CHAIRPERSON: Senator Matt Lesser, Representative Sean Scanlon.

SENATORS: Hartley, Kelly

REPRESENTATIVES: de la Cruz, Dathan, Delnicki, Floren, Hughes, O'Neill, Pavalock-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. Before I begin I'm going to read the safety announcements. In the interest of safety I would ask that you note the location of an access to the exits in this hearing room. The two doors through which you entered the room are the emergency exits and are marked with exit signs. In an emergency the door behind the legislators can also be used. Or there is a door behind us. In the event of an emergency please walk quickly to the nearest exit. After exiting the room, go to your left and exit the building by the main entrance or follow the exit signs to one of the other exits. Please quickly exit the building and follow any instructions of the Capital 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 announcements are heard.
As is our usual procedure in this Committee, we are going to proceed by Bills but the first hour of testimony is reserved for Legislators, Agencies, Municipalities and other elected officials and first up we are going to hear from the State Controller, Kevin Lembo regarding the House Bill 7174. Good morning, Kevin.

CONTROLLER KEVIN LEMBO: Good morning Senator Lesser and members of the Committee. Thank you. Thank you for paying attention to House Bill 7174, talking about it today and hopefully passing it unanimously through this Committee and once it hits the floor. Like any piece of legislation I'm sure we're going to talk as time goes on about different aspects of the Bill that may need refinement or slight editing but I think the spirit of the Bill is one that we can all agree on. And that is, generally speaking there is a market failure. And that is at the cost of prescription drugs, outpaces, any other indicator in the -- in the economy and our constituents are really asking us to step into this space and try to help, but in the same time not step on innovation. So how do we do that? I'm going to focus on a couple of things today and draw your attention to them.

The Bill has a number of elements to it. I'll focus on three today. One is that as you know, the State of Connecticut and my office in particular negotiates for healthcare for about a quarter million people, 200,000 depending on how you count it but definitely 190,000 that are pre-Medicare retirees or active employees, that whole sort of range. And we've become pretty good and we're getting smarter every day about the work that we do.
And owning your data is always step one and we have done that and as we mine that data we see where we can control medical trend, which we have done as you know pretty admirably over the last seven years or so. And now we're looking at pharmaceutical trend because no matter what we do on the healthcare side, the pharmacy trend always outpaces it and hasn't in my view given the relief that had been originally promised. We were often told, well, you're going to spend a little bit more at pharmacy but that's going to help you avoid fill in the blank. Emergency room utilization, hospitalization, not quite seeing the payoff for that. It's a separate question but we need to look at that trend. If I thought it was avoiding other costs then this might be a whole different conversation.

So the elements of the Bill that I want to call your attention to are really grounded in the fact that the State of Connecticut through my office now is out with a request for proposals. We're actually coming to the final set of negotiations around who the next pharmacy benefit manager will be for the State of Connecticut. And we've taken thinking from some of the best places in the country and in the world and incorporated that into our fee process. And in doing so, we have a potential contract now, and we'll see how the rest of the negotiation goes, that pharmacy benefit managers who administer these kinds of plans, are actually competing against one another for the terms of the contract and the cost of the medication in what we call an auction. So we got down to a number of PBMs that could provide service for us and when we put them in competition with each other and did a series of auctions around price and terms to get to the lowest possible prices
and the best possible terms for the State of Connecticut, taxpayers of the State of Connecticut. We're coming to the end of that and what we're seeing is as a result, our pricing and our terms will be the ending of most businesses in the state and perhaps other businesses around the country. So then what we do with that? Well it's great if it helps the accounts that I administer because I get to come to those of you who are sitting on the Appropriations Committee and say, good news we're going a great job and we saved you a boat-load of money, but what else can we do? How do we leverage what we're doing to make an impact on the lives of people who don't have a pharmacy benefit through their insurer, have a high deductible plan that still puts medications out of reach or you know, there's a lot of folks out there who are walking away from meds and treatment and help because they simply can't afford it. So how do we make this contract available? Two elements of the Bill that's before you. One would create a discount card. Now we've all heard about discount cards and pharmacy discount cards in particular. Some are better than others. Really depends on the term, depends on the sponsor, it depends on who is getting paid on the backend by those cards. This will be a pharmacy card that will go right off the pricing that I have negotiated. We have used the full force, the full knowledge, all of the consultants that we have to get to what I think is going to be the best prices available. Individuals then could get a copy of a discount card, use it at their pharmacy if they're in a high deductible or if they have no coverage and be able to get the same prices that we have
leveraged. Something they could never do on their own.

Second, we would make available the terms of our contract to any business in the State of Connecticut that wants on board. Now that doesn't mean they would come in with us and we would be in a common pool, it means they would call the pharmacy benefit manager, say I understand this is a self-insured plan, I want in and I want the state's terms, and they would get all of the work that we've already done and that would certainly benefit their bottom line in many, many cases.

Third, I've been asked and I support the idea of the State of Connecticut exploring reimportation or importation of drugs, in particular from Canada and potentially for other sources. This is something that we've talked about for a long time. And there may or may not be Federal support to get it done but at least let's take a look. Let's calculate, let's model, let's figure out what it would look like, if it meets the needs or not. If it would bring price relief or not. If we could find the partners to do it or not. And then bring something back to you for your consideration that would actually enable that to go forward. That's exciting stuff. The US Government has proven on a number of occasions now that they are unwilling to negotiate, particular in Medicare, for drug pricing. I think most of us believe that's nuts. They are such a large employer, or such a large sponsor. They have so many lives in their plan. We suspect we know why that's going on but it would impact not only the Medicare program, it would serve as what I'll call a reference price for the rest of us. If I know
Medicare is paying this, I know what my negotiation window is as we go in and do a plan for our population.

So if they're not going to do that and Canada is well then maybe we can rides on the backs of the Canadian negotiation just as we're going to offer businesses in Connecticut, an opportunity to ride on our negotiations and our contract. Let's see what it looks like. But I think it's very promising and it will raise again the question of importation and negotiation that are central to the pharmaceutical question.

There are other elements of the Bill and those involve everything from relationships between pharmacy benefit managers and pharmacies and others but this is very promising. There would be no real exposure for the state in this, but we would be using our full heft in the market to make a difference in the lives of employees, particularly businesses, maybe even small businesses. A group of folks that we've said over and over and over again that we want to grow, we need to grow, we need them for our future economic success. Well, sometimes we're limited in what we can do. Not everybody is going to get an Department of Economic and Community Development you know, grant or loan to do something. The bottom line would be impacted by this and you will have done it for them. So again, I hope we have a straight-up conversation about this. As you know, I am not so in love with my own ideas at any moment that I'm unwilling to talk about others but I would quote our Governor when he said on budget day, you may like the idea but if you don't what else you got? I'm paraphrasing? What else to you have?
What other ideas do you have to bring relief? Anybody who says the private market will take care of this is either woefully uninformed or lying. And both of those are unfortunate so. Thank you very much. I appreciate your attention and I'm happy to answer any questions you may have.

SENATOR LESSER (9TH): Thank you Controller Lembo for your testimony and for your advocacy on this issue. I know it's of extreme importance to constituents all across the state who are trying to address the issue or deal with the issue of rising prescription drug prices. And I will say as a member of the Appropriations Committee, I'm certainly looking forward to much needed relief on our state employee costs. I think that would be -- would be definitely --

CONTROLLER KEVIN LEMBO: One step at a time please. (Laughing)

SENATOR LESSER (9TH): Okay. Some of the -- in reading through some of the testimony submitted on this Bill, we've gotten a number of stakeholders who have indicated that -- concerns about various aspects of the legislation and I know in particular there was one -- one organization that submitted testimony against describing that it would significantly disrupt the prescription drug marketplace. Is that something that you would agree with and how would you respond to that?

CONTROLLER KEVIN LEMBO: I think it would be a disruption but I think that's our jobs, is to disrupt. When market forces fail, when the free market fails, when there are no checks and balances, when deals are done behind the curtain of secrecy
and we have no idea who is getting paid how much and for what, then it is the responsibility of government to step in that space, disrupt that. Not with an eye toward putting anyone out of business but rather than try to balance the interest of the pharmacy benefit managers, pharmaceutical companies and the patients.

SENATOR LESSER (9TH): So the argument -- one of the arguments against state action on this and I am again trying to find, those advocate is that the market is working. But you seem to think that in many ways the market isn't working and seems to be sort of the premise of the Bill. I know part of this Section -- part of the Bill, Section III specifically concerns Pay for Delay Agreements. Can you talk about what Pay for Delay Agreements are and what you're trying to do here.

CONTROLLER KEVIN LEMBO: So Pay for Delay really involves drugs that have a generic equivalent that's coming to market and the relationships that may exist between the generic company and the name brand company in an effort to keep those drugs delayed or off the market for some prescribed period of time. It's not an area of micro interest of mine. I'm interested in it obviously Senator, but it's not an area that I spent a lot of time researching at this point and I think there are others who will come before you today who can speak in detail about what that means and what the impact would be of disrupting that dynamic.

SENATOR LESSER (9TH): Thank you. I'll have other questions but I know my colleague, Representative Scanlon is itching to get into it so I'll turn it over to Chairman Scanlon.
REP. SCANLON (98TH): Thank you, Senator Lesser. I am in fact itching. (Laughing) Good to see you.

CONTROLLER KEVIN LEMBO: There's a prescription.

REP. SCANLON (98TH): Let's hope I can afford it. (Laughing) So thank you for being here today and I just want to ask a couple of questions. So one of the things that I think you talked about a little bit was this new PBM contract and I think it's very important to what we're trying to do here and I'm wondering if you can talk a little bit about how you feel that vibe, even without that new PBM contract, folks would save money by doing what we're doing today. But with that new PBM contract, do you anticipate that they would save even more money?

CONTROLLER KEVIN LEMBO: So yes. So I think the state plan will save money once this contract is fully executed and in operation and as a result anyone who buys into the contract will save more than -- than they would if they had gone onto the contract that we have right now and I don't want to neglect to say that the contract that we have right now is actually pretty good. We've done really, really well but there is more to be done. And so full transparency around pricing, paying for the actual cost of the drug as -- the -- the PBMs and the pharmacies have an agreement, we're going to pay for the reimbursement of what they paid the pharmacy for that drug plus a small administrative fee. We're getting rid of all of the sort of spreads and margins and things that allow for mystic making and exploitation behind the curtain, particularly when it's hard to know what those actual relationships are. That we're going to align the incentives so that the pharmacy benefit manager and the pharmacy
wills all know that where there are generic equivalents, where there are multiple generic equivalents and one is either a higher value or lower price in both, that there will be sort of some decision making made about what drug is best. That a physician will know at the point of prescribing. So when they pull of your -- your electronic medical record and they go to the pharmacy tab it drops down and they find your pharmacy and are about to order the drug, that the cost of the drug, not the retail cost but the net cost to this plan would be there for the physician to see, or the provider to see. So then they could make decisions about whether that's going to impact the course of treatment or not. Because it may be the newest, and you've heard me say this a million times, the newest, brightest, most advertised medication in its class but maybe that's not the right medication for this individual. You know, why go with the bazooka when you know, a pea shooter might be the way to being before we incur all those extra costs. That we would get 100 percent of the manufacturer rebates back, no question and full auditing authority over all of that. So there's a lot about this contract. To be frank, when we put it out originally for bid I held my breath because I was unsure if they were just, they the PBMs were just going to walk away, or are they going to say we're not -- we're not doing this because we know what will happen if we do this. There's one and then there will be more. So yes, real savings here and quantifiable.

REP. SCANLON (98TH): And then you know some of the business organizations that testified against the Bill today talked about the fact that they were worried about this being an expansion of government.
I view this as an expansion of benefits to people at no cost really to government. Can you talk a little bit about that?

CONTROLLER KEVIN LEMBO: I think that's actually right. There would be little or no cost to the state, that the administrative burden of everything from this discount card that's in one section, two companies buying in onto our contract onto another would be sort of either born by their plan or would be a simple pass through the discounts we have negotiated. This is not a Bill that creates a single pharmacy benefit manager sponsored by the state and brings everyone into a common pool. That's not what this Bill does. And if it was, there would be other considerations for that including downside risk and the potential exposure to the state, and we would have to talk about that. That's not what this Bill is.

REP. SCANLON (98TH): And when you travel the state, you know whether it's in campaigns or now in your official capacity you do visit a lot of business as do I and all of us on this Committee, when you visit those businesses do you feel like the employees tell you that they feel like the healthcare is working for them to the point that they would not really like this option?

CONTROLLER KEVIN LEMBO: I feel like you keyed that one up for me but no. Mostly because over the years employers who have struggled and with the best of intentions to provide coverage for their employees have been convinced by the insurers that the only way to get to affordability is to push the member further away from care, to put high deductible plans in place, to narrow their networks that makes
getting care potentially more difficult. We have shown, we have proven on our side that that is not true. Frankly if you incentivize people and bring them closer your long-term costs are more controlled because you catch stuff early. When people have an insurance card that still leads care unobtainable for them, then it's meaningless you know absent a catastrophic event in their life. And we all want to protect against that but over the years health insurance has evolved from avoiding catastrophe, financial catastrophe to health insurance. And that was not lead by us, that was lead by the insurance carriers. They wanted to be healthcare companies and so we've lead in that direction. So now the expectation is, I will get healthcare as a result of having this card.

REP. SCANLON (98TH): Thank you Controller. Thank you for being here today and for all your great work on this. I look forward to working with you.

CONTROLLER KEVIN LEMBO: And if I may say, Representative Scanlon, I want -- I want to thank you and Senator Lesser in particular for the work that you've done around this issue. Your partnership, talking through some of the hard ideas that are imbedded in this Bill, and then being willing to be as well open to ideas and speaking with some of the stakeholders who were in the room and getting their feedback as we move forward so -- so thank you for your leadership both of you on this.

SENATOR LESSER (9TH): Thank you, Controller. I did see a question earlier from Representative de la Cruz? And then --
REP. DE LA CRUZ (41ST): Thank you, Senator. Thank you for coming out and I -- well I'm trying to figure out how this would apply to real -- real world. I run a sheet metal company in Groton where all -- I'm part of a sheet metal worker's union. We have insurance. But all the office staff, there's 15 total employees and 5 of which do not have insurance. And we asked them to either get it on Access Health Connecticut or whatever they do or pray that the spouse has insurance.

CONTROLLER KEVIN LEMBO: Right.

REP. DE LA CRUZ (41ST): That hasn't bowed to well for us as a small business because with -- with Electric Boat right around the corner from us we've lost probably four employees out of the office and I can tell you, once we train them and to lose them is devastating.

CONTROLLER KEVIN LEMBO: Yes.

REP. DE LA CRUZ (41ST): My -- My -- the way that this would apply to our business, I'm not sure how it works, we are members of a union. It's 375 members. We just -- just started doing a high deductible insurance. A union sheet metal work in Connecticut is a $4000 deductible so January -- before January 1st I had no deductible, now it's $4000 and I think what's happened in our folks that have insurance and have had it for a long time I'm now getting nervous because as I was doing the math it was about a $3.60 hour cut in pay for everybody that's in our union. And they're saying to brace yourself because next year is going to be worse because we only pay $13.00 per hour for insurance which equates to about $26,000 a year. That's
apparently not enough. So what we're thinking -- what my thought would be is how would a union like that get involved in this program that you're talking about? 'Could we just bite off the part of the prescription side or do you have to be party of the whole health plan?

CONTROLLER KEVIN LEMBO: So I'm going to give you a two part answer. One is for those who you said were in the office who were encouraged to go to Access Health or go somewhere else to get their coverage, that 15 or whatever the number is. So let's say they have no prescription coverage to speak of. They could get that discount card. They would still be paying out of pocket. It's not insurance at that point but at least the amount that they're paying at the counter would be far different than they would pay absent having that card. So that would give them some level of relief. And it could be significant depending on the drug and the class of drug.

For the larger group that actually has insurance, yes we would be talking about carving out your pharmacy. I'm assuming with a group that -- that size that it is a self-insured plan; I would be surprised if it isn't. And they would be able to call the PBM yet to be named, but hopefully in the next couple of -- a week or so we'll know who that is going to be, and say we want in on the pharmacy contract. They understand that the claims will be paid by the sponsor. In this case the union plan and they would get the same terms that I have negotiated.

REP. DE LA CRUZ (41ST): And then the second part of that we just -- along with the high deductible that
we just got put on us, my blood pressure medicine was $10.00 for a month and now between both it's $56.00 and they say to expect that to go up so that's a -- and we always talk about wage growth and we see the numbers across the country how wage -- how wages are growing but I certainly didn't get a $3.60 raise this year per hour.

CONTROLLER KEVIN LEMBO: Right.

REP. DE LA CRUZ (41ST): It's actually going in the negative direction when we start taking out the costs that are actually -- actually happening to us so. What I was surprised to find was I'm a -- as a member of a 375 person organization that buys insurance through Anthem Blue Cross/Blue Shield, they told me and I didn't believe it but it's cheaper for me to tell people I don't have insurance and buy my pills at the counter. So I -- I would assume because some of that's in purchasing and doing -- and bidding, that right now for $26.58 I get my monthly prescription for one of them. But I could save $2.00 at CVS by telling them I'm Joe Small off the street, you don't know me, so I save $2.00 but it doesn't go towards my $4,000 deductible.

CONTROLLER KEVIN LEMBO: That's right.

REP. DE LA CRUZ (41ST): So they have us in this -- in this net but -- now what -- can you speak to that? Why would it be cheaper for someone off the street that has obviously nobody negotiating for him or 375 people behind him, how is that possible that a -- that a cash price is cheaper than a group price?
CONTROLLER KEVIN LEMBO: Each of those pharmacies that -- like if you go to the Good RX app for example and you put in the drug that you want and you let it know where you are and it will tell you what the price at different pharmacies, it's a very useful tool. It sometimes means you have to go to pharmacy A for your blood pressure medication, you may have to go to pharmacy B for your stomach medication, whatever, because those are where the best prices may be. Those pharmacies may have just engaged in a better contract with a pharmacy benefit manager or with a supplier to get that drug, or they could be in the case of CVS, you know, either owned or partnered with a subsidiary with their own PBM so you better believe that the price that they're getting at that retail counter is better than you might get sort of somewhere else, same PBM, different pharmacy.

There's lots of reasons beyond that that go -- that go into it. It's important that you point out, Representative de la Cruz, whether it's your situation saying I don't have coverage, I want to pay out of pocket getting a better price but it not hitting your deductible, the same would be true to the discount card that I mentioned earlier. So if someone uses that discount card they will get a better price but it will not count toward their deductible. But in some cases people have a plan that they never really hit full coverage. They're always living in the deductible so you know, that may be enough for them, at least for now.

REP. DE LA CRUZ (41ST): So any association with that card doesn't go -- 'cause I purposely buy my -- all my prescriptions through that with the extra
added cost I guess to reduce or start chipping away at the deductible.

CONTROLLER KEVIN LEMBO: To hit the deductible, yeah.

REP. DE LA CRUZ (41ST): In case something comes up. And then I think just a comment really. I think if we're going to relate this to how business operates in Connecticut, I can tell you for sure that the small business I operate on was not going to be able to absorb anymore health costs. You know when you -- with the -- with the ten folks that we have that are in the union at $13.00 an hour we almost paid -- it's a $3 million business and health costs alone were almost $300,000 if you did the math out and now they're -- they're questioning whether they should be part of any plan because you know, they didn't get a raise, they got a deduction so. But thank you for -- thank you for bringing this forward.

CONTROLLER KEVIN LEMBO: Thank you.

SENATOR LESSER (9TH): Thank you, Representative de la Cruz. Representative Floren.

REP. FLOREN (149TH): Thank you so much for being here today and I think the goals are allottable as was the Transparency Bill that we did last year. My question, will we be the first state to implement something like this?

CONTROLLER KEVIN LEMBO: I believe we will.

REP. FLOREN (149TH): I think so too.

CONTROLLER KEVIN LEMBO: There may be a couple of others that are in the hopper but we get moving we could be first.
REP. FLOREN (149TH): That's good. All right. And secondly, with all of the mergers with the insurance companies and the PBMs, how are you going to have enough of a marketplace. So you said it wouldn't be just one PBM that would spring up and you would choose?

CONTROLLER KEVIN LEMBO: I'm sorry. Could you repeat --

REP. FLOREN (149TH): Well I don't think we're going to have a lot of options because the PBMs have been swallowed up with the merge of Express Scripts, etc., etc.

CONTROLLER KEVIN LEMBO: And we in our fee process you know have a couple of other considerations where we need national networks, we need a whole bunch of other things that don't make us unique but make us a complicated customer so that -- that helps, but you're right. You know, fewer and fewer choices the promise is often efficiency and because of size we'll get you a better price. That doesn't always come to prurition, however. Sometimes you see the benefit, sometimes you don't. Someone is benefiting but when I see premium as filed with the insurance department tick up, it seems pretty clear to me that it's not always benefiting the patient either at premium or in their deductible.

So we had a very robust RFP process with multiple options available to us and I'm pretty confident not only in the field but in the ultimate decision, though there's a little bit of a firewall between me and them right now until a final recommendation is made.
REP. FLOREN (149TH): Well you've got the critical mass that you're offering them so.

CONTROLLER KEVIN LEMBO: We do. People want our --

REP. FLOREN (149TH): And it's one-stop shopping for them so you're taking a lot of administrative burden off?

CONTROLLER KEVIN LEMBO: Yes.

REP. FLOREN (149TH): Okay. The other thing --

CONTROLLER KEVIN LEMBO: And they want -- they want our business Representative.

REP. FLOREN (149TH): Exactly.

CONTROLLER KEVIN LEMBO: Let's be clear so if we add this other piece -- other pieces on I don't know that any of them by themselves are enough for anyone to say oh no, I don't want to be part of this now because we're a big customer and as I said to you before, we're bigger in numbers than probably two or three other commercial insurance companies that are presently operating in the State of Connecticut.

REP. FLOREN (149TH): I agree with that.

CONTROLLER KEVIN LEMBO: So if we're going to do the best for the taxpayers for the state then we have to figure out how to use that heft to benefit them.

REP. FLOREN (149TH): Perfect. I had one more comment when you said you didn't want them to use a bazooka when a slingshot would work, that starts to sound like step therapy and I don't think that's right.

CONTROLLER KEVIN LEMBO: I -- I completely agree with you and I know you know over the years when I
was a healthcare advocate and even since then, I've been very careful about trying to separate those that need a rather routine prescription or a rather routine thing and those who take a specific medication for a specific reason and have either tried and failed, have commodities, have other issues going on that make that medication versus the first one, that is already covered in our plan and would be covered in the new plans -- or the new extensions to our contract as well.

REP. FLOREN (149TH): Terrific. Thank you so much.

CONTROLLER KEVIN LEMBO: Thank you, Representative.

SENATOR LESSER (9TH): Thank you, Representative Floren. Other questions? Yes, Representative Pavalock-D'Amato.

REP. PAVALOCK-D'AMATO (77TH): You may have answered this already. How are you?

CONTROLLER KEVIN LEMBO: Good, how are you?

REP. PAVALOCK-D'AMATO (77TH): Thank you for coming. Would this be different or in addition to the State Employee Plan or so would they be merged or would they be separate?

CONTROLLER KEVIN LEMBO: No, no, no. No, no, this is just in the case of discount card obviously not merged at all. That's just a card that gives you access to discounts. In the case of employers buying on the terms that I negotiated, the contract would be between the employer and the pharmacy benefit manager. Not with the State of Connecticut. No merging, no co-mingling, risk or any of that.
REP. PAVALOCK-D'AMATO (77TH): So the state employees would still be completely different, right?

CONTROLLER KEVIN LEMBO: We would be the ones running herd over the contract and negotiating the best possible prices and terms.

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

CONTROLLER KEVIN LEMBO: Thank you.

SENATOR LESSER (9TH): Thank you, Representative. Other questions or comments from members of the Committee? Yes, Representative Vail.

REP. VAIL (52ND): Thank you, Mr. Chairman. So just a followup on Representative Pavalock-D'Amato's question. So if they bought into the -- you would negotiate the price so if anyone came into it they would be paying the same price through your negotiation? It wouldn't be separate for each entity, correct?

CONTROLLER KEVIN LEMBO: Separate contract but pricing terms as I've negotiated. It would be a take or leave it would be my guess.

REP. VAIL (52ND): Yes.

CONTROLLER KEVIN LEMBO: Like here are the complete terms if you want in on this contract or you don't. And if you do, then the contract, the contracted relationship again would be between the business that is sponsoring a plan and the PBM that was have selected.

REP. VAIL (52ND): Okay. And again if it was a different business it would be this -- different contract but it would be the same terms, correct?
CONTROLLER KEVIN LEMBO: Different contract, same terms.

REP. VAIL (52ND): Okay. Thank you. Thank you.

CONTROLLER KEVIN LEMBO: I'm sorry. I just wanted to make sure I followed that, yeah.

SENATOR LESSER (9TH): Okay.

CONTROLLER KEVIN LEMBO: That's a much more artful way of saying what I struggled to say, so thank you.

SENATOR LESSER (9TH): So some of the testimony we received against this Bill expressed concern that it could expand the unfunded future liabilities of the State of Connecticut. I -- do you see any part of the Bill that could do that?

CONTROLLER KEVIN LEMBO: I'm always stunned by people who feel they have the time and effort to put in testimony but don't read the Bill, or don't understand the Bill and feel like they have to bring testimony when they don't understand the concept. These are, what's the word? Dog whistles? These are like they're saying certain things in an effort to scare people to get down to an easy sound bite to try to kill something, so no, it doesn't touch the liability at all and frankly, if representatives of business at large surveyed their members and asked if they would want relief, I'm betting without any quantifiable data in front of me that most of their business would want access to this contract, or at least have the option and knowing that it doesn't impact the state. So, you know just because someone says something doesn't make it true and I know you know this but please do not let people come and say things that are false. It just muddies the
conversation in a way that's not helpful to the people

SENATOR LESSER (9TH): And we'll -- we'll do our best.

CONTROLLER KEVIN LEMBO: I know you will.

SENATOR LESSER (9TH): The -- the other -- the other -- some of the other testimony we received argued that you know, PBMs as they exist today have substantially broader negotiating power than the State of Connecticut does because they're just so big. Is that -- if that's the case then I guess then you won't be able to achieve discounts but again I guess the Bill doesn't do anything, but you argue otherwise and you think that we would have substantial negotiating powers.

CONTROLLER KEVIN LEMBO: We are contracting with a commercial PBM for a reason and that is in part because of their heft. It's also for a number of reasons around their technology and their claims processing and all of that stuff as well. If I thought I could do it better on my own and cut out the middle man and save money as a process, you're damn right I would do it. I would absolutely do that. But that's not where we are. And so we are using the private market. We are negotiating with them and we are getting what I forecast will be best and lowest price for almost every single drug in every single class.

SENATOR LESSER (9TH): Thank you. And I note one of the pieces of this Bill that's just a study is the study of re-importation from Canada. I understand that Vermont has moved forward on it. This is an issue that has been under discussion for a while.
Could you just speak briefly to that and what the state of that is.

CONTROLLER KEVIN LEMBO:  Sure. My understanding is that they're a bit ahead of us obviously because we're going to go and study and then decide if we want to go forward. They had a little bit of an issue trying to find some partners, you know wholesalers to engage in that with them. I'm not completely sure about why that is. I think I know but I need to look at it more deeply and I've asked staff in my office to be in touch with Vermont directly to figure out what are the hurdles that they're trying to get over. And let's also keep in mind that even if we get over that hurdle, we may have a hurdle in the Federal Government that may or may not want to allow this to occur, but on behalf of the people of State of Connecticut, I hope we're also willing to challenge anything that feels arbitrary coming out of the Federal Government as well around allowing this to occur.

SENATOR LESSER (9TH):  Well just based on what the most recent remarks it sounds like he's all -- all in favor of it but that may not be true, so I don't know.

CONTROLLER KEVIN LEMBO: One of the more troubling things, Senator that during the 2016 campaign for President and this is not a political remark because it's neutral, is that I heard almost every candidate for President saying we need to negotiate prices in Medicare. This is crazy, why are we not doing this? And then the election happened and then I don't know, we forgot? You know something happened and that really did not occur and on the day that the White House announced its big sort of ideas, and I'm
going to give them credit, they have done some very interesting and in some cases, more than some of the predecessors have done around certain aspects of this, credit when it's due. But when they announced the big idea about how they were going to control costs, I was watching CNBC in my office and watched the ticker and I watched the drug prices -- the drug companies and I watched the buy going on and so that told me that whatever they were planning benefited not the patient necessarily and was actually more a stock market message, than it was a patient care message.

SENATOR LESSER (9TH): Other questions from members of the Committee? Yes, Representative Pavalock-D'Amato.

REP. PAVALOCK-D'AMATO (77TH): So can I assume to some degree then based on what you said earlier as far as the, I know somebody -- some people have -- or organizations put in opposition, that the Bill will stay somewhat the same or is it going to change a lot?

CONTROLLER KEVIN LEMBO: I would look to the Chairs and to the Ranking Members and to the Vice-Chairs of the Committee about what's going to ultimately happen. In the seven minutes it took us to get from one hearing room into here I got three bits of feedback that they think, okay we need to take a look at them, ending some of this language. So I think we need to be open to that, just as we were on the Transparency Bill last year. If it wasn't for that feedback we probably would not have been able to do this bipartisan -- in a bipartisan way.
REP. PAVALOCK-D'AMATO (77TH): And just out of curiosity as far as those price increases, the drug price increases or the stock at least, did they go down after? I don't know if --

CONTROLLEER KEVIN LEMBO: They bounced around quite a bit generally speaking.

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

CONTROLLEER KEVIN LEMBO: Yep.

SENATOR LESSER (9TH): Thank you, Representative. Any other questions or comments from members of the Committee?

CONTROLLEER KEVIN LEMBO: Going to let me go?

SENATOR LESSER (9TH): If not, congratulations Controller.

CONTROLLEER KEVIN LEMBO: Congratulations to the Committee. Important. And thank you.

SENATOR LESSER (9TH): Next up we'll hear from Ted Doolittle, our -- from -- our state's Healthcare Advocate who will be speaking regarding Senate Bill 902. Good afternoon, Ted. Morning, sorry, good morning, Ted.

TED DOOLITTLE: Good morning Senator Lesser, Representative Scanlon, Representative Pavalock-D'Amato and other honored members of the Committee. I would also like to address some brief remarks to 7174 if I might in addition to 902.

SENATOR LESSER (9TH): By me.

TED DOOLITTLE: I would like to associate myself with the remarks from the Controller of the General. My office has identified that the basic problem
facing consumers in Connecticut are healthcare costs and this is one of the few true cost control measures that is being considered and I commend everybody who has been working hard on this. It is a tough issue. I would say that Connecticut is well-poised to take advantage of this because we're -- whatever we are, eight or ten years into the campaign finance reform measures and that -- and we're governed by a Governor who is self-funded and this should give all the political players a substantial amount of independence to address this Bill on its merits and I look forward to working with all of you on that.

I'm going to turn my remarks now to Senate Bill 902, which is a high deductible plan reform effort. The thrust behind this Bill, the philosophy behind it is that healthcare costs and the rapidly rising healthcare costs are a community problem and must be solved by the community and by the community I mean consumers as well as the insurance companies as well as the healthcare providers. High deductible health plans in my view go against that principal of community. They essentially hide the true costs of our healthcare system and foist it onto consumers, and not just any consumers, onto the sickest consumers, the ones who need to hit those high deductibles year after year. So -- so sometimes high deductible health plan, sometimes I think that means HDHP must mean hide high health prices. But -- but it does essentially in my view, the high deductible structure makes the consumers a piggy-bank, not so much for the insurance companies but for the hospitals, the drug companies and the other providers that they are paying those deductibles essentially directly too. And again, not just any
consumers, the sickest consumers are the ones who are being asked to do that.

As you all know, the basic principal behind high deductible health plans is that consumers skin in the game it's call. Skin in the game. The consumers need to be exposed to the high cost of healthcare so they won't willy-nilly run to the doctor, willy-nilly go and get drugs that they don't need. I for one don't particularly, I'd like to go to the doctor in the sense that it's good for my health. I don't enjoy it. I don't seek it out. I go when it's necessary. I don't like to take unnecessary drugs. I don't like my kids to take unnecessary drugs, so I'm not sure where that myth of the consumer that is greedily seeking out unnecessary healthcare comes from. And in fact my written testimony sites to substantial amount of healthcare economic research that shows that that in fact is not the case.

The reason why this Bill I hope will be compelling to some if not all of you is that the way these are structured doesn't make any sense. If the idea is to have skin in the game and make the healthcare consumer this great comparison shopper, and that's how we're going to get healthcare costs down in our country, I ask you why if you have a family and the bread winner is on one high deductible health plan and they pay off that deductible and then the bread winner switches jobs and gets another plan in July, how come they have to pay the entire amount of the new annual deductible? They already put skin in the game, so if it truly is about skin in the game, why should any family have to pay two high deductibles just because they job switched?
Also related, let's say you're not a job switcher but you are fortunate enough to get your first job midyear and it's a $10,000 deductible. Why should your deductible not be prorated to reflected that you're only being covered for six months? Why should your deductible not become $5,000? It doesn't make sense.

In the same category if the -- if the feeling is that we need to have consumers to have skin the game why are deductibles higher for a family if there's an individual who has the exact same job and a high deductible of $5,000, it seems to be enough to influence that person's decision in the marketplace. How come if that family is with a single bread winner has more than one member, how do you think -- that person has even less disposable income than the individual. Their behavior is being influenced in my view sufficiently by $5,000 if you see what I mean. So again -- and then there's another -- there's another element that was just referred to by Representative de la Cruz. Makes no sense what-so-ever. High deductible health plans point consumers to be the comparison shopper. Representative de la Cruz is a comparison shopper. He goes and finds the drug for less but he doesn't want to buy it because it's out of network. He's found it out of network at another pharmacy that is out of network and he won't get credit for his purchases against his high deductible. He's done what the -- what the structure of these plans have asked him to do. He's been a comparison shopper, he's found the care, he's found the drug for less and he doesn't get credit against his deductible? That doesn't make any sense. So that -- that's why I asked you folks to look closely at the way these are structured. There
are some real irrationalities and craziness, the kind of thing that will really raise your eyebrows. I saw some of you thinking, jeez, I never thought of that. Why -- you have to pay two high deductibles if you switch jobs. That's unfair and it's crazy and it doesn't certainly honor or comport with the idea of having skin the game. Skin the game doesn't mean two skins in the games, right? It means whatever this skin is in the game and you don't -- you know the insurance company is lucky enough that you only insured for part of the year and they still get shielded by the whole deductible. Those things don't make sense. So I ask you to take a close look at that Bill as well as HB 7174. Happy to take any questions that the panel might have.

SENATOR LESSER (9TH): Thank you, Ted for your testimony. I know I hear all the time from constituents who may be covered on paper with insurance but feel that they can't afford to access the insurance that they have and a lot of them are folks who are in high deductible health plans.

Now I see you're wearing a button today that has an HDHP, which I think it stands for high deductible health plans with a red line through it, but the Bill -- what we're looking at today, it doesn't abolish these plans. It doesn't affect the deductibility of the who are the -- the tax advantage status of HSAs under Federal law does it?

TED DOOLITTLE: Absolutely not, absolutely not, Senator. You're absolutely true. The button is meant to express the dis -- a system -- one of many areas in the system that has some irrationalities that really need some hard look and reform.
SENATOR LESSER (9TH): Thank you. And now you know there -- this seems to tweak a number of issues that families are experiencing with these -- with these plans, provide some additional consumer protections. You know I know one particular area is increasing deductibility for family size, which is something that I guess happens now and I don't -- I'm not hearing that the people -- unless you're operating a family farm and you're putting your kids to work on it I'm not sure that people's disposal income goes up. The more kids they have it usually goes down. Is that -- is that your -- is that your intent here? Is it -- what are you trying to get at?

TED DOOLITTLE: Yeah, no, you're absolutely right. Let's say you have a farm family here and we're bringing in $50,000 a year and the brother or sister across town has the same farm. One is a single individual. If that -- if the single individual -- if $5,000 is enough skin the game for the single individual, shouldn't $5,000 be enough to influence the behavior of the larger family with less disposable income because its spread over more people?

SENATOR LESSER (9TH): Thank you. Other questions from members of the Committee? Yes, Representative de la Cruz.

REP. DE LA CRUZ (41ST): Thank you, Sir. Just back to your point and I wanted to ask Controller Lembo, what drives the fact that I can't -- that I can't claim it? And that's the frustrating part. You know you want to be part of a group, you want to do your price shopping. I can't put that piece together where that doesn't -- because you got a discount, because you price shopped, is it a law
that's in place that we need to look at or is it something that the insurance companies have in place? Because if I could buy my drugs at a cheaper rate and still work towards my deductible that would be money in, not just my pocket, but the 375 other members that are in my union so I'm not sure if there's a reason for it or if you know of it?

TED DOOLITTLE: I was looking around because you mentioned Controller Lembo. I wasn't sure if you were directly your question to him or to me. I -- there are complexities. I'm not going to say that I know every nuance or unattended consequence that might arise. My understanding is that the deductibility is largely driver by the -- the plan design. And that can be changed. So I think that a plan could allow to use purchases out of network against your deductible if they chose to. I stand to be corrected, but that's my current belief.

REP. DE LA CRUZ (41ST): And just to give a quick story, we have some members that are saving up on their injuries and surgeries and compiling how much they think they're not going to spend in this year but possibly next and if their wife could hold off just a little longer on that certain surgery they need, I can at the same year get my knee done. I don't think that's conducive for good health. And again I think -- it finally hit the shores because the guys like myself who have had great insurance for a long time, and actually I could potentially buy into the state insurance, which is a -- I think it ends up being about $500 a month for me and the folks that are telling me I should just do that don't realize that's more than my $4000 deductible from the plan that I have to be a member of. So
it's going to be a very interesting year and I think that something big has to happen so, thank you. Thank you for bringing the Bill.

TED DOOLITTLE: Yeah, I thought you were -- that's an excellent point that I agree with. I thought you were going to the phenomenon where people want to make sure they get that treatment before January 1st so they're in the year where they've already paid off their deductible. That's a phenomenon as well that really doesn't have to do with the quality of healthcare.

SENATOR LESSER (9TH): Thank you, Representative. Other questions from members of the Committee? Oh yes, Representative Pavalock-D'Amato.

REP. PAVALOCK-D'AMATO (77TH): I like parts of this and -- however, when you're talking about now it's part 2, not apply an increase annual deductible for such plan solely because the plan provides family coverage and not self only coverage. And apply the same deductible regardless of the size of the covered family. But I guess I'm confused if there's more people in the -- in the plan to possibly cover that could potentially have increased and wouldn't that be the reason for the various deductible? I don't know. I don't know if it varies by different plans but wouldn't that be the reason? I know Senator mentioned the fact that with more people the costs are there, available income doesn't go down but I don't think that's the issue here. I'm focusing more on the fact that it would be based on the increased cost for a company should something happen to those -- one of the individual members of the family.
TED DOOLITTLE: So I certainly think that this point of the Bill is an area where you should debate with your colleagues, you know about this. Remember though that the rationale behind these high deductible plans is to have skin in the game. What I am -- what I am trying to suggest to you is that this, where the deductible can be higher for family, shows that that is not the real reason for high deductible health plans. The real reason is again to use the consumers as a bank to pay the healthcare providers from. That's -- that's what -- that -- your right to focus, Representative Pavalock-D'Amato on that part of the Bill and I think that is something you should debate. But again I'm suggesting to you that the fact that deductibles vary by number of folks in the covered family shows that the insurers are not designing these plans because of the skin in the game principal. They're designing these plans to shift cost on the consumers an that might be fine, and that might be good, and it might be worthwhile. That's a policy decision to decide on. The other ones seem to me you know more cut and dried.

REP. PAVALOCK-D'AMATO (77TH): The other -- the other parts of the Bill?

TED DOOLITTLE: Yes.

REP. PAVALOCK-D'AMATO (77TH): Yeah, which I like. I like the prorated amount but that part alone by itself -- I mean when you say shift cost to the consumers I mean in essence; the consumers are paying so the shift is already there. They're the ones who are putting in the money and contributing. That's what insurance is, isn't it? So I'm kind of confused as to that statement.
TED DOOLITTLE: Well and there may -- there's different perfectly valid ways to view this. I view insurance as a way to spread risk over the entire community and anything that pinpoints the sick families gets away from that community responsibility idea. That may be a difference in philosophy.

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

TED DOOLITTLE: But that's where I'm coming from. Yeah.

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

SENATOR LESSER (9TH): Thank you. Thank you, Representative. Other questions from members of the Committee? If not, thank you very much, Ted for your testimony. And we always appreciate seeing you up here.

TED DOOLITTLE: Thank you for your time.

SENATOR LESSER (9TH): Next we will -- we have Representative Rosario but I don't think he's in the room quite yet so we'll move to the public portion of today's public hearing. First up -- we move in Bill order and first up is Senate Bill 902. First speaker signed up is Michelle Rakebrand followed by Jill Zorn.

MICHELLE RAKEBRAND: Good afternoon. My name is Michelle Rakebrand and I am Assistant Counsel at the Connecticut Business and Industry Association. CBIA opposed Senate Bill 902 because it would essentially limit the options that employers have in their healthcare offering. Within the past ten years healthcare costs and deductible spending have
outpaced employee wages, which is something we're certainly aware of and concerned about. From 2006 to 2016 deductible spending has grown 176% which places the burden on employers and employees who cost share on this up front cost under the health plan. What this Bill does is it seeks to move away from a high deductible health plan by minimizing the annual deductible and maximizing the contribution that can go towards that deductible.

But businesses offer these health plans for two reasons. Large cooperations offer them for choice purposes so if you're a younger person who is presumably healthy you can opt into this plan so you don't have to pay that larger premium every month and you can put that money towards something else, purely choice. Small businesses however don't have that option all the time. Pursuant to the Affordable Care Act small businesses, under 50 employees aren't required health insurance. So sometimes the only option they have available that they can afford is that lower monthly premium and -- because that's what they -- where they do the cost sharing between the employer and employee and that's the only option available for coverage for them.

What this Bill would do is it would lower that deductible putting the cost on the carriers so that the deductible would be met quicker and what we foresee happening is that the carriers would them raise the premiums and it would essentially eliminate high deductible health plans and the employers in a place would be stuck with higher premiums coming forward that they might not be able to meet and then the smaller employees would cease to offer these health plans or coverage at all just
because -- pursuant to the Affordable Care Act, they're not required to do so.

One thing we would like to point out also is that the high deductible health plans that are available today come in a range of options. So you can choose as an employer what type of high deductible health plan you offer. Some of them have loser deductibles, as low as for an individual I think as $1700. But all of them do have that low premium option to throw out. And that is why we're in opposition to this Bill, just for more employee choice of what they offer, particularly for the smaller employees because that's all they can afford. I'm happy to take any questions.

SENATOR LESSER (9TH): Yes, thank you and I appreciate your testimony. You argue that the Bill would eliminate high deductible health plans and I'm not sure where the Bill does that.

MICHELLE RAKEBRAND: So what we feel that would happen, down the line if this Bill were implemented is that because the deductible amount is lower and for the annual cap, and more services are put towards using -- go towards the deductible that the carriers would have to contribute more and then they'd raise premiums on the back end.

SENATOR LESSER (9TH): Okay. I don't -- I don't see any -- a cap in this Bill but you know I do see something where you know you have two customers -- two consumers. One person just is a high deductible plan on January 1st and they've got 365 days to pay off their deductible and the other person has the exact same deductible but they purchased a plan on December 30th and they got one day to pay off their
deductible. Is that -- do you think that's a fair way of assessing it because this person would have to pay the full deductible, because it's a $1000 deductible that they would have to meet on one day before they could get health insurance coverages? Is that your understanding?

MICHELLE RAKEBRAND: We don't have a problem with the language surrounding the annual limits in the Bill. We're fine with that. We just see it as the easier it is for someone to meet that deductible, that the carriers will respond by raising premiums down the line.

SENATOR LESSER (9TH): You wanted to make it harder for people to meet their deductibles?

MICHELLE RAKEBRAND: I don't want to make it harder for people to meet their deductibles but we want to make sure that high deductible health plans with lower premiums are still in place as an option. Should not be the main option, but an option for employers to offer them if they so choose if that's all they can afford for their employees at the time.

SENATOR LESSER (9TH): Okay. All right. Thank you. Yes, Representative de la Cruz.

REP. DE LA CRUZ (41ST): Thank you. Pertaining to this Bill and I always go back to my personal situation and where we stand right now. My wife and I both have good jobs. We're able to -- that $4000 deductible, although it's going to hurt, we're still going to be able to get insurance this year but in my family and in my neighborhood I'm considered a thousandaire. You guys know what millionaires are and billionaires, I'm an actual thousandaire, which means that at the end of the month after I've paid
all my bills I have more than a $1000 in my account that's liquid. And it's not a lot of thousandaires actually in my neighborhood or in my community. So the problem I see with this whole insurance, I mean I call it a scam because the folks that -- that were buying into it with -- with making $32,000 a year with a $7,000 deductible, you just might as well not have it because there's no way they're ever going to use it. And I think this Bill is trying to address how we fix it. And I understand your opposition to it but again I think some of the previous speakers -- what is the true answer? Because of the last -- you know I was never expecting as a union sheet metal worker to have a $4,000 because they got rid of the individual mandate two years -- okay two years ago so folks that were starting to contribute, and again I work with non-union folks that get the pay that I would normally get, they're working on a project. They make -- some of them make $100,000 a year, more money than I made and choose not to have insurance. So that they didn't have to pay the penalty anymore. That is one of the reasons why -- why my insurance went to a higher deductible because folks like that do use the hospital. So I do end up paying for them anyway. So I'm looking for a holistic overall plan. I think this kind of chips into it a little bit and I can see your concerns, but certainly the concerns of the people that are using these plans I think should out weigh anything. We're not able to access insurance. And like I said, my wife has a good job but if I'm -- if I was the single earner of my family that $4,000 deductible would mean a whole lot more to me and my wife so I'm trying to look at it. There's a way that CBIA could come up with how do we actually
physically lower this? What -- you know I posted something on my Facebook about prescription and I wanted to not be partisan and it ended up being that. It was just a bunch of folks that were Republicans and Democrats and wherever they came from that horrific stories about what has happened to us over the last four years and this looks like something to me that's trying to address it, and I would hope that maybe we could get together and come up with a way that this is good for everybody. But if we continue on the road that I feel that we're headed, I will not have insurance in two or three years. They told us to put on our seat belt from $0 to $4,000 just this year and I'm fortunate. My blood pressure medicine went from $120 a year to $560. I actually started a diet to see if I can get rid of the blood pressure medicine, I don't know if that's going to work. But there's certain things now that we probably won't buy. Like I'm supposed to have an Epi Pen. I probably won't fill that and I probably should, but I probably won't. So those are the kinds of choices that people are making on the ground and I hope that we can come to something, so. You know, thank you for your testimony. I would agree to disagree on some of the points, but I look forward to hearing to more about the Bill.

MICHELLE RAKEBRAND: Thank you.

REP. SCANLON (98TH): Thank you, Representative de la Cruz. Any further questions? Representative Dathan.

REP. DATHAN (142ND): Thank you, Mr. Chairman and thank you, Ms. Rakebrand for your presentation and your testimony today. I have been a small business manager, been CFO of several companies that
are less than 100 people for the last 15 years. I know as an employer how expensive healthcare costs are but as an employer I also see small companies, if I have an employee who's out sick for a long period of time that also is costing my company quite a bit of money. I'm wondering if the CBIA has done any research on what costs are lost by companies that are due to sick employees and employees who are not getting appropriate treatments in a timely manner because of the high deductible plans? Thank you.

MICHELLE RAKEBRAND: We have not done research related specifically to high deductible plans but we have looked into employee health and we are supportive at CBIA of preventative care and making sure that employees have access to that. And if that would be through a high deductible health plan we would certainly be supportive of that.

REP. DATHAN (142ND): But preventative care only covers preventative issues. If someone has a chronic pain issue or something, diabetes, or some sort of chronic issue, preventative healthcare does not cover that and so that would fall under a high deductible plan. Again going back to Representative de la Cruz' example of you know, if an employee is only making $30,000-$40,000 a year and has a $4 or even up to a $10,000 deductible you know, how like are they to get the medical attention that they need, and isn't that costing employers money? I know as a small business owner and shareholder I've always been very focused on making sure that my employees are healthy. And I just think it's important that we think about that as well. Thank you.
REP. SCANLON (98TH): Thank you. Representative Vail.

REP. VAIL (52ND): Thank you, Mr. Chairman. Good afternoon. Would you say that legislative mandates are a big cause of driving up the price of healthcare?

MICHELLE RAKEBRAND: Legis mandates are the majority of the cost of healthcare, especially in the State of Connecticut. We have over 70 on the books currently and there were another 25 proposed before the Committee this year.

REP. VAIL (52ND): And again so maybe 20 years ago people offered much better health plans but small business, because of these mandates, the cost of healthcare is so much that they've had to resort to high deductible plans because they're more affordable? Would you say that's an accurate?

MICHELLE RAKEBRAND: I would say there have been many changes in healthcare over the past few decades and we see at CBIA that high deductible health plans are an option. They are not the best option and we don't advocate that they are, but giving an employer the choice is -- can still be better than them not being able to offer insurance to their employees at all for those small businesses.

REP. VAIL (52ND): And that's a fair assessment, thank you.

MICHELLE RAKEBRAND: Yeah.

REP. SCANLON (98TH): Any further questions? If not, thank you very much.

MICHELLE RAKEBRAND: Thank you.
REP. SCANLON (98TH): Next up Jill Zorn followed by Tom Swan.

JILL ZORN: Thank you, Representative Scanlon and members of the Committee. I'm Jill Zorn and Senior Policy Officer at Universal Healthcare Foundation of Connecticut. We're here today because we're really concerned that Connecticut residents really cannot afford their care. In a recent survey 50 percent of adults said they experienced a healthcare affordability problem in the past year, 50 percent. People are delaying or avoiding care because they are under-insured. Even if they have insurance, they have to pay so much out of pocket as Representative de la Cruz has been talking about that they don't really feel like they have insurance even though they technically have it. High deductible health plans are shifting more and more the burden of paying for healthcare onto individual consumers making it hard to afford the care they need and this is true for people who are getting employer sponsored insurance as well as for people who are buying it on their own. And the number of people that have high deductible plans is going up really rapidly and those deductibles themselves are going on. One statistic we found that deductibles rose eight times faster than wages since 2008. And then if you look at the individual -- and that's for people who get their insurance from their -- from their job. If you look at our own Access Health CT we have more and more people who are being forced into these high deductible health plans. The bronze plan has a $6,000 deductible. And I was looking and 32 percent of people with subsidies are now buying a high deductible plan like that, which they really cannot afford if they actually get sick.
All these plans do is shift risk onto consumers, what the healthcare advocate was talking about. Insurance is supposed to protect people and if you have a high deductible plan your finances aren't protected. And it's supposed to motivate you to shop but because most of the time you can't shop and they really are not working for the supposed reason that they were invented. Really what they're about is shifting cost.

So we support this adjustment -- the proposals in this Bill to require insurance to give credit for all payments towards the deductible, whether in or out of network. That's one of the things in this Bill. Doesn't allow deductibles to increase based on family size, prorates deductibles for the time of year that you've joined plan, and make sure that if you enroll in a health plan you know, your -- your deductible is prorated. And while these measures do not address many of the worst cost problems, they are a good start.

REP. SCANLON (98TH): Well timed. Any questions from the Committee? Seeing none, thank you, Jill.

JILL ZORN: Thank you.

REP. SCANLON (98TH): Next up is Thomas Swan followed by Dr. Michael Crain.

TOM SWAN: Good afternoon. I had to think for a second. Representative Scanlon Senator Lessen -- Lesser, other members of the Insurance and Real Estate Committee. My name is Tom Swan and I'm the Executive Director of the Connecticut Citizen Action Group. I want to thank you for today's hearing on behalf of our members I'll too -- I'll be commenting on two Bills.
The first Bill I'd like to speak SB 902, AN ACT CONCERNING HIGH DEDUCTIBLE PLANS. We applaud your efforts to find ways to protect people who are subjected to these schemes. People hate high deductible plans. Whether it be patients finding out the coverage we believed we had isn't there or providers having to become collection agencies. These plans do not advance health. They're schemed by industry to shift more of the cost onto individuals so that they can continue to make exorbitant profits and result in people not getting needed care like Representative de la Cruz who mentioned he with the Epi Pen. These plans take away the security people use to have from health insurance and for medical providers to waste time and resources, collect money that their patients can't afford to -- can't afford.

Since 2008 people's annual deductibles have risen eight times as fast as wages and they've increased over 212 percent in the last decade. This is not sustainable. It calls for action on your part.

We support SB 902 because it attempts to address some of the challenges families have in navigating these scam plans. It helps people who change plans due to a change in status during the year and ends the failing penalty. If it is permissible we would call for an outright ban on these plans, and we believe there is strong argument for a single payer healthcare or at least the public option.

We also support the concepts included in HB 7174, AN ACT CONCERNING PRESCRIPTION DRUGS. Consumers need you to step up and figure out how the state's purchasing power can be leveraged to help make healthcare more affordable. Drug companies, PBMs
and the recently formed vertically integrated health conglomerates have proven their mission is to milk as much money as possible from the system and less about people's health every day.

I would like to share with you some STATs of the pharmaceutical industry that highlight how they are the problem and we need you to step up in act. In January alone pharmaceutical companies increased the price on 490 prescription drugs. Since the Trump tax scam passed, pharmaceutical companies have spent over $74 billion on stock buybacks benefiting only their shareholders, only their shareholders and executives. Pharmaceutical industry spent over $280 million lobbying at the Federal level in 2018 alone.

How does this help healthcare? These drugs make up nearly 20 percent of health insurance costs in our ever-increasing share of outer -- out-of-pocket expenses.

We thank you for your willingness to address this problem and have our government begin to use its purchasing power on behalf of consumers.

REP. SCANLON (98TH): Thank you. Any questions from the Committee? Seeing none, thank you. Last on this Bill is Dr. Michael Crain.

DR. MICHAEL CRAIN: Thank you Representative Scanlon and members of the Committee. My name is Dr. Michael Crain. I'm a licensed radiologist and I practiced for 30 years in Connecticut. I'm the Chairman of the Radiology Department at Middlesex Hospital and have a -- and my main private practice is in Gilford and I have another in Middletown. I'm also an officer at the Radiological Society of Connecticut and represent this organization today in
support of Connecticut Bill 902, AN ACT CONCERNING HIGH DEDUCTIBLE HEALTH PLANS. Senate Bill 902 will bring several elements of fairness to the high deductible process. These three major elements have already been detailed and are worthy of further discussion. We would also suggest the provisions from State Bill 28 be considered in the context of a comprehensive reform of health plan deductible policies.

Our members are medical doctors in the specialty radiology trained to interpret complex imaging studies to diagnose disease. They want to practice medicine and help their patients but increasingly, they're diverted from this mission as they try to help their patients navigate what costs are or are not paid by insurance companies in high deductible plans.

For instance, one of my colleagues who had a female patient who presented to their office with stage 3 breast cancer. This patient needed several imaging studies including MRI and CT scans to track the progress of her cancer treatments. The patient initially walked out of the office and cancelled all of her appointments when she learned that her plan would pay nothing towards these tests until she met her high deductible costs. Her life was at stake. The physician interceded and spent hours trying to resolve this issue. Fortunately she convinced the patient to resume her appointments.

Wonderful organizations like Sister's Journey in New Haven are working to encourage women to have their tests as needed to detect and treat breast cancer. The greatest frustration they have is many women do not want to go forward with additional necessary
tests when they find that the insurance companies will not pay for the tests until they have spent their money to satisfy the large deductible in their health plan. Physicians encounter frequent examples of patients delaying or declining care due to the deductibles.

The Radiological Society of Connecticut supports removing medical doctors from being caught in the middle with regard to payments between patients and the insurance plans, an approach embodied in Senate Bill 28, which received a public hearing before this Committee several weeks ago. Insurance companies have entered into separate contracts with physicians and with patients or their agents. The Radiological Society of Connecticut believes that contractual payments should be made to medical providers with the insurer handling deductible or co-pay issues directly with the patient. Medical doctors should not be put in the middle when it comes to the patient insurer relationship. The negative consequences for physicians are significant with wasteful administrative time and expense as well as leading to distrust between the patient and his or her physician.

The Radiological Society of Connecticut would appreciate your support for Senate Bill 902. Thank you. Any questions?

REP. SCANLON (98TH): Thank you, Dr. Crain. And as you know I've been to your practice before and I know the great work that you and your fellow colleagues do on behalf of my constituents and folks across the shoreline. You have been in a practice for a while and I'm wondering if you could sort of talk about the changes that you've seen in this --
in terms of the healthcare industry in general. You remarked about how you're having to spend increasing time in explaining to people how to navigate these high deductible plans. How has that changed for your patients and my constituents and our constituents?

DR. MICHAEL CRAIN: You know in my profession where we do imaging inside of the body many, many of the bad things or the early issues, patients don't know. So for instance, if a patient starts coughing up blood because they have lung cancer and go to the doctor they have a 15% chance of survival and that's been always, all my life lung cancer was deadly. Now with screening, if you get screened their chance of survival is 15%. But people in Connecticut don't go for these studies 'cause they're afraid of the costs and it kills me that this happens. And in fact in Gilford we offer as a community benefit, you can have a lung cancer screen and CT for $100 if you don't want to -- you know just to direct pay because we believe that this is going to help people. And so you know, that's the kind of things that we do. We try to make it as easy as possible. We don't collect money when people come in for their exams but then we have to bill them, which -- because of the high deductible plans and it puts us right in the middle. And it surely does interrupt with our -- our practice.

REP. SCANLON (98TH): Thank you, Doctor. Any questions for the Doctor? If not, that's great. Good to see you. Thank you for being here today.

DR. MICHAEL CRAIN: Thank you, Representative Scanlon.
REP. SCANLON (98TH): All right. Moving on to 7173. I saw Dr. Lynch just stepped out a second ago. Oh, he's over -- he's back over here, so Dr. Brian Lynch.

DR. BRIAN LYNCH: Thank you, Representative Scanlon and members of the Committee. I'm Dr. Brian Lynch. I'm a practicing optometrist in Branford, Connecticut. My views today are my own personal views as well as those of the Connecticut Association of Optometrists. Like other healthcare providers optometrists partner with insurers to provide covered service and products to our patients. They agree to accept less than their usual and customary fees for these services and materials. The insured pays the doctor directly for providing these covered benefits. The proposed legislation will have no effect on those relationships and the care that we deliver.

Beyond this relationship, HMOs and insurance companies often mandate that providers set certain fees or give automatic discounts on products and services that they do not cover. Insurance companies use this -- these unfair stipulations to improve their marketability at the expense of the small business optometrist, which drives up the cost of services for those outside of their plans. These steep discounts are unsustainable the overhead to operate an optometric practice and the market forces competing with the individual practices prohibited. Therefore the provider must raise their fees across the board, then discount them to comply with these mandated discounts. Our patient -- those patients who are outside of the plans end up baring the brunt
and are paying inflated fees that they would not have to if we didn't have to raise to lower.

In 2015 House Bill 6736 was AN ACT PROHIBITING INSURERS FROM MAINDATING DISCOUNTS ON NON-COVERED SERVICES we -- that we provide. The law mirrored the language that was passed dentists earlier. This Bill before you extends the same consideration that this body considered four years ago to the product that we provide our patients. The spirit of the legislation then was to prevent patients from being the brunt of these mandated discounts, those patients who are outside of the plans and insurers have found an end around by restricting and demanding rebates, discounts, what have you on the products we're providing.

In summary, House Bill 7130 will prevent insurers from shifting the cost of their promotions to small businesses and patients outside their plan eliminating this phantom benefit. It will prevent the escalation fees and it will prevent price fixing for noncovered services. It will not affect the current contract between insurers and providers for covered services or covered products, affect a patient's right nor will it affect a patient's right to choose where they want to purchase their products, either from the provider or some other supplier. I thank you for your consideration. You may also hear today from ophthalmology and they've requested substitute language to include ophthalmologist into this legislation and the Connecticut Association of Optometrists have no problems with that at all. Thank you.
REP. SCANLON (98TH): Thank you, Dr. Lynch. Thank you for being here today. Would you describe this Bill as a consumer-friendly Bill?

DR. BRIAN LYNCH: Absolutely. You know I drew the analogy. My wife was trying to get me to explain this to her last night and I drew the analogy to -- when we all purchase a hotel room somewhere, if you have an AARP card, if you have a AAA card, if you're a senior citizen, you're afforded a discount. Well, a lot of people come under that umbrella of an afforded discount and so who really ends up paying the real rate for a room? Well in order to afford those discounts the hotel has certain fixed costs. They have to get so much per rate, or per night or they just can't stay in business. So the poor guy or gal who walks in there without an AARP card, AAA card, ends up paying a fee that they would not have paid otherwise. It's the same thing. It's almost like a shell game.

REP. SCANLON (98TH): Thank you, Dr. Lynch. Representative de la Cruz.

REP. DE LA CRUZ (41ST): Thank you. So I'm two years and one day officially away from my AARP card. Tomorrow is my birthday (laughing) so I'll be -- I'll be -- I'll be enjoying that -- that discount but -- so to speak on the -- on the last Bill and almost tie it in. I don't want to talk about the last Bill with you but it's the opposite of what happens with prescription drugs. So I walk in and I pay -- because I'm covered and someone is negotiating for me already, I pay $2.00 more and this is almost -- almost the opposite effect but I'm not sure -- 'cause I'm still -- still -- still trying to figure out what happened in the last Bill
or why that happened so -- and I'm still trying to figure out this one but I thank you for your -- your testimony on this and --

DR. BRIAN LYNCH: Well, I empathized with you when I was listening to your comments and I think it speaks directly to this and that is, you entered your pharmacy with an expected discount because of your insurance and ended finding out that you were actually going to pay less if you had just paid out of pocket. Often times my patients will come into my office and they happen to be participating in a plan that we don't participate in for the product side. They then will take their prescription for their eye glasses or contact lenses, go to one of their participating locations, come back to us and say, gosh, it was going to be cheaper for me to get them through you than it was through where I was "covered." And they're really not covered. This is a phantom benefit for the most part. Those programs where we negotiate with insurers to accept a lesser fee, you do get a benefit from that. Those are legit and we participate -- my office participates in a bundle of those plans. But there's some plans that just say, no you have to give everybody a 30 percent discount on all hardware. You just can't keep an office open in Branford and cut all your fees by 30 percent and still compete with the online suppliers, the big boxes. It's just not sustainable. So you avoid those plans and that does limit access then to care.

I read the testimony of the National Vision Centers and they said, oh it's going to decrease access to care. To some degree they're right. Patients do go where their coverage is for the most part. However,
these types of plans aren't driving patients in. The plans where patients have a true covered benefit and they know going in, okay, I'm going to get a pair of glasses and it's going to cost me X amount of dollars. I have a benefit of this much towards frames, this much towards lenses and we agree to provide that for them. That is a good benefit for a patient. These discounts to represent on a scale and my point earlier, it is a consumer-friendly Bill. It's preventing the going up to coming down and then the person outside of the plan here suffering.

REP. DATHAN (142ND): Thank you very much for your testimony. Is there any other questions? Great, thank you very much.

DR. BRIAN LYNCH: Thank you for your time.

REP. DATHAN (142ND): Have a good afternoon. Next we have Robert Holden regarding House Bill 7173. Did you submit some testimony?

ROBERT HOLDEN: Yes. My name is Robert Holden and our association did submit written testimony.

REP. DATHAN (142ND): Great, thank you.

ROBERT HOLDEN: I'm here also to deliver spoken testimony hopefully more concise. We put a lot of information in the written testimony.

REP. DATHAN (142ND): I appreciate it, thank you.

ROBERT HOLDEN: My name is Robert Holden. I'm with the National Association of Vision Care Plans. We have 20 members nationally. Ten of them are doing business in a competitive market here in Connecticut. One of the things that I wanted to
addressed based on the testimony that just happened, because I think it needs some clarification. We were pleased to join the Bill that passed in 2015 for services. In that way vision care plans are very similar to dental plans, but there's a fundamental difference between a dental plan and a vision plan in terms of the transaction that a given patient will have on -- typically with their provider.

The first is the routine care, which is typically an annual or bi-annual eye examination. The other portion of that transaction is typically the purchase of a retail item. Eyewear, contact lenses, what have you. And that's how the transaction differs in the dental world and the vision world and so the exclusion of products from the legislation that was passed earlier was not an oversight or a loophole, it was intentional and reflected the difference in the markets.

One of the things that -- I also want to address the idea that this is a zero some game in terms of insured versus non-insured. As I think was mentioned in the previous testimonial although I was confused, we have directories of in-network providers. We are encouraging our enrollees who are provided vision benefits by their employer to go in network. In fact that's what our entire business model is designed towards is providing incentives and direction to enrollees to see their provider. And the reason for that is because the purchase of eyewear is the dominant reason most folks go in to have their annual eye examination. I'd like to get a new pair of glasses this year. I'm going to go in and get my annual examination and the benefits of
that annual eye examination are well beyond just getting your refraction to get your frames. You're testing for all sorts of potential issues, diabetes, glaucoma, etc., and so there is value there and that's where our benefit shines and so we're pleased to have that happen.

But the issue here is that because of the way that retail transaction, the structure you have a lot of options that are non-medically related. I can go in and get a pair of frames that are off the rack and perhaps not that expensive or I can go in and get Gucci or Prada or what have you and spend really considerably more, strictly on a fashion basis. As a result our benefits typically, although not universally are structured with an allowance to purchase that frame with a covered lens. And there are other aspects of that lens that may be add-ons. Our concern is that once a patient goes beyond that allowance, there are additional add-ons that can be provided and those are not covered and yet we would have no ability to limit pricing. The average price increase for a covered item can be upwards of 60 percent, which could translate into between $100 and $170. I provided a study in our written testimony. I would be pleased to answer questions.

REP. DATHAN (142ND): Great. Thank you very much. We have one question from Representative de la Cruz.

REP. DE LA CRUZ (41ST): Perfect, thank you. I guess my question would be if you did make that choice to have a more expensive lens and that's where I think -- I think what the -- what the folks on the opposite side are talking about. That would be their choice at that point.
ROBERT HOLDEN: Correct.

REP. DE LA CRUZ (41ST): And then if they -- if they did pay more that would all fall on the -- on the person making the choice to have the more expensive lens? Or is -- the way I'm kind of understanding it is you're asking for a discount, say if I wanted the Gucci's that my wife would never let me get or whatever. (Laughing) But they're $700 bucks say.

ROBERT HOLDEN: Yeah.

REP. DE LA CRUZ (41ST): So, so is the -- are the glasses they're talking about those glasses where you would say, if my client -- if my -- if the person I'm insuring wants those then we want you to sell them at $500 not $700, or is it -- is it -- is it something different than that?

ROBERT HOLDEN: That's a great question. The reason why we tend or our plans tend to have a allowance for frames is for that reason. We'll give you $150 or however much to buy a pair of frames. It's your choice if you want to use that towards you know a $700 pair of frames or $200 frames or pay nothing out of pocket. That's your choice. What we're concerned with is with in the transaction we're talking about, I come into my provider, an optometrist or an ophthalmologist who has a practice. I'm frequently self-referred by them to their dispensary, which again we're in support of. But in those instances you know, I am dependent on their -- on their instruction and their medical advice, and again they may say, well you know, you should think about some anti-reflection. You should think about some tinting, whatever. They want --
again it's up to them. But as a patient now I have to make a decision on that and from an insurance standpoint, from a plan standpoint I want to be able to say all right, you know we're going to cover an allowance but you can't just up it on the back end to increase that cost. There needs to be a limit there. And so that's frequently where the limit is set and in those instances, this would do away with that. And again, the American Optometric Association study, which I put in there really puts numbers to that. You're talking about significant amounts of money out of pocket, over $100 in many instances just on those add-ons. On the lens that is covered and on frames they have an allowance to go towards that.

REP. DE LA CRUZ (41ST): But basic coverage would probably -- say my coverage is $150 towards my glasses and it's every two year thing, at what point is my decision after that? So you'll -- you would cover up to $150 no matter -- no matter what I chose or what options I chose. What -- what is -- are you trying to get it less than $150? So folks --

ROBERT HOLDEN: No.

REP. DE LA CRUZ (41ST): Or you're -- you're just trying to -- you're saying -- your point is to try to control costs for your member and that's --

ROBERT HOLDEN: Correct, correct. This is not going to increase a premium cost. This is going to increase out-of-pocket. And we're talking about a patient who when they go into a particular optometrist because the pricing is set in that optometrist's office, we can't provide them with a fixed you're never going to pay more than this. But
what we can do is say, well if you go in and get tinted lenses or anti-coated or anti-reflective coating or other add-ons these are the maximum amounts you're going to pay.

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

REP. DATHAN (142ND): Thank you. Just another quick question. Maybe this might be a silly question but in terms of other products outside of lenses, contact lenses and prescription glasses is there any other products that may be might be medically necessary that this -- we're overlooking here?

ROBERT HOLDEN: What we're talking about in this particular Bill addresses products so it would be contact lenses and lenses and frames.

REP. DATHAN (142ND): Those are the only two? But I'm just asking is there any other products by an optometrist that they might prescribe to a patient that maybe should be covered?

ROBERT HOLDEN: I can't think of a product that we're talking about.

REP. DATHAN (142ND): Okay.

ROBERT HOLDEN: Unless it's a component part of one of those other products.


REP. VAIL (52ND): Thank you, Madam Chair. Good afternoon. So when you talk about allowance, is there an allowance on frames, allowance on lenses, allowance combined?
ROBERT HOLDEN: There is an allowance typically on the frame and then the lens is covered.

REP. VAIL (52ND): So the lens is usually covered at 100 percent?

ROBERT HOLDEN: Correct.

REP. VAIL (52ND): And is that a negotiated rate between you and the optometrists?

ROBERT HOLDEN: Yes.

REP. VAIL (52ND): And then frames, you mentioned $150. Is that the typical thing or did you just use that for an example?

ROBERT HOLDEN: I just used that as an example. That's an allowance amount and that allowance will vary. It will vary within plans and on the level of plan that is purchased by an employer?

REP. VAIL (52ND): Okay.

ROBERT HOLDEN: It's towards the purchase of that frame. The frame, now the retail price is determined by the optometrist.

REP. VAIL (52ND): So anything under that amount, they wouldn't pay anything?

ROBERT HOLDEN: That's correct.

REP. VAIL (52ND): Okay. Thank you.

REP. SCANLON (98TH): Thank you, Representative Vail. Any further questions? If not, thank you very much.

ROBERT HOLDEN: Thank you.

REP. SCANLON (98TH): Next up is Chris Agro.
CHRIS AGRO: Senator Lesser, Representative Scanlon, members of the Committee, before I get into my testimony, my name is Christopher Agro. I'm a licensed optometrist doctor who has been serving my patients in Enfield for 25 years. I'm member of the Connecticut Association of Optometrists Third Party Committee which meets on a regular basis with insurance companies. My role in the Committee has helped me gain a better understanding of insurance issues locally and nationally and I'm here in support of House Bill 7173.

And before I get into the rest of my testimony I just wanted to clarify a couple of things from the previous speaker. I think there's a confusion between covered services, which was -- he was relating to when they're given allowance for $150, the insurance company is going to cover that. That's a covered service versus a straight discount and the two are getting kind of intermixed between allowances and full reimbursements. Now if the insurance is going to reimburse us for those services and we accept those plans, I don't have any issues with those. This Bill is in direct relation to when the insurance companies mandate us giving discounts to patients without reimbursing the provider at all for it. And I think there's a little bit of miscommunication going on to that so.

Very simply House Bill 7173, AN ACT CONCERNING CONTRACTS BETWEEN HEALTH INSURERS AND OPTOMETRISTS make one change to the law you passed in 2015. Four years ago you enacted PA 15-122 which provides that an insurer can mandate discounts in optometric services or procedures unless the insurer provides insurance coverage for those services. The law was
prompted by the fact that a number of insurance companies were mandating members of our professions, deeply discount pricing on optometric services and procedures even though they did not provide insurance coverage for those services or procedures and did not reimburse the provider for any portion of the service.

The best example of this relates to eye glasses and contact lenses. Insurance would mandate that optometrist discount pricing 30 or 40 percent for their enrollees while reimbursing nothing for the eyewear. In 2015 we are given support of Substitute House Bill No. 6736, which became PA 15-122 on a premise that if an insurer wants to mandate discounts for our services or procedure they should have some skin in the game by covering them and reimbursing us for the portion of that lost revenue. The General Assembly agreed this practice was unfair and they stepped in to stop it by enacting PA 15-122.

We are back today because some insurers are still requiring that we discount eyewear without reimbursing us. I understand that some insurers argue that eyewear is not a service or a procedure, but rather a product and therefore PA 15-122 does not apply to eye glasses and contact lenses. House Bill 7173 closes this loophole but adding the word products to the prohibited action. Passage of this Bill would help maintain the independence of Connecticut Doctor of Optometry and allow them to conduct their practices and set fees they feel best suited for their community. We have very little negotiating power against the insurance companies and we set the majority of our fees in the context
we are obligated to accept if we want to provide service to their members. We need your help to correct this loophole.

Discounts mandated by insurance distort the marketplace in order to cover the discounts we need to increase costs to the patients to provide -- make up the loss of the differences and patients really end up paying more for the products after all and we could just price things fairly. Again, I have an office of 14 employees of outstanding costs. You know those prices don't bring in and we unfortunately need to cover that. So again, just thank you for considering our views on this Bill and I urge your support. Thank you.

REP. SCANLON (98TH): Thank you very much for your testimony. Any questions? Seeing none, thank you very much.

CHRIS ARGO: Okay. Thank you, sir.

REP. SCANLON (98TH): All right. Moving on to 7174. First up is Kelly Ryan from PhRMA.

KELLY RYAN: Good afternoon, Senator Lesser, Representative Scanlon, members of the Committee. My name is Kelly Ryan. I'm Senior Director for State Policy at the Pharmaceutical Research and Manufactures of America. PhRMA is the trade association that represents leading innovative biopharmaceutical research in biotech companies. I appreciate the opportunity to be here today to weigh in on House Bill 7174. There's a lot here. We have a lot of detail in our written testimony so I'll stick the high points. I know the -- the day is dragging on.
First I want to be very clear that the concerns we express do not stem from any unwillingness to engage in these important conversations about prescription drug affordability. In fact just last year Connecticut passed what was a first in the nation Bill that looked at the entire supply chain. It was a really innovative approach. We are happy to be a part of that conversation and we're happy to be a part of this conversation. In fact just during the conversation today the way Controller Lembo described the discount card and kind of the vision for you know, what is the -- the big part of this Bill, it sounds that the idea to use negotiation power to make sure that you know rebates and discounts in the system are passed through to patients, that's the concept that we've been very supportive of and we're happy to have conversations about details as that -- as that piece moves forward.

So where I'll focus is probably our biggest concern which is Section III of the Bill. It appears to address Patent Settlement Agreements and these are agreements that are reached between brand and generic manufactures and just a couple of points. I'm not a patent attorney so I'll do the best that I can and happy to answer any questions. But just for clarification, these settlements do not extend the patent of a brand-name drug. Where they come from is the Federal system Hatch-Waxman for regular drugs and for biosimilars essentially gives an opportunity for generic manufacturers to challenge a patent and that naturally results in litigation. So there's no extension on the kind of the backend of the term of the patent. This is all something about getting generics to market before the patent would extend.
The Settlement Agreements do exactly that. They settle litigation. So very often they result in the generic drug getting to market faster, and I think you would hear the same from the generic association. Instead of having to litigate to the end, and if the generic manufacturer loses, they cannot come to market until the patent expires. The Settlement Agreement you know, inserts certainty and gets this on the market faster. So that -- I think there's a lot of confusion about how these work and I wanted to touch on that.

Second, I'll just state really quickly. There is a ton of Federal activity in this area. We detail it in our -- there's a lot of oversight. This is not an area that is you know, unregulated. I'm happy to answer any questions.

REP. SCANLON (98TH): Thank you, Kelly, and thank you for your willingness to work with us. Last year obviously we got to know each other a little bit then and look forward to doing that here. So how -- let's talk about these settlements.

KELLY RYAN: Yeah.

REP. SCANLON (98TH): Because it's a big thing that I feel like there is a big disconnect here between us.

KELLY RYAN: Of course.

REP. SCANLON (98TH): And so it's my understanding that there was about 17 of these I think in 2018.

KELLY RYAN: Yep.

REP. SCANLON (98TH): As reported by the FTC.

KELLY RYAN: Uh-huh.
REP. SCANLON (98TH): And I just am hoping you can help me walk through here why a branded drug company would pay a generic company if it wasn't to delay that from -- why would they be paying them in order to help them expedite them bringing that drug to market? Help me understand that.

KELLY RYAN: Right. So you know litigation settlements have benefits for both, right? So from a granted perspective, right, if there are more litigation costs and more certainty and just costs to the whole system to continue to fight a lawsuit all the way through, so there could be a situation where a company makes a decision that you know, going to court is too uncertain. This happens not just in this -- in this case but in all sorts of settlements across the board in civil litigation. And so that means if they pay -- will provide this benefit for you, the benefit for us is we know you're going to come to market at this time, we don't have to spend millions of dollars litigating it and so there's -- there's benefit for both sides. But I will say, Representative that the Federal Trade Commission, especially after 2013 Supreme Court case has -- there was some question. So I would say in the past there may have -- concern may have been justified because there was some question about the scope of the FTC's authority to engage in looking at these agreements, whether there was an anti-competitive impact. That has been cleared up by the Supreme Court and since then the number of settlements that kind of touch the situation that you all seem to be concerned with, have dropped dramatically and the FTC gets all Settlement Agreements to review for anti-competitive impact and
their very, very engaged in enforcement in this area.

REP. SCANLON (98TH): Got it. And so again I don't want to put you on the spot.

KELLY RYAN: Yeah.

REP. SCANLON (98TH): We don't have the list in front of us but I think what you're trying to say is that you would venture to guess that of those 17 if it was in fact 17, there would be overwhelming majority if not all of them, would not be the so-called paper delay that we are looking at. Your seeming to suggest that it's a different --

KELLY RYAN: That -- that would be my understanding. So I think -- I think the 17 has -- is the number tied to what the FTC reports as reverse settlement. So yes, that there's -- there are funds going back and forth between funds and agreements going back and forth between the -- the parties. I will tell you that the FTC very closely looks at all 17 of those agreements and any other that are out there and take action in any area they think has anti-competitive impact.

REP. SCANLON (98TH): Got it, okay. Now something that's not in this Bill that I'm hoping what I can ask you about --

KELLY RYAN: Uh-huh.

REP. SCANLON (98TH): And again if you don't have this reporting I understand, but Maine I think last year or a few years ago passed a Bill that required samples to be given to generic drug companies and it was one of the things we considered putting in this Bill and we were at first told that we didn't
necessarily have to do that because that -- by Maine passing that law it applied to everyone. I see some heads shaking. But I'm wondering if -- what your interpretation is and whether you think by more samples being available to generic drug companies that we would be able to perhaps address the issue we were trying to address with the paper delay section of the Bill in a different way?

KELLY RYAN: Yep. So, and I will be perfectly honest that I was -- I came on board as that Bill was signed and so I didn't live through all of the negotiation but my understanding and so I'm not incredibly well-steeped, but my understanding is part of the concern is tied to the REMS programs so at PhRMA in general -- generics are good, right? We want to spend our time focused on innovation. We want to come up with new cures. We want to make people's lives better and generics save the system money. So from a policy perspective we are supportive of that. I know that there is some concern that I believe the main Bill did address that there are certain FDA requirements and it really pops up in the biosimilar space, right? Less than just kind of straight generic with the REMS Program. Like there are -- there are Federal requirements that limit the ability to just put drugs out in the marketplace and this is where the issue is with that force fail has come up. And I know the main Bill is out there and this is also being held with -- at the Federal level as well.

REP. SCANLON (98TH): Okay.

KELLY RYAN: It CREATES Bill that we've been engaged in.
REP. SCANLON (98TH): Okay. And I'm not an expert in the main Bill by any stretch and I know you aren't either but it seems to be that there still is some reports out there that there is still some delays that are being seen of those samples getting from point A to point B. How, from a pharmacist perspective could we maybe try to speed that up?

KELLY RYAN: Yeah. I'm happy -- I'm not aware of those reports but I'm happy to look into them.

REP. SCANLON (98TH): Okay.

KELLY RYAN: You know, we -- work with Maine and try to understand where that's coming from and circle back to you. I'd be happy to do that.

REP. SCANLON (98TH): That's great. I -- I appreciate that.

KELLY RYAN: Uh-huh.

REP. SCANLON (98TH): Any further questions? Senator Lesser looks like he has some.

SENATOR LESSER (9TH): Yes, thank you, Mr. Chairman and thank you for your testimony. I understand why it might be in the economic -- I assume it's always in the economic interest of two parties to sign a contract otherwise they wouldn't sign that contract.

KELLY RYAN: Right.

SENATOR LESSER (9TH): And I can understand why both the name-brand and generic manufacturers would be potentially in support of the Paper Delay Agreements. You said that earlier and that makes sense to me. But I -- I'm trying to understand -- I guess I'm trying to get my head around it as a new Chair on this Committee, why -- why they're in the
public interest and how they could possibly speed the availability of drugs onto the market. You mentioned -- I think you said 17 or 18 agreements that are out there. Are those -- are those publicly available? Is that information that's publicly available right now?

KELLY RYAN: You know that I'm not sure. There are reports from the FTC. I would assume that the Settlement Agreement itself is probably not, but there are reports from the FTC that certainly are. They do a -- a lot in this basin and report on it.

But to your first question, so how these agreements get generics to the market faster, right? So generic company A decides to challenge the patent of brand B.

SENATOR LESSER (9TH): Okay.

KELLY RYAN: And brand B absent that challenge would not go off patent until 2015. 2015? I'm living in the past apparently, 2025. So you know there's litigation into lots of money spent on both sides. If the generic company loses that litigation, I think all the way through, no settlement they -- they can't bring a drug to market until 2025. If instead brand and generic company comes to terms, that term could be, okay you know, we'll have whatever change and consideration that's involved and we're not going to fight you and you can bring the generic to market in 2022, right? So that there's this benefit for the brand company 'cause we're not going to continue to litigate. We don't have to fight this. There's no uncertainty and there's benefit for the generic and they bring the drug to market sooner.
SENATOR LESSER (9TH): Okay. That makes sense to me but I guess -- I guess that assumes that the main priority of the generic manufacturer has is bringing their drug to market as quickly as possible, which might be their goal. But I assume their actual goal is to their shareholders, which is to deliver shareholder value and it might very well be that it could be in the interest of that generic manufacturer to delay -- to delay bringing a drug onto the market longer than they would otherwise, assuming that that payment was large enough. Is that -- is that correct or?

KELLY RYAN: So we don't represent generic manufacturers so I can't -- I can't speak to that but I can understand that you know, there would be questions about incentives from both parties and that's precisely why the FTC is incredibly engaged in this phase and reviewing -- so under the Supreme Court structure all of these agreements are submitted to the FTC and then they engage specifically in any that they think have this reverse settlement impact that could be conceived as anti-competitive.

SENATOR LESSER (9TH): States also have broad discretion in this area to regulate the insurance market and that's really been the home --

KELLY RYAN: Where the interest is.

SENATOR LESSER (9TH): Of -- of -- regulation for a longstanding period. So is your testimony arguing that we are -- we are pre-empted from in this action?

KELLY RYAN: Well especially in the context of the second piece of that Bill, right? So there's two
pieces in Section III. One is just Notice. I think we're concerned about the notice because it can have a chilling effect. I don't know that we're -- we'd sit here today and say you know, you Connecticut can never ask us to give you notice of anything. That's -- that's not the position. But we are concerned about the chilling fact because we do believe that these agreements get drugs to market -- generic drugs to market faster.

And the second piece, which has a pretty -- I'll be honest, it's a little confusing, but a pretty serious price control in there. I think yes, we would absolutely agree that that raises some real preemption issues, it raises some real legal issues because it disrupts contracts, not only between manufacturers and insurers and PBMs but maybe between insurers and their beneficiaries and so that raises issues both under the Federal and the Connecticut Constitution.

SENATOR LESSER (9TH): Appreciate those answers and appreciate your willingness to work with us on the other parts of the Bill in particular.

Representative de la Cruz.

REP. DE LA CRUZ (41ST): Thank you and Control -- Controller Lembo was in earlier about this Bill and this is going off from what we've been talking about. The piece where he mentioned -- and I think what's driving the whole discussion about power together, bigger negotiating power; can you explain 'cause a lot of folks ask me all the time, why is it that a drug made in the United States of America that is shipped up to Canada, almost a half or a third of the price, for us to go on -- we have folks you know, people crossing borders to go get cheaper
prescriptions. What piece of that that he talked about, the possibility of us coming in -- into some kind of agreement with a foreign country, to me that -- that -- so it's already been shipped. It just, that part is hard for me and when -- is that something that you would support or the group would support?

KELLY RYAN: Well so, it -- going back to kind of misconceptions. I think the idea and you talked about the importation fees and wanting to take a closer look at that, and there's a lot of confusion in this space, the idea, especially in those of us that are not all that far from Canada; I'm from upstate New York. People driving up -- drive up for the weekend all the time, and so this idea that I'm just going to drive across the border and go to a Canadian pharmacy and pick up my medication and come back, that is not really how these like broad-state based or nationally based reimportation programs work, right? So, and the Canadian government has expressed concern about that. They say we don't have any regulatory authority over whether drugs are shipped in from another country just to be what they call -- it's trans-shipment is the term they use. So it comes into Canada. It sits in a warehouse in Canada and then comes into the United States. These are not the drugs that are sitting on the shelves in the Canadian pharmacy and that's where we get very concerned about safety programs. 'Cause the US has a very close system for regulate. We track every step of the process so that we know the drugs are legitimate and we know that they're safe and there's a lot of concern that this would -- would erode that and that's not just us saying that. Frankly the Federal Government has the authority to do this.
They have for a very long time. But they have to ensure that the drugs are safe and they would -- they would produce cost savings. No FDA Commissioner, either democratic or republican has done this in the decades that had this authority because of that concern.

REP. DE LA CRUZ (41ST): Okay, thank you.

KELLY RYAN: Uh-huh.

REP. SCANLON (98TH): Thank you Representative. Any further questions? If not, Kelly, thank you very much for being here today.

KELLY RYAN: Thank you.

REP. SCANLON (98TH): Next up is Dave Benoit.

DAVE BENOIT: Hello Mr. Chairman, Scanlon and Lesser, distinguished members of the Committee. I'm David Benoit a pharmacist. I work for a buy-in group from Northeast Pharmacy Service Corporation which brings together 120 independent community pharmacies here in Connecticut as well as others in four New England states. We provide services in store by professional field pharmacy consultants in the businesses of the Independent Community Pharmacists in Connecticut. We have a Connecticut-based representative. We understand these businesses from the inside out, so we're not from a think tank. We're actually hands-on business partners with people running independent community pharmacies.

There are many special services being provided by independent community pharmacies. Our limits are affordability, our budgets and so I list them here. They're submitted in my testimony. As an industry
segment, almost down to the last store we cannot afford to participate in this state employee prescription program. We think that within the budget of the state prescription employee prescription program that there are rebates monies, there are re-billings, there are all kinds of opportunities to take some of those funds, reduce patient's exposure, increase pharmacy participation, make us stronger employers and expand and solidify the local tax bases of these community pharmacies.

In Section IV we read about the expansion from state employees to cities and towns now to private enterprise and we wonder if someone can explain to us what our role and opportunity would be. We would look forward to participating as I just describe in an expansive way to offer these many services to folks.

We also think that it would be very, very important while we're taking this opportunity to look at prices. Also we are very, very supportive of the section on DIR which is clear to us. We would like to make them timely so we would know what we got paid when we get paid, not a year and a half later. We would also like to have the DIRs make sense and if their based as performance programs I would like to have them have goals that are achievable. I would like the measurements to be applied to community pharmacies and not take hostage measures which are intended to measure quality in health plans, which is where we are today. So we're being unfairly measured.

We believe that transparency is important and there's a National Counsel of Insurance Legislatures model legislation for pharmacy benefit and manager
licensure, regulation, reporting, encouraging, trans -- and supporting transparency. We think being paid fairly is very, very important and we have unsuccessfully submitted MAC legislation under industry consensus and come up against a fiscal note. I think under the umbrella of net costs that we're talking about here that MAC legislation could be revived and included in that and I refer to last year's Bill.

We think it's very, very important to be able to provide quality care services at an affordable price to all of Connecticut's residents, to our neighbors, to our friends, to our -- to our local communities. An investment in us brings back out of state corporate profits and expands the tasks and labor base of local small business. There's much work to be done and much to understand. We look forward to the opportunity to work to be participants and valued partners in the new programs. Thank you for your time and attention.

REP. SCANLON (98TH): Thank you very much for being here today. And questions from the Committee? Representative Vail.

REP. VAIL (52ND): Thank you, Mr. Chairman. Good afternoon. So I heard everything you said but I had a hard time dissecting whether you support or don't support this Bill.

DAVE BENOIT: I'm here to testify. (Laughing)

REP. VAIL (52ND): You're here to testify? Okay. Because there's other written testimony submitted the Connecticut Pharmacists Association and they represent a thousand pharmacists and they are submitting testimony in support of the Bill and so I
was just curious -- I was trying -- trying to get a grasp.

DAVE BENOIT: Well I --

REP. VAIL (52ND): Do you -- do you think it's good and you want to make changes or you just?

DAVE BENOIT: I wish I knew what it was.

REP. VAIL (52ND): Okay. That's fair.

DAVE BENOIT: So I would -- I would work wholeheartedly to make it flesh out to be something we can all work together to work well. I don't represent community pharmacists, chain pharmacists, hospital pharmacists, managed care pharmacists. I represent 120 independent community pharmacies here in Connecticut who are in the business of filling prescriptions and caring for people.

REP. VAIL (52ND): Okay.

DAVE BENOIT: That's a different business base.

REP. VAIL (52ND): Okay.

DAVE BENOIT: Than the Connecticut Pharmacists Association.

REP. VAIL (52ND): So you're concerned but you have no position? Would that be fair? You have no position then on this?

DAVE BENOIT: I would like to -- I would like to say we're in support of it, we're in -- except for the details and when more is known we would like to very enthusiastically support the right product, yes.

REP. VAIL (52ND): Okay. All right. Thank you.
REP. SCANLON (98TH): David if I may ask you, on the DIRP specifically.

DAVE BENOIT: Okay.

REP. SCANLON (98TH): Do you feel like if we are to pass this legislation and address the DIRPs do you think that would help us keep some of your members that are the smaller independent pharmacies open and in business?

DAVE BENOIT: I think it would very much attenuate some disastrous financial consequences that have been accruing because DIR's in 2016 were one number, they doubled in 2017 and then they doubled again in 2018, which makes them four-fold. And so to put meat and potatoes on that, a store doing a million dollars a month and filling prescriptions, which is $12 million a year, that's a lot of money; might have $350,000 in DIR fees, which they couldn't wholly anticipate in 2016. Seven hundred -- or what it is? 150,000, 400,000, 800,000 and the run rate so far this year is a million-two. These are real numbers from a real business.

REP. SCANLON (98TH): Thank you. Any further questions? Seeing none, thank you very much for being here today.

DAVE BENOIT: Thank you.

REP. SCANLON (98TH): Jill Zorn followed by Nora Duncan.

JILL ZORN: Thank you, Representative Scanlon, Senator Lesser, Senator Kelly and members of the Committee. I'm here today on behalf of Universal Healthcare Foundation of Connecticut and we're here to support House Bill 7174. Connecticut has been a
leader among states trying to address the problem of unaffordable prescription drugs and we have a lot to be proud of. We've already talked today about the fact that last year the Connecticut General Assembly passed a Bill promoting major transparency legislation so that the state can collect data that will help with future regulatory efforts to reign in prices. But transparency legislation, while an important first step, takes time to produce results. Meanwhile drug manufacturers are raising prices twice a year on most brand-name drugs and the pharmaceutical industry continues to rake in record profits and spends more of our hard-earned dollars on lobbying and now marketing than on research and innovation.

Connecticut residents cannot wait. People are suffering every day in our state because they can't access the medications they need to survive and to thrive. A poll conducted by Altarum's Healthcare Value Hub in 2018 found that 20 percent of residents are rationing their medicine. Either cutting bills in half, skipping a dose or not filling a prescription at all, and I'm sure many legislatures hear regularly from their constituents about the challenges they face to afford prescription drugs and the negative impact it is having on their health.

In my role as Senior Policy Officer at the Foundation I monitor what Federal Government and other states are doing to address rising prescription drug prices. And while there's a lot of activity in Washington right now, it's unclear which of the many ideas under consideration will actually move forward and make a difference.
Meanwhile the laboratory of the states is responding to the fact that people need real relief.

One of the reasons prices are so high in Connecticut and the United States is that our negotiating powers fragmented among many insurers, PBMs, self-insured employers and government programs. HB 7174 proposed to address that problem by allowing state residents to benefit from the negotiating power of the state employee health plan. We support the Controller's effort to offer an option to municipalities and self -- self-insured employers to allow their employees to purchase prescription drugs at the price negotiated by the State Employee Plan. With the rapid shift to plans that have high deductibles and plans that rely on co-insurance, employees are paying more and more of the cost of their prescription drugs directly so they will clearly benefit from these lower prices.

We also support the creation of a discount card that could allow un-insured and under-insured individuals who are paying out of pocket for their prescriptions to buy them at the price negotiated by the state employee health plan rather than at list price.

Finally, it is certainly worth a try to investigate the possibility of importing drugs manufactured in other countries into our state so that we can benefit from much lower price tags. Ultimately though we need to fight for lower prices in our own state and country. That is why it is so gratifying to see a Bill that seeks to leverage the bargaining power that we already have in the state employee health plan, to benefit more Connecticut residents. Thank you.
REP. SCANLON (98TH): Hi Jill, thank you so much. Any questions from the Committee? If not, thank you. Nora Duncan.

NORA DUNCAN: Hi. Thank you very much for having me here, Representative Scanlon. I'm sure Senator Lesser will be back and thank you everyone. AARP in Connecticut is here today to speak in favor of House Bill 7174, AN ACT CONCERNING PRESCRIPTION DRUGS. I'm not going to read my testimony. It's submitted online as is a lengthy publication by AARP's Public Policy Institute about trends in retail prices in brand-name prescription drugs widely used by older Americans for the -- it's a 2017 year ends update so you're going to find a lot of trends the people are talking about today from a well-respected institution at AARP.

I'm here today as an advocate, not an expert. I don't claim to be an expert in prescription drugs but what I do proclaim to be an expert in is hearing from AARP members of which there are nearly 600,000 in Connecticut, almost universally with messages of concerns about the costs of prescription drugs. We have folks who are wealthy and folks who are not at all wealthy in our membership and universally they find this to be a problem. In particular you know as well as I do that someone on a fixed income, someone trying to live on Social Security and maybe a small pension or a little bit of retirement savings, are going to be the people most effected by the high cost of prescription drugs. And the average older American takes 4.5 prescription drugs each month. There are very few things that people agree on. More than this, we show in the 80-90 percent agreement range across party lines and
across age ranges that something needs to be done and the government needs to be involved in that and that regulation is actually the only thing that's going to help.

There are no single solutions to the rising cost of prescription drugs and 7174 doesn't do it all and you're going to see in my testimony from recommendations but I also just want to point out that while there is a lot of really interesting stuff happening at the Federal level, this needs to be a Federal and state solution together. The Feds aren't going to do everything and we might not be able to do everything but if we can all be working on something with the same agreement that they -- PhRMA agreed, and I'm not making bones about that, needs to be put in check and in balance with the needs of people, we're going to get to some common sense solutions.

I brought my Epi Pen and now Representative de la Cruz is not here for my prop, but -- so I don't leave home without this because every time I eat something that I'm not 100 percent sure about it is a Russ -- game of Russian roulette. He needs to get his Epi Pen filled so when he's back, tell him that. You know my volunteer State President who just went on Medicare will tell a story about how her Epi Pen costs went from you know 100 and change a month to 12 -- I mean a year to $1200 a year overnight as did many people's. It's outrageous. This is not a new technology. I've had one of these in my purse for a really long time but it's the only prop I have in my purse that I can share with you today.

You know, if the inflationary rises in prescription drugs versus anything else we pay for are
astronomical and unacceptable and in the time is now to say what are we going to do about it? Like I said, I'm not an expert, I'm an advocate. I do have experts in my policy offices in D.C. who are working with states across the country and with the Federal Government who I am happy to offer up as resources for anything you need to try to make this Bill the best Bill it can be. And with the state and Federal agreement we have across the board, I know this can be a bipartisan effort. I look forward to it being a bipartisan effort. There's not a one of you that didn't go campaigning that didn't hear about this and we all know it. As -- as we heard, many of you are experiencing the same thing. So any asset that we can be, I plan to be there to do that and I appreciate this Bill and the effort behind the whole thing.

REP. SCANLON (98TH): Thank you, Nora for being here today and for joining us earlier this morning and sharing some of the story that you heard from your members. Any questions from the Committee? Thank you.

NORA DUNCAN: Thank you.

REP. SCANLON (98TH): And we'll tell de la Cruz to come see you for an Epi Pen, yeah. Next up is Michelle Rakebrand from CBIA.

MICHELLE RAKEBRAND: Good afternoon again to the distinguished members of the Insurance Real Estate Committee. CBIA is opposed to House Bill 7174. Like your constituents we are no strangers to know that our membership is very concerned about the high cost of healthcare that is put on employers. Currently prescription drugs take up approximately
10 percent of the total cost of healthcare spending in the United States and the Center for Medicare and Medicaid Services has projected that retail prescription drug costs will be the highest projected growth category in healthcare spending in the coming years.

Pharmacy Benefit Managers and the industries and the experts have worked to reduce the cost of prescription drugs to both employers and employees. They are projected to be able to save approximately 30 percent on average on drug costs, which over the next decade will amount to $654 billion. They're able to realize these savings by creating a select network -- network of affordable pharmacies, encouraging the use of generic medications, negotiating rebates for manufacturers and negotiating discounts from drug stores and managing high cost special pain medications.

In terms of the -- how it works economically, BPMs aggregate demand to gain leverage in the market and on a scale that's something that can't be done by the State of Connecticut but know the Controller did speak to this point earlier today.

Something else our members are concerned about are the fees that are associated with this program, and we appreciate that pursuant to the language of the Bill the fees would only be applied to those two fees who participate in the program on -- and we would just like to make sure that going forward that those fees aren't expanded to small employers or individuals who are outside of the participating market. And I am happy to answer any questions that you may have.
REP. SCANLON (98TH): Thank you, Michelle for being here today. So obviously I think you were in the room when the Controller held up a copy of your quote from the article. Wondering if you could -- or if you're willing to respond --

MICHELLE RAKEBRAND: Sure.

REP. SCANLON (98TH): To what he said about that.

MICHELLE RAKEBRAND: Sure. So we see that as, I do call it a government run program and the Controller did say that he didn't feel it was a government run program; that the government was more going to facilitate and pick a PBM to contract with to carry out an elective program for anyone who would like to participate. We still see that as pretty hefty government participation, especially -- Connecticut is very innovative in the healthcare market and the insurance market and we understand what they're trying to accomplish by doing this. I don't know if a government activity in this sense is going to accomplish that goal necessarily.

REP. SCANLON (98TH): Okay. How many businesses do you represent in the state?

MICHELLE RAKEBRAND: About 7,000-8,000.

REP. SCANLON (98TH): 7,000? Okay. Of the 7,000 have you done any communication with your members to sort of ask them what their biggest concerns are with regard to the cost of healthcare? Is that something you've actively polled your members on?

MICHELLE RAKEBRAND: We have, yes. Uh-huh.

REP. SCANLON (98TH): And were the results of that, of the 7,000 the majority then had experienced
concerns about the rising cost of their -- healthcare costs in general but also drugs?

MICHELLE RAKEBRAND: Sure. So we generally hear from members that their biggest concerns for healthcare costs surround mandate. They feel that mandates are what drive up costs and even though prescription drugs certainly contribute to the overall cost of healthcare, that's not what they're necessarily the most concerned about in terms of healthcare costs, especially for the smaller employers.

REP. SCANLON (98TH): So just to clarify, with all due respect, I'm just asking these questions.

MICHELLE RAKEBRAND: Sure.

REP. SCANLON (98TH): So if I went around to the 7,000 businesses and asked the front line, you know men and women that are you know making widgets and doing things, what their biggest concern would be, you think it would be mandates and not the cost of their health insurance?

MICHELLE RAKEBRAND: It would be the healthcare mandate that they believe drive up the cost of their health insurance.

REP. SCANLON (98TH): Okay. And then on this specific plan that we're talking about, extends the state prescription plan to Connecticut private employers, do you feel like most employers right now of the 7,000 are having affordable time paying for those drugs or is that costing them more and more money to pay for the drug claims that are coming through employers?
MICHELLE RAKEBRAND: I find that our employers feel that healthcare costs are going up across the board and that does include prescription drugs.

REP. SCANLON (98TH): Okay. All right. I would just say as somebody who is proud to have been endorsed by the CBIA a couple of times in my -- in my time up here, that I look forward to hopefully finding a day that we can work together on this because that our constituents and the employers and employees that you represent are all looking for change and this is our you know, proposal to try to get to that place and I hope that we can try to find a way to work together on that because I think it's a shared problem that we both are facing and I'd love to see a shared solution that we can get agreement on, so thank you for being here today.

MICHELLE RAKEBRAND: Absolutely. Thank you.

REP. SCANLON (98TH): Any other questions from the Committee? Senator Lesser.

SENATOR LESSER (9TH): Unlike you, Mr. Chairman I haven't yet received my first CBIA endorsement (laughing) but there's always hoping.

REP. SCANLON (98TH): Try running unopposed and you can probably get it. (Laughing)

SENATOR LESSER (9TH): Always hoping for that too. So of your 7,000 members how many of them are PBMs?

MICHELLE RAKEBRAND: I do not have a great grasp on our membership offhand so I can't answer that but I'll get that answer to you, sir.

SENATOR LESSER (9TH): And you generally feel that your members are -- I guess CBIA as an entity. Are
they generally happy with the state of the prescription drug marketplace? Do you think it's working well the way it is right now?

MICHELLE RAKEBRAND: We don't hear too much from them on the prescription drug marketplace. We hear from them mostly on the overall cost of healthcare that they provide to their employees and the contribution especially through the cost sharing system.

SENATOR LESSER (9TH): Okay. So we hear a lot from families and from businesses out there that do seem to be concerned and do think we should be doing something on this issue so it's -- I'm surprised that they haven't -- they haven't reached out to you and maybe -- maybe you should poll them that and ask them if that's a concern. Because I -- you know I read your testimony and I heard what you said and I guess -- I guess I'm trying to square that away with what I'm hearing, which is that inaction is not an option. And even the pharmaceutical industry was saying a few minutes ago that they were willing to work with us on important and much-needed reforms to lower the costs of prescription drugs. So if you're saying that no change is needed, that to me is surprising and it doesn't square with my experience and my own -- you know, what I'm hearing from constituents and from businesses across the state.

MICHELLE RAKEBRAND: Sure. And I certainly appreciate that. I think CBIA feels that certainly change is needed. I don't know if we'd focus specifically on prescription drug to start out with if we're looking to immediately reduce costs just because they make up 10 percent of the overall market. We feel that costs are higher elsewhere
that we could reduce, but I think polling our members is a good idea and we will certainly do that. Thank you.

SENATOR LESSER (9TH): Well we have other Bills that are also attempting -- you know there are other cost drivers on the provider's side or the insurance side. I'm sure you could speak to your members there if they would prefer us to focus on that but I'm hoping that we can build on our past bipartisan work on prescription drugs as one of the major drivers of cost, and I think that concludes my questions. Thank you, Mr. Chairman.

MICHELLE RAKEBRAND: Thank you.

REP. SCANLON (98TH): Thank you, Senator. Any further questions? Seeing none, thank you.

MICHELLE RAKEBRAND: Thank you.

REP. SCANLON (98TH): Tom Swan? I think he has departed. So we will move on to Senate Bill 900, Courtney Larkin. Okay. Oh, Courtney, hang on a second. (Laughing). I know. I'm sorry. I know. So, okay. Sorry about that.

SUSAN HALPIN: Good afternoon, and thank you for your indulgence. My name is Susan Halpin. I'm with the Connecticut Association of Health Plans and I'm here to testify on House Bill 7174 in opposition. And I'll say at the outset, we would be glad to offer you the endorsement of the Association of Health Plans (laughing). You have my written testimony and I think as its indicative by some of the various testimony that you've heard today it was interpreted in many different ways and I was here to hear the Controller talk about his vision and intent
under the legislation and we are certainly happy to take a second look at it with that information before us. I think having only five days, five business days really to look at a Bill of this magnitude with this amount of potential intended and unintended impact is significant. I will say that we did view it as a transformational change, and I understand that may be part of what's intended. But I think that if you go in this direction you should not go in this direction quickly without understanding the full implications of what's before you. And we do think that if this legislation would pass it would create significant market disruption. And frankly we view this proposal and other proposals that are going to come before you this session as about single payer. And I think there's a lot of questions that you have to ask of both the Controller, of us, of PhRMA, of everyone in the context of this conversation that doesn't necessarily lend itself to you know, the next couple months of session given everything that's on everyone's table. I think you need to ask yourselves what impact this will have on the rate that health carriers have to file in just two months. And those are rates that will have to be paid by small employers come January 2020 and they have to look at the whole market when they're developing those rates, and look at what the various impacts are going to be to come up with that and you know, you may have the unintended consequence of significantly escalating those rates.

I think you have to ask about the impact this will have on the exchange, on much lotted product. While it may not be perfect, should we instead be looking at how to improve the exchange instead of building a
separate entity on top of it. And if we're going to build a separate entity on top of it, what does that mean for that entity? Are we just building a bureaucracy on top of a bureaucracy? I don't know how Federal subsidies function within this framework, within -- I guess I heard the Controller say that it was a discount plan, and I certainly hope he didn't take offense to our testimony. I was a bit taken aback when you know he said that you know, folks haven't read the Bill. We had some very high-level folks read this Bill and they came away with a different interpretation of what it was intended to do.

So you know, I think that if you look at Medicaid as an example, it's subject to a lot of oversight and a lot of scrutiny and I think the Controller's office between the proposals that are before you, the State Employee Plan, the partnership plan, the MEHIP plan there is -- there is a lot of plans and policies that are now under the Controller's purview and I guess I would ask and we ask ourselves and its incumbent on this body to look at those programs and to take a pause and see if they are -- they are doing what we want them to do, what they're expected to do, what the cost benefit analysis is, what the impact on the private market frankly is. You know I don't hide from the fact that I'm up here representing the insurance industry here in the State of Connecticut and all the jobs that that insurance industry accounts for. Those are high-paying jobs that are high educated, you know highly-educated jobs that account for a lot of the income tax revenue in the state and we are of course concerned about what a consolidation of market power would mean under one entity or a few entities. We
think that a health competitive market is a way that we should approach this and would ask that you work with us in that endeavor.

If I -- I think we're all intrigued by the innovative approaches that the Controller is undertaking. He has a very innovative RFP out there for pharmacy at the moment. You know he's done some unique and challenging things and I think we all respect that and look forward to what the outcomes are around that, but I don't think that we would concur that just the undertaking of those initiatives should warrant putting them in state statute at this point in time.

And we fear quite frankly that if you do too much and those pilot programs, I'll call them that for lack of a better word, if they -- if they don't work you may find yourself without you know the carriers in the market to return to. So you know I throw that out just a cautionary tale. We've seen that in other places and I would just hope it would be something that you would consider as you move forward.

Just a couple of other things, you know points that folks were texting me while -- while conversations were ongoing here. You know I think it's important to point out you -- there's been a lot of questions about what the -- what the private market is doing wrong versus what the Controller might be able to do. I think we have to remember that the Controller in those plans are self-insured. And they are not bound by all the regulations and mandates that the fully-insured market is bound by. And I can tell you I know that firsthand because we get a lot of constituent matters that refer back to the State
Employee Plan around step therapy, around formulary changes. So when we look very carefully at what we can do to control the pharmacy costs for that small business market, I think we have to look inward a bit and say, are we allowing the tools and the mechanisms to be used in that small employer market? And with that I will conclude and I thank you for your consideration.


SENATOR LESSER (9TH): Thank you, Mr. Chairman. One of the recent trends we've seen in the industry has been consolidation ledgers between PBMs and insurers. Obviously a lot of this Bill speaks to PBMs and so I was wondering if you were wearing a PBM hate or an insurance hat or both and how you sort of draw the line between the two?

SUSAN HALPIN: Sure. You know I think whether a carrier is affiliated with a PBM or a carrier contracts with a PBM, I do see the issues as being linked no matter which hat you're wearing. I think the issues are largely the same; is providing for the tools for companies to manage that pharmacy benefit. I think there's been a lot of focus on integrated health and I think you -- they see some of that -- that market power block to bare as integration under those situations but I guess -- I guess you know I wear both hats depending upon the issue that's before me.

SENATOR LESSER (9TH): And certainly in many cases I imagine that those interests are aligned but I can imagine as well that the interest of insurers and PBMs that have not yet merged into something already have -- they may not be aligned? Is that -- is that
something that you see ever or are they always one in the same direction on this question?

SUSAN HALPIN: I'm trying to think. In the last year since the larger mergers have under -- undertaken I have seen a point at which we have diverged but you know, I do represent the Association of Health Plans so that is my purview.

SENATOR LESSER (9TH): So you know, on the one hand I'm hearing two different arguments. On the one hand you mentioned that this Bill, which I guess we should be flattered about is, would lead to transformational change in the path of the single payer, which is a lot more than I saw in it so I guess -- I guess who knew? But on the other hand, talking about how much less market power the Controller has relative to PBMs that are in the marketplace currently. So I'm trying to figure out, does this Bill everything or does it not, and if in fact the Controller doesn't have that much market power why is it so disruptive?

SUSAN HALPIN: I think part of what your sensing is the fact that we've only had five days to review it and perhaps our testimony embodies some of the broader discourse that's been transpiring in the building around single -- you know single payer, Medicaid buy-in, public option and perhaps viewed this legislation with that lens as well. And so I think that's probably the you know, what you're sensing from the industry. So -- now I lost my point. (Laughing) My apologies, so again, I think what you -- what you said is you were surprised that this Bill does as much as you -- you -- as much as we think it does. I think what you're -- what
you're sensing from the industry is conceptual in terms of the broader conversation that is going on.

SENATOR LESSER (9TH): So the other thing you mentioned was that the Controller might be at a competitive advantage because he administers a self-insured plan and I see the language that is sort of tied to the self-insured plans that are out there in the private sector as well, but that he's complying with the rules that apply to fully-insured plans, can you -- you sort of eluded to step therapy and the formulary, but are there specific -- are there specific mandates that apply to fully-insured plans that the Controller is not currently complying with?

SUSAN HALPIN: I am not an expert in the benefit structure that is under the Controller's office at the present time. I guess what I would say is he has flexibility that fully insured folks do not. And I think he eluded to that in his testimony earlier by saying he -- you know I don't -- I'm not going to do it as eloquently as he does; he's a -- he's a wonderful speaker but I think he eluded to you know, kind of looking at clinical pathways on certain drugs, those kinds of things and you know, he has that flexibility, he has that expertise within the PBM structure, etc. I just -- I guess I would say that the fully-insured market should be allowed to have that flexibility as well through their contracts with PBMs and others.

SENATOR LESSER (9TH): I understand that. I guess -- I've heard that argument I guess from -- from insurers before that they feel that there isn't a competitive marketplace because the Controller has the flexibility and you may not and I -- I guess -- I guess I hear that and yet when I -- my
conversation with the Controller and his office, they say that the practice of the Controller's office is to meet the same requirements. And that may not be a legal requirement, but you know certainly whenever we pass -- my understanding at least is that whenever we passed the healthcare mandate for example and the industry is kicking and screaming we also drag the Controller kicking and screaming to meet the same requirements. And so if there are differences I think that would be really important for the Committee in detail as opposed to just say in theory they could do this but in practice they're not.

SUSAN HALPIN: Sure. You know I think you raise a valid point, that there's continued conversation. I think probably you hear some of that from us relative to fiscal notes that come through the legislature -- you know through the process because often times what you will see in the fiscal note that there isn't an impact because the State Employee Plan does not have to pick up the mandate because they are self-insured. So, so therefore it doesn't look like it would have a fiscal impact. So I think -- I think there's a couple of different things that are going on in this conversation but that would certainly be one of them.

SENATOR LESSER (9TH): Well I -- then I'm going to ask you for your help on fiscal that's going forward because they all seem to anticipate that the state employee would plan to cover whatever -- whatever mandates that I'm working on, so. (Laughing). I would --

SUSAN HALPIN: I think there's been some revised ones a few times.
SENATOR LESSER (9TH): Well thank you that -- I think that concludes my questions. Thank you for sharing.

SUSAN HALPIN: Thank you.

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

REP. VAIL (52ND): Thank you Mr. Chairman. Good afternoon.

SUSAN HALPIN: Good afternoon.

REP. VAIL (52ND): This Bill is -- it's 250 lines long so I have some concerns about some parts of it but I'm having trouble seeing the problem with allowing the Controller to negotiate lower rates for people. It -- I think it's mainly that we require him, I would prefer allow him to negotiate things and then offer those to private businesses. I'm having a hard time seeing the problem with that concept. There's a lot more to this Bill than just that. Can you try to enlighten me why that would be a bad thing?

SUSAN HALPIN: I think at the --

REP. VAIL (52ND): I know I listened to all that. I know you kind of answer it, but --

SUSAN HALPIN: Yeah, I guess at the outset I would say we read the Bill but differently and we'll certainly a second look at it in the context of the conversation that has unfolded here today. But the second -- or the last section of the Bill certainly calls for a study around importation. I guess I would say that the language and the concepts are complex enough in the first couple sections of the
Bill that they would warrant study as well before embarking in that direction. So, so I think the questions you're asking me are good ones. I don't have the answers for you today but I think it's incumbent upon this body to ask and answer those questions before moving forward with a proposal.

REP. VAIL (52ND): That's fair. I mean again, if he has a leverage to lower rates for people and -- I think that's something we should at least, at the very least be investigating. So thank you.

SUSAN HALPIN: Thank you.

REP. SCANLON (98TH): Any further questions? Seeing none, thank you very much.

SUSAN HALPIN: Thank you very much as always.

REP. SCANLON (98TH): Courtney, it's showtime. You're up. (Laughing)

SUSAN HALPIN: And the endorsement stands.

REP. SCANLON (98TH): Yeah. (Laughing).

COURTNEY LARKIN: Good afternoon.

REP. SCANLON (98TH): Good afternoon.

COURTNEY LARKIN: Good afternoon, Senator Lesser, Representative Scanlon, members of the Insurance and Real Estate Committee. My name is Courtney Larkin and I am Vice-President of Government Relations at Travelers. Travelers' major base of operations is in Hartford and we're one of the leading US providers of property and casualty insurance for auto, home and business and we primarily place our coverage through independent agents and brokers. I'm here to offer some comments on Senate Bill 900.
In a perfect world, we would be seeking to eliminate appointments all together. We believe this is a process that is antiquated and has outlived its usefulness. It's from a time where we used to -- we used to appoint a handful of agents and now we literally appoint thousands. In this Bill there are no consumer protections lost. Agents are still licensed by the state. Companies are still licensed by the state and the DOI does not lose any authority.

Finally, this Bill does not contemplate any revenue loss for the state and so we urge passage of the Bill. Do you have any questions?

REP. SCANLON (98TH): Thank you very much. Any questions from the Committee? Senator Lesser, do you have any?

SENATOR LESSER (9TH): Yes, I do, thank you Mr. Chairman. You don't anticipate this will have any revenue to property insurance?

COURNEY LARKIN: No, we believe the agent appointments go to the General Fund but as -- I think as the Bill is written it's a little different than we were thinking but our -- our goal was to not have a revenue loss to the state.

SENATOR LESSER (9TH): Okay, great. Thank you.

REP. SCANLON (98TH): Seeing no further questions, thank you. Senate Bill 901, Aron Szapiro.

ARON SZAPIRO: Thanks very much Chairs Lesser and Scanlon and all members of the Insurance and Real Estate Committee for the opportunity to testify today on transparency in retirement plan lineups for a bit of change of pace here. For the record I'm
Aron Szapiro, Director of policy research at Morningstar. You've probably heard of us from star ratings for mutual funds but we're a global firm in 27 countries committed to helping investors reach their goals.

Enhancing disclosures for 403(b) plan investments and insuring these new disclosures can be accessed and analyzed by policymakers, third party advisers and researchers could dramatically improve the quality of investment options for teachers and other public servants. If nothing else, such a policy change would cast light on an important segment of the retirement savings market and help direct future reforms.

For 35 years Morningstar has illuminated investing for ordinary people. We have often highlighted the importance of transparency to help investors or those who are advising them, make good decisions. In helping ordinary people invest has become extremely important over the past three decades as the United States has shifted from a defined benefits system to a defined contribution system. As a result of this shift ordinary workers are largely responsible for their own retirement savings and most people, most investors are in fact ordinary people saving for retirement. In fact, according to our analysis of the 2016 Survey of Consumer Finances, 65 percent of all US households invest and the median income of these households was just $50,000 so we're not talking about you know, investors, we're just talking about ordinary people.

So I've got some really good news for the Committee. There's never been a better time to be an investor. For example, the asset-weighted average expense
ratio for all mutual funds which is the most common way most people invest, fell to 0.25 percent in 2017 and that was a continuation of a decades long decline. In fact in 2000 at the start of a new millennium the average asset-weighted expense ratio for mutual funds was double what it is today. And you know, reducing fees is the easiest way for investors to boost their returns and increase their long-term retirement security. Over decades small fees add up to thousands of dollars.

Turning from good news to bad, there's a key policy problem with transparency and date of 403(b) plans that makes it very hard to assess whether teachers or other public servants have access to best-in-class investment options or even appropriate investment options. What we do know about 403(b) plans is that they often provide a large number of choices, many of which may be expensive relative to other options commonly available in private sector define-contribution plans. For example, the cost of most investments subaccounts, at the least the ones we tracked, variable annuities that are common in 403(b) plans average around 1 percent. And that's just the sub investment accounts. You tack another 1 percent in other kinds of annuity fees, and that's before benefit riders, for a total cost of around 2 percent to invest in a -- in a typical variable annuity and 403(b) or about four times as much as investing in a mutual fund.

So I think enhanced transparency as SB 901 would bring would help for three years. First, public sector workers themselves would just benefit from clear disclosures on fees. They might be able to sort through some of their options. Second,
transparency in our experience always leads to better markets by revealing major price differences. Outside advisors, financial technology companies and other private sector competition can take newly-available data and use it to help public sector workers make better decisions. Lower cost competitors would be better positioned to demonstrate the advantages of their offerings. And third and perhaps most importantly, regulators could assess the extent to which 403(b) plans cost more than other options relative to the value of their investments and look at you know, whether other options such as 457 plan you know, based on its widely available might make sense. That concludes my prepared remarks. Just ten seconds over the bell here. Again, thank you for the opportunity to testify.


SENATOR LESSER (9TH): Thank you, Mr. Chairman and thank you, Aron for your -- for your testimony. I think this builds on some earlier legislation that I helped push forward in another role but I'm glad to see you up here testifying in support and I'm really trying to wrap my head around it. Just because we think of -- when we think of teacher's retirements we're thinking for the most part of defined benefits as in the State Teacher's Retirement System that exists out there but we're also seeing these 403(b) plans proliferate. Can you just explain a little bit more for the -- you know for the Committee members who may not be familiar with this, you know why that's happening and what's going on out there.
ARON SZAPIRO: Yeah, so I mean it -- it is true that of course you know, teachers in Connecticut are covered by defined benefit plans but as people move back and forth between career's, they're almost certainly not going to be covered by a defined benefit plan in another you know, with another employer. And so it becomes very important to have supplemental savings. I think that's true even for people who are career employees because if you have supplemental savings it gives you a lot more flexibility in your retirement. Defined benefit plans are great. They provide a steady stream of retirement income but having additional savings lets you kind of you know, plan out where you want to spend money in retirement and just provides a lot more -- a lot more flexibility. And again, a lot of people are moving back and forth between -- between jobs and so building up that nest egg early can be extremely important.

SENATOR LESSER (9TH): So you mentioned that there's some -- there's some bad options out there in the marketplace and the need for transparency. Why are there so many bad options in this space?

ARON SZAPIRO: You know one simple reason is that when framers of ERISA which the Federal legislation is covering, when retirement plans set it up in 1974, they covered private sector plans and they were focused on DV plans at the time and for you know a variety of reasons they didn't cover public sector plans. When we operate as a company in the ERISA covered 4019(k) space there's a lot of scrutiny on what's available. For example, a plan sponsor knows regulators are going to be looking to make sure I don't have too many options where I
overwhelm people, I don't have too few so that I'm restricting them from picking the right option for them, and there's a lot of scrutiny on those fees in those options. And what we usually see in 403(b) plans to the extent that we can see them is just kind of a platform with every investment under the sun. That's overwhelming and it's confusing and it puts a lot of sort of questionable investments to get onto the platform.

Another part of this is just history. Traditionally 403(b) plans could only have annuity options. That was expanded to include mutual funds. It doesn't include other kinds of things such as collective investment trusts, which tend to be a little bit cheaper, and there's sort of a irony to this. Because if you're covered by a benefit plan you're really probably the last person who needs a longevity benefit rider on a variable annuity. Right? If you're -- because you already had that longevity insurance coming from the defined medical plan. And so, you listen to your mismatch between who is getting access to you know, variable annuities and which workers might get the most benefit from them.

SENATOR LESSER (9TH): Thank you and I think we're -- we've been trying to copy some of the protections that already exist for 401(k) folks, the coverage by ERISA and sort of apply them to 403(b) plans. One of the components of this Bill is in response to I think questions from industry. We did designate a regulator for this in the insurance department to provide assurance to industry players that -- that they would be satisfying the requirements. You don't have any problems with that particular --
ARON SZAPIRO: No, I think that kind of certainty makes a lot of sense. The other thing that this Bill does is it -- is it cross references regulations in 26, USC 4485, which --

SENATOR LESSER (9TH): I don't know what that is.

ARON SZAPIRO: So the industry is broadly familiar with and those are -- those are the disclosure requirements that are already required for the millions of people inside ERISA covered 401(k) plans. And so that's an established standard. It works quite well. We know people are able to digest that information. You know, obviously who are not financially sophisticated will need to rely on -- on others to help them with that but that's a very robust, clear accepted and widely understood standard, so that makes a lot of sense.

SENATOR LESSER (9TH): And your testimony references a lot of data bout 403(b). Where are you getting the data?

ARON SZAPIRO: So to the extent that we can get data on that, we scrape it from the Securities and Exchange Commissions IARD system but I should caution you we -- you know I mention that there's not a lot of transparency into 403(b) so I want to be clear, we have a partial picture at best unfortunately. Variable annuities are securities, so says the Supreme Court so we have data on it from the Security and Exchange Commission. Other kinds of products that end up in 403(b), fixed index annuities or mutual funds are really not disclosed anywhere so it's hard for us to get that. But we were using our database variable annuity finance.

SENATOR LESSER (9TH): Thank you.
REP. SCANLON (98TH): Any further questions from the Committee? Seeing none, thank you Aron for being here today. Next up is Jan Hochadel. Not here yet? I don't see Ed either so we'll come back to them. All right. So next up is 7170, Eric George. He's already ready.

ERIC GEORGE: I anticipated correctly. Hello Committee. This is Eric George. Senator Lesser, Representative Scanlon, thank you for having us here today. We are here to offer testimony on House Bill 7170 and we're here to oppose this. This would prohibit auto insurance from using post bind changes in auto insurance premiums. Basically when you reach out to an insurer to get a quote, you provide information to the insurer. The insurer relies on that information and provides the quote real-time. And afterwards the insurer usually has to go and corroborate the information, pertaining especially to driving history. Now not all the time are -- you know sometimes there might be some people withholding information but that's not usually what happens. Sometimes the system over at DMV is down. Sometimes you provide just a tiny piece of information incorrectly like say you give us the wrong license number, or you don't disclose all of the people who are your driving or on your policy. So what happens is, is if we are not able to then look at the actual driving history we cannot make -- cannot underwrite and set the rates properly. And also, in conversation that I was having with Representative Pavalock-D'Amato, I -- there are instances where insurance needs to be procured prior to us being able to do the full vetting of driving history. And if you want examples I can definitely get them to you, but there are instances where --
where we are trying not to have people drive naked if you will, so that they're not going without insurance. We want to make sure insurance is in place.

Those are my comments. I'm happy to answer any questions.

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

REP. DELNICKI (14TH): Thank you, Mr. Chair and good afternoon Mr. George. Just a couple of questions pertaining to the concept of prior to quote versus prior to binding checks on someone's driver's license because I've gone that personally. I know folks that have that have not had a prior to binding check and then find out basically like a sticker shock, they've secured insurance with a company and suddenly it's $200, $300, $400 higher than the quotation. Would you support, and I can understand not supporting prior to quote, but prior to binding a check at that point in time?

ERIC GEORGE: So I had that conversation with the proponents of the Bill as well. I have not had the conversation with my clients, my members. So I would have to -- we would have to continue the conversation from here. I'm only prepared to speak on the Bill as its drafted in front of me.

REP. DELNICKI (14TH): Which I understand, but just from a conceptual standpoint. Prior to binding would give you that information and quite frankly if they gave you the wrong license number you would get the information for someone who would state who it is and you would realize immediately that it's erroneous and that would ensure also protection of
the consumer and protection to the agent in wanting to give the most honest and accurate quotation.

ERIC GEORGE: And I would hope that that's exactly what is going on, but until we have the full conversation and I see the language, it's difficult to commit. It's impossible until we see the language that is being proposed. I mean I know I -- I know you want a more definitive answer. I'm not going to be able to give you one unfortunately.

REP. DELNICKI (14TH): But would you and your association be warm to the concept of prior to binding?

ERIC GEORGE: Again, as a concept --

REP. DELNICKI (14TH): As a concept.

ERIC GEORGE: In concept I'm not just going -- would never so no to anything. It's always in the details that we have --

REP. DELNICKI (14TH): Now we're not talking concrete foundations now.

ERIC GEORGE: I'm sorry. My brain was in a different place. (Laughing). We have -- we have to look at the language Representative Delnicki. But nice Segway. (Laughing)

REP. DELNICKI (14TH): Thank you.

REP. SCANLON (98TH): And with that I've turned it up. So let's just -- say it's for another day, Mr. Chair. (Laughing)

ERIC GEORGE: And we'll have this conversation at late night, I'm sure we will.

REP. SCANLON (98TH): Any further questions?
REP. DELNICKI (14TH): I don't have any further questions to the concept of prior to binding. Thank you, Mr. Chair.

REP. SCANLON (98TH): Any further questions from the Committee?

ERIC GEORGE: Thank you. And thank you for the liberty.

REP. SCANLON (98TH): Next up, Brad from PIA.

BRAD LACHUT: Thank you, Representative Scanlon and Committee. My name is Brad Lachut. I'm Director of Government Administrative Affairs for the Professional Insurance Agents of Connecticut, PIA. I'm here in support of 7170 with maybe some slight modifications. There currently is a practice in the state of some insurance carriers binding a policy after quoting and maybe a questionnaire offering one price to the consumer and then after the policy is bound, they run a driver history report, MVR which I will refer to it, and then that price will increase based on the findings of the MVI. We find this practice to be damaging to the industry and harmful to the consumer. It does not breed trust in the insurance producer or the insurance industry at all to be given one price at one time and have it raised afterwards. It's really the only time that happens, right? You don't buy a gallon of milk and then after you leave the store, somebody runs out and says, hey you owe me $5.00 more for that milk. It's just how -- it doesn't work that way.

The majority of the industry does these reports prior to binding of the policy so that the price that a consumer gets is the price they are actually going to pay. That's what we would advocate for.
The modification that we've asked for in this Bill is what Representative Delnicki was getting to. Instead of prior to quoting, we would ask prior to binding. Currently insurance producers will get quotes from all their carriers for consumers. That might be 10 or 15 different carriers. If they're required to run MVRs prior to quoting that would be a huge expense. I was just talking to one of our members who has a very fairly small book of auto business actually, about 200 clients. If he was to run MVRs on all 200 clients, MVR is about $20.00 a pop, that's 2,000 MVRs a year and $40,000 which is the cost of a staff salary. If the Bill was amended to require the MVR be done run prior to binding, that would significantly reduce the cost while not adding any difference to the consumer itself. The consumer is still getting the benefit of having that MVR run prior to the binding of the policy so they know the price they're getting without having the additional cost that really does not benefit them at all.

We are not saying the MVR has to be done totally -- if somebody decides not to run the MVR, they don't have to run it, whether it before or after. It's just that if an MVR is going to be run we ask that it be done prior to binding. That concludes my testimony, thank you.

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

REP. DELNICKI (14TH): Thank you, Mr. Chairman and thank you for your testimony there. Just as an aside typically if you get the lowest quote prior to binding and prior to quotation, you get the lower quote prior to actually checking the driver's
license and driving record, is that typically the lowest quote after you've actually done the motor vehicle department check on the driving record? Just from the standpoint of I realize there's a concern about people you know shopping around and then costing you folks a lot of money, a lot of time and a lot of effort and I ask it in that context.

BRAD LACHUT: You know I hate to speak in generalizations because the way that a -- an accident or a ticket might be rated by a carrier is different for each carrier so I generally say if the price is lower, you know if it increases it's still going to be low, you know what I mean? So that's -- I don't want to get into carrier practices. I don't know that information and I don't want to pretend that I do but, so, sorry it's kind of a non-answer. That's the attorney in me.

REP. DELNICKI (14TH): Which I can understand, especially if you don't have the statistics. But you are obviously welcoming to prior binding quotation though?

BRAD LACHUT: Absolutely. We would encourage that, absolutely.

REP. DELNICKI (14TH): And to get the real -- the number and that -- would that benefit the industry as a whole there from a reputation perspective?

BRAD LACHUT: I think absolutely. You know, again you are getting the price that you thought you were getting. I think the insurance industry has somewhat unfairly has a bad rap, maybe only less than attorneys. So anything that can help to remedy that is helpful.
REP. DELNICKI (14TH): Okay. Thank you, Mr. Chair.

REP. SCANLON (98TH): Thank you, Representative. Any further questions? Seeing none, thank you very much.

BRAD LACHUT: Thank you very much.

REP. SCANLON (98TH): We will now go back to 901, Jan Hochadel.

JAN HOCHADEL: Good afternoon, Senator Lesser, Representative Scanlon and members of the Committee. My name is Jan Hochadel. I am the President of AFT Connecticut and I help with more than 90 locals, more than 30,000 public and private employees including educators and it's on their behalf that I am submitting testimony in favor of Raised Bill 901.

Prior to becoming a teacher was an engineer. I worked in the private sector. I guess you could say I didn't know what I wanted to do when I grew up. Midlife I decided to make a career change and went into teaching. So I had 401(k)s going into teaching. I became a state employee for the vocational system and I was afraid that I wasn't going to have enough time in the system that I would have a livable pension from the state. So I chose to go to Voya and look at 403(b)s and I will admit, I did not look at what the percentage that they were taking out, I was merely going on somebody else's advise when I got my 403(b). So I was very supportive of last year, the legislation that was passed because I thought it did a lot of things.

First, it made people aware of the difference between a 401(k), which is the employer managed and the 403(b), which is the employee managed. And it
also made -- brought to light that there are some predatory and unscrupulous practices going on. And this Bill has been praised by the way, across the nation by AFT. So much in fact that I have been put on their 403 Committee, which I probably don't deserve, but thank you.

And in recent meetings this last fall at that 403(b) Committee meetings the discussion was, okay so we now have this standard that they have to do these things but where's the oversight and where's the authority to make sure that it's happening and I think this Bill takes care of that and so I support it very much. Thank you.

REP. SCANLON (98TH): Thank you very. Senator Lesser.

SENATOR LESSER (9TH): Well thank you, thank you, Mr. Chairman and condolences that you're now on this Committee. Sometimes we're on entirely too many Committees in this building, so I feel for you. But no, I appreciate your testimony and support. It's not often that you see the insurance industry, teachers and outside folks all moving the same -- same direction so I think -- it sounds like this is about consumer approach. So this Bill, one of the things that the Bill does obviously it does try to designate a regulator at the -- at the request of the industry, which is a good sign. But it's also trying to provide additional transparency to teachers by -- and other folks with 403(b) plans having central repository of information, and you think that would be helpful as those people are trying to figure out whether they get -- they're getting a good plan offering through Voya or whoever is out there in the market.
JAN HOCHADEL: Yeah, and my teachers thank you very much for that.

SENATOR LESSER (9TH): Sure. Thank you so much and thank you for being here.

JAN HOCHADEL: Thank you.

REP. SCANLON (98TH): All right. On to 7171, Jonathan Miller.

JONATHAN MILLER: Good afternoon. My name is Jonathan Miller. I'm the Chairman of the Securix Organization, which is 27 companies including the Connecticut Public Safety Company but public safety companies all around the nation. I'm also on the board of an organization called NLETS, N-L-E-T-S and NLETS is the organization that handles all information interstate for vehicle registration, insurance and all matters involving criminal conduct. It is how this state gets DHS and ICE but it also is the system that allows you to have access to interstate information.

I'm here to support this Bill 7101. I'd like to provide an addition submission next week because there's actually some additional things that we'd like to talk about in regards to making privacy stronger. We feel very strongly that --

REP. SCANLON (98TH): Excuse me, sir. Did you submit written testimony?

JONATHAN MILLER: I haven't. Can I still do that?

REP. SCANLON (98TH): If you can, yes. If you can get it to the Clerks we would appreciate that just so we can circulate to the members that weren't here today.
JONATHAN MILLER: Yes, sir. And by the way I should also more officially thank you, you know Representative Scanlon and Senator Lesser and also the members of the Insurance and Real Estate Committee. I really do appreciate the opportunity to be here today.

What we're suggesting has no cost or impact of any kind to insurers. It actually will help them. Vehicle insurers right now are disadvantaged a great deal by the way the systems sometimes work or doesn't. And especially in regards to interstate traffic. So I do want to be very clear about this. Nothing that we would ever suggest would have any impact financially or work effort to any vehicle insurers or to DMV. You actually have a really good system in place that you -- you actually passed a Bill recently, a few years ago. That system is in place now. The only things that I can offer to you is that it's not yet interstate. There are some privacy protections that we would strongly recommend. We feel very strongly that technology should be the slave not the master of mankind. This also -- this system, we would propose -- our suggestions would mean that it would be impossible to identify the driver of any vehicle. People feel very strongly about red lights and other issues, which we would agree with frankly. There's been a great deal of abuse. So we feel very strongly that whatever goes forward with this Bill should protect everyone 100 percent. NLETs is an example, runs 1.8 billion transactions a year. It has never once been comprised. It does not use names and addresses. We cannot use names and addresses in your system. We have a portal for the ACOU so the ACOU can see that no names or addresses are required. This is only
about objects. It's only about cars. It's not about people.

So again, we just -- we really appreciate the opportunity to speak about this. We feel that damage is being done to the families, to drivers, to policyholders and to the insurers and it needs to stop. And we are happy to be part of that solution. I thank you so very much and I'm open to any questions you may have.

REP. SCANLON (98TH): Thank you, Jonathan. Just -- so -- because I don't have your written testimony in front of me, just so I understand. So you are basically a contractor that state or entity can contract with to provide the data security, right?

JONATHAN MILLER: Yes, we would but it would be at no cost to the state.

REP. SCANLON (98TH): Okay.

JONATHAN MILLER: And I'm also here representing NLETS as an organization.

REP. SCANLON (98TH): Okay. So one of the things that when we -- when our Committee addressed this last time I -- my brother and mother-in-law are both police officers, my dad is a retired police officer and one of the things that is unique I think about Connecticut is that our computer police -- dashboard computer system doesn't have the insurance information whereas for example in New York State they do. Is it in your experience, do most states have law enforcement, do they have the ability to see the insurance information on their cruiser computers?
JONATHAN MILLER: Yes, they do sir and we do that -- that's part of the NLETS system, and there's different companies, CPI, DCI, Datanice and so forth but we port that information to those screens for every law enforcement agency and every officer at roadside.

REP. SCANLON (98TH): And in your experience and estimation does it help the members of you know, the men and women of law enforcement do their job by having that real time information on their computer as opposed to let's say if they pull me over, I hand them an insurance card and you know, who knows when that was issued or whether that's still current?

JONATHAN MILLER: It helps them enormously. I'll just share this with from -- I had a state policeman in another state, Missouri. I just heard this only yesterday. His comment was, it's horror -- it's horrifying to think that a young trooper on a cold dark night is approaching a vehicle. They know the registration, if it's out of state, they've already got them from NLETS in 1.2 seconds. They know everything except insurance. And when they're approaching the vehicle they do so with fear because the person is looking in their glove box or their seat, they have to be worried about their personal safety. It's a major issue. For instance and Georgia is an example right now. They use ALPR. They check it. The insurance report every night, which you don't need because you've got this already. You've got a really good system in place. You just need to link it up. But they don't ask for insurance at roadside. They don't need to. They already know what the insurance status is and that's what you need to hear.
REP. SCANLON (98TH): And it takes to your point, takes the whole glove compartment out of the equation which is something that usually makes situations escalate in my personal experience from my family members from you know, a situation that can get out of control quickly.

JONATHAN MILLER: Absolutely. It's not only more respectful for the officer, it's more respectful for the public because they're not feeling hassled. It's just better for everyone.

REP. SCANLON (98TH): Got it. Thank you, John. Any -- any further questions from the Committee?

JONATHAN MILLER: Thank you so very much. We really appreciate your time.

REP. SCANLON (98TH): Thank you. And please submit it to the Clerk so we can have your testimony.

JONATHAN MILLER: Absolutely, sir. Thank you.

REP. SCANLON (98TH): All right. On to 7172. Brad from PIA again.

BRAD LACHUT: Thank you, Representative Scanlon and the Committee. I am still Brad Lachut and I think I still work for PIA. I have not been notified I've been terminated yet so fingers crossed on that one. I am here to support Bill 7172. This would grant six continuing education CE credits to members of -- active members of Insurance Producer Association.

Recognizing that Connecticut Insurance Producer Associations promote professionalism, best practices, ethical compliance, continued education and now with the opportunities we feel that the awarding of CE credits is well merited. Quite
frankly, members of Producer Associations are more educated and more informed, more keyed in than those producers who are not involved. They are updated on the latest technology and laws and regulations, industry trends and this all leads to getting the best product possible to their clients. The point of continuing education is to make sure the producers are educated, know what they're selling and what they -- their customers are buying. By being a member of an association they are given another avenue of information in which to be informed. And just because they're getting information, not in a classroom setting where they need to take a quiz and raise their hand and use a #2 pencil or by sitting behind a computer screen, does not make that education any less relevant and maybe even more so because it is more real time and -- and more relative to their clients day to day.

So for that reason, the Association supports this Bill and encouraged the Committee to support it as well. Thank you.

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

REP. PAVALOCK-D'AMATO (77TH): So I'm a little confused. As an attorney, if I'm part of the Bar Association I don't get automatic CLE credits so I'm kind of confused as to why joining the Association converts to automatic, we call them CLEs or --

BRAD LACHUT: CEs, yeah.

REP. PAVALOCK-D'AMATO (77TH): CEs. So how does that exactly convert? And I understand what you said about they're going to have to be in a classroom and the -- the old fashion way of having
classes and learning but still, there's still something missing for me.

BRAD LACHUT: Yeah. So the Bill would not award CE credits to anybody who joined the Association. The join -- I being an attorney as well, just because I'm part of the Bar Association does not mean I get CEL just like you. It would award it for active members. That means they would actually need to be proactive and go out and either attend a conference, attend a seminar, attend a class so they're going to something that is educational that currently is not considered for CE because it's kind of outside the bounds of what we usually consider it but would -- would not afford something just for signing a check at the beginning the year and being a number.

REP. PAVALOCK-D'AMATO (77TH): Okay. That I like. And are you going to keep track, or would the Association keep track of that? Who keeps track of that and decides what qualifies as a CE credit?

BRAD LACHUT: My assumption would be that the insurance department would keep track of that because they currently award classes, CE credit now so I assume that would just fall on -- on them.

REP. PAVALOCK-D'AMATO (77TH): The department?

BRAD LACHUT: Yes, the insurance department, correct.

REP. PAVALOCK-D'AMATO (77TH): So they would decide what qualifies and then also keep track?

BRAD LACHUT: As far as keeping track I assume there would be probably some cooperation between the Association and the insurance department on that. We would have a list of our members and those who
attended our events. We obviously could share that information with departments to cross reference if you will, somebody that was at a qualifying event.

REP. PAVALOCK-D'AMATO (77TH): Is it possible that somebody joins and then -- then is not -- decides to no longer be a member part way through or how does that work with the Association? Like I think we -- we have a prorated amount I believe if we join after a certain date.

BRAD LACHUT: For -- like I say, for our Association they pay for a year. So they're paid for the year, there would be no way for them to drop their membership midyear if you will. Hypothetically speaking, a person could I guess do that but they again they still have to meet the qualifications of an active, which requires them to be dues paying, to be updated on code of ethics and also to attend an event.

REP. PAVALOCK-D'AMATO (77TH): Okay. Thank you.
BRAD LACHUT: You're welcome.

REP. SCANLON (98TH): Any further questions? Representative Delnicki.

REP. DELNICKI (14TH): Thank you, Mr. Chair and I just want to bring to your attention because I like the idea that you've brought forward but concern from the insurance department pertaining to the Bill would reduce conformity, would the NAIC standards and requirements, and let's make it more difficult for licensees to benefit from reciprocity? Which is a dimension I hadn't even thought of here until I read the testimony.
BRAD LACHUT: I guess I don't know. I can't speak -- I know that states currently have a reciprocity. You know, as long as the -- your home state --

REP. DELNICKI (14TH): Right.

BRAD LACHUT: Recognizes the -- the state you have your primary license in recognizes this then another state will as well. I don't know how this would impact that. I know that this legislation has also been pursued in other states as well so it could be a moot point at some point. If it is a point now, I can't speak to that more fully. I'm sorry. I certainly can look into it.

REP. DELNICKI (14TH): Yeah, if at all possible.

BRAD LACHUT: Absolutely.

REP. DELNICKI (14TH): Because I hate to see us do something conceivably that would cause problems to agents when it comes to that issue.

BRAD LACHUT: Absolutely.

REP. DELNICKI (14TH): Okay. Thank you, Mr. Chair.

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

BRAD LACHUT: Thank you. This is the last time you'll see me, I promise. (Laughing)

REP. SCANLON (98TH): All right. Final Bill of the day, 6091 Nate Moran.

NATE MORAN: Hello, good afternoon. Chairs, members and public, my name is Nate Moran. I'm an insurance agent in the Bridgeport area. I'm here to testify Bill 6091 as you mentioned. I believe that having Insurance Commissioner offer Spanish language
version of the examination to the insurance agent in the state will help our communities at multiple levels. For example, the first Bill will be able to help many talented individuals to face disadvantage because English is their second language. These individuals will be able to build a career path to support their family without having to depend on anyone to support their children and other way, they will be able to help the state through income taxes, right?

Second, secondly having them take the exam in their native language will create a better understanding of the concept of insurance for themselves and others for stability that we come -- that would come with being a trusted advisor. As an insurance agent or professional, it is important the customer understand in a plain language what professions -- sorry, in a plain language covers what they are buying from their insurance agents. With such a Hispanic community in the state of cities such as Bridgeport where a significant amount of the population are Spanish speaking, customers will benefit you know -- customers will benefit from having a Spanish agent that can properly provide a factor in their native language when they have questions concerning regarding their insurance policy.

Third, this Bill would help many companies such as Allstate, State Farm, the Moran Insurance Agency to recruit bilingual professionals to educate our clients when it comes to insurance and financial service. Our job is essential to the state economy with helping people manage their everyday risks. As an insurance agency owner in a Hispanic community
such as Bridgeport I strongly believe this state needs Hispanic professionals to assist -- assist Latin American customers for better understanding the importance of insurance without leaving them with doubt of any kind.

Basically to conclude, right? I just asking for all to be fair. We have multiple states that already offer the examination in Spanish. This exam is really tough and complex so this Bill would benefit the Hispanic community but not only that, also the State of Connecticut you know, through the fee that the state collects for the new license and the renewal license, and finally we will have more Hispanic professionals adding value to our community and to help people.

REP. SCANLON (98TH): Nate, thank you for your testimony and for coming here today. I know Representative Rosario has some questions but if you don't mind I have just a couple myself.

NATE MORAN: Please.

REP. SCANLON (98TH): Spanish as far as I can tell, just from a Google search is the second most commonly spoken language in the State of Connecticut; is that your -- ?

NATE MORAN: That is correct, yes sir, yeah.

REP. SCANLON (98TH): Yeah. And in the -- in the Department of Insurances testimony say that say that if English is not the primary language the person may qualify for attention time to complete the examination and as you just eluded to, it's a tough test. Would you say that if a person is more comfortable speaking Spanish as their first
language, that it would be easier for them to demonstrate their knowledge and skills by using their native language as opposed to their second language like English.

NATE MORAN: That's what I -- especially because the complex and this is exam I would say they build to make people fail you know, because it's a test. So definitely, you know the person would be able to -- you know the person would be able to study the material, go through the process and then go and take the exam. Definitely it would help tremendously. Not only would it help with basically taking the exam but also for themselves because they will understand better the concept of insurance and would be able to explain the customer you know, the you know, how -- how important insurance is. 'Cause insurance you know, I mean I can -- I can't think what a state or country without having insurance company be in the -- you know be in the corner. For example, we as insurance agent we have to explain to customers coverage and everything else but not only that but you know, think about for a second we identify when we go and we face them, right? If there's a car accident and somebody hurt, we go and we go to check for medical expense. Somebody become an agent, we deliver the check, right? So insurance is very important for the economy itself so we've got to make sure the agents, especially in the Hispanic population in Connecticut are able to -- you know understand the concept completely and be able to explain to a Hispanic, you know a Hispanic customer population in our area. So that whole idea, right? So be able to give insurance to these talented people that we have in cities such as Bridgeport, to be able to take the test and pass
understanding the concepts of insurance and how our community to help our people.

REP. SCANLON (98TH): Thank you, Nate. I just want to -- I want to thank Representative Rosario for bringing this to our attention. This is something I actually can't even believe that this was not something that's already offered from the Insurance Department and I want to let you know you've got a really good guy behind you. He's really working on this Bill and because of him, I think our Committee is going to take leadership action on this, so I want to thank him for that and thank you for being here today. Representative Rosario.

REP. ROSARIO (128TH): Thank you, Mr. Chairman. Good afternoon, Nate. Good to see you up here.

NATE MORAN: Thank you.

REP. ROSARIO (128TH): Just a few brief questions 'cause I know it's the last Bill. How many agencies do you have? How many people do you employ in the greater Bridgeport area?

NATE MORAN: I employ 20 people with our agencies. In Bridgeport we have three agencies and the Stanford area we also have an Allstate office.

REP. ROSARIO (128TH): So this wouldn't necessarily just impact Bridgeport? This would be a statewide economic driver?

NATE MORAN: Definitely. 'Cause we not only have Hispanic -- we not only have a huge Hispanic population in Bridgeport, you go to places like Stanford, even Hartford, this would help everyone. Every single city and town in our area.
REP. ROSARIO (128TH): So another question. You sell -- you say you sell Allstate. So if you were to take your test in English, but were to sell an Allstate policy do they provide materials in Spanish? Do they have specific campaigns, leaflets geared toward the Hispanic community?

NATE MORAN: Definitely. I mean even with Allstate Company every single -- take like package that is sent to our customers, the Spanish customer, we'll send a copy in English because we have to but also we will send a copy in Spanish if we know they speak Spanish. And send the brochures you know -- booklet, all that, we have in Spanish. Especially Allstate. They huge with Hispanic community. A lot of customers, at least in my book of business in Bridgeport at least 70 percent is Spanish.

REP. ROSARIO (128TH): With that being said, you think this would make Connecticut much more attractive to Spanish-speaking agents, insurance agents that may be practicing in New York, New Jersey, Massachusetts to obtain their license here in the State of Connecticut?

NATE MORAN: Of course, of course, 100 percent. And the main reason because we're so close to, for example New York. So New York already doing -- they already have those Spanish, you know those Spanish agents they don't really have to take the exam in English if they don't want to. They can -- they have the privilege of taking it in Spanish, in their own language. So that would attract all those towns maybe in Massachusetts and New York and all the areas of New Jersey to come down to Connecticut. But I'm -- but I’m that be more profit you know for city, town and state.
REP. ROSARIO (128TH): Thank you, Mr. Moran. In closing I just want to say I was involved Met Life Long Term Care about 15 years ago and I just want to say with everything there's cultural differences, there's cultural issues and when you're dealing with insurance, when you're dealing with a certain population just certain things that can be better communicated in your native language and especially when it comes to life, auto insurance. I think that we should be able to offer this opportunity to gain and have folks come to the State of Connecticut and move here and provide insurance so that we all become safe and provide for the economy for the State of Connecticut. So thank you, Mr. Moran for your passion and your hard work in the community.

NATE MORAN: Thank you, Representative Rosario, I appreciate it.

REP. SCANLON (98TH): Thank you both. Any further questions? Representative Pavalock-D'Amato.

REP. PAVALOCK-D'AMATO (77TH): Thank you and thank you for coming to testify.

NATE MORAN: Thank you.

REP. PAVALOCK-D'AMATO (77TH): Is there, and this might also be a question kind of for the rest of the panel as well. Currently, does it require English the way the statute is written now 'cause I can see that it says given in English or Spanish at the option of the applicant. Do you guys know whether, is there a requirement of English?

REP. SCANLON (98TH): I don't know whether the -- what the current statute reads. I just know that based on the department's testimony they only offer
it in English with the exception of if somebody is -- if English is not the person's first language, they testified that they would give that person extra time on the test. I don't know if that's specified in the statute though.

REP. PAVALOCK-D'AMATO (77TH): So I'm fine with giving the -- I think it's a good idea to give it in Spanish and other languages as well. I mean in New Britain there's a lot of Polish speaking people. So especially be able to better serve your clientele. My only concern is that if I recall back from Constitutional Law class you have to be careful of establishing any type of language in law. So because other it could be viewed as a restriction on your First Amendment which makes me think why there isn't English in there to begin with. So now when I see English or Spanish, if we could possibly check on that and get an opinion. That would make me feel better. Otherwise I think it's great as long as it doesn't violate our Constitution and the Federal Constitution. So thank you for testifying.

REP. SCANLON (98TH): Absolutely. I see our Deputy Insurance Commission, Josh Richman over there and I think that Representative Rosario and I can -- and along with you Representative Pavalock-D'Amato can try to figure that out.

REP. PAVALOCK-D'AMATO (77TH): So you don't have to answer that question by the way, it was more of a statement. It's something for us, don't worry. Okay.

NATE MORAN: All right. (Laughing)

REP. SCANLON (98TH): Any further questions? Representative Delnicki.
REP. DELNICKI (14TH): Nate, you spoke of other states that are actually doing this. Can you tell us which states just for our edification here.

NATE MORAN: Right. For example, New York. That's our native state that we have. Also California is doing it. There's a few others that I can't remember off the top of my head right now. More state why we speaking right now, they -- they implemented it. They do -- they're trying to provide this test in Spanish to uh --

REP. DELNICKI (14TH): And you see this as an opportunity to make it easier for folks to get insurance for their cars, for their homes, health insurance, etc.?

NATE MORAN: Definitely. And the reason is, let's say I'll give you an example, right? So if a Spanish person goes to an agency they don't have no one to speak Spanish and you know, they're pretty much going to say I need car insurance. That person might have a challenge explaining the coverage about it and what would bind the policy. Give then the policy. They would say, okay sign here please. Here we go, let me take your payment, thank you have a beautiful day. So now that person not really know what they're buying. Now that person might only have minimal coverage which is $25,000 in the State of Connecticut. God forbid that person get into a car accident and kill somebody or hurt somebody really bad. The only time they're going to learn about the policy and how that policy works when they file the claim. At that time it's too late. So that's why we need. If it would be nice and could be great you know if we're given the opportunity to a Hispanic agent to be able to take the exam and
pass obviously right? And then they have a chance to explain in a simple language how insurance works and how important insurance is in people's lives. Makes sense?

REP. DELNICKI (14TH): I fully understand as I have an associate that actually specializes in -- he's an attorney and he specializes in dealing with clients that speak Spanish and it's a big help for those clients to be able to actually communicate with someone who can explain to them in a much simpler fashion than I ever could, or anyone else who doesn't speak Spanish could ever do. So thank you for coming forward with that. Appreciate it.

NATE MORAN: No, thank you, thank you guys.

REP. SCANLON (98TH): Thank you again, Mr. Moran. Appreciate it. Representative Santiago.

REP. SANTIAGO (84TH): Thank you. I didn't sign up but I'm just going to be very brief. I want to thank you for this opportunity Chairman Scanlon and the rest of the members of the Insurance Committee. My name is Ezequiel Santiago representing the 130th District in Bridgeport. I'm here to testify in support of HB 6091, AN ACT REQUIRING THE INSURANCE COMMISSIONER TO OFFER ENGLISH AND SPANISH LANGUAGE VERSIONS OF EXAMINATIONS ADMINISTERED TO CERTAIN LICENSEES IN THE STATE. Reason I'm supporting this is same, same thing that this gentleman stated. He's a business owner in the community. I've seen him grow and he continues to do so. The community trusts him. Many Spanish-speaking people who had little trepidation of going to insurance companies. They walk in there and they feel comfortable. They see people that not only look like them but speak
the same language and when you're dealing with insurance, something that can get so technical, right? And the details, not being to express and elaborate those details can definitely cause for a lot of confusion or problems somewhere along the line.

This gentleman is looking to hire people and he is running a business. He's not going to hire people that don't know what they're doing just to do so. He's looking for qualified people that know and have the skills but some of them currently have that barrier, that they are not as proficient with English as they need to be to pass this test, even though they've done this work in their previous homes. You know, they know what the job is. So because of that I'm here in support of my friend, a business owner in my community and of the many people that can benefit this.

I know that there may be a cost associated somewhere down the line but when you add people to these types of jobs and they are paying state income taxes, it can definitely make that up and then some. So with that, I want to thank you for the opportunity to testify.

REP. SCANLON (98TH): Thank you, Representative. Thank you for being here and Representative Rosario as well. Any questions? Seeing none, thank you.

REP. SANTIAGO (84TH): Thank you.

REP. SCANLON (98TH): And that concludes our February 29th Public Hearing.