 6093, I think that this in some ways falls under the same umbrella as healthcare as a human right. No individual in our state should face barriers to accessing healthcare because of their immigration status. Barriers to reproductive healthcare and access due to immigration status have a range of direct individual impact such as lack of access to cancer screenings and birth control, but they also have impacts on maternal-child health. We know that poor maternal healthcare is correlated with lower birth weights, higher rates of premature birth, or as other adverse effects to infants, and the U.S. also has the highest maternal mortality rate of any industrialized nation. The threat of death from childbirth-related complications is magnified for those women who are not able to seek regular prenatal care or appropriate follow-up care after giving birth; and therefore, from a reproductive healthcare standpoint, we strongly urge you to support HB 6093. Thank you so much.


GRETCHEN RAFFA: Hello. Good afternoon, Representative Scanlon, ranking member, and members of the committee. How are you? My name is Gretchen Raffa, Director of Public Policy and Advocacy with Planned Parenthood of Southern New England testifying in support of proposed Senate Bill 330, AN ACT ESTABLISHING HUMAN RIGHTS WITH EQUAL ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF HEALTH, and House Bill 6093, AN ACT CONCERNING CONSIDERATION OF IMMIGRATION STATUS BY HEALTHCARE CARRIERS.
Planned Parenthood of Southern New England serves over 60,000 patients yearly for reproductive and sexual health services. As a healthcare provider and advocate, we believe all people in Connecticut deserve access to quality affordable healthcare as a basic human rights regardless of income, insurance, or immigration status. Systemic and economic barriers have made is disproportionately difficult for many people of color to access healthcare. As a result, people of color have worse access to reproductive healthcare and worse health outcomes. Black women are 71 percent more likely to die from cervical cancer and 243 percent were likely to die from pregnancy or childbirth-related causes than white women, and black and Latina women make up more than 80 percent of women living with HIV and AIDS.

Senate Bill 330, is one way to ensure a commitment by our state to addressing some of these barriers that lead to such health disparities and barriers people face in our state to actually access high-quality affordable healthcare and healthcare coverage. Barriers to healthcare coverage substantially impact immigrant women and families with low income. Federal law already blocked many immigrants from accessing private and public healthcare coverage, and harsh immigration enforcement makes it more difficult for communities to seek out healthcare or raise their families without fear. Currently, the federal law prohibits undocumented immigrants, as well as many lawfully present immigrants from enrolling in Medicaid or the Children’s Health Insurance Program. Federal law bans undocumented immigrants from purchasing affordable health insurance on the marketplace even with their own funds. About 60 percent of non-U.S.
citizens, low-income immigrant women of reproductive age lack health insurance, which is more than twice the proportion of low-income U.S. foreign women. What’s more the consequences of being undocumented can also contribute to a culture of fear in the immigrant community and keep too many from seeking the life-saving care that they need. We know it happens in communities who already face barriers and access to care are driven further into the shadows. They will forego the care they need to preserve their own safety and economic security for their families.

People who are denied healthcare coverage because of their immigration status, depend on healthcare providers like Planned Parenthood who will provide them with the affordable basic primary and preventative care they deserve. One of these programs, the federal Title X Program, provides funding, which helps ensure that every person gets access to preventative services like cancer screening, and yet, the Trump/Pence administration is intent on dismantling the nations family planning program through the gag rule making it even more difficult for people with low incomes to access essential reproductive healthcare.

I will wrap up. People achieve reproductive freedom when they have full autonomy over their bodies and their lives. This not only includes access to healthcare but it’s the ability to live without fear of discriminatory policies. We believe that the ability to live and thrive without fear and access to healthcare are basic human rights. We will continue to fight for policies that protect the rights of all of our patients in our communities so that they have what they need to live healthy and
self-determined lives. We strongly support you -- support proposed bill SB 30 and HB 6093, and we urge the committee to vote in support.

REP. SCANLON (98TH): Thank you. Any questions?

Thank you. Nancy Burton, followed by Pastor Rodney Wade.

NANCY BURTON: Hello, and thank you for your time. My name is Nancy Burton. I’m a certified nurse midwife with over 40 years of clinical experience. I’m an educator currently on the faculty at Yale School of Nursing in Midwifery and Women’s Health, and I’m also the chairperson of the Board of Directors of the Universal Healthcare Foundation. I am testifying in favor of House Bill 330, AN ACT ESTABLISHING A HUMAN RIGHT TO EQUAL ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF HEALTH. The world’s health organization defines many parts to a high standard of health. My expertise is in access to medical services, so that’s will I will concentrate my testimony. I have seen for myself the results of what happens when people cannot access care they can afford. The language proposed in this bill once existed in our state’s statutes as others have said; however, disappeared with changes in law. This might seem like a purely symbolic act, but it lays the groundwork for future laws and actions by the state. It is a yardstick we can measure our success by and it sets the bar we commit to as a state. This is a human story with human consequences, so I want to tell you a few stories to put a human face on what we’re discussing.

I knew a man names Al. Al was a municipal bus driver. He developed insulin-dependent diabetes. Because of this, he lost the license he needed for
his work. His lost his job. He lost his health insurance. His doctor did what he could to help, but Al could not keep up with expenses. He gave up and stopped going for care. Al eventually made it back into care, but by then, he was in renal failure. Al died.

Wanda is a woman who came to see me for healthcare. Five years before I saw her, she had surgery. She was uninsured and she and her family were still paying the bills, so when she found a lump in her breast, she didn’t tell anyone. By the time I saw her, her right breast had been totally eaten away by cancer, and it was spreading to the left breast. It was the most appalling thing I have ever seen. I hope never to see it again.

I have a family member with chronic illnesses that keep her in constant pain and may eventually leave her disabled and possibly lead to an early death. She is self-employed. She was making a salary, $44,000-dollars a year that put her just over the cutoff to be eligible for a subsidy under the Affordable Care Act. Through the Exchange, she was going to have to pay $632 dollars a month for a plan with $7000 dollars out-of-pocket deductible. I’ll wrap up quick. This is not affordable, so she went without insurance and some healthcare until her health limited her ability to work, so her income came down, and then she could get a subsidy.

We can do better than this. We must do better than this. Martin Luther King once said of all the forms of injustice inequality in healthcare is the most shocking of them all. We just need to have the will to take care of the residents of our state. We can do it, and off the cuff, I’m also going to speak in
support of 6093, cause I have worked with immigrants. I have had times that I absolutely was unable to get them the care they needed. It’s real and people have suffered. Thank you.

REP. SCANLON (98TH): Thank you, Nancy. Any questions from the committee? Thank you. Pastor Rodney Wade. All right. Moving on to 331, Jill Zorn.

JILL ZORN: Good afternoon, members of the committee, Representative Scanlon. Thank you for the opportunity to speak today in support of Senate Bill 331. At Universal -- I’m Jill Zorn, and I work at the Universal Healthcare Foundation of Connecticut. We envision a health system at the foundation that is accountable and responsive to the people it serves and that supports our health, takes excellent care of all of us when we are sick at a cost that doesn’t threaten our financial security. I am here today because we continue to believe in that vision and in the need for leadership to address our healthcare challenges as a state.

At the foundation, we believe strongly that affordability to individuals and employers who purchase insurance should be added to the Connecticut Insurance Department’s rate review authority. A recent poll conducted in Connecticut by Altarum’s Healthcare Value Hub and posted on our website shows that many Connecticut residents are worried both about affording their coverage and they’re afraid to use their coverage. The poll shows 62 percent of those with employer-sponsored insurance and 82 percent of those who buy insurance on their own are worried or very worried about affording their coverage, and the poll also shows 43
percent of residents afraid to use their coverage and has a variety of statistics about people who delay going to the doctor or avoid going to the doctor or having a procedure done altogether. Fifteen percent of people in our state did not fill a prescription because of cost. This information points to the fact that affordability must focus not only on premiums but also on out-of-pocket expense. What we have now is maybe premiums go up a little bit less, but then there’s more and more of a costing shifted onto people in the form of copays, coinsurance, and deductibles, and that’d no way to do it either. Insurance rates are going up because the cost of healthcare including prescription drugs, inpatient/outpatient hospital services are going up, and healthcare prices are going up much faster than wages. The bottom line is that these costs are unsustainable for consumers and employers. Something has got to change and the rate review process is one way to push back. Connecticut can learn from what other states have done. There is examples in my testimony about several other states. That had been a question I heard earlier. Vermont, Rhode Island, and Washington state are all examples of states that have worked to -- on this concept in view of their rate review thinking about affordability in -- in one way or another.

So, and I just also wanted to bring your attention to testimony that we submitted on Senate Bill 322, which is about the Board of Directors of the Connecticut Health Insurance Exchange, and we -- we were in opposition to requiring that everyone on the board must have experience with insurance, unless they mean using insurance, but if they mean working in insurance, that doesn’t seem to be the mission of
Access Heath CT is much broader. It’s about access to healthcare, not just about insurance. Any questions?

REP. SCANLON (98TH): Thank you Jill.

JILL ZORN: Thank you.


CHRISTINE CAPPIELLO: Goo afternoon, my name is, for the record, it’s Christine Cappiello. I’m the Director of Government Relations for Anthem Blue Cross/Blue Shield. I’m here to speak on Senate Bill 331, AN ACT REQUIRING THE INSURANCE COMMISSIONER TO CONSIDER AFFORDABILITY IN REVIEWING HEALTH INSURANCE PREMIUM RATES. As -- as I was looking at this bill last night and as we were drafting the testimony, I recall that -- that this bill was before us previously, and I went back and looked and low and behold we did, and it was actually right around this exact same date 7 or 8 years ago, so I think that some -- we have -- at that point, it was -- it was not passed and I think for good reason.

The legislature -- let me first start off by saying that Anthem Blue Cross-Blue Shield obviously cares about our consumers. We want to increase our customer base until we are quite concerned about the rising cost of healthcare. However, we also feel it’s important to remember that health insurance rates reflect the healthcare costs, and they continue to increase faster than the growth of premiums. As provider provides prices and consumer utilization increases, the health insurance premiums must keep up. If insurers are unable to price premiums to adequately cover the cost, they become
unable to pay the claims on behalf of their members, and it’s -- it’s in fact I think an important piece to remember. Also, want to let folks know that under the Affordable Care Act there were some very important components of the rate review process that were established under the Affordable Care Act. There’s an annual rate review process that takes place through the Department of Health and Human Services where and by an annual review is done of unreasonable premiums, increases in premiums, and it’s also worth noting that the ACA does not consider affordability as a factor in health insurance premiums. Prior justification of rates before we are implanting any unreasonable rate increases, insurers have to provide justifications to HHS and to the state. Connecticut was one of the first states to adopt that rule. Mandatory publications of our rate justifications we have to post on the HHS website and again, state of Connecticut was one of the first in the state that began publishing the rates that are submitted by the carriers and allow people to -- as you know, there is a very public review process. There were grants that were made to premium review that were states could obtain money and Connecticut was one of those states to set up sites -- an internet site where people could review the filings. There’s a state reporting requirement where states participating in the program had to report to HHS about the premium increases, trends, and what’s based on that information. We now have a limit on our medial loss ratio. As you know, it’s 80 percent in the individual market, 85 in the group market. Consumer rebates if we do not meet those MLR scanners we are required to issue rebates. There’s also a detailed federal rate rating rules where all premiums must be
community rated, premium variations limited to age, family size, tobacco use, and geography. Those premium increases can lead to exchange exclusion where exchanges are required to consider the reasonableness of premium rates when deciding participation. There’s a mandatory rate review process of a comparison inside and outside the exchanges. There’s a justification for any rate increase that has to be done on an exchange. As a mandatory publication, again, of the rates and justifications for the exchange, mandatory transportation -- transparency. Sorry. Where transparency requirements are placed on reporting of cost shares, claims, payments, denials. There’s a long list of things that the federal government has done, and therefore, the states have done. I think it’s also worthy to note, recall, and remember that rate increases as the department used them are actuarial based, and while it would be nice to have affordability as a factor, I think maybe my version of what affordable would be would be different than what someone else’s version of what affordable would be, and that’s why the department looks at it from a purely actuarial base because that truly is sort of a black and white way of looking at it, so thank you for your time, and any questions you may have.

REP. SCANLON (98TH): Thank you. Any questions? Thank you, Christine. Moving on to Senate Bill 332. First up is Dave Benoit.

DAVE BENOIT: Representative Scanlon and distinguished committee members. My name is David Benoit. I’m a pharmacists and vice-president for Northeast Pharmacy Service Corporation, which binds together independent community pharmacies in four New England states. Independent community
pharmacists are very proud of the very valuable extended services they provide on top of pills in a bottle, fast, accurate, and cheap. We like to make sure that our patients are taking the medications the way they’re supposed to so that they achieve the health outcomes that are intended, relief of symptoms. We’ll even package it. We’ll deliver it to their homes to make sure they’re getting it on time. We’ll custom make medications for people who can’t swallow or have special needs of one kind or another, and we do all this for the same payment that other pharmacies are reimbursed. We think that the pot of money, the pot of gold of rebates and funds that are being managed by PBMs needs to be divvied up and shared among the participants in the market from consumers all the way through to these companies making a profit. There is nothing wrong with that. We don’t want to reduce the special services that are out there. We think it is a wonderful idea to start a discussion and taking a stand on the importance and value of paying every pharmacy provider an equal and fair amount for each prescription product, and that’s not a pipe dream. That exists in some systems now where each PBM is not free to design their own magic number for penicillin, but each of them shares the same number, which has been done with the 50 states and a regular survey of actual acquisition pricing.

I think that PBMs have gotten to a place where they handle 80 to 90 percent of the funds that are spent on prescription drugs, they force manufacturers to pay rebates, which drives up the prices, the base prices we see for brand-name products. Same goes for generics, and as the pressure is on for the provider side to get squeezed, a number of manufacturers have
left the market, again, making drugs less affordable, so I think with the beginning of a conversation focused on having a fair price for all products across dividers, we can get to some other discussions.

The second thing that concerns us is when we complete a transaction we believe it should be complete, so these -- these masterful performance programs and DIR fees and generic equivalent rates should be looked at and considered, and we should find a way to follow the feds into getting us a payment, which is final now, not 6 months from now or a year and a half from now. I have submitted my testimony. I think these are too high priorities, but there are many other levels of (inaudible - 04:07:40). Thank you for your time.

REP. SCANLON (98TH): Okay. Thank you for coming in today. We will be hearing a bill related to DIR fees at a later date, and that’s something I know. I have talked to my local pharmacies about it and local pharmacists across the state and trying to make sense of those fees is something I -- you probably spend your entire life doing and not understand it, so.

DAVE BENOIT: Don’t waste your time.

REP. SCANLON (98TH): So, tell me a little bit about what -- how you think, from your perspective, we could find that unit price? What -- what’s the mechanism that you think we can get all those parties that you mention of which there are a lot of them to come up with that price?

DAVE BENOIT: In the final detail of getting everybody to give up a piece of their pies is going
to be a big straw, but if you want to have a conversation about a central single price, you can talk to your folks at Medicaid. You can talk to folks at CMS. There’s something called NADAC, so finding an average acquisition cost by regions is a dual endeavor and if the load and expense were shared across the business partners, probably fairly inexpensive, and then it would be transparent as well.

REP. SCANLON (98TH): Thank you. Any questions from the committee? This is a topic that we will be spending some significant time on this year, so thank you for being here today.

DAVE BENOIT: I’ll be here again.

REP. SCANLON (98TH): [Laughing]. Jane Garibay. There is also a representative named Jane Garibay here, and I was wondering if she got a new job, but I guess it’s a different Jane Garibay.

JANE GIGASKY: Well, my -- my maiden name was Porter. May name is actually Jane Gigasky, so.

REP. SCANLON (98TH): Okay. Well --

JANE GIGASKY: I apologize. That’s -- [Laughing].

REP. SCANLON (98TH): No. That’s okay.

JANE GIGASKY: Thank you for having me here today. My name is Jane Gigasky. I’m a pharmacist. I own Woodbury Drug in Woodbury, Connecticut. I graduated from the University of Connecticut in 1998, and I bought my pharmacy in 1999, so 20 years have gone by and I’ve seen the evolution of these PBMs, which are these pharmacy benefit managers, and they started out as claims processors, which was needed because we process a lot of prescriptions, but they’ve
evolved to this money-making machine, so it was interesting to listen to some of the testimony of the other people before me in talking about the rising healthcare costs, and we can prove that they are a large contributor to that. They offer unfair contracts to us, one-sided contracts. They reimburse is below the cost of our product. They charge us large unjustified fees, and they take back large reimburse -- large recoupments through unfair audits. If you ever read a contract from a PBM to a pharmacy it’s always what the pharmacy can do for the PBM, what the pharmacy can do for the PBMs, nothing about what the PBM will do for us, and 2019 will be devastating to independent pharmacies if this is not addressed. Independent pharmacies will not be going out of business due to a lack of business but rather than all these tactics that they impose on us. You know, we can’t buy at $100 dollars and sell it for $50 dollars, and think we’re gonna stay in business for very long, and every pharmacy -- I now there’s been a lot of testimonies submitted in writing -- and every pharmacy can show you examples of all the different things that they do to us. The contracts are take it or leave it, so here’s the contract, and -- and we either pay you under your cost and you go out of business that way or you don’t take the contract and you lose a customer to a big-box store. PBMs are very good salesmen. They’ll tell you that they negotiate better drug pricing, that because they’ll get lower copays and none of that is true. So, in my desperation because I love my pharmacy and I love what I do, I reached out to a couple other states, and New York has made some interesting discoveries. They have a PBM that handles there Medicaid program, and they’ve been able to unveil that the PBMs
middleman has taken $300-million-dollars out of the healthcare industry, so we ask why are premiums rising, why are drug costs rising? These PBMs are taking a huge cost, pretty hefty fee for just processing a claim.

Georgia has also made some progress in trying to make a level playing field. Here in Connecticut, we have a PBM that manages our prescription drug program for our state employees, and so I would encourage Insurance commissioner to possibly look into that, especially since our state is in the situation that it’s in. Mandatory mail order promises to save money. It doesn’t save money. There’s no proof of that, so we think as independent pharmacies that this is a great way to start this conversation. The taxpayers and the government is being policed by the PBMs. Patient care is -- is compromised, and pharmacies have been put out of business, so we appreciate your time. Do you have any questions?

REP. SCANLON (98TH): I thank you for being here today, and last year, we became the first state in the nation to require PBMs to disclose the rebates that they are either -- how much they’re getting and how much they are then passing on, which was something I think this committee was pretty proud of, and we passed it on a bipartisan basis last year --

JANE GIRGASKY: Yeah.

REP. SCANLON (98TH): Which is great, but it’s --

JANE GIRGASKY: Thank you.

REP. SCANLON (98TH): Only the beginning of a longer effort to -- to your plan, and I know that to give
him a little credit where it’s due, our state comptroller, Kevin Lembo, recently announced that he’s going out to bid for the new PBM contract for the state employee plan, and if you haven’t read about what he’s doing, it’s pretty revolutionary in my personal opinion, and I think it will bring about some additional savings that you sort of mentioned, so you should check that out, cause it’s pretty innovative stuff.

JANE GIRGASKY: Thank you. I will, but just one last comment. We just want an equal playing field.

REP. SCANLON (98TH): Sure.

JANE GIRGASKY: We don’t want any special treatment. We can compete with the chains.

REP. SCANLON (98TH): Thank you so much.

JANE GIRGASKY: Thank you for your time.

REP. SCANLON (98TH): All right. 5850. Zaraya Irizary.

ZARAYA IRIZARY: Hi, my name is Zaraya Irizary. I’m in support of the HB 5850. We actually have a service dog from ECAD, Educated Canines Assisting with Disabilities, helping with us for 5 -- 6 years -- 6 years. He’s a medical equipment. [Sigh] He helps -- when I got Mickey [phonetic], our service dog, my daughter’s and mine, the purpose was to help my daughter because she had a little psychotic issue that medication were not helping to her. Decided she needs stronger medications her body cannot tolerate, so before I had -- we had Mickey [phonetic], I -- my daughter tried to kill me one time. There was another time that she -- I was holding her from her waist because she wanted to
jump out from the window where I used to live. It was very hard deal with. We were going through therapy, medication like I said was very challenging. When our service dog arrived -- oh, by the way, at school -- she goes to a therapy school -- she -- they could see the difference when we didn’t have Mickey [phonetic] and when he arrived because her -- she started to do better at school. Right now, she is a special Olympic athlete. In -- in one year, she became global messenger. That was set aside for her being a little people because they usually take a leader more getting into that spot. She was nominated and even didn’t know about that part. She is a high honor roll student, and since we have Mickey [phonetic], she has been more stable in our lives. By the way, she was taking out one of the medication, Haldol, because she started to pretend (inaudible - 04:16:30), and I was terrified because that helped her to stop having hallucinations, but it was (inaudible - 04:16:37) to take it out, and no other medications have been replaced, and we decided to workup. The thing is that -- that Mickey [phonetic] helped us to -- to keep us safe. My daughter used to wake up during the -- she wake up sleep, so he let -- let us know -- let me know when -- when she want to -- she’s getting out of the room or run away. She help -- he helped me. Mickey [phonetic] helps me to support in my working. I have PTSD, fibromyalgia. I go through a lot of disassociation and sadly, the regular medication doesn’t work well for me, so I have to (inaudible -- 04:17:24) and eat natural -- more natural resources, like Mickey [phonetic] he’s -- I’m relying on him too much to keep stable. We need this bill to be approved because these kind of dogs are medical equipment, and somehow my daughter
and I we are saving a lot of money to the state because we are not, cannot take certain medications, but we are relying on medical equipment that we need to -- we are terrified when his time comes to pass away. I cannot afford this, and I don’t have no more the strength because of this chronic pain and chronic (inaudible - 04:18:10). I don’t have the effort to do fundraising, and the cost of these dogs are now -- are elevated more than way higher than when I got Mickey [phonetic], so the next time my daughter and I -- of course, we are terrified, again, when dogs pass how we are going to deal with our life.

REP. SCANLON (98TH): Well, Zaraya, I want to thank you for coming here today and testifying. We really appreciate that.

ZARAYA IRIZARY: Thank you.

REP. SCANLON (98TH): Any questions from the committee? Thank you. Representative Pavalock-D’Amato.

REP. PAVALOCK-D'AMATO (77TH): Excuse me.

REP. SCANLON (98TH): Zaraya. One second. We got a question for you.

REP. PAVALOCK-D'AMATO (77TH): Just one. Do other states provide this kind of coverage? Do you know?

ZARAYA IRIZARY: I -- I -- I don’t know. Yes. Four of them -- four of them are paying insurance for -- for service dogs, and it’s very important. Service dogs are different from emotional support dogs.

REP. PAVALOCK-D'AMATO (77TH): Right. Yes. I’m aware. Thank you very much.
ZARAYA IRIZARY: You’re welcome.


CAROLYN SIRES: Thank you. Good afternoon. Carolyn Sires. I’m probably sitting here since 11. I’m very grateful because what I have to say I’m not going to say at all. I have a total different twist on everything, and I have to commend you as Representative of the state for hearing so many people we want, we want, we want, we need, we want, and you just have a budget that’s just so big, and I say this as a physical therapist in private practice as well as a multi-joint replacement patient, which is why I have Blue. I wanted to clarify that, but let me say what I’m noticing, and -- and maybe this is -- why have I been in business for 30 years? Why have I succeeded when everyone on Campbell Avenue has closed their doors? And, that is because I accept what is reasonable and customary from all insurance companies. I don’t ask for anymore and I have been blessed with patients. I have been blessed with a longevity of a -- of a practice where big companies are taking over -- Hartford Hospital and Yale, yet I’m still surviving and thriving in a small private practice, so what I’m saying with the bill, which service dogs are expensive, believe me. My eyeballs pop out. I’m like that -- I mean I have a $30,000-dollar dog? I cannot even accessorize when I go to a wedding. He doesn’t match anything I wear. [Laughing]. It’s a visible sign, hey, lady you’re disabled, okay, so you know, it’s just not a -- a privilege to have a service dog. He’s huge. He can’t even fit under the table here. He changes furniture everywhere we go, but what I’m saying to everyone and I’m -- I’m saying to what I think you
guys have the hardest job is why can’t we agree to take what’s reasonable and customary? Why do we want to say you got to give us all the $25,000 or $30,000 dollars. It is my responsibility if I need him to help fundraise and to do it, and if I can’t do it for myself, I will help other people do it, but if insurance companies could just I think recognize the need for it and pay a little bit, it does offset the cost for -- for the bills and everything, and -- and an example is -- is what I’m hearing from all the surgeries, and so let me just do physical therapy. If I bill $150, insurance pays me $35 or $55 dollars. The max is $65 dollars. That’s it, but I accept that, and I do take that in volume, and so I accept that as my giving back. It’s okay. I’ll do that, and I’ve been here 30 years, so something is right with that, so if the state hears all the people, we all want something, everybody needs, it’s a rough state to live in, everything is very expensive, but for the service dogs, so you can’t pay all of it, maybe we could consider whatever’s reasonable and customary, and then everybody else has to adapt to that, you know. Maybe we cut back on a little bit of -- of different things, and maybe we say to the state, thank you for recognizing these are medical assistive devices, they are not dogs -- you can’t fit. [Service dog moving around]. Don’t even try. Oh my God. Like he’s in church and we kick the pews for the people in front all the time -- but so to give back to the people who have to make the decisions on all these committees from everybody all day is all you hear. I’m exhausted from hearing it, but everybody does need something, and there’s only so much of a pie that you guys can offer. Maybe we should consider each person in a reasonable and customary and
whatever we bill, we bill, and as you know, I can’t change my bill. I can’t say well I bill you $100 dollars, you $35 dollars, you -- I have to have one bill. It goes out and whatever comes back is what I accept, and it’s worked for 30 years I’ve been through the turmoil, so for this bill, maybe if you realize yes other states do realize as a medical assistive device because if you think about it people who have service dogs don’t say I have a pet, emotional, or therapy dog. We have a service dog, but people who have those other dogs when I need them, they’re like oh I have a service dog, but you don’t, so we don’t -- we don’t trade down. We try to trade up, so there’s got to be some reason why people say they have a service dog but they don’t, and the reason being is they are well trained, they are expensive, but they do a service -- a medical need service, so if the bill gets passed or considered, it doesn’t have to be the whole thing. Whatever the state considers reasonable and customary should be accepted and they pay the balance. That’s how it has to go in the world of -- it’s hard but there’s just not that much money to go around to everybody here, and I think everybody has very good causes, very good compelling stories, but I’m willing to say at this point what I came to say versus now is that maybe a little instead of a lot. Thank you.

REP. SCANLON (98TH): Thank you, and appreciate you hanging out all day.

CAROLYN SIRES: Thank you.

REP. SCANLON (98TH): Okay. I know it’s a long day for you to be here, but thank you for sharing your voice with us. We appreciate it.
CAROLYN SIRE: Thank you so much.

REP. SCANLON (98TH): Any questions? Thank you.

CAROLYN SIRE: Okay. Happy Valentine’s Day.

REP. SCANLON (98TH): Happy Valentine’s Day.

CAROLYN SIRE: I forgot about that one. [Laughing].


PAUL DIMAIO: Good afternoon, Representative Scanlon and members of the committee. Thanks for your time today. I know it’s been a long day for you all. I appreciate your patience. I’m the senior vice-president of Delta Dental of Connecticut. I’m here today to profess our opposition to 6080. We’ve submitted written testimony that further outlines our opposition to the bill and the reasons therefore, but it’s a little bit by way back on who Delta Dental of Connecticut is. We’re actually very small dental only insurance provider. We were just licensed in the state in 2016. We provide fully insured insurance -- dental insurance products to approximately 20,000 to 21,000 Connecticut residents, and our parent company, DDNJ, Delta Dental New Jersey, provides -- is a licensed third-party administrator in the state that provides those -- those services to approximately 190,000 to 200,000 of Connecticut residents. And, approximately 80 to 85 percent of the dentist licensed in the state are with our network, so we’re proud of that. We’re proud of what we’re trying to do as a relatively new and smaller entity.
As you know 6088 seeks to amend current statutes 438a, 479, and 479b, under the Offices of Transparency and to make it similar to what -- what our medical providers do, and frankly, we are a little concerned that we don’t believe the medical model is one we should follow. We’ve heard today I don’t know how many times about the skyrocketing medical costs. Dental costs are -- are relatively inexpensive compared to -- to medical, but yet far fewer people have dental insurance, and they do medical insurance cause it’s sort of -- it is an ancillary product that sometimes people just can’t afford, and we fear with this bill requiring insurers to publish fees effectively it would be, and I know this happened earlier. There was some testimony earlier. There would be a sort of race to the top or a potential for that or a likelihood of that. It’s not just cast aspersions on the dentists or the dental industry, it’s just a matter of what the market will bear for them, and they will charge what they can get, and that in turn will just initiate a vicious cycle of -- of higher costs for individuals who try to buy this on their own if their employer doesn’t offer it or offers it on a voluntary basis, or for the groups that are paying it on a self-insured basis for their employees, so -- so we have a very real concern over that, and we believe that ultimately that kind of inflation would cause people to not get insurance, to drop their dental insurance, which would obviously then result in their not seeking care for -- for oral health care, oral health issues, which will let those issues fester. They would become more serious. By the time they got care, it would be exorbitantly expensive and it may also lead to other -- other health issues. As we know, many health issues do
start in the mouth but if they are -- if they are untreated, so for those reasons, we -- we do oppose the bill, and I would take any questions that you might have.

REP. SCANLON (98TH): Thank you, Paul, for being here today. I just have one question.

PAUL DIMAIO: Sure.

REP. SCANLON (98TH): We’ll see if anybody else does. So, you said, I think 95 percent of the dentist in Connecticut --

PAUL DIMAIO: Approximately 80-85, yes.

REP. SCANLON (98TH): So, an overwhelming staggering number of dentists.

PAUL DIMAIO: Yeah. We’re proud of that.

REP. SCANLON (98TH): So, for the -- the dentists that you contract with and work with; how right now do they get notified when the fees change? There’s no requirement. How does that typically happen?

PAUL DIMAIO: Yeah, and I did hear earlier testimony, and I would respectfully submit that -- that was not correct. We -- we notified dentists. We did do a rate change in 2017, a rate adjustment. We notified dentists by letter more than 90 days, I believe, in advance of that change. We notified the Connecticut Dental Association as well of that -- of that change, and clearly, they were not happy, and it’s understandable, but it was a market decision that we -- that we needed to make. Any dentist at any time -- and we put this in our -- in our testimony -- can -- we will provide their -- the fee that they have received, and the fees haven’t changed in that period of time, so they will know
what they get. Any dentist and patient can get a pre-treatment estimate at any time by going either online or contacting our customer service operation or dental network coordinator, and get the fee that they will get for a procedure that they proposed to -- that they proposed to perform, so we don’t think there’s -- there’s you know complete unknown as it relates -- as it relates to the fees, and we just think that, you know, we just be careful. We want to be careful what kind of problem we’re solving and what other problems we might be creating.

REP. SCANLON (98TH): Thank you, Paul. Any questions from the committee? Thank you.

PAUL DIMAIO: Thank you. I appreciate that.

REP. SCANLON (98TH): Next up, Dr. Jennifer You. Good to see you.

DR. JENNIFER YOU: Good to see you too, Representative Scanlon. Thank you for allowing me to testify. It’s my first time, so I’m a little nervous, so I --

REP. SCANLON (98TH): You’re from Gilford, so it’s gonna go great.

DR. JENNIFER YOU: [Crosstalk] [Laughing].

REP. SCANLON (98TH): I can assure you of that.

DR. JENNIFER YOU: Hello, committee members. I am Jennifer You. I am a general dentist, and I’ve been practicing general dentistry in the state of Connecticut since 2005. More recently, I purchased a private practice in New Haven, so I am a small business owner and have been for over 5 years. I’m here to give my support for HB 6088, so currently, as you heard, dental insurance companies are not
required to notify dental providers changes to their reimbursement rates or what kind of a fee schedule. I did experience this in early 2017, and I, unfortunately, did not receive anything verbally or in writing. It came as a surprise to me, and even though I’m an in-network provider with this national company, it wasn’t until we got about 3-months-worth of claim history that I became fully aware of what the new fee schedule was, so at the end of the year, effectively what we determined was that this reduction in fee schedule was about 15 percent, so had I been aware of this reduction previously, I may have made a different business decision, so I was faced with the reality of this reduction in fee schedule, which was approximately the cost of about -- the wages and salary of about two of my employees, so the question of how my practice would be able to continue providing the same level of dental care to my patients with less resources was and still continues to be a source of concern and anxiety.

I personally did not receive any notice, and I don’t know if the CSDA did as well. That’s just my experience with what happened with that incident, so dental -- dental insurances are not required to notify us of changes in their fee schedule, but also, they are not required to disclose actual fees that they will pay for any given procedure. Many times what will happen is we cannot accurately tell a patient what their out-of-pocket expense will be, and some patients will not move forward with treatment -- simple treatments such as a filling if they don’t know their financial obligations, and to me, this is a disservice to the patient because they are not utilizing benefits that they have actually
already paid for, but from the healthcare providers perspective when patients don’t move forward with simple treatment that is less costly, it can lead to discomfort, pain, potential infection, and we all know that can lead to more complex and more expensive dental treatment. Fortunately, Connecticut legislation for transparency does already exist for our medical colleagues and for medical insurance companies, and actually, there are some dental insurance companies that feel this type of law already applies to them, so by amending the language and simply including dentist in these already existing statutes, it will require the outlying companies to follow the intention of the current laws, so all we are asking for is that dentists be included along with our health -- with our colleagues and other healthcare providers, so I urge you to adopt HB 6088. Thank you for your time.

REP. SCANLON (98TH): Thank you, Dr. You. Just a simple question for you.

DR. JENNIFER YOU: Sure.

REP. SCANLON (98TH): Do you think that if most of your patients found out that there was transparency for their regular primary care physician, for example, and not for you, do you think that they would probably want transparency for your fee schedules as well?

DR. JENNIFER YOU: Yes. I do. I mean I just think a lot of times patients, if we can’t accurately tell them what their portion is for a particular procedure, a lot of times they will not move forward with treatment, with good reason. I mean they want to be good patients to us and be faithful and
baneful to their obligation to us, and they don’t want to “rack up a dental bill”, so.

REP. SCANLON (98TH): Any questions from the committee? Representative Dathan.

REP. DATHAN (142ND): Thank you for coming to testify. Are you aware of any dentists that may have, you know, suffered financial loss because they -- they haven’t had this in place and that either because their patients didn’t know what the schedule of services was, it had a high number of maybe some bad debts and things like that?

DR. JENNIFER YOU: I don’t know of any personally. I just know from my experience I have had to change the status of some of my employees from full-time to part-time, and I’ve had to decrease their benefits package. I employ 25 --

REP. DATHAN (142ND): Wow.

DR. JENNIFER YOU: People in my office, so you know, there -- I -- I do feel badly when those instances and things like that have to be made, but it’s in order, again, to continue the level of care that I feel is necessary for our patients.

REP. DATHAN (142ND): So, having this might offer -- you know, a better --

DR. JENNIFER YOU: Right. Just some sustainability --

REP. DATHAN (142ND): Sustainability.

DR. JENNIFER YOU: For my business --

REP. DATHAN (142ND): Right.
DR. JENNIFER YOU: To continue to thrive in Connecticut, correct.

REP. DATHAN (142ND): Okay. Thank you very much for your testimony.

DR. JENNIFER YOU: Thank you.

REP. SCANLON (98TH): Thank you. Dr. Al Natali.

AL NATALI: Chairman Scanlon, committee members, thank you very much for allowing me to testify, and before I go much further, happy Valentine’s Day to everybody in this room and for putting up with a very long day. I really appreciate it. My name is Dr. Al Natali. My first paragraph will probably take up more than a minute. Let me summarize by saying really please permit me to note that my testimony here reflects my individual opinion, not the opinion or physician of an entity, including my employer and/or the University of Connecticut School of Dental Medicine where I’ve been a faculty -- volunteer, nonpaid faculty member for over 20 years, and I’ve enjoyed every minute of teaching. I am in support of HB 6088.

Piggybacking on what Dr. You said, let me just share with you my experience. Yes, I received a letter in September 2016. It did not tell me what changes would occur, other than they will occur January 1, 2017. We got reimbursements that first week. My office manager came to me and said, “Can you believe this?” We didn’t lose 15 percent. We lost between 20 and 30 plus percent on this one issue. The value of my practice dropped 10 percent in 6 months, and yes, it did affect our business model, and I looked for a way, and yes, I sold my practice to another organization where they would then deal with this
and other things that occur. We deserve transparency. I think the citizens of Connecticut deserve transparency. Transparency is important. It’s an important word that we hear today all the time. Why shouldn’t we have transparency? Why shouldn’t we know what a fee decrease might look like and be able to plan for it in our practices? Why do we have to be surprised? I want to know how this transparency might increase a premium fee. I don’t understand how you can’t generate a piece of paper and send it out. Maybe it’s the cost of the paper and maybe it’s the cost of these several employees generating this packing in the mail and sending it out. On the other hand, it certainly could be send out as a PDF. That I just don’t understand. If we have and we treat our profession as part of healthcare and we have this transparency on the medical side, physicians, chiropractors, etc., aren’t we part of that and doesn’t it make sense as a legislature to legislate that transparency? I think so.

I served as a town council member, so while I haven’t necessarily been in your specific shoes here at the legislature, I’ve heard testimony, and it’s at times very hard and very difficult, but I think today this is probably easier than we have in front of us because we have precedent previously.

Lastly, we’re not asking for, as you might see in some testimony, for an unauthorized disclosure of third-party proprietary information. Not at all. All we’re asking for is the ability to create a business model in real time, so I would propose to you the following; if you were in our shoes, you ran a business and all of a sudden you got a letter saying we’re going to pay you something down the
road but you don’t know, how would that make you feel? Again, I’m Dr. Al Natali. These are my own opinions, and I welcome any questions and feel free to contact me at anytime.

REP. SCANLON (98TH): Timed like a true pro.

AL NATALI: [Laughing].

REP. SCANLON (98TH): I must say. Thank you.

AL NATALI: Thank you.


REP. PAVALOCK-D’AMATO (77TH): I just want to thank you for your testimony and actually when you asked the last question, I actually am in your shoes. My father’s a dentist, so I have -- I did run his office for years until I went off to law school, and so I did experience this information, and it’s been definitely quite a few years since I’ve been there, but I wasn’t sure if things changed, so I want to thank you again for your testimony.

AL NATALI: It is my pleasure, and again, if I can answer questions privately, I’d be delighted to. You all have a great day and a great night.

REP. SCANLON (98TH): Thank you very much. All right. Moving on to 6093. Rosana Ferraro.

ROSANA FERRARO: Good afternoon to the committee. I am Rosana Garcia Ferraro. I’m the Policy and Program Officer at Universal Healthcare Foundation of Connecticut. I thank the committee for the opportunity to testify in support of House Bill 6093, AN ACT CONCERNING CONSIDERATION OF IMMIGRATION STATUS BY HEALTH CARRIERS. At the foundation, as
you may have heard, our mission is to serve as a catalyst that engages residents in communities in shaping a democratic health system that provides universal access to quality affordable healthcare and promotes health in Connecticut. We believe that healthcare is a fundamental way and that our work is part of a broader movement for social and economic justice, so support of this bill aligns with our missions and reflects our values. One of the guiding principles of our work is universality. To us, universal means everyone. It means no one is left out. We support access to healthcare for our immigrant communities regardless of status because health is a human right and we all need access to affordable care and coverage. Immigrant residents need real solutions. Their health and their lives are on the line.

The chair of our board, Nancy Burton, who spoke earlier shared a story with me specifically for this testimony. She writes, of a woman, an undocumented resident, that she remembers a woman who had a very enlarged uterus from fibroids. It was the size of a 4 or 5-month pregnancy. She was uncomfortable and her heavy leading to anemia. However, it was not the point of being life-threatening yet. She was unable to get her the hysterectomy surgery she clearly needed at any kind of price that she could afford. She was then lost to care, and so Nancy has no idea what happened to this woman. We may not know what happened to her, but if she had access to quality affordable care, we know her story it would be different. It’s right and it’s time for the state to take bold steps to address the healthcare challenges of all of our residents including our undocumented neighbors, friends, and family. It’s
good policy, and it’s good humanity. There are discussions about a public option for the state of Connecticut. Just yesterday, this committee held a joint informational hearing on the subject. I watched. It was very interesting. Thank you for holding that. When considering a public option, we implore this committee to address healthcare access, coverage, and affordability challenges of again, all Connecticut residents including our immigrant communities regardless of status. We ask that you remember all residents in this state and facilitate undocumented residents access to this particular option. We support the committee advancing HB 6093, as well as taking a deeper look into other solutions that can help immigrants regardless of status access quality affordable coverage and care. Like I said, it’s time, it’s right, and it’s our values.

REP. SCANLON (98TH): Thank you very much. Any questions from the committee? Thank you so much. Dominique Torok, followed by Nita Asani.

DOMINIQUE TOROK: Hello, my name is Dominique Torok. I am pursuing my master’s degree at UCONN school of Social Work focusing on community organizing and I also intern with Connecticut Citizen Action Group. Today, I stand in support of House Bill 6093, AN ACT CONCERNING EQUALIZING ACCESS TO HEALTH INSURANCE REGARDLESS OF IMMIGRATION STATUS. As a social worker and as a community activist, I’m called upon by the NASW code of ethics to empower individuals that make up the most vulnerable of our population. Although I would argue that our most vulnerable are our most hardworking and often our most resilient. Immigrant children and families come to this country with hope for calling a promise of an American dream that is currently slipping through our fingers.
They are fighters, and they are what make our communities, this state, and our nation great. Over the last year, I had the opportunity to work with Protect Our Care CT, and during that time, I heard countless stories from individuals across the state regarding issues with access to high quality healthcare, high cost of prescription drugs, and the impact this issue has on their lives and their families. While working on this campaign, Connecticut students For a Dream stepped up to join is in the fight. They educated community members, they registered voters, and they shared their stories all with the hope of protecting a system that they currently have limited access to. These individuals represent what community is for me. They continue to work hard for all of us to have this access, and -- sorry, I’ve lost my place -- but they currently continue to work with us and currently fight for access to healthcare.

With the recent access to institutional aid bill that passed last session, this bill is also one of common sense. Immigrants work. They pay taxes, approximately $145 million dollars in state and local taxes, and they buy goods to help ensure the economic wellbeing of all of us, so if we ask ourselves why would I pay to a service that I can’t use? This is what we’re asking them to do, so it just makes sense. This is -- everyone should have access to healthcare and that’s what I’m asking for you guys to vote on today. Thank you for your time.

REP. DATHAN (142ND): Thank you, Dominique. I appreciate you coming out today and for all the work that you’re doing to support our immigrant community. Does anyone have any questions for
Dominique? Great. Thank you very much. Next, we have Nita Asani. Welcome.

NITA ASANI: Dear members of the Insurance and Real Estate Committee of Connecticut General Assembly, good afternoon. My name is Nita Asani. I’m a resident of Bethel, Connecticut. I am pursuing my master’s in social work at the University of Connecticut. I stand in strong support of HB 6093, AN ACT CONCERNING EQUALIZING ACCESS TO HEALTH INSURANCE REGARDLESS OF IMMIGRATION STATUS. This bill will prohibit health insurance and health carriers from denying health insurance to anyone in Connecticut based on their immigration status. I am Albanian immigrant who came to this country 8 years ago from Macedonia. The decision to move to United States was not easy but it was necessary. The beginning was difficult. I felt the difficulties my family faced while trying to build a life in a new country. However, it wasn’t until my aunt ended up in the emergency room risking kidney failure that I realized how lucky I was. At first, I was angry and mad at my aunt for letting things get so bad. I asked myself, why didn’t she take care of herself? Why didn’t she see a doctor? Why didn’t she take the insulin like she was supposed to? I was even angrier when I learned the truth regarding healthcare in undocumented immigrants. The truth was that my aunt ended up in the emergency room because of her high blood sugar levels. Her levels were in the 500s and had been for a while. I learned that my aunt had seen a doctor, and she was prescribed short-acting insulin three times a day and long-acting insulin overnight. I also learned that she was not taking her medication as it was prescribed because like many of us she couldn’t
afford her medication. I learned that my aunt chose to use her insulin only when she felt her worst.

Although my aunt and uncle work tirelessly to support their family, they like many of us, didn’t make enough to pay thousands of dollars for insulin every month. My aunt and her family did not have access to health insurance because of their immigration status even though they pay taxes every year. During her 4-day hospital stay, my aunt could only focus on how she was going to pay the bill. While her kidney improved and her sugar levels were normalized, her blood pressure remained high due to the stress of wondering how she would pay for everything. She wondered what she be paid first, her medication, hospital bill or her rent, food, and utilities. These were the choices she had to face when she should have been focused on healing and her health. Today, my aunt and family are still experiencing similar hardships. Nothing has changed. They are still uninsured. They pray they don’t get sick. Her kids now are of working age are faced with the choices saving for their future or assisting in paying for their mother’s medical bills. Why should they have to choose between their mother’s life or getting education? But, this is the reality and this is the reality of 130,000 undocumented immigrants in the State of Connecticut who are making difficult decision every day. That is why I am urging you, esteemed members of this committee, to vote in favor of HB 6093. I believe in this country, I believe in its people, and I believe in this committee to support HB 6093. Thank you for your time.

REP. SCANLON (98TH): Thank you for your testimony. Any questions? I’m seeing none. Thank you so much.
Lucas Codognolla, followed by Camila Bortela -- Bortoletto. Sorry.

LUCAS CODOGNOLLA: Good afternoon. Happy Valentine’s Day.

REP. SCANLON (98TH): Lucas, tell me how to pronounce your last name.

LUCAS CODOGNOLLA: Codognolla.

REP. SCANLON (98TH): All right. I got to practice that.

LUCAS CODOGNOLLA: [Laughing]. Honorable Chair and members of the committee, my name is Lucas Codognolla, and I have the pleasure to serve as Executive Director of Connecticut Students for a Dream. We Connecticut Students for a Dream strongly call on the members of this committee to pass HB 6093. The Connecticut legislature must pass legislation that would equalize access to health insurance for all, and we feel that this bill is a first step to doing so as it prohibits health insurance carriers from discriminating against individuals based on immigration status. So I, myself, am undocumented. I am also a recipient of the Deferred Action for Childhood Arrivals Program, DACA. C4D is a statewide youth-led network that fights for the rights of undocumented young people here in the state, and many of our brave members will be sharing their stories with you today as well as the testimonies that they have submitted.

So, we testified today because our immigrant community and young people in the state they yearn to live unafraid, and one of the things for us about living unafraid is having access to safe, accessible, and affordable healthcare, health
insurance, and health coverage that does not discriminate based on immigration status. In Connecticut, undocumented immigrants, regardless of social economic status and age, are discriminated against in accessing healthcare and health insurance. We are prohibited from buying into Access Health CT and are ineligible for Medicaid, Medicare, and other state or federal programs. Also, private insurance companies, as we heard from a lot of our members have refused to issue health insurance to individuals because of their immigration status.

So, you have our testimony where it outlines a lot of our points, so I just wanted to briefly go through them. With more than, you know, and obviously the number of undocumented in the state is hard to calculate but with more than 110,000 estimated undocumented immigrants residing in our state we see this as a public health concern, and so given the urgency of the moment, we believe that legislators in our state need to make healthcare more accessible for immigrant communities. So a couple of points I would like to point out:

1. Undocumented immigrants in our state pay roughly $145 million dollars in taxes in state and local taxes every year so obviously, these taxes fund a lot of health programs that undocumented immigrants may not have access to.

Is that my time? And, just to wrap it up, we believe that this -- again, this is not the -- the legislation that would open healthcare access to all, but it’s a great first step in that path to make, you know, health communities in our state.
REP. SCANLON (98TH): Thank you for testifying. A couple questions.

LUCAS CODOGNOLLA: Sure.

REP. SCANLON (98TH): So, when I talk to the folks that run Yale, for example. You hear a lot about the phrase uncompensated care, which is when folks that they’re either undocumented or do not have health insurance, come into the emergency room, they must be treated. That adds up to staggering costs, obviously --

LUCAS CODOGNOLLA: Right.

REP. SCANLON (98TH): For health systems and frankly, for the state --

LUCAS CODOGNOLLA: Right.

REP. SCANLON (98TH): In many ways.

LUCAS CODOGNOLLA: Right.

REP. SCANLON (98TH): Do you see that as a strong reason why, in addition to the moral reasons that we’re all well aware of; do you see that also as a reason why we should consider something along these lines?

LUCAS CODOGNOLLA: Yeah, of course. I think it’s -- you know, when we’re talking about preventative care, it’s a public health and also an economic issue, and uncompensated costs would be an example of that.

REP. SCANLON (98TH): And, so, I know we’re gonna hear from a lot of folks on this, and I don’t want to spoil their testimony, but anecdotally, many of the members of your organization or from the
 undocumented community; where do they usually seek care, if they do even go to seek care?

LUCAS CODOGNOLLA: Right. It’s really difficult to find out. I mean from my personal experience, and I’m not an expert on healthcare and how sort of local health clinics work, but from my experience, I’ve had a couple of medical situations like getting kidney stones that was really scary for me to just go to the hospital to the ER not knowing how I would pay for it and I’m still paying [laughing] for one of the visits. So, it’s -- it’s really hard, so it’s -- you know anecdotally, from my experience and from my family’s and from my members, it’s this extra barrier that we have to think about, consider. It’s not just let me go seek for help. A lot of the time we don’t know if the healthcare opportunities are available to us and many times are not, and so we have to always think about the barrier -- the financial barrier before we even think about seeking support.

REP. SCANLON (98TH): Thank you. Any other questions from the committee? Thank you very much.

LUCAS CODOGNOLLA: Thank you.

REP. SCANLON (98TH): Camila Bortoletto, followed by Jonathan Jimenez [phonetic]. We can make that work. [Laughing].

CAMILA BORTOLETTO: Hi. Good afternoon, members and chairs of the committee. So, my name is Camila Bortoletto. I live in Brookfield, Connecticut. I am also a member and a leader of Connecticut Students for a Dream, so much of my testimony is similar, so I will just summarize what I’m going to say. So, I’m here in support of HB 6093, AN ACT CONCERNING
CONSIDERATION OF IMMIGRATION STATUS BY HEALTH CARRIERS. This issue is very personally important to me because I am undocumented myself. I came here when I was 9 years old from Brazil with my family. We came to Connecticut like many families do undocumented, but I went to, you know, elementary, middle, and high school in Danbury, Connecticut, and I consider it my home.

Access to healthcare for me and my family growing up was always a hazard affair, so we didn’t have a doctor for most of my grade school years, so getting care was a mix of going to school nurses, long lines at the community health centers, and more often than not, emergency rooms. I am not privileged enough to have good health insurance. I have DACA, Deferred Actions for Childhood Arrivals, which is a renewable temporary status for people who came here at a young age like myself. With the DACA status, I am able to have a 2-year work permit, a social security number, and get a job, and that allows me to get insurance through my employer.

However, most immigrant families don’t have DACA or work permits -- for example, my parents -- and so getting health insurance through employer is not an option at all. Undocumented immigrants are also barred from buying into Access Health CT, and they are ineligible for any state health program. As a result, the health coverage options for undocumented families are very limited and many families, including my own, cannot seek the proper healthcare they need due to the combined factors of status and inability to pay. Even for me, even though I have DACA now, DACA go away later this year. The DACA program itself has been under attack by the current administration and depending on Supreme Court
decision, either later this year or early next year, it could end, and then if DACA was to end, I will lose my job and I will lose my healthcare, and I have no other means of getting health insurance.

Access to healthcare should not be a commodity only for the wealthy and the privileged. It needs to be a human right and no person should be denied or face obstacles in obtaining the healthcare they need due to their ability to pay or their immigration status. So, I urge the committee to support HB 6093 as a starting point, but to know that this bill is not enough as it does not address the core issue of affordability and accessibility for immigrant communities. Like I mentioned, undocumented immigrants will still be ineligible for most or all the state health programs and Access Health CT, so that still makes healthcare very unaffordable for people. Just end off by saying that our current health insurance system and healthcare system is broken in the fact that most immigrant families are left out of the system is a symptom of death. Thank you.

REP. SCANLON (98TH): Thank you. I know your -- your movement has many leaders, but you obviously have been one of them for quite some time, and I don’t want to ask you to speak for everyone, but I’d be interested, especially of what you said in the beginning of growing up and the feeling that you felt; if you could maybe speak to the anxiety a little bit of living without insurance and unlike some folks who maybe don’t have insurance because they lost a job or because they’re, you know, deciding not to go with or without it or they’re going without it on reason. You just can’t get
access to it. Can you talk a little bit about the anxiety that that would bring you?

CAMILA BORTOLETTO: Yeah, so growing up, I think we first got insurance -- I was in college when I first got insurance to you know (inaudible - 04:58:40). Before that, they (inaudible - 04:58:43) have insurance and we didn’t really have a doctor, and neither my parents. For example, one time, my dad was working. I don’t remember what kind of job he was working, but he hurt his hands, and his hands were like swollen, and he had no way to go to the doctor to get it treated, so he just waited and eventually wound up in the emergency room because of his hands being like swollen, so it’s -- that is like a common thing where you just wait and wait and wait until you can no longer wait because you have no other option to get help from a doctor because you -- you’re weighing the cost to your family with how much you can tolerate the pain or how much you can wait just a little bit longer.

REP. SCANLON (98TH): Thank you. Any questions from the committee? Thank you. Jonathan, followed by Hillary Bridges.

JONATHAN GONZALEZ-CRUZ: Dear members of the Insurance and Real Estate Committee of Connecticut General Assembly. My name is Jonathan Gonzalez-Cruz. I am a graduate student pursuing a Master of Science and Quantitative Economics at the University of Connecticut, and I am also the Policy Coordinator at Connecticut Students for a Dream, and I am also undocumented with DACA, and I stand in support of HB 6093, and before I continue, I just simply wanted to frame the issue that our community is facing. In Connecticut, there are realistically only two ways
that an undocumented immigrant could purchase health insurance. The first one is if you participate at their university, but then even so, because we don’t qualify for any other parts of aid other than institutional aid, which doesn’t go into effect until 2020, paying tuition, and then also around $3000 dollars for health insurance is extremely expensive, and then the second way is if you purchase it through your employer, but unless you have DACA and they offer it to you, then it is unrealistic for a lot of people to also purchase it from their employer. And, in turn, because there are an estimated 130,000 undocumented individuals in this state, that it is a massive health concern. As when someone said before, because of uncompensated care, that is spread through both private and public institutions. That will then force others to pay for that cost, and in fact, we are all paying for that cost, so in order to save money, it will be better to insure folks, so then that they can get preventative treatment rather than let issues develop on, and then become even worse, and I just want to share a quick story about my -- my growing up undocumented, and it’s actually my mothers.

On my 18th birthday, I actually ended up going with her to one of the -- the clinics that we go to because for months her lungs had been causing her so much pain and agony, but time-and-time again, regardless of what treatment they gave her, she couldn’t be helped, so I vividly remember sitting in the hallway with her, and she was balling her eyes out because they literally told her that because you are uninsured there is nothing more we can do for you, and in the car ride home she told me, “Should something happen to me, I want you to take care of
your brothers.” And, my mother’s story is not an isolated one but the norms that our communities face every day. Right now, at this very moment while all of us are deliberating whether we should pass this bill or not, there is a family who is thinking how am I gonna get treatment? How am I going to go to a doctor without breaking the bank and with the ability of still being able to provide for their children. In turn, it is a common-sense bill that we insure all Connecticut residents, and as -- just to wrap it up. As state legislators, you are given the tremendous privilege of serving our communities including those of undocumented communities in your own districts. It is the Connecticut’s legislative responsibility to ensure the well being of all families, and so to neglect the needs of a community echoing a call for help is to ignore the very values Connecticut has distilled in us. Right now, our undocumented communities are issuing a call to make healthcare more accessible and affordable. To all state legislators, we ask you this; will you answer that call for help? I support HB 6093, and I hope you will as well. Thank you.

REP. SCANLON (98TH): Thank you, Jonathan. So of the 130,000 undocumented population give or take in Connecticut; how many of them have DACA currently?

JONATHAN GONZALEZ-CRUZ: So, I -- I think the rough estimate is between 8500 and 10,000.

REP. SCANLON (98TH): So, almost 120,000 of the 130,000 do not have eligibility to get insurance through DACA, correct?

JONATHAN GONZALEZ-CRUZ: Yes, that is correct, and even of the ones who do have DACA, unless they are purchasing it through their employer or they’re
purchasing it through their university, then that could be the last as well.

REP. SCANLON (98TH): And, both of those things whether it’s — you’re through university or your employer, are very not open-ended things, right? University you graduate, hopefully. If you don’t, you know, you lose it. If you go to a job, you could lose that job at anytime and therefore, lose your insurance. Is that correct?

JONATHAN GONZALEZ-CRUZ: Yes, that is correct, and just to add onto the university. I — when I had to purchase my through Southern, I think it was roughly $400 or $300 dollars per month, so then I actually ended up wanting to purchase my own private insurance plan because I couldn’t afford that, so then when I went to Access CT to see which plan I could afford, when I went through the process of it, it actually told me that there were no plans that they could offer me, so once again, that speaks to the inaccessibility of insurance here in the state.

REP. SCANLON (98TH): Thank you. Any questions from the committee? Thank you.

JONATHAN GONZAELZ-CRUZ: Thank you.

REP. SCANLON (98TH): Hillary Bridges, followed by Camille Kritzman.

HILLARY BRIDGES: Hello. Good afternoon to members of the committee and Chair. Thank you. My name is Hillary Bridges, and I’m from New Haven, and I’m here in support of Bill H — Bill 6093, and I just wanted to share a quick personal story about the importance, the necessity of preventative healthcare. So my mother’s father was her favorite person in the world and I heard many wonderful
stories about him from here. I heard that he was a deep listener, a calming force, a talented golfer, and just an incredibly loving father, and all the -- all I know about my grandfather are from my mother and because he died before I was born, and my grandmother as always just in too deep of state of grief to really be able to talk about him, and so my grandfather died a gradual and painful death in 1985 as a result of prostate cancer, and this was just before prostate screenings were the norm, and today, these screenings have led to a huge reduction I prostate cancer, death as I’m sure many of you know, and as we all know, preventive healthcare saves lives, and we live in a count where we have the best doctors, best scientists, best engineers in the world, and yet, there are people on our own soil who can’t access that care. And, so we -- we choose to continue to be a country that does not offer these services to poor people and to undocumented people.

And, so my entire family was brought here to this country enslaved against their will with no compensation, and now I watch as we continue to oppress our fellow human being by denying them basic human rights like healthcare, and I really find it disgusting, and I honestly find it scary to live in a country that does that, so I really hope that Connecticut can change these ties and show the rest of the country that we won’t stand for this kind of continued discrimination in our country and -- and oppression, and that we value the lives of our citizens too much to do that here and to deny them some as essential as healthcare no matter where they came from or when or how. It doesn’t really matter, and so healthcare is a human right. It’s just a human right that we should all have, and it pains me
to think that my grandfather if he had been born a little bit earlier, I could have met him, which would be really cool because I’ve just heard such wonderful things about him, but in his case, these screenings just weren’t an option. They didn’t exist. There wasn’t a choice; whereas today, it is a choice because -- because they do exist and we know that they are saving tons of lives. Prostate cancer isn’t even -- I mean it’s serious, but so many people get screened and then they are able to get it taken care of, so to me -- and that’s not just true of prostate cancer. It’s true of many illnesses and diseases that can be prevented, and so today, I really -- I was thinking about it. We really choose unnecessary deaths and trauma for people -- and I’m almost finished. For our fellow residents, and so with this bill, we have the opportunity to make a new choice for these people and for their loved ones, unlike my grandfather, and so I -- I hope that we can make this choice to help them live and to have them live, and so I hope you will support Bill 6093. Thank you so much.

REP. SCANLON (98TH): You’re welcome, and as I’m sitting here listening to you testify about healthcare as a human right, I’m realizing that we had a conversation about that a couple minutes ago, and that would not apply to everyone in humanity, and that’s a very dangerous precedent that we have used in the past wrongly as a society in this country, and I hope that we don’t do it again, so.

HILLARY BRIDGES: I really hope not. Yeah, and we have an opportunity to choose now. We can choose this, so.

REP. SCANLON (98TH): Yeah.
HILLARY BRIDGES: Thank you very much.

REP. SCANLON (98TH): You’re welcome. Camille Kritzman, followed by Alex Rodriguez.

CAMILLE KRITZMAN: My name is Camille Kritzman. Hello, members of the committee. I’m -- I live in Hartford. I’m part of Connecticut Students for a Dream. I’m here today to support HB 6093, AN ACT CONCERNING IMMIGRATION STATUS BY AN -- AN ACT CONCERNING CONSIDERATION OF IMMIGRATION STATUS BY HEALTH CARRIERS. This bill would prohibit health insurance and health carriers from denying health insurance policies to anybody in the state based on immigration status. Throughout my time at Connecticut Students for a Dream, I’ve had the privilege of getting to know many bright and talented students from Hartford and around the state. I’m here testifying today because of them. The students I work with tell me about the fear of going to the hospital without health insurance, unsure of how much the services will cost their family until they receive the bill later on in the mail. I work with students who haven’t been to the doctor in years because of the high price without insurance. I work with students whose families need to make the tough choice between medication and food. I work with students whose families are short on rent because of the cost of medicine or medical care for their children. This is a choice no person should have to make; yet, in Connecticut, it’s a reality for the hundreds of thousands of undocumented people.

Going to the doctor or dentist is proven to be a preventative measure and is beneficial and checkups are beneficial to save both the healthcare industry
and the taxpayer money. If we want a healthier state, we must allow all people regardless of immigration statute the ability to sign up for health insurance. Undocumented people are essentially subsidizing the healthcare system here in Connecticut. Undocumented people in Connecticut pay approximately $145 million dollars in state and federal taxes. This money goes towards funding healthcare programs for others that they are unable to access themselves. This bill would give undocumented people the option for signing up for health insurance. Healthcare is a human right, and denying access to affordable healthcare based on immigration status is discrimination. Today, we have an opportunity to work towards a healthier Connecticut.

As I read this, I personally know a mother who’s worried about paying for medicine for her young son. We can help her and so many others in Connecticut who are suffering without health insurance. Thank you so much for hearing my testimony, and I hope that the committee will support HB 6093.

REP. SCANLON (98TH): Thank you very much. Any questions from the committee? Thank you. Alex Rodriguez, followed by Reveiz. Did he leave the room? Oh, there he is in the back there. Okay.

ALEX RODRIGUEZ: Thank you, Mr. Chairman. Thank you members of the Real Estate -- Real Estate -- of the -- thank you members of the Insurance and Real Estate Committee of the Connecticut General Assembly. My name is Alex Rodriguez. I’m from West Hartford. I am a community organizer for the Connecticut League of Conservation Voters, CTLCV, program. It is the mission of CTLCV to advocate for
environmental justice for communities of color and low-income communities whom are often left out of policy decisions. I am here today because I want to stand with -- with my friends in support of HB 6093, AN ACT CONCERNING EQUALIZING ACCESS TO HEALTH INSURANCE REGARDLESS OF IMMIGRATION STATUS. I firmly believe that everyone should have health insurance regardless of your legal status in this country. I support this legislation because again I don’t believe your legal status in this country should play any role in barring from access to healthcare, and it’s very often that immigrant communities are disproportionately exposed to pollution and toxins on the job, at school, and in our homes.

A 2015 study done by Washington State University has raised concerns that economically disadvantaged immigrant neighborhoods and non-English speaking Latinos are more exposed to cancer-causing air toxins than other racial groups in the country. This study shows that in a 1 and 3 chance that immigrants to be located in air polluted metropolitan areas such as Hartford, New York, and Los Angeles are exposed to very much air pollutants such as nitrogen oxide and dioxin. Exposure to these harmful pollutants has been found to potentially cause serious reproductive and birth defects such as cancer. This committee should support the bills because healthcare is a human right. Access to healthcare is a human right and no one should be denied or face obstacles in obtaining the healthcare they need due to the ability to pay or immigration status. Every treatment effectively reduces the amount an individual will pay for healthcare in the long-term
by preventing health issues from developing further. Uncompensated care costs are shared across both public and private pairs including the state and local governments. Undocumented immigrants in our state pay roughly $145 million dollars into state and local taxes every year.

As you’re reading the sentence right now, there is a family worried about how they will pay for a loved one’s doctor’s appointment, treatment, medication without being left with little to no money. We have the power to help a family. Let’s make a difference. Please support HB 6093.

REP. SCANLON (98TH): Thank you.

ALEX RODRIGUEZ: Thank you.

REP. SCANLON (98TH): Appreciate your testimony today. Any questions from the committee. Thank you. Reveiz, followed by Vanessa Caro [phonetic].

KENNETH REVEIZ: Thank you to the Insurance and Real Estate Committee for your time and for your dedication to the constitution state. First, happy 2019. I want to congratulate you on your new terms. I want to personally thank Chairs Lesser and Scanlon and all members of the committee for bringing HB 6093 to a public hearing today. It is my pleasure to be here in support of this bill. My name is Kenneth Reveiz. I am testifying today as the representative of Ward 14 on the New Haven Board of Alders. I am also testifying as a proud community organizer for Connecticut Students for a Dream, C4D.

I would like to highlight mental healthcare. Representative Delnicki, I know that this is important to you. Mental healthcare is a critical component to healthcare that is often forgotten.
This bill would increase access to mental health. Mental healthcare is imperative for building a culture in Connecticut where we privilege non-violent communication, emotion intelligence, empathy, wellness, self-reflection, and healing. I would also like to highlight this bill as a racial justice and a gender justice matter, in particular black undocumented folks face the highest rates of detention and deportation of any immigrant community in our country. The recent high-profile detention of Sheyaa Bin Abraham-Joseph, also known as 21 Savage, highlights that we must take action locally to oppose the terror and attacks on the bodies of black people being inflicted federally by ICE. Black undocumented folks, like everyone, deserve to feel safe, seen, healthy, and well cared for. Immigrant trans women face outrageous obstacles as well. The neglect and lack of medical care killed Roxsana Hernandez when she was held in ICE detention. She suffered 5 days of freezing temperatures, was physically abused, and ultimately, died from complications from HIV. A November 2018 New York Time’s article notes “there has also been a spike in the number of openly LGBTQ people from Central American countries and Mexico seeking asylum in the United States because of the violence they often face in their home countries. LGBTQ undocumented folks like everyone deserve to feel safe, seen, healthy, and well cared for.

We must do everything we can to break the cycle of violence and discrimination. Everyone will benefit. The legislature must ensure that our residents do not experience death, deportation, illness, alienation, and poverty, but instead enjoy wellness and prosperity. Let us contribute to breaking the
cycle of dehumanization and violence by beginning with the passage of HB 6093 this session. Thank you so much for everything you do.

REP. SCANLON (98TH): Thank you for your testimony and for bringing up mental health. Obviously, when people never had access to primary care, they’re probably not getting routine access to mental health, which is obviously such an important thing, and can link to behavioral health and physical health as well, so thank you for bringing that up Alder. Any questions from the committee? Thank you. Vanessa Caro [phonetic]. [Background conversation]. It says Vanessa Caro on here. I’m sorry if it was a -- if it’s -- all right.

VANESSA CARDOSO: Good afternoon. Dear members of the state Insurance and Real Estate Committee of Connecticut General Assembly. My name is Vanessa Cardoso. I am a student at Capitol Community College. I am from New Britain, and I stand in support of HB 6093, AN ACT CONCERNING EQUALIZING ACCESS TO HEALTH INSURANCE REGARDLESS OF IMMIGRATION STATUS. The bill will -- the bill would prohibit health insurance and health carriers from denying health insurance policies to anyone in the state based on immigrant status. I come from a mixed-status family, meaning that my parents are undocumented and my brother, but I am not. My family has been living in New Britain for over 20 years. My father currently runs a small landscaping business, which means he comes home frequently with a lot of injuries. My mother as well she works -- well, she used to work. Now she doesn’t because she got hurt on the job very severely in her knee, and she has not been working for months now. I’m here because of them, and also my brother.
Like I said, my dad usually comes home with a lot of serious injuries. One time well, 2 years ago, he slit his thumb clean in half, and yeah, he the doctor was like yeah, just go back. He was like just go home and take rest and take these antibiotics, and what did he do? He did not rest. He did not rest because he has to work because of the medical bills. Same with my mother. Since she got injured at work, my mother has not been walking well, and the only help she can get was home remedies and massages, and yeah, that’s all she can afford and that’s all you can get.

So, having this bill would mean a lot to me and my family, and yeah, and many other families (inaudible - 05:20:48), which are going through the same thing. Yeah, so I support [Laughing] -- I support HB 6093, and hope the committee will vote (inaudible - 05:21:03).

REP. SCANLON (98TH): Thank you Vanessa, and thank you for sharing your family’s story with us. Any questions? Last on this bill, Carolina Bortolleto.

CAROLINA BORTOLLETO: Thank you members of the committee for listening to testimony today. My name is Carolina, and you just heard my twin sister speak. I know you’ve heard a lot about the different views on the policy, so I’m not going to repeat what everyone just said. I’m just going to share a little bit about my personal theory on why healthcare is important, so like my sister said, I am undocumented, but I’m lucky enough to currently have health insurance through my employer, but in 2014, I was not that lucky. I did not have health insurance, so one night in December 2014 when I woke up with really bad stomach pain, I just thought okay
it’s fine. I’ll wait until the next day, it will go away, it will be fine, but the next day came and it wasn’t better, and then I eventually couldn’t wait anymore, so we went to the emergency room, and I found out -- I did find this out, so after I got there, what was causing my horrible stomach pain was that I had a hidden stomach obstruction and eventually, my stomach ruptured, and I only found this out about 2 weeks after I went to the emergency room because that’s how long I was in a coma after I got to the emergency room, so in total after my stomach ruptured, I had 9 surgeries -- 9 major surgeries. I spent 7 months in the hospital in Danbury Hospital and Yale New Haven Hospital. My care was paid for through a mix of uncompensated care, charity care from Yale New Haven Hospital, a Go Fund Me account, Zumba fundraisers, and our family savings.

So, at a time when my parents who had been worried about whether I was going to survive onto the next day, they were also very worried about how they were going to pay for this, and if one day, I was going to be kicked out of the hospital because they were uninsured and couldn’t pay. So, after 7 months in the hospital, I was released. I got out of the hospital, but my life hasn’t been the same since. I get out of the hospital. I had a feeding tube and a whole bunch of medical equipment attached all over me from my total of 9 surgeries, so after I got out of the hospital, uncompensated care or charity care wasn’t an option anymore because my life was no longer at risk, so after my life was no longer at risk, I spent 3 years on a feeding tube, not being able to eat because I couldn’t get the surgery that
would allow me to eat again because I didn’t have health insurance to pay for the surgery.

So, last year, I was finally able to get health insurance through my employer. I had two more surgeries and since then, I am now able to eat again. I don’t have a feeding tube. I don’t have all the medical equipment and bags and tubes attached to my abdomen, and that was because I was finally able to get health insurance, and that was after 3 years of not being able to eat and not being able to live my life, so I’m here just speaking in support of that everyone wants to be able to access health insurance, especially in the medical system where not everyone has access to healthcare, access to -- access to health insurance, and access to healthcare is kind of the same thing in the system, so everyone can have access to healthcare. Thank you.

REP. SCANLON (98TH): Thank you so much for testifying and for sharing your story with us. Any questions? Representative de la Cruz.

REP. DE LA CRUZ (41ST): Thank you, Mr. Chairman. Thank everyone. I wanted to talk to everyone of you when you guys were up there. Your story is our story, and I -- I for one believe that human -- that healthcare is a right and sorry that you even have to go through this, but this is a process, and we all know that you’re not sometimes fighting for yourselves but you’re fighting for your kids and your future generation, so I -- I personally want to thank you guys for coming out and saying everything you did. I know it’s not easy.

REP. SCANLON (98TH): Any further questions? Thank you very much, and thank you all for your patience
today. I know it’s been a long day for you as well, so thank you very much. All right. A few more bills left. 6095. Maureen Dinnan. We may have lost Maureen a long time ago. 6687. Eric George.

ERIC GEORGE: Change of pace. Now, we’ll go on to auto insurance, so my name is Eric George. I’m the president of the Insurance Association of Connecticut. I am here to offer testimony on House Bill 6687, which would prohibit the use of territorial rating and credit in the underwriting of auto insurance. We oppose this bill. These two factors are extremely determinative of risks, and I want to talk to you about them both in turn.

Territorial rating -- so insurance works when we both have the best ability, the most accurate ability to determine what a risk is, and we use several factors in auto insurance to get there. Driving history is obviously one of them, credit history, which is the insurance score is one of them. The age of and model of your car. That is another one. Also, where you garage your car is a factor. It’s a factor and there are two rules and I would like to just bring to the committee’s attention when we deal with territory. First of all, all territories in the state of Connecticut have to be approved by the Department of Insurance, so there’s the regulatory overlay there. The other one -- that -- that’s just -- back up. Rule number one is the principle garaging rule. This is what that says. If you take somebody like me. I live on Glastonbury and drive to Hartford every single day. I garage my car in Glastonbury. I get into an accident in this hypothetical in Hartford. Hartford does not get that experience. That experience goes to where I garage my car, so if my
car, again, garaged in Glastonbury. I drive it to Hartford and it’s stolen. That experience does not go to Hartford. That experience goes to Glastonbury. That’s number one the principle garaging rule. The other is the 75/25 rule, which says that we are going to allow for territorial rating, but we’re not going to have pure territorial rating. Insurance company, when you are assessing territory, can only attribute 75 percent of the weight to the actual premium. The other 25 percent you’re not allowed to attest, and the reason that they do that is to keep a moderate subsidization from more not as populated, not as dense locals as more dense locals, so that is the backup on territory.

You’ve heard me speak about credit but I just wanted to bring up a couple of the major points that I’ve spoken before. Credit score and insurance score are very different. While we just like lenders look at credit history, look at it differently. When we look at credit history, it’s the insurance score, which goes to determine or predict what is the likelihood of you filing a claim as opposed to the way a lender looks at it, which is what is the likelihood of you defaulting on a loan. It is a very -- you have my testimony. You’ve been here a long time. It is very regulated. We have many systems in place. All of the reports that I refer to before, I’ll just refer to them and from my previous testimony. Thank you very much.


ERIC GEORGE: Thank you very much.
REP. SCANLON (98TH): And, last but not least, Joy Avallone. 6690.

JOY AVALLONE: Hello everyone. I am Joy Avallone, general counsel for the Insurance Association of Connecticut, IAC. I want to thank you for allowing me to come before you, and discuss some of the IACs opposition to House Bill 6690. I also realize this has been a very long day, so I will try to keep my comments very brief.

Essentially, this bill will require each home owner insurance carrier in Connecticut to cover cost of removal of every tree in every yard of every policy holder so long as that tree fell onto such property due to a natural disaster and regardless of whether or not that fallen tree caused any damage to property, any damage to a home or other structures on the property and regardless of whether or not the fallen tree posed any safety risk at all. Now, as I’m sure you are all aware, typical home insurance policies already cover the cost of removal of fallen trees that have fallen and damaged homes or other structures so long as the tree fell due to covered peril, such as wind or snow storm, etc. Coverage also actually extends where there is no damage under circumstances where there is a safety risk, so if a fallen tree lands across the driveway and it blocks the driveway or it blocks the handicap ramp, that also is going to be covered.

Now, these coverage limits are set in order to keep premiums affordable for policy holders. Coverage of every single tree in every single yard is just too policy frankly for two reasons. One, the cost of removing each tree ranging in the hundreds to thousands of dollars, and also as we all know living
in Connecticut it’s not uncommon for their to be multiple trees on any residential property, and/or actual heavily wooded areas. So, I guess it’s also important to note that tree coverage isn’t limited to rural areas, but it’s also notable in urban areas as well. According to the U.S. Department of agriculture our urban areas actually have 49.3 coverage of -- tree canopy coverage, if you will, which comes -- and we come in first out of the 48 states in which this information was accessible.

So, basically in short, if this bill is passed, it’s gonna have the unintended consequence of increasing premiums essentially across the board, and for that reason, we urge you to oppose it.


REP. DATHAN (142ND): Thank you very much. Just I can’t even fathom how much this could possibly cost.

JOY AVALLONE: [Laughing].

REP. DATHAN (142ND): What is the average cost of tree removals are you aware of?

JOY AVALLONE: I don’t have an actual like one average number. We do have numbers we pulled up that it can range anywhere from $1000 to $4000 dollars depending on the type of the tree, the size of the tree, and the location in the actual residential area.

REP. DATHAN (142ND): So, presumably if you offered this insurance, you would have to go out to a insured house every so many years to see how many trees they have to price the policy, a lot of extra work for providers, as well as underwriters and
things like that to look at weather patterns, the effects of global warming so on and so forth?

JOY AVALLONE: Yes. Absolutely.

REP. DATHAN (142ND): Okay.

JOY AVALLONE: If you have something potentially uninsurable risks and then risk extend across the population in order to provide these policies to homeowners.

REP. DATHAN (142ND): Cost prohibitive.

JOY AVALLONE: Exactly.

REP. DATHAN (142ND): Thank you very much.


REP. PAVALOCK-D'AMATO (77TH): So, if the tree was about to fall though, I mean at what point -- does it have to fall and cause damage for you to cover it? And, like I was saying just at the start of my sentence, if it was about to fall and damage and you can see that it was heading in that direction; would you remove it then?

JOY AVALLONE: I think that typical -- my understanding is that typical homeowner’s covers fallen trees that actually cause damage, so they typically aren’t in the business of covering maintenance, if you will. If -- if policies routinely did that, then I think it would, again, have another unintended consequence of having homeowners being disincentivized to actually care for their property, so -- [Crosstalk].

REP. PAVALOCK-D'AMATO (77TH): But, if it was -- it was already -- you could see that it was already
heading in that direction and it was just a matter of time with the next ice storm that it was going to fall on a roof, then I’m just not sure what the difference between the when you actually would cover it and when you don’t or when it’s considered maintenance and when it’s an actual risk and hazard if it’s about to fall.

JOY AVALLONE: Well, policies are intended to cover damage stuff caused --

REP. PAVALOCK-D'AMATO (77TH): Yeah.

JOY AVALLONE: To actual maintenance. I think that’s the difference, and that’s kind of the best way that I can answer that for you.

REP. PAVALOCK-D'AMATO (77TH): And, is there any language that you think would be sufficient -- any narrowing language that would be sufficient to reduce it from being so broad and have those unintended consequences?

JOY AVALLONE: I don’t have any language that I personally would advance, and I haven’t received specific language from members either, but I’d be happy to ask them and provide that to you at a later date if that’s helpful.

REP. PAVALOCK-D'AMATO (77TH): Thank you.

REP. SCANLON (98TH): Any further questions? I’m seeing none. Thank you, and that will conclude our February 14, Valentine’s Day public hearing. Good luck to everyone tonight enjoying their Valentine’s Day further than we have today. [Laughing].